

MediExcel Health Plan: 2025 VP-5 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 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 ? | \$0 | See the Common Medical Events chart below for your costs for services this Plan covers. |
| Are there services covered before you meet your deductible ? | Yes. All services are covered as there is no deductible . | There is no deductible amount before this Plan begins to pay for any service. |
| 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 ? | \$4,500 Individual/ \$9,000 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 bill, 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 | \$5 copay /visit | Not covered | Member pays maximum of one copay per calendar month for primary care physician services. |
| | Specialist visit | \$10 copay /visit | Not covered | None. |
| | Preventive care/screening/immunization | No charge | Not covered | You may have to pay for services that aren't preventive . 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) | No charge | 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) | No charge | Not covered | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage available at www.mediexcel.com | Generic drugs (Tier 1) | \$5 copay /prescription drug | Not covered | Covers up to a 30-day supply for retail. |
| | Preferred brand drugs (Tier 2) | \$10 copay /prescription drug | Not covered | In accordance with formulary guidelines. |
| | Non-preferred brand drugs (Tier 3) | \$15 copay /prescription drug | Not covered | Oral anticancer drugs shall not exceed \$250 per month. |
| | Specialty drugs (Tier 4) | 20% coinsurance , 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) | No charge | Not covered | Preauthorization is required for outpatient surgery. Failure to obtain preauthorization may result in non-payment of services. |
| | Physician/surgeon fees | No charge | Not covered | None. |
| If you need immediate medical attention | Emergency room care | 15% coinsurance | 15% coinsurance | Coinsurance applies to the entire episode of emergency care services. Maximum patient cost will not exceed \$250 for outpatient emergency coverage services. |
| | Emergency medical transportation | \$100 copay | \$100 copay | |
| | Urgent Care | <u>Outside of Mexico:</u> \$35 copay /visit | <u>Outside of Mexico:</u> \$35 copay /visit | Urgent Care services from non-participating providers located in Mexico are covered only when the member is outside the Plan's service area. |
| | | <u>In Mexico:</u> \$15 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 | Preauthorization is required for non-emergency hospital stays. Failure to obtain preauthorization may result in non-payment of services. |
| | 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 copay /visit | Not covered | None. |
| | Inpatient services | No charge | Not covered | |
| If you are pregnant | Office visits | \$5 copay /visit | Not covered | Prenatal and postnatal services have no cost-sharing as they are considered preventive care services. |
| | Childbirth/delivery professional services | No charge | Not covered | |
| | Childbirth/delivery facility services | No charge | Not covered | |
| If you need help recovering or have other special health needs | Home health care | No charge | Not covered | None. |
| | Rehabilitation services | \$5 copay /visit | Not covered | None. |
| | Habilitation services | \$5 copay /visit | Not covered | None. |
| | Skilled nursing care | No charge | Not covered | None. |
| | Durable medical equipment | 10% coinsurance | Not covered | None. |
| | Hospice services | No charge | 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 | 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 .) | | | |
|---|---------------------------------------|--|--|
| • Chiropractic care | • Hearing aids | • Private duty nursing | |
| • Cosmetic surgery | • Long-term care | • Routine foot care | |
| • Dental care treatment | • Non-emergency care when in the U.S. | • 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.) | | |
|--|-------------------------|------------------------|
| • Acupuncture (if prescribed for rehabilitation purposes) | • Infertility treatment | • Weight loss programs |
| • 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.dmhca.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.dmhca.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, llama al (619) 365-4346.

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 | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|-------------|
| Deductibles | \$0 |
| Copayments | \$15 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$75 |

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 | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|--------------|
| Deductibles | \$0 |
| Copayments | \$279 |
| Coinsurance | \$86 |
| What isn't covered | |
| Limits or exclusions | \$55 |
| The total Joe would pay is | \$420 |

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

| | |
|---|------|
| ■ The Plan's overall deductible | \$0 |
| ■ Specialist copayment | \$50 |
| ■ Hospital (facility) copayment | 20% |
| ■ 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 | \$0 |
| Copayments | \$35 |
| Coinsurance | \$80 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$115 |

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.