

## SimplePay Health HDHP Plan Summary(Non-Financing)

Client Name: American Financial Network, Inc Plan Year: June 1st, 2025 - May 31st, 2026

Network: Aetna Choice POS II

	<u> </u>	dical Benefits		
	In-Network			Out-of-Network
	✓ Tier 1	Compared Tier 2	U Tier 3	
Calendar Year Deductible	Ş	Single \$4,000* / Family \$6,00	00*	
You must meet your deductible before r	medical copays apply			
Out-of-Pocket Maximum (Includes copays - combine with orescription drug card)	Single \$6,000* / Family \$12,000*			Unlimited
OOP Max applies to in-network services	s only; Out-of-Network OOI	P Max is unlimited*		
		In-Network		Out-of-Network
Medical Services	▼ Tier 1	- Tier 2	U Tier 3	
Physician Services: You must meet yo	ur deductible before copay	s apply		
Primary Care Physician	\$25 after ded.	\$25 after ded.	\$25 after ded.	\$50 after ded.
Retail Health Clinic CVS Minute Clinic is a \$0 copay after ded.	\$25 after ded.	\$25 after ded.	\$25 after ded.	\$50 after ded.
Specialist	\$50 after ded.	\$50 after ded.	\$50 after ded.	\$95 after ded.
Preventative Services & Routine Care	: No deductible needs to b	e met		
Well-Child Care (including exams and mmunizations)	No Charge / No Ded.			
Adult Physical Examination (including routine GYN visit)	No Charge / No Ded.			
Routine Eye Care	No Charge / No Ded.			
COVID 19 Vaccine	No Charge / No Ded.			
Breast Cancer Screening (any age)	No Charge / No Ded.			
Pap Test		No Charge	e / No Ded.	
Prostate Cancer Screening		No Charge	e / No Ded.	
Colorectal Cancer Screening	See	plan document for specific of	coverage based on age/neces	ssity
Teledoc Services: You must meet your	deductible before copays	apply		
Teladoc- Medical & Behavioral	No charge after ded.	No charge after ded.	No charge after ded.	N/A
Maternity: You must meet your deductik	ole before copays apply ex	cept for Routine/Ongoing Pro	enatal Office Visit	
nitial Prenatal Office Visit	\$25 after ded.	\$25 after ded.	\$25 after ded.	\$50 after ded.
Routine/Ongoing Prenatal Office Visit	No Charge	No Charge	No Charge	\$50 after ded.
Delivery & Postnatal Care	\$2,180 after ded.	\$2,180 after ded.	\$2,180 after ded.	\$4,425 after ded
Hospital Expenses or Long-Term Acu				
npatient Hospital	\$2,180 after ded.	\$2,180 after ded.	\$2,180 after ded.	\$4,425 after ded
Outpatient Hospital	\$715 after ded.	\$715 after ded.	\$715 after ded.	\$1,445 after ded
Skilled Nursing /Rehabilitation Facility (100 days)	\$1,920 after ded.	\$1,920 after ded.	\$1,920 after ded.	\$3,900 after ded
Ambulance Services	\$305 after ded.	\$305 after ded.	\$305 after ded.	\$305 after ded.
Ambulatory Surgical Center	\$715 after ded.	\$715 after ded.	\$715 after ded.	\$1,445 after ded
Home Health Care (100 visits per plan year)	\$50 after ded.	\$50 after ded.	\$50 after ded.	\$95 after ded.
Home Infusion	\$50 after ded.	\$50 after ded.	\$50 after ded.	\$95 after ded.
Hospice Care	\$240 after ded.	\$240 after ded.	\$240 after ded.	\$485 after ded.

