California Schools Voluntary Employees Benefits Association

Prescription Drug Summary of Benefits

Effective January 1, 2018

This summary of benefits provides detailed information about the California Schools VEBA Prescription Drug Program and how it works. This summary does not constitute an implied or express contract or guarantee of employment. Similarly, your eligibility or your right to benefits under your prescription drug benefit plan should not be interpreted as an implied or express contract or guarantee of employment. Your employer’s employment decisions are made without regard to benefits to which you are entitled upon employment.
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INTRODUCTION

This summary of benefits contains detailed information about the prescription drug benefit plan administered by Express Scripts Holding Company (Express Scripts or ESI), offered by the California Schools Voluntary Employees Benefits Association (California Schools VEBA or VEBA) to participating school districts and associations. This summary applies to you if you meet the eligibility requirements on pages 2-3 of this summary.

In this summary, you’ll find eligibility information, how coverage works, how to submit and appeal claims, and legal information about your rights as a prescription drug benefit plan participant. Please keep this summary in a safe place for future reference. If you have any questions about your prescription drug coverage, please contact Express Scripts Member Services toll-free at 800-918-8011 24 hours a day, 7 days a week (except for Christmas and Thanksgiving from 12:00 a.m. to 11:59 p.m.)

Certain prescription drugs may be provided through the United Healthcare medical plan and not under this California Schools VEBA Prescription Drug Program. The types of drugs where United Healthcare may provide coverage are noted in the section entitled ‘What’s Not Covered’ starting on page 21. Nothing in this document provides any guarantee that the United Healthcare medical plan will provide coverage for any particular drug.

The information in this summary is effective January 1, 2018.
ELIGIBILITY FOR PRESCRIPTION DRUG BENEFITS

Employees
If you are an employee, you are eligible for the prescription drug benefit plan if:

- Your school district participates in the California Schools VEBA;
- You meet the eligibility requirements for coverage within your district as stated in the collective bargaining agreement or the memorandum of understanding establishing eligibility for the district’s plan with California Schools VEBA; and
- You are participating in any of the following VEBA-sponsored United Healthcare or its successor medical plans:
  - Health Maintenance Organization (HMO), including the Performance HMO and Alliance HMO (excluding Kaiser Permanente, SIMNSA, or any plan that requires Medicare enrollment)
  - Preferred Provider Organization (PPO)
  - Exclusive Provider Organization (EPO)
  - Non-Differential PPO (Out-of-Area)
  - AB 1401 participants (Cal COBRA), including dependents, are excluded from this prescription drug benefit.

Dependents
Dependents are eligible for coverage when you (the employee) become eligible. Dependents are eligible as soon as and for the same period of time that they remain eligible under one of the medical benefit plans cited in the previous paragraph. A dependent is eligible for benefits pursuant to (1) the collective bargaining agreement memorandum of understanding, (2) the employer’s administrative policy applicable to the eligible employee, or (3) VEBA’s Administrative Policies and Procedures.

The insurer’s contract, collective bargaining agreements, employer policy, or VEBA’s Administrative Policies and Procedures may limit dependent coverage.

If your (dependent) coverage is noncontributory, it becomes effective on the day your medical benefits are effective.

If your (dependent) coverage is contributory, it becomes effective on the day you:

- Elect benefits
- Agree to make the required contributions, and
- Have an effective date
If you (the employee) notify your participating district that you want your dependent to participate more than 31 days after you meet the eligibility requirements, your dependent’s effective date will be deferred until your district’s next annual enrollment date (except for instances cited in the section titled “HIPAA Special Enrollment Rights,” and qualified changes in status, such as marriage, birth or adoption of a child, or a change in employment status for you, your spouse or a covered dependent).

**Early Retirees**

Early retirees (i.e., not eligible for Medicare) are covered for this plan if you (the retiree) are eligible and enrolled in any of the following VEBA-sponsored United Healthcare or its successor medical plans:

- Health Maintenance Organization (HMO), including the Performance HMO and Alliance HMO (excluding Kaiser Permanente, SIMNSA or any plan that requires Medicare enrollment)
- Preferred Provider Organization (PPO)
- Exclusive Provider Organization (EPO)
- Non-Differential PPO (Out-of-Area)

Retired employees or dependents of retired employees who are eligible for Medicare are not eligible under this prescription drug plan. VEBA sponsors other programs with prescription coverage for those individuals.
WHEN COVERAGE BEGINS AND ENDS

Enrolling in Your Prescription Drug Benefit Plan
Prescription drug coverage is automatically provided as part of your prescription drug benefit plan if you enroll in one of the following plans and is included with the medical plan premium:

- HMO, including the Performance HMO and Alliance HMO (excluding any plan in which the insurance company provides coverage for prescription drugs as described in this document); specifically excluding plans underwritten by Kaiser, SIMNSA, or any plan that requires Medicare enrollment.

- PPO, EPO or Out-of-Area Plan (excluding any plan in which the carrier provides coverage for prescription drugs as described in this document including plans that require Medicare enrollment).

Prescription drug coverage is effective on the same date as the coverage for HMO, PPO, EPO, or Out-of-Area Plan and ends when medical coverage ends under one of those plans.
HIPAA SPECIAL ENROLLMENT RIGHTS

Loss of Eligibility for Other Medical Coverage
If you are declining plan enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan, or switch medical benefit options under this plan, if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents’ other non-COBRA coverage). However, you must request enrollment within 31 days after the date your or your dependents’ other coverage ends (or after the employer stops contributing towards the other coverage). Loss of eligibility for coverage includes (but is not limited to):

- Loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under your prescription drug benefit plan), death of an employee, termination of employment, reduction in the number of work hours of employment to a level not deemed eligible for coverage by the employer and any applicable collective bargaining agreement.

- In the case of coverage offered through an HMO, or other arrangement, in the individual or group market that does not provide benefits to individuals who no longer reside, live or work in the service area, loss of coverage because an individual no longer resides, lives or works in the service area (whether or not within the choice of the individual), and with respect to an HMO in the group market, no other benefit package is available to the individual.

- A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual, and

- In the case of an individual who has COBRA continuation coverage, at the time the COBRA continuation coverage is exhausted.

However, loss of eligibility for other coverage does not include a loss of coverage due to:

- The failure of the employee or dependent to pay premiums on a timely basis,

- Voluntary disenrollment from a plan, or

- Termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with your prescription drug benefit plan).
When Coverage Begins After Loss of Eligibility for Other Medical Coverage
If you enroll yourself, your spouse, domestic partner and/or your eligible dependent child(ren) in this plan due to a “loss of eligibility for coverage” event described above, benefit coverage under this plan will begin the first day of the first calendar month after the completed special enrollment form is received.

When Coverage Begins After Loss or Gain of Eligibility for a State Children's Health Insurance Program (CHIP) or Medicaid
If you enroll yourself, your spouse and/or your eligible dependent child(ren) in this medical plan due to a loss or gain of eligibility for coverage event described above, medical coverage under this plan will begin the first day of the first calendar month after the completed special enrollment form is received.
HOW THE PRESCRIPTION DRUG BENEFIT PLAN WORKS

As a participant, you can use:

- Express Scripts’ participating retail network pharmacies
- Out-of-Network pharmacies
- Express Scripts Pharmacy home delivery service Pharmacy

Your prescription drug benefit plan offers several advantages, including easy access to prescribed medication and no claim forms to complete. In addition, you have the choice of using generic or brand name drugs.

Note that all prescription drug benefit plan participants may use out-of-network pharmacies and submit a paper claim; however, the reimbursement will be less than if you are using in-network pharmacy (and your copay may be higher).

Preferred Drugs

Your prescription drug benefit plan maintains access to a wide array of prescription drugs, as described later. Drugs vary in effectiveness and cost, and Express Scripts has established and maintains a list of preferred products (more than 90% of the drugs used by VEBA members are considered preferred). The drugs on the preferred list have been selected by Express Scripts through a process that involves its independent Pharmacy and Therapeutics Committee, which is composed of physicians and one pharmacist. This Committee evaluates and updates this list of medications that are clinically required to be on formulary. Following this clinical, a separate review is performed by an ESI internal committee which considers cost but always designates drugs as formulary or preferred drugs consistent with what is clinically required by the ESI Pharmacy and Therapeutics Committee.

Preferred drugs will usually have a lower copayment for a participant than non-preferred drugs.

Generic Drug Substitution

To help contain the high cost of prescription drugs, your Express Scripts participating retail or home delivery pharmacist may dispense a generic product whenever possible. If your doctor writes a prescription for a brand name drug but a generic equivalent is available and can be safely and effectively substituted, you will receive the generic.

You have the option of requesting the brand name drug as long as you are willing to pay the additional cost yourself.

A generic drug will be dispensed if one is available. If you or your physician request a brand name drug instead of the generic (for which a generic is available), you will pay the difference between the cost of the brand name drug and the generic drug, in addition to the generic drug copayment. You or
your physician may request a review of the charge for the copayment differential. Your physician will need to provide Express Scripts with the reason you are unable to take the generic equivalent. If approved, you will only be responsible for the applicable generic copayment. This applies to retail, Express Scripts Pharmacy home delivery service, and out-of-network pharmacy claims.
Common Brand Names and Their Generic Counterparts

*FDA generic equivalent products meet the same FDA standards as their brand name counterpart.* The table below shows a few examples of common brand name drugs and their generic counterparts.

