

**MediExcel Health Plan: Value Plan 5 (VP-5)**

The Summary of Benefits & 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> ?	\$2,000 Individual/ \$4,000 Family.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a yearly period 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> , 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> .

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	\$5 <a href="#">copay</a> /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	\$10 <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 services that aren't <a href="#">preventive</a> . 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)	No charge	Not covered	Prior authorization is required for CT/PET scans, MRIs.
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.mediexcel.com">www.mediexcel.com</a>	Tier 1 Drugs [Most generic drugs and low cost preferred brands]	\$5 <a href="#">copay</a> /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]	\$10 <a href="#">copay</a> /prescription drug	Not covered	
	Tier 3 Drugs [Most Non-preferred brand drugs]	\$15 <a href="#">copay</a> /prescription drug	Not covered	
	Tier 4 Drugs [limited to Specialty pharmacies; <a href="#">specialty drugs</a> requiring self-administration training and clinical monitoring; Plan cost greater than \$600]	20% <a href="#">coinsurance</a> , up to \$250 per prescription drug	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	<a href="#">Preauthorization</a> is required.
	Physician/surgeon fees	No charge	Not covered	None.
If you need immediate medical attention	<a href="#">Emergency room care</a>	15% <a href="#">coinsurance</a>	15% <a href="#">coinsurance</a>	<a href="#">Coinsurance</a> applies to the entire episode of emergency care services. Maximum patient cost will not exceed \$150 for outpatient emergency coverage services.  <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.
	<a href="#">Emergency medical transportation</a>	No charge	No charge	
	<a href="#">Urgent care</a>	<u>Outside of Mexico:</u> \$35 copay/visit  <u>In Mexico:</u> \$15 copay/visit	<u>Outside of Mexico:</u> \$35 copay/visit  <u>In Mexico:</u> \$15 copay/visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	<a href="#">Preauthorization</a> is required.
	Physician/surgeon fees	No charge	Not covered	None.

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 need mental health, behavioral health, or substance abuse services	Outpatient services	\$5 <a href="#">copay</a> /visit	Not covered	None.
	Inpatient services	No charge	Not covered	
If you are pregnant	Office visits	\$5 <a href="#">copay</a> /visit	Not covered	Preconception and prenatal services are covered under preventive care.
	Childbirth/delivery professional services	No charge	Not covered	None.
	Childbirth/delivery facility services	No charge	Not covered	None.
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>	\$5 <a href="#">copay</a> /visit	Not covered	None.
	<a href="#">Habilitation services</a>	\$5 <a href="#">copay</a> /visit	Not covered	
	<a href="#">Skilled nursing care</a>	No charge	Not covered	None.
	<a href="#">Durable medical equipment</a>	10%	Not covered	None.
	<a href="#">Hospice services</a>	No charge	Not covered	<a href="#">Preauthorization</a> is required.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	None.
	Children's glasses	Not covered	Not covered	None.
	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](#).)

<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 [Plan](#) 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 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](#) \$10
- Hospital (facility) [Copayment](#) \$0
- Other [Coinsurance](#) 10%

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	\$105
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$165

**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](#) \$10
- Hospital (facility) [Copayment](#) \$0
- Other [Coinsurance](#) 10%

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	\$250
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$55
The total Joe would pay is	\$305

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

- The [Plan's](#) overall [Deductible](#) \$0
- [Specialist Copayment](#) \$10
- Hospital (facility) [Copayment](#) \$0
- Other [Coinsurance](#) 10%

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	\$25
Coinsurance	\$75
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$100

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).