INLAND EMPIRE HEALTH PLAN + COVERED CALIFORNIA

2024 Broker Guide

That feeling when
you know you're covered
by IEHP.

IEHP Covered

COVERED CALIFORNIA

Why choose IEHP?

With the **lowest cost Silver Plan in the IE,** you can get coverage from the name you trust at a price that fits your budget.

Lost your Medi-Cal coverage? Select the local health plan you know and trust.

If you no longer qualify for Medi-Cal and have been in enrolled in a Covered California plan, you can choose your providers and stay insured at an affordable rate.

Access quality care whenever you need it.

We have a local network of providers and hospitals, and we want to help you find care close to you.

Enjoy our friendly support.

You can also access healthcare education, free health & wellness classes, and more at our bilingual community resources centers. Need help after hours? We also have a 24/7 nurse advice line.

Receive care in your language.

We have a care team that speaks your language and can help you get answers to your questions.

Like sipping hot cocoa on a cold night

Copays start at $0 for select plans

Bronze, Silver, Gold, and Platinum plans help you take care of your health at an affordable cost. You can access these benefits and more:

$0

- preventive services
- prenatal care
- pediatric vision and preventive dental

You can also enjoy low-cost benefits such as primary care, specialty care, urgent care, retail and mail order pharmacy services, and more with select plans.

2024 Covered California Plan Benefits

PLAN NAME	PLATINUM COPAY	GOLD COPAY	SILVER 70	SILVER 73 CSR 250
Deductible -- Ind	$0	$0	$5,400	$0
Deductible -- Fam	$0	$0	$10,800	$0
Rx Deductible -- Ind	$0	$0	$150	$0
Rx Deductible -- Fam	$0	$0	$300	$0
Max OOP -- Ind	$4,500	$8,700	$9,100	$6,100
Max OOP -- Fam	$9,000	$17,400	$18,200	$12,200
Primary Care Office Visit	$15	$35	$50	$35
Specialist Office Visit	$30	$65	$90	$85
Preventive Services	**$0**	**$0**	**$0**	**$0**
Lab	$15	$40	$50	$50
X-ray/Diag Imaging	$30	$75	$95	$95
Adv Imaging (CT/PET, MRI)	$75	$75	$325	$325
OP Surgery Facility	$75	$130	30%	30%
OP Surgical Physician/Surgeon	$20	$40	30%	30%
OP Visit	10%	20%	30%	30%
ER Facility (waived if admitted)	$150	$350	$450	$350
ER Physician (waived if admitted)	$0	$0	$0	$0
Ambulance	$150	$250	$250	$250
Non-Emergent Medical Transportation	$150	$250	$250	$250
Urgent Care Facility	$15	$35	$50	$35

SILVER 87 CSR 200	SILVER 94 CSR 150	BRONZE	MINIMUM COVERAGE CATASTROPHIC	$0 AIAN
$0	$0	$6,300	$9,450	$0
$0	$0	$12,600	$18,900	$0
$0	$0	$500	combined w/ medical	$0
$0	$0	$1,000	combined w/ medical	$0
$3,000	$1,150	$9,100	$9,450	$0
$6,000	$2,300	$18,200	$18,900	$0
$15	$5	$60 deductible applies after the first three non-preventive visits, combined with primary care, specialty care, and urgent care	0% deductible applies after the first three non-preventive visits, combined with primary care, urgent care, BH/SUD office visits	$0
$25	$8	$95 deductible applies after the first three non-preventive visits, combined with primary care, specialty care, and urgent care	0% after ded	$0
$0	**$0**	**$0**	**$0**	**$0**
$20	$8	$40	0% after ded	$0
$40	$8	40% after ded	0% after ded	$0
$100	$50	40% after ded	0% after ded	$0
20%	10%	40% after ded	0% after ded	$0
20%	10%	40% after ded	0% after ded	$0
20%	10%	40% after ded	0% after ded	$0
$150	$50	40% after ded	0% after ded	$0
$0	$0	$0	$0	$0
$75	$30	40% after ded	0% after ded	$0
$75	$30	40% after ded	0% after ded	$0
$15	$5	$60 deductible applies after the first three non-preventive visits, combined with primary care, specialty care, and urgent care	0% deductible applies after the first three non-preventive visits, combined with primary care, urgent care, BH/SUD office visits	$0

