Inland Empire Health Plan – Covered California Plans
Schedule of Benefits

Covered California Silver 94 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	$0
Medical Deductible, per Family	$0

Pharmacy Deductible, per Member	$0
Pharmacy Deductible, per Family	$0

- 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	$1,150
OOPM, per Family	$2,300

- 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	$50 Copayment /visit
Emergency room physician	$0 Copayment/visit
Urgent care center or facility	$5 Copayment/visit

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.
  For urgent care services, you are required to pay the urgent care facility cost share as described and may be required to pay additional cost share for other covered services rendered during the urgent care visit (e.g., laboratory services). Refer to "Ambulance Services" below for emergency medical transportation Copayment.

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

Benefit	Member Pays
Ground ambulance	$30 Copayment/transport
Air ambulance	$30 Copayment/transport

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	$5 Copayment/visit
Other Practitioner (includes nurse practitioners, physician assistants, physical therapists, acupuncture therapists)	$5 Copayment/visit
Specialist office visit	$8 Copayment/visit

Benefit	Member Pays
Hearing exam for diagnosis or treatment	$5 Copayment/visit
Physician visit to a Member's home (at the discretion of the Physician in accordance with the rules and criteria established by IEHP)	$5 Copayment/visit
Specialist visit to a Member's home (at the discretion of the Physician in accordance with the rules and criteria established by IEHP)	$8 Copayment/visit

- 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 routine office 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

- 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 non-Preventive services.

Laboratory and Diagnostic Services

Benefit	Member Pays
Laboratory services	$8 Copayment/visit
Diagnostic imaging (including x-ray) services	$8 Copayment/visit
Advanced imaging (CT, SPECT, MRI, MUGA and PET)	$50 Copayment/visit

Allergy, Immunizations, and Medical Injections

Benefit	Member Pays
Allergy testing	$8 Copayment
Allergy serum	10% Coinsurance
Allergy injection services	$5 Copayment per day
Immunizations for occupational purposes or foreign travel	Not a Covered Benefit
Medical Injections (excluding injections for Infertility) and office-based injectable medications (per dose)	10% Coinsurance

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

Outpatient Rehabilitation and Habilitation Therapy

Benefit	Member Pays
Physical therapy	$5 Copayment/visit
Occupational therapy	$5 Copayment/visit
Speech therapy	$5 Copayment/visit
Pulmonary therapy	$5 Copayment/visit
Cardiac therapy	$5 Copayment/visit
Habilitation therapy	$5 Copayment/visit

- 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
Non-Preventive Prenatal and Postpartum care office visit	$5 Copayment/visit
Newborn care office visit (birth through 30 days)	$5 Copayment/visit
Physician visit to the mother or newborn at a Hospital	10% Coinsurance/visit
Professional Services for Normal delivery, including Cesarean section	10% Coinsurance
Other services for Normal delivery, including Cesarean section	10% Coinsurance
Genetic testing of fetus	$8 Copayment/visit

Benefit	Member Pays
Circumcision of newborn (birth through 30 days)	10% Coinsurance

- 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
Sterilization of male	$0 Copayment

- 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	10% Coinsurance
Assistance at surgery	10% Coinsurance
Hospital visits by Physician	10% Coinsurance
Administration of anesthetics	10% Coinsurance
Chemotherapy	10% Coinsurance
Radiation therapy	10% Coinsurance

Nuclear medicine (use of radioactive materials)	10% Coinsurance
Renal dialysis	10% Coinsurance
Organ, tissue, or stem cell transplant	10% Coinsurance
Infusion therapy in a home, outpatient or office setting	10% Coinsurance
Wound Care	10% Coinsurance
Patient education for diabetes, weight management and smoking cessation	$0 Copayment

- 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	10% Coinsurance
Orthotics (such as bracing, supports and casts)	10% Coinsurance
Diabetic Equipment	10% Coinsurance
Corrective Footwear	10% Coinsurance
Skin grafts and tissue replacement	10% Coinsurance
Prostheses (internal or external)	10% Coinsurance
Cranial Prostheses (Wigs)	10% Coinsurance
Blood or blood products, including blood factors not obtained through Prescription Drug benefit.	10% Coinsurance

- 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	$3 Copayment/visit

- Limited to 100 visits per Calendar Year.

