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 www.umr.com or by calling 1-800-826-9781. 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.umr.com or call 1-800-826-9781 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** person / **$1,000** family	Generally, you must pay all 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 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?	**$2,000** person / **$4,000** family In-network **$4,000** person / **$8,000** family Out-of-network	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?	Penalties, 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 www.umr.com or call 1-800-826-9781 for a list of network 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 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 (a 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.

(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.

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 per visit; Deductible Waived	30% Coinsurance	None
	Specialist visit	$20 Copay per visit; Deductible Waived	30% Coinsurance	None
	Preventive care/screening/ immunization	No charge; Deductible Waived	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; Deductible Waived	30% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% Coinsurance	30% Coinsurance	Preauthorization is required.

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.

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 need drugs to treat your illness or condition. More info. about prescription drug coverage is available at www.express-scripts.com.	Generic drugs (Tier 1)	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 Prescription Drug plan.
	Preferred brand drugs (Tier 2)	Not Applicable.	Not Applicable.	
	Non-preferred brand drugs (Tier 3)	Not Applicable.	Not Applicable.	
	Specialty drugs (Tier 4)	Not Applicable.	Not Applicable.	
If you have outpatient surgery **A Carrum Health Surgery Benefit (CHSB) is available.**	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance for non-CHSB procedures. No charge; Deductible Waived, for eligible procedures obtained with CHSB.	30% Coinsurance	Preauthorization is required for non-CHSB procedures. For detailed information on the CHSB, pre-certification process and list of eligible procedures, please see the SPD Supplemental Summary or call 1-888-855-7806 or visit carrum.me/CSVEBA.
	Physician/surgeon fees	10% Coinsurance for eligible procedures not obtained with CHSB will apply.	30% Coinsurance	None

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.

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 need immediate medical attention	Emergency room care	$100 Copay per visit; Deductible Waived	$100 Copay per visit; Deductible Waived	Copay may be waived if admitted
	Emergency medical transportation	10% Coinsurance	10% Coinsurance	In-network deductible applies to Out-of-network benefits; Preauthorization is required for Non-emergency.
	Urgent care	$50 Copay per visit; Deductible Waived	30% Coinsurance	None
If you have a hospital stay **A Carrum Health Surgery Benefit (CHSB) is available.**	Facility fee (e.g., hospital room)	10% Coinsurance for non-CHSB procedures. No charge; Deductible Waived, for eligible procedures obtained with CHSB.	30% Coinsurance	Preauthorization is required for non-CHSB procedures. For detailed information on the CHSB, pre-certification process and list of eligible procedures, please see the SPD Supplemental Summary or call 1-888-855-7806 or visit carrum.me/CSVEBA.
	Physician/surgeon fee	10% Coinsurance for eligible procedures not obtained with CHSB will apply.	30% Coinsurance	None
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	$20 Copay per visit; Deductible Waived Office visit; 10% Coinsurance for Partial Hospitalization & Intensive Outpatient Treatment	30% Coinsurance	Preauthorization is required for Partial Hospitalization & Intensive Outpatient Treatment.
	Inpatient services	10% Coinsurance	30% Coinsurance	Preauthorization is required.

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.

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 are pregnant	Office visits	No charge; Deductible Waived	30% Coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, deductible, copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% Coinsurance	30% Coinsurance	
	Childbirth/delivery facility services	10% Coinsurance	30% Coinsurance	
If you need help recovering or have other special health needs	Home health care	10% Coinsurance	30% Coinsurance	Preauthorization is required.
	Rehabilitation services	$20 Copay per visit; Deductible Waived	30% Coinsurance	Preauthorization is required after 30th visit. If your plan excludes Learning Disabilities, habilitation services for learning disabilities are not covered, please refer to your plan document.
	Habilitation services	$20 Copay per visit; Deductible Waived	30% Coinsurance	
	Skilled nursing care	10% Coinsurance	30% Coinsurance	Preauthorization is required.
	Durable medical equipment	10% Coinsurance	30% Coinsurance	Limited to a single purchase (including repair and replacement) every 3 years; Preauthorization is required for DME in excess of $500 for rentals or $1,500 for purchases.
	Hospice service	10% Coinsurance	30% Coinsurance	None

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.

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 your child needs dental or eye care	Children's eye exam	$20 Copay per visit; Deductible Waived	Not covered	1 Maximum exam every 2 years
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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 services.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- 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 (only for pain &nausea related to surgery, pregnancy, or chemotherapy)
- 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 is U.S. 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 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

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 Standard? 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 al1-800-826-9781.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-826-9781.
Chinese (中文): 如果需要中文的帮助， 请拨打这个号码1-800-826-9781.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-826-9781.

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	$500
Specialist copayment	$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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$900
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$1,470**

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

The plan's overall deductible	$500
Specialist copayment	$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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$4,600**

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

The plan's overall deductible	$500
Specialist copayment	$20
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$200
Coinsurance	$80
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$790**

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

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

(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.

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	

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.