Inland Empire Health Plan – Covered California Plans
Schedule of Benefits

Covered California Bronze 60 HMO Plan

This Schedule of Benefits ("SOB") is part of the Evidence of Coverage ("EOC") and shows the amount that You will pay for Covered Services under this benefit plan. Please refer to both documents for a complete description of provisions, benefits, exclusions, prior authorization requirements and other important facts about this benefit plan.

The SOB shows the Copayments (fixed dollar amounts) and Coinsurance (percentage amounts) that You must pay for this Plan's Covered Services and supplies.

You must pay the stated fixed dollar Copayments at the time You get the services. Percentage Coinsurance amounts are usually billed after services are received.

There is a limit to the amounts You must pay in a Calendar Year. Refer to the "Out-of-Pocket Maximum" section to learn more.

For some services and supplies under this Plan, a Calendar Year Deductible applies. You must pay certain amounts for Covered Services that are subject to the Deductible.

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. Please refer to the "Telehealth/Virtual Services" definition in the "Definitions" section to learn more.

Calendar Year Deductible For Certain Services

In any Calendar Year, You must pay certain amounts for medical services subject to the Deductible until You meet one of the Deductible amounts below:

Medical Deductible, per Member	$6,300
Medical Deductible, per Family	$12,600

Pharmacy Deductible, per Member	$500
Pharmacy Deductible, per Family	$1000

- The Calendar Year Deductible is required for certain medical services and is applied to the Out-of-Pocket Maximum. You must pay an amount of covered expenses for these services equal to the Calendar Year Deductible shown above before the benefits are paid by Your Plan. After the Deductible is satisfied, You remain financially responsible for paying any other applicable cost share until You meet the Individual or Family Out-of-Pocket Maximum. 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.
- The Calendar Year Deductible does not apply to Pediatric Vision or Pediatric Dental services.
- The Calendar Year Deductible applies unless noted below.
- The Calendar Year Deductible does not apply to Preventive Care Services.

Calendar Year Out-of-Pocket Maximum

The Out-of-Pocket Maximum ("OOPM") amounts below are the maximum amounts You must pay for Covered Services during a particular Calendar Year, except as described in "Exceptions to OOPM" below.

Once the total amount of all Deductibles, Copayments, and Coinsurance You pay for Covered Services and supplies under this EOC in any one Calendar Year equals the Out-of-Pocket Maximum amount, no payment for Covered Services and supplies may be imposed on any Member. Your payments for services or supplies that this plan does not cover will not be applied to the OOPM amount.

OOPM, per Member	$9,100
OOPM, per Family	$18,200

- If a Member pays cost share amounts for Covered Services and supplies in a Calendar Year that equal the OOPM amount shown above for a Member, no further payment is required for that Member for the rest of the Calendar Year.
- Once an individual Member in a Family satisfies the individual OOPM, the remaining enrolled Family Members must continue to pay cost share and the Calendar Year Deductibles until either (a) the aggregate of such Copayments and Deductibles paid by the Family reaches the Family OOPM or (b) each enrolled Family Member individually satisfies the individual OOPM.
- If amounts for Covered Services and supplies paid for all enrolled Members equal the OOPM amount shown for a Family, no further payment is required from any enrolled Member of that Family for the rest of the Calendar Year for those services. (NOTE: For the Family OOPM to apply, all Family Members must be enrolled under a single Subscriber. Family Members enrolled as separate Subscribers are each subject to the one Member 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 for Yourself that would otherwise apply to Your individual OOPM but exceeds the above stated OOPM amount for one Member will be refunded to You by IEHP and will not apply toward Your Family's OOPM. Individual members cannot give more than their individual OOPM amount to the Family OOPM.
- You will be notified by us when You have reached Your OOPM amount for the Calendar Year. You can also get an update on Your OOPM accumulation by visiting IEHP's website at www.iehp.org or by calling the Member Services at the phone number on Your ID card. Please keep a copy of all receipts and canceled checks for costs for Covered Services and supplies as proof of payments made.

Other Charges

Emergency or Urgent Care in an Emergency Room or Urgent Care Facility

Benefit	Member Pays
Emergency room facility	40% Coinsurance /visit subject to deductible
Emergency room physician	$0 Copayment not subject to deductible
Urgent care center or facility	$60 Copayment/visit not subject to deductible for first 3 non-preventive office visits, combined with primary care, specialty care, or urgent care. $60 Copayment/visit subject to deductible for subsequent visits.

Copayment Exceptions:

- If You are admitted to a Hospital as an inpatient directly from the emergency room, the emergency room facility Copayment will not apply.
- If You get care from an urgent care center owned and operated by Your Primary Care Physician ("PCP"), the urgent care Copayment will apply.
- For emergency care in an emergency room or urgent care center, You are required to pay only the Copayment amounts required under this plan as described above. Refer to "Ambulance Services" below for emergency medical transportation Copayment.

Ambulance Services – Medical, Mental Health, and Substance Use Disorders

Benefit	Member Pays
Ground ambulance	40% Coinsurance /transport subject to deductible
Air ambulance	40% Coinsurance /transport subject to deductible

To learn more about ambulance services coverage, refer to the “Ambulance Services” portions of the “Plan Benefits” section, and the “Exclusions and Limitations” section.

Office Visits

Benefit	Member Pays
Primary Care Physician (“PCP”) office visit	$60 Copayment/visit not subject to deductible for first 3 non-preventive office visits, combined with primary care, specialty care, or urgent care. $60 Copayment/visit subject to deductible for subsequent visits.
Other Practitioner (includes nurse practitioners, physician assistants, physical therapists, acupuncture therapists)	$60 Copayment/visit not subject to deductible for first 3 non-preventive office visits, combined with primary care, specialty care, or urgent care. $60 Copayment/visit subject to deductible for subsequent visits.
Specialist office visit	$95 Copayment/visit not subject to deductible for first 3 non-preventive office visits, combined with primary care, specialty care, or urgent care. $95 Copayment/visit subject to deductible for subsequent visits.
Hearing exam for diagnosis or treatment	$60 Copayment/visit subject to deductible
Physician visit to a Member's home (at the discretion of the Physician in accordance with the rules and criteria established by IEHP)	$60 Copayment/visit subject to deductible
Specialist visit to a Member's home (at the discretion of the Physician in accordance with the rules and criteria established by IEHP)	$95 Copayment/visit subject to deductible

- Self-referrals are allowed for obstetrician and gynecological services, and reproductive and sexual health care services. (Refer to "Obstetrician and Gynecologist (OB/GYN) Self-Referral" and “Self-Referral for Reproductive and Sexual Health Care Services” portions of the "Plan Benefits" section.)

- The Specialist consultation Copayment applies to services that are performed by a Network Physician who is not Your PCP. When a Specialist is Your PCP, the PCP office visit Copayment will apply to visits to that physician, except as noted below for certain Preventive Care Services. See “Primary Care Physician” in the “Definitions” section to learn more about the types of physicians You can choose as Your Primary Care Physician.

Preventive Care Services

Benefit	Member Pays
Preventive Care Services	$0 Copayment, not subject to deductible

- Covered Services include, but are not limited to, annual preventive physical exams, immunizations, screening and diagnosis of prostate cancer, well-woman exams, preventive services for pregnancy, other women’s preventive services as supported by the Health Resources and Services Administration (HRSA), breast feeding support and supplies and preventive vision and hearing screening exams. Refer to the "Preventive Care Services" portion of the "Plan Benefits" section for details.
- If You get any other Covered Services in addition to Preventive Care Services during the same visit, You will also pay the applicable Copayment for those services.

Laboratory and Diagnostic Services

Benefit	Member Pays
Laboratory services	$40 Copayment/visit not subject to deductible
Diagnostic imaging (including x-ray) services	40% Coinsurance/visit subject to deductible
Advanced imaging (CT, SPECT, MRI, MUGA and PET)	40% Coinsurance/visit subject to deductible

Allergy, Immunizations, and Medical Injections

Benefit	Member Pays
Allergy testing	$95 Copayment subject to deductible
Allergy serum	40% Coinsurance subject to deductible
Allergy injection services	$60 Copayment per day subject to deductible
Immunizations for occupational purposes or foreign travel	Not a Covered Benefit
Medical Injections (excluding injections for Infertility) and office-based injectable medications (per dose)	40% Coinsurance subject to deductible

- Refer to “Preventive Care Services” in this section for Immunizations that are covered under the Preventive Services benefit.

- Certain injectable drugs which are considered self-administered are covered on the Specialty Drug tier under the pharmacy benefit. Specialty Drugs are not covered under the medical benefits even if they are administered in a Physician's office. If You need to have the provider administer the Specialty Drug, You will need to get the Specialty Drug through our contracted specialty pharmacy vendor and bring it with You to the Physician's office. Alternatively, You can coordinate delivery of the Specialty Drug directly to the provider office through our contracted specialty pharmacy vendor. Please refer to the "Tier 4 (Specialty Drugs)" portion of this "Schedule of Benefits" section for the applicable Copayment.

Outpatient Rehabilitation and Habilitation Therapy

Benefit	Member Pays
Physical therapy	$60 Copayment/visit not subject to deductible
Occupational therapy	$60 Copayment/visit not subject to deductible
Speech therapy	$60 Copayment/visit not subject to deductible
Pulmonary therapy	$60 Copayment/visit not subject to deductible
Cardiac therapy	$60 Copayment/visit not subject to deductible
Habilitation therapy	$60 Copayment/visit not subject to deductible

- These services will be covered when Medically Necessary.
- Coverage for physical, occupational and speech rehabilitation and habilitation therapy services is subject to certain conditions as described under "Rehabilitation and Habilitation Therapy" of the "Exclusions and Limitations" section.

