The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you 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 http://whyuhc.com/csveba or by calling 1-888-586-6365. 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.healthcare.gov/sbc-glossary/ or call 1-888-586-6365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services 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?	For participating providers $3,000 individual / $6,000 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?	Copayments for certain services, premiums, balance-billing charges, and health care this plan doesn't cover.	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. See http://whyuhc.com/csveba or call 1-888-586-6365 for a list of participating providers.	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 a non-participating 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 participating provider might use a non-participating 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?	Yes, written or oral approval is required, based upon medical policies.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating 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 / office visit and $20 copay / Virtual visits by a designated virtual participating provider	Not covered	If you receive services in addition to office visit, additional copayments or coinsurance may apply.
	Specialist visit	$20 copay / visit	Not covered	Member is required to obtain a referral to specialist or other licensed health care practitioner, except for OB/GYN Physician services, reproductive health care services within the Participating Medical Group and Emergency / Urgently needed services. If you receive services in addition to office visit, additional copayments or coinsurance may apply.
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need drugs to treat your illness or condition Refer to your pharmacy plan for coverage details.	Tier 1	Not covered	Not covered	Refer to your pharmacy plan for coverage details.
	Tier 2	Not covered	Not covered	
	Tier 3	Not covered	Not covered	
	Tier 4	Not covered	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	None
	Physician/surgeon fees	No charge	Not covered	
If you need immediate medical attention	Emergency room care	$100 copay / visit	$100 copay / visit	Copayment waived if admitted.
	Emergency medical transportation	No charge	No charge	None
	Urgent care	$20 copay / visit	$50 copay / visit	If you receive services in addition to urgent care, additional copayments or coinsurance may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	None
	Physician/surgeon fees	No charge	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay / office visit and No charge for all other outpatient services	Not covered	Substance abuse outpatient services are covered at No charge.
	Inpatient services	No charge	Not covered	
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply to certain preventive services. Routine pre-natal care and first postnatal visit is covered at No charge. Depending on the type of services, additional copayments or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	No charge	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	None
	Rehabilitation services	$20 copay / visit	Not covered	Coverage is limited to physical, occupational, and speech therapy.
	Habilitative services	$20 copay / visit	Not covered	Coverage is limited to physical, occupational, and speech therapy.
	Skilled nursing care	No charge	Not covered	Up to 100 days per benefit period.
	Durable medical equipment	No charge	Not covered	None
	Hospice services	No charge	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	1 exam per year.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	No coverage for Dental check-ups.

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)
- Dental care (Child)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Routine eye care (Adult)

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 are: Department of Managed Health Care California Help Center, 980 9th Street Suite #500, Sacramento, CA 95814-4275 at 1-888-466-2219 or www.dmhc.ca.gov., or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol.gov/ebsa/healthreform. 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 on how 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: your human resource department, and the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program may help you file your appeal. Contact Department of Managed Health Care California Help Center, 980 9th Street Suite #500, Sacramento, CA 95814-4275 at 1-888-466-2219 or www.dmhc.ca.gov.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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:
Spanish (Español): Para obtener asistencia en Español, llame al 1-888-586-6365.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-586-6365.
Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 1-888-586-6365.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-586-6365.

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 participating provider pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) copayment	$0
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits *(pre-natal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$70**

Managing Joe's Type 2 Diabetes
(a year of routine participating provider care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) copayment	$0
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visit *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$4,400**

Mia's Simple Fracture
(participating provider emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) copayment	$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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$210**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-888-586-6365.

This is only a summary of the prescription drug benefits you will receive if you enroll in medical benefits offered by California Schools VEBA. This must be read in conjunction with the applicable medical summary of benefits and coverage document. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at express-scripts.com or by calling 1-800-918-8011.

Important Questions	Answers	Why This Matters
What is the overall deductible?	$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. Preventive care (if applicable) and prescription drug benefits 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, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	For the RX portion of your plan: $3,000 individual / $6,000 family. See your medical SBC for other out-of-pocket limits.	The out-of-pocket limit is the most you could pay in a plan 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-billing charges and prescription drug costs this plan doesn't cover.	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. See express-scripts.com/ or call 1-800-918-8011 for a list of participating pharmacies.	If you use an in-network pharmacy, this plan will pay some or all of the cost of covered services. Plans use the terms in-network, preferred or participating for providers in their network. This plan uses Express Scripts Advantage Network (EAN) for short-term drugs (up to 30 day supply), Express Scripts Smart90 pharmacy or Express Scripts Home Delivery for maintenance drugs, and Express Scripts Accredo for specialty drugs. See the chart starting on page 2 for how this plan pays by different providers.
Do you need a referral to see a specialist?	Not Applicable	Not Applicable

