

Hospice Care	\$240 after ded.	\$240 after ded.	\$240 after ded.	\$485 after ded.
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	In-Network			Out-of-Network
Medical Services	✓ Tier 1	⊖ Tier 2	⚠ Tier 3	
<b>Radiology Services:</b> <i>You must meet your deductible before copays apply</i>				
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.
<b>Laboratory Services:</b> <i>You must meet your deductible before copays apply</i>				
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.
<b>Emergency Services/Urgent Care:</b> <i>You must meet your deductible before copays apply</i>				
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.
<b>Mental Disorders &amp; Substance Use Disorders:</b> <i>You must meet your deductible before copays apply</i>				
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.
<b>Therapy Services:</b> <i>You must meet your deductible before copays apply</i>				
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.
<b>Durable Medical Equipment*:</b> <i>You must meet your deductible before copays apply</i>				
Durable Medical Equipment (DME) / Item	\$100 after ded.	\$100 after ded.	\$100 after ded.	\$205 after ded.
<b>Other Healthcare Facilities/Services:</b> <i>You must meet your deductible before copays apply</i>				
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			

\*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](http://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](mailto:healthvalet@simplepayhealth.com)

**Phone:** 800-606-3564

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## Pharmacy Drug Vendor: CVS Caremark



### Pharmacy Benefits

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

Calendar Year Deductible Single \$4,000\* / Family \$6,000\*

\*You must meet your deductible before RX copays

Out-of-Pocket Maximum (Includes copays) Single \$6,000\* / Family \$12,000\* N/A

Pharmacy Plan Feature	✓ Tier 1	✗ Tier 2	! Tier 3
	CVS	In-Network Pharmacies Excluding CVS/Walgreens	Walgreens
<b>Retail Pharmacy:</b> <i>You must meet your deductible before copays(except for preventive medications)</i>			
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 meet your deductible before copays 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 must meet your deductible before copays(except for preventive medications)*

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 drugs must be purchased at a CVS retail pharmacy or through the mail order program to receive the savings of a 90-day supply.

### 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 alternatives 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](http://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.