



SimplePay Health Benefits Summary - High Deductible Health Plan

Client Name: Patriot Rail

Plan Year: January 1, 2026 - December 31, 2026

Medical Benefits				
Plan Year Deductible - aggregate				
Single				\$1,700
Family				\$3,400
Out-of-Pocket Maximum - embedded (includes medical copays combined with prescriptions copays)		In-Network		Out-of-Network
Single				\$6,800
Family				\$13,600
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		
		In-Network		Out-of-Network
Medical Services	✔ Tier 1	⊖ Tier 2	⚠ Tier 3	
Physician Services				
Primary Care Physician	\$5	\$10	\$20	\$50
Specialist	\$20	\$30	\$50	\$100
Teladoc™ (all services)	\$20 copay (not subject to deductible)			N/A
Maternity				
Initial Prenatal Office Visit	\$5	\$10	\$20	\$50
Routine/Ongoing Prenatal Office Visit	Included in Delivery Copay			\$50
Delivery & Postnatal Care	\$1,200	\$1,500	\$1,800	\$3,600
Hospital Expenses or Long-Term Acute Care Facility/Hospital (Facility Charges)				
Inpatient Hospital	\$1,200	\$1,500	\$1,800	\$3,600
Outpatient Hospital	\$350	\$500	\$650	\$1,500
Skilled Nursing /Rehabilitation Facility (60 days combined max per plan year)	\$1,200	\$1,500	\$1,800	\$3,600
Ambulatory Surgical Center	\$350	\$500	\$650	\$1,500
Home Health Care (60 visits per plan year)	\$20	\$30	\$50	\$100
Home Infusion	\$20	\$30	\$50	\$100
Hospice Care	\$150	\$200	\$250	\$600



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	In-Network			Out-of-Network
Medical Services	✓ Tier 1	⊖ Tier 2	! Tier 3	
Radiology Services				
Diagnostic X-Rays	\$15	\$25	\$40	\$125
Advanced Imaging (MRI, MRA, CAT & PET Scans)	\$75	\$125	\$175	\$325
Laboratory Services				
Routine Basic Labs	\$5	\$10	\$30	\$75
Advanced Diagnostic Labs	\$15	\$25	\$40	\$125
Emergency Services/Urgent Care				
Emergency Services/Emergency Room		\$150		
Ambulance Services		\$150		
Urgent Care Facility		\$50		
Mental Disorders & Substance Use Disorders				
Office Visit	\$5	\$10	\$20	\$50
Inpatient	\$1,200	\$1,500	\$1,800	\$3,600
Outpatient	\$350	\$500	\$650	\$1,500
Therapy Services				
Chiropractic Care/Spinal Manipulation (20 visits per plan year)	\$20	\$30	\$50	\$100
Outpatient Therapies (PT, OT, ST) (60 combined visits per plan year)	\$20	\$30	\$50	\$100
Durable Medical Equipment**				
Durable Medical Equipment (DME) / Item	\$50	\$75	\$100	\$250
Other Healthcare Facilities/Services				
Allergy Injections, Serum & Testing	\$20	\$30	\$50	\$100
Hearing Aids (One set every 3 years, \$5,000 maximum)	\$50	\$75	\$100	\$250
Transplants - Aetna IOE Program* (Travel/lodging \$10,000 per transplant)	\$1,200	\$1,500	\$1,800	\$3,600

*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

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Pharmacy Drug Vendor: MedOne Rx



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	\$25	\$40
Non-Preferred Brand Drugs	\$40	\$50	\$70
Specialty Drug Program			
Specialty Drugs	\$100 For specialty drugs, contact the RxAllly patient care team at 1-877-794-2218.		
Mail Order (90 Day Supply**)			
Generic Drugs (Tier 1)	\$15		
Preferred Brand Drugs (Tier 2)	\$45		
Non-Preferred Brand Drugs (Tier 3)	\$120		
**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 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.

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