

2027

Combined Evidence of Coverage and Disclosure Form (“EOC/DF”)

Covered California HMO Plan

Issued by Inland Empire Health Plan

To the extent herein limited and defined, this Evidence of Coverage ("EOC") provides for comprehensive health services provided through the Inland Empire Health Plan (“IEHP”). This plan has been certified as a Qualified Health Plan by Covered California, the state’s health insurance marketplace. Upon timely payment of plan premiums in the manner provided in this EOC, IEHP hereby agrees to furnish services and benefits as defined in this EOC to eligible Subscribers and their eligible Family Members according to the terms and conditions of this EOC.

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CEO

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Use of Special Words

Special words used in this EOC to explain Your Plan have their first letter capitalized and appear in the "Definitions" section.

The following words are used frequently:

- **“You” or “Your”** refers to anyone in Your Family who is covered; that is, anyone who is eligible for coverage in this Plan and who has been accepted for enrollment.
- **“We” or “Our”** refers to IEHP.
- **“Subscriber”** means the primary Member.
- **“Member” or “Enrollee”** is the Subscriber or an enrolled Family member who receives services from the Plan.
- **“Primary Care Physician” or “PCP”** is the individual physician each Member selected who will provide and obtain IEHP authorization for all covered medical care.
- **“Plan” or “Evidence of Coverage (EOC)”** have similar meanings. You may think of these as meaning Your IEHP benefits.

Please read the content below so You will know from whom or what group of providers health care may be obtained.

Term of Your Coverage

For Subscribers and any Family Members whose application for enrollment is accepted by IEHP, this EOC becomes effective on the date stated on Your confirmation of enrollment, at 12:00 midnight. The EOC will remain in effect subject to the payment of plan premiums.

You may terminate this EOC by notifying Covered California or IEHP at least 14 calendar days before the date of Your requested termination date. For example, if notice is provided on June 14, disenrollment will be effective July 1. Your coverage will end at 12:01am. 14 days after You notify Covered California or IEHP. Or on an earlier date that You request if Covered California or IEHP agrees to this date.

IEHP may not renew this EOC for causes as set forth in the "Termination for Cause" section below. If the terms of this EOC are altered by IEHP as the result of State or Federal law, no resulting reduction in coverage will adversely affect a Member at the time of such change. Change in coverage will not take effect until the next plan year unless required by State or Federal law.

Plan Premiums (Prepayment Fees)

Payment of Plan Premiums

The Subscriber is responsible for payment of Plan premiums to IEHP.

The first Plan Premium must be paid to IEHP on or before the last day of the first coverage month of your IEHP Covered policy. After that, full payment is due on the 25th of each month for the next coverage month while the EOC is in effect.

Have questions? Contact IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711), Monday-Friday 8am-6pm PST. Visit us online at iehp.org.

Plan premiums are payable by the Subscriber and are based on number of covered individuals. Plan Premiums must include those Members whose coverage starts during the month and those Members whose coverage terminates during the month. Regarding coverage of newly born or newly adopted children, see the “Newly Acquired Dependents” section below.

Premium payments can be made by any one of these options: a personal checking account, check, cashier’s check, money order, cash, debit card or credit card, or general purpose pre-paid debit card.

Premium payments by a paper (check, cashier’s check, or money order) must be mailed to:

IEHP
P.O. Box 511399
Los Angeles, CA 90051-7954

To make a payment by phone, call IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711) and dial 1.

Premium Payments may also be made in person at the IEHP office Monday-Friday between 8 am and 4 pm:
10801 Sixth Street
Rancho Cucamonga, CA 91730

Plan Premiums may be changed by IEHP effective January 1st of each year with at least 60 calendar days written notice to the Subscriber prior to the date of such change.

If this EOC is terminated for any reason, the Subscriber shall be liable for all Plan Premiums for any time this EOC is in force during any notice period.

30-Day Grace Period

If You do not pay Your plan premiums by the invoice due date of the month for which plan premiums are due after the first coverage month IEHP will send a Notice of Start of Grace Period which will provide:

- (a) dollar amount due which must be paid in full to avoid termination of coverage.
- (b) date of the last day of paid coverage.
- (c) names of all enrollees affected by the notice.
- (d) additional details regarding the grace period.
- (e) consequences of losing coverage for nonpayment of Plan premiums.
- (f) the date the grace period begins and expires

The grace period begins on the first day after the last day of paid coverage. Coverage will continue during the 30-day grace period. However, You are still responsible to pay unpaid premiums and any cost share or deductible amounts required under the EOC. If full payment is not received by the end of the 30-day grace period, the EOC will be cancelled.

Have questions? Contact IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711), Monday-Friday 8am-6pm PST. Visit us online at iehp.org.

IEHP will mail a termination notice that will provide the following information:

- (a) that the EOC has been cancelled for non-payment of Plan Premiums.
- (b) the specific date and time when coverage is terminated for the Subscriber and all Dependents.
- (c) Your right to submit a grievance.

IEHP will allow one reinstatement during any twelve-month period, if reinstatement requirements are met and the amounts owed are paid within 15 calendar days of the date the notice confirming Your termination is mailed. If You do not obtain reinstatement of the cancelled EOC within the required 15 days or if the EOC has previously been cancelled for non-payment of Plan Premiums during the previous or current contract year, then IEHP is not required to reinstate You and You will need to reapply for coverage. Amounts received after the termination date will be refunded to You by IEHP within 20 business days.

Three-Month Grace Period

Subscribers and enrolled Dependents who are getting Federal Advance Premium Tax Credits (“APTC”) or California Premium Subsidy have a three-month grace period instead of a 30-day grace period for failure to pay Plan Premium charges. If You do not pay the outstanding Plan Premium for each Family Member receiving coverage for the month by the first day of the month for which Plan Premiums are due after the first coverage month, IEHP will send You a Notice of Start of Federal Grace Period.

IEHP will pay claims for Covered Services during the first month of the three-month grace period. However, IEHP will suspend Your coverage and pend claims for services in the second and third months of the three-month grace period. If You pay the entire amount of plan premiums due before the end of the three-month grace period, coverage that was suspended will be reinstated and IEHP will proceed to process pended claims for services rendered by health care providers in the second and third month of the three-month grace period.

If You DO NOT pay the entire amount of outstanding plan premiums in full before the end of the three-month grace period, IEHP will terminate Your coverage and indicate that Your coverage effectively ended on the first day of the second month of Your three-month grace period. IEHP will mail a termination notice. If IEHP terminates Your coverage because You have not paid plan premiums in full before the end of the three-month grace period, any pended claims will be denied. Providers whose claims are denied by IEHP may bill You for payment and You may be responsible for payment. If Your coverage terminates for this reason, You will not be allowed to reinstate coverage after the three-month grace period ends.

Introduction to IEHP

The coverage described in this EOC includes the Essential Health Benefits required by the Affordable Care Act (“ACA”). These are not subject to any annual dollar limits.

American Indians and Alaskan Natives (“AIAN”) eligibility will be confirmed by Covered California. AIAN Members have no cost sharing for Essential Health Benefits that are provided by a Network provider that is also a provider of the Indian Health Service (IHSI), an Indian Tribe, Tribal Organization, or Urban Indian Organization. Plus, an American Indian or Alaskan Native who is enrolled in a zero-cost sharing plan has no cost sharing for Essential Health Benefits that are provided by any Network Provider.

The benefits described under this EOC do not discriminate on the basis of race, ethnicity, color, nationality, ancestry, gender, gender identity, gender expression, age, disability, sexual orientation, genetic information, health status, need for health care services, marital status, Domestic Partner status or religion. And these benefits are not subject to any pre-existing condition or exclusion period.

How to Get Care – Choice of Physicians and Providers

When You enroll in this Plan, You must select a Network Primary Care Physician (“PCP”). Your PCP will manage Your medical care. PCP will provide or obtain authorization for covered medical service except for:

- Emergency services.
- Out-of-network urgent care while out of the service area.
- Preventive health services (including immunizations) in-network.
- Obstetrician and gynecological services in-network.
- Sexual and reproductive health care services in-network.
- Certain behavioral health and substance use disorder services in-network.

Call Your PCP directly to set up a visit. To learn more about how to select a PCP and a listing of the Network Primary Care Physicians in the IEHP Service Area, visit the IEHP website at iehp.org. You can also call IEHP Member Services 1-855-433-IEHP (4347) (TTY 711).

Selecting a Primary Care Physician

Each member of Your household that is enrolled with IEHP may select a different PCP. Contact IEHP Member Services to select a PCP. If You and Your Enrolled Dependent(s) did not select a PCP after enrolling, IEHP will assign a PCP based on:

- The language You speak.
- The distance to a PCP office from Your house. We try to assign You a PCP within 10 miles.
- The PCP’s specialty most appropriate for the Member’s age.

For children, a pediatrician may be assigned as the PCP. Until You make Your PCP choice, IEHP assigns one for You.

Have questions? Contact IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711), Monday-Friday 8am-6pm PST. Visit us online at iehp.org.

Changing Your PCP

If You would like to change Your or Your Dependent's PCP, please call IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711). You may also make this change by visiting the IEHP website at iehp.org. The change to Your or Your Dependent's PCP will be effective the following business day.

IEHP's Covered California Network

Benefits for Physician and Hospital services are only available when You live or work in the IEHP Service Area and use a Network Provider. You must also get Covered Services and supplies from Network ancillary, Pharmacy, and Behavioral Health Providers.

The benefits of this plan are only available for Covered Services received from Network Provider, except for:

- (a) Urgent Care while outside of the IEHP Service Area.
- (b) all Emergency Care.
- (c) Covered Services provided by a non-contracted provider when authorized by IEHP.

Note: Not all Physician and Hospitals that contract with IEHP are Network Providers for this plan. Only those Physicians and Hospitals identified as participating in the Covered California Network may provide services under this plan. The continued participation of any one physician, hospital, or other provider cannot be guaranteed. Please call IEHP Member Services or visit the IEHP website at iehp.org for help identifying Network Providers in the Covered California network.

If You have a doctor You want to keep, or You want to find a new PCP, You can look in the IEHP Provider Directory. It has a list of all PCPs in the IEHP network. The Provider Directory has other information to help You choose a PCP. If You need a Provider Directory, call IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711). You can also find the IEHP Provider Directory on IEHP's website iehp.org.

Non-Contracted Provider Services Obtained at a Network Facility

While getting Covered Services at a Network health facility, if You receive Covered Services from a non-contracted provider, You will pay the Network cost sharing amount for these services. Non-contracted Providers at Network facilities cannot bill You for their services when the services are approved by IEHP.

IEHP Pharmacy Network

Except in an emergency, only pharmacies identified as Network Pharmacies may provide the Prescription Drug benefit under this plan. For a list of pharmacies in the IEHP Covered California Pharmacy Network, call IEHP Member Services or visit the IEHP website at iehp.org. Pharmacies that are not in the IEHP Covered California Pharmacy Network are considered non-contracted Pharmacies under this Plan.

Have questions? Contact IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711), Monday-Friday 8am-6pm PST. Visit us online at iehp.org.

Continuity of Care

Members who are in a course of treatment from a provider that leaves IEHP's network or new Members that were being treated by a non-participating provider, including a hospital, under a prior health plan and meet any of the conditions below can request Continuity of Care:

Qualifying Condition	Timeframe
Acute Condition	As long as the condition lasts
Serious Chronic Condition	No more than 12 months
Pregnancy	During Pregnancy and immediate postpartum care
Terminal Illness	As long as the person lives
Care of a Child up to 36 months	Up to 12 months
An already scheduled surgery or procedure	The surgery or procedure must be scheduled to happen within 180 days of your doctor or hospital leaving the Health Plan

IEHP may provide coverage for continued care, subject to cost share and any limitations of this Plan. You must request the coverage within 60 days of Your effective date unless You can show that it was not reasonably possible to make the request within the 60-day timeframe. The non-contracted provider must be willing to accept the same contract terms applicable to providers contracted with IEHP and who practice in the same or similar geographic region. If the provider does not accept such terms, IEHP is not obligated to provide coverage with that provider.

Transition of Care for New Enrollees

You may request continued care from a provider, including a hospital, that does not contract with IEHP if Your prior coverage was with another plan prior to enrollment with IEHP and You had to change plans because your individual health plan is no longer available in the marketplace. A prior health plan may be responsible for coverage until Your coverage starts with IEHP. IEHP would assume responsibility for Covered Services upon the effective date of Your coverage with IEHP, not prior.

Existing Member from a Terminated Provider

If IEHP's contract with a Physician or other provider ends, IEHP will transfer any affected Members to another Network Physician or provider and make every effort to ensure continuity of care. At least 60 days prior to termination of a contract with a Physician or acute care Hospital, IEHP will provide a written notice to affected Members. For all other hospitals that terminate their contract with IEHP, a written notice will be provided to affected Members within 5 days after the effective date of the contract termination.

To request continued care, You will need to complete a Continuity of Care Request Form. If You would like to learn more about how to request continued care, call Member Services at 1-855-433-IEHP (4347) (TTY 711).

Have questions? Contact IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711), Monday-Friday 8am-6pm PST. Visit us online at iehp.org.

Selecting a Network Mental Health Professional

Mental Health and Substance Use Disorder benefits are covered under this Plan. If You need help finding a Network Mental Health Professional, call IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711). IEHP will help You identify a Network Mental Health Professional or a Network physician close to where You live or work, with whom You can set up a visit. IEHP has a Maternal Mental Health Program which includes treatment for pre- and post-partum maternal mental health conditions. Your PCP or You can call IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711) to set up a visit.

Certain services and supplies for Mental Health and Substance Use Disorders may require prior authorization by IEHP to be covered. Please refer to “Mental Health and Substance Use Disorders” in the “Plan Benefits” section for a complete description of Mental Health and Substance Use Disorder services and supplies.

Specialist, Referral Care, and Authorizations

Sometimes You may need care that the PCP cannot provide. At such times, Your PCP will submit a referral for You to see to a Specialist or other health care provider for that care. Your PCP or another Specialist will provide You a referral to visit a Specialist within the time frame listed in the “Access to Care Guidelines” section of this EOC. A Specialist is a doctor who has extra education in one area of medicine. Your PCP will work with You to choose a Network Specialist. Your PCP may give You a form to take to the Specialist. The Specialist will fill out the form and send it back to Your PCP. The Specialist will treat You for as long as they think You need treatment. If You have a health problem that needs special medical care for a long time, You may need a standing referral. Refer to the “Standing Referral to Specialty Care for Medical and Surgical Services” section below.

You are completely financially responsible for medical care that the PCP does not provide or IEHP does not authorize except for Medically Necessary care provided in a legitimate emergency.

Timeframes by type of referral request:

- Routine or regular referral – 5 Business days
- Urgent referral – 24 to 72 hours

Please call IEHP if You do not get a response within the above time frames.

Prior Authorizations

Some health care services are reviewed, approved, or denied according to medical necessity. This is called Prior Authorization. IEHP will work with Your provider to receive and review all necessary information in order to analyze the request for authorization. If the request is denied, You will be informed and told how to appeal the denial. Call IEHP Member Services if You would like a copy of the policies and procedures used to decide if a service is medically necessary. If medically necessary services are not available in network within geographic and timely access standards, IEHP will arrange out-of-network and follow-up services.

Have questions? Contact IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711), Monday-Friday 8am-6pm PST. Visit us online at iehp.org.

The following services do not require prior authorization:

- Emergency services (go to “Emergency Care Services” section to learn more).
- Preventive health services (including immunizations) in-network.
- Obstetrician and gynecological services in-network.
- Sexual and reproductive health care services in-network.

Some Mental Health and Substance Use Disorder services require prior authorization, including the benefits listed below:

- Outpatient procedures that are not part of an office visit
- Crisis Residential Program
- Inpatient Mental Health and Inpatient Substance Use Disorder Services
- Inpatient non-Medical Transitional Residential Recovery Services for Mental Health and Substance Use
- Inpatient Services to treat acute medical complications of detoxification
- Outpatient Partial Hospitalization
- Psychological and Neuropsychological Testing
- Psychiatric Observation
- Substance Use Disorder Day Treatment and half-day partial hospitalization.
- Outpatient Detoxification
- Substance Use Disorder Intensive Outpatient Treatment Programs
- Mental Health Intensive Outpatient Treatment Programs
- Substance Use Disorder Medical Treatment for Withdrawal
- Behavioral Health Treatment for Autism Spectrum Disorder
- Outpatient Transcranial Magnetic Stimulation.
- Electroconvulsive Therapy (ECT).

The following Mental Health and Substance Use Disorder services do not require a prior authorization:

- Emergency Room Services
- Individual Therapy
- Group Therapy
- Diagnostic Evaluation.
- Outpatient Medication Management
- Opioid Replacement Therapy
- Crisis Intervention

To learn more about services accessible without a prior authorization and the general process for getting prior authorization for all other Mental Health and Substance Use Disorder services, please call IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711).

Note: The fact that a physician or other provider may perform, prescribe, order, recommend or approve a service, supply, or hospitalization does not, in itself, make it Medically Necessary or make it a Covered Service. Call IEHP Member Services 1-855-433-IEHP (4347) (TTY 711) or visit IEHP’s website at iehp.org for more details about Covered Services.

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Obstetrical/Gynecological (OB/GYN) Physician Services

You do not need a referral from Your PCP or prior authorization from IEHP to get access to obstetrical or gynecological care from a Network provider who specializes in obstetrics or gynecology. The Network provider may be required to comply with getting prior authorization for certain services, following a pre-approved treatment plan, or processes for making referrals. For a list of Network providers who specialize in obstetrics or gynecology, call IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711) or visit IEHP's website at iehp.org.

Obstetrical and gynecological services are defined as:

- Physician services related to prenatal, perinatal, and postnatal (pregnancy) care.
- Physician services provided to diagnose and treat disorders of the female reproductive system and genitalia.
- Physician services for the diagnosis and treatment of breast cancer and other disorders of the breast. Medically Necessary services related to the diagnosis and treatment of breast cancer, include but are not limited to labs, outpatient services, inpatient services (such as mastectomy and lymph node dissection), and prescription drugs.
- Routine annual gynecological exams.

Reproductive and Sexual Health Care Services Self-Referral

You may get reproductive and sexual health care Physician services from a Network Provider without first contacting or getting a referral from Your PCP. Reproductive and sexual health care services include but are not limited to:

- Pregnancy services
- Contraceptives and treatment
- Home test kit for sexual transmitted disease (STD), covered with no cost sharing.
- Diagnosis and treatment of sexual transmitted disease (“STD”)
- Medical care due to rape or sexual assault, including collection of medical evidence, emergency room care and follow-up health care without imposing cost sharing for the first nine months after initial treatment. Coverage does not require any of the following:
 - A police report file on the rape or sexual assault
 - Charges to be brought to the assailant
 - Assailant to be convicted of rape or sexual assault
- HIV testing

The reproductive and sexual health care Physician will consult with Your PCP regarding Your condition, treatment and any need for follow-up care. Cost share requirements may differ depending on the service provided. Refer to the “Schedule of Benefits” section.

Standing Referral to Specialty Care for Medical and Surgical Services

A standing referral is a referral to a Network Specialist or specialty care center for more than one visit without Your PCP having to provide a referral for each visit. You may receive a standing referral to a Specialist if Your continuing care and recommended treatment plan is determined

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Medically Necessary by IEHP, in consultation with the Specialist, and You. The treatment plan may limit the number of visits to the Specialist, the period of time that the visits are authorized, or require that the Specialist provide Your PCP or IEHP with regular reports on the health care provided. Extended access to a Network Specialist is available to Members who have a life threatening, degenerative, or disabling condition. To request a standing referral, ask Your PCP, Specialist or call the IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711) or visit IEHP's website at iehp.org.

If You see a Specialist before You get a referral and prior authorization from IEHP, You may have to pay for the cost of the treatment. If IEHP denies the request for a referral, IEHP will send You a letter to explain the reason. The letter will also tell You what to do if You don't agree with this decision.

Utilization management process

IEHP has specific processes for Utilization Management (UM). These processes are used when Your Doctor's Utilization Management Committee and/or Medical Director approves or denies referral requests.

IEHP also has guidelines or criteria that are used in specific cases to approve or deny requested health care services. In all cases, Your Doctor's Utilization Management Committee and/or Medical Director is required to take a Member's needs into account when making decisions to approve or deny requested health care services.

If You would like a copy of the IEHP Utilization Management processes, or would like a specific treatment guideline or criteria, please call IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711).

The Utilization Management (UM) staff is on hand between 8am and 5pm during working days to talk about any UM issues. Staff may send outbound messages regarding UM inquiries during normal working hours and will always identify themselves by name, title, and organization name when calling or returning Your calls.

Your Financial Responsibility

Your PCP will coordinate and obtain authorization for all Your care. You are responsible for any required Deductible, Copayment, or Coinsurance amount for certain services, as described in the "Schedule of Benefits."

However, You are completely financially responsible for medical care that the PCP does not provide or IEHP does not authorize except for Medically Necessary care provided in a legitimate emergency. You are also financially responsible for care and all services that this Plan does not cover.

Deductibles

For certain services and supplies under this Plan, a calendar year Deductible applies. You must

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pay an amount of covered expenses for these services equal to the Calendar Year Deductible before the benefits are paid by Your Plan. Refer to the "Schedule of Benefits" section for more details on Deductibles.

The Calendar Year Deductible is required for certain medical services and is applied to the Out-of-Pocket Maximum ("OOPM"). After the Deductible is satisfied, You are still responsible for paying any other applicable cost share until You satisfy the Individual or Family OOPM. If You are a Member in a Family Plan (with two or more Members), You reach the Deductible either when You meet the amount for one Member, or when Your entire Family reaches the Family amount.

Calendar Year Out-of-Pocket Maximum ("OOPM")

The OOPM is the maximum amount You must pay for Covered Services during a Calendar Year.

Once the total amount of all Deductibles and cost share You pay for Covered Services and supplies in one Calendar Year equals the OOPM amount, no payment for Covered Services and supplies will be required by You. If amounts for Covered Services and supplies paid for all enrolled Members in a Family Plan equals the Family OOPM amount, no further payment is required from any enrolled Member of that Family for the rest of the Calendar Year. Your payments for non-Covered Services or supplies will not be applied to the OOPM amount.

Once an individual Member in a Family satisfies the individual OOPM, the remaining enrolled Family Members must continue to pay the cost share and the Calendar Year Deductibles until either (a) the sum of such cost share and Deductibles reaches the Family OOPM or (b) each enrolled Family Member individually satisfies the individual OOPM.

Only amounts that are applied to the individual Member's OOPM amount may be applied to the Family's OOPM amount. Any amount You pay for Covered Services that exceeds the individual OOPM amount for one Member will be refunded to You by IEHP and will not apply toward Your Family's OOPM. Individual Members cannot pay more than their individual OOPM amount to the Family OOPM.

IEHP will provide You with up-to-date accrual balances toward Your annual deductible and OOPM. You can obtain these accrual balances by calling IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711), or visit the IEHP website at iehp.org and logon to your profile. For every month in which benefits are used until the calendar year deductible and OOPM are met, IEHP will mail You an explanation of benefits (EOB) that will provide an updated accrual balance for Your deductible and OOPM. You can opt out of mailed notices and request electronic notification by calling IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711), or visit the IEHP website at iehp.org and logon to your profile to change your notification preferences.

Timely Access to Care

The California Department of Managed Health Care (DMHC) has issued regulations (California

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Code of Regulations Title 28, Section 1300.67.2.2) with requirements for timely access to non-emergency health care services. IEHP provides access to covered health care services in a timely manner.

To access triage or screening services 24/7, contact the IEHP Nurse Advice Line at 1-888-244-IEHP (4347) (TTY 711).

Please see the "Language Assistance Services" section, and the "Notice of Language Services" section to learn more about no cost interpreter services.

Definitions Related to Timely Access to Care

Triage or Screening is the evaluation of a Member's health concerns and symptoms by talking to a doctor, nurse, or other qualified health care professional to determine the Member's urgent need for care.

Triage or Screening Wait Time will not exceed 30 minutes. It is the time it takes to speak by phone with a doctor, nurse, or other qualified health care professional to screen or triage a member who may need care.

Business Day is every official working day of the week. Typically, a business day is Monday through Friday, and does not include weekends or holidays.

Services	Access to Care Guidelines
PCP visit	within 10 business days of request for an appointment
Urgent PCP visit	within 48 hours of request for an appointment
Routine Check-up/Physical Exam	within 30 business days of request for an appointment
Psychiatrist (Behavioral Health Physician) visit	within 10 business days of request for an appointment.
A therapist or social worker, non-Physician visit	within 10 business days of request for an appointment
Urgent Mental Health or Substance Use Disorder visit	within 48 hours of request for an appointment
Non-life threatening behavioral health emergency	within 6 hours of request for an appointment
Specialist visit	within 15 business days of request for an appointment
Urgent Specialist visit	within 96 hours of request for an appointment
Ancillary services	within 15 business days of request for an appointment
Urgent Ancillary services	within 96 hours of request for an appointment

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Setting up Appointments

Your Primary Care Physician or Network Mental Health Professional

When You need to see Your PCP or Network Mental Health Professional, call his or her office for an appointment. When You set up a visit, identify Yourself as an IEHP Covered California Member, and tell the receptionist when You would like to see Your doctor. The receptionist will make every effort to schedule an appointment at a time best suited for You. If You need to cancel Your visit, notify Your Physician as soon as You can.

As defined above, You may need to wait for a visit. Wait times depend on Your condition and the type of care You need. Your PCP or Network Mental Health Professional may decide that it is okay to wait longer for a visit if it does not harm Your health.

Specialist for Medical and Surgical Services

Your PCP is Your main doctor who makes sure You get the care You need when You need it. Sometimes Your PCP will send You to a Specialist. Once You get approval to receive the Specialist services call the Specialist's office to set up an appointment.

Telehealth/Virtual Care Services

Telehealth/Virtual care is a way of getting services without being in the same physical location as Your provider. Telehealth/Virtual care may involve speaking in real-time with Your provider or involve sharing information with Your Network Provider via the phone or other virtual options. However, Telehealth/Virtual care may not be available for all Covered Services. You can contact Your PCP or IEHP to learn which types of services may be available through Telehealth/Virtual care. Additional information related to telehealth care options can be found at IEHP.org. It is important that both You and Your provider agree that the use of Telehealth/Virtual care for a service is appropriate for You. You have the right to in-person services and are not required to use Telehealth/Virtual Care even if Your provider agrees that it is appropriate for You.

Canceling or Missing Your Appointment

If You cannot go to Your appointment, it is important that You call the doctor's office right away. By canceling or rescheduling Your appointment, You let someone else be seen by the doctor.

24-Hour Nurse Advice Line

When you have health care needs, you should always attempt to see your Primary Care Doctor first. When you can't reach your doctor after-hours or your doctor is not available, You can call the 24-Hour Nurse Advice at 1-888-244-IEHP (4347) (TTY 711). This service is available to You 24 hours a day, seven (7) days a week, to help answer Your health care questions and have Your health concerns and symptoms reviewed by a registered nurse. This service is free of charge and available to You in Your language. The PCP or IEHP nurse will answer Your questions and help You decide if You need to come into the clinic/doctor's office.

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If You have a life-threatening emergency, call “911” or go to the closest emergency room right away. Use “911” only for true emergencies as explained below.

If You are experiencing a mental health or substance use crisis, or have thoughts of suicide, call or Text “988” or chat 988lifeline.org/chat.

What is 988?

The 988 Suicide & Crisis Lifeline gives 24/7, confidential support to people going through emotional distress, suicide or substance use crisis. The 988 Suicide and Crisis Lifeline offers free and confidential support for anyone in crisis. Get in touch with trained crisis counselors, who will listen, give emotional support and connect you with needed resources. Call or text 988 anytime. Coverage includes behavioral health crisis services provided by the 988 call center and referrals from this call center to a mobile crisis team or other behavioral health crisis service. Behavioral health crisis stabilization services and care provided by the 988 call center, mobile crisis or other behavioral health crisis service are covered regardless of whether the service is provided by an in-network or out-of-network provider or facility.

How is 988 different than 911?

Dial 988 to access the Lifeline network and crisis support. This is distinct from the 911 public safety number, which focuses on dispatching emergency medical services, fire and police as needed.

Emergency Care

This section provides details about what to do when You need medical care right away.

In an emergency call “911” or go to the nearest Hospital.

IEHP covers emergency medical care 24 hours a day, 7 days a week, whether inside or outside of IEHP’s service area. Emergency medical services are Medically Necessary Covered Services, including

Ambulance and Mental Health services, which a Member reasonably believes are necessary to stop or relieve:

- A serious illness or symptom
- An injury, severe pain, or active labor
- A condition that needs immediate diagnosis and treatment

Emergency services include a medical screening, exam, and evaluation by a doctor or other appropriate provider. Emergency services also include both physical and mental emergency conditions. Examples of some emergencies include, but are not limited to:

- Breathing problems
- Seizures (convulsions)
- Extreme bleeding
- Unconsciousness/blackouts (will not wake up)
- Severe pain (including chest pain)
- Swallowing of poison or medicine overdose

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- Broken bones

If You are admitted to a Hospital as an inpatient directly from the emergency room, the emergency room facility Copayment will not apply.

You must contact Your PCP, Your Network Mental Health Professional, or IEHP within 48 hours, or as soon as You can after receiving emergency services from non-contracted providers. Your PCP or the Network Mental Health Professional will evaluate Your circumstances and make all necessary arrangements for Your continuing care. Any treatment provided that is not authorized by Your PCP or IEHP, and which is later determined by IEHP not to be for emergency services, will not be covered.

After Your medical problem ceases to be an emergency and Your condition is stable, any additional care You receive is considered Follow-Up Care or post-stabilization care. Follow-up Care services must be performed by Your PCP or Your Network Mental Health Professional or authorized by IEHP, or it will not be covered.

If You are outside of the United States, You will have to pay for the emergency services that You receive. IEHP will reimburse You for the covered emergency services up to the maximum Allowable Amount. Please submit Your bill, proof of payment and medical records within one year of the service date. You may do so using any one of the following options:

- Email: Covered@iehp.org
- Fax: (909) 890-5877 or (909) 477-8546
- In Person: 10801 Sixth Street, Suite 120, Rancho Cucamonga CA 91730
- Mail: Attention Member Services, P.O. Box 1800, Rancho Cucamonga, CA 91729

Follow-up Care after Emergency Care at a Hospital that is not contracted with IEHP

If You are treated for Emergency Care at a Hospital that is not contracted with IEHP, Follow-Up Care must be authorized by IEHP or it will not be covered. Once Your Emergency Medical Condition or Psychiatric Emergency Medical Condition is stabilized, and Your treating health care provider at the Hospital believes that You require additional Medically Necessary Hospital services, the non-contracted Hospital must contact IEHP to get timely authorization. If IEHP determines that You may be safely transferred to a Hospital that is contracted with IEHP and You refuse to consent to the transfer, the non-contracted Hospital must provide You with written notice that You will be financially responsible for 100% of the cost for services provided to You after Your Emergency condition is stable.

Urgent Care

There is a difference between needing care urgently and an emergency. Urgent care is when a condition, illness or injury is not life-threatening, but needs medical care right away. For urgent care, call Your PCP. Many of IEHP's doctors have urgent care hours in the evening and on weekends. If You cannot reach Your PCP, call IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711) for Network Urgent Care locations. Or You can call 24/7 Nurse Advice Line at 1-888-244-IEHP (4347) (TTY 711), to learn the level of care that is best for You.

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Common conditions that may fall under urgent care are:

- Cold/flu
- Vomiting/Diarrhea
- Rashes
- Urinary Tract Infections
- Earache/headache
- Back pain
- Sprains/Strains
- Skin/eye infections
- Wheezing or cough
- Abdominal pain

As a IEHP Member, You have access to triage or screening services, 24 hours per day, 7 days per week. Except in an emergency, the Covered Services of this plan must be performed by Your PCP or Your Network Mental Health Professional.