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2024 Covered California Plan Benefits

PLAN NAME	PLATINUM COPAY	GOLD COPAY	SILVER 70	SILVER 73 CSR 250
Hospital Facility	$225 per day up to 5 days	$330 per day up to 5 days	30% after ded	30%
IP Physician/Surgeon	$0	$0	30%	30%
BH/SUD Office Visit	$15	$35	$50	$35
BH/SUD Other OP	$15	$35	$50	$35
BH/SUD Inpatient Facility	$225 per day up to 5 days	$330 per day up to 5 days	30% after ded	30%
Prenatal/Preconception Visit	$0	$0	$0	$0
Home Health (per visit)	$20	$30	$45	$40
OP Rehab	$15	$35	$50	$35
OP Habilitation	$15	$35	$50	$35
Skilled Nursing Care	$125 per day up to 5 days	$150 per day up to 5 days	30% after ded	30%
DME	10%	20%	20%	20%
Hospice	$0	$0	$0	$0
Retail (up to 30-day supply)				
Tier 1 -- Generic	$7	$15	$19	$15
Tier 2 -- Preferred Brand	$16	$60	$60 after Rx ded	$55
Tier 3 -- Non-Pref Brand	$25	$85	$90 after Rx ded	$85
Tier 4 -- Specialty	10% up to $250 per script	20% up to $250 per script	20% up to $250 per script after Rx ded	20% up to $250 per script
Mail Order (2X retail cost share up to 100-day supply)				
Tier 1 -- Generic	$14	$30	$38	$30
Tier 2 -- Preferred Brand	$32	$120	$120 after Rx ded	$110
Tier 3 -- Non-Pref Brand	$50	$170	$180 after Rx ded	$170
Pediatric Services				
Routine Eye Exam	$0	$0	$0	$0
Eyewear	$0	$0	$0	$0
Dental -- Preventive	$0	$0	$0	$0
Dental -- Basic	*see 2024 dental copay schedule	*see 2024 dental copay schedule	*see 2024 dental copay schedule	*see 2024 dental copay schedule
Dental -- Major	*see 2024 dental copay schedule	*see 2024 dental copay schedule	*see 2024 dental copay schedule	*see 2024 dental copay schedule
Dental -- Orthodontics	$1,000	$1,000	$1,000	$1,000

SILVER 87 CSR 200	SILVER 94 CSR 150	BRONZE	MINIMUM COVERAGE CATASTROPHIC	$0 AIAN
20%	10%	40% after ded	0% after ded	$0
20%	10%	40% after ded	0% after ded	$0
$15	$5	$60	0% deductible applies after the first three non-preventive visits, combined with primary care, urgent care, BH/SUD office visits	$0
$15	$5	$60	0% after ded	$0
20%	10%	40% after ded	0% after ded	$0
$0	$0	$0	$0	$0
$15	$3	40% after ded	0% after ded	$0
$15	$5	$60	0% after ded	$0
$15	$5	$60	0% after ded	$0
20%	10%	40% after ded	0% after ded	$0
15%	10%	40% after ded	0% after ded	$0
$0	$0	$0	0% after ded	$0
$5	$3	$17 after Rx ded	0% after ded	$0
$25	$10	40% up to $500 per script after Rx ded	0% after ded	$0
$45	$15	40% up to $500 per script after Rx ded	0% after ded	$0
15% up to $150 per script	10% up to $150 per script	40% up to $500 per script after Rx ded	0% after ded	$0
$10	$6	$34 after Rx ded	0% after ded	$0
$50	$20	40% up to $1,000 per script after Rx ded	0% after ded	$0
$90	$30	40% up to $1,000 per script after Rx ded	0% after ded	$0
$0	$0	$0	$0	$0
$0	$0	$0	$0	$0
$0	$0	$0	0% after ded	$0
*see 2024 dental copay schedule	*see 2024 dental copay schedule	*see 2024 dental copay schedule	0% after ded	$0
*see 2024 dental copay schedule	*see 2024 dental copay schedule	*see 2024 dental copay schedule	0% after ded	$0
$1,000	$1,000	$1,000	0% after ded	$0

