# MediExcel Health Plan: Gold 80 HMO 250/35 INF 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 healthcare 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 **(619) 365-4346**. 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 **(619) 365-4346** to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $250 Individual/ $500 Family | 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 primary care services are covered before you meet your deductible. | This Plan covers 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?** | $7,800 Individual/ $15,600 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, balance billing, 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 (619) 365-4346 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. |

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 | $35 copay/visit; deductible does not apply | Not covered | None. |
| | Specialist visit | $55 copay/visit; deductible does not apply | Not covered | None. |
| | Preventive care/screening/ Immunization | No charge: deductible does not apply | Not covered | You may have to pay for non-preventive services. 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) | $55 copay/X-ray; deductible does not apply<br>$35 copay/blood work; deductible does not apply | Not covered | Preauthorization is required for CT/PET scans, MRIs. Failure to obtain preauthorization may result in non-payment of services. |
| | Imaging (CT/PET scans, MRIs) | $250 copay/visit | Not covered | |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** available at **www.mediexcel.com** | Tier 1 Drugs (most generic drugs and low-cost preferred brands) | $15 copay/prescription drug; deductible does not apply | Not covered | Covers up to a 30-day supply for retail.<br>Certain drugs may be covered at a different cost share<br>In accordance with formulary guidelines.<br>Oral anticancer drugs shall not exceed $250 per month.<br>The Plan does not offer mail order delivery service for prescription drugs. |
| | Tier 2 Drugs (most non-preferred generic drugs and preferred brand drugs) | $40 copay/prescription drug; deductible does not apply | Not covered | |
| | Tier 3 Drugs (most non-preferred brand drugs) | $70 copay/prescription drug; deductible does not apply | Not covered | |
| | Tier 4 Drugs (limited to specialty pharmacy and specialty drugs requiring self-administration training and clinical monitoring; Plan cost greater than $600) | 20% coinsurance up to $250 per prescription drug; deductible does not apply | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $300 copay/visit | Not covered | Preauthorization is required for outpatient surgery. Failure to obtain preauthorization may result in non-payment of services. |
| | Physician/surgeon fees | $35 copay; deductible does not apply | Not covered | None. |
| **If you need immediate medical attention** | Emergency room care | $250 copay/visit | $250 copay/visit | Waived if admitted. |
| | Emergency medical transportation | $250 copay | $250 copay | None. |
| | Urgent care | $35 copay; deductible does not apply | $35 copay; deductible does not apply | Non-Plan providers covered when outside the service area |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $600 copay/day, up to 5 days | Not covered | Preauthorization is required for non-emergency hospital stays. Failure to obtain preauthorization may result in non-payment of services. |

[*For more information about limitations and exceptions, see the Plan or policy document at www.mediexcel.com.]

| 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) | |
| | Physician/surgeon fees | No charge: deductible does not apply | Not covered | None. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $35 copay/visit; deductible does not apply | Not covered | None. |
| | Inpatient services | Physician/ Surgeon fee: No charge<br>Facility fee: $600 copay/day, up to 5 days | Not covered | Preauthorization is required for non-emergency hospital stays. Failure to obtain preauthorization may result in non-payment of services. |
| **If you are pregnant** | Office visits | $35 copay/visit, deductible does not apply | Not covered | Prenatal and postnatal services have no cost-sharing as they are considered preventive care services. |
| | Childbirth/delivery professional services | No charge: deductible does not apply | Not covered | |
| | Childbirth/delivery facility services | $600 copay/day, up to 5 days | Not covered | |
| **If you need help recovering or have other special health needs** | Home health care | $30 copay/visit; deductible does not apply | Not covered | Post-operative home health care only. |
| | Rehabilitation services | $35 copay/visit; deductible does not apply | Not covered | None. |
| | Habilitation services | $35 copay/visit; deductible does not apply | Not covered | |
| | Skilled nursing care | $300 copay/day up to 5 days | Not covered | None. |
| | Durable medical equipment | 20% coinsurance per item; deductible does not apply | Not covered | Preauthorization is required for durable medical equipment. Failure to obtain preauthorization may result in non-payment of services. |
| | Hospice services | No charge: deductible does not apply | Not covered | Preauthorization is required for hospice services. Failure to obtain preauthorization may result in non-payment of services. |
| **If your child needs dental or eye care** | Children's eye exam | No charge: deductible does not apply | Not covered | None. |
| | Children's glasses | No charge: deductible does not apply | 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: deductible does not apply | Not covered | Limited to dental treatment plan and prophylaxis (cleaning) every 6 months, up to age 19. |

[*For more information about limitations and exceptions, see the Plan or policy document at www.mediexcel.com.]

## 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
- Adult 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 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: (619) 365-4346. Additionally, a consumer assistance program can help you file your appeal. Contact the California Department of Managed Health Care at 1-888-466-2219 or www.dmhc.ca.gov.

**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? 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 (619) 365-4346.

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

[*For more information about limitations and exceptions, see the Plan or policy document at www.mediexcel.com.]

## 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 | $250 |
| Specialist copayment | $55 |
| Hospital (facility) copayment | $600 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* | $250 |
| Copayments | $976 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$1,286** |

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

| | |
|---|---|
| The Plan's overall deductible | $250 |
| Specialist copayment | $55 |
| Hospital (facility) copayment | $600 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** | **$5,600** |

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $20 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $55 |
| **The total Joe would pay is** | **$175** |

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

| | |
|---|---|
| The Plan's overall deductible | $250 |
| Specialist copayment | $55 |
| Hospital (facility) copayment | $600 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** | **$2,800** |

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $250 |
| Copayments | $250 |
| Coinsurance | $406 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$906** |

Note: these numbers assume the member 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, contact MediExcel Health Plan at (619) 365-4346 or www.mediexcel.com. *This Plan has other deductibles for specific services included in these coverage example. See "Are there other deductibles for specific services?" row above.

The **Plan** would be responsible for the other costs of these SAMPLE covered services.