Urgent Care within the Service Area -- Services must be performed by Your PCP, Network urgent care provider, or Network Mental Health Professional in order to be covered.

Call Your PCP or Your Network Mental Health Professional regarding medical care that You believe is needed right away. They will evaluate Your situation and give You directions about where to go for the care You need.

Urgent Care outside of the Service Area – If you are outside of the service area and need urgent care, you may visit any urgent care center near you.

Always present Your IEHP Member ID Card to health care providers regardless of where You are. It will help them understand the type of coverage You have. They may be able to assist You in contacting IEHP, Your PCP or the Network Mental Health Professional.

Prescription Drugs

If You purchase a covered Prescription Drug for a medical Emergency or Urgent Care from a non-participating pharmacy, IEHP will reimburse You the retail cost of the drug, less any required Deductible and cost share shown in the "Schedule of Benefits." Exclusions and Limitations and requirements of the Formulary Drug List also apply when drugs are dispensed by a Nonparticipating Pharmacy. You will have to pay for the Prescription Drug when it is dispensed. To be reimbursed, You must file a claim with IEHP. Call IEHP Member Services at 1- 855-433-IEHP (4347) (TTY 711) or visit the IEHP website at iehp.org.

Pediatric Vision Services

In the event Your covered Dependent requires Emergency Pediatric Vision Care, please contact a IEHP Network Vision Provider. Certain Network Vision Providers are available during extended hours and weekends and can provide services for urgent or unexpected conditions that occur after-

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hours or visit the IEHP website at iehp.org to find a provider at [Find Care](#).

Pediatric Dental Services

Emergency dental services are dental procedures rendered in a dentist's office, dental clinic, or other comparable facility, to evaluate and stabilize dental conditions of a recent onset and severity. Illness can be accompanied by excessive bleeding, severe pain, or acute infection that a person could reasonably expect that immediate dental care is needed.

IEHP Covered California Network General Dentists provide emergency dental services twenty-four (24) hours a day, seven (7) days a week. We encourage You to seek care from Your selected Network General Dentist. If You require emergency dental services, You may go to any dental provider, go to the closest emergency room, or call 9-1-1 for assistance, as necessary. Prior Authorization for emergency dental services is not required.

Reimbursement for emergency dental services is limited to the treatment that directly relates to emergency dental services, such as, to evaluate and stabilize the dental condition. Reimbursements will be based on Your Plan benefits, subject to any exclusions and limitations. Hospital charges and/or other charges for care received at any hospital or outpatient care facility that are not related to treatment of the actual dental condition are not covered benefits.

Complex Care Management

If You are sick or have a serious illness, IEHP will work with You and Your Doctor to make sure You get the care You need. The **IEHP Integrated Care Management (ICM) Department** helps Members who may need extra support managing their health. IEHP identifies Members for Complex Care Management (CCM) by reviewing certain health information, such as diagnoses, medications, lab results, and recent hospital or emergency room visits. Members may be enrolled in CCM if they are at higher health risk. For example, Members who have **two of the following three conditions** may be identified for added support:

1. Diabetes
2. High blood pressure (Hypertension)
3. Depression

The Care Management Team will work with You to understand Your medical, mental health, and social needs. Your Care Manager can help You manage Your conditions and medicines, coordinate Your care with Your Doctors, and connect You to community resources and benefits that support Your overall health.

An Interdisciplinary Care Team (ICT) can also help You with Your personal plan of care. An ICT consists of Your PCP, Nurse care manager, Behavioral Health care manager (when needed), and others who support Your health care needs.

There are several ways that You can be referred into IEHP's Complex Care Management (CCM)

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program such as:

- A Practitioner Referral (Your Doctor or Specialist can make a referral for You.)
- A Member or Caregiver Referral (You or Your caregiver can call IEHP to ask for help from a Complex Care Manager.)
- A Discharge Planner Referral (If You are leaving the hospital and have many complicated care needs.)
- A Medical Management Referral (For example, a nurse from IEHP's Nurse Advice Line may recommend the program.)

Members who are enrolled in CCM have an Assigned Care Manager at IEHP who can help with basic care management, and an expanded set of transitional care supports that are available if you are discharged from a hospital, skilled nursing facility, psychiatric hospital, or residential treatment.

To check eligibility and to opt in to the CCM Program, you will need to complete a health survey to assess your needs. This survey will help to determine if you are eligible for the program. If you are eligible for the program and wish to opt in, you will be automatically enrolled. If you are not eligible for the CCM program but want more information on other Care Management Services available, please contact Member Services at 1-800-440-4347.

After enrollment into the CCM program, you will be assigned a Primary Case Manager. The Case Manager will contact you at least once every 30 days to discuss your health goals. They will also assist you with a plan to meet those goals. To get started, call IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711), Monday–Friday, 8am–6pm.

Once enrolled you may opt out of the program at any time. To opt out contact IEHP Member Services at 1-855-433-4347 and let them know you no longer wish to be involved with the program.

Eligibility, Enrollment, and Termination

Who is Eligible and How to Enroll for Coverage

To enroll in and receive coverage under this Plan, the Subscriber and each Family Member that apply for enrollment must:

- Live in the IEHP Service Area (San Bernardino or Riverside County) throughout the eligibility period.
- Be a citizen or national of the United States or an alien lawfully present in the United States.
- Not be incarcerated.
- And must apply during an open enrollment period or during a special enrollment period.

The following individuals and lawful spouses are **not eligible for coverage** under this Plan:

- Individuals eligible for a group plan with minimum essential coverage.
- Individuals aged 65 and older and eligible for Medicare benefits, except for dependent parents or stepparent.

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- Individuals who are incarcerated.
- Individuals eligible for Medi-Cal or other state or federal programs.

If You have end-stage renal disease (“ESRD”) and are eligible for Medicare, You remain eligible for enrollment in this Plan until You are enrolled in Medicare. The plan will work with You to obtain Medicare coverage if You qualify.

Subscribers may apply to enroll Family Members who satisfy the eligibility requirements for dependents:

- Spouse: The Subscriber’s lawful spouse, as defined by California law. (The term “spouse” also includes the Subscriber’s Domestic Partner when the domestic partnership meets all requirements under California law.)
- Children: The children of the Subscriber or his or her spouse (including legally adopted children, stepchildren, and children for whom the Subscriber is a court-appointed guardian).
- A parent or stepparent who meets the definition of a qualifying relative under Section 152(d) of Title 26 of the United States Code and who lives or resides within the IEHP Service Area.

Dependent Children

Each child is eligible for enrollment as a covered dependent until the age of 26. An enrolled Dependent child who reaches age 26 may remain enrolled as a dependent until the end of that Calendar Year. The dependent coverage shall end on the last day of the Calendar Year during which the Dependent child becomes ineligible.

Covered dependents who reach age 26 are eligible for continued benefit coverage under the parent/guardian’s plan if both of these conditions apply:

- The child is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition; and
- The child is chiefly dependent upon the Subscriber for support and maintenance.

IEHP will provide You notice at least 90 days prior to the date at which the dependent child’s coverage will terminate. You must provide IEHP with proof of Your child’s incapacity and dependency within 60 days of the date You get this notice from IEHP to continue coverage for a disabled child past the age limit. You must provide the proof of incapacity and dependency at no cost to IEHP. A disabled child may remain covered by this Plan as a Dependent for as long as he or she remains incapacitated and keeps meeting the eligibility standards described above.

Open Enrollment Period

Open Enrollment begins November 1st each year and continues through December 31st. For enrollments received from November 1st through December 31st coverage will begin on January 1st. During the open enrollment period, existing IEHP Members may add eligible dependents, report demographic changes, change carriers, or change Benefit Plans by updating their application with Covered California. To do so, You may go to www.coveredca.com, call Covered California at 1-800-300-1506 (TTY 1-888-889-4500), or call the IEHP enrollment support services at 1-855-433-IEHP (4347) (TTY 711). To confirm Your eligibility for tax credits and/or Cost Share Reduction plans for each Benefit Period, You must update Your

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income with Covered California. If You make no changes, You will be automatically renewed and enrolled into Your current IEHP plan.

Starting Date of Coverage

Only Covered California can approve applications and the effective date of coverage. The initial premium payment may be submitted upon successful completion of application, or You may choose to wait for a bill from IEHP. Once the application has been approved and full payment has been received and completed for the first month, IEHP will send You a New Member Welcome Packet and an IEHP Member ID Card that includes the effective date of coverage. Premium Payments after the initial month must be made payable to IEHP by the due date.

Change in Eligibility

You must notify Covered California at 1-888-975-1142 (TTY 1-888-889-4500) of changes that will affect Your eligibility, including no longer residing in the IEHP Service Area. You can also mail notices to Covered California at: Covered California, P.O. Box 989725, West Sacramento, CA 95798. Covered California will make all eligibility determinations for health benefit coverage and subsidy level(s), including advance premium tax credits and cost-sharing subsidies. Any changes to a Member's eligibility status, including termination, plan change, will be processed by IEHP only after confirmation from Covered California.

Please report all income level changes, household size changes, address changes, citizenship and legal residence status changes, loss or gain of employer sponsored health insurance, and other demographic changes to Covered California at 1-800-300-1506 (TTY/TDD 1-888-889-4500). These changes will help redetermine Your eligibility and the amount of premium assistance or subsidy You qualify for.

Eligibility for Tax Credits and Cost Sharing Reductions

Covered California uses a single application to assess if You qualify for financial assistance that can lower the cost of Your health insurance. There are two new types of subsidy programs: (1) Tax Credits: will lower the cost of Your monthly premium; and (2) Cost Sharing Reductions: will reduce Your out-of-pocket costs for Covered Services. These programs are available to individuals and families who meet certain income requirements and do not have access to other affordable insurance. Please visit iehp.org, call IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711) or Covered California at 1-888-975-1142 (TTY 1-888-889-4500) to learn more about these programs.

Eligibility for a Catastrophic Plan

Individuals under the age of 30 years can enroll on a minimum coverage or Catastrophic Plan. This is a type of high-deductible health plan that is designed to provide coverage in a worst-case scenario but offers minimal coverage for routine services other than preventive care. Those 30 and older can buy catastrophic coverage only if they apply and are approved for an affordability or general hardship exemption through Covered California. Minimum Coverage plans do not qualify for Tax Credits to lower the monthly premium. Please visit iehp.org, call IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711) or Covered California at 1-888-975-1142 (TTY

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1-888-889-4500) to learn more.

Special Enrollment Periods for Newly Acquired Dependents

The Subscriber may enroll these newly acquired dependents:

Spouse: If You are the Subscriber and You marry while You are covered by this Plan, You may apply to enroll Your new spouse (and Your spouse's eligible children) within 60 days of the date of marriage by submitting a new Enrollment Application to Covered California. If Your spouse is eligible and accepted for coverage, coverage begins on the date indicated on the Notice of Acceptance for the new enrollee.

Domestic Partner: If You are the Subscriber and You enter into a domestic partnership while You are covered by this Plan, You may apply to enroll Your new Domestic Partner (and his or her eligible children) within 60 days of the date a Declaration of Domestic Partnership is filed with the Secretary of State by enrolling with Covered California. If Your Domestic Partner is eligible and accepted for coverage, coverage begins on the date indicated on the Notice of Acceptance for the new enrollee.

Newborn Child: A child newly born to the Subscriber or his or her spouse will automatically be covered for 31 days (including the date of birth). To keep enrollment past the initial 31 days, You must enroll the newborn with Covered California and pay any applicable Plan Premiums within 31 days of birth. If You do not enroll the child within 31 days (including the date of birth), Your child will be eligible to enroll under a special enrollment period within 60 days of birth. **NOTE:** This provision does not amend the EOC to restrict any terms, limits, or conditions that may otherwise apply to Surrogates and children born from Surrogates. To learn more, please refer to the "Surrogacy Arrangement" portion of the "General Provisions" section.

Adopted Child: A newly adopted child or a child who is being adopted becomes eligible on the date of adoption or the date of placement for adoption, as requested by the adoptive parent. Coverage begins automatically and will continue for 30 days from the date of eligibility. You must enroll the child within 31 days for coverage to continue beyond the first 30 days by enrolling with Covered California and paying any applicable Plan Premiums. If You do not enroll the child within 31 days of adoption/placement, Your child will be eligible to enroll under a special enrollment period within 60 days of adoption placement.

Court Ordered Dependent or Legal Ward (Guardianship): If the Subscriber or spouse is required by a court order, as defined by applicable state or federal law, to provide coverage for a minor child or becomes the legal guardian of a child, the child is eligible to enroll on the effective date of the court order. The Subscriber must enroll with Covered California and pay any applicable Plan Premiums within 60 days of the effective date of the court order. Once Covered California approves the child's enrollment is approved, IEHP will provide coverage in accordance with the requirements of the court order. The child's coverage under this provision will not extend beyond any Dependent age limit.

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Special Enrollment Periods

In addition to the Open Enrollment Period (OEP), You are eligible to enroll in this plan within 60 days of certain events, including but not limited to:

- Gained, lost or changed dependent status due to marriage, domestic partnership, divorce, legal separation, dissolution of domestic partnership, birth, adoption, placement for adoption, or assumption of a parent-child relationship.
- Mandated to be covered as a dependent due to a valid state or federal court order.
- Lost health coverage due to a mistake by a previous health plan.
- Your provider left the health plan network while you were receiving care for one of the following conditions: (a) an acute or serious condition; (b) a terminal illness; (c) a pregnancy; (d) care of a newborn between birth and 36 months; or (e) a surgery or other procedure authorized as part of a documented course of treatment to occur within 180 days of the contract's termination date or the effective date of coverage for a newly covered member.
- Did not enroll during the prior enrollment period because You were misinformed that You were covered under minimum essential coverage.
- A member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty under Title 32 of United States Code.
- Not allowed to enroll through Covered California due to the intentional, inadvertent or erroneous actions of the Exchange.
- Gain or maintain status as an Indian, as defined by section 4 of the Indian Health Care Improvement Act.
- Not enrolled as a result of misconduct on the part of a non-Covered California entity providing enrollment assistance or conducting enrollment activities.
- Are a victim of domestic abuse or spousal abandonment, as defined by 26 Code of Federal Regulation 1.36B-2, including a dependent or unmarried victim within a household, are enrolled in minimum essential coverage and seek to enroll in coverage separate from the perpetrator of the abuse or abandonment. Dependents of the victim, who are on the same application as the victim, are also eligible to enroll at the same time as the victim.
- Applied for coverage with Medi-Cal during the annual Open Enrollment Period and are determined ineligible for Medi-Cal after Covered California Open Enrollment Period has ended.
- Did not enroll while waiting for the United States Department of Health and Human Services to verify citizenship, status as a national or lawful presence.
- Gain access to the Individual Coverage Health Reimbursement Arrangement ("ICHRA") and are not already covered by the ICHRA.
- Were not provided timely notice of an event that triggers eligibility for a special enrollment period.

For the following, You are eligible to enroll 60 days before and 60 days after the event:

- Lost coverage in a plan with minimum essential coverage. This does not include voluntary termination, loss due to non-payment of premiums or situations allowing for a rescission.

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- Were enrolled in any non-Calendar Year plan that expired or will expire, even if You or Your Dependent had the option to renew the plan. The date of the loss of coverage shall be the date of the expiration of the non-Calendar Year plan.
- Lost medically needed or pregnancy-related coverage under Medi-Cal (not including voluntary termination).
- Lost access to existing benefit plan due to a permanent move.
- Were released from incarceration.
- Newly become a citizen or national of the United States or an alien lawfully present in the United States.
- Are newly eligible or newly ineligible for advance payments of the premium tax credit or have a change in eligibility for cost-sharing reductions. Covered California must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value to access this special enrollment period prior to the end of the eligible employer-sponsored plan.
- Enrolled in COBRA continuation coverage for which an employer is paying all or part of the premiums. Or coverage for which a government entity is providing subsidies, and the employer completely ceases its contributions to the COBRA continuation coverage or government subsidies completely ceased.
- Assessed by Covered California as potential eligible for Medi-Cal and are determined ineligible for such coverage.

There are also monthly special enrollment periods for Native American Indians or Alaskan Natives and individuals at or below 138% of the Federal Poverty Level. Please call our IEHP California Enrollment Support Services at 1-855-538-4347 (TTY 711) if You have questions regarding these special enrollment periods or about other qualifying life events. To qualify for special enrollment period, You must apply for coverage within sixty (60) days of the qualifying life event.

Legal Separation or Final Decree of Dissolution of Marriage or Domestic Partnership or Annulment

On midnight of the last day of the month in which legal separation occurs or entry of the final decree of dissolution of marriage or Domestic Partnership or annulment occurs, a spouse shall no longer be an eligible Family Member. Children of the spouse who are not also the natural or legally adopted children of the Subscriber shall cease to be eligible Family Members at the same time.

Renewal Provisions

This Plan is an individual health benefit plan, guaranteed renewable at the option of the enrollee except as permitted to be terminated, cancelled, rescinded, or not renewed under applicable State and federal law described below. Coverage will remain in effect for each month Plan Premiums are received and accepted by IEHP. IEHP reserves the right to change the amount of premium due each year.

Have questions? Contact IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711), Monday-Friday 8am-6pm PST. Visit us online at iehp.org.

Re-enrollment

If You terminate coverage for Yourself or any of Your Family Members, You may apply for re-enrollment subject to the eligibility requirements described above.

Termination of Benefits

Voluntary Disenrollment

You may terminate this EOC by notifying Covered California or IEHP at least 14 calendar days before the date of Your requested termination date. For example, if notice is provided on June 14, disenrollment will be effective July 1. Your coverage will end at 12:01am 14 days after You notify Covered California or IEHP. Or on an earlier date that You request if Covered California or IEHP agrees to this date. If the terms of this EOC are altered by IEHP, no resulting reduction in coverage will adversely affect a Member who is confined to a Hospital at the time of such change. IEHP may terminate this EOC together with all like EOCs by giving 90 days' written notice to the Subscriber and the California Department of Managed Health Care.

Termination for Cause

IEHP may individually terminate or not renew Your, and Your covered Dependents' benefit coverage for these reasons or circumstances:

- Failure of the Subscriber to pay any Plan Premiums when due in the manner specified in the "Plan Premiums" section:
 - a. If full payment is not received by the end of the 30-day grace period, the EOC will be cancelled upon approval by IEHP.
 - b. Subscribers and enrolled Dependents who are getting Federal Advance Premium Tax Credits ("APTC") or California Premium Subsidy have a three-month grace period instead of a 30-day grace period for failure to pay Plan Premium charges. If You do not pay the entire amount of outstanding plan premiums in full before the end of the three-month grace period, IEHP will terminate Your coverage and indicate that Your coverage effectively ended on the first day of the second month of Your three-month grace period.
- If You commit any act or practice which constitutes fraud, or for any intentional misrepresentation of material fact under the terms of the agreement, in which case a notice of termination will be sent and termination will be effective upon the date the notice of termination is mailed. Some examples include:
 - a. Misrepresenting eligibility details about You or a Dependent
 - b. Presenting an invalid prescription or physician order
 - c. Misusing a IEHP Member ID Card (or letting someone else use it)
- Termination of this EOC due to loss of eligibility. Termination will be effective as noted below:
 - a. When the Subscriber or Family Member ceases to reside in the Service Area, coverage will be terminated 30 days from the date the letter is mailed.

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- b. When the Subscriber ceases to be eligible according to any other eligibility provisions of this health plan, coverage will be terminated for Subscriber and any enrolled Family Members effective on midnight of the last day of the month for which loss of eligibility occurs.
- c. When the Family Member ceases to be eligible according to any other eligibility provisions of this health plan, coverage will be terminated only for that person effective on midnight of the last day of the month in which loss of eligibility occurred.

If IEHP initiates termination for coverage for any reason noted above, other than failure to pay plan premiums, a cancellation or nonrenewal notice will be sent by IEHP only after the termination is approved by Covered California. The termination notice will be sent to You at least 30 days prior to the termination which will provide:

- (a) The effective date of the termination.
- (b) Names of all enrollees affected by the notice.
- (c) Your right to submit a grievance.

If coverage is terminated for failure to pay plan premiums or for committing any act or practice which constitutes fraud, or for any intentional misrepresentation of material fact under the terms of the agreement, You may lose the right to re-enroll in IEHP in the future. We may also report criminal fraud and other illegal acts to the authorities for prosecution. IEHP will conduct a fair investigation of the facts before any termination or involuntary transfer for any of the above reasons is carried out.

Members are responsible for payment for any services received after termination of this EOC. This is also applicable to Members who are hospitalized or undergoing treatment for an ongoing condition on the termination date of this EOC.

Rescission or Cancellation of Coverage for Fraud or Intentional Misrepresentation of Material Fact

IEHP can rescind or cancel this EOC

Within the first 24 months of coverage, IEHP may rescind this EOC for any act or practice which constitutes fraud, or for any intentional misrepresentation of material fact in the written information submitted by You or on Your behalf on or with Your enrollment application.

IEHP may cancel this EOC for any act or practice which constitutes fraud, or for any intentional misrepresentation of material fact under the terms of the EOC. A material fact is information which, if known to IEHP, would have caused IEHP to decline to issue coverage.

Cancellation of the EOC

If this EOC is cancelled, You will be sent a cancellation or nonrenewal notice at least 30 days prior to the termination which will provide:

- (a) The effective date of the termination.

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- (b) Names of all enrollees affect
- (c) Your right to submit a grievance.

Rescission of the EOC

If this EOC is rescinded, IEHP shall have no liability for the provision of coverage under this Plan. By signing the enrollment application, You represented that all responses were true, complete and accurate. The enrollment application will become part of the agreement between IEHP and You. By signing the enrollment application, You further agreed to comply with the terms of this EOC. If this EOC is rescinded, You will be sent a rescission notice at least 30 days prior to the rescission which will provide:

- (a) The reason for and effective date of the termination.
- (b) Names of all enrollees affected by the notice.
- (c) Your right to submit a grievance.

If this EOC is rescinded:

- IEHP may revoke Your coverage as if it never existed and You will lose health benefits including coverage for treatment already received.
- IEHP will refund all premium amounts paid by You, less any medical expenses paid by IEHP on behalf of You and may recover from You any amounts paid under the EOC from the original date of coverage.
- IEHP reserves its right to obtain any other legal remedies arising from the rescission that are consistent with California law.
- If You believe IEHP has improperly rescinded Your coverage, You may file a grievance to appeal the decision. See the “Grievance, Appeals, Independent Medical Review and Arbitration” portion of the “General Provisions” section of this Evidence of Coverage.

Plan Benefits

Benefits are provided only for services that are Medically Necessary. A full explanation of medical necessity can be found in the “Definitions” section.

The fact that a Physician or other provider may perform, prescribe, order, recommend or approve a service, supply or hospitalization does not, in itself, make it Medically Necessary or make it a covered service. Hospital inpatient services that are Medically Necessary include only those services that satisfy the above requirements, require the acute bed-patient (overnight) setting, and could not have been provided in a Physician’s office, the Outpatient Department of a Hospital, or in another facility without adversely affecting the patient’s condition or the quality of medical care rendered. All Covered Services and supplies, except for Emergency and Urgent Care, for Subscribers and their eligible dependents must be performed by Network Providers or authorized by IEHP to be performed by nonparticipating provider.

Any covered service or supply may require a Copayment or Coinsurance, be subject to a Deductible or have a benefit maximum. Please refer to the "Schedule of Benefits" section for

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details.

Certain limitations may apply. Be sure You read the section entitled “Exclusions and Limitations,” before getting care.

Acupuncture

For all acupuncture services, IEHP has contracted with American Specialty Health Plans of California, Inc. (“ASH”) to act as the Plan's acupuncture services administrator. Covered benefits include services for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain. Acupuncture services must be provided by a Network Physician, licensed acupuncturist, or other appropriately licensed or certified Health Care Provider.

American Specialty Health Plans of California, Inc. (“ASH”) will arrange covered Acupuncture Services for You. Contact ASH with questions about acupuncture services, ASH Network Providers, or acupuncture Benefits call 1-800-678-9133, TTY 711.

All covered Acupuncture Services may be subject to verification of Medical Necessity by American Specialty Health Plans of California, Inc. (“ASH”):

- New patient exam performed by a Network Acupuncturist for the initial evaluation of a patient with a new condition or new episode to determine the appropriateness of Acupuncture Services. A new patient is one who has not received any professional services from the provider, or another provider of the same specialty who belongs to the same group practice, within the past three years.
- Established patient exams are performed by a Network Acupuncturist to assess the need to initiate, continue, extend, or change a course of treatment. An established patient is one who has received professional services from the provider, or another provider of the same specialty who belongs to the same group practice, within the past three years.
- Subsequent office visits, as set forth in a treatment plan approved by ASH, may involve acupuncture treatment, a re-exam and other services, in various combinations. A Copayment will be required for each visit to the office.

Allergy Testing and Immunotherapy Services

Benefits are available for allergy testing and immunotherapy services. Benefits include:

- Allergy testing on and under the skin such as prick/puncture, patch and scratch tests.
- Preparation and provision of allergy serum.
- Allergy serum injections.

Ambulance and Non-emergency Medical Transportation

All air and ground ambulance and ambulance transport services provided as a result of a “9-1-1” emergency response system request for assistance will be covered when medically necessary or when the standards for Emergency Care, as defined in this EOC, have been met:

- Emergency ambulance transportation (ground and air) when used to transport You from the place of illness or injury to the closest medical facility that can provide appropriate medical

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care.

- Non-emergency medical transportation via ground ambulance from one medical facility to another when authorized by IEHP.
- Non-emergency medical transportation via air ambulance transport when prior authorized by IEHP from one medical facility to another.
- Non-emergency ambulance and psychiatric transport services inside the Service Area if: (1) IEHP determines and authorizes that the enrollee's condition requires the use of services that only a licensed ambulance (or psychiatric transport van) can provide; and (2) the use of other means of transportation would endanger the enrollee's health.

Emergency or non-emergency medical transport when authorized by IEHP via air ambulance services are covered at the Network Provider Cost Share, even if You receive services from a Non-Participating Provider.

Non-Medical transportation by car, taxi, bus, and any other type of non-medical transportation is not covered, even if it is the only way to travel to a Participating Provider. Ground ambulance services from a non-contracting provider is covered at the same cost-sharing amount for the same services from a contracted ground ambulance provider. Additionally, non-contracted ground ambulance providers are prohibited from collecting more than the in-network cost-sharing amount.

Biomarker Testing

Biomarker testing shall be covered for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a disease or condition to guide treatment decisions. Biomarker testing is covered when medically necessary, is provided in a manner that limits disruptions in care and is subject to utilization management review and approval by IEHP. Coverage shall include biomarker tests that meet any of the following:

- A labeled indication for a test that has been approved or cleared by the United States Food and Drug Administration (FDA) or is an indicated test for an FDA-approved drug.
- A national coverage determination made by the federal Centers for Medicare and Medicaid Services.
- A local coverage determination made by a Medicare Administrative Contractor for California.
- Evidence-based clinical practice guidelines, supported by peer-reviewed literature and peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.
- Standards set by the National Academy of Medicine.

Blood

Blood transfusions, including blood processing, the cost of blood, unreplaced blood and blood products, are covered. However, self-donated (autologous) blood transfusions are covered only for a surgery that IEHP has authorized and scheduled.

Have questions? Contact IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711), Monday-Friday 8am-6pm PST. Visit us online at iehpa.org.

Clinical Trials

Benefits are available for routine patient care when You have been accepted into an approved clinical trial for treatment of cancer or a life-threatening disease or condition. A life-threatening disease or condition means the likelihood of death is probable unless the course of the disease or condition is interrupted.

An approved clinical trial is a phase I, II, III, or IV trial conducted in relation to the prevention, detection, or treatment of cancer or life-threatening disease or condition and either approved or funded by one of the following:

- The National Institutes of Health (NIH).
- The Federal Centers for Disease Control and Prevention (CDC).
- The Agency for Healthcare Research and Quality.
- The Federal Centers for Medicare and Medicaid Services (CMS).
- A cooperative group or center of the above agencies such as the Department of Defense or United States Department of Veteran Affairs.
- A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants.
- In limited instances, studies and investigations conducted by the Department of Veterans Affairs; Department of Defense; or Department of Energy. These studies and investigations must be reviewed and approved through a system of peer review that the U.S. Secretary of Health and Human Services determines is comparable to the NIH system of peer review and assures unbiased review of the highest scientific standard by qualified people who have no interest in the outcome of the review.
- A drug trial conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration (FDA).
- A drug trial exempt under federal regulations from a new drug application reviewed by the FDA.

Your Primary Care Physician or another Network Provider determines whether Your participation in the clinical trial would be appropriate based on the trial protocol. IEHP may also determine Your eligibility to participate if You provide IEHP with medical and scientific information that shows Your participation is appropriate based on the trial protocol.

Qualified participants are required to participate in an approved clinical trial through an IEHP provider in California unless the clinical trial is not offered or available through an IEHP provider in this state. You must obtain prior authorization from IEHP to get coverage for routine patient costs involved with the clinical trial. You are responsible for the cost sharing for routine patient care, including drugs, items, devices, and services doctor visits for other conditions not associated with the clinical trial, You receive while in the clinical trial. When You are authorized to participate in a clinical trial out of network because an in-network option does not exist, You will pay the in-network cost share for Your routine care. These Copayments and Coinsurance will count toward Your OOPM.

Routine patient care does not include:

- The investigational item, device, or service itself.
- Any item or service that is provided solely to satisfy data collection and analysis needs and

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- that is not used in the direct clinical management of the patient.
- Drugs, items, devices, and services excluded from coverage in this EOC, except for drugs, items, devices, and services required to be covered pursuant to H&S code section 1370.6 or other applicable law.
- Services normally provided by the research sponsor free for any enrollee in the trial; or

COVID-19

Diagnosis and screening testing and health care services related to testing, immunization, and COVID-19 therapeutics. Cost sharing only applies for services, testing, and treatment provided by an out-of-network provider.

Community Emergency and Paramedicine Program

You will not have to pay more if you get covered services from an out-of-network community paramedicine program, or triage to alternate destination program, or mobile integrated health program. You will pay the same amount as you would for these services from an in-network program. A PCP cost share will apply for these services.

Dental Services

Dental services or supplies are limited to the following standards except as specified in the Dental Summary of Benefits and the “Pediatric Dental Services” portion of “Plan Benefits” section of this EOC.

Covered benefits include Medically Necessary medical treatment of the teeth, gums, jaw joints, and jaw bones when authorized by IEHP. Medical dental benefits include outpatient, Hospital, and professional services provided for treatment of the jaw joints and jaw bones, including adjacent tissues:

- Dental exams and treatment of the gums are performed for the diagnosis or treatment of gum tumors.
- Immediate emergency care or stabilization to sound natural teeth as a result of an accidental, traumatic injury independent of disease, illness, or any other cause.
- Surgical treatment of temporomandibular joint syndrome (TMJ).
- Custom made oral appliances (intra-oral splint or occlusal splint and surgical procedures) to correct disorders of the temporomandibular (jaw) joint (also known as TMD or TMJ disorders) are covered if they are Medically Necessary).
- Medically Necessary dental, orthodontic services, or orthognathic surgery that are an integral part of reconstructive surgery for skeletal deformity or cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.
- Dental services to prepare the jaw for radiation therapy for the treatment of head or neck cancers.

General anesthesia and associated facility charges during dental treatment due to the Member's underlying medical condition or clinical status is covered only when:

- The Member is Younger than seven years old; or
- The Member is developmentally disabled; or
- The Member's health is compromised and general anesthesia is Medically Necessary.

