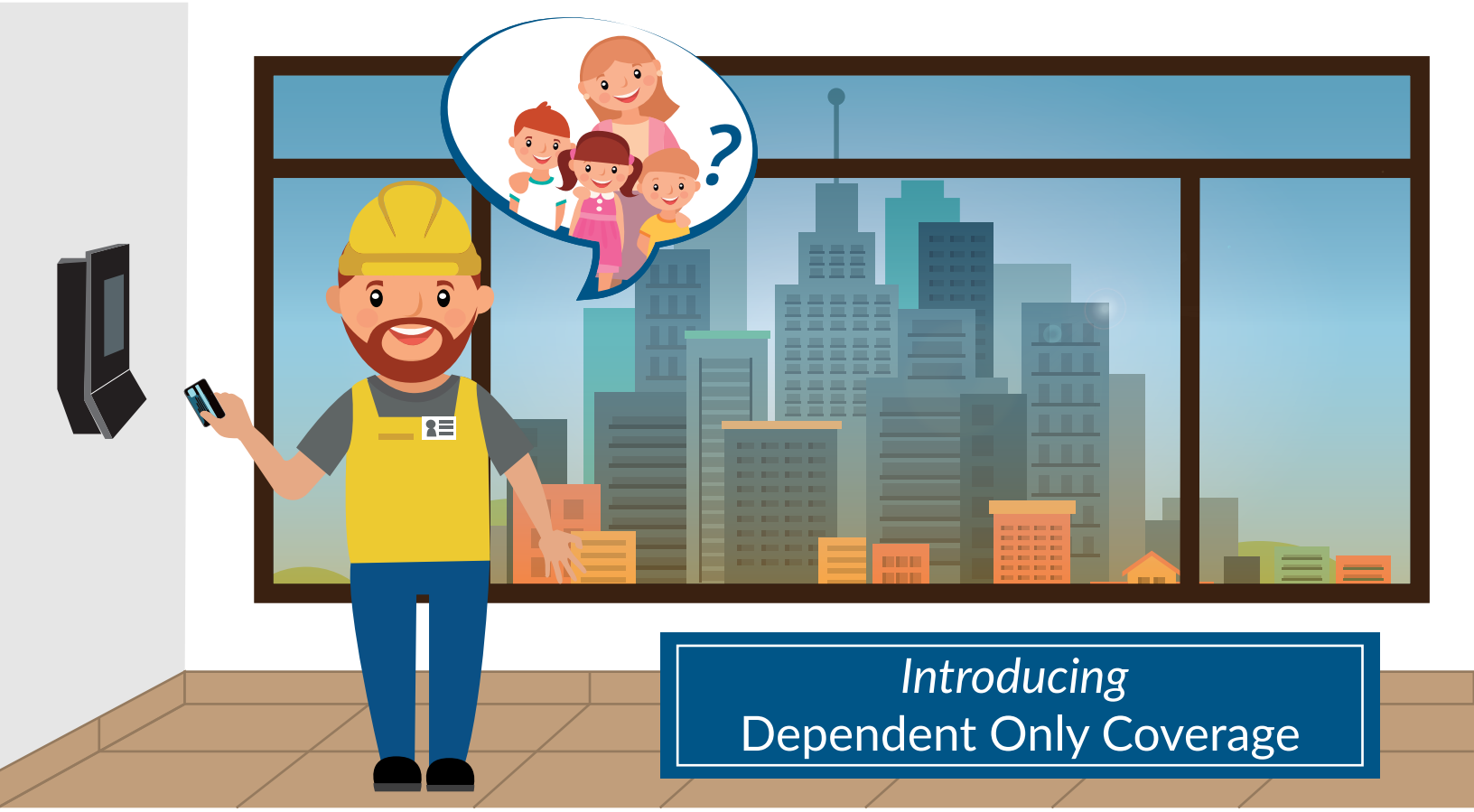

Introducing
Dependent Only Coverage

MediExcel's **Dependent Only Coverage** allows Employees in San Diego and Imperial County to cover their dependents in Mexico with affordable, and compliant binational healthcare benefits.