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

		What You Will Pay:		
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Not Applicable	Not Applicable	For information on whether this is a covered service and your cost if you use an In-Network Provider or an Out-of-Network Provider, refer to the separate Summary of Benefits Coverage (SBC) document that describes the Medical plan.
	Specialist visit	Not Applicable	Not Applicable	
	Preventive care/screening/immunization	Not Applicable	Not Applicable	
If you have a test	Diagnostic test (x-ray, blood work)	Not Applicable	Not Applicable	
	Imaging (CT/PET scans, MRIs)	Not Applicable	Not Applicable	
If you need drugs to treat your illness or condition More information about prescription drug coverage See express-scripts.com/	Generic drugs (Tier 1)	$10/$15 copay EAN/non-EAN retail 30 day supply; $20 copay Smart90 or Home Delivery 90 day supply	You must pay out-of-pocket and submit a claim online or download the Prescription Drug Reimbursement form at express-scripts.com by selecting Forms from the main menu under the Benefits. The plan will reimburse you based on the allowed amount less any applicable member copay.	For maintenance drugs, by the 4th fill members must be setup for 90 day supply with Smart90 or Home Delivery. Note: If you continue to fill a maintenance medication at a pharmacy other than Smart90 retail or Express Scripts home delivery after the 3rd refill, the copays will be twice what is shown for retail copays in the Network Provider column.
	Preferred brand drugs (Tier 2)	$30/$35 copay EAN/non-EAN retail 30 day supply; $60 copay Smart90 or Home Delivery 90 day supply		
	Non-preferred brand drugs (Tier 3)	50% w/copay of $40/$45 min and $175/$180 max EAN/non-EAN retail 30 day supply; 50% w/copay of $80 min and $350 max Smart90 or Home Delivery 90 day supply		
	Specialty drugs (Tier 4)	$0 copay SaveOnSP or applicable Tier 1, 2 or 3 copays for non-SaveOnSP	Not covered. Specialty drugs must be ordered through Express Scripts Accredo.	Specialty drugs that are covered but not part of SaveOnSP will have a Tier 1, 2 or 3 copay. Specialty drugs that are part of SaveOnSP will have a no copay if the member signs up with SaveOnSP before filling the script.

For more information about limitations and exceptions, see the plan or policy document provided with your open enrollment materials. If you need to request a copy of the applicable plan or policy document, please contact the VEBA Advocacy Team at 888-276-0250.

		What You Will Pay:		
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Applicable	Not Applicable	For information on whether this is a covered service and your cost if you use an In-Network Provider or an Out-of-Network Provider, refer to the separate Summary of Benefits Coverage (SBC) document that describes the Medical plan.
	Physician/surgeon fees	Not Applicable	Not Applicable	
If you need immediate medical attention	Emergency room care	Not Applicable	Not Applicable	
	Emergency medical transportation	Not Applicable	Not Applicable	
	Urgent care	Not Applicable	Not Applicable	
If you have a hospital stay	Facility Fee (e.g., hospital room)	Not Applicable	Not Applicable	
	Physician/surgeon fees	Not Applicable	Not Applicable	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not Applicable	Not Applicable	
	Inpatient services	Not Applicable	Not Applicable	
If you are pregnant	Office visits	Not Applicable	Not Applicable	
	Childbirth/delivery professional services	Not Applicable	Not Applicable	
	Childbirth/delivery facility services	Not Applicable	Not Applicable	
If you need help recovering or have other special needs	Home health care	Not Applicable	Not Applicable	
	Rehabilitation services	Not Applicable	Not Applicable	
	Habilitation services	Not Applicable	Not Applicable	
	Skilled nursing care	Not Applicable	Not Applicable	
	Durable medical equipment	Not Applicable	Not Applicable	
	Hospice services	Not Applicable	Not Applicable	
If your child needs dental or eye care	Children's eye exam	Not Applicable	Not Applicable	
	Children's glasses	Not Applicable	Not Applicable	
	Children's dental checkups	Not Applicable	Not Applicable	

For more information about limitations and exceptions, see the plan or policy document provided with your open enrollment materials. If you need to request a copy of the applicable plan or policy document, please contact the VEBA Advocacy Team at 888-276-0250.

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 prescription drugs.)
• Drugs dispensed by a hospital during an inpatient confinement • Most drugs that are covered as a medical benefit • Over the counter (OTC) drugs • Prescription drugs with an OTC equivalent • Experimental drugs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)
For information on other covered medical services and any limitations on medical coverage, refer to the separate Summary of Benefits Coverage (SBC) document that describes the medical plan.

Your Rights to Continue Coverage: If you want to continue your coverage after it ends, contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 on how 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 the VEBA Advocacy Team at 888-276-0250.

Does this plan provide Minimum Essential Coverage? Yes

This prescription drug plan combined with the related medical plan of benefits (as described in a related SBC), does provide Minimum Essential Coverage similar to health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

This prescription drug plan combined with the related medical plan of benefits (as described in a related SBC), does meet the Minimum Value Standards, as a result, you may not be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al [insert telephone number].]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码[insert telephone number].]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.