



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.whyuhc.com/csveba](http://www.whyuhc.com/csveba) or call 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/](http://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 <u>deductible</u> ?	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> and primary care services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For <u>participating providers</u> \$1,500 individual / \$3,000 family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Copayments</u> for certain services, <u>premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.whyuhc.com/csveba">www.whyuhc.com/csveba</a> or call 1-888-586-6365 for a list of <u>participating providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use a <u>non-participating provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>participating provider</u> might use a <u>non-participating provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes, written or oral approval is required, based upon medical policies.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .

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)	
<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	\$10 <u>copay</u> / office visit and No charge / Virtual visits by a designated virtual <u>participating provider</u>	Not covered	If you receive services in addition to office visit, additional <u>copayments</u> or <u>coinsurance</u> may apply.
	<a href="#">Specialist</a> visit	\$10 <u>copay</u> / visit	Not covered	Member is required to obtain a <u>referral</u> to <u>specialist</u> or other licensed health care practitioner, except for OB/GYN <u>Physician services</u> , reproductive health care services within the <u>Participating Medical Group</u> and Emergency / Urgently needed services. If you receive services in addition to office visit, additional <u>copayments</u> or <u>coinsurance</u> may apply.
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (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)	
<b>If you need drugs to treat your illness or condition</b> Refer to your pharmacy <a href="#">plan</a> for coverage details.	Tier 1	Not covered	Not covered	Refer to your pharmacy <a href="#">plan</a> for coverage details.
	Tier 2	Not covered	Not covered	
	Tier 3	Not covered	Not covered	
	Tier 4	Not covered	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	None
	Physician/surgeon fees	No charge	Not covered	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$100 <u>copay</u> / visit	\$100 <u>copay</u> / visit	<u>Copayment</u> waived if admitted.
	<a href="#">Emergency medical transportation</a>	No charge	No charge	None
	<a href="#">Urgent care</a>	\$10 <u>copay</u> / visit	\$10 <u>copay</u> / visit	If you receive services in addition to <u>urgent care</u> , additional <u>copayments</u> or <u>coinsurance</u> may apply.
<b>If you have a hospital stay</b>	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)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$10 <u>copay</u> / 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	
<b>If you are pregnant</b>	Office visits	No charge	Not covered	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Routine pre-natal care and first postnatal visit is covered at No charge. Depending on the type of services, additional <u>copayments</u> or <u>coinsurance</u> 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	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No charge	Not covered	None
	<a href="#">Rehabilitation services</a>	\$10 <u>copay</u> / visit	Not covered	Coverage is limited to physical, occupational, and speech therapy.
	<a href="#">Habilitative services</a>	\$10 <u>copay</u> / visit	Not covered	Coverage is limited to physical, occupational, and speech therapy.
	<a href="#">Skilled nursing care</a>	No charge	Not covered	Up to 100 days per benefit period.
	<a href="#">Durable medical equipment</a>	No charge	Not covered	None
	<a href="#">Hospice services</a>	No charge	Not covered	None
<b>If your child needs dental or eye care</b>	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    | • Infertility treatment                              | • Private-duty nursing |
| • Dental care (Adult) | • Long-term care                                     | • Routine foot care    |
| • Dental care (Child) | • Non-emergency care when traveling outside the U.S. | • Weight loss programs |

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

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

**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 9<sup>th</sup> Street Suite #500, Sacramento, CA 95814-4275 at 1-888-466-2219 or [www.dmhc.ca.gov](http://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](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** To begin an appeal, call VEBA Direct's TPA's (United Healthcare) Customer Service department at 1-800-624-8822, where a Customer Service representative will document your oral appeal. You may also file an appeal using the Online Grievance form at [www.myuhc.com](http://www.myuhc.com) or write to the Appeals department at:

Appeals & Grievances UnitedHealthcare  
P.O. Box 6107  
Mailstop CA124-0160 Cypress, CA 90630-9972

**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, kwijigo 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](#) \$10
- 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$20
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$20</b>

**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](#) \$10
- 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$15
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$15</b>

**Mia's Simple Fracture**

([participating provider](#) [emergency room](#) visit and follow up care)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$10
- 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$110
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$110</b>

## **Nondiscrimination Notice and Access to Communication Services**

VEBA Direct does not exclude, deny Covered Health Care Benefits to, or otherwise discriminate against any Member on the ground of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability for participation in, or receipt of the Covered Health Care Services under, any of its Health Plans, whether carried out by VEBA Direct directly or through a Network Medical Group or any other entity with which VEBA Direct arranges to carry out Covered Health Care Services under any of its Health Plans.

