

 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](http://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](http://www.cvtrust.org) or call 1-800-288-9870 to request a copy.

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



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)	
<b>If you visit a health care provider's office or clinic</b>	<a href="#">Primary care</a> visit to treat an injury or illness	\$60 <a href="#">copay</a> /visit, for first 3 visits; additional visits 30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	\$60 <a href="#">copay</a> /visit, for first 3 visits additional visits 30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	For non-emergency medical issues, contact MDLIVE for a \$5 <a href="#">copay</a> . 1-888-632-2738 or <a href="#">mdlive.com/cvt</a>
	<a href="#">Specialist</a> visit	\$70 <a href="#">copay</a> / visit after <a href="#">deductible</a>	\$70 <a href="#">copay</a> / visit after <a href="#">deductible</a>	
	<a href="#">Preventive care/screening/</a> Immunization	No charge	No charge	
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required
	Imaging (CT/PET scans, MRIs)	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="#">www.cvtrust.org/plan-documents</a>	Generic drugs	\$25 <a href="#">copay</a> /30 day supply; \$50 <a href="#">copay</a> /90 day supply after <a href="#">deductible</a>	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 <a href="#">copay</a> /30 day supply; \$100 <a href="#">copay</a> /90 day supply after <a href="#">deductible</a>	100% up-front cost; paper claim may be submitted to request partial reimbursement	
	Non-preferred brand drugs	\$50 <a href="#">copay</a> /30 day supply; \$100 <a href="#">copay</a> /90 day supply after <a href="#">deductible</a>	100% up-front cost; paper claim may be submitted to request partial reimbursement	
	<a href="#">Specialty drugs</a>	Specialty <a href="#">copays</a> follow the tier structure above.	100% up-front cost; Not payable if not filled through Caremark's separate specialty <a href="#">network</a>	Covers up to a 30 day supply. <a href="#">Preauthorization</a> 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% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$250 <a href="#">copay</a> /visit after <a href="#">deductible</a>	\$250 <a href="#">copay</a> /visit after <a href="#">deductible</a>	<a href="#">Copay</a> waived if admitted
	<a href="#">Emergency medical transportation</a>	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
	<a href="#">Urgent care</a>	\$120 <a href="#">copay</a> /visit after <a href="#">deductible</a>	\$120 <a href="#">copay</a> /visit after <a href="#">deductible</a>	For non-emergency medical issues, contact MDLIVE for a \$5 <a href="#">copay</a> . 1-888-632-2738 or <a href="#">mdlive.com/cvt</a>
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required.
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
	Inpatient services	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required
If you are pregnant	Office visits	\$60 <a href="#">copay</a> /visit, for first 3 visits; additional visits 30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	\$60 <a href="#">copay</a> /visit, for first 3 visits; additional visits 30% <a href="#">coinsurance</a> after <a href="#">deductible</a>	
	Childbirth/delivery professional services	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	100 visit/calendar year limitation
	<a href="#">Rehabilitation services</a>	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
	<a href="#">Habilitation services</a>	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	OT coverage limited to <a href="#">home health care</a>
	<a href="#">Skilled nursing care</a>	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	100 day/calendar year limitation
	<a href="#">Durable medical equipment</a>	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> required for amounts above \$1,000
	<a href="#">Hospice services</a>	No charge	No charge	

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)	
<b>If your child needs dental or eye care</b>	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](#).)

- |  |   |  |
|--|---|--|
| <ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care (Adult) (payable as a self-funded benefit, if bargained to be administered by CVT)</li> <li>• Hearing aids</li> </ul> | <ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Private-duty nursing</li> <li>• Weight loss programs</li> </ul> | <ul style="list-style-type: none"> <li>• Routine eye care (Adult) (payable as a self-funded benefit, if bargained to be administered by CVT)</li> <li>• Routine foot care</li> </ul> |
|--|---|--|

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

- |   |  |   |
|---|--|---|
| <ul style="list-style-type: none"> <li>• Non-emergency care when travelling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Chiropractic care</li> <li>• Acupuncture</li> </ul> | <ul style="list-style-type: none"> <li>• Bariatric surgery</li> </ul> |
|---|--|---|

**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](http://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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$5,000
■ <a href="#">Specialist copay</a>	\$70
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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#### In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$5,000
Copayments	\$0
Coinsurance	\$1,350
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$6,410</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$5,000
■ <a href="#">Specialist copay</a>	\$70
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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#### In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$5,000
Copayments	\$560
Coinsurance	\$558
<i>What isn't covered</i>	
Limits or exclusions	\$163
<b>The total Joe would pay is</b>	<b>\$6,282</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$5,000
■ <a href="#">Specialist copay</a>	\$70
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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#### In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,375
Copayments	\$210
Coinsurance	\$315
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,900</b>