



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](http://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](http://www.iehp.org) or call 1-855-433-4347 to request a copy.

| Important Questions                                                                   | Answers                                                                                                                                              | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall <a href="#">deductible</a>?</b>                                | \$1,400/individual, \$2,800/family                                                                                                                   | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .                                                                                                                                                                                                            |
| <b>Are there services covered before you meet your <a href="#">deductible</a>?</b>    | Yes. <a href="#">Preventive care</a> and services indicated in chart starting on Page 2.                                                             | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                                       |
| <b>Are there other <a href="#">deductibles</a> for specific services?</b>             | Yes. \$50/individual pharmacy <a href="#">deductible</a> , \$100/family pharmacy <a href="#">deductible</a> ; <a href="#">applies to Tiers 2-4</a> . | You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b> | \$3,350/individual, \$6,700/family                                                                                                                   | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                                                                                                                             |
| <b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>               | <a href="#">Premiums</a> and healthcare this <a href="#">plan</a> doesn't cover.                                                                     | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Will you pay less if you use a <a href="#">network provider</a>?</b>               | Yes. For a list of preferred providers, visit <a href="http://www.iehp.org">www.iehp.org</a> or call 1-855-433-4347.                                 | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| <b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>    | Yes. Requires written <a href="#">prior authorization</a> .                                                                                          | This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                      |

 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<br>(You will pay the least)                                                                                                   | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                           |
| <b>If you visit a health care provider's office or clinic</b>                                                                                                                                     | Primary care visit to treat an injury or illness       | \$15 <a href="#">copayment</a> /visit                                                                                                          | Not covered                                        | None.                                                                                                                                                                                     |
|                                                                                                                                                                                                   | <a href="#">Specialist</a> visit                       | \$25 <a href="#">copayment</a> /visit                                                                                                          | Not covered                                        | Requires <a href="#">prior authorization</a> .                                                                                                                                            |
|                                                                                                                                                                                                   | <a href="#">Preventive care/screening/immunization</a> | No charge                                                                                                                                      | Not covered                                        | You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. |
| <b>If you have a test</b>                                                                                                                                                                         | <a href="#">Diagnostic test</a> (x-ray, blood work)    | \$50 <a href="#">copayment</a> /visit (x-ray), \$30 <a href="#">copayment</a> /visit (blood work)                                              | Not covered                                        | Requires physician order.                                                                                                                                                                 |
|                                                                                                                                                                                                   | Imaging (CT/PET scans, MRIs)                           | \$100 <a href="#">copayment</a> /visit                                                                                                         | Not covered                                        | Requires <a href="#">prior authorization</a> .                                                                                                                                            |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.iehp.org">www.iehp.org</a> . | Tier 1 - Generic drugs                                 | \$8 <a href="#">copayment</a> (retail), \$16 <a href="#">copayment</a> (mail order)                                                            | Not covered                                        | Supply/order: up to 30-day (retail); 30-100 day (mail order), except where quantity limits apply. <a href="#">Prior authorization</a> is required for select drugs.                       |
|                                                                                                                                                                                                   | Tier 2 - Preferred brand drugs                         | \$25 <a href="#">copayment</a> (retail), pharmacy deductible applies; \$50 <a href="#">copayment</a> (mail order), pharmacy deductible applies | Not covered                                        |                                                                                                                                                                                           |
|                                                                                                                                                                                                   | Tier 3 - Non-preferred brand drugs                     | \$45 <a href="#">copayment</a> (retail), pharmacy deductible applies; \$90 <a href="#">copayment</a> (mail order), pharmacy deductible applies | Not covered                                        |                                                                                                                                                                                           |

