**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?** | Only for prescription drug coverage –<br>$0 Individual/$0 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, 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?** | See appropriate CVT medical plan SBC | 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.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 | See medical SBC | See medical SBC | Medical coverage provided by another vendor |
| | Specialist visit | See medical SBC | See medical SBC | Medical coverage provided by another vendor |
| | Preventive care/screening/ immunization | See medical SBC | See medical SBC | Medical coverage provided by another vendor |
| **If you have a test** | Outpatient Diagnostic test (x-ray, blood work) | See medical SBC | See medical SBC | Medical coverage provided by another vendor |
| | Outpatient Imaging (CT/PET scans, MRIs) | See medical SBC | See medical SBC | Medical coverage provided by another vendor |
| **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 | |
| | | | | |

| 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) | |
| | 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.<br><br>If you are enrolled in the PrudentRx Copay Program your out-of-pocket cost for covered specialty medications that are on the Exclusive Specialty Drug List will be $0 when you fill at CVS Specialty®. If you do not enroll in the PrudentRx Copay Program, you will be subject to a 30% coinsurance for those specialty medications. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | See medical SBC | See medical SBC | Medical coverage provided by another vendor |
| | Physician/surgeon fees | See medical SBC | See medical SBC | Medical coverage provided by another vendor |
| **If you need immediate medical attention** | Emergency room care | See medical SBC | See medical SBC | Medical coverage provided by another vendor |
| | Emergency medical transportation | See medical SBC | See medical SBC | Medical coverage provided by another vendor |
| | Urgent care | See medical SBC | See medical SBC | Medical coverage provided by another vendor |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | See medical SBC | See medical SBC | Medical coverage provided by another vendor |
| | Physician/surgeon fees | See medical SBC | See medical SBC | Medical coverage provided by another vendor |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | See medical SBC | See medical SBC | Medical coverage provided by another vendor |
| | Inpatient services | See medical SBC | See medical SBC | Medical coverage provided by another vendor |
| **If you are pregnant** | Office visits | See medical SBC | See medical SBC | Medical coverage provided by another vendor |
| | Childbirth/delivery professional services | See medical SBC | See medical SBC | Medical coverage provided by another vendor |
| | Childbirth/delivery facility services | See medical SBC | See medical SBC | Medical coverage provided by another vendor |
| **If you need help** | Home health care | See medical SBC | See medical SBC | Medical coverage provided by another vendor |

| 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) | |
| **recovering or have other special health needs** | Rehabilitation services | See medical SBC | See medical SBC | Medical coverage provided by another vendor |
| | Habilitation services | See medical SBC | See medical SBC | Medical coverage provided by another vendor |
| | Skilled nursing care | See medical SBC | See medical SBC | Medical coverage provided by another vendor |
| | Durable medical equipment | See medical SBC | See medical SBC | Medical coverage provided by another vendor |
| | Hospice services | See medical SBC | See medical SBC | Medical coverage provided by another vendor |
| **If your child needs dental or eye care** | Children's eye exam | See medical SBC | See medical SBC | Medical coverage provided by another vendor |
| | Children's glasses | See medical SBC | See medical SBC | Medical coverage provided by another vendor |
| | Children's dental check-up | See medical SBC | See medical SBC | Medical coverage provided by another vendor |

## 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.)**

- Over the counter medications
- Certain cosmetic medications
- Topical analgesic/pain patch
- Nutritional and dietary supplements
- Hair growth products
- Bulk powders, compounding bases and compounding kits
- Medical devices
- Blood and blood plasma
- Cough and cold products

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

- Fertility medications up to a lifetime maximum of $7,500

**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)

- **Generic drug copay** **$5**
- **Preferred brand drug copay** **$22**

**This EXAMPLE event includes services like:**

Prescription drug coverage only

See appropriate CVT medical plan SBC for medical coverage example cost

| **Total Example Cost** | **$12,700** |
|---|---|

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $10 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $12,690 |
| **The total Peg would pay is** | **$12,700** |

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

- **Generic drug copay** **$5**
- **Preferred brand drug copay** **$22**

**This EXAMPLE event includes services like:**

Prescription drug coverage only

See appropriate CVT medical plan SBC for medical coverage example cost

| **Total Example Cost** | **$5,600** |
|---|---|

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $300 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $2,100 |
| **The total Joe would pay is** | **$2,400** |

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

- **Generic drug copay** **$5**
- **Preferred brand drug copay** **$22**

**This EXAMPLE event includes services like:**

Prescription drug coverage only

See appropriate CVT medical plan SBC for medical coverage example cost

| **Total Example Cost** | **$2,800** |
|---|---|

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $10 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $2,790 |
| **The total Mia would pay is** | **$2,800** |

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