<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Generic</th>
<th>Common Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurontin</td>
<td>Gabapentin</td>
<td>To treat certain neurological-related pain and convulsions</td>
</tr>
<tr>
<td>Lipitor</td>
<td>Atorvastatin</td>
<td>To treat cholesterol, including HDL and LDL</td>
</tr>
<tr>
<td>Tylenol with Codeine</td>
<td>Acetaminophen with Codeine</td>
<td>To treat moderate to moderately severe pain</td>
</tr>
<tr>
<td>Prozac</td>
<td>Fluoxetine</td>
<td>To treat depression</td>
</tr>
</tbody>
</table>

Express Advantage Network (EAN)

Express Scripts maintains a large national network of retail pharmacies. Within this broad network, Express Scripts has created a network of cost-effective pharmacies called Express Advantage Network (EAN). When you purchase drugs at an EAN pharmacy, you show your Express Scripts ID card and pay the required copayment. Your copayment is generally less when you use an EAN pharmacy than for other Express Scripts Retail Network pharmacies. You do not file a claim. There are over 34,000 EAN locations in the U.S. You can locate the closest EAN pharmacy on the Express Scripts website.

Other Express Scripts Retail Network Pharmacies

As an alternative, you may choose to fill your script at another Express Scripts Retail Network pharmacy that is not part of EAN. Your copay may be higher when you do this. You do not file a claim.

Out-of-Network Pharmacies

When you use an out-of-network pharmacy, you pay the entire prescription cost, then complete and submit a Prescription Reimbursement Form to receive your partial reimbursement. Send the claim form and the itemized receipt for the purchased drug to: Express Scripts Health Solutions – P.O. Box 14711, Lexington, KY, 40512. When you submit a claim with a receipt, the receipt should include the following:

- Date prescription filled
- Name and address of pharmacy
- Doctor name or ID number
- NDC number (drug number)
- Name of drug and strength
- Quantity and days’ supply
- Prescription number (Rx number)
- DAW (Dispense As Written)

For questions about an outstanding claim, call Express Scripts Member Services’ toll-free number any time at 800-918-8011, 24 hours a day, 7 days a week (except for Christmas and Thanksgiving).

**Prior Authorization**
Prior authorization is required for certain drugs or quantities of drugs when additional information is needed to determine if the prescription meets your prescription drug benefit plan’s approved coverage rules. If an authorization is required, your physician or physician’s representative should contact Express Scripts to initiate a coverage review. Express Scripts will evaluate the information provided by the physician to determine if your prescription is covered according to your prescription drug benefit plan rules. Examples of drugs which may require prior authorization include but are not limited to: topical acne products, drugs to treat erectile dysfunction, migraine medications, and drugs to promote weight loss.

**Copayment Amounts**
The amount you pay for prescriptions depends on whether you use the Express Advantage Network, home delivery or another pharmacy, whether you purchase generic drugs, preferred brand name drugs or non-preferred brand name drugs. Your cost will generally be the lowest when you purchase generic drugs.

When you use your prescription drug benefit plan, you pay the following amounts as long as your prescription is in compliance with the program coverage rules (including use of generics and prior authorizations, where required). Your prescription drug benefit plan pays the balance of the cost.

**Retail Pharmacy Prescription Drug Benefits**
Each school district or association participating in the California Schools VEBA selects the medical plan(s) to be offered to eligible employees and retirees from the VEBA-sponsored United Healthcare (or its successor medical plans) options. Prescription drug benefits under the United Healthcare medical plan options are administered by Express Scripts and vary based on the medical plan(s) offered by each school district or association.

The following tables list the retail options for prescription drug benefits that may be available to you as part of the medical plan(s) offered through your school district or association. These copays apply to scripts up to a 30-day supply of the drug. For a listing of the medical plans and specific prescription drug benefits available to you, visit [www.vebaonline.com](http://www.vebaonline.com).
Calendar Year Deductible

For members enrolled in a Performance HMO Network 3 option, there is a $250 calendar year individual deductible ($500 maximum per family) applicable to brand drugs only. This deductible applied to all retail, Smart90, and home delivery brand prescriptions. The copay will apply after the deductible is satisfied.

<table>
<thead>
<tr>
<th>Type of Drug</th>
<th>EAN Retail Pharmacy Prescription Drug Options (to see school district-specific benefits, go to <a href="http://www.vebaonline.com">www.vebaonline.com</a>)</th>
<th>Bronze Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred generic</td>
<td>$5 copay</td>
<td>$10 copay</td>
</tr>
<tr>
<td>Preferred brand name</td>
<td>$25 copay</td>
<td>$25 copay</td>
</tr>
<tr>
<td>Non-preferred brand name, covered drugs</td>
<td>50% coinsurance with $40 min and $175 max per prescription</td>
<td>Not covered</td>
</tr>
<tr>
<td>Intranasal steroids, antihistamines, and proton pump inhibitors</td>
<td>100% copay*</td>
<td>100% copay*</td>
</tr>
</tbody>
</table>

*For these three classes of drugs there are substantial numbers of drugs available on an over-the-counter basis without a prescription. Members can either purchase drugs over-the-counter outside the VEBA program or obtain a prescription and pay 100% of the VEBA-negotiated cost at the pharmacy. Over-the-counter drugs may or may not be less expensive for the member. Members are encouraged to review prices to determine the best choice for them. Drugs purchased over-the-counter will not count toward the Maximum Out-of-Pocket.

<table>
<thead>
<tr>
<th>Type of Drug</th>
<th>EAN Retail Pharmacy Prescription Drug Options (to see school district-specific benefits, go to <a href="http://www.vebaonline.com">www.vebaonline.com</a>)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred generic</td>
<td>$10 copay</td>
</tr>
<tr>
<td>Preferred brand name</td>
<td>$25 copay</td>
</tr>
<tr>
<td>Non-preferred brand name, covered drugs</td>
<td>$40 copay</td>
</tr>
<tr>
<td>Intranasal steroids, antihistamines, and proton pump inhibitors</td>
<td>100% copay*</td>
</tr>
</tbody>
</table>

*See note above
<table>
<thead>
<tr>
<th>Type of Drug</th>
<th>Non-EAN Retail Pharmacy Prescription Drug Options</th>
<th>Bronze Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(to see school district-specific benefits, go to <a href="http://www.vebaonline.com">www.vebaonline.com</a>)**</td>
<td></td>
</tr>
<tr>
<td>Preferred generic</td>
<td>$10 copay $15 copay $15 copay $20 copay $20 copay $20 copay $25 copay</td>
<td>$20 copay</td>
</tr>
<tr>
<td>Preferred brand name</td>
<td>$30 copay $30 copay $35 copay $35 copay $40 copay $45 copay $40 copay</td>
<td>$250 deductible, then $40</td>
</tr>
<tr>
<td>Non-preferred brand name, covered drugs</td>
<td>50% coinsurance with $40 min and $175 max per prescription</td>
<td>Not covered</td>
</tr>
<tr>
<td>Intranasal steroids, antihistamines, and proton pump inhibitors</td>
<td>100% copay*</td>
<td>100% copay</td>
</tr>
</tbody>
</table>

*See note on page 13  **See note on calendar year deductible on page 14

The Retail Pharmacy copay is applicable for the first three fills of maintenance drugs (initial script and first two refills); thereafter, starting on the fourth fill, the Express Scripts Pharmacy home delivery service copay applies for each 30-day fill at a retail pharmacy (with a minimum of $10). See Express Script by Mail Prescription Drug Benefits for mail copayments. Rite Aid and Costco prescription drug locations are treated with the same copays as Express Scripts Pharmacy home delivery service for all scripts of 84-90 days. Filling an 84-90 day script at Rite Aid or
Costco will be deemed the same as Express Scripts Pharmacy home delivery service. These two pharmacies are considered VEBA’s Smart90 Network.

NOTES:

Copays are waived for oral contraceptives and for some over-the-counter drugs as mandated by the Affordable Care Act. Over-the-counter drugs require a formal prescription to receive the copay waiver.

If you receive a brand name drug where a generic is available, you will pay the generic copayment plus the difference in cost between the brand drug and the generic drug.

If the actual cost of the drug (also known as the pharmacy’s usual and customary price) is less than the copayment, you will be billed the actual cost.

For certain high cost specialty drugs, these copays do not apply. This includes drugs for treating Hepatitis C, but other drugs are also included. The copay for a 30-day supply of these high cost specialty drugs will be equal to the out-of-pocket limit applicable to the prescription drug benefit. See the section on Out-of-Pocket Maximum for further information.

Express Scripts Pharmacy home delivery service Prescription Drug Benefits

Long-term use medications (such as asthma medication, high blood pressure, and cholesterol) may be purchased through the Express Scripts Pharmacy home delivery service Program. You can order up to a 90-day supply for an amount equal to two retail network pharmacy copayments. As noted earlier, using Rite Aid or Costco pharmacies for 90-day supplies will qualify the member for the same copay as Express Scripts Pharmacy home delivery service.

Each school district or association participating in the California Schools VEBA selects the medical plan(s) to be offered to eligible employees and retirees from the VEBA-sponsored United Healthcare (or its successor medical plans) options. Prescription drug benefits under the United Healthcare medical plan options are administered by Express Scripts and vary based on the medical plan(s) offered by each school district or association.

The following tables list the mail-order options for prescription drug benefits that may be available to you as part of the medical plan(s) offered through your school district or association. For a listing of the medical plans and specific prescription drug benefits available to you, visit www.vebaonline.com.
### Type of Drug

<table>
<thead>
<tr>
<th>Type of Drug</th>
<th>Home delivery or VEBA Smart90 Prescription Drug Options (to see school district-specific benefits, go to <a href="http://www.vebaonline.com">www.vebaonline.com</a>)*</th>
<th>Bronze Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred generic</td>
<td>No copay</td>
<td>$10 copay</td>
</tr>
<tr>
<td>Preferred brand name</td>
<td>$50</td>
<td>$60</td>
</tr>
<tr>
<td>Non-preferred brand name, covered drugs</td>
<td>50% coinsurance with $80 min and $350 max per prescription</td>
<td>Not covered</td>
</tr>
<tr>
<td>Intranasal steroids, antihistamines, and proton pump inhibitors</td>
<td>Not covered at home delivery and 100% copay at Smart 90 pharmacies</td>
<td>Not covered at home delivery and 100% copay at Smart 90 pharmacies</td>
</tr>
</tbody>
</table>

*See note on calendar year deductible on page 14

The Home delivery copay is applicable for the fourth fill of each 30-day fill at a retail pharmacy for maintenance drugs (minimum of $10).

