MediExcel HEALTH PLAN

2017 Small Group Plan P5 Summary of Benefits and Coverage
Effective 1/1/2017

Individual/Family Overall Annual Deductible	$0
Individual/Family Annual Out–of–Pocket Maximum	$3,200/$6,400

Common Medical Event	Service Type	Member Cost Share
Health Care Provider's Office or Clinic Visit	Office Visits – PCP or Primary Care (including Mental Health)	$5 per visit
	Office Visits – Specialist	$10 per visit
	Office Visits - Other Healthcare Practitioners	$5 per visit
	Preventive Care/Screening/Immunization*	No Copay
	Telemedicine	No Copay
	Dental Prophylaxis Cleaning (for all Members)	No Copay
Tests	Laboratory Tests	No Copay
	X-rays and Diagnostic Imaging	No Copay
	Imaging – (CT/Pet Scans, MRIs)	$100 per visit
Outpatient Prescription Drug Coverage to treat illness or condition	Tier 1	$10 per drug
	Tier 2	$10 per drug
	Tier 3	$15 per drug
	Tier 4	40%, up to $250 per script
Outpatient Surgery	Facility Fee	$50 per visit
	Physician/Surgeon Fee	No Copay
Need Immediate Attention	Emergency Room Facility Fee	15%, Not to Exceed $150
	Ambulance Services or emergency medical transportation	15%
	Urgent Care in Mexico	$20 per visit
	Urgent Care outside of Mexico	$50 per visit
Hospital Stays	Inpatient Hospital Facility Fees	No Copay
	Inpatient Physician/Surgeon Fees	No Copay
Mental Health, Behavioral Health, or Substance Abuse Needs	Mental/Behavioral health outpatient office visits	$5 per visit
	Mental/Behavioral health other outpatient items and services	No Copay
	Mental/Behavioral health inpatient services (hospital room)	No Copay
	Mental/Behavioral health inpatient physician/surgeon fee	No Copay
	Substance use disorder outpatient office visits	$5 per visit
	Substance use disorder other outpatient items and services	No Copay
	Substance use disorder inpatient services (hospital room)	No Copay
	Substance use disorder inpatient physician/surgeon fee	No Copay
Pregnancy	Prenatal care and preconception visits	No Copay
	Delivery and all inpatient services - Hospital	No Copay
	Delivery and all inpatient services - Professional	No Copay
Help Recovering or other Special Health Needs	Home health care	No Copay
	Outpatient Rehabilitation/Habilitation Therapy Services	$10 per visit
	Skilled Nursing Care	No Copay
	Durable Medical Equipment (including Diabetic Equipment)	50%, not to exceed $100
	Prosthetics/Orthotics	No Copay
	Hospice Services	$50/day
Child Eye Care	Eye exam	No Copay
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No Copay
Child Dental Diagnostic and Preventive	Oral Exam	No Copay
	Preventive – Cleaning & X-ray	No Copay
	Sealants per Tooth	No Copay
	Topical Fluoride Application	No Copay
	Space Maintainers – Fixed	No Copay
Child Dental Basic Services	Amalgam Fill - 1 Surface	$25

Child Dental Major Services	Root Canal- Molar	$300
	Gingivectomy per Quad	$150
	Extraction- Single Tooth Exposed Root or Erupted	$65
	Extraction- Complete Bony	$160
	Porcelain with Metal Crown	$300
Child Orthodontics	Medically necessary orthodontics	$350

See Endnotes

Endnotes:

1) Family out-of-pocket maximums are equal to 2 times the individual values. Cost sharing payments (copayments and coinsurance, but not yet premiums) made by each individual in a family contribute to the family out-of-pocket maximums. Once the family out-of-pocket maximum is reached, the plan pays all costs for covered services for all family members. In a family plan, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum.
2) The cost-sharing payments cannot exceed the out of pocket limits set for self-only coverage and family coverage.
3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount (the maximum amount on which payment is based for covered health care services).
4) For drugs to treat an illness or condition the supply of drugs for which the copay or coinsurance applies is for the prescription term, not to exceed 30 days.
5) Preventive Care Includes checkups; periodic screenings; Well-baby visits up to age 2; Well-woman visits; Pap and HPV tests; Maternity/prenatal care; Immunizations for children; Vision and hearing exams; Dental cleanings; health education classes; and a wellness program.
6) Coinsurance applies to the entire episode of emergency care services. Maximum patient cost will not exceed $150 for outpatient emergency care services.
7) Cost-sharing payments for drugs that are not on-formulary but are approved as exceptions accumulate toward the Plan's out-of-pocket maximum.
8) Copayments may never exceed the Plan's actual cost of the service. For example, if urgent care services rendered in California cost less than the $50 copayment, the lesser amount is the Member's applicable cost-sharing amount.
9) Member's cost-sharing amount for oral anti-cancer drugs shall not exceed $200 per month per state law.
10) The Outpatient Visit line item within the Outpatient Services category includes but is not limited to the following types of outpatient visits: outpatient chemotherapy, outpatient radiation, outpatient infusion therapy and outpatient dialysis and similar outpatient services.
11) Copayments may never exceed the Plan's actual cost of the service. For example, if laboratory tests cost less than the $20 copayment, the lesser amount is the Member's applicable cost-sharing amount.
12) Cost-sharing for services subject to the federal Mental Health Parity and Addiction Equity Act (MHPAEA) may be less than those listed in these standard benefit plan designs if necessary for compliance with MHPAEA.
13) Mental/Behavioral Health Outpatient Services at a $5 copay level include: individual and group evaluation; individual and group treatment; and, individual and group chemical dependency counseling.
14) Mental/Behavioral Health Outpatient Services at a $0 copay level include: psychology testing; outpatient monitoring of drug therapy; partial hospitalization; and, multidisciplinary treatment in an intensive outpatient psychiatric treatment program.
15) Substance Use Disorder (SUD) Outpatient Services at a $5 copay level include: intensive outpatient programs, individual and group evaluation; individual and group treatment; and, individual and group chemical dependency counseling.
16) Substance Use Disorder (SUD) Outpatient Services at a $0 copay level include: day treatment programs.
17) Mental/Behavioral Health Inpatient Services at a no copay level include: inpatient psychiatric hospitalization, psychiatric observation, and crisis residential program.
18) SUD Inpatient Services at a no copay level include: inpatient detoxification; medication treatment for withdrawal; and, transitional residential recovery services in a non-medical setting.
19) Drug tiers are defined as follows:

Tier	Definition
1	1) Most generic drugs and low cost preferred brands.
2	1) Non-preferred generic drugs or; 2) Preferred brand name drugs or; 3) Recommended by the plan's pharmaceutical and therapeutics (P&T) committee based on drug safety, efficacy and cost.
3	1) Non-preferred brand name drugs or; 2) Recommended by P&T committee based on drug safety, efficacy and cost or; 3) Generally have a preferred and often less costly therapeutic alternative at a lower tier.
4	1) Food and Drug Administration (FDA) or drug manufacturer limits distribution to specialty pharmacies or; 2) Self administration requires training, clinical monitoring or; 3) Drug was manufactured using biotechnology or; 4) Plan cost (net of rebates) is >$600.

20) This Plan Design was previously name Plan P10 in 2016.