**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.**
**This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.cvtrust.org/plan-documents . For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cvtrust.org or call 1-800-288-9870 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $5,000 Individual/$10,000 Family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care is covered before you meet your deductible | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | No | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | $6,350 Individual/$12,700 Family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billed charges, health care this plan does not cover, pharmacy copayments for members enrolled in Medicare Part D prescription benefits | Even though you pay these expenses, they don't count toward the out–of–pocket limit. |
| **Will you pay less if you use a network provider?** | Yes, for a list of preferred providers, see www.anthem.com/ca or call 1-800-234-4333 and www.caremark.com or call 1-888-354-6390 | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from the provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | No | You can see the specialist you choose without a referral. |

All coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies. You may be responsible for paying additional out-of-network provider charges. You might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing).

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $60 copay/visit, for first 3 visits; additional visits 30% coinsurance after deductible | $60 copay/visit, for first 3 visits additional visits 30% coinsurance after deductible | For non-emergency medical and dermatology issues, contact MDLIVE for a $5 copay. 1-888-632-2738 or mdlive.com/cvt |
| | Specialist visit | $70 copay/ visit after deductible | $70 copay/ visit after deductible | |
| | Preventive care/screening/ Immunization | No charge | No charge | |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 30% coinsurance | 30% coinsurance | Preauthorization required |
| | Imaging (CT/PET scans, MRIs) | 30% coinsurance | 30% coinsurance | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.cvtrust.org/plan-documents | Generic drugs | $25 copay/30 day supply; $50 copay/90 day supply after deductible | 100% up-front cost; paper claim may be submitted to request partial reimbursement | Covers up to a 30 day supply (retail); 31-90 day supply (mail order and CVS retail for maintenance medications). Generic medications are required in certain instances |
| | Preferred brand drugs | $50 copay/30 day supply; $100 copay/90 day supply after deductible | 100% up-front cost; paper claim may be submitted to request partial reimbursement | |
| | Non-preferred brand drugs | $50 copay/30 day supply; $100 copay/90 day supply after deductible | 100% up-front cost; paper claim may be submitted to request partial reimbursement | |
| | Specialty drugs | Specialty copays follow the tier structure above. | 100% up-front cost; Not payable if not filled through Caremark's separate specialty network | Covers up to a 30 day supply. Preauthorization required. Specialty medications must be filled through CVS Caremark specialty mail order. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 30% coinsurance | 30% coinsurance | |
| | Physician/surgeon fees | 30% coinsurance | 30% coinsurance | |
| **If you need immediate medical attention** | Emergency room care | $250 copay/visit after deductible | $250 copay/visit after deductible | Copay waived if admitted |
| | Emergency medical transportation | 30% coinsurance | 30% coinsurance | |
| | Urgent care | $120 copay/visit after deductible | $120 copay/visit after deductible | For non-emergency medical and dermatology issues, contact MDLIVE for a $5 copay. 1-888-632-2738 or mdlive.com/cvt |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 30% coinsurance | 30% coinsurance | Preauthorization required. |
| | Physician/surgeon fees | 30% coinsurance | 30% coinsurance | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 30% coinsurance | 30% coinsurance | $70 Specialist Copay will apply, after deductible is met. Use MDLIVE for licensed therapist and psychiatrist visits via secure video ($70 copay will apply). 1-888-632-2738 or mdlive.com/cvt |
| | Inpatient services | 30% coinsurance | 30% coinsurance | Preauthorization required |
| **If you are pregnant** | Office visits | $60 copay/visit, for first 3 visits; additional visits 30% coinsurance after deductible | $60 copay/visit, for first 3 visits; additional visits 30% coinsurance after deductible | |
| | Childbirth/delivery professional services | 30% coinsurance | 30% coinsurance | |
| | Childbirth/delivery facility services | 30% coinsurance | 30% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 30% coinsurance | 30% coinsurance | 100 visit/calendar year limitation |
| | Rehabilitation services | 30% coinsurance | 30% coinsurance | |
| | Habilitation services | 30% coinsurance | 30% coinsurance | Outpatient OT coverage limited to home health care, hospice or home infusion provider |
| | Skilled nursing care | 30% coinsurance | 30% coinsurance | 100 day/calendar year limitation |
| | Durable medical equipment | 30% coinsurance | 30% coinsurance | Preauthorization required for amounts above $1,000 |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Hospice services | No charge | No charge | |
| If your child needs dental or eye care | Children's eye exam | No charge | No charge | Limited to the eye exam portion of a preventive visit. You may have other vision coverage not described here |
| | Children's glasses | Not covered | Not covered | You may have other vision coverage not described here |
| | Children's dental check-up | Not covered | Not covered | You may have other dental coverage not described here |

**Excluded Services & Other Covered Services:**

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Cosmetic surgery
- Dental care (Adult) (payable as a self-funded benefit, if bargained to be administered by CVT)
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Weight loss programs
- Routine eye care (Adult) (payable as a self-funded benefit, if bargained to be administered by CVT)
- Routine foot care

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Non-emergency care when travelling outside the U.S.
- Chiropractic care
- Acupuncture
- Bariatric surgery

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: CVT Member Services Department at 1-800-288-9870.

**Does this plan provide Minimum Essential Coverage? Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards? Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Language Access Services:** Para obtener asistencia en Español, llame al 1-800-288-9870. 如果需要中文的帮助，请拨打这个号码 1-800-288-9870.

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| The plan's overall deductible | $5,000 |
| Specialist copay | $70 |
| Hospital (facility) coinsurance | 30% |
| Other coinsurance | 30% |

**This EXAMPLE event includes services like:**
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| **Total Example Cost** | **$12,800** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $5,000 |
| Copayments | $0 |
| Coinsurance | $1,350 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$6,410** |

### Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| The plan's overall deductible | $5,000 |
| Specialist copay | $70 |
| Hospital (facility) coinsurance | 30% |
| Other coinsurance | 30% |

**This EXAMPLE event includes services like:**
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

| **Total Example Cost** | **$7,400** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $5,000 |
| Copayments | $560 |
| Coinsurance | $558 |
| *What isn't covered* | |
| Limits or exclusions | $163 |
| **The total Joe would pay is** | **$6,282** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| The plan's overall deductible | $5,000 |
| Specialist copay | $70 |
| Hospital (facility) coinsurance | 30% |
| Other coinsurance | 30% |

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| **Total Example Cost** | **$1,900** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,375 |
| Copayments | $210 |
| Coinsurance | $315 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,900** |

The plan would be responsible for the other costs of these EXAMPLE covered services.