

 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 ?	\$100 Individual/\$300 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 , office visits and prescription drug coverage are 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 ?	\$1,250 Individual/\$3,750 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 a 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	\$20 copay	\$20 copay	For non-emergency medical issues, contact MDLIVE for a \$5 copay . 1-888-632-2738 or mdlive.com/cvt
	Specialist visit	\$20 copay	\$20 copay	
	Preventive care/screening/immunization	No charge	No charge	
If you have a test	Diagnostic test (x-ray, blood work)	No charge	No charge	Preauthorization required
	Imaging (CT/PET scans, MRIs)	No charge	No charge	
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	\$7 copay /30 day prescription; \$15 copay /90 day prescription; deductible does not apply	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	\$15 copay /30 day prescription; \$35 copay /90 day prescription; deductible does not apply	100% up-front cost; paper claim may be submitted to request partial reimbursement	
	Non-preferred brand drugs	\$30 copay /30 day prescription; \$70 copay /90 day prescription; deductible does not apply	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	

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)	No charge	No charge	
	Physician/surgeon fees	No charge	No charge	
If you need immediate medical attention	Emergency room care	\$100 copay /visit	\$100 copay /visit	Copay waived if admitted
	Emergency medical transportation	No charge	No charge	
	Urgent care	\$20 copay	\$20 copay	For non-emergency medical 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)	No charge	No charge	Preauthorization required
	Physician/surgeon fees	No charge	No charge	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 copay	\$20 copay	Copay will apply if claim is billed as an office visit.
	Inpatient services	No charge	No charge	Preauthorization required
If you are pregnant	Office visits	\$20 copay	\$20 copay	
	Childbirth/delivery professional services	No charge	No charge	
	Childbirth/delivery facility services	No charge	No charge	
If you need help recovering or have other special health needs	Home health care	No charge	No charge	100 visit/calendar year limitation
	Rehabilitation services	No charge	No charge	
	Habilitation services	No charge	No charge	OT coverage limited to home health care
	Skilled nursing care	No charge	No charge	100 day/calendar year limitation
	Durable medical equipment	No charge	No charge	Preauthorization required for amounts above \$1,000
If your child needs dental or eye care	Hospice services	No charge	No charge	
	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

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)	
				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](#).)

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|--|---|--|
| <ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult) (payable as a self-funded benefit, if bargained to be administered by CVT) • Hearing aids | <ul style="list-style-type: none"> • Infertility treatment • Long-term care • Private-duty nursing • Weight loss programs | <ul style="list-style-type: none"> • Routine eye care (Adult) (payable as a self-funded benefit, if bargained to be administered by CVT) • Routine foot care |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

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|---|--|---|
| <ul style="list-style-type: none"> • Non-emergency care when travelling outside the U.S. | <ul style="list-style-type: none"> • Chiropractic care • Acupuncture | <ul style="list-style-type: none"> • Bariatric surgery |
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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	\$100
■ Specialist copay	\$20
■ Hospital (facility) coinsurance	0
■ Other coinsurance	0

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$100
Copayments	\$68
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$228

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$100
■ Specialist copay	\$20
■ Hospital (facility) coinsurance	0
■ Other coinsurance	0

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	\$7400
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$100
Copayments	\$612
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$55
The total Joe would pay is	\$767

Mia's Simple Fracture

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

■ The plan's overall deductible	\$100
■ Specialist copay	\$20
■ Hospital (facility) coinsurance	0
■ Other coinsurance	0

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	\$1900
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$100
Copayments	\$60
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$160