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2024 Silver Plan Benefits

PLAN NAME	SILVER 70	SILVER 73 CSR 250	SILVER 87 CSR 200	SILVER 94 CSR 150
Deductible -- Ind	$5,400	$0	$0	$0
Deductible -- Fam	$10,800	$0	$0	$0
Rx Deductible -- Ind	$150	$0	$0	$0
Rx Deductible -- Fam	$300	$0	$0	$0
Max OOP -- Ind	$9,100	$6,100	$3,000	$1,150
Max OOP -- Fam	$18,200	$12,200	$6,000	$2,300
Primary Care Office Visit	$50	$35	$15	$5
Specialist Office Visit	$90	$85	$25	$8
Preventive Services	**$0**	**$0**	**$0**	**$0**
Lab	$50	$50	$20	$8
X-ray/Diag Imaging	$95	$95	$40	$8
Adv Imaging (CT/PET, MRI)	$325	$325	$100	$50
OP Surgery Facility	30%	30%	20%	10%
OP Surgical Physician/Surgeon	30%	30%	20%	10%
OP Visit	30%	30%	20%	10%
ER Facility (waived if admitted)	$450	$350	$150	$50
ER Physician (waived if admitted)	$0	$0	$0	$0
Ambulance	$250	$250	$75	$30
Non-Emergent Medical Transportation	$250	$250	$75	$30
Urgent Care Facility	$50	$35	$15	$5
Hospital Facility	30% after ded	30%	20%	10%
IP Physician/Surgeon	30%	30%	20%	10%
BH/SUD Office Visit	$50	$35	$15	$5

PLAN NAME	SILVER 70	SILVER 73 CSR 250	SILVER 87 CSR 200	SILVER 94 CSR 150
BH/SUD Other OP	$50	$35	$15	$5
BH/SUD Inpatient Facility	30% after ded	30%	20%	10%
Prenatal/Preconception Visit	$0	$0	$0	$0
Home Health (per visit)	$45	$40	$15	$3
OP Rehab	$50	$35	$15	$5
OP Habilitation	$50	$35	$15	$5
Skilled Nursing Care	30% after ded	30%	20%	10%
DME	20%	20%	15%	10%
Hospice	$0	$0	$0	$0
Retail (up to 30-day supply)				
Tier 1 -- Generic	$19	$15	$5	$3
Tier 2 -- Preferred Brand	$60 after Rx ded	$55	$25	$10
Tier 3 -- Non-Pref Brand	$90 after Rx ded	$85	$45	$15
Tier 4 -- Specialty	20% up to $250 per script after Rx ded	20% up to $250 per script	15% up to $150 per script	10% up to $150 per script
Mail Order (2X retail cost share up to 100-day supply)				
Tier 1 -- Generic	$38	$30	$10	$6
Tier 2 -- Preferred Brand	$120 after Rx ded	$110	$50	$20
Tier 3 -- Non-Pref Brand	$180 after Rx ded	$170	$90	$30
Pediatric Services				
Routine Eye Exam	$0	$0	$0	$0
Eyewear	$0	$0	$0	$0
Dental -- Preventive	$0	$0	$0	$0
Dental -- Basic	*see 2024 dental copay schedule	*see 2024 dental copay schedule	*see 2024 dental copay schedule	*see 2024 dental copay schedule
Dental -- Major	*see 2024 dental copay schedule	*see 2024 dental copay schedule	*see 2024 dental copay schedule	*see 2024 dental copay schedule
Dental -- Orthodontics	$1,000	$1,000	$1,000	$1,000

Like coming home to a friendly smile

Choose the health plan you know and trust.

Inland Empire Health Plan is now available through Covered California. If you no longer qualify for Medi-Cal, you can stay with the plan you know and trust with IEHP.

Like a loving hug from family

Find the right plan for you!

IEHP.org | 1-855-538-IEHP

<Broker Name>

<1-XXX-XXX-XXXX> | <BrokerSite.org>

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