Copays for certain specialty medications may be set to the maximum out-of-pocket limit for the plan or any available manufacturer-funded copay assistance.

**NOTES:**
If you receive a brand name drug where a generic is available, you will pay the generic copayment plus the difference in cost between the brand and the generic.

If the actual cost of the drug is less than the copayment, you will be billed the actual cost.

VEBA Smart90 Network

Members may elect to use a pharmacy in the VEBA Smart90 Network in lieu of Express Scripts Pharmacy home delivery service. The same copays apply for the Smart90 as Express Scripts Pharmacy home delivery service for prescriptions of 84-90 days. If you use the Smart90 Network for single scripts of 83 days or less in duration, you will be charged the copay applicable to all other retail pharmacies (see Retail Pharmacy Prescription Drug Benefits).

For 2016, the Smart90 Network is comprised of Rite Aid and Costco pharmacies.

Out-of-Pocket Maximum

The Prescription Drug Plan limits how much a covered member may have to spend for copays or deductibles for medications allowed and covered by the Prescription Drug Plan during a calendar year. This limit is stated on a calendar year basis per person (with an aggregate limit for households covering more than two members). This limit is separate from any out-of-pocket limit that may apply for medical coverage through United HealthCare.

Once a member has reached the Out-of-pocket maximum, no further copays or deductibles will apply for prescriptions allowed and covered by the Prescription Drug Plan for the remainder of that calendar year. Please note, if you choose to take a brand name drug where a generic is available, you will still pay the difference in cost between the brand and the generic even after your out-of-pocket maximum has been met (and such payments do not count toward the Out-of-Pocket Maximum).

Certain pharmaceutical manufacturers offer copay assistance programs for members with high copays for their drugs. If a member receives copay assistance for a drug covered under the VEBA program, the amount of the copay assistance will not count toward the Out-of-Pocket Maximum. For example, if a member has a $3,000 copay for a Hepatitis C medication and receives $2,950 in copay assistance, only the remaining $50 paid by the member and not reimbursed by the copay assistance will count toward the Out-of-Pocket Maximum.

The Out-of-Pocket limit does not apply to the costs of prescriptions or devices not allowed or covered under the program, including drugs where a prior authorization is not obtained, plan quantity levels
are exceeded, or drugs are excluded under the plan. Other limitations may apply. The Out-of-Pocket Maximum does not extend to any additional copays paid for a brand name drug where a generic for that drug is available. Any member expenditures for drugs now allowed/not covered or additional copays for a brand name drug with a generic do not count towards the Out-of-Pocket Maximum.

The prescription drug Out-of-Pocket maximum is $3,000 for a single (not more than a total of $6,000 for a family) during a calendar year. For the following plans the calendar year prescription drug Out-of-Pocket maximum is $1,600 (not more than $3,200 for a family):

- $2,000 deductible or $2,500 deductible PPO plans
- $2,000 deductible Alliance HMO plans
- Performance HMO plans B and D (Networks 2 and 3 only) and Package E (all networks)
Making the Most of Your Prescription Drug Benefits

The following steps will help you get the most out of your prescription drug benefits.

Ask your doctor about:

- Alternatives to prescription drugs
- Low-cost options in prescription drugs (including generic alternatives)
- Side effects of the drug
- Interactions the drug might have with other medication you are taking
- Whether a plan-preferred drug will work for you (if the proposed drug is not plan-preferred)

Remember to:

- Use an Express Scripts participating retail network pharmacy or the Express Scripts Pharmacy home delivery service Program for other long-term maintenance medications.
- Take the medication as instructed by the physician and/or pharmacist.
- Call Express Scripts Member Services toll free at 800-918-8011 to ask questions.

Don’t forget to ask your pharmacist:

- The drug’s expiration date: make sure it appears on the label as required by law
- If a preferred drug is available (when the prescription is not preferred)
- What effect this drug will have on other drugs you are taking
- Side effects of the drug
- What to do if you miss a dose
- How the drug should be stored to maintain its potency
- Whether an “old” prescription is still safe to use, taking into consideration its age, the method of storage, and your current health and medications.
- If any of your prescription drugs interact with any over-the-counter (non-prescription medications or supplements) you may be taking
- About any unexpected, unusual or unpleasant effects that you may experience after taking any medication

For more information about the drugs your doctor prescribes, consult these resources:
• Express Scripts’ Specialist Pharmacists: Call your Express Scripts Member Services number at 800-918-8011 and ask to speak with a pharmacist. He or she can give you detailed information about any prescription drug you are taking, including possible side effects or hazardous drug combinations.

• The pharmacist at a local retail network pharmacy.

• The National Health Information Center: Call this free health information and referral service at 800-336-4797.
**What’s Covered**

In general, VEBA’s prescription drug program covers most prescription medications used on an outpatient basis and approved by the U.S. Food and Drug Administration (FDA), as well as certain medical supplies. Prescriptions must be written by an authorized prescriber, must meet your prescription drug benefit plan’s conditions of coverage, and not be experimental in nature or prescribed in an experimental manner. Prescriptions must be for covered participants of your prescription drug benefit plan.

In addition, some prescriptions require a prior authorization by your prescription drug benefit plan (through Express Scripts) to be covered. Your physician may initiate the prior authorization process by contacting Express Scripts and providing information related to your therapy. Your pharmacist may also facilitate the process by contacting Express Scripts. Express Scripts will then contact your physician to obtain the information needed to review your therapy. The prescription coverage may be approved or denied, or an alternative may be suggested.

Unless otherwise excluded, covered prescription medications and supplies include the following when ordered by an authorized prescriber (subject to any prior authorization and/or quantity limits applied by your prescription drug benefit plan):

- Federal legend drugs (drugs that require a prescription)
- Compounded medications of which at least one ingredient is a legend drug (but only for the covered cost of that ingredient) and of which no ingredient is a bulk powder of a legend drug
- Insulin
- Insulin needles and syringes
- Over-the-counter (OTC) diabetic test strips and lancets
- Oral, transdermal, intravaginal, implantable and injectable contraceptives
- Seasonale – up to a 90-day supply
- Retin-A/Avita covered through age 34
- Tazorac Cream covered through age 34
- Certain OTC and legend vitamins (except injectables)
- OTC and legend prenatal vitamins for women only through age 50
- Pediatric fluoride vitamins through age 16
- Select self-administered injectable drugs (varies by plan) – contact Express Scripts for specific drugs
● Drugs to treat impotency (all dosage forms, except Yohimbine) for men only age 18 and over

● Inhaler spacers

**What’s Not Covered**
Certain types of prescriptions are not covered under your prescription drug benefit plan. These include, but are not limited to, the following:

● Non-federal legend drugs (non-prescription drugs)

● Compounded medications containing bulk powders

● Non Systemic Contraceptives, Devices and Implants (except as listed above)

● PCSK9 inhibitors including, but not limited to, Praluent and Repatha

● Injectable medications (except certain self-injectable drugs --- contact Express Scripts for information on these drugs for your plan). Some injectable medications may be covered by the United Healthcare plan. Members may contact United Healthcare through the phone number on their ID card.

● Medications purchased without a prescription (over-the-counter drugs)

● Fertility agents

● Smoking deterrents except as provided by the Affordable Care Act

● Synarel

● Homeopathic drugs

● Ostomy supplies

● DHEA

● Dental fluoride products

● Mifeprex

● Vimovo and Duexis

● Glumetza and its generic equivalents

● Drugs that are infused at home regardless of whether the drug is self-infused or requires professional assistance. These drugs may be covered by the United Healthcare medical plan. Members may contact United Healthcare through the phone number on their ID card.

● Therapeutic devices or appliances
- Drugs whose sole purpose is to promote or stimulate hair growth (i.e. Rogaine®, Propecia®) or for cosmetic purposes only
- Allergy serums
- Biologicals, immunization agents or vaccines
- Blood or blood plasma products
- Drugs labeled "Caution-limited by Federal law to investigational use", or experimental drugs, even though a charge is made to the individual
- Medication for which the cost is recoverable under any workers' compensation or occupational disease law or any state or governmental agency, or medication furnished by any other drug or medical service for which no charge is made to the member
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order
- Charges for the administration or injection of any drug with the exception of pharmacy-administered vaccines
- Any prescription in excess of a 30-day supply at a retail pharmacy except for scripts filled at a VEBA Smart90 pharmacy
- For mail service, any prescription in excess of a 90-day supply.
- In addition, individual drugs may not be covered as determined by drug formularies administered by Express Scripts.
- Drugs where a prior authorization is required but not obtained (or is denied) from Express Scripts.
- Drugs prescribed for services or treatments not covered by the VEBA medical plan.

