


# MediExcel Health Plan: P10 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](http://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 <a href="#">deductible</a> ?	\$0	See the Common Medical Events chart below for your costs for services this <a href="#">Plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. All services are covered as there is no <a href="#">deductible</a>	There is no <a href="#">deductible</a> amount before this <a href="#">Plan</a> begins to pay for any service.
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$4,000 Individual/ \$8,000 Family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">Plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , balance billing and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.mediexcel.com">www.mediexcel.com</a> or call 1-855-633-4392 for a list of <a href="#">network providers</a> .	This <a href="#">Plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Yes.	This <a href="#">Plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$10 <a href="#">copay</a> /office visit	Not covered	Member pays maximum of one <a href="#">copay</a> per calendar month for primary care physician services.
	<a href="#">Specialist</a> visit	\$20 <a href="#">copay</a> /visit	Not covered	None.
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	You may have to pay for non- <a href="#">preventive</a> services. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$5 <a href="#">copay</a> /X-ray \$5 <a href="#">copay</a> /blood work	Not covered	<a href="#">Preauthorization</a> is required for CT/PET scans, MRIs. Failure to obtain <a href="#">preauthorization</a> may result in non-payment of services.
	Imaging (CT/PET scans, MRIs)	\$100 <a href="#">copay</a> /visit	Not covered	
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> available at <a href="http://www.mediexcel.com">www.mediexcel.com</a>	Tier 1 Drugs (most generic drugs and low-cost preferred brands)	\$10 <a href="#">copay</a> /prescription drug	Not covered	Covers up to a 30-day supply for retail.
	Tier 2 Drugs (most non-preferred generic drugs and preferred brand drugs)	\$20 <a href="#">copay</a> /prescription drug	Not covered	Certain drugs may be covered at a different cost share.
	Tier 3 Drugs (most non-preferred brand drugs)	\$30 <a href="#">copay</a> /prescription drug	Not covered	In accordance with formulary guidelines. Oral anticancer drugs shall not exceed \$250 per month.
	Tier 4 Drugs (limited to specialty pharmacy and <a href="#">specialty drugs</a> requiring self-administration training and clinical monitoring; Plan cost greater than \$600)	40% <a href="#">coinsurance</a> , up to \$250 per prescription drug	Not covered	The Plan does not offer mail order delivery service for prescription drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$80 <a href="#">copay</a> /visit	Not covered	<a href="#">Preauthorization</a> is required for outpatient surgery. Failure to obtain <a href="#">preauthorization</a> may result in non-payment of services.
	Physician/surgeon fees	No charge	Not covered	None.
If you need immediate medical attention	<a href="#">Emergency room care</a>	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	<a href="#">Coinsurance</a> applies to the entire episode of emergency care services. Maximum patient cost up to \$250 for outpatient emergency coverage services.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
	<a href="#">Urgent care</a>	Outside of Mexico: \$40 <a href="#">copay</a> /visit  In Mexico: \$20 <a href="#">copay</a> /visit	Outside of Mexico: \$40 <a href="#">copay</a> /visit  In Mexico: \$20 <a href="#">copay</a> /visit	<a href="#">Urgent care</a> services from non-participating providers located in Mexico are covered only when the member is outside the Plan's service area.

[\* For more information about limitations and exceptions, see the [Plan](#) or policy document at [www.mediexcel.com](http://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)	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 <a href="#">copay</a> /day, up to 5 days	Not covered	<a href="#">Preauthorization</a> is required for non-emergency hospital stays. Failure to obtain <a href="#">preauthorization</a> may result in non-payment of services.
	Physician/surgeon fees	No charge	Not covered	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$10 <a href="#">copay</a> /visit	Not covered	None.
	Inpatient services	\$100 <a href="#">copay</a> /day, up to 5 days	Not covered	<a href="#">Preauthorization</a> is required for non-emergency hospital stays. Failure to obtain <a href="#">preauthorization</a> may result in non-payment of services.
If you are pregnant	Office visits	\$10 <a href="#">copay</a> /visit	Not covered	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive</a> services.
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	\$100 <a href="#">copay</a> /day, up to 5 days	Not covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	No charge	Not covered	Post-operative home health care only.
	<a href="#">Rehabilitation services</a>	\$10 <a href="#">copay</a> /visit	Not covered	None.
	<a href="#">Habilitation services</a>	\$10 <a href="#">copay</a> /visit	Not covered	None.
	<a href="#">Skilled nursing care</a>	\$50 <a href="#">copay</a> /day	Not covered	None.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a> per item	Not covered	<a href="#">Preauthorization</a> is required for durable medical equipment. Failure to obtain <a href="#">preauthorization</a> may result in non-payment of services.
	<a href="#">Hospice services</a>	\$50 <a href="#">copay</a> /day	Not covered	<a href="#">Preauthorization</a> is required for hospice services. Failure to obtain <a href="#">preauthorization</a> may result in non-payment of services.
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.

[\* For more information about limitations and exceptions, see the [Plan](#) or policy document at [www.mediexcel.com](http://www.mediexcel.com).]

## Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<input type="checkbox"/> Chiropractic care	<input type="checkbox"/> Hearing aids	<input type="checkbox"/> Private Duty Nursing
<input type="checkbox"/> Cosmetic Surgery	<input type="checkbox"/> Long Term Care	<input type="checkbox"/> Routine Foot Care
<input type="checkbox"/> Dental Care Treatment	<input type="checkbox"/> Non-emergency care when in the U.S.	<input type="checkbox"/> Services that are not <u>medically necessary</u>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<input type="checkbox"/> Acupuncture (if prescribed for rehabilitation purposes)	<input type="checkbox"/> Infertility treatment	<input type="checkbox"/> Weight Loss Programs
<input type="checkbox"/> Bariatric Surgery		

**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](http://www.dmhc.ca.gov), 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). 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](http://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: 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 or [www.dmhc.ca.gov](http://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 1-855-633-4392.

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-----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](#) 15%

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$221
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$281</b>

**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](#) 15%

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$40
Coinsurance	\$201
What isn't covered	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$296</b>

**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](#) 15%

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$70
Coinsurance	\$438
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$508</b>

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](http://www.mediexcel.com).