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: $1,600 individual / $3,200 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

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(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	Retail: with submission of a paper claim, member will be reimbursed at the rate the Plan would have paid had the member used an in-network pharmacy less the member's copay. Mail-Order: In-Network only.	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 2nd 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.

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: 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	

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: McGregor & Associates, A Gallagher Company, 1843 Hotel Circle Drive North, Suite 300, San Diego, CA 92108 (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.