SIMPLEPAY HEALTH

SimplePay Benefits Summary: Immanuel SimplePay

Plan Plan Year: January 1st- December 31st, 2023

MEDICAL BENEFITS				
Medical Services	**Tier 1**	**Tier 2**	**Tier 3**	**Out-of-Network**
Calendar Year Deductible				
Individual	N/A			Not Covered
Family	N/A			Not Covered
Out-Of-Pocket Maximum (includes Copays – combined with Prescription Drug Card)				
Individual	$3,500			Not Covered
Family	$7,000			Not Covered
OOP Max applies to In-Network services only; Out-of-Network OOP Max is unlimited				
Medical Services	**Tier 1**	**Tier 2**	**Tier 3**	**Out-of-Network**
Covid 19 Services				
Covid 19 Testing	No Charge			
Covid 19 Vaccine (Moderna, Pfizer, Johnson & Johnson)	No Charge			
Durable Medical Equipment				
Durable Medical Equipment (DME)	$100	$135	$230	Not Covered
Emergency Services/Urgent Care				
Emergency Services/Emergency Room Services	$650			
Urgent Care Facility	$55	$80	$120	Not Covered
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)				
Inpatient Hospital	$2,700	$3,000	$3,500	Not Covered
Outpatient Hospital	$880	$1,170	$1,950	Not Covered
Infertility Treatment Diagnostic (Treatment not covered)	Not Covered			
Skilled Nursing Facility (160 visit limit)	$2,700	$3,000	$3,500	Not Covered
Ambulance Services	$650			
Ambulatory Surgical Center	$880	$1,170	$1,950	Not Covered
Home Health Care (50 visit limit)	$55	$80	$120	Not Covered
Hospice Care	$245	$330	$550	Not Covered
Laboratory Services				
Routine Diagnostic Labs	$20	$30	$40	Not Covered
Diagnostic Labs	$55	$80	$120	Not Covered
Maternity				
Initial Office Visit	$55	$105	$120	Not Covered
Preventive & On-going Prenatal Care	No Charge (included in global delivery copay)			
Delivery & Postnatal Care	$2,700	$3,000	$3,500	Not Covered
Mental Disorders & Substance Use Disorders				
Office Visit	$25	$55	$120	Not Covered
Inpatient	$2,700	$3,600	$5,300	Not Covered
Outpatient	$880	$1,170	$1,950	Not Covered
Physician Services				
Primary Care Physician	$25	$40	$60	Not Covered
Specialist	$55	$80	$120	Not Covered
Teladoc	No Charge			Not Covered
Preventive Services and Routine Care				
Well-Child Care (including exams & immunizations)	No Charge			
Adult Physical Examination (including routine GYN visit)	No Charge			

Breast Cancer Screening (any age)	No Charge			
Pap Test	No Charge			
Prostate Cancer Screening	No Charge			
Colorectal Cancer Screening	No Charge			
Routine Eye Exam	No Charge			
Radiology Services				
Diagnostic X-Rays	$55	$80	$120	Not Covered
Advanced Imaging MRI, MRA, CAT & PET Scans	$270	$475	$600	Not Covered
Other Healthcare Facilities/Services				
Therapy Services				
Chiropractic Care/Spinal Manipulation (20 visit limit)	$55	$80	$120	Not Covered
Outpatient Therapies (PT, OT, ST) (20 visit limit each)	$55	$80	$120	Not Covered
Other Healthcare Facilities/Services				
Temporomandibular Joint Dysfunction ($5,000 Lifetime Maximum Benefit)	Not Covered			Not Covered
Allergy Injections, Serum & Testing	$55	$80	$120	Not Covered
Acupuncture (10 visit limit)	$55	$80	$120	Not Covered
Transplants (Aetna IOE Program) *	$2,700	$3,000	$3,500	Not Covered
*Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit, including travel and lodging maximums. No charge for travel and lodging.				
Weight Control/Bariatric Surgery ($75,000 Lifetime Benefit)	Not Covered			

*Diabetic equipment and supplies provided by Livongo are covered at $0. All other Diabetic Supplies that are provided by an in-network preferred provider will be paid according to the applicable category of this Medical Schedule of Benefits, such as Durable Medical Equipment (DME).

aetna MERITAIN HEALTH

Medical Network: Aetna Choice POS II Network
How to Find a Provider: Log in to your member portal at www.simplepayhealth.com and find the "Find A Doctor and Compare Costs" under the "Benefits" tab

For Questions about your SimplePay Health Plan, please contact your SimplePay Health Pro.
Email: HealthPro@simplepayhealth.com
Phone: 800-606-3564

PHARMACY BENEFITS

NOTE: There is no coverage under the Plan for Prescription Drugs obtained from a Non-Participating Provider.

Individual Family		If you reach your out-of-pocket maximum, SimplePay Health will pay 100% of the applicable allowed benefit for most covered services for the remainder of the year. All copays and other eligible out-of-pocket costs count toward your out-of-pocket maximum, except balance billed amounts.

Pharmacy Plan Feature	All other In-Network Pharmacies	CVS	Walgreens	Description
Retail Pharmacy				
Generic Drugs (Tier1) (Up to a 31-day supply)	$5	$15	$20	Generic drugs are covered at this copay level.
Preferred Brand Drugs (Tier 2) (Up to a 31-day supply)	$40	$60	$80	All preferred brand drugs are covered at this copay level.
Non-Preferred Brand Drugs (Tier 3) (Up to a 31-day supply)	$60	$80	$120	All non-preferred brand drugs on this copay level are not on the Preferred Drug List. * Discuss using alternatives with your physician or pharmacist.
Specialty Drug Program				
Specialty Drugs (Tier 4) (Up to a 31-day supply)	$80			Specialty medications are required to be filled through Mail Order.
Mail Order Pharmacy (90-day supply)				
Generic Drugs (Tier 1)	$10			Maintenance drugs of up to a 90-day supply is available for twice the copay through Mail Service Pharmacy.
Preferred Brand Drugs (Tier 2)	$80			
Non-Preferred Brand Drugs (Tier 3)	$120			

Pharmacy Drug Vendor: Medone RX

How to Find a Drug: Look up the cost of your medications in the SimplePay member portal on the Benefits tab under the card that says, "Find Drug Prices".

Visit www.simplepayhealth.com for the most up-to-date drug lists, including the prescription guidelines. Prescription guidelines indicate drugs that require your doctor to obtain prior authorization from SimplePay Health before they can be filled and drugs that can be filled in limited quantities.

This plan summary is for comparison purposes only and does not create rights not given through the benefit plan.