MediExcel HEALTH PLAN

2022 Large Group Summary of Benefits & Coverage

		VP-5 HMO	VP-10 HMO	VP-20 HMO
Individual/Family Overall Annual Deductible		**$0**	**$0**	**$0**
Individual/Family Annual Out-of-Pocket Maximum		$3,000/$6,000	$3,500/$7,000	$4,000/$8,000
Medical Event	**Service type**	**Copay**	**Copay**	**Copay**
Health Care Provider's Officer or Clinic Visit	Office Visits - Primary Care (incl. mental health)	$5 per visit	$10 per visit	$20 per visit
	Office Visits - Specialist	$10 per visit	$15 per visit	$20 per visit
	Office Visits - Other Healthcare Practitioners	$5 per visit	$10 per visit	$20 per visit
	Preventive Care/Screening/Immunization	No Copay	No Copay	No Copay
	Telemedicine Consultation	No Copay	No Copay	No Copay
	Dental Exam & Cleaning (for all members)	No Copay	No Copay	No Copay
Tests	Laboratory Tests	No Copay	$5 per visit	$5 per visit
	X-rays & Diagnostic Imaging	No Copay	$5 per visit	$5 per visit
	Imaging - (CT/Pet Scans, MRIs)	No Copay	$30 per visit	$30 per visit
Outpatient Prescription Drug Coverage	Tier 1 - Generic/Low-cost brands	$5 per drug	$10 per drug	$20 per drug
	Tier 2 - Brand Formulary	$10 per drug	$15 per drug	$20 per drug
	Tier 3 - Brand Non-Formulary	$15 per drug	$20 per drug	$30 per drug
	Tier 4 - Specialty Drugs	20%, up to $250	25%, up to $250	30%, up to $250
Outpatient Services	Surgery Facility Fee	No Copay	$50 per visit	$100 per visit
	Physician/Surgeon Fee	No Copay	No Copay	No Copay
	Outpatient Visit	10%	10%	20%
Emergency & Urgent Care*	Emergency Room Facility Fee	15%, up to $250	15%, up to $250	20%, up to $250
	Emergency Medical Transportation	$100 Copay	$150 copay	15%
	Urgent Care in Mexico	$15 per visit	$20 per visit	$25 per visit
	Urgent Care in the US/Outside of Mexico	$35 per visit	$40 per visit	$50 per visit
Hospital Stays	Inpatient Hospital Facility Fee	No Copay	$50 per day	$150 per day
	Inpatient Physician/Surgeon Fee	No Copay	No Copay	No Copay
Mental Health, Behavioral Health, or Substance Abuse Needs	Outpatient Office Visits	$5 per visit	$10 per visit	$20 per visit
	Other Outpatient Items & Services	No Copay	No Copay	No Copay
	Inpatient Services (hospital room)	No Copay	$50 per day	$150 per day
	Inpatient Physician/Surgeon Fee	No Copay	No Copay	No Copay
Pregnancy	Preconception Care & Prenatal Visits	No Copay	No Copay	No Copay
	Delivery & All Inpatient Services (professional & hospital)	No Copay	$50 per day	$150 per day
Help Recovering or Other Special Health Needs	Home Health Care	No Copay	No Copay	No Copay
	Outpatient Rehabilitation/Habilitation Therapy	$5 per visit	$10 per visit	$20 per visit
	Skilled Nursing Care	No Copay	$25 per day	$75 per day
	Durable Medical Equipment (incl. diabetic equip.)	10%	10%	20%
	Prosthetics/Orthotics	10%	10%	20%
	Hospice Services	No Copay	No Copay	No Copay

In regard to ACA Compliancy, please note that all of the above plan designs provide Minimum Essential Coverage (MEC) and have Minimal Value (MV). See 2022 specific plan design Summary of Benefits for all applicable notes, limitations and conditions.

*Coinsurance applies to the entire episode of emergency care services. Maximum cost will not exceed $250 for outpatient emergency care services except where a copay amount is already indicated.