Pregnancy and Maternity Services

Benefit	Member Pays
Preventive Prenatal and Postpartum care office visits	$0 Copayment/visit not subject to deductible
Non-Preventive Prenatal and Postpartum care office visit	$60 Copayment/visit subject to deductible
Newborn care office visit (birth through 30 days)	$60 Copayment/visit subject to deductible
Physician visit to the mother or newborn at a Hospital	40% Coinsurance/visit subject to deductible
Professional Services for Normal delivery, including Cesarean section	40% Coinsurance/visit subject to deductible
Other services for Normal delivery, including Cesarean section	40% Coinsurance/visit subject to deductible
Genetic testing of fetus	$40 Copayment/visit subject to deductible
Circumcision of newborn (birth through 30 days)	40% Coinsurance/visit subject to deductible

- Prenatal, postpartum and newborn care that are Preventive Care Services are covered in full. If other non-Preventive Care Services are received during the same office visit, the above cost share will apply for the non-Preventive Care Services. Refer to "Preventive Care Services" and "Pregnancy" under "Plan Benefits."
- The above cost share amounts apply to the noted professional services only. Care that is rendered in a Hospital or in an outpatient surgery setting is also subject to the applicable inpatient and outpatient professional and facility cost share. Refer to "Hospital Visits by Physician," "Other Professional Services," "Inpatient Hospital Services" and "Outpatient Facility Services" to determine any additional cost share that may apply.
- Circumcisions for Members age 31 days and older are covered when Medically Necessary under outpatient surgery. Refer to "Other Professional Services" and "Outpatient Facility Services" for applicable cost share. For Hospitals that do not separate charges for inpatient facility and inpatient professional services, the inpatient facility fee applies. Look under the "Inpatient Hospital Services" heading to determine any cost share that may apply.

Family Planning Professional Services

Benefit	Member Pays
Sterilization of female	$0 Copayment not subject to deductible
Sterilization of male	$0 Copayment not subject to deductible

- Sterilization of females and women's contraception methods and counseling, as supported by HRSA guidelines, are covered under "Preventive Care Services" in this section.
- The above cost shares apply to professional services only. Care that is rendered in a Hospital or in an outpatient surgery setting is also subject to the applicable facility cost share. Look under the "Inpatient Hospital Services" and "Outpatient Facility Services" headings to determine any additional cost share that may apply.
- For Hospitals that do not separate charges for inpatient facility and inpatient professional services, the inpatient facility fee applies. Look under the "Inpatient Hospital Services" heading to determine any additional cost share that may apply.

Other Professional Services

Benefit	Member Pays
Surgery	40% Coinsurance/visit subject to deductible
Assistance at surgery	40% Coinsurance/visit subject to deductible
Hospital visits by Physician	40% Coinsurance/visit subject to deductible
Administration of anesthetics	40% Coinsurance/visit subject to deductible
Chemotherapy	40% Coinsurance/visit subject to deductible
Radiation therapy	40% Coinsurance/visit subject to deductible
Nuclear medicine (use of radioactive materials)	40% Coinsurance/visit subject to deductible
Renal dialysis	40% Coinsurance/visit subject to deductible
Organ, tissue, or stem cell transplant	40% Coinsurance/visit subject to deductible
Infusion therapy in a home, outpatient or office setting	40% Coinsurance/visit subject to deductible
Wound Care	40% Coinsurance/visit subject to deductible
Patient education for diabetes, weight management and smoking cessation	$0 Copayment not subject to deductible

- The above cost shares apply to professional services only. Care that is rendered in a Hospital or in an outpatient surgery setting is also subject to the applicable facility cost share. Look under the "Inpatient Hospital Services" and "Outpatient Facility Services" headings to determine any cost share that may apply.
- Surgery includes surgical reconstruction of a breast incident to a mastectomy, including surgery to restore symmetry, also includes prosthesis and treatment of physical complications at all stages of mastectomy, including lymphedema.
- For Hospitals that do not separate charges for inpatient facility and inpatient professional services, the inpatient facility fee applies. Look under the "Inpatient Hospital Services" heading to determine any cost share that may apply.
- Covered health education counseling for diabetes, weight management and smoking cessation, including programs provided online and counseling over the phone, are covered as preventive care and have no cost sharing. However, if other medical services are provided that are not solely for the purpose of covered health education counseling, the related cost share will apply.

Medical Supplies

Benefit	Member Pays
Durable Medical Equipment, nebulizers, face masks and tubing	40% Coinsurance/visit subject to deductible
Orthotics (such as bracing, supports and casts)	40% Coinsurance/visit subject to deductible
Diabetic Equipment	40% Coinsurance/visit subject to deductible
Corrective Footwear	40% Coinsurance/visit subject to deductible
Skin grafts and tissue replacement	40% Coinsurance/visit subject to deductible
Prostheses (internal or external)	40% Coinsurance/visit subject to deductible
Cranial Prostheses (Wigs)	40% Coinsurance/visit subject to deductible
Blood or blood products, including blood factors not obtained through Prescription Drug benefit.	40% Coinsurance/visit subject to deductible

- Breastfeeding devices and supplies, as supported by HRSA guidelines, are covered under “Preventive Care Services”. For more details, please refer to the "Preventive Care Services" provision in the “Plan Benefits” section.
- Medically necessary corrective footwear is covered.
- Ostomy and urological supplies are covered items. See “Ostomy and Urological Supplies” portion of “Plan Benefits”.
- Cranial Prostheses (wigs) following chemotherapy and/ or radiation therapy services, burns, or for Members who suffer from alopecia are covered and are subject to one wig per Calendar Year. No other coverage will be provided for wigs. Hair transplantation, hair analysis and hairpieces are not covered.
- Drugs for the treatment of hemophilia, including blood factors, are considered self-injectable drugs and covered as a Tier 4 Specialty Drug under the Prescription Drug benefit.

Home Health Services

Benefit	Member Pays
Home Health Care Services	40% Coinsurance/visit subject to deductible

- Limited to 100 visits per Calendar Year.

Hospice Services

Benefit	Member Pays
Hospice Care	$0 Copayment not subject to deductible

Inpatient Hospital Services

Benefit	Member Pays
Room and board in a semiprivate or private room or special care unit including ancillary (additional) services	40% Coinsurance subject to deductible
Mental Health Physician visit to Hospital, Behavioral Health Facility or Residential Treatment Center	40% Coinsurance subject to deductible
Inpatient Services at a Hospital, Behavioral Health Facility or Residential Treatment Center	40% Coinsurance subject to deductible
Detoxification	40% Coinsurance subject to deductible

- The above Coinsurance applies to facility services only. Care that is rendered in a Hospital is also subject to the professional services cost share. Refer to "Pregnancy and Maternity Services" and "Other Professional Services" headings to determine any additional cost share that may apply.
- The above Coinsurance for inpatient Hospital services or Special Care Unit services is applicable for the hospitalization of an adult, pediatric or newborn Member. For an inpatient stay for the delivery of a newborn, the newborn will not be subject to a separate Coinsurance for inpatient Hospital services unless the newborn Member requires admission to a Special Care Unit or requires a length of stay greater than 2 days for vaginal delivery or 4 days for caesarean section.

Outpatient Facility Services

Benefit	Member Pays
Outpatient surgery facility (surgery performed in a hospital outpatient setting or Outpatient Surgical Center)	40% Coinsurance subject to deductible
Outpatient facility services (other than surgery	40% Coinsurance subject to deductible

- The above Coinsurance applies to outpatient facility services only. Care that is rendered in an outpatient surgery setting is also subject to the professional services cost share. Look under the "Pregnancy and Maternity Services," "Family Planning" and "Other Professional Services" headings to determine any additional cost share that may apply.
- Other professional services performed in the outpatient department of a hospital, such as a visit to a Physician (office visit), lab and X-ray services, physical therapy, etc. are subject to the same cost share which is required when these services are performed at Your Physician's office. Look under the headings for the various services such as office visits, rehabilitation, and other professional services to determine any additional cost share that may apply.

- Screening colonoscopy and sigmoidoscopy procedures (for the purposes of colorectal cancer screening) will be covered under the "Preventive Care Services" section above. Diagnostic endoscopic procedures (except screening colonoscopy and sigmoidoscopy), performed in an outpatient facility require the cost share applicable for outpatient facility services (other than surgery).

Skilled Nursing Facility Services

Benefit	Member Pays
Room and board in a semiprivate or private room with ancillary (additional) services	40% Coinsurance subject to deductible

- Skilled Nursing Facility services are limited to 100 days per Calendar Year for each Member.

Outpatient Mental Health and Substance Use Disorder Services

Benefit	Member Pays
Outpatient office visit/professional consultation (psychological evaluation or therapeutic session in an office setting, medication management and drug therapy monitoring)	$60 Copayment/visit not subject to deductible
Outpatient group therapy session	$30 Copayment/visit not subject to deductible
Outpatient services other than an office visit/professional consultation (psychological and neuropsychological testing, other outpatient procedures, outpatient detoxification, intensive outpatient care program, day treatment and partial hospitalization).	$60 Copayment/visit not subject to deductible
Mental Health Professional visit to a Member's home	$60 Copayment/visit not subject to deductible

- Each group therapy session counts as one half of a private office visit for each Member participating in the session.
- Inpatient visits by Network Mental Health Professionals other than physicians are included in the Inpatient Services facility fee.
- If two or more Members in the same Family attend the same outpatient treatment session, only one Copayment will be applied.