| Common Medical Event                                                      | Services You May Need                            | What You Will Pay                                                                                                                                                                                               |                                                                 | Limitations, Exceptions, & Other Important Information                                                                                                                         |
|---------------------------------------------------------------------------|--------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                  | Network Provider<br>(You will pay the least)                                                                                                                                                                    | Out-of-Network Provider<br>(You will pay the most)              |                                                                                                                                                                                |
|                                                                           | Tier 4 - <a href="#">Specialty drugs</a>         | 15% <a href="#">coinsurance</a> up to \$150 per prescription, pharmacy deductible applies                                                                                                                       | Not covered                                                     | <a href="#">Prior authorization</a> is required for select drugs. Quantity limits may apply to select drugs. Supply/order: up to a 30-day supply filled by specialty pharmacy. |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center)   | 20% <a href="#">coinsurance</a>                                                                                                                                                                                 | Not covered                                                     | Requires <a href="#">prior authorization</a> .                                                                                                                                 |
|                                                                           | Physician/surgeon fees                           | 20% <a href="#">coinsurance</a>                                                                                                                                                                                 | Not covered                                                     | None                                                                                                                                                                           |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | \$200 <a href="#">copayment</a> /visit, ER Physician-No charge                                                                                                                                                  | \$200 <a href="#">copayment</a> /visit, ER Physician- No charge | <a href="#">Copayment</a> waived if admitted into the hospital. Out-of-network services must meet the criteria for emergency care.                                             |
|                                                                           | <a href="#">Emergency medical transportation</a> | \$75 <a href="#">copayment</a> /transport                                                                                                                                                                       | \$75 <a href="#">copayment</a> /transport                       | Out-of-network services must meet the criteria for emergency care.                                                                                                             |
|                                                                           | <a href="#">Urgent care</a>                      | \$15 <a href="#">copayment</a> /visit                                                                                                                                                                           | \$15 <a href="#">copayment</a> /visit                           | Out-of-network <a href="#">Urgent care</a> services are covered while you are out of the service area.                                                                         |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | 20% <a href="#">coinsurance</a> deductible applies                                                                                                                                                              | Not covered                                                     | Requires <a href="#">prior authorization</a> .                                                                                                                                 |
|                                                                           | Physician/surgeon fees                           | 20% <a href="#">coinsurance</a>                                                                                                                                                                                 | Not covered                                                     | None                                                                                                                                                                           |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | Office visit-individual therapy session \$15 <a href="#">copayment</a> /visit; group therapy session - \$7.50 <a href="#">copayment</a> /visit<br>Other than office visit \$15 <a href="#">copayment</a> /visit | Not covered                                                     | Requires <a href="#">prior authorization</a> except for the initial behavioral health assessment.                                                                              |
|                                                                           | Inpatient services                               | 20% <a href="#">coinsurance</a> deductible applies                                                                                                                                                              | Not covered                                                     | Requires <a href="#">prior authorization</a> .                                                                                                                                 |
| If you are pregnant                                                       | Office visits                                    | Prenatal-No charge<br>Postnatal-\$15 <a href="#">copayment</a> /visit                                                                                                                                           | Not covered                                                     | <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> .                                                                                          |
|                                                                           | Childbirth/delivery professional services        | 20% <a href="#">coinsurance</a>                                                                                                                                                                                 | Not covered                                                     | Coverage includes abortion services.                                                                                                                                           |
|                                                                           | Childbirth/delivery facility services            | 20% <a href="#">coinsurance</a> deductible applies                                                                                                                                                              | Not covered                                                     | Coverage includes abortion services.                                                                                                                                           |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.iehp.org](http://www.iehp.org)