MediExcel Health Plan
Dental HMO Plan

Dental Plan 200

Benefit Summary

THIS MATRIX IS ONLY A SUMMARY AND IS INTENDED TO HELP YOU COMPARE COVERAGE BENEFITS. FOR A DETAILED DESCRIPTION OF BENEFITS AND LIMITATIONS, PLEASE CONSULT YOUR *EVIDENCE OF COVERAGE* AND PLAN CONTRACT.

Using Your Dental Plan

Your Plan grants you access to a network of dental providers without deductibles or the filing of claim forms. To schedule an appointment, including referrals for consultation and emergency services, contact MediExcel's Member Line toll-free at (855) 633-4392.

PLAN FEATURES	IN-NETWORK PROVIDERS
Calendar Year Deductible	$0
Annual Benefit Maximum	None

ADA CODE	COVERED SERVICES	COPAY
	DIAGNOSTIC SERVICES	
D0120	Oral Evaluations	$0
D0210	Full Mouth Series X-rays	$0
D0220	Periapical X-ray Film	$0
D0230	Each Additional Film	$0
D0460	Pulp Vitality Test	$0
D1130	Emergency Oral Examinations	$0
	PREVENTIVE SERVICES	
D1110	Cleaning (Prophylaxis) – Adult	$0
D1120	Cleaning (Prophylaxis) – Child	$0
D1203	Fluoride - Child	$0
D1204	Fluoride - Adult	$0
- Diagnostic and Preventive services may be subject to age and frequency limitations. See your Evidence of Coverage for details.		
	SPACE MAINTAINERS	
D1510	Space Maintainer – Fixed Unilateral	$20
D1520	Space Maintainer – Removable Unilateral	$25
	RESTORATIVE SERVICES	
	PRIMARY OR PERMANENT TEETH	
D2140	Amalgam (Cavity) – 1 Surf Primary of Permanent	$5
D2150	Amalgam (Cavity) – 2 Surf Primary of Permanent	$8
D2160	Amalgam (Cavity) – 3 Surf Primary of Permanent	$10
D2161	Amalgam (Cavity) – 4+ Surf Primary of Permanent	$10
D2210	Silicate Cement – Per Restoration	$15
D2310	Acrylic or Plastic Restoration, Anterior	$15
D2330	Resin-Based Composite 1 Surf, Anterior	$20
D2331	Resin-Based Composite 2 Surf, Anterior	$20
D2332	Resin-Based Composite 3 Surf, Anterior	$25
D2335	Resin-Based Composite 4+ Surf, Anterior	$25