Prescription Drugs

Retail Pharmacy Benefit (up to a 30-day supply)	Member Pays
Tier 1 Drugs (most Generic Drugs and low cost preferred Brand Name Drugs)	$17 Copayment/script subject to the pharmacy deductible
Tier 2 Drugs (non-preferred generic and preferred Brand Name Drugs)	40% Coinsurance up to $500/script subject to the pharmacy deductible
Tier 3 Drugs (non-preferred Brand Name Drugs)	40% Coinsurance up to $500/script subject to the pharmacy deductible
Tier 4 (Specialty Drugs)	40% Coinsurance up to $500 per script subject to the pharmacy deductible
Preventive drugs and women's contraceptives	$0 Copayment, not subject to pharmacy deductible

Mail-Order Pharmacy Benefit for Maintenance Formulary Drugs (up to a 100-day supply)	Member Pays
Tier 1 Drugs (most Generic Drugs and low cost preferred Brand Name Drugs)	$34 Copayment/script subject to the pharmacy deductible
Tier 2 Drugs (non-preferred generic and preferred Brand Name Drugs)	40% Coinsurance up to $1000/script subject to the pharmacy deductible
Tier 3 Drugs (non-preferred Brand Name Drugs)	40% Coinsurance up to $1000/script subject to the pharmacy deductible
Preventive drugs and women's contraceptives	$0 Copayment, not subject to pharmacy deductible

- Copayments above apply to formulary drugs. Non-formulary drugs are covered as an exception and Tier 3 Copayments will apply.
- You will be charged a Copayment per Prescription Drug. If the pharmacy's or mail order administrator's retail price is less than the applicable Copayment, the Member will only pay the pharmacy's retail price or the mail order administrator's retail price.
- Your financial responsibility for covered Prescription Drugs varies by the type of drug dispensed. For a complete description of Prescription Drug benefits, exclusions and limitations, please refer to the "Prescription Drugs" portion of the "Plan Benefits" and the "Exclusions and Limitations" sections.
- Coinsurance will be based on IEHP's contracted pharmacy rate.
- Regardless of prescription drug tier, Generic Drugs will be dispensed when a Generic Drug equivalent is available. IEHP will cover Brand Name drugs, including Specialty Drugs, that have generic equivalents only when the Brand Name Drug is Medically Necessary and the Physician obtains Prior Authorization from IEHP.
- Prior Authorization may be required. Refer to the "Prescription Drugs" portion of the "Plan Benefits" section for a description of Prior Authorization requirements or visit our website at www.iehp.org to get a list of drugs that require Prior Authorization.

- Specialty drugs may be required through a specialty pharmacy vendor. The Tier 4 Specialty drug Copayments will include non-formulary Specialty drugs that are covered as an exception.
- Orally administered anti-cancer drugs will have a Copayment maximum of $250 for an individual prescription of up to a 30-day supply.

Pediatric Vision Services

Benefit	Member Pays
Routine eye exam with dilation	$0 Copayment not subject to deductible
Exam for Contact Lenses (lens fit and follow-up)	$0 Copayment not subject to deductible
Standard Frames and lenses (one pair every 12 months)	$0 Copayment not subject to deductible
Standard and Premium Contact lenses in lieu of eyeglass lenses	$0 Copayment not subject to deductible
Low vision testing and equipment (exam every 5 years)	$0 Copayment not subject to deductible

- Pediatric vision services are covered until the last day of the month in which the Member turns nineteen years of age.
- All Covered Services must be provided by an IEHP Network Vision Provider. Refer to the "Pediatric Vision Services" portion of "Exclusions and Limitations" for limitation on covered pediatric vision services.
- Limited one complete vision exam once every calendar year.
- Exam for contact lenses is in addition to the Member's vision exam. There is no additional Copayment for up to two contact lens follow-up visits after the initial fitting exam.
- Benefits may not be combined with any discounts, promotional offerings or other group benefit plans. Allowances are one time use benefits. No remaining balance.
- Coverage includes standard plastic or glass eyeglass lenses (single vision, bifocal, trifocal, lenticular) and standard lens enhancements (polycarbonate impact-resistant, UV coating, scratch resistant, and progressive lenses).
- Standard frames or standard/premium contact lenses have a maximum benefit allowance of $150. You are responsible for costs above $150.
- Standard contact lens includes hard or soft, spherical and daily wear contact lenses. Premium contact lens includes toric, bifocal, multifocal, cosmetic color, post-surgical and gas permeable contact lenses; there is a maximum benefit allowance of $60 for premium contact lenses.
- One low vision device is covered per Calendar Year.

Pediatric Dental Services

Benefit	Member Pays
Diagnostic and Preventive Services – Oral exam, preventive cleaning and x-rays, sealants per tooth, topical fluoride application, fixed space maintainers	$0 Copayment not subject to deductible
Basic Services – restorative procedures, periodontal maintenance services	Refer to Dental Summary of Benefits and 2024 Dental Copayment Schedule
Major Services – crowns, casts, endodontics, periodontics other than maintenance, prosthodontics, oral surgery	Refer to Dental Summary of Benefits and 2024 Dental Copayment Schedule
Child Orthodontics – medically necessary orthodontics	$1,000 Copayment not subject to deductible

- Pediatric dental services are covered until the last day of the month in which the Member turns nineteen years of age.
- All Covered Services must be provided by an IEHP Network Dental Provider. Refer to the "Dental Summary of Benefits" for detailed benefit information and limitations on covered pediatric dental services.
- If You have purchased a separate, supplemental pediatric dental benefit plan, pediatric dental benefits covered under this plan will be paid first, with the supplemental pediatric dental benefit plan covering non-Covered Services and/or cost sharing as described in Your supplemental pediatric dental benefit plan coverage document.
- A Network Dental Provider may charge You his or her usual and customary rate for dental services that are not Covered Services under this plan. Before rendering these services, the dentist should disclose the services to be provided and the estimated cost of each service.

Acupuncture Services

Benefit	Member Pays
New patient exam	$60 Copayment/visit subject to deductible
Each subsequent visit	$60 Copayment/visit subject to deductible
Re-exam visit	$60 Copayment/visit subject to deductible
Second opinion	$60 Copayment/visit subject to deductible

- IEHP contracts with American Specialty Health Plans of California, Inc. ("ASH Plans") to provide acupuncture benefits. You can select a Network Acupuncturist from the ASH Plans Contracted Acupuncturist Directory.
- If the re-evaluation occurs during a subsequent visit, only one Copayment will be required.

Acupuncture Services, typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain, are covered when Medically Necessary.

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

Covered California Bronze 60 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.

Jarrod McNaughton
CEO

IEHP
P.O. Box 1800
Rancho Cucamonga, CA 91729
1-855-433-IEHP (4347) or TTY 711

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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 Effective Date of this EOC. After that, full payment is due on or before the first day of each coverage month while the EOC is in effect.

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: monthly automatic deduction from a personal checking account, check, cashier's check, money order, 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.

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 first day of the month for which plan premiums are due, 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. 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 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 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, 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.

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 request must be received by the 20th day of the month to be effective the first day of the next month. If the request is received after the 20th day of the month, the change may not be effective until the first day of the following month.

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 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.

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 a Covered California plan prior to enrollment with IEHP. 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.

Continuity of Care – for Existing Member from a Terminated Provider

If IEHP's contract with a Physician or other provider is terminated, 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.

Members who are in a course of treatment from a now terminated provider and meet any of the conditions below can submit a Continuity of Care Request.
You were getting care from a provider for any of these conditions:

- An acute condition.
- A serious chronic condition within twelve months from the Member's Effective Date under this Plan.
- A pregnancy (including the duration of the pregnancy and immediate postpartum care).
- Maternal mental health, not to exceed 12 months from the diagnosis or from the end of the pregnancy, whichever occurs later.
- A newborn up to 36 months of age not to exceed twelve months from Your Effective Date under this Plan.
- A terminal illness (for the duration of the terminal illness).
- A surgery or other procedure that has been authorized by Your prior Covered California health plan as part of a documented course of treatment.

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 this time. 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.

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).

IEHP may provide coverage for completion of services from a provider whose contract has been terminated, subject to cost share and any other limitations of this Plan. The provider must be willing to accept the same contract terms applicable to the provider prior to the contract termination. You must request continued care within 30 days of the provider's date of termination, unless You can show that it was not reasonably possible to make the request within this time.

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. Other services that might need a referral include in-office procedures:

- X-rays
- Lab work
- Physical therapy
- EKG
- EEG
- Medical social services
- Home health care

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 48 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 Mental Health or Substance Use Disorder service is not available in network within geographic and timely access standards, IEHP will arrange out-of-network and follow-up services.

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
- Outpatient Mental Health and Substance Use Care
- 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.

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
- Diagnosis and treatment of sexual transmitted disease ("STD")
- Medical care due to rape or sexual assault, including collection of medical evidence
- 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 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 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 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 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.

Please call IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711), 7 days per week, 24 hours per day to access triage or screening services. If You reach IEHP Member Services after hours, You will be able to leave a voice message. IEHP Member services telephone wait times during normal business hours:

- Calls received after normal business hours (Monday – Friday, 7am-7pm) are returned within one (1) business day.
- Calls received after midnight are responded to the same business day.

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

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. It is important that both You and Your PCP 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 are sick and cannot reach Your doctor, You can call IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711). You can also 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.

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

Emergency and Urgent 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 care services received in the emergency room of a Hospital 24 hours a day, 7 days a week. Emergency room Member Copayment is waived if You are admitted to the hospital. Emergency care 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
- Broken bones

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). 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.

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 or authorized by IEHP to be performed by others.

Urgent Care <u>within the Service Area</u> and all non-Emergency Care -- Services must be performed by Your PCP, Network urgent care provider, Network Mental Health Professional or authorized by IEHP in order to be covered. These services performed by non-contracted providers, will not be covered unless they are authorized by IEHP.

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 and all Emergency Care (including care outside of California) – Covered Services by non-contracted providers will be covered if the facts demonstrate that You require Emergency or Urgent Care. Authorization is not mandatory to secure coverage.

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.

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. Access claim forms online at iehp.org. Please submit Your claim form and medical records within one year of the service date.

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.

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 to get claim forms.

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-hours.

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 Behavioral Health and Care Management Team (BHCMT) can help You if have a serious illness, like heart disease, lung disease, kidney disease, AIDS, Hepatitis C, spinal injury, or other chronic problems. The IEHP CMT can help You manage Your condition and medicines, coordinate Your care by working with Your doctors, and can help You get any needed medical equipment. 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 program such as:

- A Medical Management Referral (example: A nurse from IEHP's Nurse Advice Line thinks You would benefit from the program).
- A Discharge Planner Referral (example: If You are being discharged from a hospital and have many complicated needs).

- A Member or Caregiver Referral (example: You can call IEHP to ask for a Complex Care Manager's help).
- A Practitioner Referral (example: Your doctor can make a referral on Your behalf).
- Call IEHP Member Services if You are interested in enrolling or feel that You or Your caregiver would benefit from being in the program or talk to Your doctor if You would like to learn more about this no-cost Complex Care Management Program, speak with Your ICT, create a personal plan of care, or if You just need help with Your health care. Call IEHP Member Services at 1-855-433-IEHP (4347) (TTY 711), Monday–Friday, 7am–7pm, and Saturday–Sunday, 8am–5pm.

