**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.iehp.org or call 1-855-433-4347 For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or www.iehp.org or call 1-855-433-4347 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $6,300/individual, $12,600/family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care and services indicated in chart starting on Page 2. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | Yes. $500/individual pharmacy deductible, $1,000/family pharmacy deductible | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | $9,100/individual, $18,200/family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums and healthcare this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | Yes. For a list of preferred providers, visit www.iehp.org or call 1-855-433-4347. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | Yes. Requires written prior authorization. | This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist. |

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

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $60 copayment/visit deductible applies | Not covered | Deductible does not apply to first 3 non-preventive office visits, combined with primary care, speciality care, and urgent care. |
| | Specialist visit | $95 copayment/visit deductible applies | Not covered | Deductible does not apply to first 3 non-preventive office visits, combined with primary care, speciality care, and urgent care. Requires prior authorization. |
| | Preventive care/screening/ immunization | No charge | Not covered | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 40% coinsurance/visit deductible applies (x-ray), $40 copayment/visit deductible does not apply (blood work) | Not covered | Requires physician order. |
| | Imaging (CT/PET scans, MRIs) | 40% coinsurance/visit deductible applies | Not covered | Requires prior authorization. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.iehp.org. | Generic drugs | $17 copayment (retail), pharmacy deductible applies; $34 copayment (mail order), pharmacy deductible applies | Not covered | Supply/order: up to 30-day (retail); 30-100 day (mail order), except where quantity limits apply. Prior authorization is required for select drugs. Deductible applies, $500/individual, $1,000/family. |
| | Preferred brand drugs | 40% coinsurance up to $500 per prescription (retail), pharmacy deductible applies; 40% coinsurance up to $1,000 per prescription (mail order), pharmacy deductible applies | Not covered | |

* For more information about limitations and exceptions, see the plan or policy document at www.iehp.org

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Non-preferred brand drugs | 40% coinsurance up to $500 per prescription (retail), pharmacy deductible applies; 40% coinsurance up to $1,000 (mail order), pharmacy deductible applies | Not covered | |
| | Specialty drugs | 40% coinsurance up to $500 per prescription, pharmacy deductible applies | Not covered | Prior authorization is required for select drugs. Quantity limits may apply to select drugs. Supply/order: up to a 30-day supply filled by specialty pharmacy. Deductible applies, $500/individual or $1,000/family. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 40% coinsurance deductible applies | Not covered | Requires prior authorization. |
| | Physician/surgeon fees | 40% coinsurance deductible applies | Not covered | None. |
| **If you need immediate medical attention** | Emergency room care | 40% coinsurance/visit deductible applies, ER Physician- No charge | 40% coinsurance/visit deductible applies, ER Physician- No charge | Coinsurance waived if admitted into the hospital. Out-of-network services must meet the criteria for emergency care. |
| | Emergency medical transportation | 40% coinsurance/ transport deductible applies | 40% coinsurance/ transport deductible applies | Out-of-network services must meet the criteria for emergency care. |
| | Urgent care | $60 copayment/visit deductible applies | $60 copayment/visit deductible applies | Deductible waived for first 3 non-preventive office visits, combined with primary care, speciality care, and urgent care. Out-of-network Urgent care services are covered while you are out of the service area. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 40% coinsurance deductible applies | Not covered | Requires prior authorization. |
| | Physician/surgeon fees | 40% coinsurance deductible applies | Not covered | None |

* For more information about limitations and exceptions, see the plan or policy document at www.iehp.org

