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

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and services indicated in chart starting on Page 2.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$3,000/individual, $6,000/family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums and healthcare this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. For a list of preferred providers, visit www.iehp.org or call 1-855-433-4347.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes. Requires written prior authorization.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copayment/visit	Not covered	None
	Specialist visit	$25 copayment/visit	Not covered	Requires prior authorization.
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$40 copayment/visit (x-ray), $20 copayment/ visit (blood work)	Not covered	Requires physician order.
	Imaging (CT/PET scans, MRIs)	$100 copayment/visit	Not covered	Requires prior authorization.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.iehp.org.	Generic drugs	$5 copayment (retail), $10 copayment (mail order)	Not covered	Supply/order: up to 30-day (retail); 30-100 day (mail order), except where quantity limits apply. Prior authorization is required for select drugs.
	Preferred brand drugs	$25 copayment (retail), $50 copayment (mail order)	Not covered	
	Non-preferred brand drugs	$45 copayment (retail), $90 copayment (mail order)	Not covered	
	Specialty drugs	15% coinsurance up to $150 per prescription	Not covered	Prior authorization is required for select drugs. Quantity limits may apply to select drugs. Supply/order: up to a 30-day supply filled by specialty pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	Requires prior authorization.
	Physician/surgeon fees	20% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	$150 copayment/visit, ER Physician- No charge	$150 copayment/visit, ER Physician- No charge	Copayment waived if admitted into the hospital. Out-of-network services must meet the criteria for emergency care.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Emergency medical transportation	$75 copayment/ transport	$75 copayment/transport	Out-of-network services must meet the criteria for emergency care.
	Urgent care	$15 copayment/visit	$15 copayment/visit	Out-of-network Urgent care services are covered while you are out of the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	Requires prior authorization.
	Physician/surgeon fees	20% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit-individual therapy session $15 copayment/visit; group therapy session-$7.50 copayment/visit Other than office visit $15 copayment/visit	Not covered	Requires prior authorization except for the initial behavioral health assessment.
	Inpatient services	20% coinsurance	Not covered	Requires prior authorization.
If you are pregnant	Office visits	Prenatal-No charge; $15 copayment/visit	Not covered	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	20% coinsurance	Not covered	Coverage includes abortion services.
	Childbirth/delivery facility services	20% coinsurance	Not covered	Coverage includes abortion services.
If you need help recovering or have other special health needs	Home health care	$15 copayment/visit	Not covered	Limited to 100 visits each calendar year. Requires prior authorization.
	Rehabilitation services	$15 copayment/visit	Not covered	Requires prior authorization.
	Habilitation services	$15 copayment/visit	Not covered	Requires prior authorization.
	Skilled nursing care	20% coinsurance	Not covered	Limited to 100 days per calendar year. Requires prior authorization.
	Durable medical equipment	15% coinsurance	Not covered	Requires prior authorization.
	Hospice services	No charge	Not covered	Requires prior authorization.
If your child needs	Children's eye exam	No charge	Not covered	Limited to 1 visit per year.

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

Excluded Services & Other Covered Services:

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

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

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

- Abortion services
- Acupuncture
- Bariatric surgery

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

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

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

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

- IEHP at 1-855-433-4347 (TTY 711), Monday-Friday, 8:00am to 6:00pm PST. Give your Member ID number, your name and the reason for your complaint.
- By mail: Call IEHP at 1-855-433-4347 (TTY 711), Monday-Friday, 8:00am to 6:00pm PST, and ask to have a form sent to you. When you get the form, fill it out. Be sure to include your name, Member ID number and the reason for your complaint. Tell us what happened and how we can help you.
  Mail the form to:
  IEHP
  Attention: Grievance and Appeals Department
  P.O. Box 1800

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

Rancho Cucamonga, CA 91729-1800

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

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

Does this plan provide Minimum Essential Coverage? **Yes**

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

Does this plan meet the Minimum Value Standards? **Not Applicable**

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

Language Access Services:

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

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

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

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

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

About these Coverage Examples:

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

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

The plan's overall deductible	$3,000
Specialist cost sharing	$25
Hospital (facility) cost sharing	20%
Other cost sharing	$15

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

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$800
Copayments	$350
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,210**

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

The plan's overall deductible	3,000
Specialist cost sharing	$25
Hospital (facility) cost sharing	20%
Other cost sharing	$15

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

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$50
Copayments	$700
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$970**

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

The plan's overall deductible	$3,000
Specialist cost sharing	$25
Hospital (facility) cost sharing	20%
Other cost sharing	$15

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

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$560**

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