Hospice Services

Benefit	Member Pays
Hospice Care	$0 Copayment

Inpatient Hospital Services

Benefit	Member Pays
Room and board in a semiprivate or private room or special care unit including ancillary (additional) services	10% Coinsurance
Mental Health Physician visit to Hospital, Behavioral Health Facility or Residential Treatment Center	10% Coinsurance
Inpatient Services at a Hospital, Behavioral Health Facility or Residential Treatment Center	10% Coinsurance
Detoxification	10% Coinsurance

- 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)	10% Coinsurance
Outpatient facility services (other than surgery	10% Coinsurance

- 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	10% Coinsurance

- 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)	$5 Copayment/visit
Outpatient group therapy session	$2.50 Copayment/visit

Benefit	Member Pays
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).	$5 Copayment/visit
Mental Health Professional visit to a Member's home	$5 Copayment/visit

- 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.
- Coverage includes services obtained from the 988 or 988lifeline.org crisis hotline. Cost share for any out-of-network services provided by a 988 center/mobile crisis team or other Behavioral Health crisis services will be the same as in network cost shares above. You are not liable for any amounts beyond in-network outpatient services listed. Contact IEHP if you receive any billed amounts for 988 services beyond cost sharing. You may also contact the California Department of Managed Health Care at 1-888-466-2219 (TTY 1-877-688-9891 or 711).

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)	$3 Copayment/script
Tier 2 Drugs (non-preferred generic and preferred Brand Name Drugs)	$10 Copayment/script
Tier 3 Drugs (non-preferred Brand Name Drugs)	$15 Copayment/script
Tier 4 (Specialty Drugs)	10% up to $150 per script
Preventive drugs and Essential Health Benefit drugs	$0 Copayment/script

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)	$6 Copayment/script
Tier 2 Drugs (non-preferred generic and preferred Brand Name Drugs)	$20 Copayment/script
Tier 3 Drugs (non-preferred Brand Name Drugs)	$30 Copayment/script
Preventive drugs and Essential Health Benefit drugs	$0 Copayment/script

- 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 cost share per Prescription Drug. If the pharmacy's or mail order administrator's retail price is less than the applicable cost share , the Member will only pay the pharmacy's retail price or the mail order administrator's retail price. You will pay the lesser of:
    - The pharmacy benefit Copayment or coinsurance as described above; or
    - The pharmacy's retail price; or
    - 50 percent of IEHP's cost of the Prescription Drug; or
    - $250 for oral oncology drugs
- 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. If there is a generic equivalent to a brand name drug, You will pay the lowest cost sharing that would be applied for the brand name drug, whether or not both the generic equivalent and the brand name drug are on the formulary.
- 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 and shall be provided consistent with the appropriate standard of care for that drug.

Pediatric Vision Services

Benefit	Member Pays
Routine eye exam with dilation	$0 Copayment
Exam for Contact Lenses (lens fit and follow-up)	$0 Copayment
Standard Frames and lenses (one pair every 12 months)	$0 Copayment
Standard and Premium Contact lenses in lieu of eyeglass lenses	$0 Copayment
Low vision testing and equipment (exam every 5 years)	$0 Copayment

- 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. Your Network Provider will order your materials from a network lens manufacturer. Frames and lenses not ordered from a Network Provider are not covered. 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
Basic Services – restorative procedures, periodontal maintenance services	Refer to Dental Summary of Benefits and 2025 Dental Copayment Schedule
Major Services – crowns, casts, endodontics, periodontics other than maintenance, prosthodontics, oral surgery	Refer to Dental Summary of Benefits and 2025 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	$5 Copayment/visit
Each subsequent visit	$5 Copayment/visit
Re-exam visit	$5 Copayment/visit
Second opinion	$5 Copayment/visit

- 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.