The following sources can be used in determining whether these requirements have been met:

- Published reports in authoritative medical literature
● Regulations, reports, publications, or evaluations issued by government agencies such as the Agency for Health Care Policy and Research, the National Institutes of Health, and the Food and Drug Administration (FDA)

● Listings in the following drug compendia: The American Hospital Formulary Service Drug Information, and The United States Pharmacopoeia Dispensing Information

● Other authoritative medical sources as necessary.
CLAIMING BENEFITS

After you pay the required copayment or coinsurance, including any additional cost incurred for requesting a brand name drug instead of a generic one, benefits are paid at 100% of covered charges. When you use an Express Scripts participating retail network pharmacy, claim forms are not required. If you obtain services out of network, you must claim benefits by submitting a completed claim form and an itemized receipt. Send the claim form and receipt to:

Express Scripts
Attn: Commercial Claims
P.O. Box 2872
Clinton, IA 52733-2872

Information That Should Appear on Your Bills
You should keep a careful record of prescription medication bills incurred by you and each of your covered dependents. You can submit a claim whenever you have an eligible expense. When you submit a claim with a bill, the bill should include:

- Date prescription filled
- Name and address of pharmacy
- Doctor name or ID number
- NDC number (drug number)
- Name of drug and strength
- Quantity and days’ supply
- Prescription number (Rx number)
- DAW (Dispense As Written)

For questions about an outstanding claim, call Express Scripts Member Services toll-free at 800-918-8011 24 hours a day, 7 days a week (except for Christmas and Thanksgiving from 12:00 a.m. to 11:59 p.m.)

Denied Claims and Appeals Process
If you have a claim that is denied, Express Scripts will provide an explanation for the denial of the claim. For questions about a denied claim, call Express Scripts Member Services toll-free at 800-918-8011.
Appeal Process for Electronic Claims Not Submitted by a Member

In the event you receive an adverse determination following a request for coverage of a prescription benefit claim, you have the right to appeal the adverse benefit determination in writing within 180 days of receipt of notice of the initial coverage decision. To initiate an appeal for coverage, you or your authorized representative (such as your physician), must provide in writing: your name, member ID, phone number, the prescription drug for which benefit coverage has been denied, and any additional information that may be relevant to your appeal. A clinical coverage review request is a request for coverage of a medication that is based on clinical conditions of coverage that are set by the Plan. For example, medications that require a prior authorization. An administrative appeal request is a request for coverage of a medication that is based on the Plan’s benefit design. For example, medications that are not covered by the plan or requesting a copay review.

This information should be mailed to:

Clinical appeal requests:
Express Scripts
Attn: Clinical Appeals Department
PO Box 66588
St Louis, MO 63166-6588
Fax: 1 877- 852-4070

Administrative appeal requests:
Express Scripts
Attn: Administrative Appeals Department
PO Box 66587
St Louis, MO 63166-6587
Fax: 1 877- 328-9660

A decision regarding your appeal will be sent to you within 15 days of receipt of your written request. The notice will include the specific reasons for the decision and your prescription drug benefit plan provisions on which the decision is based. You have the right to receive, upon request and at no charge, the information used to review your appeal.

If you are not satisfied with the coverage decision made on appeal, you may request in writing, within 90 days of the receipt of notice of the decision, a second level appeal. To initiate a second level appeal, you or your authorized representative (such as your physician), must provide in writing: your name, member ID, phone number, the prescription drug for which benefit coverage has been denied, and any additional information that may be relevant to your appeal. This information should be mailed to:
Clinical appeal requests:
Express Scripts
Attn: Clinical Appeals Department
PO Box 66588
St Louis, MO 63166-6588
Fax: 1 877- 852-4070

Administrative appeal requests:
Express Scripts
Attn: Administrative Appeals Department
PO Box 66587
St Louis, MO 63166-6587
Fax: 1 877- 328-9660

A decision regarding your request will be sent to you in writing within 15 days of receipt of your written request for appeal. You have the right to receive, upon request and at no charge, the information used to review your second level appeal. The decision made on your second level appeal is final and binding.

In the case of a claim for coverage involving urgent care, you will be notified of the benefit determination within 72 hours of receipt of the claim. An urgent care claim is any claim for treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed. If the claim does not contain sufficient information to determine whether, or to what extent, benefits are covered, you will be notified within 24 hours after receipt of your claim, of the information necessary to complete the claim. You will then have 48 hours to provide the information and will be notified of the decision within 48 hours of receipt of the information.

You have the right to request an urgent appeal of an adverse determination if you request coverage of a claim that is urgent. Urgent appeal requests may be oral or written. You or your physician may call 1 800-753-2851, or send a written request to:

Clinical appeal requests:
Express Scripts
Attn: Clinical Appeals Department
PO Box 66588
St Louis, MO 63166-6588
Fax: 1 877- 852-4070
Administrative appeal requests:
Express Scripts
Attn: Administrative Appeals Department
PO Box 66587
St Louis, MO 63166-6587
Fax: 1 877- 328-9660

In the case of an urgent appeal for coverage involving urgent care, you will be notified of the benefit determination within 72 hours of receipt of the claim. This coverage decision is final and binding. You have the right to receive, upon request and at no charge, the information used to review your appeal.

**Appeal Process for Member-Submitted Paper Claims**

Your HMO and PPO prescription drug benefit plan provides for reimbursement of prescriptions when you pay 100% of the prescription price at the time of purchase. This claim will be processed based on your prescription drug plan benefit. You will receive an explanation of benefits within 30 days of receipt of your claim. If you are not satisfied with the decision regarding your benefit coverage, you have the right to appeal this decision in writing within 180 days of receipt of notice of the initial decision. To initiate an appeal for coverage, you or your authorized representative (such as your physician), must provide in writing, your name, member ID, phone number, the prescription drug for which benefit coverage has been reduced or denied and any additional information that may be relevant to your appeal. A **clinical coverage review request** is a request for coverage of a medication that is based on clinical conditions of coverage that are set by the Plan. For example, medications that require a prior authorization. An **administrative appeal request** is a request for coverage of a medication that is based on the Plan’s benefit design. For example, medications that are not covered by the plan or requesting a copay review.

This information should be mailed to:

Clinical appeal requests:
Express Scripts
Attn: Clinical Appeals Department
PO Box 66588
St Louis, MO 63166-6588
Fax: 1 877- 852-4070

Administrative appeal requests:
Express Scripts
Attn: Administrative Appeals Department
A decision regarding your appeal will be sent to you within 30 days of receipt of your written request. The notice will include the specific reasons for the decision and your prescription drug benefit plan provision on which the decision is based. You have the right to receive, upon request and at no charge, the information used to review your appeal.

If you are not satisfied with the coverage decision made on appeal, you may request in writing, within 90 days of the receipt of notice of the decision, a second level appeal. To initiate a second level appeal, you or your authorized representative (such as your physician), must provide in writing: your name, member ID, phone number, the prescription drug for which benefit coverage has been reduced or denied, and any additional information that may be relevant to your appeal. This information should be mailed to:

**Clinical appeal requests:**
Express Scripts  
Attn: Clinical Appeals Department  
PO Box 66588  
St Louis, MO 63166-6588  
Fax: 1 877-852-4070

**Administrative appeal requests:**
Express Scripts  
Attn: Administrative Appeals Department  
PO Box 66587  
St Louis, MO 63166-6587  
Fax: 1 877-328-9660

A decision regarding your request will be sent to you in writing within 30 days of receipt of your written request for appeal. The decision made on your second level appeal is final and binding.

**How to Dispute a Determination**
If you believe that a determination is not correct, you have the right to appeal the decision by filing a grievance with Express Scripts. Express Scripts requests that you submit your grievance within 180 days from the postmark date of this determination. You or someone you designate
(your authorized representative) may submit your grievance verbally or in writing. You may call Express Scripts to learn how to name your authorized representative.

You may write, call or fax your grievance to Express Scripts.

You will receive notice of a determination within 30 days following receipt of your request.

An appeal can be expedited if a plan member has a terminal illness and the appeal involves an experimental or investigational issue. In this situation, the member can request a conference with your prescription drug benefit plan, as part of your prescription drug benefit plan’s grievance process (form to be mailed separately within 5 business days from date of this letter). Upon receiving the member’s request for a conference, your prescription drug benefit plan will arrange a conference within 30 calendar days. The purpose of this conference is to review the medical and scientific reasons for denying the coverage and to discuss alternative treatment, services, or supplies covered by your prescription drug benefit plan. The conference may take place by telephone or in person. The member, a designee of the member, or both may attend the conference. If the member is a minor or incompetent, then the parent, guardian, or conservator of the member may attend, as appropriate. If the effectiveness of either the proposed treatment, services, or supplies or any alternative treatment, services, or supplies covered by your prescription drug benefit plan would be materially reduced if not provided at the earliest possible date, then the conference would be arranged within 5 calendar days. Cases meeting expedited criteria are resolved within three (3) days. In these situations, we encourage you to speak with your Express Scripts representative to explore these options. The treating practitioner may contact your prescription drug benefit plan’s Medical Director to discuss alternative treatment, services, or supplies covered by your prescription drug benefit plan, if any.

In addition to the above, if you believe that your prescription drug benefit plan provider has improperly denied, delayed or modified requested health care services, you may be eligible for an Independent Medical Review (IMR) through Express Scripts. Eligibility for independent medical reviews normally requires that you first submit a grievance to Express Scripts. If you decide not to request an IMR, you may give up the right to pursue some legal actions against Express Scripts. Additional information about IMR can be obtained through Express Scripts.

If you are not satisfied with the final internal review, you may be able to ask for an independent, external review of our decision, as determined by your prescription drug benefit plan and any federal requirements.