- Allows Employees working in San Diego or Imperial County to enroll in their employer sponsored U.S. plan, while covering their family in Mexico with MediExcel Health Plan.
- Subscriber enrolls in both U.S. coverage & MediExcel. MediExcel provides immediate premium credit for subscriber.
- Employer must offer both U.S. carrier and MediExcel Health Plan.
- Will Accept a Minimum of 1 Enrolled Employee.
- Affordable premiums with $0 deductibles
- Available on all MediExcel Health Plans.

MediExcel
HEALTH PLAN

The Next Generation of Binational Healthcare

www.mediexcel.com

MediExcel Health Plan Announces Dependent Only Coverage SALES Q&A

1. **What is Dependent Only Coverage?**

   This new coverage option created by MediExcel allows the primary subscribing employee to enroll in their company sponsored U.S. Health Plan and enroll his/her dependents in MediExcel Health Plan.

2. **When will Dependent Only coverage be effective?**

   Dependent Only Coverage will be available on all Small Group and Large Group health plans, for new and renewing groups effective 09/01/2017.

3. **How does Dependent Only Coverage work?**

   The technical term approved by the DMHC is *Premium Credit for Employee's Duplicate Coverage.* The employee is required to enroll in the company sponsored U.S. coverage and MediExcel Health Plan. The employee would enroll dependents in MediExcel Health Plan only. MediExcel will credit back the primary's premium, resulting in dependent only premiums billed. Only the dependents will be medically active with MediExcel Health Plan.

4. **What is the minimum required employee enrollment?**

   Minimum of 1 Employee enrolled in a company sponsored Medical Plan.

5. **Will there be a separate enrollment forms?**

   Yes. Employers will need to complete an application for the Premium Credit for Duplicate Coverage for each employee. Employees will need to fill out a Dependent Only Coverage application.

6. **What is the process for enrollment for the Dependent Plan?**

   The employer will fill out an application for Premium Credit for Duplicate Coverage with an Dependent Only Coverage Enrollment Form, and standard master application. Also, a copy of the completed enrollment form for the

employer-sponsored U.S. health plan. This is submitted to applications@mediexcel.com.

7. **What Plans Qualify for Dependent Only Coverage?**

   All MediExcel health plans can be sold with Dependent Only Coverage.

8. **Why did MediExcel launch Dependent only coverage?**

   Some clients offer high contributions towards employee-only health benefits and have asked about dependent only coverage. Employees now have a low-cost option for covering family in Mexico.

9. **What kind of groups will this be ideal for?**

   Dependent Only Coverage is ideal for groups with employees who commute the border region regularly for work, personal or medical reasons.

10. **Is there an additional cost or fee to the client or member?**

    No. There is no fee associated with enrolling in MediExcel Dependent Only Coverage.

11. **How is this going to affect possible COBRA subscribers?**

    If the primary employee enrolls in COBRA, their dependents will also be enrolled.

12. **Does MediExcel need to review possible applicants before enrollment?**

    Yes, MediExcel will review the application form for Enrollment and Credit Reimbursement.

13. **Can groups with buy up coverage offer dependent plan?**

    Yes, all MEHP Plans qualify for Dependent Only coverage.

14. **How will employer/employee receive credit?**

    MediExcel will credit back the primary subscriber premium each month. The Employer deducts from Employee's pay the applicable employee contribution associated with the reduced tier premium rate for the enrolling employee's dependents.

15. **Does this impact the 1095B process?**

    No. It will be processed normally in the first two weeks of 2018.

PREMIUM CREDIT FOR EMPLOYEE'S DUPLICATE COVERAGE APPLICATION FORM

Purpose: This form is used for a Group Employer to receive a premium credit for when an Employee has duplicate employer-sponsored health care coverage. Duplicate coverage means that the Employee has enrolled in two employer-sponsored health coverage programs at the same time, such as MediExcel Health Plan (MEHP) and an Associated Health Plan (which means a California health plan such as Aetna, Anthem, Blue Shield, CIGNA, Health Net, Kaiser, Sharp Health Plan, etc.).