	In-Network			Out-of-Network
Medical Services		Tier 2	① Tier 3	
Radiology Services: You must meet yo	our deductible before copay	s apply		
Diagnostic X-Rays	\$65 after ded.	\$65 after ded.	\$65 after ded.	\$125 after ded.
Advanced Imaging (MRI, MRA, CAT & PET Scans)	\$215 after ded.	\$215 after ded.	\$215 after ded.	\$435 after ded.
Laboratory Services: You must meet y	our deductible before copay	/s apply		
Basic Labs	\$15 after ded.	\$15 after ded.	\$15 after ded.	\$35 after ded.
Advanced Diagnostic Labs	\$65 after ded.	\$65 after ded.	\$65 after ded.	\$125 after ded.
Emergency Services/Urgent Care: Yo	u must meet your deductible	e before copays apply		
Emergency Services/Emergency Room	\$305 after ded.	\$305 after ded.	\$305 after ded.	\$305 after ded.
Urgent Care Facility	\$35 after ded.	\$35 after ded.	\$35 after ded.	\$35 after ded.
Mental Disorders & Substance Use Di	sorders: You must meet yo	our deductible before copay	s apply	
Office Visit	\$25 after ded.	\$25 after ded.	\$25 after ded.	\$50 after ded.
Inpatient	\$2,180 after ded.	\$2,180 after ded.	\$2,180 after ded.	\$4,425 after ded.
Outpatient	\$715 after ded.	\$715 after ded.	\$715 after ded.	\$1,445 after ded.
Therapy Services: You must meet you	r deductible before copays a	apply		
Chiropractic Care/Spinal Manipulation (30 visits per plan year)	\$50 after ded.	\$50 after ded.	\$50 after ded.	\$95 after ded.
Outpatient Therapies (PT, OT, ST) (60 visits per plan year)	\$50 after ded.	\$50 after ded.	\$50 after ded.	\$95 after ded.
Durable Medical Equipment*: You mu	st meet your deductible befo	ore copays apply		
Durable Medical Equipment (DME) / Item	\$100 after ded.	\$100 after ded.	\$100 after ded.	\$205 after ded.
Other Healthcare Facilities/Services:	You must meet your deduct	tible before copays apply		
Allergy Injections, Serum & Testing	\$50 after ded.	\$50 after ded.	\$50 after ded.	\$95 after ded.
Acupuncture(20 visits per year)	\$50 after ded.	\$50 after ded.	\$50 after ded.	\$95 after ded.
Transplants - Aetna IOE Program (Travel/lodging \$10,000 per transplant)	See plan document for coverage details			
Bariatric Surgery	See plan document for coverage details			

<sup>\*</sup>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 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

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## **Pharmacy Drug Vendor: CVS Caremark**



	Pha	rmacy Benefits				
NOTE: There is no coverage under the	e plan for prescription drugs of	obtained from a Non-Participating Partner.				
Calendar Year Deductible	Single \$4,000* / Family \$6,000*					
*You must meet your deductible before	e RX copays					
Out-of-Pocket Maximum (Includes copays)	Single \$6,000* / Family \$12,000*		N/A			
		C Tier 2	① Tier 3			
Pharmacy Plan Feature	cvs	In-Network Pharmacies Excluding CVS/Walgreens	Walgreens			
Retail Pharmacy: You must meet you	ır deductible before copays(e	xcept for preventive medications)				
Preventive Drugs	No Charge/No Ded.	No Charge/No Ded.	No Charge/No Ded.			
Generic Drugs (Up to a 30-day supply)	\$10 after ded.	\$10 after ded.	\$10 after ded.			
Preferred Brand Drugs (Up to a 30-day supply)	\$20 after ded.	\$20 after ded.	\$20 after ded.			
Non-Preferred Brand Drugs	\$25 after ded.	\$25 after ded.	\$25 after ded.			
Specialty Drug Program: You must r	meet your deductible before c	opays apply				
Specialty Drugs* (Up to a 30-day supply)	\$35 for a 30-day supply after ded.					
*Specialty medications are required to	be filled through Mail Order.					
Mail Order (90 Day Supply*): You me	ust meet your deductible befo	re copays(except for preventive medication	s)			
Preventive Drugs	No Charge/No Ded.					
Generic Drugs (Tier 1)	\$20 after ded.					
Preferred Brand Drugs (Tier 2)	\$30 after ded.					
Non-Preferred Brand Drugs (Tier 3)	\$50 after ded.					
*A 90-day supply of maintenance drug day supply.	s must be purchased at a CV	S retail pharmacy or through the mail order	program to receive the savings of a 90			
Drug Descriptions						
Preventive Drugs	Items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website: <a href="https://www.healthcare.gov/what-are-my-preventive-care-benefits">https://www.healthcare.gov/what-are-my-preventive-care-benefits</a>					
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 alternative with your physician or pharmacist.					

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."

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.