Following completion of the appeals process explained above, if your claim is denied you have a right to arbitration. You and the California Schools VEBA agree to this forum for resolving
disputes and each acknowledge that they are giving up the right to a trial by court or jury. The Federal Arbitration Act will govern the interpretation and enforcement of the arbitration proceedings and the arbitration is begun by your making a written demand to California Schools VEBA. The arbitration will be conducted by Judicial Arbitration and Mediation Services (JAMS) according to its applicable Rules and Procedures. The arbitration findings will be final and binding except to the extent that state or federal law provides for judicial review of arbitration proceedings.
ADDITIONAL RULES THAT APPLY TO THIS PLAN

Qualified Medical Child Support Order (QMCSO)
Your prescription drug benefit plan will comply with all the terms of a qualified medical child support order (QMCSO). A QMCSO is an order or judgment from a court or administrative body that directs your prescription drug benefit plan to cover a child of a participant under the medical plan. Federal law provides that a medical child support order must meet certain form and content requirements in order to be a qualified medical child support order. When an order is received, each affected participant and each child (or the child’s representative) covered by the order will be given notice of the receipt of the order and a copy of your prescription drug benefit plan’s procedure for determining if the order is valid. Coverage under your prescription drug benefit plan pursuant to a medical child support order will not become effective until California Schools VEBA determines that the order is a QMCSO. If you have any questions, or if you would like to receive a copy of the written procedure for determining whether a QMCSO is valid, please contact the benefits representative at your district or association.

Subrogation
These benefits apply when plan benefits are paid as a result of injuries or illness you sustained, and you have a right to a recovery or have received a recovery.

Express Scripts has the right to recover plan payments made on your behalf from any party responsible for compensating you for your injuries. The following apply:

- Express Scripts has the first priority for the full amount of benefits they have paid from any recovery regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses and injuries.
- You and your legal representative must do whatever is necessary to enable Express Scripts to exercise its rights and do nothing to prejudice Express Scripts.
- Express Scripts has the right to take whatever legal action it sees fit against any party or entity to recover the benefits paid under your prescription drug benefit plan.
- To the extent that the total assets from which a recovery is available are insufficient to satisfy in full Express Scripts’ subrogation claim and any claim still held by you, the Express Scripts’ subrogation claim shall be first satisfied before any part of a recovery is applied to your claim, your attorney fees, other expenses or costs.
- Express Scripts is not responsible for any attorney fees, other expenses or costs without its prior written consent. Express Scripts further agrees that the “common fund” doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Express Scripts.
**Reimbursement**

If you obtain a recovery and Express Scripts has not been repaid for the benefits paid on your behalf, Express Scripts shall have a right to be repaid from the recovery in the amount of the benefits paid on your behalf and the following apply:

- You must reimburse Express Scripts to the extent of plan benefits Express Scripts paid on your behalf from any recovery.

- Notwithstanding any allocation made in a settlement agreement or court order, Express Scripts shall have a right of recovery, in first priority, against any recovery.

- You and your legal representative must hold in trust for Express Scripts proceeds of the gross recovery (i.e., the total amount of your recovery before attorney fees, other expenses or costs) to be paid to Express Scripts immediately upon your receipt of the recovery. You must reimburse Express Scripts, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The “common fund” doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Express Scripts.

- If you fail to repay Express Scripts, Express Scripts shall be entitled to deduct any of the unsatisfied portion of the amount of benefits Express Scripts administrator has paid or the amount of your recovery whichever is less, from any future benefit under your prescription drug benefit plan if:

  1. The amount Express Scripts paid on your behalf is not repaid or otherwise recovered by Express Scripts administrator; or

  2. You fail to cooperate.

- In the event that you fail to disclose to Express Scripts the amount of your settlement Express Scripts shall be entitled to deduct the amount of their lien from any future benefit under your prescription drug benefit plan.

- Express Scripts shall also be entitled to recover any of the unsatisfied portions of the amount they have paid or the amount of your settlement, whichever is less, directly from the providers to whom Express Scripts has made payments. In such a circumstance, it may then be your obligation to pay the provider the full billed amount, and Express Scripts would not have any obligation to pay the provider.

- Express Scripts is entitled to reimbursement from any recovery, in first priority, even if the recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make you whole.
Your Duties

● You must notify Express Scripts promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred, and all information regarding the parties involved.

● You must cooperate with Express Scripts in the investigation, settlement and protection of your prescription drug benefit plan's rights.

● You must not do anything to prejudice the rights of Express Scripts.

● You must send Express Scripts copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.

● You must promptly notify Express Scripts if you retain an attorney or if a lawsuit is filed on your behalf.

Coordination with Medicare (Active Employees)

Benefits for Individuals Who Are Entitled to Medicare
If you (or one of your dependents) are entitled to Medicare benefits but the employee is still actively working and eligible for this plan, the following rules apply.

The California Schools VEBA Prescription Drug Benefit Plan (“your prescription drug benefit plan”) is the primary payer – in other words, your claims go to your prescription drug benefit plan first – if any of the following apply:

● You are currently working for a district or association participating in the California Schools VEBA, or are enrolled as a legal opposite-sex spouse of an active employee, and you (or your covered spouse) first becomes entitled to Medicare benefits because of age,

● You are currently working for a district or association participating in the California Schools VEBA or are enrolled as a family member of an active employee and you (or your covered family member) first becomes entitled to Medicare benefits because of disability, or

● You (or your covered family member) first become entitled to Medicare benefits because you (or your covered family member) have end-stage renal disease. In this case, your prescription drug benefit plan is the primary payer for the first 30 months of Medicare entitlement due to end-stage renal disease. At the end of the 30-month period, Medicare will become the
primary payer. This rule applies regardless of whether or not you are currently working for a
district or association participating in the California Schools VEBA.

Your prescription drug benefit plan pays secondary and Medicare is the primary payer if you (or your
covered family member) are covered by Medicare, you (or your covered family member) do not have end-stage renal disease, and you are not currently working for a district or association participating in
the California Schools VEBA. IF MEDICARE IS PRIMARY, NOT ELIGIBLE FOR THIS RX PLAN.

If you (or your legal spouse) are over age 65 and your prescription drug benefit plan would otherwise
be the primary payer because you are still working, you or your spouse may also enroll in Medicare
and decline coverage under your prescription drug benefit plan. If you are working and you (or your
spouse) continue to receive coverage under your prescription drug benefit plan and also decide to
enroll in Medicare, your prescription drug benefit plan will pay primary and Medicare will pay
secondary. If you are working and elect Medicare, your prescription drug benefit plan cannot, by law,
pay benefits secondary to Medicare, except for certain individuals with end-stage renal disease.

Benefits for Disabled Individuals
If you stop working at a district or association participating in the California Schools VEBA because of a
disability, or if you retire before age 65 and subsequently become disabled as defined by Social
Security, you must apply for Medicare Parts A and B. Medicare Part A provides inpatient
hospitalization benefits, and Medicare Part B provides outpatient medical benefits, such as doctor’s
office visits. Medicare is the primary plan payer for most disabled persons.

Under the coordination of benefits rule for employees who qualify for Medicare because of disability,
Medicare generally is the primary payer. In other words, your claims go to Medicare first. If Medicare
pays less than the current benefit allowable by your prescription drug benefit plan, your prescription
drug benefit plan may pay the difference, up to the maximum current benefits allowable. In addition,
if Medicare denies payment for a service that your prescription drug benefit plan considers eligible,
your prescription drug benefit plan will pay up to its normal benefit amount after you meet the
calendar-year deductible, if any.

When Medicare is the primary payer, no benefits will be payable under your prescription drug benefit
plan for eligible Medicare benefits that are not paid because you did not enroll, qualify or submit
claims for Medicare coverage. This same rule applies if your doctor or hospital does not submit bills to
Medicare on your behalf. Medicare generally will not pay benefits for care received outside the United
States. Contact your local Social Security office for more information on Medicare benefits.

Important Reminder
Covered services and benefit levels under Medicare are subject to change by the federal government.
Contact your local Social Security office or log on to www.medicare.gov to obtain the most recent
information on Medicare costs and coverages.
Remember, enrollment in Medicare is not always automatic. You may have to apply for it with your local Social Security office.

**Special Note**
In certain situations, an individual may be eligible for coverage under your prescription drug benefit plan and Medicare.
CONTINUATION OF YOUR PRESCRIPTION DRUG BENEFIT PLAN COVERAGE

Continuation Coverage Rights Under COBRA

Introduction
You are receiving this summary because you are covered or have recently become covered under the California Schools Voluntary Employees’ Benefits Association (VEBA) Prescription Drug Benefit Plan by enrolling in medical coverage. This section of the summary contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under your prescription drug benefit plan. This section generally explains COBRA continuation coverage, when it may become available to you and your covered spouse and dependent children, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”). COBRA continuation coverage can become available to you when you would otherwise lose coverage under your prescription drug benefit plan. It can also become available to your spouse and dependent children who are covered under your prescription drug benefit plan when they would otherwise lose such coverage. Under Federal Law, Domestic Partners are not entitled to elect COBRA continuation coverage.

What is COBRA Continuation Coverage
COBRA continuation coverage is a continuation of your prescription drug benefit plan coverage when you would otherwise lose such coverage because of a life event known as a “qualifying event.” Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if covered under your prescription drug benefit plan at the time of a qualifying event, and such coverage is lost because of the qualifying event. Additionally, a child who is born to or adopted or placed for adoption with you (the covered employee) during the COBRA continuation coverage period is also considered a qualified beneficiary, provided that you elected COBRA continuation coverage for yourself. Under your prescription drug benefit plan, qualified beneficiaries must pay for the COBRA continuation coverage they elect, as described later in this section.

