

 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> ?	Medical and pharmacy combined \$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 plan 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> ?	\$7,000 Individual/\$14,000 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	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 preferred providers, see <a href="http://www.caremark.com">www.caremark.com</a> or call 1-888-354-6390	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">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 a <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 <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	See medical SBC	See medical SBC	Medical coverage provided by another vendor
	<a href="#">Specialist</a> visit	See medical SBC	See medical SBC	Medical coverage provided by another vendor
	<a href="#">Preventive care/screening/immunization</a>	See medical SBC	See medical SBC	Medical coverage provided by another vendor
<b>If you have a test</b>	Outpatient <a href="#">Diagnostic test</a> (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
<b><a href="#">Prescription drug coverage</a> is administered by CVS/Caremark</b>  <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="http://www.cvstrust.org">www.cvstrust.org</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.  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

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)	
				to a 30% coinsurance for those specialty medications.
<b>If you have outpatient surgery</b>	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
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	See medical SBC	See medical SBC	Medical coverage provided by another vendor
	<a href="#">Emergency medical transportation</a>	See medical SBC	See medical SBC	Medical coverage provided by another vendor
	<a href="#">Urgent care</a>	See medical SBC	See medical SBC	Medical coverage provided by another vendor
<b>If you have a hospital stay</b>	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
<b>If you need mental health, behavioral health, or substance abuse services</b>	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
<b>If you are pregnant</b>	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
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	See medical SBC	See medical SBC	Medical coverage provided by another vendor
	<a href="#">Rehabilitation services</a>	See medical SBC	See medical SBC	Medical coverage provided by another vendor
	<a href="#">Habilitation services</a>	See medical SBC	See medical SBC	Medical coverage provided by another vendor
	<a href="#">Skilled nursing care</a>	See medical SBC	See medical SBC	Medical coverage provided by another vendor
	<a href="#">Durable medical equipment</a>	See medical SBC	See medical SBC	Medical coverage provided by another vendor
	<a href="#">Hospice services</a>	See medical SBC	See medical SBC	Medical coverage provided by another vendor
<b>If your child needs dental or eye care</b>	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](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)

After deductible:

■ Generic drug <a href="#">copay</a>	\$25
■ Preferred brand drug <a href="#">copay</a>	\$50

This EXAMPLE event includes services like:

[Prescription drug coverage](#) only

See appropriate CVT medical plan SBC for coverage example cost

<b>Total Example Cost</b>	<b>\$72</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$11
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$61
<b>The total Peg would pay is</b>	<b>\$72</b>

### Managing Joe's type 2 Diabetes

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

After deductible:

■ Generic drug <a href="#">copay</a>	\$25
■ Preferred brand drug <a href="#">copay</a>	\$50

This EXAMPLE event includes services like:

[Prescription drug coverage](#) only

See appropriate CVT medical plan SBC for coverage example cost

<b>Total Example Cost</b>	<b>\$3,512</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,490
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$22
<b>The total Joe would pay is</b>	<b>\$3,512</b>

### Mia's Simple Fracture

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

After deductible:

■ Generic drug <a href="#">copay</a>	\$25
■ Preferred brand drug <a href="#">copay</a>	\$50

This EXAMPLE event includes services like:

[Prescription drug coverage](#) only

See appropriate CVT medical plan SBC for coverage example cost

<b>Total Example Cost</b>	<b>\$5</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$5
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$5</b>