




SimplePay Benefits Summary: HD Supply - Health and Welfare Program

Plan Year: January 1st, 2025 – December 31st, 2025

MEDICAL BENEFITS				
Medical Services	Tier 1	Tier 2	Tier 3	Out-of-Network
Calendar Year Deductible				
Single	None			None
Family	None			None
Out-Of-Pocket Maximum (includes Copays – combined with Prescription Drug Card)				
Single	\$5,000			Unlimited
Family	\$10,000			Unlimited
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 Vaccine (Moderna, Pfizer, Johnson & Johnson)	No Charge			
Durable Medical Equipment				
Durable Medical Equipment (DME) per item	\$100	\$200	\$300	\$500
Emergency Services/Urgent Care				
Emergency Services/Emergency Room Services	\$500			
Urgent Care Facility	\$60			\$150
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)				
Inpatient Hospital	\$2,200	\$3,000	\$5,000	\$6,000
Outpatient Hospital	\$750	\$1,000	\$1,700	\$3,000
Infertility Treatment	See plan document for specific coverages and exclusions			
Skilled Nursing Facility	\$2,000	\$2,700	\$4,500	\$5,400
Ambulance Services	\$500			
Ambulatory Surgical Center	\$750	\$1,000	\$1,700	\$3,000
Home Health Care (150 visits per calendar year)	\$45	\$60	\$100	\$120
Hospice Care	\$250	\$350	\$550	\$750
Laboratory Services				
Routine Labs	\$15	\$25	\$35	\$50
Diagnostic Labs	\$65	\$85	\$145	\$175
Maternity				
Initial Office Visit	\$25	\$30	\$50	\$120
Preventive & On-going Prenatal Care	No Charge (included in global delivery copay)			
Delivery & Postnatal Care	\$2,200	\$3,000	\$5,000	\$6,000
Mental Disorders & Substance Use Disorders				
Office Visit	\$25	\$30	\$50	\$120
Inpatient	\$2,200	\$3,000	\$5,000	\$6,000
Outpatient	\$750	\$1,000	\$1,700	\$3,000
Physician Services				
Primary Care Physician	\$25	\$30	\$50	\$120
Specialist	\$45	\$60	\$100	\$250
Telehealth Services				
Teladoc including Behavioral Health	\$0			N/A

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	\$65	\$85	\$145	\$175
Advanced Imaging MRI, MRA, CAT & PET Scans	\$250	\$350	\$500	\$600
Other Healthcare Facilities/Services				
Therapy Services				
Chiropractic Care/Spinal Manipulation	\$45	\$60	\$100	\$120
Outpatient Therapies (PT, OT, ST) (90 visits combined, per calendar year)	\$45	\$60	\$100	\$120
Other Healthcare Facilities/Services				
Temporomandibular Joint Dysfunction (\$5,000 Lifetime Maximum Benefit)	\$750	\$1,000	\$1,700	\$3,000
Allergy Injections, Serum & Testing	\$45	\$60	\$100	\$250
Acupuncture	\$45	\$60	\$100	\$250
Transplants (Aetna IOE Program) * travel and lodging \$10,000 per transplant	\$2,200	\$3,000	\$5,000	\$6,000
*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				
Bariatric Surgery (Once every 2 years)	\$2,200	\$3,000	\$5,000	\$6,000
*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).				
				
<p align="center">Medical Network: Aetna Open Choice POS II Network</p> <p align="center">How to Find a Provider: Log in to your member portal at www.simplepayhealth.com and click on "Find A Doctor and Compare Costs" under the "Benefits" tab</p>				
<p align="center">For Questions about your SimplePay Health Plan, please contact your SimplePay Health Valet.</p> <p align="center">Email: HealthValet@simplepayhealth.com</p> <p align="center">Phone: 800-606-3564</p>				

PHARMACY BENEFITS

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

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.

All copays and other eligible out-of-pocket pharmacy costs are due at the time of service and are not eligible for financing.

Pharmacy Plan Feature	In-Network	Description
Retail Pharmacy		
Generic Drugs (Tier 1) (Up to a 31-day supply)	\$10	Generic drugs are covered at this copay level.
Preferred Brand Drugs (Tier 2) (Up to a 31-day supply)	\$50	All preferred brand drugs are covered at this copay level.
Non-Preferred Brand Drugs (Tier 3) (Up to a 31-day supply)	\$70	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 Drugs MUST be obtained directly from the specialty pharmacy. Specialty Drugs are not available at mail order pharmacies, and there are no grace fills provided to Covered Persons.
Mail Order Pharmacy (90-day supply)		
Generic Drugs (Tier 1)	\$15	Maintenance drugs of up to a 90-day supply is available for twice the copay through Mail Service Pharmacy.
Preferred Brand Drugs (Tier 2)	\$60	
Non-Preferred Brand Drugs (Tier 3)	\$90	

Pharmacy Drug Vendor: CapitalRx

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