COBRA Qualifying Events
If you are an employee, you will become a qualified beneficiary if you lose coverage under your prescription drug benefit plan because either one of the following qualifying events happens:

- Your hours of employment are reduced to a level where you are no longer eligible for prescription drug coverage through your district; or

- Your employment ends for any reason other than your gross misconduct.
If you are the spouse of an employee, you will become a qualified beneficiary if you lose coverage under your prescription drug benefit plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse’s hours of employment are reduced;
- Your spouse’s employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to (i.e., enrolled in) Medicare benefits as a retiree (under Part A, Part B, or both); or
- You become divorced from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under your prescription drug benefit plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee’s hours of employment are reduced;
- The parent-employee’s employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to (i.e., enrolled in) Medicare benefits as a retiree (Part A, Part B, or both);
- The parents become divorced; or
- The child stops being eligible for coverage under your prescription drug benefit plan as a “dependent child.”

For this purpose, “lose coverage” means to cease to be covered under the same terms and conditions as in effect immediately before the qualifying event. For example, any increase in the premium or contribution that must be paid by you (or your covered spouse or dependent children) for coverage under your prescription drug benefit plan that results from the occurrence of a qualifying event is a loss of coverage.

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under your prescription drug benefit plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee’s spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under your prescription drug benefit plan. For this purpose, “loss of coverage” also means any substantial elimination of retiree health coverage within one year before or after the date the bankruptcy
proceeding commences, for a covered employee who had retired on or before the date of the substantial elimination of group health plan coverage.

### Giving Notice that a COBRA Qualifying Event (or Second Qualifying Event) has Occurred

Your prescription drug benefit plan will offer COBRA continuation coverage to qualified beneficiaries only after your district’s COBRA administrator has been timely notified that a qualifying event has occurred. When the qualifying event is the employee’s termination of employment (other than for gross misconduct) or reduction of work hours, death of the employee, commencement of a proceeding in bankruptcy with respect to your employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify your district’s COBRA administrator of the qualifying event.

**Important Note:** For the other qualifying events: divorce of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child, you must notify the benefits administrator at your district in writing within 60 days after the later of: 1) the date of the qualifying event (or second qualifying event) or 2) the date the qualified beneficiary loses (or would lose) coverage under your prescription drug benefit plan as a result of the qualifying event (or second qualifying event).

### How is COBRA Continuation Coverage Provided

Once your district’s COBRA administrator receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered (through a “COBRA Continuation Coverage Election Notice”) to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

If coverage under your prescription drug benefit plan is changed for active employees, the same changes will be provided to individuals receiving COBRA continuation coverage. Qualified beneficiaries also may change their coverage elections during the annual enrollment periods, if a change in status occurs, or at other times under your prescription drug benefit plan to the same extent that similarly situated non-COBRA employees or retirees may do so.

### Duration of COBRA Continuation Coverage

COBRA continuation coverage is a temporary continuation of health coverage. When the qualifying event is the employee’s termination of employment (other than for gross misconduct) or reduction of work hours, COBRA continuation coverage for the employee and the employee’s covered spouse and dependent children generally lasts for only up to a total of 18 months from the date of the qualifying event or the loss of coverage.

When the qualifying event is the death of the employee, the employee becoming entitled to (i.e., enrolled in) Medicare benefits as a retiree (under Part A, Part B, or both), or a divorce, COBRA continuation coverage for the employee’s spouse and/or dependent children (but not the employee) lasts for up to a total of 36 months. Also, the employee’s dependent children are entitled to COBRA
continuation coverage for up to 36 months after losing eligibility as a dependent child under the terms of your prescription drug benefit plan.

When the qualifying event is the bankruptcy of your employer, retiree health coverage under your prescription drug benefit plan for you and your covered spouse and dependent children may be continued for the rest of your (the retiree’s) life. After your death (including if you have already died when the bankruptcy proceeding commences), your surviving spouse and children may continue retiree health coverage for an additional 36 months after your death.

There are three ways in which the 18-month period of COBRA continuation coverage due to the employee’s termination of employment or reduction of work hours can be extended.

1. **Employee’s Medicare Entitlement Occurs Prior to a Qualifying Event That is Employee’s Termination of Employment or Reduction of Work Hours** - When the qualifying event is the employee’s termination of employment (other than for gross misconduct) or reduction of work hours, and the employee became entitled to (i.e., enrolled in) Medicare benefits less than 18 months before the qualifying event (even if Medicare entitlement was not a qualifying event for the employee’s spouse or dependent children because their coverage was not lost), COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of the employee’s Medicare entitlement. For example, if the employee becomes entitled to Medicare 8 months before the date on which employment terminates, COBRA continuation coverage for the employee’s covered spouse and dependent children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

2. **Disability Extension** - If either you, your spouse or any of your dependent children covered under your prescription drug benefit plan is determined by the Social Security Administration (SSA) to be disabled on the date of the employee’s termination of employment or reduction of work hours, or at any time during the first 60 days of COBRA continuation coverage due to such qualifying event, each qualified beneficiary (whether or not disabled) may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. To qualify for this disability extension, you must notify your district’s COBRA administrator [in writing] of the person’s disability status BOTH: 1) within 60 days after the latest of: i) the date of the disability determination by the SSA, ii) the date on which the qualifying event occurs, iii) the date on which you lose (or would lose) coverage under your prescription drug benefit plan, or iv) the date on which you are informed of both the responsibility to provide this notice and your prescription drug benefit plan procedures for providing such notice to your prescription drug benefit plan administrator, AND 2) before the original 18-month COBRA continuation coverage period ends. Also, if Social Security determines that the qualified beneficiary is no longer disabled, you are required to notify your
district’s COBRA administrator (in writing) within 30 days after this determination. If these procedures are not followed or if the notice is not provided in writing to your district’s COBRA administrator within the required period, you will not receive a disability extension of COBRA continuation coverage.

3. **Second Qualifying Event Extension** - If the employee’s spouse and/or dependent children experience a second qualifying event while receiving the initial 18 months of COBRA continuation coverage, the employee’s spouse and dependent children (but not the employee) can get up to 18 additional months of COBRA continuation coverage, for a maximum of **36 months** from the initial qualifying event, if timely [written] notice of the second qualifying event is given to your prescription drug benefit plan. This extension may be available to the employee’s spouse and any dependent children receiving COBRA continuation coverage if the employee or former employee dies, becomes entitled to (i.e., enrolled in) Medicare benefits as a retiree (under Part A, Part B, or both), or gets divorced or if the dependent child stops being eligible under your prescription drug benefit plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under your prescription drug benefit plan had the first qualifying event not occurred. If a second qualifying event occurs at any time during the 29-month disability continuation period (as described above), then each qualified beneficiary who is the employee’s spouse or dependent child (whether or not disabled) may further extend COBRA continuation coverage for seven (7) more months, for a total of up to 36 months from the employee’s termination of employment or reduction of work hours. (See above - “Giving Notice that a COBRA Qualifying Event [or Second Qualifying Event] has Occurred” - for important details on the proper procedures and timeframes for giving this notice to your prescription drug benefit plan administrator). If these procedures are not followed or if the notice is not provided in writing to your prescription drug benefit plan administrator within the required 60-day period, you will not receive an extension of COBRA continuation coverage due to a second qualifying event.

The table below provides a summary of the COBRA provisions outlined in this section.

<table>
<thead>
<tr>
<th>Qualifying Events That Result in Loss of Coverage</th>
<th>Maximum Continuation Period</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Employee</td>
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<tr>
<td>Employee’s reduction of work hours (e.g., full-time to part-time)</td>
<td>18 months</td>
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<tr>
<td>Employee’s termination of employment for any reason (other than gross misconduct)</td>
<td>18 months</td>
</tr>
</tbody>
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42
<table>
<thead>
<tr>
<th>Event</th>
<th>N/A</th>
<th>36 months</th>
<th>36 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee becomes entitled to Medicare (i.e., enrolled in Medicare)</td>
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<td></td>
</tr>
<tr>
<td>Employee or employee’s covered spouse or dependent child is disabled (as determined by the Social Security Administration) at the time of the qualifying event or becomes disabled within the first 60 days of COBRA continuation coverage that begins as a result of termination of employment or reduction of work hours</td>
<td>29 months</td>
<td>29 months</td>
<td>29 months</td>
</tr>
<tr>
<td>Employee dies</td>
<td></td>
<td>36 months</td>
<td>36 months</td>
</tr>
<tr>
<td>Employee and spouse divorce [legally separate]</td>
<td></td>
<td>36 months</td>
<td>36 months</td>
</tr>
<tr>
<td>Employee becomes entitled to Medicare within 18 months prior to termination of employment or reduction in work hours (even if such Medicare entitlement was not a qualifying event for the covered spouse or dependent child because their coverage was not lost)</td>
<td></td>
<td>36 months</td>
<td>36 months</td>
</tr>
<tr>
<td>Child no longer qualifies as a dependent child under the terms of your prescription drug benefit plan</td>
<td></td>
<td>N/A</td>
<td>36 months</td>
</tr>
</tbody>
</table>

1 36-month period is counted from the date the employee becomes entitled to Medicare.

**ELECTING COBRA CONTINUATION COVERAGE**

You and/or your covered spouse and dependent children must choose to continue coverage within 60 days after the later of the following dates:

- The date you and/or your covered spouse and dependent children would lose coverage under your prescription drug benefit plan as a result of the qualifying event; or
- The date your district’s COBRA administrator notifies you and/or your covered spouse and dependent children (through a “COBRA Continuation Coverage Election Notice”) of your right to choose to continue coverage as a result of the qualifying event.