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These services are ordinarily a non-covered dental service which would normally be treated in the dentist's office and without general anesthesia, must instead be treated in a Hospital or Outpatient Surgical Center due to the conditions above. The general anesthesia and associated facility services must be Medically Necessary and are subject to the other exclusions and limitations of this EOC.

For more information, contact Liberty Dental at 1-866-544-2981, Monday-Friday, 8am-5pm.

Diabetes Care

The services and items below are covered when medically necessary from a Network Provider. Diabetes testing supplies and insulin-administration devices:

- Ketone test strips.
- Blood glucose monitors designed to assist the visually impaired.
- Certain brands of continuous glucose monitors
- Lancets and lancet puncture devices.
- Certain brands of blood glucose monitors and blood glucose testing strips.
- Certain brands of pen delivery systems for the administration of insulin, including pen needles, disposable needles and syringes.
- Certain brands of insulin pumps and all related necessary supplies.

These items (as well as insulin and Prescription Drugs for the treatment and management of diabetes) are covered under the Prescription Drug benefits when written on a Prescription. Please refer to the "Prescription Drugs" portion of this section and Your Drug Formulary to learn more including the services with limited brand coverage (blood glucose monitors and test strips).

In addition, the supplies below are covered under the medical benefit as specified:

- Visual aids (excluding eyewear) to assist the visually impaired with proper dosing of insulin are provided through the prostheses benefit (refer to "Prostheses" section below).
- Glucagon is provided through the Prescription Drug benefits (refer to "Prescription Drug Benefits" section below).
- Podiatric devices (such as special footwear or shoe inserts) to prevent or treat diabetes-related complications when prescribed by a participating physician or by a Network Provider who is a podiatrist (refer to "Durable Medical Equipment" section below).
- Medically necessary diabetic foot care (refer to "Foot Care" section below).
- Patient education programs on how to prevent illness or injury and how to maintain good health, including diabetes management programs and asthma management programs are covered. IEHP will pay for a diabetes instruction program supervised by a Physician. A diabetes instruction program is a program designed to teach You and Your covered Dependent about the disease process, the daily management of diabetic therapy and medical nutrition therapy.

Dialysis

Benefits are available for dialysis services at a freestanding dialysis center, in the Outpatient Department of a Hospital, in a physician office setting or in Your home. Benefits include:

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- Renal dialysis.
- Hemodialysis.
- Peritoneal dialysis.
- Self-management training for home dialysis.

Your cost share for covered services will vary depending on the facility type that you choose. Services obtained in a stand-alone Network dialysis facility are often less compared to services obtained in a Network hospital or hospital-based facility. Equipment and medical supplies required for home hemodialysis and home peritoneal dialysis are covered after You receive appropriate training at a dialysis facility approved by IEHP.

Coverage is limited to the standard item of equipment or supplies that adequately meets Your medical needs.

Benefits do not include:

- Comfort, convenience, or luxury equipment.
- Non-medical items, such as generators or accessories to make home dialysis equipment portable.

Dialysis services for Members with end stage-renal disease (“ESRD”) who are traveling within the United States are also covered. Outpatient dialysis services within the United States but outside of IEHP’s Service Area must arranged and authorized by IEHP in order to be performed by providers in Your temporary location. Outpatient dialysis received out of the United States is not a covered service.

Durable Medical Equipment

Durable Medical Equipment (DME) is medically necessary equipment that is ordered by Your physician and for use in the home. Inside our Service Area, we cover the durable medical equipment specified in this section for use in Your home (or another location used as Your home) in accordance with our durable medical equipment guidelines.

DME for home use is an item that is:

- Intended for repeated use.
- Primarily and customarily used to serve a medical purpose.
- Generally not useful to a person who is not ill or injured.
- Appropriate for use in the home.

Covered DME (including repair or replacement of covered equipment, unless due to loss or misuse) is provided. We decide whether to rent or purchase the equipment, and we select the vendor. You must return the equipment to us or pay us the fair market price of the equipment when we are no longer covering it.

Examples of covered DME include but is not limited to:

- Standard curved handle or quad cane and supplies.
- Crutches.

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- Dry pressure pad for a mattress.
- IV pole.
- Enteral pump and supplies.
- Bone stimulator.
- Cervical traction (over door).
- Phototherapy blankets for treatment of jaundice in newborns.
- Dialysis care equipment (refer to “Dialysis” section above).
- Mobility devices, such as wheelchairs.
- Nebulizers, face masks, tubing, and peak flow meter for the self-management of asthma.
- Glucose monitor for the self-management of diabetes.
- Apnea monitors for the management of newborn apnea.
- Oxygen and respiratory equipment.
- Disposable medical supplies used with DME and respiratory equipment.
- Standard breast pumps.

Asthma inhalers and inhaler spacers are covered under the Prescription Drug Benefit.

Select DME items will have benefit/quantity limitations per Member or may require further authorization. Contact IEHP for further detail.

Examples of Non-covered DME include but not limited to:

- Shower chairs/bench
- Bedside commode
- Compression stockings
- Heating pads
- Maternity belts

Corrective Footwear

Corrective Footwear for the management and treatment of diabetes-related medical conditions is covered under the “Diabetes Care” benefit as Medically Necessary. Corrective Footwear (including specialized shoes, arch supports and inserts) for other conditions is only covered when Medically Necessary and custom made for You.

Medically Necessary Contact Lenses

We also cover up to two Medically Necessary Contact Lenses per eye (including fitting and dispensing) in any 12-month period to treat conditions of aniridia (missing iris). An aniridia Contact Lens will not be covered if we provide an allowance toward (or otherwise covered) two Medically Necessary aniridia contact lens per eye within the previous 12 months.

Special Contact Lenses are covered when prescribed for conditions of aphakia. Up to six Medically Necessary aphakic Contact Lenses per eye (including fitting and dispensing) per Calendar Year to treat aphakia (absence of the crystalline lens of the eye). We will not cover an aphakic Contact Lens if we provided an allowance toward (or otherwise covered) more than six aphakic Contact Lenses for that eye during the same Calendar Year.

Have questions? Contact IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711), Monday-Friday 8am-6pm PST. Visit us online at iehp.org.

Breast Pump and Supplies

Breastfeeding devices and supplies, as supported by HRSA guidelines, are covered as Preventive Care Services (refer to the “Preventive Care Services” section below).

Family Planning

Family planning services covers counseling and planning for contraception, fitting exam for a vaginal contraceptive device (diaphragm and cervical cap) and insertion or removal of an intrauterine device (IUD). Sterilization of females and women’s contraception methods and counseling, as supported by the Health Resources and Services Administration (“HRSA”) guidelines are covered as Preventive Care Services. Sterilization of males is also a covered Family Planning benefit. Covered services are not subject to prior authorization or Plan Deductible, Coinsurance, or Copayments. You may receive Family planning services from a Network Provider that is licensed to provide these services. Examples of Family planning providers include:

- Your PCP.
- Clinics.
- Certified Nurse Midwives and Certified Nurse Practitioners.
- OB/GYN specialists.
- Physician Assistant.

Contraceptives that are covered under the medical benefit include intrauterine devices (IUDs), injectable and implantable contraceptives. Prescribed contraceptives for women are covered as described in the “Prescription Drugs” section below.

Family planning services also include surgical procedures for the termination of pregnancy (called an abortion). Abortion and abortion related services are covered without cost share, deductible, annual or lifetime limits or prior authorization requirements. Please call IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711) to learn more about the centers that perform these services.

Fertility Preservation and Infertility Services

This Plan covers Medically Necessary services and supplies for standard fertility preservation treatments if either of the following paragraphs are true:

- (1) Your Provider has recommended You receive within the next 12 months a covered medical treatment that may cause infertility, and You attest that you plan to undergo such treatment in the next 12 months; OR
- (2) You have received a covered medical treatment that may cause infertility, Your medical condition was such that You were unable to undergo fertility preservation or complete Your fertility preservation cycle(s), and You face an ongoing risk for infertility due to reproductive damage caused by those treatments.

Iatrogenic Infertility is Infertility that is caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment. Iatrogenic infertility does not include infertility caused by a medical treatment performed for the purpose of preventing pregnancy, including vasectomy or

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tubal ligation.

Standard fertility preservation services are any of the following procedures consistent with the established medical treatment practices and professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine. Pre-implantation genetic diagnosis is covered when Medically Necessary.

- (1) Retrieval of gametes as follows:
 - a. A lifetime limit of up to two cycles for oocyte retrieval for Members with ovaries.
 - b. A lifetime limit of up to two attempts to collect sperm for Members with testicles.
- (2) A lifetime limit of up to two attempts at embryo creation.
 - a. IEHP is not required to cover any costs associated with retrieval of gametes from anyone other than the Member undergoing the medical treatment that may cause iatrogenic infertility.
- (3) A lifetime limit of up to two attempts to retrieve gonadal tissue.
- (4) These lifetime limits specified above apply to a Member regardless of the number of health care service plans the Member enrolls in during their lifetime.
- (5) Cryopreservation and storage of sperm, oocytes, gonadal tissue, and embryos as follows:
 - a. Until the Member reaches age 26, for a Member who is under the age 18 on the date the Member's genetic material is first cryopreserved.
 - b. Until the Member reaches age 26, or for three years, whichever period is longer, for a Member who is 18 years or older but not yet 26 years old on the date the Member's genetic material is first cryopreserved.
 - c. For a period of three years for a Member who is 26 years or older at the time the Member's genetic material is first cryopreserved.
- (6) IEHP retains the right to select a storage vendor of its choosing with respect to cryopreservation of genetic material.
- (7) Gonadal shielding or transposition during a procedure or treatment, if not already included in the usual coverage for that procedure or treatment.
- (8) Any other standard fertility preservation services consistent with the established medical practices published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.

Standard fertility preservation treatments do not include:

- Follow-up Assisted Reproductive Technologies ("ART") to achieve future pregnancy such as artificial insemination, in vitro fertilization, and/or embryo transfer.
- Donor eggs, sperm or embryos.
- Gestational carriers (surrogates).
- Treatment and management of other forms of infertility (not iatrogenic) is not covered.

IEHP is not obligated to continue to cover storage for an individual who is no longer enrolled with the health care service plan. If You change health care service plans during the covered storage period and your new plan deems it necessary to transport the genetic material to a different storage facility, Your new plan shall be responsible for transportation costs of genetic material to a storage facility they select; Your new plan shall be required to cover storage for the remainder of the applicable storage time frame. Your new plan will also be responsible for transportation and storage

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costs for embryo cryopreservation.

IEHP shall coordinate with Your new health care service plan to ensure the transfer and transportation of genetic material is achieved in the most cost-effective manner. IEHP shall provide the new health care service plan with information showing the beginning date of any cryopreservation of the genetic material.

30 days after receipt of a claim for cryopreservation services, IEHP shall provide You with written notice explaining the covered storage period. The notice shall include an explanation of applicable timeframes based on Your age at the time cryopreservation services are received, options for continued storage of genetic material if coverage ends prior to the expiration of the storage period, and any potential out-of-pocket costs associated with continued storage of genetic material if coverage ends prior to the expiration of the storage period.

90 days before the expiration of the cryopreservation/storage periods mentioned above, IEHP shall provide You with written notice explaining the termination of the storage period. This notice shall include options for continued storage of genetic material, and any potential out-of-pocket costs to You associated with continued storage after coverage has ended.

You have a right to receive standard fertility preservation services for iatrogenic infertility when you meet the requirements in Section 1300.74.551 of Title 28 of the California Code of Regulations. “Iatrogenic infertility” means infertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment. If IEHP fails to arrange those services for you with an appropriate provider who is in IEHP’s network, IEHP must cover and arrange needed services for you from an out-of-network provider. If that happens, you will pay no more than in-network cost-sharing for the same services.

If you do not need the services urgently, your health plan must offer an appointment for you that is no more than 10 business days for primary care and 15 business days for specialist care from when you requested the services from the health plan. If you urgently need the services, your health plan must offer you an appointment within 48 hours of your request (if the health plan does not require prior authorization for the appointment) or within 96 hours (if the health plan does require prior authorization).

If your health plan does not arrange for you to receive services within these timeframes and within geographic access standards, you can arrange to receive services from any licensed provider, even if the provider is not in your health plan's network. If you are enrolled in preferred provider organization (PPO) coverage, and your health plan can arrange care for you within the timeframes and within geographic standards, your voluntary use of out-of-network benefits may subject you to incur out-of-network charges.

If you have questions about how to obtain standard fertility preservation services for iatrogenic infertility or are having difficulty obtaining services you can: 1) call your health plan at the telephone number on your health plan identification card; 2) call the California Department of Managed Care's Help Center at 1-888-466-2219; or 3) contact the California

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Department of Managed Health Care through its website at www.DMHC.ca.gov to request assistance in obtaining standard fertility preservation services for iatrogenic infertility.

Foot Care

Podiatric (foot care) services are covered when Medically Necessary, including diagnosis and treatment of conditions affecting the foot, ankle and structures of the leg. Routine foot care is Medically Necessary when the individual suffers from a metabolic, neurologic or peripheral vascular condition which causes severe circulatory impairment or areas of reduced sensation in the individual's legs or feet. Routine foot care that is not Medically Necessary is not covered.

Gender Affirming Services

Medically Necessary gender affirming services to treat gender dysphoria or gender identity disorder are covered. Covered Services include, but are not limited to, mental health evaluation and treatment, surgery, pre-surgical and post-surgical hormone therapy, and speech therapy. Surgical services include hysterectomy, ovariectomy, orchiectomy, genital surgery, breast surgery, mastectomy, and other reconstructive surgery. Services not Medically Necessary for the treatment of gender dysphoria or gender identity disorder are not covered. Surgical services must be performed by a qualified Network Provider and facility in conjunction with gender affirming surgery or a documented gender affirming surgery treatment plan.

Habilitation Services

Benefits are available for outpatient habilitative services. Habilitative services are therapies that help You learn, keep, or improve the skills or functioning You need for Activities of Daily Living ("ADL").

Coverage for habilitative services must be provided by a Network Physician, licensed physical, speech or occupational therapist or other Network Provider, acting within the scope of his or her license, to treat physical conditions and Mental Health and Substance Use Disorders. For autism, Network Provider must be a Qualified Autism Service (QAS) Provider, QAS professional or QAS paraprofessional to treat pervasive developmental disorder or autism. Covered Services are subject to authorization from IEHP. The services must be based on a treatment plan authorized, as required by IEHP and address the skills and abilities needed for functioning in interaction with an individual's environment. IEHP may periodically review the provider's treatment plan and records for Medical Necessity. You can keep getting habilitative services as long as Your treatment is Medically Necessary.

Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, and speech language pathology. Covered Services can be rendered in a variety of inpatient and/or outpatient settings. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under this EOC.

Home Health Care Services

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Home health care services are provided in the home by nurses, medical social workers, home health aides, and physical, occupational, and speech therapists. We cover home health care only if all the standards below are met:

- You are substantially confined to Your home (or a friend's or relative's home within IEHP Service Area) because of illness or injury. This means that the Member is normally unable to leave home unassisted, and, when the Member does leave home, it must be to get medical care, or for short, infrequent non-medical reasons such as a trip to attend religious services or adult day care.
- The skilled nursing care is appropriate for the medical treatment of a condition, illness, disease, or injury. The services are in place of a continued hospitalization, confinement in a Skilled Nursing Facility, or outpatient services provided outside of the Member's home.
- Your condition requires the services of a nurse, physical therapist, occupational therapist, or speech therapist (home health aide services are not covered unless You are also getting covered home health care from a nurse, physical therapist, occupational therapist, or speech therapist that only a licensed provider can provide).
- A Network Provider determines that it is feasible to maintain effective supervision and control of Your care in Your home and that the services can be safely and effectively provided in Your home.
- The services are provided inside our Service Area.

Benefits are available through a Network home infusion provider for home infusion, enteral, and injectable medication therapy. Benefits include but are not limited to:

- Home infusion agency provider Skilled Nursing visits.
- Infusion therapy provided in a Network infusion facility.
- Parenteral nutrition services and associated supplies and solutions.
- Enteral nutrition services and associated supplies, covered formulas, and solutions.
- Medical supplies used during a covered visit.
- Administration of injectable medications in the home setting.

There is no Calendar Year visit maximum for home infusion agency services.

This Benefit does not include the following (refer to "Prescription Drugs" and "Diabetes Care" sections):

- Insulin.
- Insulin syringes.

Services are limited to those authorized by IEHP up to 100 visits per year, 3 visits per day, up to 2 hours per visit (nurse, social worker, physical/ occupational/ speech therapist) or up to 4 hours for a home health aide. If a service can be provided in more than one location, IEHP will work with the provider to choose the location.

Note: If a visit by a nurse, medical social worker, or physical, occupational, or speech therapist lasts longer than 2 hours, then each additional increment of 2 hours counts as a separate visit. If a

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visit by a home health aide lasts longer than 4 hours, then each additional increment of 4 hours counts as a separate visit. Also, each person providing services counts toward these visit limits. For example, if a home health aide and a nurse are both at Your home during the same 2 hours that counts as two visits.

Custodial Care services and Private Duty Nursing, as described in the "Definitions" section and any other types of services primarily for the comfort or convenience of the Member, are not covered even if they are available through a Home Health Care Agency and are Medically Necessary. Home Health Care Services do not include Private Duty Nursing or shift care, including any portion of shift care services. Private Duty Nursing (or shift care) is not a covered benefit under this Plan even if it is available through a Home Health Care Agency or is determined to be Medically Necessary.

Home Physician Visits

Visits by a Member's Physician to a Member's home are covered at the Physician's discretion in accordance with the rules and standards set by IEHP and if the Physician concludes that the visit is medically and otherwise reasonably indicated.

Hospice

Hospice care is a specialized form of interdisciplinary health care designed to provide palliative care and to alleviate the physical, emotional, and spiritual discomforts of a Member due to a terminal illness. It also provides support to the primary caregiver and the Member's Family. A Member who chooses hospice care is choosing to receive palliative care for pain and other symptoms associated with the terminal illness, but not to receive care to try to cure the terminal illness. You may change Your decision to receive hospice care benefits at any time.

We cover the hospice services listed below when all the requirements below are met:

- A participating provider has diagnosed You with a terminal illness and determines that Your life expectancy is 12 months or less.
- The Covered Services are provided inside our Service Area.
- The services are provided by a Network licensed hospice agency.
- The services are necessary for the palliation and management of Your terminal illness and related conditions.

If all the above requirements are met, we cover the hospice services listed below, which are available on a 24-hour basis if necessary for Your hospice care:

- Participating physician services.
- Skilled nursing care, including assessment, evaluation, and case management of nursing needs. Also, treatment for pain and symptom control (palliative care), provision of emotional support to You and Your Family, and instruction to caregivers.
- Physical, occupational, or speech therapy for purposes of symptom control or to enable You to maintain ADLs.
- Respiratory therapy.
- Medical social services.

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- Home health aide and homemaker services.
- Palliative drugs prescribed for pain control and symptom management of the terminal illness in accord with our drug formulary guidelines. You must get these drugs from plan pharmacies.
- Durable medical equipment.
- Incontinence supplies
- Counseling and bereavement services.
- Dietary counseling.
- Growth Hormone.
- The following care during periods of crisis when You need continuous care to achieve palliation or management of acute medical symptoms:
 - Nursing care on a continuous basis for as much as 24 hours a day as necessary to maintain You at home.
 - Short-term inpatient care required at a level that cannot be provided at home.

Hospice program enrollment needs prior authorization for a specified period of care based on Your Physician's certification of eligibility. Your Hospice care continues through to the next period of care when Your Physician recertifies that You have a terminal illness. The Hospice Agency works with Your Physician to ensure that Your Hospice enrollment continues without interruption.

Respite care when necessary to relieve Your caregivers is covered, on an occasional basis, limited to a maximum of five (5) consecutive days at a time. Inpatient or home health care for the Member may be authorized by IEHP.

Benefits do not include:

- Services provided by a non-contracted Hospice Agency, except in certain circumstances where there are no Network Hospice Agencies in Your area and services are prior authorized.
- Hospice care that is not certified / re-certified by Your physician.

Immunization and Injections

Immunizations and injections are covered and include the professional services to inject the medications and the medications. Injectable medications approved by the Food and Drug Administration ("FDA"), administered by a health care professional in the office setting are covered. Preventive Care Services are covered under the "Preventive Care Services" section. Immunizations required for travel are not covered.

The prior authorization process for self-administered prescription Drugs available at a retail, specialty, or mail order pharmacy is explained in the "Prescription Drug Benefits" section.

Infusion Therapy

Network Outpatient infusion therapy used to administer covered drugs and other substances by injection or aerosol is covered when authorized by IEHP and appropriate for the Member's

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illness, injury or condition.

Infusion therapy includes but is not limited to:

- Total parenteral nutrition (TPN) (nutrition delivered through the vein).
- Injected or intravenous antibiotic therapy.
- Chemotherapy.
- Injected or intravenous Pain management.
- Intravenous hydration (substances given through the vein to maintain the patient's fluid and electrolyte balance, or to provide access to the vein).
- Aerosol therapy (delivery of drugs or other Medically Necessary substances through an aerosol mist).
- Tocolytic therapy to stop premature labor.

Covered Services include Network professional services (including clinical pharmaceutical support) to order, prepare, compound, dispense, deliver, administer, or monitor covered drugs or other covered substances used in infusion therapy.

Covered supplies include injectable prescription drugs or other substances which are approved by the California Department of Health or the FDA for general use by the public. Other Medically Necessary supplies and DME necessary for infusion of covered drugs or substances are covered.

All services must be billed and performed by a Network Provider licensed by the state. Only a 30-day supply will be covered per delivery.

Infusion therapy benefits will not be covered in connection with:

- Infusion medication administered in an outpatient Hospital setting that can be administered in the home or a non-Hospital infusion facility setting.
- Non-prescription drugs or medications.
- Any drug labeled “Caution, limited by Federal Law to Investigational use” or Investigational drugs not approved by the FDA.
- Drugs or other substances obtained outside of the United States.
- Homeopathic or other herbal medications not approved by the FDA.
- FDA approved drugs or medications prescribed for indications that are not approved by the FDA, or which do not meet medical community standards (except for non-Investigational FDA approved drugs used for off-label indications when the conditions of state law have been met).
- Supplies used by a health care provider that are incidental to the administration of infusion therapy, including but not limited to: cotton swabs, bandages, tubing, syringes, medications and solutions.

Inpatient and Hospital Services

Benefits include room and board, such as:

- Semiprivate Hospital room, or private room if Medically Necessary.
- Specialized care units, including adult intensive care, coronary care, pediatric and neonatal

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- intensive care, and subacute care.
- General and specialized nursing care.
- Meals, including special diets.

Other inpatient Hospital services and supplies that are medically necessary, including:

- Operating, recovery, labor and delivery, and other specialized treatment rooms.
- Anesthesia, oxygen, and IV solutions.
- Drugs and medicines approved for general use by the Food and Drug Administration which are supplied by the Hospital for use during Your stay.
- Clinical pathology, laboratory, radiology, and diagnostic services and supplies.
- Dialysis services and supplies.
- Blood and blood products.
- Medical and surgical supplies, surgically implanted devices, prostheses, and appliances.
- Radiation therapy, chemotherapy, and associated supplies.
- Therapy services, including physical, occupational, respiratory, and speech therapy.
- Acute detoxification.
- Acute inpatient rehabilitative services.
- Emergency room services resulting in admission.

Medically Necessary services by a physician, surgeon, assistant surgeon, nurse anesthetist or anesthesiologist are covered.

We cover hospital inpatient care related to bariatric surgical procedures (including room and board, imaging, laboratory, special procedures, and participating physician services) when performed to treat morbid obesity by modification of the gastrointestinal tract to reduce nutrient intake and absorption, if all the requirements below are met:

- You complete the IEHP–approved presurgical educational preparatory program regarding lifestyle changes necessary for long term bariatric surgery success.
- A Network physician who is a specialist in bariatric care determines that the surgery is Medically Necessary and authorized by IEHP.
- For Covered Services related to bariatric surgical procedures that You receive, You will pay the cost sharing You would pay if the services were not related to a bariatric surgical procedure. For example, see “Hospital Stay” in the Summary of Benefits for the cost sharing that applies for hospital inpatient care.

If You live 50 miles or more from the nearest IEHP Bariatric Surgery Performance Center, You are eligible to receive travel expense reimbursement. All requests for travel expense reimbursement must be prior approved by IEHP.

Approved travel-related expenses will be reimbursed as follows:

- Transportation for the Member to and from the Bariatric Surgery Performance Center up to \$130 per trip for a maximum of four (4) trips (pre-surgical work-up visit, one pre-surgical visit, the initial surgery and one follow-up visit).
- Transportation for one companion (whether or not an enrolled Member) to and from the Bariatric Surgery Performance Center up to \$130 per trip for a maximum of three (3) trips (work-up visit, the initial surgery and one follow-up visit).

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- Hotel accommodations for the Member not to exceed \$100 per day for the pre-surgical work-up, pre-surgical visit and the follow-up visit, up to two (2) days per trip or as Medically Necessary. Limited to one room, double occupancy.
- Hotel accommodations for one companion (whether or not an enrolled Member) not to exceed \$100 per day, up to four (4) days for the Member's pre-surgical work-up and initial surgery stay and up to two (2) days for the follow-up visit. Limited to one room, double occupancy.
- Other reasonable expenses not to exceed \$25 per day, up to two (2) days per trip for the pre-surgical work-up, pre-surgical visit and follow-up visit and up to four (4) days for the surgery visit.

Expenses for tobacco, alcohol, telephone, television, and recreation are excluded. Submission of adequate documentation including receipts is required to receive travel expense reimbursement from IEHP.

Reconstructive surgery is covered as follows:

- Surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to improve function or create a normal appearance to the extent possible.
- Dental and orthodontic surgery services directly related to cleft palate repair.
- Surgery and surgically implanted prosthetic devices.

This does not include cosmetic surgery that is performed to alter or reshape normal structures of the body in order to improve appearance. This does not include dental services, supplies, or treatment for disorders of the jaw except as set out under "Dental Services" and "Exclusions and Limitations" sections. Reconstructive surgery includes Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate includes cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate.

In accordance with the Women's Health and Cancer Rights Act of 1998 ("WHCRA"). Reconstructive Surgery and surgically implanted and non-surgically implanted prosthetic devices (including prosthetic bras) are covered for either breast to restore and achieve symmetry following a mastectomy. Also covered is the treatment of the physical complications of a mastectomy, including lymphedemas. Medically Necessary services will be determined by Your attending Physician in consultation with You.

Benefits will be provided in accordance with guidelines established by IEHP and developed in conjunction with plastic and reconstructive surgeons, except as required under the WHCRA.

WHCRA benefits do not include:

- Cosmetic surgery, which is surgery that is performed to alter or reshape normal structures of the body to improve appearance.
- Reconstructive Surgery when there is a more appropriate procedure that will be approved.
- Reconstructive Surgery to create a normal appearance when it offers only a minimal improvement in appearance.

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- Prior authorization is required and may not be covered if not obtained prior to getting services.

Laboratory and Diagnostic Imaging Services

Benefits are available for Network imaging, pathology, and laboratory services for preventive screening or to diagnose or treat illness or injury. Some services may be subject to prior authorization. Benefits include but are not limited to:

- Diagnostic and therapeutic imaging services, such as X-rays and ultrasounds.
- Radiological and nuclear imaging, including CT, PET, and MRI scans.
- Clinical pathology services.
- Laboratory services.
- Other areas of diagnostic testing, including respiratory, neurological, vascular, cardiological, genetic, and cerebrovascular.
- Prenatal diagnosis of genetic disorders of the fetus in cases of high-risk pregnancy.

Medical Nutrition Therapy

Dietary, nutritional supplements and specialized formulas are not covered except when prescribed for the treatment of Phenylketonuria (PKU) or as indicated on the U.S. Preventive Services Task Force (USPSTF) Grade A & B recommendations. The items must be part of a diet prescribed and managed by a Physician or appropriately licensed Health Care Provider.

Benefits include enteral formulas and special food products for the dietary treatment of PKU.

Benefits do not include:

- Grocery store foods used by the general population.
- Food that is naturally low in protein, unless specially formulated to have less than one gram of protein per serving.

Dietary or nutritional supplements and specialized formulas may be covered as deemed Medically Necessary for Mental Health and Substance Use Disorder treatments when the dietary, nutritional supplement or specialized formula is a component of a behavioral health treatment plan. Treatment plan must be rendered by a qualified Network Provider for treatment of the Mental Health and Substance Use Disorder diagnosis. Coverage for the dietary or nutritional supplements and specialized formulas must be authorized by IEHP. IEHP will cover only those Mental Health and Substance Use Disorder services which are delivered by Network Providers who are licensed in accordance with California law and are acting within the scope of such license or as otherwise authorized under California law.

IEHP covers medically necessary pasteurized donor human milk from a tissue bank licensed by the California Department of Public Health for infants who cannot receive their mother's breast milk due to medical or physical reasons. This benefit is available for both hospital and at-home use.

Mental Health and Substance Use Disorder Services

Have questions? Contact IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711), Monday-Friday 8am-6pm PST. Visit us online at iehp.org.

We provide coverage for Medically Necessary treatment of mental health and substance use disorders, including maternal mental health conditions (refer to definition of Medically Necessary Treatment of a Mental Health or Substance Use Disorder). We cover all mental health and substance use disorders listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, the DSM-5, or the most recent edition of the International Classification of Diseases. (Please see section 1374.72(a) of the California Health and Safety Code). To learn more about nonprofit associations' Mental Health and Substance Use Disorder clinical review criteria, education and training materials, please call IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711).

Basic health care services that are covered under Mental Health and Substance Use Disorders include the following:

- coordinated specialty care for the treatment of first episode psychosis,
- drug testing,
- gender dysphoria,
- intensive home-based treatment,
- polysomnography,
- school site services for a mental health condition or substance use disorder, and
- preventive health care services.

Mental Health and Substance Use Disorder coverage includes the full range of levels of care pursuant to Health and Safety Code section 1374.72(b)(2) and is not limited to short-term or acute treatment pursuant to Health and Safety Code section 1374.72(a)(6). Some services and supplies for Mental Health and Substance Use Disorders require prior authorization by IEHP to be covered. The services and supplies for Mental Health and Substance Use Disorders that require prior authorization are listed in the "Specialist, Referral Care, and Authorizations" section.

All prior authorizations, utilization review determination criteria, and any education program materials are available upon request at no cost to you. All materials, including this EOC, and additional information related to Mental Health and Substance Use Disorders can also be found on the plan's website at www.iehp.org. If there are any changes to this benefit, the criteria or prior authorizations we will notify You immediately.

We do not cover services for conditions that the DSM identifies as something other than a "mental disorder." For example, the DSM identifies relational problems as something other than a "mental disorder," so we do not cover services (such as couples counseling or Family counseling) for relational problems. To learn more about limitations and exclusions, please read the "Exclusions and Limitations" section of this EOC.

You have a right to receive timely and geographically accessible Mental Health/Substance Use Disorder (MH/SUD) services when you need them. If IEHP fails to arrange those services for you with an appropriate provider who is in the health plan's network, the health plan must cover and arrange needed services for you from an out-of-network provider. If that happens, you do not have to pay anything other than your ordinary in-

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network cost-sharing.

If you do not need the services urgently, your health plan must offer an appointment for you that is no more than 10 business days from when you requested the services from the health plan. If you urgently need the services, your health plan must offer you an appointment within 48 hours of your request (if the health plan does not require prior authorization for the appointment) or within 96 hours (if the health plan does require prior authorization).

If your health plan does not arrange for you to receive services within these timeframes and within geographic access standards, you can arrange to receive services from any licensed provider, even if the provider is not in your health plan's network. To be covered by your health plan, your first appointment with the provider must be within 90 calendar days of the date you first asked the plan for the MH/SUD services.