General: MEHP recognizes that some Employees with eligible dependents may encounter hardship situations where it may not be practical for Employees (but it is practical for their dependents) to utilize MEHP health coverage due to the Employee's temporary inability to cross into Mexico to access health care. Some of these situations include the federal application processing for Citizenship which could take several months. As such, Employees may need coverage from an Associated Health Plan while at the same time have their eligible dependents enrolled in MEHP. This Form allows the Employer to receive an immediate premium credit on the Group Billing Statement for the Employee's portion of the MEHP Premium when the Employee and his/her dependents enroll in MEHP.

How it Works:

- ✓ Employee enrolls in an employer-sponsored Associated Health Plan for health care in California at single employee level.
- ✓ Employee and eligible dependent(s) enroll in MEHP.
- ✓ Employee receives his/her health care in California from the Associated Health Plan.
- ✓ Enrolled Dependents receive their health care in Mexico from MEHP.
- ✓ For the Associated Health Plan: Employer deducts the applicable Employee contribution from Employee's pay related to the Single Employee Tier in the Associated Health Plan.
- ✓ For MEHP: Employer deducts the applicable Employee contribution from Employee's pay for just the enrolling Dependent(s) in MEHP.
- ✓ The MEHP monthly group billing statement will reflect the premium credit (at the single EE Tier Rate or Age Rate).
- ✓ The resulting MEHP premium amount is calculated by subtracting the amount of the premium credit (for the Employee) from the amount of the regular premium (for Employee and enrolled Dependents).
- ✓ Once the Employee terminates his/her Associated Health Plan coverage, Employer notifies MEHP for the cancellation of the premium credit.
- ✓ If Employee accesses health benefits from MEHP, MEHP will contact the Employee to determine if the accessing of health services from MEHP was inadvertent. If the Employee acknowledges that it was inadvertent, the Plan will educate the Employee so that on the next occurrence, the Plan will cancel the premium credit from Group Billing Statement.

How to Apply:

- To apply, the Employer must complete the below section, sign and attach the following:
  - ❑ Completed MEHP Enrollment Form for the Employee and eligible dependents
  - ❑ Copy of Employee's completed enrollment form for the employer-sponsored Associated Health Plan. Employer must redact all Protected Health Information (PHI) and Personally Identifiable Information (PII) on the copy of this form.

Employer Understands:

- ✓ The MEHP premium credit shall continue as long as Employee does not access any MEHP covered benefits.
- ✓ If Employee accesses MEHP covered benefits, MEHP will rescind the premium credit on Group Billing Statement.
- ✓ When Employee terminates his/her employer-sponsored Associate Health Plan Coverage, Employer agrees to notify MEHP to stop applying the premium credit to the Group Billing Statement.
- ✓ MEHP will not grant any premium credit without this completed form.
- ✓ Amount of Employer contribution for dependent coverage in an Associated Health Plan must be same amount as in MEHP.

EMPLOYEE INFORMATION			
Last Name	First Name	Name of Associated Health Plan	Start Date of Coverage

Name of Representative_____ Name of Employer_____

Signature _____ Date _____ Group #_____

DEPENDENT ONLY COVERAGE - ENROLLMENT FORM

Telephone: (619) 421•1659
E-mail: applications@mediexcel.com
Web: www.mediexcel.com

*** HR, please fill-in shaded area of this application***

☐ Open Enrollment ☐ New Hire ☐ Rehire ☐ Termination ☐ Dependent Termination

Employer Group Name or Number	Effective Date Month/Year

EMPLOYEE INFORMATION

Last Name	First Name	Birthdate (MM/DD/YYYY)