**PAYING FOR COBRA CONTINUATION COVERAGE**

**Cost:** Generally, each qualified beneficiary is required to pay the entire cost of COBRA continuation coverage. The cost of COBRA continuation coverage is 102% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA continuation coverage. With regards to the 11-
month disability extension of COBRA continuation coverage, the cost of coverage for the 19th through 29th months of coverage is: 1) 150% of the cost of group health plan coverage for all family members participating in the same coverage option as the disabled individual, and 2) 102% for any family members participating in a different coverage option than the disabled individual, except as provided in the next sentence. If a second qualifying event occurs during the first 18 months of coverage, the 102% rate applies to the full 36 months even if the qualified beneficiary is disabled. However, if a second qualifying event occurs during the otherwise applicable disability extension period (that is, during the 19th through 29th months), then the cost of coverage for the 19th through 36th months of coverage is: 1) the 150% rate for all family members participating in the same coverage option as the disabled qualified beneficiary, and 2) the 102% rate for any family members in a different coverage option than the disabled qualified beneficiary.

Premium Due Dates: If you elect COBRA continuation coverage, you must make your initial payment for continuation coverage (including all premiums due but not paid) not later than 45 days after the date of your election. (This is the date the COBRA Election Notice is post-marked, if mailed.) If you do not make your initial payment for COBRA continuation coverage within 45 days after the date of your election, you will lose all COBRA continuation coverage rights under your prescription drug benefit plan. Payment is considered made on the date it is sent to your prescription drug benefit plan.

After you make your initial payment for COBRA continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The premium due date and exact amount due for each coverage period for each qualified beneficiary will be shown in the COBRA Election Notice you receive. Although periodic payments are due on the dates shown in the COBRA Election Notice, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under your prescription drug benefit plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you elect COBRA continuation coverage, but then fail to make an initial or periodic payment before the end of the 45 or 30 day grace period, respectively, for that coverage period, you will lose all rights to COBRA continuation coverage under your prescription drug benefit plan, and such coverage will be terminated retroactively to the last day for which timely payment was made (if any).

When COBRA Continuation Coverage Ends
COBRA continuation coverage for any person will end when the first of the following occurs:

- The applicable 18, 29 or 36-month COBRA continuation coverage period ends;
- Any required premium is not paid on time;
After the date COBRA continuation coverage is elected, a qualified beneficiary first becomes covered (as an employee or otherwise) under another group health plan not offered by the California Schools VEBA that does not contain any exclusion or limitation affecting a qualified beneficiary’s pre-existing condition, or the other group health plan’s preexisting condition limit or exclusion does not apply or is satisfied because of the HIPAA rules;

After the date COBRA continuation coverage is elected, a qualified beneficiary first becomes entitled to (i.e., enrolled in) Medicare benefits (under Part A, Part B, or both). This does not apply to other qualified beneficiaries who are not entitled to Medicare and does not apply at all to end retiree COBRA continuation coverage if bankruptcy is the qualifying event;

In the case of extended COBRA continuation coverage due to a disability, there has been a final determination, under the Social Security Act, that the qualified beneficiary is no longer disabled. In such a case, the COBRA continuation coverage ceases on the first day of the month that begins more than 30 days after the final determination is issued, unless a second qualifying event has occurred during the first 18 months of COBRA continuation coverage;

For newborns and children adopted by or placed for adoption with you (the employee) during your COBRA continuation coverage, the date your COBRA continuation coverage period ends unless a second qualifying event has occurred; or

Your employer ceases to provide any group health plan for its employees and retirees.

COBRA continuation coverage may also be terminated for any reason your prescription drug benefit plan would terminate coverage of a participant or beneficiary not receiving COBRA continuation coverage (such as fraud).

If You Have Questions
Questions concerning your prescription drug benefit plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.)

Keep Your Prescription Drug Benefit Plan Informed of Address Changes
In order to protect your rights, as well as the rights of your spouse and dependent children, you should keep district benefit’s administrator informed of any changes in the addresses of your spouse and/or dependent children. You should also keep a copy, for your records, of any notices you send to your prescription drug benefit plan administrator.
Plan Contact Information
McGregor & Associates, Inc.
Administrator for the California Schools VEBA
(619) 278-0021

Continuation of Coverage for Employees in the Uniformed Services (USERRA)
The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) guarantees certain rights to eligible employees who enter military service. The terms “Uniformed Services” or “Military Service” mean the Armed Forces (i.e., Army, Navy, Air Force, Marine Corps, Coast Guard), the reserve components of the Armed Services, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

Upon reinstatement, you are entitled to the seniority, rights and benefits associated with the position held at the time employment was interrupted, plus additional seniority, rights and benefits that would have been attained if employment had not been interrupted.

If your military leave is for less than 31 days, you may continue your prescription drug coverage by paying the same amount charged to active employees for the same coverage. If your leave is for a longer period of time, you will be charged up to the full cost of coverage plus a [2%] administrative fee.

The maximum period of continuation coverage available to you and your eligible dependents is the lesser of 24 months after the leave begins or the day the leave ends.

When you go on military leave, your work hours are reduced. As a result, you and your covered dependents may become eligible for COBRA. Any COBRA continuation period for which you are eligible will run concurrently with any USERRA continuation period for which you are eligible.

If you choose not to continue your prescription drug coverage while on military leave, you are entitled to reinstated health coverage with no waiting periods or exclusions (however, an exception applies to service-related disabilities) when you return from leave.

In general, to be eligible for the rights guaranteed by USERRA, you must:

- Return to work on the first full, regularly scheduled workday following your leave, safe transport home, and an eight-hour rest period if you are on a military leave of less than 31 days.

- Return to or reapply for employment within 14 days of completion of such period of duty, if your absence from employment is from 31 to 180 days.
Continuation of Coverage While on Family Medical Leave (FMLA)
Under the federal Family Medical Leave Act (FMLA), employees are generally allowed to take up to 12 weeks of unpaid leave for certain family and medical situations and continue their prescription drug benefit coverage benefits during this time. The company is required to maintain group health plan coverage for an employee on FMLA leave: a) if the employee had such coverage before taking the leave, and b) on the same terms as if the employee had continued to work. If applicable, employees may need to make arrangements to pay their share of group health plan contributions while on leave. In some instances, the company may recover contributions it paid to maintain health coverage for an employee who fails to return to work from FMLA leave.

If you are eligible, you can take up to 12 weeks of unpaid leave in a 12-month period for the following reasons:

- For the birth and care of your newborn child or a child that is placed with you for adoption or foster care
- For the care of a spouse, child, or parent who has a serious health condition
- For your own serious health condition.
- For “any qualifying exigency” (a qualifying urgent situation or pressing need) arising out of the fact that the spouse, son, daughter or parent of the employee is on active duty or called to active duty status as a member of the National Guard or Reserves in support of a contingency operation.

In addition, an eligible employee who is the spouse, son, daughter, parent or next of kin (that is, nearest blood relative) of a covered service member who is recovering from a serious illness or injury sustained in the line of duty on active duty is entitled to up to 26 weeks of leave in a single 12-month period to care for the service member. This leave may also be taken in the case of the eligible employee needing to care for a veteran with a qualifying serious injury or illness. This military caregiver leave is available during “a single 12-month period” during which an eligible employee is entitled to a combined total of 26 weeks for all types of FMLA leave. See U.S. Department of Labor, Employment Standards Administration, Wage and Hour Division, for Fact Sheets #28 and #28A, which provide further details on FMLA (http://www.dol.gov/compliance/laws/comp-fmla.htm).

Depending on the state where you live, the number of weeks of unpaid leave available to you for family and medical reasons may vary based on state law requirements.
IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this section of the summary carefully, and keep this summary for future reference. This section has information about your current prescription drug coverage with California Schools VEBA and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of your prescription drug benefit plans offering Medicare prescription drug coverage in your area. If you choose to enroll in a Medicare drug plan, your coverage under this plan will end on the effective date of the Medicare drug plan.

California Schools VEBA has determined that the prescription drug coverage offered by the California VEBA Prescription Drug Benefit Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.
PERMITTED USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Department of Health and Human Services has issued comprehensive federal regulations that give individuals broad protections over the privacy of their health records. These regulations are part of the Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Provision, which in part governs the transmission, privacy and security of health care information. The purpose of this law is to standardize and safeguard the transmission of protected health information, protect the privacy of your health information, and allow you access to your prescription drug benefit records.

HIPAA protection applies to the Medical including Vision, Dental, Prescription Drug, Employee Assistance Program (EAP), and Health Care Reimbursement Account programs. By providing privacy protections at a federal level, all employees, no matter which state they live in, will be covered by a national rule of privacy. Compliance with state law and other federal laws will be included as part of our total compliance program. These regulations apply to your health care providers, such as Physicians and Hospitals, as well as to your prescription drug benefit plan.

What Are My Rights Under the HIPAA Regulations?
The privacy regulations affect every individual who receives prescription drug benefit care and treatment. You will have the following rights and protections:

- Assurance that your prescription drug benefit information is kept private.
- Assurance that your prescription drug benefit information is not used for unrelated purposes, such as making employment or financial decisions, unless specifically authorized by you. This authorization may be limited or revoked at a later time.
- Access to your prescription drug benefit records. You have the right to see and obtain a copy of certain designated prescription drug benefit records, and to request changes to those records. It’s possible that your prescription drug benefit plan may not have these kinds of records.
- The right to request in writing an accounting of any uses and disclosures of your protected health information.
- The right to request a restriction or limitation on how your prescription drug benefit plan can use or disclose your private prescription drug benefit information for purposes of treatment, payment or health care operations. We are not required to agree to your request.
- The right to a reasonable request for confidential communications, so that we communicate with you about prescription drug benefit matters in a certain way or at a certain location.
- Assurance that your prescription drug benefit plan will follow the privacy guidelines described in this Summary Plan Description, and will inform you of any changes to its privacy policies.
• Access to a complaint resolution process, and to the Department of Health and Human Services (HHS), if you believe the privacy of your protected health information has been violated.