If you have questions about how to obtain MH/SUD services or are having difficulty obtaining services you can: 1) call your health plan at the telephone number on the back of your health plan identification card; 2) call the California Department of Managed Care's Help Center at 1-888-466-2219; or 3) contact the California Department of Managed Health Care through its website at www.healthhelp.ca.gov to request assistance in obtaining MH/SUD services.

Outpatient Services: We cover the services below when provided by Network physicians or other Network providers who are licensed health care professionals acting within the scope of their license:

- Mental Health evaluation, treatment, and care
- Individual and group therapy
- Psychological testing when clinically necessary to evaluate a mental health disorder
- Medication Management and drug therapy monitoring
- Psychiatric Observation for an acute psychiatric crisis

Other Outpatient Mental Health and Substance Use Disorder Services include but are not limited to:

- Behavioral Health Treatment: professional services and treatment programs, including applied behavior analysis Evidence-based intervention programs, prescribed by a Physician, licensed psychologist, or Qualified Autism Service Provider, and provided under a treatment plan approved by IEHP to develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism spectrum disorder.
 - The treatment plan must have measurable goals over a specific timeline that is developed and approved by the Qualified Autism Service Provider for the specific patient being treated and must be reviewed by the Qualified Autism Service Provider at least once every six months and modified whenever appropriate. The treatment plan must not be used for purposes of providing or for the reimbursement of respite, day care or educational services, or to reimburse a parent for taking part in a treatment program.

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- The Qualified Autism Service Provider must submit updated treatment plans to IEHP for continued behavioral health treatment beyond the initial six months and at ongoing intervals of no more than six months thereafter. The updated treatment plan must include documented evidence that progress is being made toward the goals set forth in the initial treatment plan.
- IEHP may deny coverage for continued treatment if the requirements above are not met or if ongoing efficacy of the treatment is not demonstrated.
- Electroconvulsive therapy: the passing of a small electric current through the brain to induce a seizure, used in the treatment of severe depression.
- Intensive Outpatient Program: outpatient care for mental health or substance use disorders when Your condition requires structure, monitoring, and medical/psychological intervention at least three hours per day, three days per week.
- Office-based opioid treatment: substance use disorder maintenance.
- Methadone maintenance treatment.
- Partial Hospitalization Program: an outpatient treatment program that may be in a free-standing or Hospital-based facility and provides services at least five hours per day, four days per week when You are admitted directly or transferred from acute inpatient care following stabilization.
- Transcranial magnetic stimulation: a non-invasive method of delivering electrical stimulation to the brain for the treatment of severe depression.

Pediatric Acute-onset Neuropsychiatric Syndrome (PANS) and Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) services are covered when prescribed or ordered by the treating physician and surgeon and is medically necessary. Treatment will include antibiotics, medication and behavioral therapies to manage neuropsychiatric symptoms, immunomodulating medicines, plasma exchange, and intravenous immunoglobulin therapy. PANDAS/PANS services will not be subject to a copayment, coinsurance, deductible, or other cost-sharing that is greater than the cost share that is applied to covered benefits under this Plan.

Inpatient Services:

Benefits are available for inpatient facility and professional services that are medically necessary for the treatment of Mental Health and Substance Use Disorders in:

- A Hospital; or
- A free-standing residential treatment center that provides 24-hour care when You do not require acute inpatient care.

Any psychiatric hospital may be used in case of a psychiatric emergency without authorization. Psychiatric emergency conditions are defined as when You have thoughts or actions about hurting Yourself or someone else.

IEHP covers the cost of evaluations and services provided pursuant to a Community Assistance, Recovery and Empowerment (CARE) Court Program. The services available through the CARE agreement or plan must be approved by a court and are available without prior authorization and cost sharing. Prescription drugs included in a CARE agreement are subject to prior authorization and You will have to pay the applicable co-payment.

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Transitional residential recovery services for substance use disorder in a licensed recovery home when approved by IEHP are covered.

Mental Health Parity and Addiction Equity Act: IEHP complies with the federal Mental Health Parity and Addiction Equity Act. IEHP ensures that the financial requirements and treatment limitations on Mental Health Services or Substance Use Disorder benefits provided are no more restrictive than those on medical or surgical benefits.

Second Opinion of a Mental Health Professional

You may request a second opinion when:

- Your Network Mental Health Professional renders a diagnosis or recommends a treatment plan that You are not satisfied with.
- You are not satisfied with the result of the treatment You have received.
- You question the reasonableness or necessity of recommended surgical procedures.
- You are diagnosed with, or a treatment plan is recommended for, a condition that threatens loss of life, limb or bodily function or a substantial impairment, including but not limited to a Serious Chronic Condition.
- Your Primary Care Physician or a referral Physician is unable to diagnose Your condition or test results are conflicting.
- The treatment plan in progress is not improving Your medical condition within an appropriate period of time for the diagnosis and plan of care.
- If You have attempted to follow the plan of care, You consulted with the initial Primary Care Physician or a referral Physician due to serious concerns about the diagnosis or plan of care.

To request an authorization for a second opinion contact IEHP. IEHP will review Your request in accordance with the second opinion policy. When You request a second opinion, You will be responsible for any applicable Copayments. You may obtain a copy of this policy by visiting iehp.org or by calling IEHP Member Services.

Second opinions will only be authorized for Network Mental Health Professionals, unless it is demonstrated that an appropriately qualified Network Mental Health Professional is not available. IEHP will ensure that the provider selected for the second opinion is appropriately licensed and has expertise in the specific clinical area in question.

Any service recommended by the second opinion must be authorized by IEHP in order to be covered.

Unless medically necessary to treat a mental health or substance use disorder, IEHP does not cover:

- Alternative Therapies are therapies with inadequate evidence in the peer-reviewed published medical literature of their effectiveness and are considered unproven practices that should not be used in place of conventional medicine. This does not include Alternative Therapies that are newly approved as evidence-based practice.

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- Biofeedback, unless the treatment is Medically Necessary and prescribed by a licensed physician and surgeon or by a licensed psychologist.
- Services performed by unlicensed people when licensure is required in order to provide the service.
- Treatment for the purposes of providing respite, day care or educational services, or to reimburse a parent for participation in the treatment.

Ostomy and Urological Supplies

Ostomy and urological supplies are covered under the “Prostheses” benefit and include the items listed below:

- Adhesives (liquid, brush, tube, disc, or pad).
- Adhesive removers.
- Belts (hernia or ostomy).
- Catheters (indwelling, foley, intermittent, Male external catheter with integral collection chamber).
- Catheter Insertion Trays.
- Cleaners.
- Drainage Bags/Bottles -bedside and leg.
- Dressing Supplies.
- Irrigation Supplies.
- Lubricants.
- Male and female external collecting devices.
- Miscellaneous Supplies (urinary connectors; gas filters; ostomy deodorants; drain tube attachment devices; gloves; stoma caps; colostomy plugs; ostomy inserts; irrigation syringes, bulbs and pistons; tubing; catheter clamps and plugs, leg straps and anchoring devices; penile or urethral clamps and compression devices).
- Ostomy Rings and face plates.
- Pouches (urinary, drainable, ostomy) and pouch closures.
- Skin barriers.
- Skin sealant.
- Sterile individual packets
- Tape (all sizes, waterproof and non-waterproof).
- Incontinence supplies for hospice patients: disposable incontinence under pads, adult incontinence garments.

Outpatient Facility and Surgical Services

Network Professional services, outpatient Hospital facility services and outpatient surgery performed in a Hospital or Outpatient Surgical Center are covered.

Professional services performed in an outpatient department of a Hospital, including but not limited to:

- A visit to a Physician.
- Rehabilitation therapy (including physical, occupational and speech therapy, pulmonary rehabilitation therapy).
- Cardiac rehabilitation therapy.

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- Laboratory tests.
- X-rays, radiation therapy and chemotherapy.

Professional services are subject to the same Copayment or Coinsurance when these services are performed by other Network providers.

Many of the more common, outpatient surgical procedures can be performed at an Ambulatory Surgery Center. Your cost at an Ambulatory Surgery Center may be less than it would be for the same outpatient surgery performed at a Hospital.

Palliative Care

Palliative care is patient and family-centered care that improves quality of life by anticipating, preventing, and treating suffering. Palliative care does not require the member to have a life expectancy of 12 months or less. Palliative care may be provided at the same time as curative care. Palliative care includes:

- Advance care planning
- Palliative care assessment and consultation
- Plan of care including all authorized palliative and curative care
- Palliative care team including, but not limited to:
 - Doctor of medicine or osteopathy
 - Physician assistant
 - Registered nurse
 - Licensed vocational nurse or nurse practitioner
 - Social worker
 - Chaplain
 - Care coordination
 - Pain and symptom management
 - Mental health and medical social services

Adults who are age 21 or older cannot get both palliative (curative) care and hospice care at the same time. If you are getting palliative care and qualify for hospice care, you can ask to change to hospice care at any time.

Pediatric Asthma

This Plan covers services to treat pediatric asthma. Asthma inhalers and inhaler spacers are covered under the Prescription Drug Benefit. Please refer to the “Durable Medical Equipment” section for additional coverage information.

Pediatric Dental Services

All Benefits must be provided by the Member’s Primary Dentist to receive Benefits under this dental plan. This dental plan does not provide Benefits for services and supplies provided by a dentist who is not the Member’s Primary Dentist, except as described under the "Pediatric Dental Services" portion of “Introduction to IEHP” section.

Have questions? Contact IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711), Monday-Friday 8am-6pm PST. Visit us online at iehp.org.

Pediatric dental services are covered until the last day of the month in which the individual turns 19 of age.

Choice of Provider

When You enroll, You must choose a Selected General Dentist from our network. Please refer to the Directory of Participating Dentists for a complete listing of Selected General Dentists.

Medically Necessary Dental Services

Medically Necessary dental services are dental benefits which are necessary and appropriate for treatment of a Member's teeth, gums and supporting structures according to professionally recognized standards of practice and is:

- Necessary to treat decay, disease, or injury of the teeth; or
- Essential for the care of the teeth and supporting tissues of the teeth

Copayments

When You receive care from either a General Dentist or Specialist, You will pay the Copayment described on Your "Dental Summary of Benefits." When You are referred to a Specialist, Your Copayment may be either a fixed dollar amount, or a percentage of the dentist's usual and customary fee. Please refer to the "Dental Summary of Benefits" for specific details. When You have paid the required Copayment, if any, You have paid in full. If You choose to receive services from a non-contracted provider, You may be liable to the non-contracted provider for the cost of services unless authorized by us or in accordance with emergency care provisions.

Dental Customer Service

We provide toll-free access to Liberty Dental Member Services to assist You with benefit coverage questions, resolving problems or changing Your dental office. Liberty Dental Member Services can be reached at 1-866-544-2981, Monday-Friday, 8am-5pm.

Pediatric Vision Services

Pediatric vision services are covered until the last day of the month in which the individual turns 19 years of age.

All pediatric vision services must be provided by a IEHP Network Vision Provider in order to receive benefits under this plan. Call IEHP Member Services at 1-855-433- IEHP (4347) [TTY 711] for help in finding Network Vision Providers or visit our website at iehp.org. This plan does not cover services and materials provided by a provider who is not a Network Vision Provider. The Network Vision Provider is responsible for the provision, direction and coordination of the Member's complete vision care.

When You receive benefits from a Network Vision Provider You only pay the applicable Copayment amount that is stated in the "Pediatric Vision Services" portion of the "Schedule of Benefits." For materials, You are responsible for payment of any amount in excess of the allowances specified in the "Pediatric Vision Services" portion of the "Schedule of Benefits."

Have questions? Contact IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711), Monday-Friday 8am-6pm PST. Visit us online at iehp.org.

Exam

Routine optometric or ophthalmic vision exams (including refractions) by a licensed Optometrist or Ophthalmologist, for the diagnosis and correction of vision, up to the maximum number of visits stated in the "Schedule of Benefits."

Contact Lens Fit and Follow-up Exam

If the Member requests or requires contact lenses, there is an additional exam for contact lens fit and follow-up as stated in the "Schedule of Benefits." Follow-up exam(s) for contact lenses include up to two (2) subsequent visit(s) to the same provider who provided the initial contact lens fit exam.

This Plan covers both standard and premium contact lenses. Standard Contact Lens fit and follow-up applies to routine application soft, spherical, daily wear contact lenses for single vision prescriptions. Standard Contact Lens fit and follow-up does not include extended or overnight wear for any prescription. Premium contact lens fit and follow-up applies to complex applications, including but not limited to toric, bifocal, multifocal, cosmetic color, post-surgical and gas permeable. Premium Contact Lens fit and follow-up includes extended and overnight wear for any prescription.

Low Vision

This Plan covers one comprehensive low vision evaluation every 5 years; low vision aids, including high-power spectacles, magnifiers, telescopes, and follow-up care (limited to 4 visits every 5 years and a maximum charge of \$100 each follow-up visit).

Materials - Frames

If an exam indicates the necessity of eyeglasses, this vision benefit will cover one frame, up to the maximum number described in the "Schedule of Benefits."

Materials - Eyeglass Lenses

If an exam results in corrective lenses being prescribed for the first time or if a current wearer of corrective lenses needs new lenses, this vision plan will cover a pair of lenses subject to the benefit maximum as specified in the "Schedule of Benefits." Your Network Provider will order your materials from a network lens manufacturer. Frames and lenses not ordered from a Network Provider are not covered.

Cosmetic Eyewear, including contact lenses, is only covered when there is a need for vision correction.

Medically Necessary Contact Lenses

Coverage for prescriptions for Medically Necessary contact lenses is subject to Medical Necessity and all applicable exclusions and limitations. Contact Lenses are considered Medically Necessary for the following conditions:

- After cataract surgery
- Keratoconus

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- Anisometropia
- Astigmatism
- Hyperopia
- Myopia

Contact lenses may be determined to be Medically Necessary in the treatment of these conditions: Keratoconus, Pathological Myopia, Aphakia, Anisometropia, Aniridia Aniseikonia, Corneal Disorders, Post-Traumatic Disorders, and Irregular Astigmatism. For coverage of Medically Necessary Contact Lenses to treat conditions of aniridia, refer to the “Durable Medical Supplies” section above to learn more.

Contact Lenses for Conditions of Aphakia

Special Contact Lenses are covered when prescribed for conditions of aphakia. Up to six Medically Necessary aphakic Contact Lenses per eye (including fitting and dispensing) per Calendar Year to treat aphakia (absence of the crystalline lens of the eye). We will not cover an aphakic Contact Lens if we provided an allowance toward (or otherwise covered) more than six aphakic Contact Lenses for that eye during the same Calendar Year. For adults age 19 and older, see the “Durable Medical Equipment” section above to learn more.

Phenylketonuria (PKU)

Coverage for testing and treatment of phenylketonuria (PKU) includes formulas and special food products that are part of a diet prescribed by a Physician and managed by a licensed health care professional in consultation with a Physician who specializes in the treatment of metabolic disease. The diet must be deemed Medically Necessary to prevent the development of serious physical or mental disabilities or to promote normal development or function. Coverage is provided only for those costs which exceed the cost of a normal diet.

"Formula" is an enteral product or enteral products for use at home that is prescribed by a Network Physician or nurse practitioner or ordered by a registered dietitian upon referral by a health care provider authorized to prescribe dietary treatments, as Medically Necessary for the treatment of PKU.

"Special food product" is a food product that is prescribed by a Network Physician for treatment of PKU and used in place of normal food products, such as grocery store foods. It does not include a food that is naturally low in protein.

Other specialized formulas and nutritional supplements are not covered.

Pregnancy and Maternity Services

Hospital and professional services for pregnancy are covered, including but not limited to:

- Prenatal care
- Postnatal care
- Doula Services

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- Involuntary complications of pregnancy
- Inpatient Hospital services including labor
- Delivery and postpartum care
- Elective newborn circumcision within 18 months of birth
- Pregnancy termination services
- Pre- and post-partum mental health conditions

The Newborns' and Mothers' Health Protection Act requires health plans to provide a minimum Hospital stay for the mother and newborn child of 48 hours after a normal, vaginal delivery and 96 hours after a Cesarean section. Longer stays in the hospital will require authorization. The performance of elective cesarean sections must be authorized.

The attending Physician, in consultation with the mother, may determine that a shorter length of stay is adequate. If Your Hospital stay is shorter than the minimum stay, You can receive a follow-up visit with a Health Care Provider whose scope of practice includes postpartum and newborn care. This follow-up visit may occur at home or as an outpatient, as necessary. This visit will include parent education, assistance and training in breast or bottle feeding, and any necessary physical assessments for the mother and child. Prior authorization is not required.

In cases of identified high risk pregnancy, prenatal diagnostic procedures, alpha fetoprotein testing and genetic testing of the fetus are also covered. Prenatal diagnostic procedures include services provided by the California Prenatal Screening Program (formerly Expanded Alpha-Fetoprotein Program) administered by the California State Department of Public Health and are covered at no cost to the Members.

IEHP is committed to helping pregnant and postpartum members stay healthy. Our Maternal Health team provides important services, including support for mental health. Part of your covered maternal health benefit includes depression screenings during pregnancy, and another within six weeks postpartum, with more screenings as clinically needed. This helps us find any mental health concerns early so we can provide care and support on time.

If you are currently receiving care for a maternal mental health condition and your provider is no longer in IEHP's network – or if you're new to IEHP and were previously receiving care from a provider outside of the IEHP network, You can continue receiving covered services for up to 12 months after your diagnosis or after your pregnancy ends, whichever is later.

By focusing on maternal mental health, we help ensure healthier pregnancies, safer births, and stronger families in our community. For more information, call Member Services at 1-855-433-IEHP (4347).

Preventive services for pregnancy, as listed in the U.S. Preventive Services Task Force A&B recommendations and Health Resources and Services Administration's ("HRSA") Women's Preventive Service, are covered as Preventive Care Services. Prenatal exams, prenatal supplements, and the first post-partum follow-up consult is covered as Preventive Care.

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Refer to “Lab and Diagnostic Imaging” and “Preventive Services” section to learn more about coverage of genetic testing and diagnostic procedures related to pregnancy and maternity care.

Preventive Care Services

Preventive Care Services are covered for children and adults, as directed by Your PCP or other Network Provider based on the guidelines from these resources:

- U.S. Preventive Services Task Force (“USPSTF”) Grade A & B recommendations (www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/)
- The Advisory Committee on Immunization Practices (“ACIP”) that have been adopted by the Center for Disease Control and Prevention (<http://www.cdc.gov/vaccines/schedules/index.html>)
- California Department of Public Health (CDPH) recommendations (<https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/publichealth4all/vaccines.aspx>)
- Guidelines for infants, children, adolescents, and women’s preventive health care as supported by the Health Resources and Services Administration (“HRSA”) (www.hrsa.gov/womensguidelines/)

IEHP only covers Preventive Care Services when You get them from a Network Provider. Provider office visit cost share will not apply when You receive preventive care services during that visit.

Benefits include, but are not limited to:

- Evidence-based items, drugs, or services with a rating of A or B in the current recommendations of the United States Preventive Services Task Force (“USPSTF”). This includes:
 - Periodic health evaluations.
 - Preventive hearing and vision screening.
 - Blood pressure, diabetes, and cholesterol tests.
 - Screening for cancer, such as colorectal cancer, cervical cancer, breast cancer, and prostate cancer.
 - Screening and FDA-approved vaccination for the human papilloma virus (HPV).
 - Screening, diagnosis, and treatment for osteoporosis.
 - Health education.
- Immunizations recommended by either the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. Or the most current version of the Recommended Childhood Immunization Schedule/United States (adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians).
- Evidence-informed preventive care and screenings for infants, children, and adolescents as listed in the comprehensive guidelines supported by HRSA. Including screening for risk of lead exposure and blood lead levels in children at risk for lead poisoning.
- Counseling, screening, and immunizations to ensure healthy pregnancies.
- Regular well-baby and well-child visits.
- Human immunodeficiency virus (HIV) screening and counseling.

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- Home test kit for sexually transmitted disease (STD)
- Well-woman visits.
- California Prenatal Screening Program.
- Additional preventive care and screenings for women not described above as provided for in comprehensive guidelines supported by HRSA. For more details, see the “Family Planning Benefits” section.
- Developmental screenings to diagnose and assess potential developmental delays.
- Counseling on such topics as quitting smoking, lactation, losing weight, eating healthfully, treating depression, prevention of sexually transmitted diseases and reducing alcohol use.
- FDA-approved prescription or over-the-counter contraceptives include vaginal, oral, transdermal, and emergency contraceptive devices. Devices include contraceptive rings, cervical caps, male and female condoms and diaphragms. Over-the-counter contraceptives do not require a prescription from in-network pharmacies.
- Prevention of Acquisition of HIV: Pre-Exposure prophylaxis and Post-exposure prophylaxis furnished by a pharmacist who has successfully completed the required training at an in-network pharmacy or out-of-network pharmacy in accordance with out-of-network rules.
 - Pre-exposure prophylaxis medications, services, and related testing furnished by a pharmacist will be covered if all the following conditions are met
 - You have HIV negative status as documented by a negative HIV test
 - You do not exhibit signs or symptoms of acute HIV infection
 - You do not take any contraindicated medications
 - Post-exposure prophylaxis medications, services, and related testing furnished by a pharmacist will be covered

Preventive Care Services for women also include screening for gestational diabetes; sexually-transmitted infection counseling; FDA-approved contraception methods for women and contraceptive counseling; breastfeeding support, supplies and counseling; and domestic violence screening and counseling.

One breast pump and the necessary supplies to operate it (as prescribed by Your Physician) will be covered for each pregnancy at no cost to the Member. We will determine the type of equipment, whether to rent or purchase the equipment and the vendor who provides it. This includes one retail-grade breast pump (either a manual pump or a standard electric pump) as prescribed by Your Physician. You can find out how to get a breast pump by calling IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711) or visit IEHP’s website at iehp.org. If there is a new recommendation or guideline in any of the resources described above, IEHP will implement coverage to comply with applicable State or Federal requirements. Coverage will start for plan years (based on calendar years) that begin one year after the date of recommendation or on such other date as required by law.

Professional Services and Office Visits

Benefits are available for services performed by a Network Physician, surgeon, or other Health Care Provider to diagnose or treat a medical condition. Benefits include, but are not limited to:

- Office visits for exam, diagnosis, counseling, education, consultation, and treatment.
- Specialist office visits.

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- Urgent care center visits.
- Second medical opinions.
- Administration of injectable medications.
- Outpatient services.
- Inpatient services in a Hospital, Skilled Nursing Facility, residential treatment center, or emergency room.
- Home visits at provider discretion.
- Telehealth/Virtual consultations, provided remotely via communication technologies, for exam, diagnosis, counseling, education, and treatment.

Prostheses and Orthotics

Benefits are available for prosthetic appliances and devices used to replace a part of Your body that is missing or does not function, including fitting and adjustment, and related supplies.

IEHP will select the provider or vendor for the items. If two or more types of medically appropriate devices or appliances are available, IEHP will determine which device or appliance will be covered. The device must be among those that the Food and Drug Administration has approved for general use. Benefits include but are not limited to:

- Tracheoesophageal voice prosthesis (e.g., Singer device) and artificial larynx for speech after a laryngectomy.
- Artificial limbs and eyes.
- Internally implanted devices such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints.
- Contact lenses to treat eye conditions such as keratoconus or keratitis sicca, aniridia to treat aphakia following cataract surgery when no intraocular lens has been implanted.
- Supplies necessary for the operation of prostheses.
- Device replacement at the end of its expected lifespan.
- Repair due to normal wear and tear.

In addition, enteral formula for Members who require tube feeding is covered in accord with Medicare guidelines.

Prostheses to restore symmetry after a Medically Necessary mastectomy (including lumpectomy), and prostheses to restore symmetry and treat complications, including lymphedema, are covered. Lymphedema wraps and garments are covered, as well as, up to three (3) brassieres in a 12-month period to hold prostheses.

Benefits do not include:

- Speech or language assistance devices, except as listed.
- Backup or alternate items.
- Repair or replacement due to loss or misuse.

Benefits are available for orthotic equipment and devices You need to perform Activities of Daily Living. Orthotics are orthopedic devices used to support, align, prevent, or correct deformities or to improve the function of movable body parts. Benefits include but are not limited to:

- Shoes only when permanently attached to orthotic devices.
- Special footwear required for foot disfigurement caused by disease, disorder, accident, or

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developmental disability.

- Knee braces for post-operative rehabilitation following ligament surgery, instability due to injury, and to reduce pain and instability for patients with osteoarthritis.
- Custom-made rigid orthotic shoe inserts ordered by a Physician or podiatrist and used to treat mechanical problems of the foot, ankle, or leg by preventing abnormal motion and positioning when improvement has not occurred with a trial of strapping or an over-the-counter stabilizing device.
- Device fitting and adjustment.
- Device replacement at the end of its expected lifespan.
- Repair due to normal wear and tear.

Benefits do not include:

- Orthotic devices intended to provide additional support for recreational or sports activities.
- Orthopedic shoes and other supportive devices for the feet, except as listed.
- Backup or alternate items.
- Repair or replacement due to loss or misuse.

Rehabilitation Therapy

Benefits are available for outpatient rehabilitative services. Rehabilitative services help to restore the skills and functional ability You need to perform ADLs when You are disabled by injury or illness.

These services include physical therapy, occupational therapy, and speech therapy. Your Network Physician or Health Care Provider must prepare a treatment plan. Treatment must be provided by an appropriately licensed or certified Health Care Provider. You can keep getting rehabilitative services as long as Your treatment is Medically Necessary. IEHP may periodically review the provider's treatment plan and records for Medical Necessity.

Cardiac rehabilitation therapy services provided in connection with the treatment of heart disease is covered when Medically Necessary.

Pulmonary rehabilitation therapy services provided in connection with the treatment of chronic respiratory impairment is covered when Medically Necessary and when continuous functional improvement in response to the treatment plan is demonstrated by objective evidence.

Refer to “Hospital Services” section to learn more about inpatient rehabilitative benefits and “Home Health Care Services” for more details about coverage for rehabilitative services provided in the home.

Second Opinion by a Physician

You have the right to request a second opinion when:

- Your Primary Care Physician or a referral Physician gives a diagnosis or recommends a treatment plan that You are not satisfied with;
- You are not satisfied with the result of treatment You have received;
- You are diagnosed with or a treatment plan is recommended for, a condition that threatens

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loss of life, limb or bodily function or a substantial impairment, including but not limited to a Serious Chronic Condition, or

- Your Primary Care Physician or a referral Physician is unable to diagnose Your condition or test results are conflicting.

To request an authorization for a second opinion, contact Your PCP or IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711). IEHP will review Your request in accordance with IEHP's processes and timelines as stated in the second opinion policy. When You request a second opinion, You will be responsible for any applicable Copayments or Coinsurance. You may get a copy of this policy from IEHP Member Services. All authorized second opinions must be provided by a Network Physician who has training and expertise in the illness, disease or condition associated with the request.

Skilled Nursing Care

We cover up to 100 days of inpatient skilled nursing care provided by a participating skilled nursing facility and the services are prior authorized before they begin. The skilled inpatient services must be customarily provided by a Network Skilled Nursing Facility, and above the level of custodial or intermediate care. A prior stay in an acute care hospital is not required to be eligible for Skilled Nursing Facility care. We cover these services:

- Physician and nursing services.
- Room and board.
- Drugs prescribed by a Network Provider as part of Your plan of care in the participating Skilled Nursing Facility in accord with Our Drug Formulary Guidelines. Drugs are administered to You in the participating Skilled Nursing Facility by medical personnel.
- DME in accord with our durable medical equipment formulary if Skilled Nursing Facilities ordinarily furnish the equipment.
- Imaging and laboratory services that Skilled Nursing Facilities ordinarily provide.
- Medical social services.
- Blood, blood products, and their administration.
- Medical supplies.
- Physical, occupational, and speech therapy.
- Respiratory therapy.
- Behavioral health treatment for pervasive developmental disorder or autism.

Care in a room of two or more is covered. Benefits for a private room are limited to the facility's most common charge for a two-bed room unless a private room is Medically Necessary.

Benefits do not include continuous nursing services provided by a registered nurse or a licensed vocational nurse, on a one-to-one basis, in an inpatient or home setting. These non-covered services may also be described as "shift care" or "private duty nursing." Covered services do not include:

- Custodial care.
- Care that an unlicensed Family member or layperson could provide safely/effectively.
- Care in the home if the home setting does not allow safe and effective treatment.

Have questions? Contact IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711), Monday-Friday 8am-6pm PST. Visit us online at iehps.org.

Surgically Implanted Drugs

Surgically implanted drugs are covered under the medical benefit when Medically Necessary and may be provided in an inpatient or outpatient setting. Prior authorization may be required.

Telehealth/Virtual Services

Covered Services for medical conditions and Mental Health and Substance Use Disorders provided appropriately as Telehealth/Virtual Services are covered on the same basis and to the same extent as Covered Services delivered in-person.

Transplants

IEHP covers Medically Necessary transplants of organs, tissue, or bone marrow, which are not experimental or investigational in nature. We cover transplants of organs, tissue, or bone marrow if authorized by IEHP and performed at an approved Network transplant facility. After transplant services and transplant facility is authorized by IEHP, the following applies:

- If either IEHP or the transplant facility determines that You do not satisfy its respective criteria for a transplant, we will only cover services You receive before that determination is made.
- IEHP, Network hospitals and physicians are not responsible for finding, furnishing, or ensuring the availability of an organ, tissue, or bone marrow donor.

In accord with our guidelines for services for living transplant donors, we provide certain donation-related services for a donor, or an individual identified by IEHP as a potential donor, whether or not the donor is a Member:

These services must be directly related to a covered transplant for You, which may include certain services for harvesting the organ, tissue, or bone marrow and for treatment of complications. Our guidelines for donor services are the following:

- Donor receives covered services no later than 90 days following the harvest or evaluation service.
- Donor receives services in the United States, with the exception of that geographic limitations do not apply to treatment of stem cell harvesting.
- Donor receives written authorization for evaluation and harvesting services
- For services to treat complications, the donor either receives non-emergency services after written authorization, or receives emergency services the plan would have covered if the enrollee had received them.
- In the event the enrollee's plan membership terminates after the donation or harvest, but before the expiration of 90 day time limit for services to treat complications, the plan shall continue to pay for medically necessary services for donor for 90 days following the harvest or evaluation service.

Evaluation of potential candidates is subject to prior authorization. More than one evaluation (including tests) at more than one transplant center will not be authorized unless it is determined to be Medically Necessary.

Have questions? Contact IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711), Monday-Friday 8am-6pm PST. Visit us online at ieh.org.

Organ donation extends and enhances lives and is an option that You may want to consider. To learn more about organ donation, including how to elect to be an organ donor, please visit the Department of Health and Human Services organ donation website at www.organdonor.gov.

Travel expenses and hotel accommodations associated with organ, tissue and stem cell transplants are not covered.

If Your transplant is denied on the basis that it is experimental or investigational in nature, please refer to the “Grievance & Appeals” section to learn more about Your right to an “Independent Medical Review for Denials of Experimental/Investigational Therapies.” For covered transplant services that You receive, You will pay the cost sharing You would pay if the services were not related to a transplant.

Vision and Hearing

Vision and hearing exams for diagnosis and treatment are covered. Preventive vision and hearing screening are covered as Preventive Care Services as shown in the "Schedule of Benefits." See the “Pediatric Vision Services” section to learn more about vision exams for children under 19 years of age.

Prescription Drug Benefits

Covered service expenses and supplies in this benefit subsection are limited to charges from a licensed pharmacy for the prescription and over-the-counter drugs, devices, and supplies listed on the IEHP Formulary or prior authorized by IEHP.