Street Address	City	State	Zip Code	Country

Sex	Social Security #	Telephone Number	Emergency Telephone Number
☐ M ☐ F	__ __ __ • __ __ • __ __ __ __	(__ __ __) __ __ __ • __ __ __ __	(__ __ __) __ __ __ • __ __ __ __

Marriage Status	Select Your Plans	Preferred Language	Preferred Region
☐ Single ☐ Married ☐ Domestic Partnership	☐ Medical ☐ Buy up	☐ Spanish ☐ English	☐ Tijuana ☐ Mexicali

DEPENDENT INFORMATION – IF YOU ARE COVERING YOUR DEPENDENTS, PLEASE COMPLETE THE FOLLOWING SECTION. ATTACH ANOTHER SHEET IF NEEDED.

Last Name	First Name	Birthdate	Sex M/F	Social Security #	Select Your Plans
Spouse/Domestic Partner					☐ Medical ☐ Dental ☐ Both ☐ Term
Dependent					☐ Medical ☐ Dental ☐ Both ☐ Term
Dependent					☐ Medical ☐ Dental ☐ Both ☐ Term
Dependent					☐ Medical ☐ Dental ☐ Both ☐ Term
Dependent					☐ Medical ☐ Dental ☐ Both ☐ Term

OTHER MEDICAL COVERAGE

SIGNATURE REQUIRED: By signing below, I acknowledge that I have read, understand and agree to the terms and arbitration agreement stated below.

A. On behalf of myself and my eligible Dependents, I hereby apply for health care service coverage offered by MediExcel Health Plan through my Employer, and agree to be bound by the MediExcel Health Plan Group Subscriber Agreement, Evidence of Coverage and Disclosure Form, and this Enrollment Form.

B. I attest the information provided in this application is true and complete.

C. I attest that I and my enrolling dependents (if applicable) have the necessary border crossing documents to cross into Mexico to access healthcare.

D. **MANDATORY BINDING ARBITRATION:** **I understand** that MediExcel Health Plan uses mandatory binding arbitration to resolve disputes. I am agreeing to arbitrate claims that relate to my or a dependent's membership in MediExcel Health Plan (except for Small Claims Court cases and claims that cannot be subject to binding arbitration under governing law.) **I understand** that any dispute between myself, my heirs, relatives, or other associated parties on the one hand and MediExcel Health Plan, any contracted health care providers, administrators, or other associated parties on the other hand for alleged violation of any duty arising out of or related to membership in the Health Plan, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently or incompletely rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. **I agree** to give up our right to a jury trial and accept the use of binding arbitration. **I understand** that the full arbitration provision is in the MediExcel Health Plan Evidence of Coverage, which is available for my review.

Employee Signature X _____ Date X _____

CALIFORNIA LAW PROHIBITS ANY HIV TEST FROM BEING REQUESTED OR USED BY HEALTHCARE SERVICE PLANS AS A CONDITION OF OBTAINING HEALTH COVERAGE

MediExcel HEALTH PLAN

SOLICITUD DE INSCRIPCION MEDICA SOLO PARA DEPENDIENTES

Teléfono: (619) 421•1659
E-mail: applications@mediexcel.com
Página Web: www.mediexcel.com

*** Recursos Humanos, favor de completar el área sombreada de esta solicitud***

☐ Periodo de Inscripción ☐ Nuevo Ingreso ☐ Reingreso ☐ Terminación ☐ Terminación de Dependiente

Nombre o Número del Empleador	Fecha Efectiva (Mes/Año)

INFORMACION DEL EMPLEADO

Apellido	Nombre		Fecha de Nacimiento (Mes/Día/Año)	
Domicilio	**Ciudad**	**Estado**	**Código Postal**	**País**

Sexo ☐ M ☐ F	Número de Seguro Social __ __ __ • __ __ • __ __ __ __	Número Telefónico Principal (__ __ __) __ __ __ • __ __ __ __	Número Telefónico de Emergencia (__ __ __) __ __ __ • __ __ __ __

Estado Civil	Seleccione su Plan	Idioma de Preferencia	Región de Preferencia
☐ Soltero/a ☐ Casado/a ☐ Pareja Domestica	☐ Médico ☐ aumento de categoría	☐ Español ☐ Inglés	☐ Tijuana ☐ Mexicali

INFORMACION DE DEPENDIENTE – SI DESEA COBERTURA PARA SUS DEPENDIENTES, FAVOR DE LLENAR LA SIGUIENTE SECCION. AGREGUE OTRA HOJA SI ES NECESARIO.