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Office visit-individual therapy session $60 copayment/visit deductible does not apply; group therapy session-$30 copayment/visit deductible does not apply<br>Other than office visit $60 copayment/visit deductible does not apply | Not covered | Requires prior authorization except for the initial behavioral health assessment. |
| | Inpatient services | 40% coinsurance deductible applies | Not covered | Requires prior authorization. |
| If you are pregnant | Office visits | Prenatal-No charge; $60 copayment/visit deductible applies | Not covered | Cost sharing does not apply for preventive services. |
| | Childbirth/delivery professional services | 40% coinsurance deductible applies | Not covered | Coverage includes abortion services. |
| | Childbirth/delivery facility services | 40% coinsurance deductible applies | Not covered | Coverage includes abortion services. |
| If you need help recovering or have other special health needs | Home health care | 40% coinsurance deductible applies | Not covered | Limited to 100 visits each calendar year. Requires prior authorization. |
| | Rehabilitation services | $60 copayment/visit deductible does not apply | Not covered | Requires prior authorization. |
| | Habilitation services | $60 copayment/visit deductible does not apply | Not covered | Requires prior authorization. |
| | Skilled nursing care | 40% coinsurance deductible applies | Not covered | Limited to 100 days per calendar year. Requires prior authorization. |
| | Durable medical equipment | 40% coinsurance deductible applies | Not covered | Requires prior authorization. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Hospice services | No charge | Not covered | Requires prior authorization. |
| **If your child needs dental or eye care** | Children's eye exam | No charge | Not covered | Limited to 1 visit per year. |
| | Children's glasses | No charge | Not covered | Selected frames; 1 per calendar year; contact lenses covered in lieu of glasses. |
| | Children's dental check-up | No charge | Not covered | 1 routine preventive exam/6 months |

## Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Chiropractic care
- Cosmetic Surgery
- Dental care (adults)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (adult)
- Routine foot care
- Weight loss programs (exclusion does not apply to preventive care behavioral interventions)

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

- Abortion services
- Acupuncture
- Bariatric surgery

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- Department of Labor's Employee Benefits Security Administration: 1-866-444-EBSA (3272) or visit https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa
- California Department of Managed Health Care: 1-888-466-2219 or TDD line 1-877-688-9891 for the hearing and speech impaired or visit www.dmhc.ca.gov.
- Office of Personnel Management Multi-State Plan Program: https://www.opm.gov/healthcare-insaurance/multi-state-plan-program/consumer/

Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- IEHP at 1-855-433-4347 (TTY 711), Monday-Friday, 8:00am to 6:00pm PST. Give your Member ID number, your name and the reason for your complaint.
- By mail: Call IEHP at 1-855-433-4347 (TTY 711), Monday-Friday, 8:00am to 6:00pm PST, and ask to have a form sent to you. When you get the form, fill it out. Be sure to include your name, Member ID number and the reason for your complaint. Tell us what happened and how we can help you.

Mail the form to:
IEHP
Attention: Grievance and Appeals Department
P.O. Box 1800
Rancho Cucamonga, CA 91729-1800

- Your doctor's office will have complaint forms available.
- Online: visit the IEHP website at www.iehp.org

Additionally, a consumer assistance program can help you file your appeal. Contact the California Department of Managed Health Care at the contact information provided above.

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

**Does this plan meet the Minimum Value Standards? Not Applicable**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-433-4347 (TTY 711).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-433-4347 (TTY 711).

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-855-433-4347 (TTY 711).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-433-4347 (TTY 711).

***To see examples of how this plan might cover costs for a sample medical situation, see the next section.***

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## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| **The plan's overall deductible** | **$6,300** |
| **Specialist *cost sharing*** | **$95** |
| **Hospital (facility) *cost sharing*** | **40%** |
| **Other *cost sharing*** | **$60** |

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

| **Total Example Cost** | **$12,700** |
|---|---|
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| Deductibles | $6,300 |
| Copayments | $500 |
| Coinsurance | $2,000 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$8,860** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$6,300** |
| **Specialist *cost sharing*** | **$95** |
| **Hospital (facility) *cost sharing*** | **40%** |
| **Other *cost sharing*** | **$60** |

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

| **Total Example Cost** | **$5,600** |
|---|---|
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| Deductibles | $2,100 |
| Copayments | $400 |
| Coinsurance | $1,200 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$3,720** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$6,300** |
| **Specialist *cost sharing*** | **$95** |
| **Hospital (facility) *cost sharing*** | **40%** |
| **Other *cost sharing*** | **$60** |

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

| **Total Example Cost** | **$2,800** |
|---|---|
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles | $2,100 |
| Copayments | $200 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,300** |

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