Free services are available to help you communicate with us such as letters in other languages, or in other formats like large print. Or, you can ask for an interpreter at no charge. To ask for help, please call the toll-free number listed on your health plan ID card.

If you think you weren't treated fairly because of your sex, age, race, color, national origin, or disability, you can send a complaint.

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the toll-free phone number listed on your health plan ID card, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.


**Online:** <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

**Phone:** Toll-free 1-800-368-1019, 800-537-7697 (TDD)

**Mail:** U.S. Dept. of Health and Human Services

200 Independence Avenue, SW Room 509F, HHH Building  
Washington, D.C. 20201

 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](https://express-scripts.com) or by calling 1-800-918-8011.

Important Questions	Answers	Why This Matters
What is the overall <a href="#">deductible</a> ?	\$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> (if applicable) and prescription drug benefits are 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, but see the chart starting on page 2 for other costs for services this plan covers.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For the RX portion of your <a href="#">plan</a> : \$3,000 individual / \$6,000 family. See your medical SBC for other <a href="#">out-of-pocket limits</a> .	The <a href="#">out-of-pocket limit</a> is the most you could pay in a <a href="#">plan</a> year for covered services. If you have other family members in this plan, 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-billing</a> charges and prescription drug costs this <a href="#">plan</a> doesn't 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. See <a href="https://express-scripts.com/">express-scripts.com/</a> or call 1-800-918-8011 for a list of participating pharmacies.	If you use an in-network pharmacy, this <a href="#">plan</a> will pay some or all of the cost of covered services. Plans use the terms in-network, preferred or participating for <a href="#">providers</a> in their <a href="#">network</a> . This <a href="#">plan</a> 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 <a href="#">plan</a> pays by different <a href="#">providers</a> .
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Not Applicable	Not Applicable

 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 <a href="#">provider's</a> 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.
	<a href="#">Specialist</a> visit	Not Applicable	Not Applicable	
	<a href="#">Preventive care/screening</a> /immunization	Not Applicable	Not Applicable	
If you have a test	<a href="#">Diagnostic test</a> (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 <a href="#">prescription drug coverage</a> See <a href="#">express-scripts.com/</a>	Generic drugs (Tier 1)	\$5/\$10 <a href="#">copay</a> EAN/non-EAN retail 30 day supply; \$10 <a href="#">copay</a> Smart90 or Home Delivery 90 day supply	You must pay out-of-pocket and submit a <a href="#">claim</a> online or download the Prescription Drug Reimbursement form at <a href="#">express-scripts.com</a> by selecting Forms from the main menu under the Benefits. The <a href="#">plan</a> will reimburse you based on the allowed amount less any applicable member <a href="#">copay</a> .	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 3 <sup>rd</sup> refill, the copays will be twice what is shown for retail copays in the Network Provider column.
	Preferred brand drugs (Tier 2)	\$25/\$30 <a href="#">copay</a> EAN/non-EAN retail 30 day supply; \$50 <a href="#">copay</a> Smart90 or Home Delivery 90 day supply		
	Non-preferred brand drugs (Tier 3)	50% w/ <a href="#">copay</a> of \$40/\$45 min and \$175/\$180 max EAN/non-EAN retail 30 day supply; 50% w/ <a href="#">copay</a> of \$80 min and \$350 max Smart90 or Home Delivery 90 day supply		
	<a href="#">Specialty drugs</a> (Tier 4)	\$0 <a href="#">copay</a> SaveOnSP or applicable Tier 1, 2 or 3 copays for non-SaveOnSP	Not covered.  Specialty drugs must be ordered through Express Scripts Accredo.	

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 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	<a href="#">Emergency room care</a>	Not Applicable	Not Applicable	
	<a href="#">Emergency medical transportation</a>	Not Applicable	Not Applicable	
	<a href="#">Urgent care</a>	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	<a href="#">Home health care</a>	Not Applicable	Not Applicable	
	<a href="#">Rehabilitation services</a>	Not Applicable	Not Applicable	
	<a href="#">Habilitation services</a>	Not Applicable	Not Applicable	
	<a href="#">Skilled nursing care</a>	Not Applicable	Not Applicable	
	<a href="#">Durable medical equipment</a>	Not Applicable	Not Applicable	
	<a href="#">Hospice services</a>	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](http://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](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 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, kwijigo holne' [insert telephone number].]

## **PRA Disclosure Statement**

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