Formulary and Tiers

IEHP uses an approved list of drugs called the formulary to make sure that the most appropriate, safe, and effective prescription medications are available to You. Certain covered drugs have restrictions such as Step Therapy (ST), Quantity Limits (QL), and/or require a Prior Authorization (PA).

The Formulary is updated and posted monthly. FDA approved generic drugs will be used in most situations, even when a brand-name drug is available. IEHP covers all Medically Necessary drugs on the formulary if Your doctor or other prescriber says You need them to get better or stay healthy, and You fill the prescription at a IEHP network pharmacy. Drugs that are not on the formulary require that Your doctor or other Network provider get approval before You fill the prescription. Please refer to the section “Non-Formulary Drugs” below. The formulary is reviewed and approved by a committee of physicians and pharmacists on a quarterly basis and includes generic, brand name, and specialty drugs covered under the prescription drug benefit. IEHP will provide sixty (60) days written notice of a Formulary change to You, if the change negatively affects You. The notice will include the date You will be impacted by the change. Some examples of Formulary changes that will result in a notice include, but are not limited to:

- A drug or dosage form is moved to a higher Drug Tier that results in an increase in cost sharing

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- A drug or dosage form is removed from the Formulary
- Drug Coverage Requirements or Limits for a drug are added or changed

Changes to the Formulary that may occur without prior written notice to You include:

- A drug is removed from the Formulary because it is removed from the market by either the drug manufacturer or the FDA
- A drug is added to the Formulary
- A drug is moved to a lower Drug Tier
- A Drug Coverage Requirement or Limit is removed from a drug

You can view the Formulary on IEHP's website at <https://www.iehp.org/en/browse-plans/covered-california/prescription-drugs>. You can also call IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711) to ask for a copy of the formulary. You may also request a copy of the formulary in Your preferred language or format such as large print or audio.

The IEHP Formulary includes:

- Prescription drugs and some over-the-counter drugs.
- Diabetic supplies: Insulin needles, insulin syringes, glucose test strips, lancets, continuous glucose monitors and associated supplies.
- Inhaler spacers and extender devices.
- Non-insulin needles and syringes needed to self-administer a covered drug when written on a prescription.

What drugs are covered?

We cover outpatient drugs, supplies, and supplements specified in this section when prescribed as follows and obtained at a Network Pharmacy or through our mail-order service:

- Items prescribed by Network Physicians in accordance with our drug formulary guidelines.
- Items prescribed by the following non-contracted Providers; unless a Plan Physician determines that the item is not Medically Necessary:
 - Dentists if the drug is for covered dental care.
 - Non-contracted Physicians if IEHP authorizes a written referral to the non-contracted Physician and the drug, supply, or supplement is covered as part of that referral.
 - Non-contracted Physicians if the prescription was obtained as part of covered Emergency Services, post-stabilization care, or Out-of-Area Urgent Care.

How to get covered items

You must obtain covered items at a Network Pharmacy or through our mail-order service unless You get the item as part of covered Emergency Services, post-stabilization care, or Out-of-Area Urgent Care described in the "Emergency Care Services" section.

For a list of pharmacies in the IEHP Covered California Pharmacy Network, call IEHP Member

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Services or visit the IEHP website at iehp.org.

If IEHP's coverage is amended to exclude a drug that we have been covering and providing to You under this Evidence of Coverage, we will keep providing the drug if a prescription is required by law and a Network Physician continues to prescribe the drug for the same condition and for a use approved by the Food and Drug Administration.

IEHP covers generic, brand name, and specialty drugs. You are responsible for a Copayment or Coinsurance for each drug filled at the pharmacy. The amount of Your Copayment or Coinsurance depends on the drug category and/or Tier indicated on the Formulary (example: Tier 1, 2, 3, 4) and Your benefit plan (for example: Gold, Silver or Bronze). Please refer to the "Summary of Benefits" for pharmacy Copayments, Coinsurance, Deductibles, and/or out-of-pocket limits that may apply.

Tier 1: Most generic drugs and low-cost, preferred brand drugs.

Tier 2: Non-preferred generic drugs, preferred brand drugs, or drugs recommended by the P&T Committee based on drug safety, efficacy, and cost.

Tier 3: Non-preferred brand drugs; drugs recommended by the P&T Committee based on safety, efficacy, and cost; or drugs that generally have a preferred and often less costly therapeutic alternative at a lower tier.

Tier 4: Drugs that the FDA or drug manufacturer requires to be distributed by specialty pharmacies; drugs that require training or clinical monitoring for self-administration; or drugs with a plan cost (net of rebates) greater than \$600 for a one-month supply.

Applicable Cost Share will apply by tier and quantity of drug dispensed. For example, two 30-day copayments may be due when picking up a 60-day prescription, three copayments may be due when picking up a 100-day prescription at the pharmacy. The prescription drug benefit shall provide that if the pharmacy's retail price for a prescription drug is less than the applicable copayment or coinsurance amount, You shall not be required to pay more than the retail price. The payment rendered shall constitute the applicable cost sharing and shall apply to the deductible, if any, and also to the maximum out-of-pocket limit in the same manner as if You had purchased the prescription medication by paying the cost-sharing amount. For covered outpatient prescription drugs, a copayment or percentage coinsurance shall not exceed 50 percent of the cost to IEHP. If there is a generic equivalent to a brand name drug, You are subjected to the lowest cost sharing that would be applied, whether or not both the generic equivalent and the brand name drug are on the formulary.

- You will pay the lesser of:
 - The pharmacy benefit Copayment or coinsurance as described above; or
 - The pharmacy's retail price; or
 - 50 percent of IEHP's cost of the Prescription Drug; or
 - \$250 for up to a 30-day supply of an oral oncology drugs; or
 - \$35 for a 30-day supply of a Tier 1 or Tier 2 insulin
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Generally, a biosimilar product or interchangeable biosimilar product works the same as the original biological product. Biosimilar products may be available at a lower cost than the original biological product. The lower cost is not a reflection of the effectiveness or safety of the biosimilar product. There may be instances where You would have to try a biosimilar product or interchangeable biosimilar product before receiving the original biological product. However, if Your prescribing physician submits a prior authorization request and explains the medical reason for requiring the original biologic product, then IEHP will cover the original biological product. See “Prior Authorization” portion of “Prescription Drug Benefits”.

Covered Formulary Drugs include:

- FDA-approved medications that require a prescription either by California or Federal law.
 - Insulin.
 - Pen delivery systems for the administration of insulin, as Medically Necessary.
 - Diabetic testing supplies, including these:
 - Lancets.
 - Lancet puncture devices.
 - Blood and urine testing strips.
 - Over-the-counter drugs with a United States Preventive Services Task Force (“USPSTF”) rating of A or B.
 - Contraceptive drugs and devices, including these:
 - Diaphragms.
 - Cervical caps.
 - Contraceptive rings.
 - Contraceptive patches.
 - Oral contraceptives.
 - Emergency contraceptives.
 - Over-the-counter contraceptive products.
 - Disposable devices that are Medically Necessary for the administration of a covered outpatient prescription Drug such as needles, syringes and inhaler spacers.
 - Injectable drugs administered in the home infusion setting are covered under the Prescription Drug Benefit.
 - At least one Medication-Assisted Treatment (MAT) for Substance Use Disorder in each of the following categories without prior authorization, step therapy, or utilization review:
 - Medication for the reversal of opioid overdose, including a naloxone product or another opioid antagonist.
 - Medication for the detoxification or maintenance treatment of a substance use disorder, including a daily oral buprenorphine product.
 - A long-acting buprenorphine product.
 - A long-acting injectable naltrexone product.
 - Medications for prophylaxis of HIV infection.
 - Mifepristone (brand name or generic) for use in an abortion.
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Outpatient Drug Formulary

IEHP's Drug Formulary is a list of FDA-approved Generic and Brand Drugs. This list helps Physicians or Health Care Providers prescribe Medically Necessary and cost-effective Drugs. Drugs not listed on the formulary may be covered when approved by IEHP through the exception request process. Refer to the “Non-formulary Drugs” section below.

IEHP's formulary is established and maintained by a Pharmacy and Therapeutics (“P&T”) Committee. This committee consists of Physicians and pharmacists responsible for evaluating Drugs for relative safety, effectiveness, evidence-based health benefit, and comparative cost. The committee also reviews new Drugs, dosage forms, usage, and clinical data to update the Formulary four times a year.

Prior Authorization

The prior authorization process (“PA”) is used to ensure that drug benefits are applied as intended and that Plan Members receive the most appropriate, safe, and cost-effective medication therapy. Prescribers are required to get pre-approval before prescribing a specific non-formulary drug in order for that medication to qualify for coverage under the terms of a pharmacy benefit plan. Your Physician will need to submit the Prescription Drug Prior Authorization or Step Therapy Exception Request Form, Form 61-211 to request prior authorization. Your Physician's request for prior authorization will be evaluated once the submitted information has been received and a determination made based on established clinical criteria for the specific medication. The criteria used for prior authorization are developed by the Pharmacy and Therapeutics Committee. Your physician may contact us to get the policy. Before payment can be approved for drugs requiring prior authorization, the conditions for approval must be met and the prior authorization must be entered into the system. Once a medication is approved, its authorization becomes effective right away. You may get a list of drugs requiring Prior Authorization. Visit the IEHP website at iehp.org or call IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711).

Prior Authorization is required for most brand name drugs with generic equivalents to determine Medical Necessity. IEHP will cover brand name drugs that have generic equivalents if the PA request is approved.

Non-formulary Drugs

Sometimes, doctors may prescribe a drug that is not on the formulary. This will require that the doctor get authorization from IEHP before You fill the prescription. To decide if the non-formulary drug will be covered, IEHP may ask the doctor for a “supporting statement”, which explains why the drug You are asking for is Medically Necessary. IEHP will reply to the doctor and/or pharmacist within 24 hours for requests that are for exigent circumstances or 72 hours for standard requests after getting the requested medical information. Exigent circumstances exist when a health condition may seriously jeopardize life, health, or the ability to regain maximum function or when undergoing a course of treatment using a non-formulary drug.

Some drugs have coverage rules or limits on the amount You can get. In some cases, Your doctor

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or other prescribers must do something before You can fill the prescription. For example, for some drugs, Your doctor or other prescribers must get approval from IEHP before You fill Your prescription. If You do not get approval, IEHP may not cover the drug.

Quantity Limits

For Your safety, IEHP may limit the amount of some drugs You can get per prescription or limit the number of times You can refill some drugs. If Your doctor or other prescriber thinks that the limited amount is not enough for Your medical condition, then an exception to the quantity limits can be requested.

Step Therapy

Some drugs have a special rule called step therapy. This means that You must first try another drug on the formulary before the prescribed drug is covered. If Your doctor or other prescriber thinks the first drug does not work for You, then an exception to the step therapy rule can be requested.

Step therapy is the process of beginning therapy for a medical condition with drugs considered first-line treatment or that are more cost-effective, then progressing to drugs that are the next line in treatment or that may be less cost-effective. Step therapy requirements are based on how the FDA recommends that a drug should be used, nationally recognized treatment guidelines, medical studies, and the relative cost. If step therapy coverage requirements are not met for a prescription and Your physician or health care provider believes the drug is Medically Necessary, the prior authorization process may be used and timeframes previously described will also apply.

Requests for prior authorization, non-formulary, quantity limit, or step therapy exceptions may be submitted electronically, by phone or fax via the Prescription Drug Prior Authorization or Step Therapy Exception Request Form, Form 61-211 available on IEHP's website at iehps.org. A prior authorization request based on exigent circumstances is when a Member suffers from a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function. Exigent requests from Physicians for authorization are processed, and prescribing providers are notified of IEHP's determination as soon as You can, not to exceed 24 hours, after receipt of the request and any additional information requested by IEHP that is reasonably necessary to make the determination.

Routine requests from Physicians are processed, and prescribing providers are notified of IEHP's determination in a timely fashion, not to exceed 72 hours. For both exigent circumstances and routine requests, IEHP must also notify the Member or their designee of its decision.

If You are denied Prior Authorization, please refer to the "Grievance, Appeals, Independent Medical Review and Arbitration" portion of this Evidence of Coverage.

Preventive and Contraceptive

Our plan covers FDA-approved prescription and over-the-counter contraceptives, including these vaginal, oral, transdermal, and emergency contraceptives devices at a \$0 co-pay, such as oral

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contraceptives, emergency contraception pills, contraceptive rings, contraceptive patches, cervical caps, male and female condoms, and diaphragms.

Your medical practitioner can request that IEHP authorize the use of a non-covered contraceptive drug or device if a covered contraceptive is unavailable or deemed medically inappropriate for Your medical or personal history. If a covered therapeutic equivalent is deemed medically inadvisable, IEHP shall defer to the determination and judgment of Your doctor and provide coverage for the non-covered drug. These contraceptive drugs and devices are provided at \$0 co-pay if IEHP approves Your authorization request. In addition, FDA-approved, self-administered hormonal contraceptives are covered for 12 months. A prescription is not required for coverage of over-the-counter FDA-approved contraceptive drugs, devices, and products.

Members are not responsible for the cost of preventive medications. Drugs that are covered under the program include over-the-counter drugs and prescription drugs used for preventive health purposes per the American Preventive Services Task Force A and B recommendations, including smoking cessation drugs. Treatment for nicotine withdrawal symptoms requires a prescription from the treating physician.

Emergency Contraceptive Drugs

You may get emergency contraceptive drugs from Your doctor or pharmacy with a prescription from Your doctor at no cost to You. You may also get emergency contraceptive drugs from a certified pharmacist without a prescription. To learn more about pharmacies offering emergency contraceptive drugs from certified pharmacists without a prescription, please call IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711).

Emergency contraceptive drugs are also covered when You receive emergency care services. You may receive emergency care services from doctors, hospitals, pharmacies or other health care professionals whether or not they are contracted with IEHP.

Oral Anticancer Drugs

Member's cost share for orally administered anticancer medications covered under the Plan shall not exceed \$250 for an individual prescription of up to a thirty (30) day supply and shall be provided consistent with the appropriate standard of care for that drug.

Other Outpatient Drugs, Supplies, and Supplements

Off-Label Drugs

A prescription drug prescribed for a use that is not stated in the indications and usage information published by the manufacturer is covered only if the drug meets all the coverage criteria in California Health & Safety Code Section 1367.21:

1. The drug is approved by the Food and Drug Administration.
2. The drug meets one of these conditions:
 - a. The drug is prescribed by a participating licensed health care professional for the treatment of a life-threatening condition, OR
 - b. The drug is prescribed by a participating licensed health care professional for the

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- treatment of a chronic and seriously debilitating condition, the Drug is Medically Necessary to treat such condition and the drug is either on the Formulary Drug List or Prior Authorization by IEHP has been obtained for such Drug; AND
3. The drug is recognized for treatment of the life-threatening or chronic and seriously debilitating condition by one of these sources:
 - a. The American Hospital Formulary Service Drug Information; OR
 - b. One of the following compendia, if recognized by the Federal Centers for Medicare and Medicaid Services as part of an anticancer therapeutic regimen:
 - i. The Elsevier Gold Standard's Clinical Pharmacology.
 - ii. The National Comprehensive Cancer Network Drug and Biologics Compendium.
 - iii. The Thomson Micromedex DrugDex; OR
 - c. Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal; AND
 4. The drug is otherwise Medically Necessary.

The definitions below apply to the terms mentioned in this provision only.

“Life-threatening” means either or both of these statements:

- a. Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.
- b. Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

“Chronic and seriously debilitating” refers to diseases or conditions that require ongoing treatment to maintain remission or prevent deterioration and cause significant long-term morbidity.”

Compounded Drugs

A compounded drug is one that has at least one Federal Legend ingredient in a therapeutic amount that is Medically Necessary and requires a prescription order for dispensing. A health care professional mixes or manufactures them and puts them into an ointment, capsule, tablet, solution, suppository, cream, or some other form. It must not be commercially available from any pharmaceutical manufacturer in the dosage form, route of administration, or dose. Compounded drugs are subject to Prior Authorization by the Plan and Medical Necessity.

Pharmacy Network

Obtaining Outpatient Prescription Drugs at a Participating Pharmacy

You must present an IEHP Member ID Card at a Participating Pharmacy to get prescription Drugs. You can get prescription Drugs at any retail Participating Pharmacy unless the drug is a Specialty Drug (see the “Specialty Pharmacy” portion). If You get Drugs at a Nonparticipating Pharmacy, IEHP will deny the claim and will not pay anything toward the cost of the Drugs unless they are for an Emergency or Urgent Care situation.

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Visit iehp.org to locate a retail Participating Pharmacy.

You must pay the applicable Copayment or Coinsurance for each prescription Drug purchased from a Participating Pharmacy. When the Participating Pharmacy's contracted rate is less than Your Copayment or Coinsurance, You only pay the contracted rate. This amount will apply to any applicable Deductible and OOPM. IEHP covers FDA-approved prescription contraceptives or over-the-counter contraceptives at \$0 co-pay. See the “Preventive and Contraceptive” section under Prescription Drug Benefits to learn more.

Pharmacy Lock-In Program

The purpose of a Pharmacy Lock-In Program is to carry out an effective Drug Management Program that addresses overutilization of frequently abused drugs while maintaining access to such drugs, that are medically necessary. Members enrolled in this program will be limited to using a specific retail pharmacy for one year to get all Prescription Drugs, except for Prescription Drugs dispensed in conjunction with Emergency Care, 100-day supply of maintenance drugs through the mail-order program and Specialty Drugs obtained through the specialty pharmacy vendor. No benefits will be paid under the Prescription Drug benefit for services provided or expenses incurred for any Drug dispensed from a non-lock-in retail pharmacy, even if the retail pharmacy is a Participating Pharmacy.

Medical Management will enroll Members in the Pharmacy Lock-In Program based on specific criteria. A member will be considered for the Pharmacy Lock-In Program, based on Member's average daily dose of opioids, concurrent medications and the number of prescribers and pharmacies they have used.

The program enrollment notice will be sent to the Member, prescribing physician, and designated Pharmacy. The notice will include details on the duration of enrollment and the pharmacy to which the Member is locked-in. The Member may appeal a determination under the program. Please refer to the “Grievance, Appeals, Independent Medical Review and Arbitration” section of this EOC for more details.

Obtaining outpatient prescription Drugs at a Nonparticipating Pharmacy in an emergency

When You receive Drugs from a Nonparticipating pharmacy for an Emergency or Urgent Care situation, You must pay for the prescription in full and then submit a claim form for reimbursement. To be reimbursed, You must file a claim with IEHP. Call IEHP Member Services at 1- 855-433-IEHP (4347) (TTY 711) or visit the IEHP website at iehp.org.

Mail Order

You can fill a prescription through our convenient mail order program.

These items must be sent to the designated mail order administrator in order to get prescription drugs by mail:

- The completed Prescription Mail Order Form.
 - The original (not a copy) Prescription Drug Order, for up to a 100-consecutive-calendar-
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day supply of a Maintenance Drug, which is a prescription taken continuously to manage chronic or long-term conditions where the Member responds positively to a medication treatment plan required in a constant dosage. Your provider may also e-prescribe medications to the pharmacy.

- The Copayment or Coinsurance.

You may get a Prescription Mail Order Form and further information by contacting IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711) or visit IEHP's website at iehp.org. The mail order administrator may only dispense up to a 100-consecutive calendar day supply of a covered Maintenance Drug and each refill allowed by that order. After You satisfy the Prescription Drug Calendar Year Deductible, if applicable, the required Copayment applies each time a drug is dispensed.

Specialty Pharmacy

Specialty Drugs may have limited pharmacy availability or distribution, may be self-administered orally, topically, by inhalation, or by injection (subcutaneously, intramuscularly or intravenously) requiring the Member to have special training or clinical monitoring for self-administration, includes biologics and drugs that the FDA or drug manufacturer requires to be distributed through a Specialty Pharmacy, or have high cost as established by Covered California.

Quantity Limits and Partial Fills

Unless stated in this section, You may receive up to a 30-day supply of outpatient prescription Drugs. If a Drug is available only in supplies greater than 30-days, You must pay the applicable retail Copayment or Coinsurance for each additional 30-day supply.

When filling a prescription, You may get a partial fill. You may only be charged one full Copayment or Coinsurance for the completed prescription. If You have been charged twice (once for the partial fill and again for the complete fill) contact IEHP Member Services at 1-855-433- IEHP (4347) (TTY 711) to learn more about getting reimbursed for the excess Copayment. You may be required to provide copies of pharmacy receipts showing payment of multiple Copayments for the prescription.

If You, Your Physician, or Your Health Care Provider request a partial fill of a Schedule II Controlled Substance prescription, Your Copayment or Coinsurance will be prorated. The remaining balance of any partially filled prescription cannot be dispensed more than 30-days from the date the prescription was written.

Exclusions and Limitations

The Plan does not cover the services or supplies listed below that are excluded from coverage or exceed limitations as described in the Evidence of Coverage (EOC). These exclusions and limitations do not apply to Medically Necessary basic health care services required to be covered under California or federal law, including but not limited to Medically

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Necessary treatment of a Mental Health or Substance Use Disorder, as well as preventive services required to be covered under California or federal law.

These exclusions and limitations do not apply when covered by the Plan or required by law.

General Exclusions and Limitations

Acupuncture Services

This plan does not cover acupuncture services, except as described in this EOC in the “Acupuncture” section as required by law.

Chiropractic Services

This plan does not cover chiropractic services, except as required by law.

Clinical Trials

This Plan does not cover clinical trials, except Approved Clinical Trials as described in this EOC in “Clinical Trials” section or as required by law.

Coverage of Approved Clinical Trials does not include the following:

- The investigational drug, item, or service itself.
- Drugs, items, devices, and services provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the Member.
- Drugs, items, devices, and services specifically excluded from coverage in this EOC, except for drugs, items, devices, and services required to be covered pursuant to state and federal law.
- Drugs, items, devices, and services customarily provided free of charge to a clinical trial participant by the research sponsor.

This exclusion does not limit, prohibit, or modify a Member’s rights to the Experimental Services of Investigational Services independent review process as described in this EOC in “Clinical Trials” section, or to the Independent Medical Review (IMR) from the Department of Managed Health Care (DMHC) as described in this EOC in “Clinical Trials”.

Cosmetic Services, Supplies, or Surgeries

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This Plan does not cover cosmetic services, supplies, or surgeries that slow down or reverse the effects of aging, or alter or reshape normal structures of the body, in order to improve appearance rather than function except described in this EOC in “Inpatient and Hospital Services”, or as required by law. The Plan does not cover any services, supplies, or surgeries for the promotion, prevention, or other treatment of hair loss or hair growth except as described in this EOC in “Prescription Drugs/ Outpatient Prescription Drugs” or required by law.

This exclusion does not apply to the following:

- Medically Necessary treatment of complications resulting from cosmetic surgery, such as infections or hemorrhages.
- Reconstructive surgery as described in this EOC in “Inpatient and Hospital Services”
- For gender dysphoria, reconstructive surgery of primary and secondary sex characteristics to improve function, or create a normal appearance to the extent possible, for the gender with which a Member identifies, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery who are competent to evaluate the specific clinical issues involved in the care requested as described in the EOC in “Gender Affirming Services”.

Custodial or Domiciliary Care

This Plan does not cover custodial care, which involves assistance with activities of daily living, including but not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications that are ordinarily self-administered, or domiciliary care, which involves a supervised living arrangement in a home-like environment for adults who are unable to live alone because of age-related impairments or physical, mental, or visual disabilities, except as described in this EOC in “Home Health Care Services” or as required by law.

This exclusion does not apply to the following:

- Assistance with activities of daily living that requires the regular services of or is regularly provided by trained medical or health professionals.
- Assistance with activities of daily living that is provided as part of covered hospice, skilled nursing facility services, inpatient hospital care, or services provided in a healthcare facility, including Mental Health or Substance Use Disorder services.

Dietary or Nutritional Supplements

This Plan does not cover dietary or nutritional supplements, except as described in this EOC in “Medical Nutrition Therapy” or as required by law.

Disposable Supplies for Home Use

This Plan does not cover disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, diapers, and incontinence supplies, except as required by law.

Experimental Services or Investigational Services

This Plan does not cover Experimental Services or Investigational Services, except as described in this EOC in “Independent Medical Review for Denials of Experimental/Investigational Therapies” or as required by law.

Experimental Services means drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or animal studies prior to testing in humans. Experimental Services are not undergoing a clinical investigation.

Investigational Services means those drugs, equipment, procedures or services for which laboratory and/or animal studies have been completed and for which human studies are in progress but:

- (1) Testing is not complete; and
- (2) The efficacy and safety of such services in human subjects are not yet established; and
- (3) The service is not in wide usage.

The determination that a service is an Experimental Service or Investigational Service is based on:

- (1) Reference to relevant federal regulations, such as those contained in Title 42, Code of Federal Regulations, Chapter IV (Health Care Financing Administration) and Title 21, Code of Federal Regulations, Chapter I (Food and Drug Administration);
- (2) Consultation with provider organizations, academic and professional specialists pertinent to the specific service;
- (3) Reference to current medical literature.

However, if the Plan denies or delays coverage for your requested service on the basis that it is an Experimental Service or Investigational Service and you meet all the qualifications set out below, the Plan must provide an external, independent review.

Qualifications

1. You must have a Life-Threatening or Seriously Debilitating condition.
2. Your Health Care Provider must certify to the Plan that you have a Life-Threatening or Seriously Debilitating condition for which standard therapies have not been effective in improving your condition, or are otherwise medically inappropriate, or there is no more beneficial standard therapy covered by the Plan.
3. Either (a) your Health Care Provider, who has a contract with or is employed by the Plan,

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has recommended a drug, device, procedure, or other therapy that the Health care Provider certifies in writing is likely to be more beneficial to you than any available standard therapies, or (b) you or your Health Care Provider, who is licensed, board-certified, or board-eligible physician qualified to practice in that area of practice appropriate to treat your condition, has requested a therapy that, based on two documents from acceptable medical and scientific evidence, is likely to be more beneficial for you than any available standard therapy.

4. You have been denied coverage by the Plan for the recommended or requested service.
5. If not the Plan's determination that the recommended or requested service is an Experimental Service or Investigational Service, it would be covered.

External, Independent Review Process

If the Plan denies coverage of the recommended or requested therapy and you meet all of the qualifications, the Plan will notify you within five business days of its decision and your opportunity to request external review of the Plan's decision. If your Health Care Provider determines that the proposed service would be significantly less effective if not promptly initiated, you may request expedited review and the experts on the external review panel will render a decision within seven days of your request. If the external review panel recommends that the Plan cover the recommended or requested service, coverage for the services will be subject to terms and conditions generally applicable to other benefits to which you are entitled.

DMHC's Independent Medical Review (IMR)

This exclusion does not limit, prohibit, or modify a Member's rights to an IMR from the DMHC as described in this EOC in "Independent Medical Review". In certain circumstances, you do not have to participate in the Plan's grievance or appeals process before requesting an IMR of denials for Experimental Services or Investigational Services. In such cases you may immediately contact the DMHC to request an IMR of this denial.

Hearing Aids

This Plan does not cover hearing aids, except as required by law.

The Hearing Aid Coverage for Children Program (HACCP) offers state-funded hearing aid coverage to eligible children and youth, ages 0-20. To learn more and apply, visit www.dhcs.ca.gov/HACCP

Immunizations

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This Plan does not cover non-Medically Necessary or non-preventative immunizations solely for foreign travel or occupational purposes, except as described in this EOC in “Immunizations and Injections”.

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Non-licensed or Non-certified Providers

This Plan does not cover treatments or services rendered by a non-licensed or non-certified Health Care Provider, except as required by law.

This exclusion does not apply to Medically Necessary treatment of a Mental Health or Substance Use Disorder furnished or delivered by, or under the direction of, a Health Care Provider acting within the scope of practice of the provider’s license or certification under applicable state law.

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Personal or Comfort Items

This Plan does not cover personal or comfort items, such as internet, telephones, personal hygiene items, food deliver services, or services to help with personal care, except as required by law.

Prescription Drugs/ Outpatient Prescription Drugs

This Plan does not cover the following Prescription Drugs, except as described in this EOC in “Prescription Drug Benefits”.

- When prescribed for cosmetic services. For purposes of this exclusion, cosmetic means drugs solely prescribed for the purpose of altering or affecting normal structure of the body to improve appearance rather than function.
- When prescribed solely for the treatment of hair loss, sexual dysfunction, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance. The exclusion does not apply to drugs for mental performance when they are Medically Necessary to treat diagnosed mental illness or medical conditions affecting memory, including, but not limited to, treatment of the conditions or symptoms of dementia or Alzheimer’s disease.
- When prescribed solely for the purpose of losing weight, except when Medically Necessary for the treatment of [Class III] obesity. Enrollment in a comprehensive weight loss program, if

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covered by the Plan, may be required for a reasonable period of time prior to or concurrent with receiving the Prescription Drug.

- When prescribed solely for the purpose of shortening the duration of the common cold.
- Prescription Drugs available over the counter or for which there is an over-the-counter equivalent (the same active ingredient, strength, and dosage form as the Prescription Drug).

This exclusion does not apply to:

- Insulin,
 - Over-the-counter drugs as covered under preventive services, e.g., over-the-counter FDA-approved contraceptive drugs,
 - Over-the-counter drugs for reversal of an opioid overdose, or
 - An entire class of Prescription Drugs when on drug within that class becomes available over the counter.
- Replacement of lost or stolen drugs.
 - Drugs when prescribed by non-contracting provider for non-covered procedures and which are not authorized by a plan or a plan provider, except when coverage is otherwise required in the context of Emergency Services and Care.

Private Duty Nursing

This Plan does not cover private duty nursing in the home, hospital, or long-term care facility except as required by law.

Reversal of Voluntary Sterilization

This Plan does not cover reversal of voluntary sterilization, except for Medically Necessary treatment of medical complications or as required by law.

Routine Physical Examination

This Plan does not cover physical examinations for the sole purpose of travel, insurance, licensing, employment, school, camp, court-ordered examinations, pre-participation examination for athletic programs, or other non-preventive purpose, except as required by law.

Surrogate Pregnancy

This Plan does not cover testing, services, or supplies for a person who is not covered under this Plan for a surrogate pregnancy, except as required by law.

Have questions? Contact IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711), Monday-Friday 8am-6pm PST. Visit us online at iehp.org.

Therapies

This Plan does not cover the following physical and occupational therapies, except as required by law:

- Massage therapy, unless it is a component of a treatment plan;
- Training or therapy for the treatment of learning disabilities or behavioral problems;
- Social skills training or therapy; and
- Vocational, educational, recreational, art, dance, music, or reading therapy.

Travel and Lodging

This Plan does not cover transportation, mileage, lodging, meals and other Member-related travel costs, except for licensed ambulance or psychiatric transport as described in this EOC in “Ambulance and Non-emergency Medical Transportation” or as required by law.

Weight Control Programs and Exercise Programs

This Plan does not cover weight control programs and exercise programs, except as required by law.

Dental Exclusions and Limitations

Adult Dental Services

This Plan does not cover dental services or supplies for Members age 19 and older, except as described in this EOC in “Dental Services” or required by law.

Pediatric Dental Services

This Plan does not cover dental services or supplies for Members up to age 19, except as described in this EOC in “Pediatric Dental Services” or required by law. The exclusions and limitations for covered pediatric dental services are provided in the Liberty Dental Plan Pediatric Dental’s EOC

Vision Exclusions and Limitations

Adult Vision Services

This Plan does not cover vision services for Members age 19 and older, except as described in this EOC in “Vision and Hearing” or as required by law.

Pediatric Vision Services

Have questions? Contact IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711), Monday-Friday 8am-6pm PST. Visit us online at iehp.org.

