SimplePay Health Benefits Summary - SimplePay HDHP Plan

Client Name: Metro Fire

Plan Year: January 1, 2025 - December 31, 2025

Medical Benefits	
Plan Year Deductible - embedded	
Single	$3,400
Family	$6,800
Out-of-Pocket Maximum (includes medical copays combined with prescriptions copays) - embedded	
Single	$6,800
Family	$13,600

Deductible and OOP Maximum apply to in-network services only; Out-of-Network OOP Max is unlimited
All copays are applied after the deductible has been met

	In-Network			Out-of-Network
Medical Services	**Tier 1**	**Tier 2**	**Tier 3**	
Physician Services				
Primary Care Physician	$20	$25	$40	$50
Specialist	$35	$50	$80	$95
Teladoc General Medicine / Behavioral Health / Dermatology	$20			N/A
Preventative Services & Routine Care				
Well-Child Care (including exams and immunizations)	No Charge			
Adult Physical Examination (including routine GYN visit)	No Charge			
COVID 19 Vaccine	No Charge			
Breast Cancer Screening	No Charge			
Pap Test	No Charge			
Prostate Cancer Screening	No Charge			
Colorectal Cancer Screening	See plan document for specific coverage based on age/necessity			
Maternity				
Initial Prenatal Office Visit	$20	$25	$40	$50
Routine/Ongoing Prenatal Office Visit	Included in Delivery Copay			$50
Delivery & Postnatal Care	$1,640	$2,180	$3,690	$4,425
Hospital Expenses or Long-Term Acute Care Facility/Hospital (Facility Charges)				
Inpatient Hospital	$1,640	$2,180	$3,690	$4,425
Outpatient Hospital	$535	$715	$1,205	$1,445
Skilled Nursing /Rehabilitation Facility (180 days combined max per plan year)	$1,445	$1,920	$3,250	$3,900
Ambulance Services	$305			
Ambulatory Surgical Center	$535	$715	$1,205	$1,445
Home Health Care (up to 6 hours/day)	$35	$50	$80	$95
Home Infusion	$35	$50	$80	$95
Hospice Care	$180	$240	$405	$485

Medical Services	In-Network Tier 1	Tier 2	Tier 3	Out-of-Network
Radiology Services				
Diagnostic X-Rays	$50	$65	$105	$125
Advanced Imaging (MRI, MRA, CAT & PET Scans)	$165	$215	$365	$435
Laboratory Services				
Routine Basic Labs	$10	$15	$30	$35
Advanced Diagnostic Labs	$50	$65	$105	$125
Emergency Services/Urgent Care				
Emergency Services/Emergency Room		$305		
Urgent Care Facility		$35		$95
Mental Disorders & Substance Use Disorders				
Office Visit	$20	$25	$40	$50
Inpatient	$1,640	$2,180	$3,690	$4,425
Outpatient	$535	$715	$1,205	$1,445
Therapy Services				
Chiropractic Care/Spinal Manipulation (60 visits per plan year)	$35	$50	$80	$95
Outpatient Therapies (PT, OT, ST) (120 combined visits per plan year)	$35	$50	$80	$95
Durable Medical Equipment**				
Durable Medical Equipment (DME) / Item	$75	$100	$170	$205
Other Healthcare Facilities/Services				
Allergy Injections, Serum & Testing	$35	$50	$80	$95
Hearing Aids	$75	$100	$170	$205
Transplants - Aetna IOE Program* (Travel/lodging $10,000 per transplant)	$1,640	$2,180	$3,690	$4,425

*Please refer to the Aetna Institute of Excellence (IOE) Program section in the plan document for a more detailed description of this benefit, including travel and lodging maximums. No charge for travel and lodging.

**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).
All copays are applied after the deductible has been met

Medical Network: Aetna Choice POS II
How to Find a Provider: Log into your member portal at www.simplepayhealth.com and click on “Find a Doctor and Compare Costs” under the “Benefits” tab.

For questions about your SimplePay Health Plan, please contact your SimplePay Health Valet:

Email: healthvalet@simplepayhealth.com
Phone: 800-606-3564

SIMPLEPAY HEALTH

Pharmacy Drug Vendor: MedOne Rx

medone

Pharmacy Benefits

NOTE: There is no coverage under the plan for prescription drugs obtained from a Non-Participating Partner.
All copays are applied after the deductible has been met

Pharmacy Plan Feature	In-Network Retail Pharmacies	CVS	Walgreens
Retail Pharmacy			
Generic Drugs (Up to a 31-day supply)	$5	$10	$15
Preferred Brand Drugs (Up to a 31-day supply)	$15	$20	$25
Non-Preferred Brand Drugs	$20	$25	$40
Specialty Drug Program			
Specialty Drugs	Not covered under the basic pharmacy benefit. For specialty drugs, contact the RxAlly patient care team at 1-877-794-2218		
Mail Order (90 Day Supply)**			
Generic Drugs (Tier 1)		$12.50	
Preferred Brand Drugs (Tier 2)		$37.50	
Non-Preferred Brand Drugs (Tier 3)		$50	

**90-day Prescriptions must be filled via mail order or through in-network retail pharmacies (except CVS/Walgreens) in order to receive the savings of a 90-day supply.

Drug Descriptions	
Generic Drugs	Generic drugs are covered at this copay level.
Preferred Brand Drugs	All preferred drugs are covered at this copay level.
Non-Preferred Brand Drugs	All non-preferred brand drugs on this copay level are not on the Preferred Drug List. Discuss using alternatives with your physician or pharmacist.

How to Find a Drug: Log into your member portal at www.simplepayhealth.com and click on “Find Drug Prices” under the “Benefits” tab.

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.