North American Holdings

HDHP Plan

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

Medical Benefits				
Medical Services	**In-Network**			**Out-of-Network**
Calendar Year Deductible(Deductible must be met before copays)				
Single Family	$1,700 $3,400			None None
Out-of-Pocket Maximum				
Single Family	$4,300 $8,600			Unlimited 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**
Physician Services				
Primary Care Visit	$15 after ded.	$20 after ded.	$30 after ded.	$40
Specialist Visit	$30 after ded.	$40 after ded.	$65 after ded.	$80
Emergency Services/Urgent Care				
Emergency Services/Emergency Room	$250 after ded.			
Urgent Care Facility	$30 after ded.			$80
Hospital Expenses or Long-Term Acute Care Facility/Hospital				
Inpatient Hospital	$1,425 after ded.	$1,900 after ded.	$2,600 after ded	$3,150
Outpatient Hospital	$465 after ded.	$615 after ded.	$1,030 after ded.	$1,236
Infertility Treatment	See plan document for specific coverages and exclusions			
Skilled Nursing Facility/Rehabilitation Facility(100 visit limit)	$1,255 after ded.	$1,675 after ded.	$2,600 after ded.	$3,150
Ambulance Services	$250			
Ambulatory Surgical Center	$465 after ded.	$615 after ded.	$1,030 after ded.	$1,236
Home Health Care (120 visits per plan year)	$30 after ded.	$40 after ded.	$65 after ded.	$80
Hospice Care	$155 after ded.	$205 after ded.	$345 after ded.	$420
Laboratory Services				
Routine Labs	$10 after ded.	$15 after ded.	$20 after ded.	$30
Diagnostic Labs	$40 after ded.	$55 after ded.	$90 after ded.	$110
Maternity				
Initial Office Visit	$30 after ded.	$40 after ded.	$65 after ded.	$80
Preventive & Ongoing Prenatal Care	No Charge (Included in global delivery copay)			
Delivery & Postnatal Care	$1,425 after ded.	$1,900 after ded.	$2,600 after ded.	$3,150

Mental Disorders & Substance Use Disorders				
Office Visit	$15 after ded.	$20 after ded.	$30 after ded.	$40
Inpatient	$1,425 after ded.	$1,900 after ded.	$2,600 after ded.	$3,150
Outpatient	$465 after ded.	$615 after ded.	$1,030 after ded.	$1,236
24/7 Virtual Care: Teladoc.com or 1-800-Teladoc				
Teledoc General Medical	$0 after deductible Reach highly qualified, board-certified and state-licensed physicians, 24/7 by phone, online or on-the-go using the Teladoc mobile app			N/A
Teledoc Behavioral	$0 after deductible Build a relationship with an experienced therapist or psychiatrist of your choice by phone or video			N/A
Preventive Services & Routine Care				
Well-Child Care (Including exams and immunizations)	No Charge/ No Deductible			
Adult Physical Examination (Including routine GYN visit)	No Charge/ No Deductible			
Breast Cancer Screening (any age)	No Charge/ No Deductible			
Pap Test	No Charge/ No Deductible			
Prostate Cancer Screening	No Charge/ No Deductible			
Colorectal Cancer Screening	No Charge/ No Deductible			
Radiology Services				
Diagnostic X-Rays	$40 after ded.	$55 after ded.	$90 after ded.	$110
Advanced Imaging (MRI, MRA, CAT & PET Scans)	$140 after ded.	$190 after ded.	$315 after ded.	$400
Therapy Services				
Chiropractic Care/Spinal Manipulation (15 visits per plan year)	$30 after ded.	$40 after ded.	$65 after ded.	$80
Outpatient Therapies (PT, OT, ST) (20 visits per plan year)	$30 after ded.	$40 after ded.	$65 after ded.	$80
Durable Medical Equipment				
Durable Medical Equipment (DME) / item	$65 after ded.	$85 after ded.	$140 after ded.	$170
Other Healthcare Facilities/Services				
Temporomandibular Joint Dysfunction	$465 after ded.	$615 after ded.	$1,030 after ded.	$1,236
Allergy Injections, Serum & Testing	$30 after ded.	$40 after ded.	$65 after ded.	$80
Acupuncture(15 visit limit)	$30 after ded.	$40 after ded.	$65 after ded.	$80
Weight Control/Bariatric Surgery	$465 after ded.	$615 after ded.	$1,030 after ded.	$1,236
Hearing Aids	$65 after ded.	$85 after ded.	$140 after ded.	$170
Transplants (Aetna IOE Program)* (Travel/lodging $10,000 per transplant)	$465 after ded.	$615 after ded.	$1,030 after ded.	$1,236

*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.

*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).

Medical Network: Aetna Open Choice POS II Network
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

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Pharmacy Benefits

NOTE: There is no coverage under the plan for prescription drugs obtained from a Non-Participating Provider.

Single 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	In-Network Pharmacies & CVS	Walgreens	Description
Retail Pharmacy (Deductible must be met before RX copays)			
Generic Drugs (Tier 1) (Up to a 31-day supply)	$5 after ded.	$1 after ded.	Generic drugs are covered at this copay level.
Preferred Brand Drugs (Tier 2) (Up to a 31-day supply)	$10 after ded.	$15 after ded.	All preferred brand drugs are covered at this copay level.
Non-Preferred Brand Drugs (Tier 3)	$15 after ded.	$20 after ded.	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 Drugs (Tier 4) (Up to a 31-day supply)	$10 after ded.		Specialty medications are required to be filled through Mail Order
Mail Order Pharmacy (90-day supply)			
Generic Drugs (Tier 1)	$15 after ded.		Maintenance drugs of up to a 90-day supply is available for 1.5 the copay through Mail Service Pharmacy.
Preferred Brand Drugs (Tier 2)	$25 after ded.		
Non-Preferred Brand Drugs (Tier 3)	$30 after ded.		

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.” Please refer to the “MedOne Preventative Drug List 2021” found on the Employer Benefits page within the SimplePay Health Member Portal for all preventative medications covered at 100% with a $0 cost to you.

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 right not given through the benefit plan.

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