This Plan does not cover the following vision services for Members up to age 19, except as described in this EOC in “Pediatric Vision Services” or as required by law. The exclusions and limitations for covered pediatric vision services are provided in “Pediatric Vision Services” Schedule of Benefit.

The Plan’s exclusions and limitations for covered pediatric vision services are also addressed in IEHP’s Schedule of Benefits.

General Provisions

Content of the EOC

Only an IEHP officer can make changes to this EOC. Any changes will be made through an endorsement signed and authorized by an IEHP officer. No agent or other employee of IEHP is authorized to change the terms, conditions, or benefits of this EOC. Any changes to this EOC is subject to prior approval of the DMHC.

Entire Agreement

This EOC, the Notice of Acceptance and the application shall constitute the entire agreement between IEHP and the Member.

The specimen of the Plan contract will be furnished upon request.

Right to Receive and Release Information

As a condition of enrollment in this health plan and a condition precedent to the provisions of benefits under this health plan, IEHP, its agents, independent contractors and Network physicians shall be entitled to release to or get from, any person, organization or government agency, any information and records, including patient records of Members, which IEHP requires or is obligated to provide pursuant to legal process, federal, state or local law or as otherwise required in the administration of this health plan.

Regulation

IEHP is subject to the requirements and the implementing regulations of the California Knox-Keene Health Care Service Plan Act of 1975, as amended, as set forth at Chapter 2.2 of Division 2 of the California Health and Safety Code (beginning with Section 1340) and its implementing regulations, as set forth at Subchapter 5.5 of Chapter 3 of Title 28 of the California Code of Regulations (beginning with Section 1300.43). Any provisions required to be in this EOC by either of the above sources of law shall bind IEHP whether or not provided in this EOC.

Notice of Certain Events

Any notices required hereunder shall be deemed to be sufficient if mailed to the Subscriber at the address appearing on the records of IEHP. The Subscriber can meet any notice requirements by mailing the notice to: IEHP, P.O. Box 1800, Rancho Cucamonga, CA 91729.

Have questions? Contact IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711), Monday-Friday 8am-6pm PST. Visit us online at iehp.org.

Changes to Benefit or Plan Premium Charges

IEHP will provide Subscriber at least 60 days notice of any changes in benefits, Plan Premium charges or EOC provisions. There is no vested right to receive the benefits of this health plan.

Non-Discrimination

No person who is otherwise eligible and accepted for enrollment under this EOC will be refused enrollment or have their coverage terminated because of race, color, national origin, ancestry, religion, sex, gender identity, gender expression, marital status, sexual orientation, age, health status, need for health care services or physical or mental disability.

An enrollee who believes their enrollment has been cancelled or not renewed because of the enrollee's health status or need for health care services may request a review of the cancellation by the DMHC.

Interpretation of EOC

The laws of the State of California shall be applied to interpretations of this EOC. Where applicable, the interpretation of this EOC shall be guided by the direct service nature of IEHP's operations as opposed to a fee for service indemnity basis.

Members' Rights And Responsibilities

As a Member, You have a right to:

- Receive information about your rights and responsibilities.
 - Receive information about your Plan, the services your Plan offers you, and the Health Care Providers available to care for you.
 - Make recommendations regarding the Plan's member rights and responsibilities policy.
 - Receive information about all health care services available to you, including a clear explanation of how to obtain them and whether the Plan may impose certain limitations on those services.
 - Know the costs for your care, and whether your deductible or out-of-pocket maximum have been met.
 - Choose a Health Care Provider in your Plan's network, and change to another doctor in your Plan's network if you are not satisfied.
 - Receive timely and geographically accessible health care.
 - Have a timely appointment with a Health Care Provider in your Plan's network, including one with a specialist.
 - Have an appointment with a Health Care Provider outside of your Plan's network when your Plan cannot provide timely access to care with an in-network Health Care Provider.
 - Certain accommodations for your disability, including:
 - Equal access to medical services, which includes accessible examination rooms and medical equipment at a Health Care Provider's office or facility.
 - Full and equal access, as other members of the public, to medical facilities.
 - Extra time for visits if you need it.
-

Have questions? Contact IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711), Monday-Friday 8am-6pm PST. Visit us online at iehp.org.

- Taking your service animal into exam rooms with you.
- Purchase health insurance or determine Medi-Cal eligibility through the California Health Benefit Exchange, Covered California.
- Receive considerate and courteous care and be treated with respect and dignity.
- Receive culturally competent care, including but not limited to:
 - Trans-Inclusive Health Care, which includes all Medically Necessary services to treat gender dysphoria or intersex conditions.
 - To be addressed by your preferred name and pronoun.
- Receive from your Health Care Provider, upon request, all appropriate information regarding your health problem or medical condition, treatment plan, and any proposed appropriate or Medically Necessary treatment alternatives. This information includes available expected outcomes information, regardless of cost or benefit coverage, so you can make an informed decision before you receive treatment.
- Participate with your Health Care Providers in making decisions about your health care, including giving informed consent when you receive treatment. To the extent permitted by law, you also have the right to refuse treatment.
- A discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage.
- Receive health care coverage even if you have a pre-existing condition.
- Receive Medically Necessary treatment of a Mental Health or Substance Use Disorder.
- Receive certain preventive health services, including many without a co-pay, co-insurance, or deductible.
- Have no annual or lifetime dollar limits on basic health care services.
- Keep eligible dependent(s) on your Plan.
- Be notified of an unreasonable rate increase or change, as applicable.
- Protection from illegal balance billing by a Health Care Provider.
- Request from your Plan a second opinion by an Appropriately Qualified Health Care Provider.
- Expect your Plan to keep your personal health information private by following its privacy policies, and state and federal laws.
- Ask most Health Care Providers for information regarding who has received your personal health information.
- Ask your Plan or your doctor to contact you only in certain ways or at certain locations.
- Have your medical information related to sensitive services protected.
- Get a copy of your records and add your own notes. You may ask your doctor or health plan to change information about you in your medical records if it is not correct or complete. Your doctor or health plan may deny your request. If this happens, you may add a statement to your file explaining the information.
- Have an interpreter who speaks your language at all points of contact when you receive health care services.
- Have an interpreter provided at no cost to you.
- Receive written materials in your preferred language where required by law.
- Have health information provided in a usable format if you are blind, deaf, or have low vision.

Have questions? Contact IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711), Monday-Friday 8am-6pm PST. Visit us online at iehp.org.

- Request continuity of care if your Health Care Provider or medical group leaves your Plan or you are a new Plan member.
- Have an Advanced Health Care Directive.
- Be fully informed about your Plan's grievances procedure and understand how to use it without fear of interruption to your health care.
- File a complaint, grievance, or appeal in your preferred language about:
 - Your Plan or Health Care Provider.
 - Any care you receive, or access to care you seek.
 - Any covered service or benefit decision that your Plan makes.
 - Any improper charges or bills for care.
 - Any allegations of discrimination on the basis of gender identity or gender expression, or for improper denials, delays, or modifications of Trans-Inclusive Health Care, including Medically Necessary services to treat gender dysphoria or intersex conditions.
 - Not meeting your language needs.
- Know why your Plan denies a service or treatment.
- Contact the Department of Managed Health Care if you are having difficulty accessing health care services or have questions about your Plan.
- To ask for an Independent Medical Review if your Plan denied, modified, or delayed a health care service.

As a Plan Member, , you have the responsibility to:

- Treat all Health Care Providers, Health Care Provider staff, and Plan staff with respect and dignity.
- Share the information needed with your Plan and Health Care Providers, to the extent possible, to help you get appropriate care.
- Participate in developing mutually agreed-upon treatment goals with your Health Care Providers and follow the treatment plans and instructions to the degree possible.
- To the extent possible, keep all scheduled appointments, and call your Health Care Provider if you may be late or need to cancel.
- Refrain from submitting false, fraudulent, or misleading claims or information to your Plan or Health Care Providers.
- Notify your Plan if you have any changes to your name, address, or family members covered under your Plan.
- Timely pay any premiums, copayments, and charges for non-covered services.

Grievance, Appeals, Independent Medical Review and Arbitration

What should I do if I am unhappy with my service from a medical provider, IEHP, or dissatisfied with my coverage, including an adverse benefit determination?

An adverse benefit determination means a decision by IEHP to deny, reduce, terminate, or fail to pay for all or part of a benefit that is based on:

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- Rescission of coverage, even if it does not have an adverse effect on a particular benefit at that time; or
- Determination of an individual's eligibility to participate in this IEHP plan; or
- Determination that a benefit is not covered; or
- An exclusion or limitation of an otherwise covered benefit based on a pre-existing condition exclusion or a source-of-injury exclusion; or
- Determination that a benefit is Experimental, Investigational, or not Medically Necessary or appropriate.

If You are not happy, are having problems or have questions about the service or care given to You, You can let Your PCP know. Your PCP may be able to help You or answer Your questions. There are two ways to report and solve problems:

1. A complaint (or grievance) is when You have a problem with IEHP or a provider, or with the health care or treatment You got from a provider.
2. An appeal is when You don't agree with IEHP's decision to change Your services or to not cover them.

You have the right to file grievances and appeals with IEHP to tell Us about Your problem. This does not take away any of Your legal rights and remedies. We will not discriminate or retaliate against You for complaining to us. Letting Us know about Your problem will help Us improve care for all members. You should always contact IEHP first to let us know about Your problem. Call IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711).

What is a grievance?

A grievance is an expression of dissatisfaction, or a complaint by a Member. The grievance can be made in writing or verbally. For grievances regarding cancellation, rescission or nonrenewal of coverage, You must file Your grievance or appeal with IEHP within 180 calendar days of the termination notice or following the date of the incident or action that caused Your grievance.

Some examples are complaints about:

- The service or care Your PCP or other providers give You
- The service or care Your pharmacy gives You
- The service or care Your hospital gives You
- The service or care IEHP gives You

How to File a Grievance

You have many ways to file a grievance. You can:

- Call IEHP at 1-855-433-IEHP (4347) (TTY 711), Monday-Friday, 8am-6pm. Give Your Member ID number, Your name and the reason for Your complaint.
- Call IEHP at 1-855-433-IEHP (4347) (TTY 711), Monday-Friday, 8am-6pm, 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:

Have questions? Contact IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711), Monday-Friday 8am-6pm PST. Visit us online at iehp.org.

IEHP
Attention: Grievance and Appeals Department
P.O. Box 1800
Rancho Cucamonga, CA 91729

- Online on IEHP's website at iehp.org

Your doctor's office will also have complaint forms. You can also get complaint forms online: visit the IEHP website at iehp.org.

Members may also call the California Department of Managed Health Care (DMHC) toll-free at 1-888-466-2219.

IEHP can help You fill out the grievance form over the phone or in-person. If You need interpreting services, we will work with You to make sure we can communicate with You in Your preferred language. For Members with hearing or speech loss, You may call IEHP's TTY phone number for IEHP Member Services at 711.

Within five (5) calendar days of receiving Your grievance, You will get a letter from IEHP saying we have Your grievance and are working on it. For grievances regarding cancellation, rescission, or nonrenewal, IEHP will acknowledge receipt within three (3) calendar days. Then, within 30 calendar days of receiving Your grievance, IEHP will send You a letter to explain how the grievance was resolved.

Filing a grievance does not affect Your medical benefits. If You file a grievance, You may be able to continue a medical service while the grievance is being resolved. To find out more about continuing a medical service, call IEHP.

If You are not satisfied with efforts to solve a problem with IEHP or Your Provider, before filing an arbitration proceeding, You must first file a grievance or appeal against IEHP by calling IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711) or by submitting a Member Grievance Form to IEHP.

If You do not agree with the outcome of Your grievance

If You do not hear from IEHP within 30 calendar days, or You do not agree with the decision about Your grievance, You may file a grievance with the California Department of Managed Health Care ("DMHC"). To learn how to file a grievance with DMHC, go to "Review by the Department of Managed Health Care (DMHC)" section.

How to file a grievance for health care services denied or delayed as not Medically Necessary

If You believe a health care service has been wrongly denied, changed, or delayed by IEHP because it was found not Medically Necessary, You may file a grievance. This is known as a disputed health care service.

Within five (5) calendar days of receiving Your grievance, You will get a letter from IEHP saying we have received Your grievance and that we are working on it. The letter will also let You know

Have questions? Contact IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711), Monday-Friday 8am-6pm PST. Visit us online at iehp.org.

the name of the person working on Your grievance. Then, within 30 calendar days You will get a letter to explain how the grievance was resolved.

Filing a grievance does not affect Your medical benefits. If You file a grievance, You may be able to continue a medical service while the grievance is being resolved. To find out more about continuing a medical service, call IEHP.

If You do not agree with the outcome of Your grievance for health care services denied or delayed as not Medically Necessary

If You do not hear from IEHP within 30 calendar days, or You do not agree with the decision about Your grievance, You can call the California Department of Managed Health Care (“DMHC”) and ask them to review Your complaint or conduct an Independent Medical Review. You can call the DMHC at 1-888-466-2219 (TTY 1-877-688-9891 or 711) or visit the DMHC website for more information: <https://www.dmh.ca.gov>. If You are not sure who You can file Your grievance with, call IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711).

How to File a Grievance for Urgent Cases

Examples of urgent cases include:

- Severe pain
- Potential loss of life, limb or major bodily function
- Immediate and serious deterioration of Your health

In urgent cases, You can request an “expedited review” of Your grievance. You will receive a call about Your grievance within 24 hours. If Your grievance meets the criteria for an urgent case, a decision will be made by IEHP within three (3) calendar days from the day Your grievance was received.

You have the right to file an urgent grievance with DMHC without filing a grievance with IEHP. To learn how to file a grievance with DMHC, go to “Review by the Department of Managed Health Care (DMHC)” section.

If You do not agree with the outcome of Your grievance for urgent cases

If You do not hear from IEHP within three (3) calendar days, or You do not agree with the decision about Your grievance, You may file a grievance with the California Department of Managed Health Care (DMHC). To learn how to file a grievance with DMHC, go to “Review by the Department of Managed Health Care (DMHC)” section.

How to file a grievance to appeal a prescription drug prior authorization decision

If You do not agree with the outcome of an exception-to-coverage decision, You, a representative, or Your provider have the right to appeal the decision. You, a representative, or Your provider may also request that the exception-to-coverage request be re-assessed by an external reviewer through an Independent Review Organization (“IRO”). You, a representative, or Your provider may also request that the exception-to-coverage decision be re-assessed by the

Have questions? Contact IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711), Monday-Friday 8am-6pm PST. Visit us online at ieh.org.

California Department of Managed Health Care (“DMHC”) through an Independent Medical Review (“IMR”). Please refer to the section “Independent Medical Review” section. You will get information on how to file an appeal, external review, and/or an IMR with Your denial letter.

Independent Medical Review (IMR)

You may request an Independent Medical Review (“IMR”) from DMHC. You have up to six (6) months or later, if DMHC agrees to extend the application deadline, from the date of denial to file an IMR. You will get information on how to file an IMR with Your denial letter. Grievance Resolution letters also include information about requesting an IMR and a copy of the IMR Request form/envelope addressed to the DMHC will be attached to the Decision letter. You may reach DMHC toll-free at 1-888-466-2219. If Your grievance requires expedited review, You may bring it to DMHC’s attention right away. DMHC may waive the requirement that You follow IEHP’s grievance process in extraordinary and compelling cases.

There are no fees for an IMR. You have the right to provide information to support Your request for an IMR. After the IMR application is submitted, a decision not to take part in the IMR process may cause You to lose certain legal rights to pursue legal action against the plan.

You may file an IMR if You meet these requirements:

- Your doctor says You need a health care service because it is Medically Necessary, and it is denied; or
- You received urgent or emergency services determined to be necessary, and they were denied; or
- You have seen a network doctor for the diagnosis or treatment of the medical condition, even if the health care services were not recommended.
- The disputed health care service is denied, changed or delayed by IEHP based in whole or in part on a decision that the health care service is not Medically Necessary, and/or
- You have filed a grievance with IEHP and the disputed decision is upheld by IEHP or the grievance remains unresolved after 30 calendar days.

The dispute will be submitted to a DMHC medical specialist if it is eligible for an IMR. The specialist will make an independent decision on whether or not the care is Medically Necessary. You will get a copy of the IMR decision from DMHC. If it is decided that the service is Medically Necessary, IEHP will provide the health care service.

Non-urgent cases

For non-urgent cases, the IMR decision must be made within 30 calendar days. The 30-day period starts when Your application and all documents are received by DMHC.

Urgent cases

If Your grievance is urgent and requires fast review, You may bring it to DMHC’s attention right away. You will not be required to participate in the health plan grievance process.

For urgent cases, the IMR decision must be made within three (3) calendar days from the time

Have questions? Contact IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711), Monday-Friday 8am-6pm PST. Visit us online at iehp.org.

Your information is received. Examples of urgent cases include:

- Severe pain
- Potential loss of life, limb or major bodily function
- Immediate and serious deterioration of Your health

Independent Medical Review for Denials of Experimental/ Investigational Therapies

You may also be entitled to an IMR, through the California Department of Managed Health Care, when we deny coverage for drugs, devices, procedures, or therapies, that we have determined to be experimental or investigational.

- You must have a life-threatening or seriously debilitating condition.
- Your Physician must certify to IEHP that You have a life-threatening or seriously debilitating condition for which standard therapies have not been effective in improving Your condition or are otherwise medically inappropriate and there is no more beneficial therapy covered by IEHP.
- Your Physician must certify that the proposed Experimental or Investigational therapy is likely to be more beneficial than available standard therapies or as an alternative, You submit a request for a therapy that, based on documentation You present from the medical and scientific evidence, is likely to be more beneficial than available standard therapies.
- You have been denied coverage by IEHP for the recommended or requested therapy.
- If not for IEHP's determination that the recommended or requested treatment is Experimental or Investigational, it would be covered.

We will notify You in writing of the opportunity to request an IMR of a decision denying an experimental/ investigational therapy within five (5) business days of the decision to deny coverage.

You are not required to participate in IEHP's grievance process prior to seeking an IMR of our decision to deny coverage of an experimental/ investigational therapy.

If a physician indicates that the proposed therapy would be significantly less effective if not promptly initiated, the IMR decision shall be rendered within seven (7) calendar days of the completed request for an expedited review. If the IMR panel recommends that IEHP cover the recommended or requested therapy, coverage for the services will be subject to the terms and conditions generally applicable to other benefits You are entitled to. A decision not to participate in the IMR process may cause You to forfeit any statutory right to pursue legal action against IEHP regarding the denial of the recommended or requested therapy. To learn more, please call IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711) or visit IEHP's website at iehp.org.

Review by the Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. If You have a grievance against your health plan, you should first telephone your health plan at 1-855-433-IEHP (4347) (TTY 711) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the

Have questions? Contact IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711), Monday-Friday 8am-6pm PST. Visit us online at iehp.org.

department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency and urgent medical services. The department also has a toll-free telephone number (1- 888-466-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's internet website www.dmhca.gov has complaint forms, IMR application forms and instructions online.

IEHP's grievance process and DMHC's complaint review process are in addition to any other dispute resolution procedures that may be available to You, and Your failure to use these processes does not preclude Your use of any other remedy provided by law.

IEHP will help You with interpreting services if You speak a language other than English. You may use the toll-free TTY numbers listed under "How to File a Grievance" if You are a deaf or hard of hearing Member. With Your written consent, Your doctor may also file an appeal on Your behalf.

BINDING ARBITRATION: AGREEMENT TO RESOLVE ALL DISPUTES, INCLUDING FUTURE MALPRACTICE CLAIM BY BINDING ARBITRATION

*****Important Information about Your Rights*****

Any and all disputes of any kind whatsoever, including but not limited to claims relating to the coverage and delivery of services under this Plan, which may include but are not limited to claims of malpractice (e.g., in the event of any dispute or controversy arising out of the diagnosis, treatment, or care of the patient by the health care provider) or claims that the medical services rendered under the product were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, between Member (including any heirs, successors or assigns of the Member) and IEHP, or any of its parents, subsidiaries, affiliates, successors, or assigns shall be submitted to binding arbitration in accordance with applicable state and federal laws, including the Federal Arbitration Act, 9 U.S.C. Sections 1-16, California Code of Civil Procedure sections 1280 et seq. and the Affordable Care Act. Any such dispute will not be resolved by a lawsuit, resort to court process, or be subject to appeal, except as provided by applicable law. Any arbitration under this provision will take place on an individual basis; class arbitrations and class actions are not permitted.

Member and IEHP agree that, by entering into the agreement enrolling Member in this product, Member and IEHP are each waiving the right to a trial by jury or to participate in a class action. Member and IEHP are giving up their constitutional rights to have any such dispute decided in a court of law before a jury and are instead accepting the use of final and binding arbitration in accordance with the Comprehensive Rules and Procedures of JAMS, and administration of the arbitration shall be performed by JAMS or such other arbitration service as the parties may agree in writing. Judgment upon the award rendered by the arbitrator may be entered in any court having jurisdiction.

The parties will endeavor to mutually agree to the appointment of the arbitrator, but if such agreement cannot be reached within 30 calendar days from the date the notice of commencement of the arbitration is received, the arbitrator appointment procedures in the JAMS Comprehensive

Have questions? Contact IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711), Monday-Friday 8am-6pm PST. Visit us online at iehpa.org.

Rules and Procedures will be utilized. The arbitrator shall hold a hearing within a reasonable time from the date of notice of selection of the neutral arbitrator.

Arbitration hearings shall be held in the County in which the Member lives or at such other location as the parties may agree in writing. Civil discovery may be taken in such arbitration in accordance with the California Code of Civil Procedure sections 1280-1294.2. The arbitrator selected shall have the power to control the timing, scope, and manner of the taking of discovery and shall further have the same powers to enforce the parties' respective duties concerning discovery as would a California state law court including, but not limited to, the imposition of sanctions. The arbitrator shall have the power to grant all remedies in accordance with, and subject to any limitations of, applicable law.

The arbitrator shall prepare in writing an award that indicates the prevailing party or parties, the amount and other relevant terms of the award, and that includes the legal and factual reasons for the decision. The requirement of binding arbitration shall not preclude a party from seeking a temporary restraining order or preliminary injunction or other provisional remedies from a court with jurisdiction; however, any and all other claims or causes of action, including, but not limited to, those seeking damages, shall be subject to binding arbitration as provided herein.

The parties shall divide equally the costs and expenses of JAMS and the arbitrator. In cases of extreme hardship, IEHP may assume all or part of the Member's share of the fees and expenses of JAMS and the arbitrator, provided the Member submits a hardship application to JAMS. The hardship application shall be made in a manner and with the information and any documentation as required by JAMS. JAMS (and not the neutral assigned to hear the case) shall determine whether to grant the Member's hardship application.

ALL PARTIES EXPRESSLY AGREE TO WAIVE THEIR CONSTITUTIONAL RIGHT TO HAVE DISPUTES BETWEEN THEM RESOLVED BEFORE A JURY AND ARE INSTEAD ACCEPTING THE USE OF BINDING ARBITRATION.

Involuntary Transfer to Another Primary Care Physician

IEHP may transfer You to another PCP under certain circumstances. Below are examples of circumstances that may result in involuntary transfer, as specified.

- **Refusal to Follow Treatment:** You may be involuntarily transferred to an alternate PCP if You continually refuse to follow recommended treatment or established procedures of IEHP or the PCP. IEHP will offer You the opportunity to develop an acceptable relationship with another PCP.
- **Disruptive or Threatening Behavior:** You may be involuntarily transferred to an alternate PCP if You repeatedly disrupt the operations of the PCP or IEHP to the extent that the normal operations of either the Physician's office or IEHP are adversely impacted.
- **Abusive Behavior:** You may be involuntarily transferred to an alternate PCP if You exhibit behavior that is abusive or threatening in nature toward the health care provider, his or her office staff, the contracting PCP or IEHP personnel.
- **Inadequate Geographic Access to Care:** You may be involuntarily transferred to an alternate PCP if it is determined that Your residence is not within reasonable access to Your current

Have questions? Contact IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711), Monday-Friday 8am-6pm PST. Visit us online at iehp.org.

PCP.

Other circumstances for involuntary transfer to an alternative PCP may exist where the treating Physician or Physicians have determined that there is an inability to continue to provide You care because the patient-physician relationship has been compromised to the extent that mutual trust and respect have been impacted. The treating Physicians must always work within the code of ethics established through the American Medical Association (“AMA”). To learn more about the AMA code of ethics, please refer to the American Medical Association website at <http://www.ama-assn.org>. Under the code of ethics, the Physician will provide You with notice prior to discontinuing as Your treating Physician that will enable You to contact IEHP and make alternate care arrangements.

IEHP will conduct a fair investigation of the facts before any involuntary transfer for any of the above reasons is carried out.

Technology Assessment

New technologies are those procedures, drugs or devices that have recently been developed for the treatment of specific diseases or conditions or are new applications of existing procedures, drugs or devices. New technologies are considered Investigational or Experimental during various stages of clinical study as safety and effectiveness are evaluated and the technology achieves acceptance into the medical standard of care. The technologies may continue to be considered Investigational or Experimental if clinical study has not shown safety or effectiveness or if they are not considered standard care by the appropriate medical specialty. Approved technologies are integrated into IEHP benefits.

IEHP determines whether new technologies should be considered medically appropriate, or Investigational or Experimental, following extensive review of medical research by appropriately specialized Physicians. IEHP requests review of new technologies by an independent, expert medical reviewer in order to determine medical appropriateness or Investigational or Experimental status of a technology or procedure.

The expert medical reviewer also advises IEHP when patients require quick determinations of coverage, when there is no guiding principle for certain technologies or when the complexity of a patient’s medical condition requires expert evaluation. If IEHP denies, modifies or delays coverage for Your requested treatment on the basis that it is Experimental or Investigational, You may request an independent medical review (“IMR”) of IEHP’s decision from the California Department of Managed Health Care. Please refer to the “Independent Medical Review of Grievances Involving a Disputed Health Care Service” above in this “General Provisions” section for additional details.

Medical Malpractice Disputes

IEHP and the health care providers that provide services to You through this Plan are each responsible for their own acts or omissions and are ordinarily not liable for the acts or omissions or costs of defending others.

Have questions? Contact IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711), Monday-Friday 8am-6pm PST. Visit us online at iehp.org.

Recovery of Benefits Paid by IEHP

When You Are Injured

If You are ever injured through the actions of another person or Yourself (responsible party), IEHP will provide benefits for all Covered Services that You get through this Plan. However, if You get money or are entitled to get money because of Your injuries, whether through a settlement, judgment or any other payment associated with Your injuries, IEHP or the medical providers retain the right to recover the value of any services provided to You through this Plan. As used throughout this provision, the term responsible party means any party actually or potentially responsible for making any payment to a Member due to a Member's injury, illness or condition. The term responsible party includes the liability insurer of such party or any insurance coverage.

Some examples of how You could be injured through the actions of a responsible party are:

- You are in a car accident; or
- You slip and fall in a store.

IEHP's rights of recovery apply to any and all recoveries made by You or on Your behalf from these sources, including but not limited to:

- Payments made by a third party or any insurance company on behalf of a third party.
- Uninsured or underinsured motorist coverage.
- Personal injury protection, no fault or any other first party coverage.
- Workers Compensation or Disability award or settlement.
- Medical payments coverage under any automobile policy, premises or homeowners' insurance coverage, umbrella coverage.
- Any other payments from any other source received as compensation for the responsible party's actions.

By accepting benefits under this Plan, You acknowledge that IEHP has a right of reimbursement that attaches when this Plan has paid for health care benefits for expenses incurred due to the actions of a responsible party and You or Your representative recovers or is entitled to recover any amounts from a responsible party.

Under California law, IEHP's legal right to reimbursement creates a health care lien on any recovery.

By accepting benefits under this Plan, You also grant IEHP an assignment of Your right to recover medical expenses from any medical payment coverage available to the extent of the full cost of all Covered Services provided by the Plan and You direct such medical payments carriers to directly reimburse the Plan on Your behalf.

Steps You Must Take

If You are injured because of a responsible party, You must cooperate with IEHP's and the medical providers' efforts to obtain reimbursement, including:

- Telling IEHP and the medical providers the name and address of the responsible party, if You know it, the name and address of Your lawyer, if You are using a lawyer, the name and

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address of any insurance company involved with Your injuries and describing how the injuries were caused;

- Completing any paperwork that IEHP or the medical providers may reasonably require to assist in enforcing the lien;
- Promptly responding to inquiries from the lienholders about the status of the case and any settlement discussions;
- Notifying the lienholders right away upon You or Your lawyer receiving any money from the responsible parties, any insurance companies, or any other source;
- Pay the health care lien from any recovery, settlement or judgment, or other source of compensation and all reimbursement due IEHP for the full cost of benefits paid under the Plan that are associated with injuries through a responsible party regardless of whether identified as recovery for medical expenses and regardless of whether You are made whole or fully compensated for Your loss;
- Do nothing to prejudice IEHP's rights as set forth above. This includes, but is not limited to, refraining from any attempts to reduce or exclude from settlement or recovery, the full cost of all benefits paid by the plan; and
- Hold any money that You or Your lawyer receive from the responsible parties, or from any other source, in trust and reimbursing IEHP and the medical providers for the amount of the lien as soon as You are paid.

How The Amount Of Your Reimbursement Is Determined

The following section is not applicable to Workers' Compensation liens and may not apply to certain ERISA plans, hospital liens, Medicare plans and certain other programs and may be modified by written agreement.*

Your reimbursement to IEHP or the medical provider under this lien is based on the value of the services You get and the costs of perfecting this lien. For purposes of determining the lien amount, the value of the services depends on how the provider was paid and as summarized below, will be calculated in accordance with California Civil Code, Section 3040, or as permitted by law.

- The amount of the reimbursement that You owe IEHP or the Physician Group will be reduced by the percentage that Your recovery is reduced if a judge, jury or arbitrator determines that You were responsible for some portion of Your injuries.
- The amount of the reimbursement that You owe IEHP or the Physician Group will also be reduced a pro rata share for any legal fees or costs that You paid from the money You received.
- The amount that You will be required to reimburse IEHP or the Physician Group for services You receive under this Plan will not exceed one-third of the money that You get if You do engage a lawyer or one-half of the money You get if You do not engage a lawyer.

* Reimbursement related to Workers' Compensation benefits, ERISA plans, hospital liens, Medicare and other programs not covered by California Civil Code, Section 3040 will be determined in accordance with the provisions of this Evidence of Coverage and applicable law.

Subrogation for a Surrogacy Arrangement

Have questions? Contact IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711), Monday-Friday 8am-6pm PST. Visit us online at iehp.org.

If a Member enters into a Surrogacy Arrangement and the Member or any other payee is entitled to receive payments or other compensation under the Surrogacy Arrangement, the Member must reimburse IEHP for Covered Services the Member receives related to conception, pregnancy, delivery, or postpartum care in connection with that arrangement (“Surrogacy Health Services”) to the maximum extent allowed under California Civil Code Section 3040. A “Surrogacy Arrangement” is one in which a woman agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether or not the woman receives payment for being a surrogate. Note: This “Surrogacy Arrangement” section does not affect the Member’s obligation to pay the Member’s Copayment or Coinsurance for these Covered Services. After the Member surrenders a baby to the legal parents, the Member is not obligated to reimburse for any Covered Services that the baby receives (the legal parents are financially responsible for any Covered Services that the baby receives).

By accepting Surrogacy Health Services, the Member automatically assigns to IEHP the Member’s right to receive payments that are payable to the Member or any other payee under the Surrogacy Arrangement, regardless of whether those payments are characterized as being for medical expenses. To secure IEHP’s rights, IEHP will also have a lien on those payments and on any escrow account, trust, or any other account that holds those payments. Those payments (and amounts in any escrow account, trust, or other account that holds those payments) shall first be applied to satisfy IEHP’s lien.

