

 **This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.mediexcel.com](http://www.mediexcel.com) or by calling 1-855-633-4392.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	<b>\$0</b>	See the chart starting on page 2 for your costs for services this <u>plan</u> covers.
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 3 for other costs for services this <u>plan</u> covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	<b>Yes. \$2,000</b> Individual/ <b>\$4,000</b> Family	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the <u>plan</u> pays?	No.	The chart starting on page 2 describes any limits on what the <u>plan</u> will pay for specific covered services, such as office visits.
Does this <u>plan</u> use a <u>network</u> of <u>providers</u> ?	<b>Yes.</b> For a list of <u>preferred providers</u> , see <a href="http://www.mediexcel.com">www.mediexcel.com</a> or call 1-855-633-4392.	If you use an <u>in-network</u> doctor or other health care <u>provider</u> , this <u>plan</u> will pay some or all of the costs of covered services. Be aware, your <u>in-network</u> doctor or hospital may use an <u>out-of-network provider</u> for some services. Plans use the term <u>in-network</u> , <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this <u>plan</u> pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	<b>Yes.</b> MediExcel Health Plan encourages you to receive specialty Services through a referral from your Personal Physician.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have the <u>plan</u> 's permission before you see the <u>specialist</u> .
Are there services this <u>plan</u> doesn't cover?	<b>Yes.</b>	Some of the services this <u>plan</u> doesn't cover are listed on page 4. See your policy or <u>plan</u> document for additional information about <u>excluded services</u> .

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- ⚠ ) **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- ⚠ ) **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the **plan's allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- ⚠ ) The amount the **plan** pays for covered services is based on the **allowed amount**. If an **out-of-network provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an **out-of-network** hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- ⚠ ) This **plan** may encourage you to use **preferred providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a		Limitations & Exceptions
		Plan Provider	Non-Plan Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$5 copay/visit	Not covered	Member pays maximum of one copay per calendar month for primary care physician services.
	Specialist visit	\$5 copay/visit	Not covered	_____none_____
	Other practitioner office visit	\$5 copay/visit	Not covered	_____none_____
	Preventive care/screening/immunization	No charge	Not covered	_____none_____
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	Prior authorization is required.
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Prior authorization is required.
	Tier 1 Drugs [Most generic drugs and low cost preferred brands]	\$5 copay/prescription drug	Not covered	Covers up to a 30-day supply for retail.  Certain drugs may be covered at a different cost share.
	Tier 2 Drugs [Most Non-preferred generic drugs and Preferred brand drugs]	\$5 copay/prescription drug	Not covered	
	Tier 3 Drugs [Most Non-preferred brand drugs]	\$5 copay/prescription drug	Not covered	

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Common Medical Event	Services You May Need	Your Cost If You Use a		Limitations & Exceptions
		Plan Provider	Non-Plan Provider	
<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <u>prescription drug coverage</u> is available at 1-855-633-4392.</p>	Tier 4 Drugs [limited to Specialty pharmacies; drugs requiring self-administration training and clinical monitoring; Plan cost greater than \$600]	20% <u>coinsurance, up to \$250 per prescription drug</u>	Not covered	<p>In accordance with formulary guidelines.</p> <p>Oral anticancer drugs shall not exceed \$200 per month.</p>
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	Prior authorization is required.
	Physician/surgeon fees	No charge	Not covered	—————none—————
<b>If you need immediate medical attention</b>	Emergency room services	10% <u>coinsurance</u>	10% <u>coinsurance</u>	<p><u>Coinsurance</u> applies to the entire episode of emergency care services. Maximum patient cost will not exceed \$100 for outpatient emergency coverage services.</p>
	Emergency medical transportation	No charge	No charge	—————none—————
	Urgent care	<p><u>Outside of Mexico:</u> \$50 copay/visit</p> <p><u>In Mexico:</u> \$5 copay/visit</p>	<p><u>Outside of Mexico:</u> \$50 copay/visit</p> <p><u>In Mexico:</u> \$5 copay/visit</p>	Urgent care services from non-participating providers located in Mexico are covered only when the member is outside the Plan's service area.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	No charge	Not covered	Prior authorization is required.
	Physician/surgeon fee	No charge	Not covered	—————none—————

