



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

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible ?	Yes.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	Not Applicable.	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit ?	Not Applicable.	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider ?	Yes. For a list of preferred providers, visit www.iehp.org or call 1-855-433-4347.	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	Yes. Requires written prior authorization .	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	No charge	None.
	Specialist visit	No charge	No charge	Requires prior authorization .
	Preventive care/screening/immunization	No charge	No charge	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	No charge	Requires physician order. Requires prior authorization .
	Imaging (CT/PET scans, MRIs)	No charge	No charge	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.iehp.org	Tier 1 - Generic drugs	No charge	No charge	Supply/order: up to 30-day (retail); 30-100 day (mail order), except where quantity limits apply. Specialty Supply/order: up to a 30-day supply filled by specialty pharmacy. Prior authorization is required for select drugs.
	Tier 2- Preferred brand drugs	No charge	No charge	
	Tier 3 - Non-preferred brand drugs	No charge	No charge	
	Tier 4 - Specialty drugs	No charge	No charge	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	No charge	Requires prior authorization .
	Physician/surgeon fees	No charge	No charge	None.

If you need immediate medical attention	Emergency room care	No charge	No charge	Out-of-network services must meet the criteria for emergency care.
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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	No charge	No charge	Out-of-network services must meet the criteria for emergency care.
	Urgent care	No charge	No charge	Out-of-network Urgent care services are covered while you are out of the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	No charge	Requires prior authorization .
	Physician/surgeon fees	No charge	No charge	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	No charge	Requires prior authorization except for the initial behavioral health assessment.
	Inpatient services	No charge	No charge	
If you are pregnant	Office visits	No charge	No charge	Cost sharing does not apply for preventive services . Coverage includes abortion services.
	Childbirth/delivery professional services	No charge	No charge	
	Childbirth/delivery facility services	No charge	No charge	
If you need help recovering or have other special health needs	Home health care	No charge	No charge	Limited to 100 visits each calendar year. Requires prior authorization .
	Rehabilitation services	No charge	No charge	Requires prior authorization .

	Habilitation services	No charge	No charge	Requires prior authorization .
	Skilled nursing care	No charge	No charge	Limited to 100 days per calendar year. Requires prior authorization .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP Provider (You will pay the most)	
	Durable medical equipment	No charge	No charge	Requires prior authorization .
	Hospice services	No charge	No charge	Requires prior authorization .
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Limited to 1 visit per year.
	Children's glasses	No charge	No charge	Selected frames; 1 per calendar year; contact lenses covered in lieu of glasses.
	Children's dental check-up	No charge	No charge	1 routine preventive exam/6 months.

Excluded Services & Other Covered Services:

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

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

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

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| • Abortion services | • Acupuncture | • Bariatric surgery |
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Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

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

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

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

- IEHP at 1-855-433-4347 (TTY 711), Monday-Friday, 8:00am to 6:00pm PST. Give your Member ID number, your name and the reason for your complaint.
- By mail: Call IEHP at 1-855-433-4347 (TTY 711), Monday-Friday, 8:00am to 6:00pm PST, and ask to have a form sent to you. When you get the form, fill it out. Be sure to include your name, Member ID number and the reason for your complaint. Tell us what happened and how we can help you.
Mail the form to:
IEHP
Attention: Grievance and Appeals Department
P.O. Box 1800
Rancho Cucamonga, CA 91729-1800
- Your doctor's office will have complaint forms available.
- Online: visit the IEHP website at www.iehp.org

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

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Not Applicable

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

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

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

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

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

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

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About these Coverage Examples:



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

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$0
■ Specialist copayment	\$0
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (*ultrasounds and blood work*)
[Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$60

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$0
■ Specialist copayment	\$0
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)
[Diagnostic tests](#) (*blood work*)
[Prescription drugs](#)
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$20

Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
■ Specialist copayment	\$0
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:

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

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$0

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