The assignment and IEHP’s lien will not exceed the total amount of the Member’s obligation to IEHP under the preceding paragraph.

Within 30 calendar days after entering into a Surrogacy Arrangement, the Member must send written notice of the arrangement, including all of the following information:

- Names, addresses, and telephone numbers of the other parties to the arrangement.
- Names, addresses, and telephone numbers of any escrow agent or trustee.
- Names, addresses, and telephone numbers of the intended parents and any other parties who are financially responsible for Covered Services the baby (or babies) receives, including names, addresses, and telephone numbers for any health insurance that will cover Covered Services that the baby (or babies) receives.
- A signed copy of any contracts and other documents explaining the arrangement
- Any other information IEHP requests in order to satisfy IEHP’s rights

The Member must send this information to the address on the first page of this Agreement.

The Member must complete and send IEHP all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for IEHP to determine the existence of any rights IEHP may have under this “Surrogacy Arrangement” section and to satisfy those rights. The Member may not agree to waive, release, or reduce IEHP’s rights under this “Surrogacy Arrangements” section without IEHP’s prior, written consent.

If the Member’s estate, parent, guardian or conservator asserts a claim against a third party based on the Surrogacy Arrangement, the Member’s estate, parent, guardian, or conservator shall be subject to IEHP’s liens and other rights to the same extent as if the Member had asserted the

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claim against the third party. IEHP may assign IEHP's rights to enforce IEHP's liens and other rights. If the Member has questions about the Member's obligations under this provision, please contact IEHP Member Services.

Relationship of Parties

Contracting Physicians, Hospitals, and other health care providers are not agents or employees of IEHP. IEHP and its employees are not the agents or employees of any Physician Group, Physician, Hospital or other health care provider.

All of the parties are independent contractors and contract with each other to provide You the Covered Services or supplies of this Plan.

The Members are not liable for any acts or omissions of IEHP, its agents or employees or of Physician Groups, any Physician or Hospital or any other person or organization with which IEHP has arranged or will arrange to provide the Covered Services and supplies of this Plan.

Provider/Patient Relationship

Physicians maintain a doctor-patient relationship with the Member and are solely responsible for providing professional medical services. Hospitals maintain a Hospital-patient relationship with the Member and are solely responsible for providing Hospital services.

Liability for Charges or Claims

While it is not likely, it is possible that IEHP may be unable to pay a IEHP provider. If this happens, the provider has contractually agreed not to seek payment from the Member.

However, this provision only applies to providers who have contracted with IEHP. You may be held liable for the cost of services or supplies received from a nonparticipating provider if IEHP does not pay that provider. This does not apply Emergency Services from a Non-contracted provider and services rendered by a Non-contracted provider in a Network facility.

This provision does not affect Your obligation to pay any required Copayment or Coinsurance or to pay for services and supplies that this Plan does not cover.

Prescription Drug Liability

IEHP will not be liable for any claim or demand as a result of damages connected with the manufacturing, compounding, dispensing or use of any Prescription Drug this Plan covers.

Contracting Administrators

IEHP may designate or replace any contracting administrator that provides the Covered Services and supplies of this Plan. If IEHP designates or replaces any administrator and as a result procedures change, IEHP will inform You.

Have questions? Contact IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711), Monday-Friday 8am-6pm PST. Visit us online at iehp.org.

Any administrator designated by IEHP is an independent contractor and not an employee or agent of IEHP, unless otherwise specified in this EOC.

Decision-Making Authority

IEHP has discretionary authority to interpret the benefits of this Plan and to determine when services are covered by the Plan.

Government Coverage

Medicare

If Medicare has made primary payment or is obligated to do so according to federal law and IEHP has provided services, IEHP will obtain reimbursement from Medicare, any organization or person receiving payments to which IEHP is entitled.

Medi-Cal

Medi-Cal is last to pay in all instances. IEHP will not attempt to obtain reimbursement from Medi-Cal.

Veterans' Administration

IEHP will not attempt to obtain reimbursement from the Department of Veterans' Affairs ("VA") for service-connected or nonservice-connected medical care.

Miscellaneous Provisions

Public Policy Participation

IEHP is an independent public managed care health plan run by a Board of Governors. The IEHP Board of Governors meets monthly. IEHP encourages You to:

- Attend Board of Governors meetings
- Offer public comment at the Board of Governors meeting
- Take part in establishing policies that assure the comfort, dignity and convenience of members, their families, and the public when seeking health care services. (Health and Safety Code section 1369)

Benefits Not Transferable

No person other than a properly enrolled Member is entitled to receive the benefits of this Plan. Your right to benefits is not transferable to any other person or entity.

If You use benefits fraudulently, Your coverage will be canceled. IEHP has the right to take appropriate legal action.

Notice of Claim for Reimbursement

In most instances, You will not need to file a claim to receive benefits this Plan provides. However, if You need to file a claim (for example, for Emergency or Urgent Care from a non-IEHP provider), You must do so within one (1) year from the date You get the services or

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supplies. Any claim filed more than one (1) year from the date the expense was incurred will not be paid unless it is shown that it was not reasonably possible to file within that time limit and that You have filed as soon as was reasonably possible. You may file a claim for reimbursement, over and above any cost sharing, if You paid for any covered services or prescriptions that were approved or does not require approval.

Call IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711) to obtain claim forms. If You need to file a claim for emergency services or for services authorized by Your PCP with IEHP, please send a completed claim form to:

IEHP
P.O. Box 4409
Rancho Cucamonga, CA 91729-1800

Outpatient Prescription Drug Claims

Please send a completed prescription drug claim form to:

IEHP
C/O MedImpact
P.O. Box 509098
San Diego, CA 92150-9108 or
FAX: 858-549-1569
Email: Claims@Medimpact.com

Please call IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711) or visit the IEHP website at iehp.org to obtain a prescription drug claim form.

Pediatric Dental Claims

If You get emergency pediatric dental services, You will be required to pay the charges to the dentist and submit a claim to us for a benefits determination. To learn more about claims for covered pediatric dental services, You may call IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711) or write to:

IEHP
c/o Liberty Dental Claims Department
P.O. Box 26110
Santa Ana, CA 92799-6110

To be reimbursed for emergency pediatric dental services, You must notify IEHP Member Services within forty-eight (48) hours after receiving such services. If Your physical condition does not permit such notification, You must make the notification as soon as it is reasonably possible to do so. Please include Your name, Family ID number, address and phone number on all requests for reimbursement.

Have questions? Contact IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711), Monday-Friday 8am-6pm PST. Visit us online at iehp.org.

For more information, contact Liberty Dental at 1-866-544-2981, Monday-Friday, 8am-5pm.

Health Care Plan Fraud

Health care plan fraud is defined as a deception or misrepresentation by a Provider, Member, or any person acting on their behalf. It is a felony that can be prosecuted. Any person who willfully and knowingly engages in an activity intended to defraud the health care plan by filing a claim that contains a false or deceptive statement is guilty of insurance fraud.

If You are concerned about any of the charges that appear on a bill or Explanation of Benefits form or if You know of or suspect any illegal activity, call IEHP's toll-free Fraud Hotline at 1-800-977-3565. The Fraud Hotline operates 24 hours a day, seven days a week. All calls are strictly confidential.

Disruption of Care

Circumstances beyond IEHP's control may disrupt care; for example, a natural disaster, war, riot, civil insurrection, epidemic, complete or partial destruction of facilities, atomic explosion or other release of nuclear energy, disability of significant Physician Group personnel or a similar event.

If circumstances beyond IEHP's control result in Your not being able to get the Medically Necessary Covered Services or supplies of this Plan, IEHP will make a good faith effort to provide or arrange for those services or supplies within the remaining availability of its facilities or personnel. In the case of an Emergency, go to the nearest doctor or Hospital. See the "Emergency and Urgent Care" section under the "Introduction to IEHP" section.

Transfer of Medical Records

A health care provider may charge a reasonable fee for the preparation, copying, postage or delivery costs for the transfer of Your medical records. Any fees associated with the transfer of medical records are the Member's responsibility. State law limits the fee that the providers can charge for copying records to be no more than twenty-five cents (\$0.25) per page, or fifty cents (\$0.50) per page for records that are copied from microfilm and any additional reasonable clerical costs incurred in making the records available. There may be additional costs for copies of x-rays or other diagnostic imaging materials.

Confidentiality of Medical Records

A statement describing IEHP's policies and procedures for preserving the confidentiality of medical records is available and will be furnished to You upon request.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Have questions? Contact IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711), Monday-Friday 8am-6pm PST. Visit us online at iehp.org.

Covered Entities Duties

IEHP* (referred to as “we” or “the Plan”) is a Covered Entity as defined and regulated under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). IEHP is required by law to maintain the privacy of Your protected health information (“PHI”), provide You with this Notice of our legal duties and privacy practices related to Your PHI, abide by the terms of the Notice in affect and notify You in the event of a breach of Your unsecured PHI. PHI is information about You, including demographic information, that can reasonably be used to identify You and that relates to Your past, present or future physical or mental health or condition, the provision of health care to You or the payment for that care.

This Notice describes how We may use and disclose Your PHI. It also describes Your Rights to access, amend and manage Your PHI and how to exercise those rights. All other uses and disclosures of Your PHI not described in this Notice will be made only with Your written authorization.

IEHP reserves the right to change this Notice. We reserve the right to make the revised or changed Notice effective for Your PHI We already have as well as any of Your PHI We receive in the future. IEHP will promptly revise and distribute this Notice whenever there is a material change to:

- The Uses or Disclosures
- Your rights
- Our legal duties
- Other privacy practices stated in the notice.

We will make any revised Notices available on our website and in the EOC.

Internal Protections of Oral, Written and Electronic PHI:

IEHP protects Your PHI. We have privacy and security processes to help. These are some of the ways we protect Your PHI.

- We train our staff to follow our privacy and security processes.
- We require our business associates to follow privacy and security processes.
- We keep our offices secure.
- We talk about Your PHI only for a business reason with people who need to know.
- We keep Your PHI secure when we send it or store it electronically.
- We use technology to keep the wrong people from accessing Your PHI.

Permissible Uses and Disclosures of Your PHI:

The following is a list of how We may use or disclose Your PHI without Your permission or authorization:

- Treatment - We may use or disclose Your PHI to a physician or other health care provider providing treatment to You, to coordinate Your treatment among providers, or to assist us in making prior authorization decisions related to Your benefits.
 - Payment - We may use and disclose Your PHI to make benefit payments for the health care services provided to You. We may disclose Your PHI to another health plan, to a
 - health care provider, or other entity subject to the federal Privacy Rules for their payment
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purposes. Payment activities may include:

- Processing claims
- Determining eligibility or coverage for claims
- Issuing premium billings
- Reviewing services for medical necessity
- Performing utilization review of claims
- Health Care Operations - We may use and disclose Your PHI to perform Our health care operations. These activities may include:
 - Providing customer services
 - Responding to complaints and appeals
 - Providing case management and care coordination
 - Conducting medical review of claims and other quality assessment
 - Improvement activities
- In Our health care operations, We may disclose PHI to business associates. We will have written agreements to protect the privacy of Your PHI with these associates. We may disclose Your PHI to another entity that is subject to the federal Privacy Rules. The entity must have a relationship with You for its health care operations. This includes:
 - Quality assessment and improvement activities
 - Reviewing the competence or qualifications of health care professionals
 - Case management and care coordination
 - Detecting or preventing health care fraud and abuse.
- Group Health Plan/Plan Sponsor Disclosures - We may disclose Your protected health information to a sponsor of the group health plan, such as an employer or other entity that is providing a health care program to You, if the sponsor has agreed to certain restrictions on how it will use or disclose the protected health information (such as agreeing not to use the protected health information for employment-related actions or decisions).

Other Permitted or Required Disclosures of Your PHI:

- Fundraising Activities - We may use or disclose Your PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance their
 - activities. If We do contact You for fundraising activities, We will give You the opportunity to opt-out, or stop, receiving such communications in the future.
 - Underwriting Purposes - We may use or disclosure Your PHI for underwriting purposes, such as to make a determination about a coverage application or request. If We do use or disclose Your PHI for underwriting purposes, We are prohibited from using or disclosing Your PHI that is genetic information in the underwriting process.
 - Appointment Reminders/Treatment Alternatives - We may use and disclose Your PHI to remind You of an appointment for treatment and medical care with Us or to provide You with information regarding treatment alternatives or other health-related benefits and
 - services, such as information on how to stop smoking or lose weight.
 - As Required by Law - If federal, state, and/or local law requires a use or disclosure of Your PHI, We may use or disclose Your PHI to the extent that the use or disclosure
 - complies with such law and is limited to the requirements of such law. If two or more laws or
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regulations governing the same use or disclosure conflict, We will comply with the more restrictive laws or regulations.

- **Public Health Activities** - We may disclose Your PHI to a public health authority for the purpose of preventing or controlling disease, injury, or disability. We may disclose Your PHI to the Food and Drug Administration (“FDA”) to ensure the quality, safety or effectiveness of products or services under the jurisdiction of the FDA.
- **Victims of Abuse and Neglect** - We may disclose Your PHI to a local, state, or federal government authority, including social services or a protective services agency authorized by law authorized by law to receive such reports if We have a reasonable belief of abuse, neglect or domestic violence.
- **Judicial and Administrative Proceedings** - We may disclose Your PHI in judicial and administrative proceedings. We may also disclose it in response to:
 - An order of a court
 - Administrative tribunal
 - Subpoena
 - Summons
 - Warrant
 - Discovery request
 - Similar legal request
- **Law Enforcement** - We may disclose Your relevant PHI to law enforcement when required to do so. For example, in response to a:
 - Court order
 - Court-ordered warrant
 - Subpoena
 - Summons issued by a judicial officer
 - Grand jury subpoena
- We may also disclose Your relevant PHI for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person.
- **Coroners, Medical Examiners and Funeral Directors** - We may disclose Your PHI to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose Your PHI to funeral directors, as necessary, to carry out their duties.
- **Organ, Eye and Tissue Donation** - We may disclose Your PHI to organ procurement organizations.
- We may also disclose Your PHI to those who work in procurement, banking or transplantation of:
 - Cadaveric organs
 - Eyes
 - Tissues
- **Threats to Health and Safety** - We may use or disclose Your PHI if We believe, in good faith, that the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.
- **Specialized Government Functions** - If You are a member of U.S. Armed Forces, We may disclose Your PHI as required by military command authorities. We may also disclose Your

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PHI:

- To authorized federal officials for national security and intelligence activities
- The Department of State for medical suitability determinations
- For protective services of the President or other authorized persons
- Workers' Compensation - We may disclose Your PHI to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.
- Emergency Situations - We may disclose Your PHI in an emergency situation, or if You are incapacitated or not present, to a Family member, close personal friend, authorized disaster relief agency, or any other person previously identified by You. We will use professional judgment and experience to determine if the disclosure is in Your best interests. If the disclosure is in Your best interest, We will only disclose the PHI that is directly relevant to the person's involvement in Your care.
- Inmates - If You are an inmate of a correctional institution or under the custody of a law enforcement official, We may release Your PHI to the correctional institution or law enforcement official, where such information is necessary for the institution to provide You with health care; to protect Your health or safety; or the health or safety of others; or for the safety and security of the correctional institution.
- Research - Under certain circumstances, We may disclose Your PHI to researchers when their clinical research study has been approved and where certain safeguards are in place to ensure the privacy and protection of Your PHI.

Uses and Disclosures of Your PHI That Require Your Written Authorization

We are required to obtain Your written authorization to use or disclose Your PHI, with limited exceptions, for these reasons:

Sale of PHI - We will request Your written authorization before We make any disclosure that is deemed a sale of Your PHI, meaning that We are receiving compensation for disclosing the PHI in this manner.

Marketing - We will request Your written authorization to use or disclose Your PHI for marketing purposes with limited exceptions, such as when We have face-to-face marketing communications with You or when We provide promotional gifts of nominal value.

Psychotherapy Notes - We will request Your written authorization to use or disclose any of Your psychotherapy notes that We may have on file with limited exception, such as for certain treatment, payment or health care operation functions.

Individuals Rights

The following are Your rights concerning Your PHI. If You would like to use any of the following rights, please contact us using the information at the end of this Notice.

- **Right to Revoke an Authorization** - You may revoke Your authorization at any time, the revocation of Your authorization must be in writing. The revocation will be effective

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immediately, except to the extent that We have already taken actions in reliance of the authorization and before We received Your written revocation.

- Right to Request Restrictions - You have the right to request restrictions on the use and disclosure of Your PHI for treatment, payment or health care operations, as well as disclosures to persons involved in Your care or payment of Your care, such as Family members or close friends. Your request should state the restrictions You are requesting and state to whom the restriction applies. We will comply with Your restriction request unless otherwise provided by law. We will restrict the use or disclosure of PHI for payment or health care operations to a health plan when You have paid for the service or item out of pocket in full.
- Right to Request Confidential Communications - You have the right to request that We communicate with You about Your PHI by alternative means or to alternative locations. You do not have to explain the reason is for Your request. We must accommodate Your request if it is reasonable and specifies the alternative means or location where You PHI should be delivered.
- Right to Access and Receive Copy of Your PHI - You have the right, with limited exceptions, to look at or get copies of Your PHI contained in a designated record set. You may request that We provide copies in a format other than photocopies. We will use the format You request unless We cannot practicably do so. You must make a request in writing to gain access to Your PHI. If We deny Your request, We will provide You a written explanation and will tell You if the reasons for the denial can be reviewed and how to ask for such a review or if the denial cannot be reviewed.
- Right to Amend Your PHI - You have the right to request that We amend, or change, Your PHI if You believe it contains incorrect information. Your request must be in writing, and it must explain why the information should be amended. We may deny Your request for certain reasons, for example if We did not create the information, You want amended and the creator of the PHI is able to perform the amendment. If We deny Your request, We will provide You a written explanation. You may respond with a statement that You disagree with Our decision and We will attach Your statement to the PHI You request that We amend. If We accept Your request to amend the information, We will make reasonable efforts to inform others, including people You name, of the amendment and to include the changes in any future disclosures of that information.
- Right to Receive an Accounting of Disclosures - You have the right to receive a list of instances within the last 6 years period in which We or Our business associates disclosed Your PHI. This does not apply to disclosure for purposes of treatment, payment, health care operations, or disclosures You authorized and certain other activities. If You request this accounting more than once in a 12-month period, We may charge You a reasonable, cost-based fee for responding to these additional requests. We will provide You with more information on Our fees at the time of Your request.
- Right to File a Complaint - If You feel Your privacy rights have been violated or that We have violated Our own privacy practices, You can file a complaint with us in writing or by phone using the contact information at the end of this Notice.
- You can also file a complaint with the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201 or calling 1-800-368-1019, (TTY: 1-866-788-4989) or visiting www.hhs.gov/ocr/privacy/hipaa/complaints. We will not take any action against You for filing

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- a complaint.
- **Right to Receive a Copy of this Notice** - You may request a copy of Our Notice at any time by using the contact information list at the end of the Notice. If You get this Notice on Our website or by electronic mail (“e-mail”), You are also entitled to request a paper copy of the Notice.

Contact Information

If You have any questions about this Notice of Privacy Practices related to Your PHI or how to exercise Your rights, You can contact us in writing or by phone using the contact information listed below.

IEHP Privacy Officer
P.O. Box 1800
Rancho Cucamonga, CA 91729
Email:
compliance@iehp.org
IEHP Compliance Hotline: 1-866-355-9038

Financial Information Privacy Notice

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are committed to maintaining the confidentiality of Your personal financial information. For the purposes of this notice, "personal financial information" means information about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available, and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We collect: We collect personal financial information about You from these sources:

- Information We receive from You on applications or other forms, such as name, address, age, medical information and Social Security Number;
- Information about Your transactions with us, Our affiliates or others, such as premium payment and claims history; and
- Information from consumer reports.

Disclosure of Information: We do not disclose personal financial information about Our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of Our general business practices, We may, as permitted by law, disclose any of the personal financial information that We collect about You, without Your authorization, to these types of institutions:

- To other insurers;
 - To nonaffiliated companies for Our everyday business purposes, such as to process Your transactions, maintain Your account(s), or respond to court orders and legal
-

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- investigations; and
- To nonaffiliated companies that perform services for us, including sending promotional communications on Our behalf.

Confidentiality and Security: We maintain physical, electronic and procedural safeguards, in accordance with applicable state and federal standards, to protect Your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access Your personal financial information.

If You have any questions about this notice: Please contact IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711).

Definitions

This section defines words that will help You understand Your Plan. These words appear throughout this EOC with the initial letter of the word in capital letters.

Acupuncture Services are services rendered or made available to a Member by an acupuncturist for treatment or diagnosis of an injury, illness or condition, if determined by American Specialty Health (“ASH”) Plan to be Medically Necessary for the treatment of that condition. Acupuncture Services are typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain.

Acute Condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and that has a limited duration. Completion of Covered Services shall be provided for the duration of the acute condition.

Advanced Health Care Directive means a legal document that tells your doctor, family, and friends about the health care you want if you can no longer make decisions for yourself. It explains the types of special treatment you want or do not want. For more information, contact the Plan or the California Attorney General's Office.

Advance Premium Tax Credits is the payment of the tax credits authorized by 26 U.S.C. 26B and its implementing regulations, which are provided on an advance basis, to an individual enrolled in a Qualified Health Plan (“QHP”) through Covered California in accordance with Section 1412 of the Affordable Care Act. These federal subsidies vary by household size, place of residence, and income, and can reduce the plan premiums that You are required to pay for Your IEHP plan. These subsidy amounts can also change on a yearly basis

Affordable Care Act (“ACA”) is a law that provides the framework, policies, regulations and guidelines for implementation of comprehensive health care reform by the states. The Affordable Care Act expands access to affordable insurance and health care.

Alternative Therapies are treatments with inadequate evidence in the peer-reviewed published medical literature of their effectiveness and are considered unproven practices that should not be used in place of conventional medicine. This does not include Alternative Therapies that are newly approved as evidence-based practice.

American Specialty Health Plans of California, Inc. (“ASH”) is a specialized health care service contracted with IEHP to arrange the delivery of Acupuncture Services through a network of Contracted Acupuncturists.

Anesthesia is the loss of sensation due to a pharmacological depression of nerve function.

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Appropriately Qualified Health Care Provider means a Health Care Provider who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion.

Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or another Life-Threatening disease or condition that meets at least one of the following:

- The study or investigation is approved or funded, which may include funding through in-kind donations, by one or more of the following:
 - The National Institutes of Health.
 - The federal Centers for Disease Control and Prevention.
 - The Agency for Healthcare Research and Quality.
 - The federal Centers for Medicare and Medicaid Services.
 - A cooperative group or center of the National Institutes of Health, the federal Centers for Disease Control and Prevention, the Agency for healthcare Research and Quality, the federal Centers for Medicare and Medicaid Services, the Department of Defense, or the United States Department of Veterans Affairs.
 - A qualified nongovernmental research entity identified in the guidelines issued by The National Institutes of Health for center support grants.
- One of the following departments, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of the United States Department of Health and Human Services determines is comparable to the system of peer review used by the National Institutes of Health and ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
 - The United States Department of Veterans Affairs.
 - The United States Department of Defense.
 - The United States Department of Energy.
- The study or investigation is conducted under an investigational new drug application reviewed by the United States Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from an investigational new drug application reviewed by the United States Food and Drug Administration.

Autism Spectrum Disorder (“ASD”) is a behavioral disorder characterized by:

- Persistent deficits in social communication and social interaction across multiple contexts.
- Restricted, repetitive patterns of behavior, interests, or activities.
- Symptoms present in the early developmental period.
- Symptoms that cause clinically significant impairment in social, occupational, or other areas of current functioning
- Disturbances that are not better explained by intellectual disability or global developmental delay.

Please see full definition of ASD in Diagnostic and Statistical Manual of Mental Disorders (“DSM-5”).

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Benefits and Coverage means the health care services available under a plan contract.

Biological Product is a generally large, complex molecule that is produced through biotechnology in a living system.

Biosimilar Product is a biological product that is highly similar and has no clinically meaningful differences from the original biological product.

Brand Name Drug is a Prescription Drug or medicine that has been registered under a brand or trade name by its manufacturer and is advertised and sold under that name and indicated as a brand in the Medi-Span or similar third-party national database used by IEHP.

Calendar Year is the twelve-month period that begins at 12:01 am Pacific Time on January 1 of each year.

Coinsurance is a cost share amount charged to You for Covered Services when You get them and is a percentage of IEHP's Allowed Amount for the service or supply, agreed to in advance by IEHP and the contracted provider. The percentage is usually billed after the service is received. The Coinsurance for each covered service is shown in the "Schedule of Benefits" section.

Copayment is a cost share amount charged to You for Covered Services when You get them and is a fixed dollar amount, agreed to in advance by IEHP and the contracted provider. The fixed dollar Copayment is due and payable to the provider of care at the time the service is received. The Copayment for each covered service is shown in the "Schedule of Benefits" section.

Corrective Footwear includes specialized shoes, arch supports and inserts and is custom made for Members who suffer from foot disfigurement. Foot disfigurement includes, but is not limited to, disfigurement from cerebral palsy, arthritis, polio, spina bifida, diabetes, and foot disfigurement caused by accident or developmental disability.

Covered Benefits means those Medically Necessary services and supplies that you are entitled to receive under an individual or group agreement and which are described in this Evidence of Coverage or under California health plan law.

Covered California is the California Health Benefit Exchange, doing business as Covered California and an independent entity within the Government of the State of California. Beginning January 2014, Covered California has selectively contracted with health plans to make available to enrollees of the Exchange health care coverage choices that seek to provide the optimal combination of choice, value, access, quality, and service.

Covered Expenses/Services are Medically Necessary medical, surgical, hospital and other services and supplies rendered by Network Providers and emergency care and supplies provided by nonparticipating providers, which are specified as being covered in the EOC.

Custodial Care is care that is rendered to a patient to assist in support of the essentials of daily

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living such as help in walking, getting in and out of bed, bathing, dressing, feeding, preparation of special diets and supervision of medications which are ordinarily self-administered and which patient:

- Is disabled mentally or physically and such disability is expected to continue and be prolonged;
- Requires a protected, monitored or controlled environment whether in an institution or in the home; and
- Is not under active and specific medical, surgical or psychiatric treatment that will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored or controlled environment.

Deductible is a set amount You pay each Calendar Year for specified covered expenses before IEHP pays any benefits for those covered expenses in that Calendar Year. Refer to the “Schedule of Benefits” for the services that are subject to Deductibles and the Deductible amounts.

Dependent includes:

- The Subscriber’s lawful spouse, as defined by California law. (The term “spouse” also includes the Subscriber’s Domestic Partner when the domestic partnership meets all Domestic Partner requirements under California law as defined below.)
- The children of the Subscriber or his or her spouse (including legally adopted children, stepchildren and children for whom the Subscriber is a court-appointed guardian).
- Domestic Partner is, for the purposes of this EOC, the Subscriber’s partner if the Subscriber and partner are a couple who are registered domestic partners that meet all the requirements of Section 297 or 299.2 of the California Family Code.

Durable Medical Equipment

- Serves a medical purpose (its reason for existing is to fulfill a medical need, it is not for convenience and/or comfort and it is not useful to anyone in the absence of illness or injury).
- Fulfills basic medical needs, as opposed to satisfying personal preferences regarding style and range of capabilities.
- Withstands repeated use.
- Is appropriate for use in a home setting.

Effective Date is the date that You become covered or entitled to receive the benefits this Plan provides. Enrolled Family Members may have a different Effective Date than the Subscriber if they are added later to the Plan.

Emergency Services and Care means (1) medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician and surgeon, to determine if an Emergency Medical Condition or active labor exists and, if it does, the care, treatment, and surgery, within the scope of that person’s license, if necessary to relieve or eliminate the Emergency Medical

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Condition, within the capability of the facility; and/or (2) an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a Psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or eliminate the Psychiatric Emergency Medical Condition within the capability of the facility.

Emergency Dental Care includes Medically Necessary services required for: (1) the alleviation of severe pain; or (2) the immediate diagnosis and treatment of an unforeseen illness or injury which, if not immediately diagnosed and treated, could lead to death or disability. The attending dentist is exclusively responsible for making these dental determinations and treatment decisions.

However, payment for Emergency Dental Care rendered will be conditioned on IEHP's subsequent review and determination as to consistency with professionally recognized standards of dental practice and IEHP's dental policies.

Emergency Medical Condition means a medical condition, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Services and Care means (1) medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician and surgeon, to determine if an Emergency Medical Condition or active labor exists and, if it does, the care, treatment, and surgery, within the scope of that person's license, if necessary to relieve or eliminate the Emergency Medical Condition, within the capability of the facility; and/or (2) an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a Psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or eliminate the Psychiatric Emergency Medical Condition within the capability of the facility.

Essential Health Benefits are a set of health care service categories (as defined by the Affordable Care Act) that must be covered by all health benefits plans starting in 2014. Categories include: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices (limits for rehabilitative and habilitative services shall not be combined), laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including dental and vision care.

Evidence of Coverage means any certificate, agreement, contract, brochure, or letter of entitlement issued to a Member setting forth the coverage to which the Member is entitled.

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Exception means any provision in a plan contract whereby coverage for a specified hazard or condition is entirely eliminated.

Experimental Services means drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or animal studies prior to testing in humans. Experimental Services are not undergoing a clinical investigation.

Family Members are dependents of the Subscriber, who meet the eligibility requirements for coverage under this Plan and have been enrolled by the Subscriber.

Follow-Up Care or post-stabilization care is the care provided after Emergency Care or Urgent Care when the Member's condition, illness or injury has been stabilized and no longer requires Emergency Care or Urgent Care.

Formulary Drug List is a list of the Prescription Drugs that are covered by this Plan. It is prepared and updated by IEHP and distributed to Members, Physicians and Network Pharmacies and posted on the IEHP website at iehp.org. Some Drugs in the Formulary Drug List require Prior Authorization from IEHP in order to be covered.

Generic Drug is the pharmaceutical equivalent of a Brand Name Drug whose patent has expired and is available from multiple manufacturers as set out in the Medi-Span or similar third party database used by IEHP. The Food and Drug Administration must approve the Generic Drug as meeting the same standards of safety, purity, strength and effectiveness as the Brand Name Drug.

Health Care Provider means any professional person, medical group, independent practice association, organization, health care facility, or other person or institution licensed or authorized by the state to deliver or furnish health services.

Health Care Services (including behavioral health care services) are those services that can only be provided by an individual licensed as a health care provider by the state of California to perform the services, acting within the scope of his/her license or as otherwise authorized under California law.

Home Health Care Agency is an organization licensed by the state of California and certified as a Medicare participating provider or accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO").

Home Health Care Services are services, including skilled nursing services, provided by a licensed Home Health Care Agency to a Member in his or her place of residence that is prescribed by the Member's attending physician as part of a written plan. Home Health Care Services are covered if the Member is homebound, under the care of a contracting physician, and requires Medically Necessary skilled nursing services, physical, speech, occupational therapy, or respiratory therapy or medical social services. Only Intermittent Skilled Nursing Services, (not to

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exceed 4 hours a day), are covered benefits under this plan. Private Duty Nursing or shift care (including any portion of shift care services) is not covered under this plan. See also “Intermittent Skilled Nursing Services” and “Private Duty Nursing” sections.

Home Infusion Therapy is infusion therapy that involves the administration of medications, nutrients, or other solutions through intravenous, subcutaneously by pump, enterally or epidural route (into the bloodstream, under the skin, into the digestive system, or into the membranes surrounding the spinal cord) to a patient who can be safely treated at home. Home Infusion Therapy always originates with a prescription from a qualified physician who oversees patient care and is designed to achieve physician-defined therapeutic end points.