| Common Medical Event                                                  | Services You May Need                     | What You Will Pay                                     |                                                    | Limitations, Exceptions, & Other Important Information                                   |
|-----------------------------------------------------------------------|-------------------------------------------|-------------------------------------------------------|----------------------------------------------------|------------------------------------------------------------------------------------------|
|                                                                       |                                           | Network Provider<br>(You will pay the least)          | Out-of-Network Provider<br>(You will pay the most) |                                                                                          |
| <b>If you need help recovering or have other special health needs</b> | <a href="#">Home health care</a>          | \$15 <a href="#">copayment</a> /visit                 | Not covered                                        | Limited to 100 visits each calendar year. Requires <a href="#">prior authorization</a> . |
|                                                                       | <a href="#">Rehabilitation services</a>   | \$15 <a href="#">copayment</a> /visit                 | Not covered                                        | Requires <a href="#">prior authorization</a> .                                           |
|                                                                       | <a href="#">Habilitation services</a>     | \$15 <a href="#">copayment</a> /visit                 | Not covered                                        | Requires <a href="#">prior authorization</a> .                                           |
|                                                                       | <a href="#">Skilled nursing care</a>      | 20% <a href="#">coinsurance</a><br>deductible applies | Not covered                                        | Limited to 100 days per calendar year. Requires <a href="#">prior authorization</a> .    |
|                                                                       | <a href="#">Durable medical equipment</a> | 15% <a href="#">coinsurance</a>                       | Not covered                                        | Requires <a href="#">prior authorization</a> .                                           |
|                                                                       | <a href="#">Hospice services</a>          | No charge                                             | Not covered                                        | Requires <a href="#">prior authorization</a> .                                           |
| <b>If your child needs dental or eye care</b>                         | 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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .) |                                                                                                                                                             |                                                                                                                                                                                                                                          |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <ul style="list-style-type: none"> <li>Chiropractic care</li> <li>Cosmetic Surgery</li> <li>Dental care (adults)</li> <li>Hearing aids</li> </ul>                                                 | <ul style="list-style-type: none"> <li>Infertility treatment</li> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>Private-duty nursing</li> <li>Routine eye care (adult)</li> <li>Routine foot care</li> <li>Weight loss programs (exclusion does not apply to preventive care behavioral interventions)</li> </ul> |  |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)                                                      |                                                                                                                                                             |                                                                                                                                                                                                                                          |  |
| <ul style="list-style-type: none"> <li>Abortion services</li> </ul>                                                                                                                               | <ul style="list-style-type: none"> <li>Acupuncture</li> </ul>                                                                                               | <ul style="list-style-type: none"> <li>Bariatric surgery</li> </ul>                                                                                                                                                                      |  |

**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](http://www.dmhc.ca.gov).
- Office of Personnel Management Multi-State Plan Program: <https://www.opm.gov/healthcare-insurance/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](http://www.HealthCare.gov) or call 1-800-318- 2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.iehp.org](http://www.iehp.org)

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](http://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, kwijigo 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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,400 |
| ■ <a href="#">Specialist cost sharing</a>                       | \$25    |
| ■ Hospital (facility) <a href="#">cost sharing</a>              | 20%     |
| ■ Other <a href="#">cost sharing</a>                            | \$15    |

**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*)

|                                        |                 |
|----------------------------------------|-----------------|
| <b>Total Example Cost</b>              | <b>\$12,700</b> |
| <b>In this example, Peg would pay:</b> |                 |
| <i>Cost Sharing</i>                    |                 |
| <a href="#">Deductibles</a>            | \$0             |
| <a href="#">Copayments</a>             | \$400           |
| <a href="#">Coinsurance</a>            | \$2,200         |
| <i>What isn't covered</i>              |                 |
| Limits or exclusions                   | \$60            |
| <b>The total Peg would pay is</b>      | <b>\$2,660</b>  |

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,400 |
| ■ <a href="#">Specialist cost sharing</a>                       | \$25    |
| ■ Hospital (facility) <a href="#">cost sharing</a>              | 20%     |
| ■ Other <a href="#">cost sharing</a>                            | \$15    |

**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*)

|                                        |                |
|----------------------------------------|----------------|
| <b>Total Example Cost</b>              | <b>\$5,600</b> |
| <b>In this example, Joe would pay:</b> |                |
| <i>Cost Sharing</i>                    |                |
| <a href="#">Deductibles</a>            | \$0            |
| <a href="#">Copayments</a>             | \$700          |
| <a href="#">Coinsurance</a>            | \$200          |
| <i>What isn't covered</i>              |                |
| Limits or exclusions                   | \$20           |
| <b>The total Joe would pay is</b>      | <b>\$920</b>   |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,400 |
| ■ <a href="#">Specialist cost sharing</a>                       | \$25    |
| ■ Hospital (facility) <a href="#">cost sharing</a>              | 20%     |
| ■ Other <a href="#">cost sharing</a>                            | \$15    |

**This EXAMPLE event includes services like:**

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

|                                        |                |
|----------------------------------------|----------------|
| <b>Total Example Cost</b>              | <b>\$2,800</b> |
| <b>In this example, Mia would pay:</b> |                |
| <i>Cost Sharing</i>                    |                |
| <a href="#">Deductibles</a>            | \$0            |
| <a href="#">Copayments</a>             | \$400          |
| <a href="#">Coinsurance</a>            | \$200          |
| <i>What isn't covered</i>              |                |
| Limits or exclusions                   | \$0            |
| <b>The total Mia would pay is</b>      | <b>\$600</b>   |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.