CROWNS/BRIDGES		
D2740	Crown – Porcelain/Ceramic Substrate	$50
D2751	Crown – Porcelain Fused to Predominantly Base Metal	$50
D2753	Crown – Acrylic	$45
D2754	Crown – Acrylic with Metal	$45
D2791	Crown – Full Cast Predominantly Base Metal	$15
D2810	Crown – 3/4	$50
D2910	Recement Inlay, Onlay or Partial Coverage Restoration	$5
D2920	Recement Crown	$5
D2930	Prefab, Stainless Steel Crown – Primary Tooth	$15
D2931	Prefab, Stainless Steel Crown – Permanent Tooth	$15
D2950	Core Buildup, Including Any Pins	$35
D2952	Post & Core in Addition to Crown	$40
D6211	Pontic – Cast Predominantly Base Metal	$60
D6241	Pontic – Porcelain Fused to Predominantly Base Metal	$70
D6251	Pontic – Resin with Predominantly Base Metal	$60
- Full mouth rehabilitation is defined as 6 or more units of covered crowns and/or pontic under one treatment plan. - Charges for crowns and bridgework are per unit. There will be additional charges for the actual cost of the gold/high noble metal.		
ENDODONTIC SERVICES		
D3110	Pulp Cap – Direct (excluding final restoration)	$5
D3120	Pulp Cap – Indirect (excluding final restoration)	$10
D3220	Therapeutic Pulpotomy (excluding final restoration)	$10
D3310	Root Canal Therapy – Anterior (excluding final restoration)	$30
D3320	Root Canal Therapy – Bicuspid (excluding final restoration)	$40
D3330	Root Canal Therapy – Molar (excluding final restoration)	$50
D3346	Retreatment of Previous Root Canal Therapy – Anterior	$50
D3410	Apicoectomy/Periradicular Surgery – Anterior	$50
D3411	Apicoectomy/per tooth, each additional root	$50
D3430	Retrograde Filling – Per Root	$60
D3940	Recalcification	$5
D3999	Culturing Canal	$5
PERIODONTICS SERVICES		
D4210	Gingivectomy or Gingivoplasty – 4 or More Teeth – Per Quadrant	$25
D4211	Gingivectomy or Gingivoplasty – 1-3 Teeth – Per Tooth	$8
D4220	Gingival Curettage – Per Quadrant	$18
D4250	Mucogingival Surgery – Per Quadrant	$36
D4260	Osseous Surgery – 4 or More Teeth – Per Quadrant	$36
D4341	Periodontal Scaling and Root Planing – 4 or More Teeth – Per Quadrant	$30
D9110	Palliative (Emergency) Treatment	$5
PROSTHODONTICS - REMOVABLE		
D5110	Complete Denture – Maxillary	$63
D5120	Complete Denture – Mandibular	$63
D5130	Immediate Denture – Maxillary	$63
D5140	Immediate Denture – Mandibular	$63
D5211	Maxillary Partial Denture – Resin Base (including retentive/clasping materials, rests and teeth)	$63
D5212	Mandibular Partial Denture – Resin Base (including retentive/clasping materials, rests and teeth)	$63
D5213	Maxillary Partial Denture – Cast Metal Framework with Resin Denture Bases (including any conventional clasps, rests and teeth)	$63
D5214	Mandibular Partial Denture – Cast Metal Framework with Resin Denture Bases (including any conventional clasps, rests and teeth)	$63
D5410	Adjust Complete Denture – Maxillary	$10
D5411	Adjust Complete Denture – Mandibular	$10

D5421	Adjust Partial Denture – Maxillary	$10
D5422	Adjust Partial Denture - Mandibular	$10
	REPAIRS TO PROSTHETICS	
D5510	Repair Broken Complete Denture Base	$15
D5520	Replace Missing or Broken Teeth – Complete Denture (each tooth)	$10
D5610	Repair Resin Denture Base	$20
D5630	Repair or Replace Broken Retentive/Clasping Materials – per tooth	$20
D5640	Replace Broken Teeth – Per Tooth	$10
D5650	Add Tooth or Existing Partial Denture ($5 each additional tooth)	$15
D5660	Add Clasp to Existing Partial Denture	$5
D5730	Reline Complete Maxillary Denture (Chairside)	$15
D5731	Reline Complete Mandibular Denture (Chairside)	$15
D5740	Reline Maxillary Partial Denture (Chairside)	$15
D5741	Reline Mandibular Partial Denture (Chairside)	$15
D5750	Reline Complete Maxillary Denture (Lab)	$18
D5751	Reline Complete Mandibular Denture (Lab)	$18
D5760	Reline Maxillary Partial Denture (Lab)	$18
D5761	Reline Mandibular Partial Denture (Lab)	$18
D5820	Interim Partial Denture (Maxillary)	$10
D6930	Recement Bridge	$10
	ORAL SURGERY SERVICES	
D7110	Single Tooth	$8
D7120	Each Additional Tooth	$8
D7210	Surgical Removal of Erupted Tooth	$15
D7220	Removal of Impacted Tooth – Soft Tissue	$30
D7230	Removal of Impacted Tooth – Partially Bony	$35
D7240	Removal of Impacted Tooth – Completely Bony	$50
D7285	Biopsy of Oral Tissue – Hard	$0
D7286	Biopsy of Oral Tissue – Soft	$0
D7310	Alveoloplasty in Conjunction with Extractions – 4 or More Teeth or Tooth Spaces – Per Quadrant	$15
D7510	Incision and Drainage of Abscess – Intraoral Soft Tissue	$0
D7960	Frenulectomy (Frenectomy, Frenotomy) Separate Procedure	$25
	MISCELLANEOUS	
D9110	Palliative (Emergency) Treatment of Dental Pain – Minor Procedure	$5
D9215	Local Anesthesia	$0
D9310	Consultation (Diagnostic Service by Additional Dentist)	$0
D9430	Post-Operative Visit	$0
D9440	Office Visit – After Hours	$10
D9999	Broken Appointment (less than 24 hours)	$10
	ORTHODONTICS	
D8080	Comprehensive Orthodontic Treatment - Adolescent	$1,200
D8090	Comprehensive Orthodontic Treatment - Adult	$1,400
	PLAN EXCLUSIONS AND LIMITATIONS*	

