MediExcel Health Plan: P20 Platinum HMO Plan

Coverage for: All Covered Members | **Plan Type:** HMO

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, go to **www.mediexcel.com** or call **1-855-633-4392**. 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 **http://www.cciio.cms.gov** or call **1-855-633-4392** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. All services are covered as there is no **deductible**	There is no deductible amount before this plan begins to pay for any service.
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?	$3,500 Individual/ $7,000 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 health care 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. See www.mediexcel.com or call 1-855-633-4392 for a list of network providers.	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.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		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	$20 copay/office visit	Not covered	Member pays maximum of one copay per calendar month for primary care physician services.
	Specialist visit	$20 copay/visit	Not covered	None
	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)	$5 copay/X-ray $5 copay/blood work	Not covered	Prior authorization is required for CT/PET scans, MRIs.
	Imaging (CT/PET scans, MRIs)	$100 per visit	Not covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.mediexcel.com**	Tier 1 Drugs [Most generic drugs and low cost preferred brands]	$10 copay/prescription drug	Not covered	Covers up to a 30-day supply for retail. Certain drugs may be covered at a different cost share. In accordance with formulary guidelines. Oral anticancer drugs shall not exceed $200 per month. The Plan does not offer mail order delivery service for prescription drugs.
	Tier 2 Drugs [Most Non-preferred generic drugs and Preferred brand drugs]	$20 copay/prescription drug	Not covered	
	Tier 3 Drugs [Most Non-preferred brand drugs]	$30 copay/prescription drug	Not covered	
	Tier 4 Drugs [limited to Specialty pharmacies; specialty drugs requiring self-administration training and clinical monitoring; Plan cost greater than $600]	40% coinsurance, up to $250 per prescription drug	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$70 copay/visit	Not covered	Preauthorization is required.
	Physician/surgeon fees	No charge	Not covered	None
If you need immediate medical attention	Emergency room care	25% coinsurance	25% coinsurance	Coinsurance applies to the entire episode of emergency care services. Maximum patient cost up to $150 for outpatient emergency coverage services. Urgent care services from non-participating providers located in Mexico are covered only when the member is outside the Plan's service area.
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	Outside of Mexico: $50 copay/visit In Mexico: $25 copay/visit	Outside of Mexico: $50 copay/visit In Mexico: $25 copay/visit	
If you have a hospital	Facility fee (e.g., hospital room)	$100 copay/day	Not covered	Preauthorization is required.

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)	
stay	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/visit	Not covered	None
	Inpatient services	$100 copay/day	Not covered	
If you are pregnant	Office visits	$20 copay/visit	Not covered	Prenatal and postnatal preventive services are covered under preventive care.
	Childbirth/delivery professional services	No charge	Not covered	None
	Childbirth/delivery facility services	$100 copay/day	Not covered	None
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Post-operative home health care only.
	Rehabilitation services	$20 copay/visit	Not covered	None
	Habilitation services	$20 copay/visit	Not covered	
	Skilled nursing care	$50 copay/day	Not covered	None
	Durable medical equipment	20% coinsurance per item	Not covered	Preauthorization is required.
	Hospice services	$50 copay/day	Not covered	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	None
	Children's glasses	No charge	Not covered	1 pair per year; up to age 19. Contact lenses are covered in lieu of glasses.
	Children's dental check-up	No charge	Not covered	Limited to dental treatment plan and Prophylaxis (cleaning) every 6 months, up to age 19.

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 Treatment
- Hearing aids
- Long Term Care
- Non-emergency care when in the U.S.
- Private Duty Nursing
- Routine Foot Care
- Services that are not medically necessary

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

- Acupuncture (if prescribed for rehabilitation purposes)
- Bariatric Surgery
- Infertility treatment
- Weight Loss Programs

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: the California Department of Managed Health Care at 1-888-466- 2219 or www.dmhc.ca.gov, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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.coveredca.com 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 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: 1-855-633-4392.

Does this plan provide Minimum Essential Coverage? **Yes**.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? **Yes**.
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 1-855-633-4392.

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	$0
Specialist copayment	$20
Hospital (facility) copayment	$100 per day
Other coinsurance	20%

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$620
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$680**

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

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) copayment	$100 per day
Other coinsurance	20%

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,010
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,065**

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

The plan's overall deductible	$0
Specialist copayment	$20
Hospital (facility) copayment	$100 per day
Other coinsurance	20%

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$100
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$400**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact MediExcel Health Plan at 1-855-633-4392 or www.mediexcel.com.

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