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.
- 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 January 31st of the following year. For enrollments received from November 1st through December 31st coverage will begin on January 1st. For enrollments received from January 1 through January 31st, coverage will begin on February 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 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 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 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.

Special Enrollment Periods

In addition to the Open Enrollment period, 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.
- Disenrolled from a prior health plan due to mistakes made by a prior health plan.
- Were receiving services under another health plan from a contracting provider, who no longer participates in that health plan, for any of these 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 contracts 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.
- Become a dependent of an Indian and are enrolled in or are enrolling on the same application as the Indian (You can change from one plan to another one time per month).
- 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.
- Assessed by Covered California as potentially eligible for Medi-Cal and are determined ineligible for such coverage either after open enrollment has ended or more than 60 days after the qualifying event.
- Apply for coverage with Medi-Cal during the annual open enrollment period and are determined ineligible for Medi-Cal after Covered California open enrollment 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 (coverage becomes effective the first of the following month after loss of coverage), not including voluntary termination, loss due to non-payment of premiums or situations allowing for a rescission (fraud or intentional misrepresentation of material fact).
- 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 needy 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.

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 1-855-433-IEHP (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.

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.
    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 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 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 reason for and effective date of the termination.
(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.

Services that are Medically Necessary include only those which have been established as safe and effective and are furnished under generally accepted professional standards to treat illness, injury, or medical condition. These services, as determined by IEHP are:

- Consistent with IEHP medical policy.
- Consistent with the symptoms or diagnosis.
- Not furnished primarily for the convenience of the patient, the attending Physician or other provider.
- And furnished at the most appropriate level that can be provided safely and effectively to the patient.

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 details.

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

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.

Acupuncture
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.

Ambulance

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 care.
- Non-emergency ground ambulance transportation from one medical facility to another when prior authorized by IEHP or Plan contracted provider.
- Non-emergency 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 or Plan contracted physician determines 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.

Air ambulance services are covered at the Network Provider Cost Share, even if You receive services from a Non-Participating Provider.

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.

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 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 will apply for services, testing, and treatment provided by an out-of-network provider.

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.

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.

Diabetes urine-testing supplies and insulin-administration devices:
- Ketone test strips.
- Sugar or acetone test tablets or tapes for diabetes urine testing.
- Lancets and lancet puncture devices.
- Insulin pumps and all related necessary supplies.
- Certain brands of blood glucose monitors and blood glucose testing strips.
- Blood glucose monitors designed to assist the visually impaired.
- Certain brands of pen delivery systems for the administration of insulin, including pen needles, disposable needles and syringes.

These items (as well as insulin and Prescription Drugs for the treatment and management of diabetes) are covered under the Prescription Drug benefits. 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 self-injectables benefit (refer to “Immunization and Injections” 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:
- Renal dialysis.
- Hemodialysis.

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

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.
- 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.

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.

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

This Plan covers Medically Necessary services and supplies for standard fertility preservation treatments for Iatrogenic Infertility. Iatrogenic Infertility is Infertility that is caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment. Standard fertility preservation services are 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.

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.

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
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 and solutions.
- Medical supplies used during a covered visit.
- Medicines injected or administered intravenously.

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 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 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.
- 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.
- 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.

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.

Benefits are available for FDA-approved and United States Public Health Service recommended vaccines for acquired immune deficiency syndrome (AIDS).

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 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).
- Growth hormone treatment.
- 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 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).

- 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.
- 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.

Mental Health and Substance Use Disorder Services
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).

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.

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.

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.

    a. 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.

b. 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.
c. 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.

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.

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.
- 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.
- 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.

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.

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 Covered Services must be provided by a IEHP Network Vision Provider in, TTY 711] order to receive benefits under this plan. Call IEHP Member Services at 1-855-433-IEHP (4347) 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."

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."

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
- 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
- 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.

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.

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 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)
- 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.

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 heath 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 for 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.

- 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.

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 limited to:
- Office visits for exam, diagnosis, counseling, education, consultation, and treatment.
- Specialist office visits.
- 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 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 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 safety/effectively.
- Care in the home if the home setting does not allow safe and effective treatment.

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.

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.

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.

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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.

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.

Prescription Drug Benefits

Covered service expenses and supplies in this benefit subsection are limited to charges from a licensed pharmacy for:

- A covered Formulary prescription drug or one that is prior authorized by IEHP.
- A drug that, under the applicable state law, may be dispensed only upon the written prescription of a medical practitioner in our Network.

Formulary and Tiers
IEHP has a list of covered drugs called a Formulary. The Formulary is updated and posted monthly, and You can find the formulary and updates on our website at iehp.org.
Certain covered drugs have restrictions such as Step Therapy (ST), Quantity Limits (QL), and or require a Prior Authorization (PA).

FDA approved generic drugs will be used in most situations, even when a brand-name drug is available. If Your drug is non-Formulary, or has a restriction, Your doctor will need to submit a request to IEHP. The request can be approved if there is a documented medical need. To see a full list and explanation of the pharmaceutical management procedures and restrictions, visit IEHP's website at iehp.org.

What drugs are covered?
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. 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. You can view the Formulary on IEHP's website at iehp.org.

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:

- Approved prescription drugs.
- Diabetic supplies: Insulin, insulin syringes, glucose test strips, lancets, continuous glucose monitors and associated supplies.
- EpiPens and Anakits.
- Inhaler spacers and extender devices.

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.

Beginning July 1, 2018, the State of California Pharmacy Law AB 1048 authorizes a pharmacist to dispense a Schedule II controlled substance as a partial fill if requested by the patient or the prescriber. The law would require the pharmacy to retain the original prescription, with a notation of how much of the prescription has been filled, the date and amount of each partial fill, and the initials of the pharmacist dispensing each partial fill until the prescription has been fully dispensed. The bill would authorize a pharmacist to charge a professional dispensing fee to cover the actual supply and labor costs associated with dispensing each partial fill associated with the original prescription.

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.

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.

Please refer to the "How to Find a Pharmacy" section for the locations of Network Pharmacies in Your area.

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 are biologics; 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.

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.
    - Test tablets.
- 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.
    - Female over-the-counter contraceptive products when ordered by a Physician.
- Disposable devices that are Medically Necessary for the administration of a covered outpatient prescription Drug such as syringes and inhaler spacers.

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 IEHP's 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 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 urgent requests or 72 hours for standard requests after getting the requested medical information. Urgent 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 or other prescribers must do something before You can fill the prescription. For example, prior approval (or prior authorization): 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 rule 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 Form 61-211 available on IEHP's website at iehp.org. A prior authorization request is urgent when a Member suffers from a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function. Urgent 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 urgent 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" portion of this Evidence of Coverage.

Preventive and Contraceptive

Our plan covers FDA-approved prescription contraceptives or over the counter, including these vaginal, oral, transdermal, and emergency contraceptives devices at a $0 co-pay, such as oral contraceptives, emergency contraception pills, contraceptive rings, contraceptive patches, cervical caps, and diaphragms.

Covered contraceptives are only available with a Prescription Drug Order. You must present the Prescription Drug Order at a participating pharmacy to get such drugs or contraceptives.

Your medical practitioner can request that IEHP authorization 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.

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 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 "Obtaining Specialty Drugs from a Network Specialty Pharmacy" section to learn more. 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 a covered emergency.

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. There is no Copayment or Coinsurance for generic, FDA-approved contraceptive Drugs and devices obtained from a Participating Pharmacy. Brand contraceptives are covered without a Copayment or Coinsurance only when Medically Necessary.

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, 90-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 "Grievances and Appeals Process" provision of the "Coverage Decisions and Disputes Resolution" 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 a covered emergency, You must pay for the prescription in full and then submit a claim form for reimbursement. See the "Claims" section under Your Payment Information to learn more.

Mail Order
You can fill a maintenance medication prescription through our convenient mail order program if it is for a maintenance drug. The term 'maintenance drug' refers to prescription drugs taken continuously to manage chronic or long-term conditions where the Member responds positively to a medication treatment plan required in a constant dosage.

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 90-consecutive-calendar-day supply of a Maintenance Drug.
- 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 90-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.

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.

Prescription Drug Exclusions
Along with any applicable "General Exclusions and Limitations" contained elsewhere in this EOC, the following "Exclusions" shall apply to the coverage described under this section. This section also contains exclusions and limitations for prescription drug coverage. The medical benefits portion of this EOC may cover services or supplies that are excluded from the Prescription Drug coverage.

- Experimental or investigational drugs, unless accepted for use by professionally recognized standards of practice.
- Any requested packaging (such as dose packaging) other than the dispensing pharmacy's standard packaging.
- Compounded products unless the drug is listed on our drug formulary or one of the ingredients requires a prescription by law.
- Drugs prescribed to shorten the duration of the common cold.
- Outpatient oral nutrition, such as dietary supplements, herbal supplements, weight loss aids, formulas, and food unless Medically Necessary for Mental Health /Substance Use Disorder treatment. This exclusion does not apply to any of these items: Amino acid–modified products and elemental dietary enteral formula covered under "Outpatient Drugs, Supplies, and Supplements" in the "Plan Benefits" section Enteral formula covered under "Prosthetic and Orthotic Devices" in the "Plan Benefits" section.
- Services not approved by the Federal Food and Drug Administration: Services that cannot be lawfully marketed without approval of the U.S. Food and Drug Administration ("FDA"), including, but not limited to:
    a. Drugs.
    b. Medicines.
    c. Supplements.
    d. Tests.
    e. Vaccines.
    f. Devices.
    g. Radioactive material.

However, drugs and medicines that have received FDA approval for marketing for one or more uses will not be denied on the basis that they are being prescribed for an off-label use if the conditions set forth in California Health & Safety Code Section 1367.21 have been met.

- Prescription Drugs which are covered by any other benefits provided by this Plan, including any Drugs provided for outpatient infusion therapy, delivered or administered to the patient

by the attending Physician, or billed by a Hospital or Skilled Nursing Facility, are not covered.

