MediExcel Health Plan: Platinum Mirror Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: Beginning on or after 1/1/2017

Coverage for: Family | **Plan Type:** HMO

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** or by calling **1-855-633-4392**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for your costs for services this **plan** covers.
Are there other deductibles for specific services?	**No**	You don't have to meet **deductibles** for specific services, but see the chart starting on page 3 for other costs for services this **plan** covers.
Is there an out–of–pocket limit on my expenses?	**Yes. $4,000** Individual/ **$8,000** Family	The **out-of-pocket limit** 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 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**.
Is there an overall annual limit on what the plan pays?	**No.**	The chart starting on page 2 describes any limits on what the **plan** will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	**Yes.** For a list of **preferred providers**, see **www.MediExcel.com or call 1-855-633-4392.**	If you use an **in-network** doctor or other health care **provider**, this **plan** will pay some or all of the costs of covered services. Be aware, your **in-network** doctor or hospital may use an **out-of-network provider** for some services. Plans use the term **in-network**, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this **plan** pays different kinds of **providers**.
Do I need a referral to see a specialist?	**Yes. MediExcel Health Plan encourages you to receive specialty Services through a referral from your Personal Physician.**	This **plan** will pay some or all of the costs to see a **specialist** for covered services but only if you have the **plan**'s permission before you see the **specialist**.
Are there services this plan doesn't cover?	**Yes.**	Some of the services this **plan** doesn't cover are listed on page 4. See your policy or **plan** document for additional information about **excluded services**.

- **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 Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay/visit	Not covered	——————none——————
	Specialist visit	$40 copay/visit	Not covered	——————none——————
	Other practitioner office visit	$15 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)	$40/X-ray $20/blood work	Not covered	Prior authorization is required.
	Imaging (CT/PET scans, MRIs)	$150	Not covered	Prior authorization is required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at 1-855-633-4392.	Tier 1 Drugs [Most generic drugs and low cost preferred brands]	$5 copay/ prescription	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.
	Tier 2 Drugs [Most Non-preferred generic drugs and Preferred brand drugs]	$15 copay/ prescription	Not covered	
	Tier 3 Drugs [Most Non-preferred brand drugs]	$25 copay/ prescription	Not covered	
	Tier 4 Drugs [limited to Specialty pharmacies; drugs requiring self-administration training and clinical monitoring; Plan cost greater than $600]	10% Coinsurance, up to $250 per prescription drug	Not covered	
If you have	Facility fee (e.g., ambulatory surgery center)	$250 copay/visit	Not covered	Prior authorization is required.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
outpatient surgery	Physician/surgeon fees	$40 copay	Not covered	——————none——————
If you need immediate medical attention	Emergency room services	$150 copay/visit	$150 copay/visit	waived if admitted
	Emergency medical transportation	$150	$150	——————none——————
	Urgent care	$15 copay	$15 copay	Non-Plan providers covered when outside the service area
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay/day Up to 5 days	Not covered	Prior authorization is required.
	Physician/surgeon fee	$40 copay	Not covered	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visit	$15 copay/visit	Not covered	——————none——————
	Mental/Behavioral health other outpatient items and services	$15 copay	Not covered	——————none——————
	Mental/Behavioral health inpatient facility fee (hospital room)	$250 copay/day Up to 5 days	Not covered	Prior authorization is required.
	Mental/Behavioral health inpatient physician/surgeon fee	$40 copay	Not covered	——————none——————
	Substance use disorder outpatient office visits	$15 copay/visit	Not covered	——————none——————
	Substance use disorder other outpatient items and services	$15 copay	Not covered	——————none——————
	Substance use disorder inpatient facility fee (hospital room)	$250 copay/day Up to 5 days	Not covered	Prior authorization is required.
	Substance use disorder inpatient physician/surgeon fee	$40 copay	Not covered	——————none——————
If you are pregnant	Prenatal and postnatal care	Prenatal care: No charge; Postnatal care: No charge	Not covered	Prenatal: Cost sharing is for routine preventive care only; Postnatal: Cost sharing is for the first postnatal visit only.
	Delivery and all inpatient services (hospital room and physician services)	$290 copay/day Up to 5 days	Not covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	$20 copay/visit	Not covered	Post-operative home health care only.
	Rehabilitation services	$15 copay/visit	Not covered	——————none——————
	Habilitation services	$15 copay/visit	Not covered	——————none——————
	Skilled nursing care	$150 copay/day Up to 5 days	Not covered	——————none——————
	Durable medical equipment	10% **coinsurance** per item	Not covered	Prior authorization is required.
	Hospice service	No charge	Not covered	Prior authorization is required.
If your child needs dental or eye care	Eye exam	No charge	Not covered	——————none——————
	Glasses	No charge	Not covered	1 pair per year; up to age 19. Contact lenses are covered in lieu of glasses.
	Dental check-up	No charge	Not covered	Limited to dental treatment plan and Prophylaxis (cleaning) every 6 months, up to age 19. See Pediatric Dental Benefits Disclosure for additional information about covered benefit services.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Chiropractic care
- Cosmetic surgery
- Non-emergency care when in the US.
- Dental Care Treatment (Adult)
- Hearing aids
- Long-term care
- Private-duty nursing
- Services that are not **medically necessary**.
- 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.)

Questions: Call 1-855-633-4392 or visit us at www.MediExcel.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-855-633-4392 to request a copy.

- Bariatric surgery
- Acupuncture
- Weight loss programs
- Infertility treatment

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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or 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 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.

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.*

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 $6,775**
- **Patient pays $765**

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
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$615
Coinsurance	$0
Limits or exclusions	$150
Total	**$765**

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

- **Amount owed to providers: $5,400**
- **Plan pays $4,910**
- **Patient pays $490**

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
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$280
Coinsurance	$130
Limits or exclusions	$80
Total	**$490**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- 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.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this **plan**.
- **Out-of-pocket** expenses are based only on treating the condition in the example.
- 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.
- 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.