Apellido	Nombre	Fecha de Nacimiento	Sexo M/F	Número de Seguro Social	Seleccione su Plan
Esposo(a)/Pareja Domestica					☐ Médico ☐ Dental ☐ Ambos ☐ Term
Dependiente					☐ Médico ☐ Dental ☐ Ambos ☐ Term
Dependiente					☐ Médico ☐ Dental ☐ Ambos ☐ Term
Dependiente					☐ Médico ☐ Dental ☐ Ambos ☐ Term
Dependiente					☐ Médico ☐ Dental ☐ Ambos ☐ Term

COBERTURA MEDICA ADICIONAL

FIRMA REQUERIDA: Al firmar a continuación, reconozco que he leído, que entiendo y que estoy de acuerdo con los términos y condiciones, y con el acuerdo de arbitraje indicado a continuación.

A. En representación de mi persona y de mis dependientes, por la presente, yo presento una solicitud de cobertura para los servicios médicos ofrecidos por MediExcel Health Plan a través de mi empleador, y accedo a ser obligado por el Contrato del Grupo (MediExcel Health Plan Group Subscriber Agreement) el Documento Combinado de Constancia de Cobertura y Formulario de Divulgación, y esta Solicitud de Inscripción.

B. Certifico que la información de esta solicitud es verídica y correcta.

C. Certifico que yo y mis dependientes inscritos (si aplica) contamos con la documentación válida para cruzar la frontera a México para recibir servicios médicos.

D. **ARBITRAJE OBLIGATORIO:** **Entiendo** que MediExcel Health Plan utiliza arbitraje obligatorio para resolver disputas. **Yo acepto** el arbitraje de reclamaciones que se relacione conmigo o con la afiliación de un dependiente en MediExcel Health Plan (excepto en casos de tribunales de demandas de menor cuantía y reclamaciones que no pueden quedar sujetas a arbitraje obligatorio de acuerdo con las leyes vigentes). **Entiendo** que cualquier disputa entre mí, mis herederos, parientes u otras personas asociadas, por una parte, y MediExcel Health Plan, cualquier proveedor de atención medica contratado, administradores u otras partes asociadas, por otra parte, por violaciones presuntas de cualquier obligación que surja de la afiliación en el Plan de salud o que se relacione con esta, incluida cualquier reclamación por negligencia médica u hospitalaria (una reclamación manifestando que los servicios médicos fueron innecesarios, no autorizados, o que se brindaron de la manera inapropiada, negligente o incompetente),responsabilidad civil en las instalaciones, o relacionada con la cobertura o subministro de servicios o artículos, independientemente de los principios de derecho, se debe decidir por arbitraje obligatorio bajo las leyes de california y no por un juicio o instancia a un proceso judicial, excepto como la ley aplicable disponga la revisión judicial de procedimientos de arbitraje. **Estoy de acuerdo** en renunciar a nuestro derecho de tener un juicio ante jurado y acepto someterme a arbitraje obligatorio. **Entiendo** que la disposición completa sobre el arbitraje se encuentra en el Documento de Constancia de Cobertura de MediExcel Health Plan, la cual está disponible para que yo lo revise.

Firma del Empleado X _____ Fecha X _____

LA LEY DE CALIFORNIA PROHIBE A LOS PLANES DE SALUD SOLICITAR O UTILIZAR UNA PRUEBA DEL VIH COMO UNA CONDICION PARA OBTENER COBERTURA MEDICA

MediExcel HEALTH PLAN