- Drugs prescribed for a condition or treatment that is not covered by this Plan. However, the Plan does cover Medically Necessary Drugs for a medical condition directly related to non-Covered Services when complications exceed routine follow-up care (such as life-threatening complications of cosmetic surgery).
- Drugs that by law require Federal Food and Drug Administration ("FDA") approval in order to be sold in the U.S., but are not approved by the FDA, may be covered when Medically Necessary. If a Covered Person has a life threatening or seriously debilitating condition and requests coverage of a non-FDA approved drug for an Experimental or Investigational purpose, he or she is entitled to an Independent Medical Review ("IMR") if IEHP delays, denies, or modifies the coverage. To learn more, please refer to the "Independent Medical Review of Grievances Involving a Disputed Health Care Service" section in this Plan.
- Services or supplies for which the Covered Person is not legally required to pay.
- Services or supplies for which no charge is made.
- Medical equipment and supplies (including insulin), that are available without a prescription, are covered only when prescribed by a Physician for the management and treatment of diabetes, for preventive purposes in accordance with the U.S. Preventive Services Task Force A and B recommendations, or for female contraception. In addition, disposable devices that are Medically Necessary for the administration of a covered outpatient Prescription Drug are covered. No other devices are covered, even if prescribed by a Physician.
- Any other non-prescription Drugs, equipment or supplies which can be purchased without a Prescription Drug Order, even if a Physician writes a Prescription for such drug, equipment or supply unless listed on the Formulary Drug List. These are commonly called over-the-counter Drugs. Insulin is an exception to this rule. However, if a higher dosage form of a non-prescription drug or over-the-counter drug is only available by prescription, that higher dosage drug will be covered.
- Cost sharing paid on Your behalf for any Prescription Drugs obtained by You through the use of a Drug Discount, Coupon, or Copayment Card provided by a Prescription Drug manufacturer will not apply toward Your plan Deductible or Your Out-of-Pocket Maximum. What You actually pay will accrue toward Your Out-Of-Pocket Maximum. Exceptions include:
    a. A Prescription Drug required under a United States Food and Drug Administration Risk Evaluation and Mitigation Strategy for the purpose of monitoring or facilitating the use of that prescription drug in a manner consistent with the approved labeling of the prescription drug.
    b. A single-tablet drug regimen for treatment or prevention of human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS) that is as effective as a multi-tablet regimen, unless, consistent with clinical guidelines and peer-reviewed scientific and medical literature, the multi-tablet regimen is clinically equally effective or more effective and is more likely to result in adherence to the drug regimen.

c. Covered Persons that have completed any applicable step therapy or prior authorization requirements for the branded Prescription Drug as mandated by IEHP. Covered persons who must take a Brand Name Drug rather than its generic equivalent due to Medical Necessity may request and obtain an exception to exclusion from the Deductible and Out-of-Pocket Maximum of cost sharing attributable to a drug manufacturer's coupon for the brand drug.

- Drugs prescribed for cosmetic or enhancement purposes, including and not limited to those intended to treat wrinkles, baldness or conditions of hair loss, athletic performance, anti-aging and cognitive performance are not covered. Examples of these Drugs that are excluded when prescribed for such conditions include, but are not limited to, Latisse, Renova, Vaniqa, Propecia or Lustra. This exclusion does not exclude coverage for Drugs when pre-authorized as Medically Necessary to treat a diagnosed medical condition affecting memory, including but not limited to, Alzheimer's dementia, Medically Necessary Drugs to treat sexual dysfunction and Medically Necessary Drugs to treat obesity.
- Cosmetics and health or beauty aids.
- Drugs used as dietary or nutritional supplements including vitamins and nutritional supplements, including when in combination with a Prescription Drug product, are limited to Drugs (such as folic acid used for preventive care) that are listed in the Formulary Drug List. Phenylketonuria (PKU) is covered under the medical benefit (see the "Phenylketonuria" provision of the "Medical Benefits" section).
- Allergy desensitization products are not covered as Prescription Drugs, whether administered by injection or drops placed in the nose or mouth (transmucosal absorption), for the purpose of treating allergies by desensitization (to lessen or end the person's allergic reactions). (These products are sometimes described as "allergy serum"). Allergy serum is covered as a medical benefit. See the "Visits to a Health Care Provider's Office or Clinic" portion of the "Schedule of Benefits" section and the "Allergy Testing and Treatment" provision in the "Medical Benefits" section.
- Prescription Drugs or medicines delivered or administered to the patient by the attending Physician, or which are billed by a Hospital or Skilled Nursing Facility or are covered under another section of this EOC.
- Hypodermic syringes and needles are limited to specific brands of insulin needles, syringes and specific brands of pen devices. In addition, disposable devices that are Medically Necessary for the administration of a covered outpatient Prescription Drug are covered. Needles and syringes required to administer self-injected medications (other than insulin) will be provided through our Specialty Pharmacy Vendor under the medical benefit. All other syringes and needles are not covered.
- Medications limited by law to Investigational use, prescribed for Experimental purposes or prescribed for indications not approved by the Food and Drug Administration (unless the drug is being prescribed or administered by a licensed health care professional for the treatment of a life-threatening or chronic and seriously debilitating condition) unless independent review deems them appropriate as described in the "Independent Medical Review of Investigational or Experimental Therapies" portion of the "Coverage Decisions and Disputes Resolution" section of this EOC.

- Self-administered injectable Drugs are covered under the Pharmacy benefit. Surgically implanted Drugs are covered under the medical benefit (see the "Surgically Implanted Drugs" provision in the "Medical Benefits" section). However, self-administered injectable Drugs, as described in the Formulary Drug List, are covered.
- Drugs on the Formulary Drug List when Medically Necessary for treating sexual dysfunction are limited to the quantity listed on the Drug List.
- Once the Covered Person has taken possession of Drugs, lost, stolen or damaged Drugs are not covered. The Covered Person will have to pay the retail price for replacing them. However, if a state of emergency is declared by the Governor and You are displaced by the disaster, this exclusion will not apply.
- Schedule II narcotic Drugs are not covered through mail order. Schedule II Drugs are Drugs classified by the Federal Drug Enforcement Administration as having a high abuse risk but also safe and accepted medical uses in the United States.
- Supply amounts for prescriptions that exceed the Food and Drug Administration's (FDA) or IEHP's indicated usage recommendation unless Medically Necessary, and Prior Authorization are obtained from IEHP.
- Some Drugs are subject to specific quantity limitations per Copayment or Coinsurance, whichever is applicable, based on recommendations for use by the FDA or IEHP's usage guidelines. Medications taken on an "as-needed" basis may have a Copayment or Coinsurance based on a specific quantity, standard package, vial, ampoule, tube, or other standard unit. In such a case, the amount of medication dispensed may be less than a 30-consecutive-calendar-day supply. If Medically Necessary, Your Physician may request a larger quantity from IEHP.
- Individual doses of medication dispensed in plastic, unit doses, or foil packages (unit dose packaging) and dosage forms used for convenience, unless Medically Necessary or only available in that form.
- Drugs used for diagnostic purposes are not covered. Diagnostic Drugs are covered under the "Plan Benefits" section when Medically Necessary.
- Irrigation solutions and saline solutions are not covered.

General Exclusions and Limitations

It is very important to read this section before You get services in order to know what IEHP will and will not cover. IEHP does not cover the services or supplies listed below. Also services or supplies that are excluded from coverage in the EOC, exceed EOC limitations or are Follow-up Care (or related to Follow-up Care) to EOC exclusions or limitations, will not be covered. However, the Plan does cover Medically Necessary services for medical conditions directly related to non-Covered Services when complications exceed routine follow-up care (such as life-threatening complications of cosmetic surgery). Please note that an exception may apply to the exclusions and limitations listed below, to the extent a requested service is either a basic health care service under applicable law (see "Regulation" in the "General Provisions" section), or is required to be covered by other state or federal law and is Medically Necessary as defined in the "Definitions" section. Exclusions will not apply to medically necessary services to treat a mental health or substance use disorder.

Ambulance Services
Air and ground ambulance and ambulance transport services are covered as shown in the "Ambulance Services" provision of the "Plan Benefits" section.

Paramedic, ambulance, or ambulance transport services are not covered in these situations:

- If IEHP determines that the ambulance or ambulance transport services were never performed.
- If IEHP determines that the criteria for Emergency Care as defined in "Emergency Care" under the "Definitions" section were not met, as discussed in the "Ambulance Services" provision of the "Plan Benefits" section.
- Upon findings of fraud, incorrect billing, that the provision of services that were not covered under the plan, or that membership was invalid at the time services were delivered for the pending emergency claim.
- Non-emergent ambulance transport services not authorized by IEHP.
- EMT/Paramedic aid on scene services without transport.

Aqua or Water Therapy
Aquatic therapy and other water therapy are not covered, except for aquatic therapy and other water therapy services that are part of a physical therapy treatment plan.

Aversion Therapy
Aversion therapy is not Covered.

Biofeedback Services
Biofeedback treatment is limited to Medically Necessary treatment of certain physical disorders (such as incontinence and chronic pain) and Mental Health and Substance Use Disorders.

Blood
This Plan does not cover treatments which use umbilical cord blood, cord blood stem cells or adult stem cells (nor their collection, preservation and storage) as such treatments are considered to be Experimental or Investigational in nature. See the "General Provisions" section for the procedure to request an Independent Medical Review of a Plan denial of coverage on the basis that it is considered Experimental or Investigational.

Certain Exams and Services
Physical exams and other services (including psychological exams or drug screening) are not covered when obtained solely for: licensure, employment, insurance, camp, school, sports, court order, parole, or probation.

This exclusion does not apply if a participating physician determines that the services are Medically Necessary. Refer to "Preventive Services" in the "Plan Benefits" section to learn more about annual physicals or wellness visits that are for preventive health purposes.

Clinical Trials

Although routine patient care costs for clinical trials are covered, as described in the "Plan Benefits" section, coverage for clinical trials does not include:

- Services that are provided solely to satisfy data collection and analysis needs.
- Services that are customarily provided by the research sponsors free of charge to enrollees in the clinical trial.
- The investigational Drug, item, device, or service.
- Health care services that are excluded from coverage under this Plan.

Cosmetic Services
Surgery that is performed to alter or reshape normal structures of the body to improve physical appearance. This exclusion does not apply to Medically Necessary treatment for complications resulting from cosmetic surgery, such as infections or hemorrhages.