***Services that May Not Be Covered Under the Plan:**

1. Services or supplies that are covered in whole or in part:
   (a) under any other part of this Dental Plan; or
   (b) under any other plan of group benefits provided by or through your employer.

2. Services and supplies to diagnose or treat a disease or injury that is not:
   (a) a non-occupational disease; or
   (b) a non-occupational injury
3. Services not listed in the Dental Care Benefit Summary that applies, unless otherwise specified in the Evidence of Coverage.

4. Those for replacement of a lost, missing or stolen appliance, and those for replacement of appliances

MediExcel Health Plan
Vision Plan

Vision Plan 100

Benefit Summary

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Using Your Vision Plan

Your Plan grants you access to a network of vision providers without deductibles or the filing of claim forms. To schedule an appointment, contact MediExcel's Member Line toll-free at (855) 633-4392.

IN-NETWORK PROVIDER

Service	Copay	Frequency
Eye Exam	$0 copay	every 12 months
Frame Allowance	$100 retail frame allowance *Member pays any amount over allowance.*	every 24 months
Standard Lenses (*up to 61mm*)	$0 copay for: • Single Vision • Bifocal	every 12 months
Lens Coatings	No copay for Pink or Rose Tints #1 or #2 *Upgrades for lens treatments such as UV coating, standard polycarbonate, standard transitions, standard progressive lenses are at an agreed discounted rate with the selected provider.*	
Elective/Convenience Contact Lenses*	$100 retail contact lens allowance. **In lieu of frame and lenses. Member pays any amount over allowance. Fit and Follow-Up additional cost.*	every 12 months
LASIK**	$825 per eye ***In lieu of frame allowance/standard lens and contact lens benefit. Qualifications:* *• 6 month no refraction change* *• Age 20-50* *• Moderate Nearsightedness (-2.25/-5.00 refraction)*	

OUT-OF-NETWORK PROVIDER

Service	Copay	Frequency
Not covered.		

LIMITATIONS:
- Repeat, follow-up procedures, or refinements are not covered.
- Contact lenses and contact lens fitting, except as specifically provided. In lieu of frames and lenses.
- Eyewear when there is no prescription change, except when benefits are otherwise available.
- Lenses or frames which are lost, stolen, or broken will not be replaced, except when benefits are available.
- Custom lenses (*non-standard*) such as no-line, (*blended type*) progressive, polycarbonate, beveled, faceted, coated or oversize exceeding the Schedule of Allowances.
- Tints, other than pink or rose #1 or #2 except as specifically provided.
- LASIK procedure is only covered at IDOC inside Excel Hospital in Tijuana.

EXCLUSIONS:
- Medical or Surgical treatment of the eyes.
- Non-Prescription (*plano*) eyewear.
- Orthoptics, Vision Training, Subnormal or Low Vision Aides.
- Services that are experimental or investigational in nature.

This is a partial list of exclusions and limitations, others may apply. Please check your Evidence of Coverage for details. Contact MediExcel's Member Line at (855) 633-4392 for additional questions.