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/$200 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/$2,500 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 cost share 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	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 and dermatology issues, contact MDLIVE for a $0 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	Outpatient Diagnostic test (x-ray, blood work)	Non-Hospital: - 10% coinsurance Hospital: After deductible, Lab work $50 copay/ Imaging $75 copay Plus 10% coinsurance	Non-Hospital: - 10% coinsurance Hospital: After deductible, Lab work $50 copay/ Imaging $75 copay Plus 10% coinsurance	If you choose to use a non-hospital (e.g. physician's office, independent lab, imaging center that do not bill as a hospital) you will avoid the additional $50 copay for lab work and $75 copay for imaging services; Preauthorization may be required
	Outpatient Imaging (CT/PET scans, MRIs)	Non-Hospital: - 10% coinsurance Hospital: After deductible, $75 copay plus 10% coinsurance	Non-Hospital: - 10% coinsurance Hospital: After deductible, $75 copay plus 10% coinsurance	If you choose to use a non-hospital (e.g. imaging center, clinic, urgent care that do not bill as a hospital) you will avoid the additional $75 copay; Preauthorization required
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	See pharmacy SBC	See pharmacy SBC	Pharmacy coverage provided by another vendor
	Preferred brand drugs	See pharmacy SBC	See pharmacy SBC	
	Non-preferred brand drugs	See pharmacy SBC	See pharmacy SBC	
	Specialty drugs	See pharmacy SBC	See pharmacy SBC	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Non-Hospital: - 10% coinsurance Hospital: After deductible, $250 copay plus 10% coinsurance	Non-Hospital: - 10% coinsurance Hospital: After deductible, $250 copay plus 10% coinsurance	If you choose to use a non-hospital (e.g. ambulatory surgery center, endoscopy center that do not bill as a hospital) you will avoid the additional $250 copay; Preauthorization may be required

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)	
	Physician/surgeon fees	10% coinsurance	10% coinsurance	
If you need immediate medical attention	Emergency room care	Emergent visit - $100 copay / Non-emergent visit - $175 copay; Plus 10% coinsurance	Emergent visit - $100 copay / Non-emergent visit - $175 copay; Plus 10% coinsurance	Copay will be higher if emergency room is used for a non-emergent visit. Copay waived if admitted
	Emergency medical transportation	10% coinsurance	10% coinsurance	
	Urgent care	$20 copay	$20 copay	For non-emergency medical and dermatology issues, contact MDLIVE for a $0 copay. 1-888-632-2738 or mdlive.com/cvt
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	10% coinsurance	Preauthorization required
	Physician/surgeon fees	10% coinsurance	10% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay or 10% coinsurance	$20 copay or 10% coinsurance	$20 Copay will apply if claim is billed as an office visit. Non-Medicare members use MDLIVE for licensed therapist and psychiatrist visits via secure video a $0 copay. 1-888-632-2738 or mdlive.com/cvt
	Inpatient services	10% coinsurance	10% coinsurance	Preauthorization required
If you are pregnant	Office visits	No charge	No charge	
	Childbirth/delivery professional services	10% coinsurance	10% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	10% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	10% coinsurance	100 visit/calendar year limitation
	Rehabilitation services	10% coinsurance	10% coinsurance	
	Habilitation services	10% coinsurance	10% coinsurance	Outpatient OT coverage limited to home health care, hospice or home infusion provider
	Skilled nursing care	10% coinsurance	10% coinsurance	100 day/calendar year limitation
	Durable medical equipment	10% coinsurance	10% 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
- Non-emergency care when travelling outside the U.S.
- 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.)

- 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	$100
Specialist copay	$20
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$100
Copayments	$0
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$1,320**

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	10%
Other coinsurance	10%

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	$100
Copayments	$200
Coinsurance	$80
What isn't covered	
Limits or exclusions	$3,500
The total Joe would pay is	**$3,880**

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	10%
Other coinsurance	10%

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	$100
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$510**

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