Chiropractic Services
This plan does not cover chiropractic care.

Custodial or Domiciliary Care
This Plan does not cover services and supplies that are provided to assist with ADLs, regardless of where performed (e.g., walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine). Home services, hospitalization, or confinement in a health facility primarily for supervisory care or supportive services, as an alternative to placement in a foster home or halfway house, rest, custodial care, or domiciliary care are not covered. This exclusion does not apply to assistance with ADLs that is provided as part of covered Hospice, or Skilled Nursing Facility care. Refer to "Hospice," and "Skilled Nursing," in the "Plan Benefits" section to learn more.

Custodial Care, as described in the “Definitions” section, is not covered even when the patient is under the care of a supervising or attending Physician and services are being ordered and prescribed to support and generally maintain the patient’s condition or provide for the patient’s comforts or ensure the manageability of the patient. Furthermore, Custodial Care is not covered even if ordered and prescribed services and supplies are being provided by a registered nurse, a licensed vocational nurse, a licensed vocational nurse, a physician assistant, physical, speech or occupational therapist or other licensed health care provider.

Dental Services
Dental services and supplies for treatment of the teeth, gums, and associated periodontal structures, including but not limited to the following are not covered:

- Routine care or treatment of teeth and gums including but not limited to dental abscesses, inflamed tissue or extraction of teeth.
- Spot grinding, restorative or mechanical devices, orthodontics, inlays or onlays, crowns, bridgework, dental splints or Orthotics (whether custom fit or not), or other dental appliances and related surgeries to treat dental conditions, including conditions related to temporomandibular (jaw) joint (TMD/TMJ) disorders. However, custom made oral appliances (intra-oral splint or occlusal splint) and surgical procedures to correct

TMD/TMJ disorders are covered if they are Medically Necessary, as described in the "Dental Services" provision of "Plan Benefits" section.
- Dental implants (materials implanted into or on bone or soft tissue) and any surgery to prepare the jaw for implants.
- Follow-up treatment of an injury to sound natural teeth as a result of an accidental injury regardless of reason for such services.

Coverage does not include cosmetic dental surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.

This exclusion does not apply to services covered under "Dental Services" and "Pediatric Dental Services," in the "Plan Benefits" section**.**

Dietary or Nutritional Supplements
Prescription and non-prescription oral food, nutritional or dietary supplements, herbal supplements, weight loss aids, formulas, food, and specialized formulas are not covered except when prescribed for the treatment of Phenylketonuria (PKU) (see the "Phenylketonuria" portion of the "Plan Benefits" section) or as indicated on the U.S. Preventive Services Task Force ("USPSTF") Grade A & B recommendations.

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 with a Network qualified 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 providers who are licensed with California law, where licensure is required, and are acting within the scope of such license or as otherwise authorized under California law.

Disposable Supplies for Home Use
This Plan does not cover items such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, diapers, underpads, and other incontinence supplies. In addition, this Plan does not cover personal or comfort items such as internet, phones, televisions, guest trays, and personal hygiene items.

This exclusion does not apply to disposable supplies covered "Ostomy and Urological Supplies", incontinence supplies in the "Hospice" section, and in the "Plan Benefits" section.

Durable Medical Equipment
Although this Plan covers Durable Medical Equipment, it does not cover these items:
- Exercise equipment.

- Hygienic equipment and supplies (to achieve cleanliness even when related to other covered medical services).
- Surgical dressings other than primary dressings that are applied by Your Physician or a Hospital to lesions of the skin or surgical incisions.
- Jacuzzis and whirlpools.
- Orthodontic appliances to treat dental conditions related to disorders of the temporomandibular (jaw) joint (also known as TMD or TMJ disorders).
- Support appliances such as stockings, except as described in the “Prostheses” provision of the “Plan Benefit” section, and over the counter support devices or Orthotics.
- Devices or Orthotics for improving athletic performance or sports-related activities.
- Orthotics and Corrective Footwear, except as described in the "Durable Medical Equipment" and "Diabetic Services" provisions of the "Plan Benefit" section.
- Other Orthotics, including Corrective Footwear, not mentioned above, that are not Medically Necessary, and custom made for the Member. Corrective Footwear must also be permanently attached to an Orthotic device meeting coverage requirements under this Plan.

Family Planning/Infertility Services and Fertility Preservation
These insemination and conception procedures are not covered:

- Artificial insemination.
- In-vitro fertilization (“IVF”).
- Gamete intrafallopian transfer (“GIFT”).
- Zygote intrafallopian transfer (“ZIFT”).
- Assisted Reproductive Technologies (“ART”).
- Pre-implantation genetic diagnosis.
- Donor eggs, sperm or embryos.
- Any process that involves harvesting, transplanting or manipulating a human ovum.
- Services or supplies (including radiology, laboratory injections and injectable medications) which prepare the Member to receive these services.
- Collection, storage or purchase of sperm or ova.
- Surrogates.

Services related to the diagnosis, evaluate, or treatment of infertility, except for treatment for Medically Necessary fertility preservation services related to iatrogenic infertility (i.e., infertility caused by medical treatment, such as surgery, chemotherapy or radiation).

Genetic Testing and Diagnostic Procedures
Genetic testing is covered when determined by IEHP to be Medically Necessary. The prescribing physician must request prior authorization for coverage. Genetic testing will not be covered for non-medical reasons or when a Member has no medical indication or Family history of a genetic abnormality.

Hair Loss or Growth Treatment
Items and services when prescribed for the promotion, prevention, or other treatment of hair loss, hair growth, or hair transplant procedures, unless Medically Necessary for Mental Health and

Substance Use Disorder treatment. This exclusion does not apply to gender affirming procedures.

Hearing Aids and Exams for Fitting of Hearing Aids
This Plan does not cover hearing aids, hearing aid exams for the appropriate type of hearing aid, fitting, and hearing aid recheck appointments.

Home Birth
Elective Home Births, attended by non-clinical providers, is not covered by this plan. A birth which takes place at home will be covered when the criteria for "Emergency Care", as defined in this EOC, have been met.

Hospitalization
This Plan does not cover services performed in a Hospital by house officers, residents, interns, or other professionals in training without the supervision of an attending Physician in association with an accredited clinical education program.

This Plan does not cover hospitalization solely for X-ray, laboratory or any other outpatient diagnostic studies, or for medical observation. In addition, hospitalizations related to non-covered medical and surgical procedures, such as cosmetic surgery, are not covered.

Immunizations and Injections
This Plan does not cover immunizations and injections for foreign travel/occupational purposes.

Ineligible Status
This Plan does not cover services or supplies provided before the Effective Date of coverage. Services or supplies provided after midnight on the effective date of cancellation of coverage through this Plan are not covered.

A service is considered provided on the day it is performed. A supply is considered provided on the day it is dispensed.

Items and Services That are Not Health Care Items and Services
Except for services related to behavioral health treatment which are covered as shown in the "Plan Benefits" section, all other services related to or consisting of education or training, including for employment or professional purposes, are not covered, even if provided by an individual licensed as a health care provider by the state of California. For example, we do not cover:

- Teaching manners and etiquette.
- Teaching and support services to develop planning skills such as daily activity planning and project or task planning.
- Items and services that increase academic knowledge or skills.
- Teaching and support services to increase intelligence.
- Academic coaching or tutoring for skills such as grammar, math, and time management.

- Teaching You how to read, whether or not You have dyslexia.
- Educational testing.
- Teaching art, dance, horse riding, music, play or swimming.
- Teaching skills for employment or vocational purposes.
- Vocational training or teaching vocational skills.
- Professional growth courses.
- Training for a specific job or employment counseling.

Long-Term Care
This Plan does not cover continuous nursing services, custodial care, private duty nursing, nursing shift care, and respite care, except as provided through a Network Hospice Provider.

Massage Therapy
This Plan does not cover massage therapy, except when such services are a component of a multimodality rehabilitative treatment plan or part of physical therapy treatment plan. The services must be based on a treatment plan authorized, as required by IEHP.

No-Charge Items
This Plan does not cover reimbursement to the Member for services or supplies for which the Member is not legally required to pay the Provider or for which the Provider pays no charge.

Noncovered Treatments
These types of services are only covered when provided in connection with covered treatment for a Mental Health or Substance Use Disorders:
- Treatment for co-dependency.
- Treatment for psychological stress.
- Treatment of marital or Family dysfunction.

Treatment of neurocognitive disorders which include delirium, major and mild neurocognitive disorders and their subtypes and neurodevelopmental disorders are covered for Medically Necessary medical services but covered for accompanying behavioral and/or psychological symptoms or Substance Use Disorder conditions only if amenable to psychotherapeutic, psychiatric, Substance Use Disorder treatment. This provision does not impair coverage for the Medically Necessary treatment of any Mental Health or Substance Use Disorder identified as a Mental Health or Substance Use Disorder in the Diagnostic and Statistical Manual of Mental Disorders, as amended in the most recent edition.

In addition, IEHP will cover only those Mental Health and Substance Use Disorder services which are delivered by Providers who are licensed with California law, where licensure is required, and are acting within the scope of such license or as otherwise authorized under California law.

This Plan covers Medically Necessary treatment for all Essential Health Benefits, including "mental disorders" described in the Diagnostic and Statistical Manual of Mental Disorders, as amended in the most recent edition.

Noneligible Institutions
This Plan only covers Medically Necessary services or supplies provided by a licensed Hospital, Hospice, Medicare-approved Skilled Nursing Facility, Residential Treatment Center or other properly licensed medical facility specified as covered in this EOC. Any institution that is not licensed to provide medical services and supplies, regardless of how it is designated, is not an eligible institution.

Non-Enrolled Newborns
Your child will be eligible to enroll under a special enrollment period within 60 days of birth. 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), any charges incurred by a baby beyond 31 days (including the date of birth) may be excluded. .

