SimplePay Benefits Summary: Immanuel

Plan Year: January 1st – December 31st, 2021

Services	Tier 1	Tier 2	Tier 3	Out-of-Network
LIFETIME MAXIMUM BENEFIT	Unlimited			Not Covered
CALENDAR YEAR MAXIMUM BENEFIT	Unlimited			Not Covered
CALENDAR YEAR DEDUCTIBLE				
Single	N/A			Not Covered
Family	N/A			Not Covered
OUT-OF-POCKET MAXIMUM (includes Copays – combined with Prescription Drug Card)				
Single	$6,500			Not Covered
Family	$13,000			Not Covered
MEDICAL BENEFITS				
Acupuncture	Not Covered			Not Covered
Allergy Injections, Serum & Testing	$80	$105	$175	Not Covered
Ambulance Services	$650 per visit			Not Covered
Ambulatory Surgical Center	$1,150	$1,540	$2,570	Not Covered
Chiropractic Care/Spinal Manipulation (20 visit limit)	$80	$105	$175	Not Covered
Diagnostic Testing, X-ray & Lab Services	$100	$135	$225	Not Covered
Routine Labs	$30	$40	$70	Not Covered
Advanced Imaging MRI, MRA, CAT & PET Scans	$350	$475	$790	Not Covered
Outpatient Therapies (PT, OT, ST) (20 visit limit each)	$80	$105	$175	Not Covered
Durable Medical Equipment (DME)*	$160	$215	$355	Not Covered
Emergency Services/Emergency Room Services	$650 per visit			Not Covered
Gender Reassignment Surgery	Not Covered			Not Covered
Hearing Aids	Not Covered			Not Covered
Home Health Care (50 visit limit)	$80	$105	$175	Not Covered
Hospice Care	$385	$515	$855	Not Covered
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)				
Inpatient	$3,560	$4,750	$6,500	Not Covered
Outpatient	$1,150	$1,540	$2,570	Not Covered
Infertility Treatment	Not Covered			Not Covered
Maternity				
Initial Office Visit	$80	$105	$175	Not Covered
Preventive & On-going Prenatal Care	No Charge (included in global delivery copay)			Not Covered
Delivery & Postnatal Care	$3,560	$4,750	$6,500	Not Covered
Mental Disorders & Substance Use Disorders				
Office Visit	$40	$55	$90	Not Covered
Inpatient	$3,560	$4,750	$6,500	Not Covered
Outpatient	$1,150	$1,540	$2,570	Not Covered
Physician Services				
Primary Care Physician	$40	$55	$90	Not Covered
Specialist	$80	$105	$175	Not Covered
Preventive Services and Routine Care				
Well-Child Care (including exams & immunizations)	No Charge			Not Covered
Adult Physical Examination (including routine GYN visit)	No Charge			Not Covered
Breast Cancer Screening	No Charge			Not Covered
Pap Test	No Charge			Not Covered
Prostate Cancer Screening	No Charge			Not Covered

AV: 75%

Colorectal Cancer Screening	No Charge			Not Covered
Routine Eye Exam	Not Covered			Not Covered
Skilled Nursing Facility (160 visit limit)	$3,150	$4,190	$6,500	Not Covered
Teladoc	No Charge			Not Covered
Temporomandibular Joint Dysfunction	Not Covered			Not Covered
Transplants (Aetna IOE Program)	$3,560	$4,750	$6,500	Not Covered
Urgent Care Facility	$80	$105	$175	Not Covered
Weight Control/Bariatric Surgery	Not Covered			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).

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

PRESCRIPTION DRUG SCHEDULE OF BENEFITS

Plan Feature	All other In-Network Pharmacies	CVS	Walgreens	Description
NOTE: There is no coverage under the Plan for Prescription Drugs obtained from a Non-Participating Provider.				
OUT-OF-POCKET MAXIMUM (includes Copays – combined with Major Medical Out-of-Pocket)				
Single Family	$6,500 $13,000			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 deductibles, copays, coinsurance and other eligible out-of-pocket costs count toward your out-of-pocket maximum, except balance billed amounts.
Retail Pharmacy				
Generic Drugs (Tier1) (Up to a 31-day supply)	$30	$35	$60	Generic drugs are covered at this copay level.
Preferred Brand Drugs (Tier 2) (Up to a 31-day supply)	$60	$75	$120	All preferred brand drugs are covered at this copay level.
Non-Preferred Brand Drugs (Tier 3) (Up to a 31-day supply)	$90	$110	$185	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)	$120			Specialty medications are required to be filled through Mail Order.
Mail Order Pharmacy (90-day supply)				
Generic Drugs (Tier1)	$60			Maintenance drugs of up to a 90-day supply is available for twice the copay through Mail Service Pharmacy.
Preferred Brand Drugs (Tier 2)	$120			
Non-Preferred Brand Drugs (Tier 3)	$185			

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.

AV: 75%