



SimplePay Health Benefits Summary - High Deductible Health Plan (HDHP)
Client Name: Landmark Properties
Plan Year: March 1, 2026 - February 28, 2027

Pharmacy Drug Vendor: CVS Caremark



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	CVS	In-Network Retail Pharmacies	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 (Up to a 31-day supply)	\$20	\$25	\$40
Specialty Drug Program			

Specialty Drugs Specialty Drug coverage is offered exclusively through OptiMed.
Call 877-884-0998 for assistance with your specialty prescription needs

Mail Order (90 Day Supply**)	
Generic Drugs (Tier 1)	\$13
Preferred Brand Drugs (Tier 2)	\$30
Non-Preferred Brand Drugs (Tier 3)	\$50

**A 90-day supply of maintenance drugs must be purchased through the mail order program or at an approved retail pharmacy (CVS/Kroger/Costco) 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 and Price Care".

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.



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Medical Benefits	
Plan Year Deductible - embedded	
Single	\$3,500
Family	\$7,000
Out-of-Pocket Maximum (includes medical copays combined with prescriptions copays) - embedded	
Single	\$8,000
Family	\$16,000

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

Preventative Services & Routine Care	(See plan document for specific coverage based on age/necessity)
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	No Charge

Medical Services	In-Network			Out-of-Network
	✓ Tier 1	⊖ Tier 2	⚠ Tier 3	
Physician Services				
Primary Care Physician	\$20	\$25	\$40	\$50
Specialist	\$35	\$50	\$80	\$95
Teladoc™		No Charge		N/A
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 (60 days combined max per plan year)	\$1,445	\$1,920	\$3,250	\$3,900
Ambulatory Surgical Center	\$535	\$715	\$1,205	\$1,445
Home Health Care (30 visits per plan year)	\$35	\$50	\$80	\$95
Home Infusion	\$35	\$50	\$80	\$95
Hospice Care	\$180	\$240	\$405	\$485

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



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Medical Services	In-Network			Out-of-Network
	✓ Tier 1	⊖ Tier 2	⚠ Tier 3	
Radiology Services				
Diagnostic Radiology	\$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	
Ambulance Services			\$305	
Urgent Care Facility			\$35	
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 (20 visits per plan year)	\$35	\$50	\$80	\$95
Acupuncture (10 visits per plan year)	\$35	\$50	\$80	\$95
Outpatient Therapies (PT, OT, ST) (30 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 (see plan document for benefit details)	\$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 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 Choice POS II

How to Find a Provider: Log into your member portal at www.simplepayhealth.com and click on "Find and Price Care".

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

Email: healthvalet@simplepayhealth.com

Phone: 800-606-3564