Nonparticipating Providers
Services and supplies rendered by a nonparticipating provider without authorization from IEHP are not covered. However, IEHP may authorize Covered Services from a nonparticipating Specialist or ancillary provider when the Member cannot get Medically Necessary care from such a Network provider because either: (1) IEHP does not have the provider type in its network; or (2) IEHP does not contract with the provider type within a reasonable distance from the Member's residence and a nonparticipating provider of that type is within such reasonable distance. When IEHP authorizes such care, the Member will pay the Copayment or Coinsurance levels described in the "Schedule of Benefits" section of this EOC.

This exclusion does not apply to Emergency Services or Urgent Care while out of Service Area.

Nonstandard Therapies and Services Not Approved by the Federal Food and Drug Administration
Experimental or Investigational services, tests, devices, procedures, vaccines, supplements, drugs and radioactive materials are not covered, including but not limited to:

- Services that by law require federal Food and Drug Administration (FDA) approval in order to be sold in the U.S. but are not approved by the FDA.
- Treatments which use umbilical cord blood, cord blood stem cells or adult stem cells (including their collection, preservation and storage).
- Nonstandard therapies or non-FDA approved bone marrow transplants involving stem cells or Car-T transplants.
- Services that do not meet national standards for professional medical health or Mental Health and Substance Use Disorder practice, such as: primal therapy, bioenergetic therapy, hypnotherapy and crystal healing therapy.

To learn more about requesting an Independent Medical Review of a denial of coverage see the "Independent Medical Review of Investigational or Experimental Therapies" portion of the "General Provisions" section.

Over-the-Counter Drugs, Equipment and Supplies
Medical equipment and supplies available without a prescription are covered only when prescribed by a Physician for the management and treatment of diabetes, or for preventive purposes in accordance with the U.S. Preventive Services Task Force A and B recommendations or for female contraception as approved by the FDA.

Any other nonprescription or over-the-counter drugs, medical equipment or supplies that can be purchased without a Prescription Drug Order is not covered, even if a Physician writes a Prescription Drug Order for such drug, equipment or supply unless listed in the Essential Rx Drug List. However, if a higher dosage form of a nonprescription drug or over-the-counter drug is only available by prescription that higher dosage drug may be covered when Medically Necessary.

Ostomy and Urological Supplies
This Plan does not cover ostomy and urological supplies for comfort, convenience, or luxury equipment or features.

Personal or Comfort Items
This Plan does not cover personal or comfort items.

Physician Self-Treatment/Services performed Immediate Family Members
This Plan does not cover Physician self-treatment rendered in a non-emergency (including, but not limited to, prescribed services, supplies and drugs). Physician self-treatment occurs when Physicians provide their own medical services, including prescribing their own medication, ordering their own laboratory test and self-referring for their own services. Claims for emergency self-treatment are subject to review by IEHP.

This Plan does not cover routine or ongoing treatment, consultation or provider referrals (including, but not limited to, prescribed services, supplies and drugs) provided by the Member's parent, spouse, Domestic Partner, child, stepchild or sibling. Members who get routine or ongoing care from a member of their immediate Family will be reassigned to another in-network Physician or Mental Health Professional (Mental Health or Substance Use Disorders).

Private Duty Nursing
This Plan does not cover private duty nursing in the home or for registered bed patients in a Hospital or long-term care facility. Shift care and any portion of shift care services are also not covered.

Prosthetics
Any type of communicator, voice enhancer, voice prosthesis, electronic voice producing machine, or any other language assistive device. This exclusion does not apply to items or services listed under "Prostheses and Orthotics" section.

Psychological Testing
Psychological testing, except as conducted by Participating Mental Health Professionals who are licensed and acting within the scope of their license, for assistance in treatment planning, including medication management or diagnostic clarification. Also excluded is coverage for scoring of automated computer-based reports, unless the scoring is performed by a provider qualified to perform it.

Rehabilitation and Habilitation Therapy
This Plan does not cover certain physical and occupational therapies, such as:

- Training or therapy for the treatment of learning disabilities or behavioral problems;
- Social skills training or therapy;
- Vocational, educational, recreational, art, dance, music, or reading therapy; and
- Testing for intelligence or learning disabilities.

This exclusion does not apply to services deemed Medically Necessary Treatment of a Mental Health or Substance Use Disorder.
Coverage for rehabilitation therapy is limited to Medically Necessary services provided by a Network physician, licensed physical, speech or occupational therapist or other contracted provider, acting within the scope of his or her license, to treat physical conditions and Mental Health and Substance Use Disorders, or a Qualified Autism Service (QAS) Provider, QAS professional or QAS paraprofessional to treat pervasive developmental disorder or autism.

Coverage is subject to any required authorization from IEHP. The services must be based on a treatment plan authorized as required by IEHP. Such services are not covered when medical documentation does not support the Medical Necessity because of the Member's inability to progress toward the treatment plan goals or when a Member has already met the treatment goals. See the "General Provisions" section for the procedure to request Independent Medical Review of a Plan denial of coverage on the basis of Medical Necessity.

Rehabilitation and habilitation therapy for physical impairments in Members with Mental Health and Substance Use Disorders, including pervasive developmental disorder and autism, that develops or restores, to the maximum extent practicable, the functioning of an individual, is considered Medically Necessary when criteria for rehabilitation or habilitation therapy are met.

Residential Treatment Center
Admission to a Residential treatment Center that is not Medically Necessary is excluded. Admissions that are considered not Medically Necessary include, but are not limited to, admissions for Custodial Care, for a situational or environmental change only, or as an alternative to placement in a foster home or halfway house.

Reversal of Surgical Sterilization
This Plan does not cover services to reverse voluntary, surgically induced sterility.

Routine Foot Care
Routine foot care items and services that are not Medically Necessary, including:

- Callus treatment.
- Corn paring or excision.
- Toenail trimming
- Treatment for fallen arches, flat or pronated feet.
- Cramping of the feet, bunions and muscle trauma.
- Over-the-counter shoe inserts or arch supports.
- Any type of massage procedure on the foot.

This exclusion does not apply to Medically Necessary treatment for a diabetic condition or peripheral vascular disease, or items/services provided as part of covered Hospice services.

Services Performed by Unlicensed Providers
This Plan does not cover services provided by an individual or entity that:

- Is not appropriately licensed or certified by the state to provide health care services.
- Is not operating within the scope of such license or certification.
- Does not maintain the Clinical Laboratory Improvement Amendments certificate required to perform laboratory testing services.
- This exclusion does not apply to services to treat MH/SUD conditions from providers that do not require licensure.

Services Not Related to Covered Condition, Illness or Injury
Any services or supplies not related to the diagnosis or treatment of a covered condition, illness or injury. However, the Plan does cover Medically Necessary services and supplies for medical conditions directly related to non-Covered Services when complications exceed routine Follow-Up Care (such as life-threatening complications of cosmetic surgery).

Services to Treat Refractive Defects of the Eye
This Plan does not cover eye surgery performed to correct refractive defects of the eye, such as nearsightedness (myopia), far-sightedness (hyperopia) or astigmatism, unless Medically Necessary, recommended by the Member's Physician and authorized by IEHP.

For Members 19 years of age and older, eye exams and refractions, lenses and frames for eyeglasses, lens options, treatments, and contact lenses, except as listed under the "Prosthetic Equipment and Devices" section, are not covered.

For all Members, these items are not covered: video-assisted visual aids or video magnification equipment for any purpose, or surgery to correct refractive error.

State Hospital Treatment
Services in a State Hospital are limited to treatment or confinement as the result of an Emergency or Urgent Care as defined in the "Definitions" section.

Sports Activities
The costs associated with sports activities, including, but not limited to, yoga, rock climbing, hiking, and swimming, are not covered.

Transportation
Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance or psychiatric transport van), that is not authorized by IEHP.

Travel Expenses
This Plan does not cover expenses for travel, housing, companion expenses, and other non-clinical expenses. This exclusion does not apply to bariatric surgical services; refer to "Inpatient and Hospital Services" to learn more.

Treatment for Obesity
Treatment or surgery for obesity, weight reduction or weight control is limited to the treatment of morbid obesity. Certain services may be covered as Preventive Care Services; refer to the "Preventive Care Services" and "Inpatient and Hospital Services" provisions in the "Plan Benefits" section.

Treatment Related to Judicial or Administrative Proceedings
Medical and Mental Health or Substance Use Disorder services as a condition of parole or probation, and court-ordered testing are limited to Medically Necessary Covered Services.

Unauthorized Services and Supplies
This Plan only covers services or supplies that are authorized by IEHP according to IEHP's procedures, except for emergency services.

Services or supplies that are rendered by a nonparticipating Provider or Facility are only covered when authorized by IEHP or when You require Emergency or Urgent Care while You are out of the Service Area.

Vision Therapy, Eyeglasses and Contact Lenses
This Plan does not cover routine vision services, therapy, eyeglasses or contact lenses, except as specified in the "Pediatric Vision Services" portion of "Plan Benefits" sections. However, this exclusion does not apply to an implanted lens that replaces the organic eye lens.

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.

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, Responsibilities, and Obligations
As a Member of IEHP, You have a right to:

- Respectful and courteous treatment. You have the right to be treated with respect, dignity and courtesy by IEHP providers and staff. You have the right to be free from retaliation or force of any kind when making decisions about Your care. You have the right to be free from restraint (including physical and mechanical restraints and drugs), used as a means of coercion, discipline, convenience, or retaliation.
- Privacy and confidentiality. You have a right to have a private relationship with Your provider and to have Your medical record kept confidential. You also have a right to get a copy of and request corrections to Your medical record. If You are a minor, You have a right to some services that do not need Your parent's consent.
- Choice and involvement in Your care. You have the right to get information about IEHP, its services, its doctors, and other providers. You have the right to choose Your Primary Care Physician (doctor) from the doctors and clinics listed in IEHP's website or provider directory. You also have the right to get appointments within a reasonable amount of time. You have a right to talk with Your doctor about any care Your doctor provides or recommends. You have the right to a second opinion. You have a right to information about treatment regardless of the cost or what Your benefits are. You have the right to say "no" to treatment. You have a right to decide in advance how You want to be cared for in case You have a life-threatening illness or injury.
- Get Timely Customer Service. You have the right to wait no more than 10 minutes to speak to a representative during IEHP's normal business hours.
- Voice Your concerns. You have the right to complain about IEHP, our providers, or the care You get without fear of losing Your benefits. IEHP will help You with the process. If You do not agree with a decision, You have a right to ask for a review. You have a right to disenroll from IEHP whenever You want.
- File a grievance in Your preferred language by using the interpreter service or by completing the translated grievance form that is available on www.iehp.org.
- Service outside of IEHP's provider network. You have a right to get emergency, urgent care while out of the Service Area, and or services in certain facilities when authorized by IEHP, outside IEHP's provider network. You have the right to get emergency treatment whenever and wherever You need it. If You get emergency care outside of the United States, You have a right to be reimbursed for the cost of emergency services up to at the maximum Allowable Amount.