Hospice is a facility or program that provides a caring environment for meeting the physical and emotional needs of the terminally ill. The Hospice and its employees must be licensed according to applicable state and local laws and certified by Medicare.

Hospital is a legally operated facility licensed by the state as an acute care Hospital and approved either by the Joint Commission on Accreditation of Healthcare Organizations (“JCAHO”) or by Medicare.

IEHP Service Area is the geographic area in Riverside and San Bernardino counties where IEHP has been authorized by the California Department of Managed Health Care to contract with providers, market products, enroll Members and provide benefits through approved individual health plans. A listing of the participating Primary Care Physicians in the IEHP Service Area are available on the IEHP website at iehp.org. You can also call IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711) or visit IEHP’s website at iehp.org to request provider information.

Independent Medical Review (IMR) means a review of your Plan’s denial, modification, or delay of your request for health care services or treatment. The review is provided by the Department of Managed Health Care and conducted by independent medical experts. If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by your Plan related to medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. Your Plan must pay for the services if an IMR decides you need it.

Inland Empire Health Plan (“IEHP”) is a federally qualified health maintenance organization (“HMO”) and a California licensed health care service plan.

Interchangeable Biosimilar Product is a biosimilar product that meets additional requirements that allow them to be substituted for the original biological product.

Intermittent Skilled Nursing Services are services requiring the skilled services of a registered nurse or Licensed Vocational Nurse, which do not exceed 4 hours in every 24 hours.

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Investigational Services means those drugs, equipment, procedures or services for which laboratory and/or animal studies have been completed and for which human studies are in progress but:

- (1) Testing is not complete; and
- (2) The efficacy and safety of such services in human subjects are not yet established; and
- (3) The service is not in wide usage.

Life-Threatening means either or both of the following:

- Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.
- Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

Limitation means any provision other than an exception or a reduction which restricts coverage under the plan.

Maintenance Drugs are Prescription Drugs taken continuously to manage chronic or long-term conditions where Members respond positively to a drug treatment plan with a specific medication at a constant dosage requirement.

Maximum Allowable Amount refers to payment amount negotiated by the IEHP and each Network Provider. For non-emergency health care services provided to an enrollee by a noncontracting individual health professional at a contracting health facility, the Maximum Allowed Amount shall be the greater of the average contracted rate, or 125% of the Medicare Reimbursement Rate as defined in Section 1371 of the Knox Keene Act. For Emergency Services and emergency transportation services from a non-contracted Provider: unless otherwise required by law or as agreed to between the non-contracted Provider and IEHP, the Maximum Allowed Amount shall be the reasonable and customary value for the health care services rendered based upon the factors stated in Cal. Code of Regs., tit. 28, section 1300.71(a)(3)(B). For Urgent Care received while out of the Service Area from a non-contracting Provider: unless otherwise required by law or as agreed to between the non-contracted Provider and IEHP, the Maximum Allowed Amount shall be 1) IEHP's average contracted rate for such service(s), or 2) 100% of the published Medicare rate for such service(s), whichever is less.

Medical Child Support Order is a court judgment or order that, according to state or federal law, requires employer health plans that are affected by that law to provide coverage to Your child or children who are the subject of such an order. IEHP will honor such orders.

Medical information means any individually identifiable information, in electronic or physical form, in possession of or derived from a provider of health care, health care service plan, pharmaceutical company, or contractor regarding a patient's medical history, mental health

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application information, reproductive or sexual health application information, mental or physical condition, or treatment. “Individually identifiable” means that the medical information includes or contains any element of personal identifying information sufficient to allow identification of the individual, such as the patient’s name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the identity of the individual.

Medically Necessary means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

- In accordance with the generally accepted standards of care, including generally accepted standards of Mental Health or Substance Use Disorder care.
- Clinically appropriate in terms of type, frequency, extent, site, and duration.
- Not primarily for the economic benefit of the health care service plan and Members or for the convenience of the patient, treating physician, or other Health Care Provider.

Medicare is the Health Insurance Benefits for the Aged and Disabled Act, cited in Public Law 89-97, as amended.

Member means a subscriber, enrollee, enrolled employee, or dependent of a subscriber or an enrolled employee, who has enrolled in the Plan and for whom coverage is active or live.

Mental Health or Substance Use Disorder means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

Network Acupuncturist means an acupuncturist who is duly licensed to practice acupuncture in California and who has entered into an agreement with American Specialty Health Plans of California, Inc. (“ASH”) to provide covered Acupuncture Services to Members.

Network Behavioral Health Facility is a Hospital, residential treatment center, structured outpatient program, day treatment, partial hospitalization program or other mental health care facility that has signed a service contract with IEHP, to provide Mental Health and Substance Use Disorder benefits. This facility must be licensed by the state of California to provide acute or intensive psychiatric care, detoxification services or Substance Use Disorder rehabilitation services.

Network Dentist is a dentist or dental facility licensed to provide Benefits and who or which, at the time care is rendered to a Member, has a contract in effect with IEHP to furnish care to Members. The names of Participating Dentists are set forth in IEHP’s Network Dentist Directory. The names of Network Dentists and their locations and hours of practice may also be obtained by

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contacting IEHP Member Services Department. This Plan does not guarantee the initial or continued availability of any particular Network Dentist.

Network Mental Health Professional is a Physician or other professional who is licensed, certified or otherwise authorized by the state of California to provide mental Health Care Services. The Network Mental Health Professional must have a service contract with IEHP to provide Mental Health and Substance Use Disorder services. See also "Qualified Autism Service Provider" below in this "Definitions" section.

Network Orthodontist is an orthodontist or dental facility licensed to provide orthodontic care and who or which, at the time care is rendered to a Member, has a contract in effect with IEHP to furnish such care to Members.

Network Pharmacy is a licensed pharmacy that has a contract with IEHP to provide Prescription Drugs to Members of this Plan.

Network Vision Provider is an optometrist, ophthalmologist or optician licensed to provide Covered Services and who or which, at the time care is rendered to a Member, has a contract in effect with IEHP to furnish care to Members. The names of Network Vision Providers are set forth in IEHP's Network Vision Provider Directory. The names of Network Vision Providers and their locations and hours of practice may also be obtained by contacting IEHP Member Services Department.

Non-participating Pharmacy is a pharmacy that does not have an agreement with IEHP to provide Prescription Drugs to Members.

Nurse Practitioner ("NP") is a registered nurse certified as a Nurse Practitioner by the California Board of Registered Nursing. The NP, through consultation and collaboration with Physicians and other health providers, may provide and make decisions about, health care.

Orthotics (such as bracing, supports and casts) are rigid or semi-rigid devices that are externally affixed to the body and designed to be used as a support or brace to assist the Member with the following:

- To restore function; or
- To support, align, prevent, or correct a defect or function of an injured or diseased body part; or
- To improve natural function; or
- To restrict motion.

Out-of-Pocket Maximum ("OOPM") is the maximum amount of Copayments, Coinsurance, and Deductibles You must pay for Covered Services for each Calendar Year. It is important to keep all receipts for Deductibles and Copayments that were actually paid so You can inform IEHP when You have satisfied the Out-of-Pocket Maximum.

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Outpatient Prescription Drug means a self-administered drug that is approved by the federal Food and Drug Administration for sale to the public through a retail or mail order pharmacy, requires a prescription, and has not been provided for use on an inpatient basis.

Outpatient Surgical Center is a facility other than a medical or dental office, whose main function is performing surgical procedures on an outpatient basis. It must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services.

Pain means a sensation of hurting or strong discomfort in some part of the body caused by an injury, illness, disease, functional disorder or condition. Pain includes low back pain, post-operative pain and post-operative dental pain.

Physician is a doctor of medicine (“M.D.”) or a doctor of osteopathy (“D.O.”) who is licensed to practice medicine or osteopathy where the care is provided.

Physician Assistant is a health care professional certified by the state as a Physician Assistant and authorized to provide medical care when supervised by a Physician.

Plan is the health benefits purchased by You and described in this EOC.

Prescription Drug or “drug” means a drug approved by the federal Food and Drug Administration (FDA) for sale to consumers that requires a prescription and is not provided for use on an inpatient basis. The term “drug” or “prescription drug” includes:

- (A) disposable devices that are medically necessary for the administration of a covered prescription drug, such as spacers and inhalers for the administration of aerosol outpatient prescription drugs;
- (B) syringes for self-injectable prescription drugs that are not dispensed in pre-filled syringes; (C) drugs, devices, and FDA-approved products covered under the prescription drug benefit of the product pursuant to sections 1367.002, 1367.25, and 1367.51 of the Health and Safety Code, including any such over-the-counter drugs, devices, and FDA-approved products; and (D) at the option of the health plan, any vaccines or other health care benefits covered under the Plan’s prescription drug benefit.

Prescription Drug Order is a written or verbal order or refill notice for a specific drug, strength and dosage form (such as a tablet, liquid, syrup or capsule) issued by a Physician.

Presenting for examination or sale means either (1) publication and dissemination of any brochure, mailer, advertisement, or form which constitutes a presentation of the provisions of the plan and which provides a plan enrollment or application for, or (2) consultations or discussions between prospective plan members or their contract agents and solicitors or representatives of a plan, when such consultations or discussions include presentation of formal, organized information about the plan which is intended to influence or inform the prospective member or contract holder, such as brochures, summaries, charts, slides, or other modes of information.

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Preventive Care Services are services and supplies that are covered under the “Preventive Care Services” heading as shown in the “Schedule of Benefits,” and the "Plan Benefits" section. These services and supplies are provided to individuals who do not have the symptom of disease or illness, and generally do one or more of the following:

- Maintain good health
- Prevent or lower the risk of diseases or illnesses
- Detect disease or illness in early stages before symptoms develop
- Monitor the physical and mental development in children

Primary Care Physician (“PCP”) is a Physician who coordinates and controls the delivery of Covered Services and supplies to the Member. Primary Care Physicians include general and Family practitioners, internists, pediatricians and obstetricians/gynecologists. Under certain circumstances, a clinic that is staffed by these health care Specialists must be designated as the Primary Care Physician.

Prior Authorization is the approval process for certain services and supplies. To get a copy of IEHP’s Prior Authorization requirements not otherwise specified in this document, call IEHP Member Services phone at 1-855-433-IEHP (4347) (TTY 711).

Private Duty Nursing means continuous nursing services provided by a licensed nurse (RN, LVN or LPN) for a patient who requires more care than is normally available during a home health care visit or is normally and routinely provided by the nursing staff of a hospital or skilled nursing facility. Private Duty Nursing includes nursing services (including intermittent services separated in time, such as 2 hours in the morning and 2 hours in the evening) that exceeds a total of four hours in any 24-hour period. Private Duty Nursing may be provided in an inpatient or outpatient setting, or in a non- institutional setting, such as at home or at school. Private Duty Nursing may also be referred to as "shift care and includes any portion of shift care services."

Professional Vision Services include exam, material selection, fitting of eyeglasses or contact lenses, related adjustments, instructions, etc.

Psychiatric Emergency Medical Condition means a mental disorder that manifests itself by acute symptoms of sufficient severity that renders the patient as being either: an immediate danger to himself or herself or to others, or immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

Qualified Autism Service Paraprofessional is an unlicensed and uncertified individual who: (1) is supervised by a Qualified Autism Service provider or qualified autism service professional at a level of clinical supervision that meets professionally recognized standards of practice; (2) provides treatment pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider; (3) meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations; (4) has adequate education, training, and experience as certified by the Qualified Autism Service Provider or an entity or group that

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employs Qualified Autism Service Providers; and (5) is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.

Qualified Autism Service Professional: (1) provides behavioral health treatment which may include clinical case management and case supervision under the direction and supervision of a Qualified Autism Service Provider; (2) is supervised by a Qualified Autism Service Provider; (3) provides treatment pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider; (4) is a behavioral service provider that has training and experience in providing services for pervasive developmental disorder or autism and who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program; (5) is a psychological associate, an associate marriage and family therapist, an associate clinical social worker, or an associate professional clinical counselor, as defined and regulated by the Board of Behavioral Sciences or Board of Psychology and meets the criteria set forth in the regulations adopted pursuant to Section 4686.4 of the Welfare and Institutions Code for a behavioral professional; (6) has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code; and (7) is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.

Qualified Autism Service Provider means either of the following: (1) A person who is certified by a national entity, such as the Behavior Analyst Certification Board with a certification, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person who is nationally certified. (2) A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and Family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech- language pathologist, or audiologist and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.

Qualified Autism Service Providers supervise qualified autism service professionals and paraprofessionals who provide behavioral health treatment and implement services for pervasive developmental disorder or autism pursuant to the treatment plan developed and approved by the Qualified Autism Service Provider.

Residential Treatment Center is a twenty-four hour, structured and supervised group living environment for children, adolescents or adults where psychiatric, medical and psychosocial evaluation can take place, and distinct and individualized psychotherapeutic interventions can be offered to improve their level of functioning in the community. IEHP requires that all Residential Treatment Centers must be appropriately licensed by their state in order to provide residential treatment services.

Have questions? Contact IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711), Monday-Friday 8am-6pm PST. Visit us online at iehp.org.

Reduction means any provision in a plan contract which reduces the amount of a plan benefit to some amount or period less than would be otherwise payable for medically authorized expenses or services had such a reduction not been used.

Serious Chronic Condition is a medical condition due to a disease, illness or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.

Seriously Debilitating means diseases or conditions that cause major irreversible morbidity.

Service Area means the geographic area designated by the plan within which a plan shall provide health care services.

Skilled Nursing Facility is an institution that is licensed by the appropriate state and local authorities to provide skilled nursing services. In addition, Medicare must approve the facility as a participating Skilled Nursing Facility.

Special Care Units are special areas of a Hospital which have highly skilled personnel and special equipment for the care of patients with Acute Conditions that require constant treatment and monitoring including, but not limited to, an intensive care, cardiac intensive care, and cardiac surgery intensive care unit, and a neonatal intensive or intermediate care newborn nursery.

Specialist is a Physician who delivers specialized services and supplies to the Member. Any Physician other than an obstetrician/gynecologist acting as a Primary Care Physician, general or Family practitioner, internist or pediatrician is considered a Specialist. With the exception of well-woman visits to an obstetrician/gynecologist, all Specialist visits must be referred by Your Primary Care Physician to be covered.

Subscriber is the person enrolled under this EOC who is responsible for payment of premiums to IEHP and whose status is the basis for Family member eligibility under this EOC.

Substance Use Disorder Care Facility is a Hospital, residential treatment center, structured outpatient program, day treatment or partial hospitalization program or other mental health care facility that is state-licensed to provide Substance Use Disorder detoxification services or rehabilitation services.

Surrogacy is services for anyone in connection with a Surrogacy Arrangement, except for otherwise-Covered Services provided to a Member who is a surrogate.

Surrogacy Arrangement is one in which a woman (the surrogate) agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child

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(or children), whether or not the woman receives payment for being a surrogate. Please refer to “Subrogation for a Surrogacy Arrangement” in the “Legal Notices” section of this Agreement for information about Member obligations to IEHP in connection with a Surrogacy Arrangement, including Member obligations to reimburse IEHP for any Covered Services IEHP covers and a Member’s obligation to provide information to IEHP about anyone who may be financially responsible for the Covered Services the baby (or babies) receive.

Surrogate means an individual who, as part of a Surrogacy Arrangement, (a) uses her own egg that is fertilized by a donor or (b) is a gestational carrier who has a fertilized egg placed in her body, but the egg is not her own.

Teledentistry refers to the use of Telehealth/Virtual systems and methodologies in dentistry. Teledentistry can include patient care and education. See the definition of "Telehealth/Virtual Services" below.

Telehealth/Virtual Services means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the provider for Telehealth/Virtual is at a distant site. Telehealth/Virtual facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers. For the purposes of this definition, the following apply:

- "Asynchronous store and forward" means the transmission of a patient's medical information from an originating site to the health care provider for Telehealth/Virtual at a distant site without the presence of the patient.
- "Distant site" means a site where a health care provider for Telehealth/Virtual who provides health care services is located while providing these services via a telecommunications system.
- "Originating site" means a site where a patient is located at the time health care services are provided via telecommunications system or where the asynchronous store and forward service originates.
- "Synchronous interaction" means a real-time interaction between a patient and a health care provider for Telehealth/Virtual located at a distant site.

Terminal Illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of Covered Services shall be provided for the duration of a terminal illness.

Tier 1 Drugs include most generic drugs and low-cost, preferred brand drugs.

Tier 2 Drugs include non-preferred generic drugs, preferred brand drugs, or drugs recommended by the P&T Committee based on drug safety, efficacy, and cost.

Tier 3 Drugs include non-preferred brand drugs; drugs recommended by the P&T Committee based on safety, efficacy, and cost; or drugs that generally have a preferred and often less costly therapeutic alternative at a lower tier.

Have questions? Contact IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711), Monday-Friday 8am-6pm PST. Visit us online at iehp.org.

Tier 4 Drugs that the FDA or drug manufacturer requires to be distributed by specialty pharmacies; drugs that require training or clinical monitoring for self-administration; or drugs with a plan cost (net of rebates) greater than \$600 for a one-month supply.

Trans-Inclusive Health Care means comprehensive health care that is consistent with the standards of care for individuals who identify as transgender, gender diverse, or intersex; honors an individual's personal bodily autonomy; does not make assumptions about an individual's gender; accepts gender fluidity and nontraditional gender presentation; and treats everyone with compassion, understanding, and respect.

Transplant Performance Center is a provider in IEHP's designated network in California for solid organ, tissue and stem cell transplants and transplant-related services, including evaluation and follow-up care. For purposes of determining coverage for transplants and transplant-related services, IEHP's network of Transplant Performance Centers includes any providers in IEHP's designated supplemental resource network.

Urgent Care includes otherwise covered medical service a person would seek for treatment of an injury, unexpected illness or complication of an existing condition, including pregnancy, to prevent the serious deterioration of his or her health, but which does not qualify as Emergency Care, as defined in this section. This may include services for which a person should have known an emergency did not exist.

Language Assistance Services

IEHP provides free language assistance services, such as oral interpretation, sign language interpretation, translated written materials and appropriate auxiliary aids for individuals with disabilities. IEHP Member Services Department has bilingual staff and interpreter services for additional languages to support Member language needs. Oral interpretation services in Your language can be used for, but not limited to, explaining benefits, filing a grievance and answering questions related to Your Plan. Also, our IEHP Member Services staff can help You find a health care provider who speaks Your language.

Call IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711) for this free service and to schedule an interpreter. Providers may not request that You bring Your own interpreter to an appointment. There are limitations on the use of Family and friends as interpreters. Minors can only be used as interpreters if there is an imminent threat to the patient's safety and no qualified interpreter is available. Language assistance is available 24 hours a day, 7 days a week at all points of contact where a covered benefit or service is accessed. If You cannot locate a health care provider who meets Your language needs, You can request to have an interpreter ready at no charge. Interpreter services shall be coordinated with scheduled appointments for health care services in such a manner that ensures the provision of interpreter services at the time of the appointment.

Notice of Non-Discrimination

In addition to the State of California nondiscrimination requirements (as described in benefit coverage documents), IEHP complies with applicable federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of race, color, national origin, ancestry, religion, marital status, gender, gender identity, sexual orientation, age, disability, or sex.

IEHP:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If You need these services, contact IEHP Member Services at:

Individual & Family Plan (IFP) Members: 1-855-433-IEHP (4347) (TTY: 711)

Individual & Family Plan (IFP) Applicants: 1-855-538-IEHP (4347) (TTY: 711)

If You believe that IEHP has failed to provide these services or discriminated in another way based on one of the characteristics listed above, You can file a grievance by calling IEHP Member Services at the number above and telling them You need help filing a grievance; IEHP Member Services can help You file a grievance. You can also file a grievance by mail, fax or email at:

IEHP Grievances & Appeals
P.O. Box 1800
Rancho Cucamonga, CA 91729

Email: grievances@iehp.org (Members) or (Non-Members)

If Your health problem is urgent, if You already filed a complaint with IEHP and are not satisfied with the decision or it has been more than 30 calendar days since You filed a complaint with IEHP You may submit an Independent Medical Review/Complaint Form with the California Department of Managed Health Care (“DMHC”). You may submit a complaint form by calling the DMHC Help Desk at 1-888-466-2219 (TDD: 1-877-688-9891) or online at www.dmhc.ca.gov/FileaComplaint.

If You believe You have been discriminated against because of race, color, national origin, age, disability, or sex, You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights (“OCR”), electronically through the OCR Complaint Portal, at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TDD: 1-800-537-7697).
You can access complaint forms at <http://www.hhs.gov/ocr/office/fileindex.html>.

Have questions? Contact IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711), Monday-Friday 8am-6pm PST. Visit us online at iehp.org.



NONDISCRIMINATION NOTICE

Discrimination is against the law. Inland Empire Health Plan (IEHP) follows State and Federal civil rights laws. IEHP does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

IEHP provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
 - ✓ Qualified sign language interpreters
 - ✓ Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
 - ✓ Qualified interpreters
 - ✓ Information written in other languages

If you need these services, contact IEHP Covered Member Services at **1-855-433-4347 (IEHP)**, Monday-Friday, 8am-6pm. If you cannot hear or speak well, please call **711**. Upon request, this document can be made available to you in braille, large print, audiocassette, or electronic form. To obtain a copy in one of these alternative formats, please call or write to:

Inland Empire Health Plan
10801 6th St., Rancho Cucamonga, CA
91730-5987
1-855-433-4347 (IEHP) (TTY: 711)

HOW TO FILE A GRIEVANCE

If you believe that IEHP has failed to provide these services or unlawfully discriminated in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, you can file a grievance with IEHP's Civil Rights Coordinator. You can file a grievance by phone, in writing, in person, or electronically:

- By phone: Contact IEHP's Civil Rights Coordinator between 8am-5pm, by calling **1-855-433-4347 (IEHP)**. Or, if you cannot hear or speak well, please call TTY: **711**.
- In writing: Fill out a complaint form or write a letter and send it to:
IEHP Civil Rights Coordinator
10801 6th St., Rancho Cucamonga, CA 91730-5987

- In person: Visit your doctor's office or IEHP and say you want to file a grievance.
- Electronically: Visit IEHP Covered's website at ***IEHP.org***.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-855-433-4347 (IEHP)** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's internet website ***www.dmhca.gov*** has complaint forms, IMR application forms and instructions online.

OFFICE OF CIVIL RIGHTS – U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

If you believe you have been discriminated against on the basis of race, color, national origin, age, disability or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- By phone: Call **1-800-368-1019**. If you cannot speak or hear well, please call **TTY/TDD 1- 800-537-7697**.
- In writing: Fill out a complaint form or send a letter to:
U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201

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

- Electronically: Visit the Office for Civil Rights Complaint Portal at ***https://ocrportal.hhs.gov/ocr/portal/lobby.jsf***



TAGLINES

English Tagline

ATTENTION: If you need help in your language call **1-855-433-4347** (TTY: **1-800-718-4347**). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call **1-855-433-4347** (TTY: **1-800-718-4347**). These services are free of charge.

الشعار بالعربية (Arabic)

يُرجى الانتباه: إذا احتجت إلى المساعدة بلغتك، فاتصل بـ **1-855-433-4347** (TTY: **1-800-718-4347**). تتوفر أيضًا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة بريل والخط الكبير. اتصل بـ **1-855-433-4347** (TTY: **1-800-718-4347**). هذه الخدمات مجانية.

Հայերեն պիտակ (Armenian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Եթե Ձեզ օգնություն է հարկավոր Ձեր լեզվով, զանգահարեք **1-855-433-4347** (TTY: **1-800-718-4347**): Կան նաև օժանդակ միջոցներ ու ծառայություններ հաշմանդամություն ունեցող անձանց համար, օրինակ՝ Բրայլի գրատիպով ու խոշորատառ տպագրված նյութեր: Չանգահարեք **1-855-433-4347** (TTY: **1-800-718-4347**): Այդ ծառայություններն անվճար են:

ឃ្លាសម្គាល់ជាភាសាខ្មែរ (Cambodian)

ចំណាំ: បើអ្នក ត្រូវ ការជំនួយ ជាភាសា របស់អ្នក សូម ទូរស័ព្ទទៅលេខ 1-855-433-4347 (TTY: 1-800-718-4347)។ ជំនួយ នឹង សេវាកម្ម សម្រាប់ ជនពិការ ដូចជាឯកសារសរសេរជាអក្សរធំ សម្រាប់ជនពិការភ្នែក ឬឯកសារសរសេរជាអក្សរពុម្ព ក៏អាចរកបានផងដែរ។ ទូរស័ព្ទមកលេខ 1-855-433-4347 (TTY: 1-800-718-4347)។ សេវាកម្មទាំងនេះមិនគិតថ្លៃឡើយ។

简体中文标语 (Simplified Chinese)

请注意：如果您需要以您的母语提供帮助，请致电 **1-855-433-4347** (TTY: **1-800-718-4347**)。我们另外还提供针对残疾人士的帮助和服务，例如盲文和大字体阅读，提供您方便取用。请致电 **1-855-433-4347** (TTY: **1-800-718-4347**)。这些服务都是免费的。

مطلب به زبان فارسی (Farsi)

توجه: اگر می‌خواهید به زبان خود کمک دریافت کنید، با **1-855-433-4347** (TTY: **1-800-718-4347**) تماس بگیرید. کمکها و خدمات مخصوص افراد دارای معلولیت، مانند نسخه‌های خط بریل و چاپ با حروف بزرگ، نیز موجود است. با **1-877-273-4347** (TTY: **1-800-718-4347**) تماس بگیرید. این خدمات رایگان ارائه می‌شوند.

हिंदी टैगलाइन (Hindi)

ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है तो 1-855-433-4347 (TTY: 1-800-718-4347) पर कॉल करें। अशक्तता वाले लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में भी दस्तावेज़ उपलब्ध हैं। 1-855-433-4347 (TTY: 1-800-718-4347) पर कॉल करें। ये सेवाएं नि: शुल्क हैं।

Nge Lus Hmoob Cob (Hmong)

CEEB TOOM: Yog koj xav tau kev pab txhais koj hom lus hu rau **1-855-433-4347** (TTY: **1-800-718-4347**). Muaj cov kev pab txhawb thiab kev pab cuam rau cov neeg xiam oob qhab, xws li puav leej muaj ua cov ntawv su thiab luam tawm ua tus ntawv loj. Hu rau **1-855-433-4347** (TTY: **1-800-718-4347**). Cov kev pab cuam no yog pab dawb xwb.

日本語表記 (Japanese)

注意日本語での対応が必要な場合は **1-855-433-4347** (TTY: **1-800-718-4347**) へお電話ください。点字の資料や文字の拡大表示など、障がいをお持ちの方のためのサービスも用意しています。 **1-855-433-4347** (TTY: **1-800-718-4347**) へお電話ください。これらのサービスは無料で提供しています。

한국어 태그라인 (Korean)

유의사항: 귀하의 언어로 도움을 받고 싶으시면 **1-855-433-4347** (TTY: **1-800-718-4347**) 번으로 문의하십시오. 점자나 큰 활자로 된 문서와 같이 장애가 있는 분들을 위한 도움과 서비스도 이용 가능합니다. **1-855-433-4347** (TTY: **1-800-718-4347**) 번으로 문의하십시오. 이러한 서비스는 무료로 제공됩니다.

ແທກໂລພາສາລາວ (Laotian)

ປະກາດ: ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໃຫ້ໂທຫາເບີ 1-855-433-4347 (TTY: 1-800-718-4347). ຍັງມີຄວາມຊ່ວຍເຫຼືອແລະການບໍລິການສໍາລັບຄົນພິການ ເຊັ່ນເອກະສານທີ່ເປັນອັກສອນນູນແລະມີໂຕພິມໃຫຍ່ ໃຫ້ໂທຫາເບີ 1-855-433-4347 (TTY: 1-800-718-4347). ການບໍລິການເຫຼົ່ານີ້ບໍ່ຕ້ອງເສຍຄ່າໃຊ້ຈ່າຍໃດໆ.

Mien Tagline (Mien)

LONGC HNYOUV JANGX LONGX OC: Beiv taux meih qiemx longc mienh tengx faan benx meih nyei waac nor douc waac daaih lorx taux **1-855-433-4347** (TTY: **1-800-718-4347**). Liouh lorx jauv-louc tengx aengx caux nzie gong bun taux ninh mbuo wuaaic fangx mienh, beiv taux longc benx nzangc-pokc bun hlou mbiutc aengx caux aamz mborqv benx domh sou se mbenc nzoih bun longc. Douc waac daaih lorx **1-855-433-4347** (TTY: **1-800-718-4347**). Naaiv deix nzie Weih gong-bou jauv-louc se benx wang-henh tengx mv zuqc cuotv nyaanh oc.

ਪੰਜਾਬੀ ਟੈਗਲਾਈਨ (Punjabi)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਾਲ ਕਰੋ 1-855-433-4347 (TTY: 1-800-718-4347). ਅਪਾਰਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਮੋਟੀ ਛਪਾਈ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ। ਕਾਲ ਕਰੋ 1-855-433-4347 (TTY: 1-800-718-4347) ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ।

Русский слоган (Russian)

ВНИМАНИЕ! Если вам нужна помощь на вашем родном языке, звоните по номеру **1-855-433-4347** (линия TTY: **1-800-718-4347**). Также предоставляются средства и услуги для людей с ограниченными возможностями, например документы крупным шрифтом или шрифтом Брайля. Звоните по номеру **1-855-433-4347** (линия TTY: **1-800-718-4347**). Такие услуги предоставляются бесплатно.

Mensaje en español (Spanish)

ATENCIÓN: si necesita ayuda en su idioma, llame al **1-855-433-4347** (TTY: **1-800-718-4347**). También ofrecemos asistencia y servicios para personas con discapacidades, como documentos en braille y con letras grandes. Llame al **1-855-433-4347** (TTY: **1-800-718-4347**). Estos servicios son gratuitos.

Tagalog Tagline (Tagalog)

ATENSIYON: Kung kailangan mo ng tulong sa iyong wika, tumawag sa **1-855-433-4347** (TTY: **1-800-718-4347**). Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan, tulad ng mga dokumento sa braille at malaking print. Tumawag sa **1-855-433-4347** (TTY: **1-800-718-4347**). Libre ang mga serbisyonang ito.

แท็กไลน์ภาษาไทย (Thai)

โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ กรุณาโทรศัพท์ไปที่หมายเลข **1-855-433-4347** (TTY: **1-800-718-4347**) นอกจากนี้ ยังพร้อมให้ความช่วยเหลือและบริการต่าง ๆ สำหรับบุคคลที่มีความพิการ เช่น เอกสารต่าง ๆ
ทปเป์ นอักษรเบรลล์และเอกสารที่พิมพ์ด้วยตัวอักษรขนาดใหญ่ กรุณาโทรศัพท์ไปที่หมายเลข **1-855-433-4347** (TTY: **1-800-718-4347**) ไม่มีค่าใช้จ่ายสำหรับบริการเหล่านี้

Примітка українською (Ukrainian)

УВАГА! Якщо вам потрібна допомога вашою рідною мовою, телефонуйте на номер **1-855-433-4347** (TTY: **1-800-718-4347**). Люди з обмеженими можливостями також можуть скористатися допоміжними засобами та послугами, наприклад, отримати документи, надруковані шрифтом Брайля та великим шрифтом. Телефонуйте на номер **1-855-433-4347** (TTY: **1-800-718-4347**). Ці послуги безкоштовні.

Khẩu hiệu tiếng Việt (Vietnamese)

CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của mình, vui lòng gọi số **1-855-433-4347** (TTY: **1-800-718-4347**). Chúng tôi cũng hỗ trợ và cung cấp các dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và chữ khổ lớn (chữ hoa). Vui lòng gọi số **1-855-433-4347** (TTY: **1-800-718-4347**). Các dịch vụ này đều miễn phí.