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Common Medical Event	Services You May Need	Your Cost If You Use a		Limitations & Exceptions
		Plan Provider	Non-Plan Provider	
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient office visits	\$5 copay/visit	Not covered	_____none_____
	Mental/Behavioral health other outpatient items and services	No charge	Not covered	_____none_____
	Mental/Behavioral health inpatient facility (hospital room)	No charge	Not covered	Prior authorization is required.
	Mental/Behavioral health inpatient physician/surgeon fee	No charge	Not covered	_____none_____
	Substance use disorder outpatient office visits	\$5 copay/visit	Not covered	_____none_____
	Substance use disorder other outpatient items and services	No charge	Not covered	_____none_____
	Substance use disorder inpatient facility fee (hospital room)	No charge	Not covered	Prior authorization is required.
	Substance use disorder inpatient physician/surgeon fee	No charge	Not covered	_____none_____
<b>If you are pregnant</b>	Prenatal and postnatal care	No charge	Not covered	_____none_____
	Delivery and all inpatient services	No charge	Not covered	_____none_____
<b>If you need help recovering or have other special health needs</b>	Home health care	No charge	Not covered	Post-operative home health care only.
	Rehabilitation services	\$5 copay/visit	Not covered	_____none_____
	Habilitation services	\$5 copay/visit	Not covered	_____none_____
	Skilled nursing care	No charge	Not covered	_____none_____
	Durable medical equipment	No charge	Not covered	_____none_____
	Hospice service	No charge	Not covered	Prior authorization is required.
<b>If your child needs dental or eye care</b>	Eye exam	No charge	Not covered	_____none_____
	Glasses	Not covered	Not covered	_____none_____
	Dental check-up	No charge	Not covered	Limited to dental treatment plan and Prophylaxis (cleaning) every 6 months.

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## Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Does NOT Cover (This isn't a complete list. Check your policy or <u>plan</u> document for other <u>excluded services</u> .)		
<input type="checkbox"/> Chiropractic care	<input type="checkbox"/> Dental Care Treatment	<input type="checkbox"/> Private-duty nursing
<input type="checkbox"/> Cosmetic surgery	<input type="checkbox"/> Hearing aids	<input type="checkbox"/> Services that are not <u>medically necessary</u> .
<input type="checkbox"/> Non-emergency care when in the US.	<input type="checkbox"/> Long-term care	<input type="checkbox"/> Routine foot care

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
<input type="checkbox"/> Bariatric surgery	<input type="checkbox"/> Routine eye care	<input type="checkbox"/> Weight loss programs
<input type="checkbox"/> Infertility treatment	<input type="checkbox"/> Acupuncture (plan provider referred)	

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-633-4392. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://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](http://www.cciio.cms.gov).

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: 1-855-633-4392. Additionally, a consumer assistance program can help you file your appeal. Contact the California Department of Managed Health Care at 1(888) 466-2219. If you have a complaint or are dissatisfied with a denial of

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coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact the California Department of Managed Health Care at 1(888) 466-2219.

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## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

## 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 page.*—————

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## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



### This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- Amount owed to providers: **\$7,540**
- Plan pays **\$7,390**
- Patient pays **\$150**

#### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$0
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$150
<b>Total</b>	<b>\$150</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: **\$5,400**
- Plan pays **\$5,030**
- Patient pays **\$370**

#### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$0
Copays	\$190
Coinsurance	\$100
Limits or exclusions	\$80
<b>Total</b>	<b>\$370</b>

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- J Costs don't include premiums.
- J Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- J The patient's condition was not an excluded or preexisting condition.
- J All services and treatments started and ended in the same coverage period.
- J There are no other medical expenses for any member covered under this plan.
- J Out-of-pocket expenses are based only on treating the condition in the example.
- J The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.
- J Plan and patient payments are based on a single person enrolled on the plan or policy.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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