- Service and information in Your language. You have the right to request an interpreter at no charge instead of using a Family member or friend to interpret for You. You should not use children to interpret for You. You have the right to request other member materials in a language or format (such as large print or audio) You understand.
- Know Your rights. You have the right to get information about Your rights and responsibilities. You have the right to make recommendations about these rights and responsibilities.

As a Member of IEHP, You have a responsibility to:

- Act courteously and respectfully. You are responsible for treating Your IEHP doctor and all our providers and staff with courtesy and respect. You are responsible for being on time for Your visits or calling Your doctor's office at least 24 hours before the visit to cancel or reschedule.
- Give up-to-date, accurate and complete information. You are responsible for giving correct information that IEHP and Your providers need in order to provide care. You are responsible for getting regular checkups and telling Your doctor about health problems before they become serious. You are responsible for notifying IEHP as soon as You can if You are billed by mistake by a provider.
- Follow Your Primary Care doctor's advice and take part in Your care. You are responsible for selecting a Primary Care doctor or accept the Primary Care doctor that IEHP will assign to You. You are responsible for talking over Your health care needs with Your Primary Care doctor, developing and agreeing on goals, doing Your best to understand Your health problems, and following the treatment You both agree on.
- Use the Emergency Room only in an emergency. You are responsible for using the emergency room in cases of an emergency or as directed by Your doctor or IEHP's 24-hour, free nurse advice line. If You are not sure You have an emergency, You can call Your doctor or call IEHP's Free 24-Hour Nurse Advice Line at 1-888-244-4347 (TTY 711)
- Report wrongdoing. You are responsible for reporting health care fraud or wrongdoing to IEHP. You can report without giving Your name by calling the IEHP Compliance Helpline toll-free at 1-866-355-9038.

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:

- 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. For all other issues, You must file Your grievance within 365 calendar days 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, 7am-7pm, Saturday-Sunday, 8am-5pm. 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, 7am-7pm, Saturday-Sunday, 8am-5pm, 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

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 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.dmhc.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 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 Grievance Resolution 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 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 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 and urgent medical services. The department 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.dmhc.ca.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

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 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.

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 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
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 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.

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 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.

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.

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 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 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 disclosure 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 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 previous 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 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 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, Our 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 Office
Attn: Privacy Officer
P.O. Box 1800
Rancho Cucamonga, CA 91729
Email: www.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 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.

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.

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.

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

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").

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

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 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 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 297or 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 Care includes medical screening, exam and evaluation by a Physician (or other personnel to the extent permitted by applicable law and within the scope of his or her license and privileges) to determine if an Emergency Medical Condition or active labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the Emergency Medical Condition, within the capability of the facility. Emergency Care will also include additional screening, exam and evaluation by a Physician (or other personnel to the extent permitted by applicable law and within the scope of his or her

license and 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 or by transferring the Member to a psychiatric unit within a general acute hospital or to an acute psychiatric hospital as Medically Necessary. Emergency Care includes air and ground ambulance and ambulance transport services provided through the "9-1-1" emergency response system.
IEHP will make any final decisions about Emergency Care. See "Independent Medical Review of Grievances Involving a Disputed Health Care Service" under "General Provisions" for the procedure to request Independent Medical Review of a Plan denial of coverage for Emergency Care.

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 is 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.
- Serious dysfunction of any bodily organ or part.

"Active labor" means labor at the time that either of the following could reasonably be expected to occur: (1) There is inadequate time to effect safe transfer to another Hospital prior to delivery; or (2) a transfer poses a threat to the health and safety of the Member or unborn child.

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 ("EOC") is this booklet that IEHP has issued to the enrolled Subscriber, describing the coverage to which You are entitled.

Exception means any provision in a plan contract whereby coverage for a specified hazard or condition is entirely eliminated.

Experimental is any procedure, treatment, therapy, drug, biological product, equipment, device or supply which IEHP has not determined to have been demonstrated as safe, effective or medically appropriate and which the United States Food and Drug Administration ("FDA") or Department of Health and Human Services ("HHS") has determined to be Experimental or Investigational or is the subject of a clinical trial.

Please refer to "Independent Medical Review of Investigational or Experimental Therapies" in the "General Provisions" section, as well as the "Medical Services and Supplies" portion of the "Plan Benefits" section for additional details.

With regard to Acupuncture Services, "Experimental" services are acupuncture care that is an unproven acupuncture service that does not meet professionally recognized, valid, evidence-based standards of practice.

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 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.

Inland Empire Health Plan ("IEHP") is a federally qualified health maintenance organization ("HMO") and a California licensed health care service plan.

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.

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 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.

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.

Investigational approaches to treatment are those that have progressed to limited use on humans but are not widely accepted as proven and effective procedures within the organized medical community. IEHP will decide whether a service or supply is Investigational.
Regarding Acupuncture Services, "Investigational" services are acupuncture care that is investigatory.

Limitation means any provision other an 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.

Medically Necessary (or Medical Necessity)
For services other than Mental Health and Substance Use Disorders: means health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice.
2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease.
3. Not primarily for the convenience of the patient, Physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, the views of Physicians practicing in relevant clinical areas and any other relevant factors.

Regarding Acupuncture Services, "Medically Necessary" services are Acupuncture Services which are necessary, appropriate, safe, effective and rendered in accordance with professionally recognized, valid, evidence-based standards of practice.

For Treatment of Mental Health and Substance Use Disorders: Medically Necessary (or Medical Necessity) 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 Mental Health and 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 subscribers or for the convenience of the patient, treating physician, or other health care provider.

For these purposes:

- "Generally accepted standards of Mental Health and Substance Use Disorder care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources establishing generally accepted standards of Mental Health and Substance Use Disorder care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.
- "Health care provider" means any of these:
    - A person who is licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.
    - An associate marriage and Family therapist or marriage and Family therapist trainee functioning pursuant to Section 4980.43.3 of the Business and Professions Code.
    - A Qualified Autism Service Provider or qualified autism service professional certified by a national entity pursuant to Section 10144.51 of the Insurance Code and Section 1374.73.
    - An associate clinical social worker functioning pursuant to Section 4996.23.2 of the Business and Professions Code.
    - An associate professional clinical counselor or professional clinical counselor trainee functioning pursuant to Section 4999.46.3 of the Business and Professions Code.
    - A registered psychologist, as described in Section 2909.5 of the Business and Professions Code.
    - A registered psychological assistant, as described in Section 2913 of the Business and Professions Code.
    - A psychology trainee or person supervised as set forth in Section 2910 or 2911 of, or subdivision (d) of Section 2914 of, the Business and Professions Code.

Medicare is the Health Insurance Benefits for the Aged and Disabled Act, cited in Public Law 89-97, as amended.

Member is the Subscriber or an enrolled Family member.

Mental Health and Substance Use Disorders 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. Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization's International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this definition as long as a condition is commonly understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties.

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 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.

Nonparticipating 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.

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 is a drug or medicine that can be obtained only by a Prescription Drug Order. All Prescription Drugs are required to be labeled "Caution, Federal Law Prohibits Dispensing Without a Prescription." An exception is insulin and other diabetic supplies, which are covered Prescription Drugs.

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 discussussions 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.

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 Health and Substance Use Disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

- An immediate danger to himself or herself or to others.
- Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the Mental Health and Substance Use 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 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) 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 (6) 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.

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.

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 (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.

Tier 4 include drugs that are biologics; 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.

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/filelindex.html.

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.dmhc.ca.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***

IEHP Covered

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: Զանգահարեք **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 និង សេវាកម្ម សម្រាប់ ជនពិការ ដូចជាឯកសារសរសេរជាអក្សរផុស សម្រាប់ជនពិការភ្នែក ឬឯកសារសរសេរជាអក្សរពុម្ពធំ ក៏អាចរកបានផងដែរ។ ទូរស័ព្ទមកលេខ **1-877-273-4347** (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 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।

Nqe 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.

ແທກໄລພາສາລາວ (Laotian)

ປະກາດ: ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອ ໃນພາສາຂອງທ່ານໃຫ້ໂທຫາເບີ **1-855-433-4347** (TTY: **1-800-718-4347**). ຍັງມີ ຄວາມຊ່ວຍເຫຼືອ ແລະການບໍລິການສໍາລັບ ຄົນ ພິ ການ ຊຶ່ ນເອກະສານທີ ເປັ ນອັ ກສອນນູ ນແລະມີ ໂຕພິ ມໃຫຍ່ ໃຫ້ໂທຫາເບີ **1-855-433-4347** (TTY: **1-800-718-4347**). ການບໍ ລິການເຫຼື ານີ ້ ບໍ ຕ້ ອງເສຍຄ່ າໃຊ້ ຈ່ ายใดๆ.

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 hluo 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).** ਅਪਾਹਜ 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 serbisyong ito.

แท็กไลน์ภาษาไทย (Thai)
โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ กรุณาโทรศัพท์ไปที่หมายเลข 1-855-433-4347 (TTY: **1-800-718-4347**) **นอกจากนี้ ยังพร้อมให้ความช่วยเหลือและบริการต่าง ๆ สำหรับบุคคลที่มีความพิการ เช่น เอกสารต่าง ๆ ที่เป็ นอักษรเบรลล์และเอกสารที่พิมพ์ด้วยตัวอักษรขนาดใหญ่ กรุณาโทรศัพท์ไปที่หมายเลข 1-855-433-4347** (TTY: **1-800-718-4347**) **ไม่มีค่าใช้จ่ ายสำหรับบริการเหล่านี้**

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.