What Type of Health Information is Protected by HIPAA?
HIPAA safeguards Protected Health Information (PHI). PHI is individually identifiable health information that is created or received by a Human Resources Representative or other authorized individual as part of administering your prescription drug benefit plan. PHI has an identifier such as your name, social security number, or date of admission that, when attached to the record, makes it clear that the record concerns your health information.

Your prescription drug benefit plan may use or disclose PHI for purposes of payment, treatment or health care operations. Information may also be disclosed in order to comply with federal, state, or local law and to avert a safety threat to you or the public.

However, every effort is made to ensure the confidentiality of all health information received by your prescription drug benefit plan and your prescription drug benefit plan Sponsor. Even when protected information is released for the purposes of payment, treatment, or health care operations, only the minimum amount of information determined necessary to achieve the goal will be released.

Your prescription drug benefit plan, in accordance with the Health Insurance Portability and Accountability Act (HIPAA), maintains policies and practices to protect the confidentiality of protected health information (PHI) it receives about you and your covered dependents. These policies and practices are documented in the California Schools VEBA Privacy Notice (“HIPAA Privacy Notice”). You can obtain a copy of the HIPAA Privacy Notice by contacting your local Human Resources Representative. Alternatively, you can obtain a copy of this Notice free of charge upon your written request to your prescription drug benefit plan Privacy Officer at the following address:

VEBA HIPAA Privacy Officer
8885 Rio San Diego Drive, Suite 300
San Diego, California 92108

For a copy of the HIPAA Privacy Notice applicable to your fully insured health care plan, please contact your insurance carrier. Contact information for California Schools VEBA insurance carriers is listed in this Summary of Benefits.

Service providers to your prescription drug benefit plan have entered into business associate agreements concerning the use and disclosure of PHI.

What if there is a Breach of my Protected Health Information?
If there is a breach of unsecured PHI, the Health Information Technology for Economic and Clinical Health Act (HITECH) provisions under the American Recovery and Reinvestment Act of 2009 (ARRA) requires that the individual must be notified “without unreasonable delay” but no later than 60 days
after discovering the breach. The notice must be written in plain language and contain the following information:

- A brief description of what happened, including the date of the breach and the date of discovery;
- The types of PHI involved (name, SSN, date of birth, diagnosis, etc.);
- Any steps individuals should take to protect themselves from potential harm;
- A description of the steps the covered entity is taking to investigate, mitigate losses, and protect against further breaches; and
- Contact information for individuals to ask questions, including a toll-free number, email address, website or postal address.

Notices must be sent to the individual’s last known address or by email if the individual agrees.

The notice must be provided only if PHI is “unsecured,” which means it is not made unusable, unreadable, or indecipherable to unauthorized individuals through the use of technologies approved by the HHS, as described on the HHS website. However, your prescription drug benefit plan is not required to make PHI unsecured.

A “breach” means the acquisition, access, use, or disclosure of unsecured PHI in a manner not permitted by HIPAA, which poses a significant risk of financial, reputational, or other harm to you or your covered dependent. A breach does not include: (i) unintentional, good faith acquisition, access, or use of PHI by a California Schools VEBA workforce member, person acting on behalf of your prescription drug benefit plan, a Plan’s business associate (i.e., a third party provider of services for your prescription drug benefit plan), which does not result in further use or disclosure of PHI in an impermissible manner, (ii) any inadvertent disclosure by one person authorized to access PHI to another person authorized to access PHI, when both such persons are either at your prescription drug benefit plan or at the same business associate, and such PHI is not further disclosed in an impermissible manner, or (iii) a disclosure where a business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such PHI.

What if I Have a Complaint About the Handling of My Protected Health Information?
You may file a written complaint with your prescription drug benefit plan, or with HHS, if you believe your privacy rights have been violated. The Privacy Officer is your prescription drug benefit plan’s first point of contact for handling your Complaint or grievance. The Privacy Officer will investigate the details of your Complaint, and get back to you within ten business days concerning the results of his/her investigation. You will not be penalized or otherwise retaliated against for filing a complaint.
If you are not satisfied that your Complaint has been resolved satisfactorily, you may file a request for additional review. The Privacy Officer will provide the background information concerning the Complaint and results of the investigation to the VEBA Board of Directors or its designee to get your Complaint resolved.
DEFINITIONS

**Brand Name Drug** — A drug protected by a patent when introduced, which prohibits other companies from manufacturing the drug while the patent remains in effect, issued to the original innovator or marketer and manufactured by a single source. The name is unique and usually does not describe the chemical makeup (for example, Tylenol, Nexium, Zestril, and Prozac).

**Coinsurance** — A set percentage you pay for drugs or supplies after the deductible has been met.

**Copayment** — A set dollar amount you pay for drugs or supplies. The set dollar amount varies based on the type of drug.

**Express Advantage Network** — Select pharmacies within the retail pharmacy network where members may receive retail prescriptions for a lower copay.

**Express Scripts Pharmacy home delivery service Pharmacy Service** — A component of the prescription drug benefit that enables you to obtain up to a 90-day supply of maintenance drugs at a time for the specified mail copayment. These drugs are delivered directly to your home or to an alternate address designated by you. The copayment amount depends on whether you purchase a generic, preferred or non-preferred brand drug.

**Generic Drug** — Drug products manufactured and distributed after the patent of the innovator brand-name drug has expired. The generic drug must have the same active ingredient, strength and dosage form as its brand-name counterpart and is generally sold under its chemical name. Food and Drug Administration (FDA) reviewed generic equivalents meet the same requirements as its brand-name equivalent. Generic drugs cost less to develop, manufacture, and market than brand-name drugs, so they’re likely to be less expensive for you and your health plan.

**Maintenance Drug** — Prescription drugs used for treatment of chronic medical conditions, such as asthma, diabetes, hypertension, and/or coronary artery disease.

**Non-Preferred Drug** — A non-preferred brand name drug may still be available to you at a higher cost than drugs on the preferred drug list.

**Participating Retail Pharmacy Network** — A nationwide listing of pharmacies that have agreed to participate in Express Scripts’ retail pharmacy network. By presenting your Express Scripts prescription drug ID card, you pay your specified copayments and have no claim forms to fill out.

**Preferred Drug** — A drug selected by Express Scripts as preferred based on criteria such as clinical effectiveness, safety and cost. Generics and preferred brands are included on the preferred drug list, and result in lower cost to both you and your prescription drug benefit plan when dispensed from a participating retail network pharmacy or Express Scripts Pharmacy home delivery service.

**Prior Authorization (or Prior Approval)** — The process under which you may obtain certain drugs only after obtaining prior plan approval (administered by Express Scripts).
Retail Network Pharmacy Prescription Drug Card — An ID card that allows you to use a Express Scripts participating retail network pharmacy to purchase prescription medication and pay only the copayment amount for covered drugs.

VEBA Smart90 Network — Rite Aid and Costco pharmacies are available as an option for members to use for 84- to 90-day prescriptions in lieu of the Express Scripts Pharmacy home delivery service Pharmacy Service. No other pharmacies are included in the VEBA Smart90 Network.

PLAN ADMINISTRATION

The information about the administration of your prescription drug benefit plan is provided below. While you should not need these details on a regular basis, the information may be useful if you have specific questions about your prescription drug benefit plan.

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<tr>
<th>Details About Plan Administration</th>
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<tr>
<td><strong>Plan Administrator</strong></td>
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<tr>
<td><strong>Employer Identification Number</strong></td>
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<tr>
<td><strong>Official Plan Name and Number</strong></td>
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<td><strong>Plan Year</strong></td>
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<td><strong>Type of Plan</strong></td>
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Plan Funding

The California Schools VEBA prescription drug benefit service is self-funded. Benefits from this plan are paid from employee and employer contributions, as applicable, and from the general assets of the California Schools VEBA, as needed. California Schools VEBA has contracted with third-party administrators to administer this plan.

VEBA’s Right to Amend or Terminate Your Prescription Drug Benefit Plan

It is California School VEBA’s intent that the California Schools VEBA prescription drug benefit services will continue indefinitely. However, VEBA reserves the right to amend, modify, suspend or terminate your prescription drug benefit plan, in whole or in part, by action of the VEBA’s Board of Directors. Any such action would be taken in writing and maintained with the records of your prescription drug benefit plan. Plan amendment, modification, suspension or termination may be made for any reason, and at any time, and may, in certain circumstances, result in the reduction of or elimination of benefits or other features of your prescription drug benefit plan to the extent permitted by law.

California School VEBA’s rights include the right to obtain coverage and/or administrative services from additional or different insurance carriers, HMOs, third-party administrators, etc., at any time, and the right to revise the amount of employee contributions. Employees will be notified of any material modification to your prescription drug benefit plan.

If the prescription drug benefit plan is terminated by VEBA, the Board of Directors will determine whether and the method through which any assets of the trust will be distributed in accordance with federal regulations.

Limitation on Assignment

Your rights and benefits under your prescription drug benefit plan cannot be assigned, sold or transferred to your creditors or anyone else. However, you may assign your rights to benefits under your prescription drug benefit plan to the health provider who provided the prescription drug benefit services.

Rescission of Benefits

Under certain circumstances, plan benefits may be denied or reduced from those described in this summary of benefits. Cancellation or discontinuation of coverage is permitted if it has only a prospective effect on coverage, or is effective retroactively due to failure to pay required premiums or contributions.
Rescission of coverage is a cancellation or discontinuance of coverage retroactively for reasons other than failure to pay required premiums or contributions, except for rescission permitted by law. For example, rescission of coverage may be permitted in limited circumstances such as fraud or intentional misrepresentation of a material fact. If coverage is subject to rescission, all affected participants must be provided with a written notice at least 30 days prior to the date of rescission.