SIMPLEPAY HEALTH

SimplePay Health Benefits Summary

Client Name: Omni Hotels
Plan Year: January 1, 2025 - December 31, 2025
Network: Aetna Choice POS II

Medical Benefits

	In-Network			Out-of-Network
	Tier 1	Tier 2	Tier 3	
Calendar Year Deductible (Indiv/Family)		$0		N/A
Out-of-Pocket Maximum (Indiv/Family)		$6,700 / $13,400		N/A
OOP Max applies to in-network services only; Out-of-Network OOP Max is unlimited				

	In-Network			Out-of-Network
Medical Services	Tier 1	Tier 2	Tier 3	
Physician Services				
Primary Care Physician + Virtual Care	$60	$70	$115	$140
Retail Health Clinic (CVS Minute Clinic is a $0 copay)	$60	$70	$115	$140
Specialist + Virtual Care	$125	$140	$230	$275
Preventative Services & Routine Care				
Well-Child Care (including exams and immunizations)		No Charge		
Adult Physical Examination (including routine GYN visit)		No Charge		
Routine Eye Care		No Charge		
COVID 19 Vaccine		No Charge		
Breast Cancer Screening (any age)		No Charge		
Pap Test		No Charge		
Prostate Cancer Screening		No Charge		
Colorectal Cancer Screening		See plan document for specific coverage based on age/necessity		
Teledoc Services				
Teladoc		No Charge		N/A
Teledoc Dermatology				N/A
Teledoc Behavioral				N/A
Maternity				
Initital Prenatal Office Visit	$60	$70	$115	$140
Routine/Ongoing Prenatal Office Visit		No Charge		$140
Delivery & Postnatal Care	$3,500	$4,745	$6,000	$7,800
Hospital Expenses or Long-Term Acute Care Facility/Hospital (Facility Charges)				
Inpatient Hospital	$3,500	$4,745	$6,000	$7,800
Outpatient Hospital	$1,200	$1,540	$2,570	$3,085
Skilled Nursing /Rehabilitation Facility (120 days combined max per plan year)	$3,200	$4,190	$6,000	$7,800
Ambulance Services			$860	
Ambulatory Surgical Center	$1,200	$1,540	$2,570	$3,085
Home Health Care (120 visits per plan year)	$125	$140	$230	$275
Home Infusion	$125	$140	$230	$275
Hospice Care	$385	$515	$855	$1,025

	In-Network			Out-of-Network
Medical Services	**Tier 1**	**Tier 2**	**Tier 3**	
Radiology Services				
Diagnostic X-Rays	$125	$140	$230	$275
Advanced Imaging (MRI, MRA, CAT & PET Scans)	$350	$475	$790	$950
Laboratory Services				
Basic Labs	$45	$60	$105	$125
Advanced Diagnostic Labs		$125		$275
Emergency Services/Urgent Care				
Emergency Services/Emergency Room			$860	
Urgent Care Facility			$125	
Mental Disorders & Substance Use Disorders				
Office Visit	$60	$70	$115	$140
Inpatient	$3,500	$4,745	$6,000	$7,800
Outpatient	$1,200	$1,540	$2,570	$3,085
Therapy Services				
Chiropractic Care/Spinal Manipulation (20 visits per plan year)	$125	$140	$230	$275
Outpatient Therapies (PT, OT, ST) (60 visits per plan year)	$125	$140	$230	$275
Durable Medical Equipment*				
Durable Medical Equipment (DME) / Item	$160	$215	$355	$425
Other Healthcare Facilities/Services				
Allergy Injections, Serum & Testing	$125	$140	$230	$275
Acupuncture	$125	$140	$230	$275
Transplants - Aetna IOE Program (Travel/lodging $10,000 per transplant)	$3,500	$4,745	$6,000	$7,800
Bariatric Surgery		See plan document for coverage details		

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: 800-606-93564

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Optum Pharmacy Benefits

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

Out-of-Pocket Maximum (Indiv/Family) (Includes copays - combine with prescription drug card)	$6,700 / $13,400	N/A

All copays and other eligible out-of-pocket costs count toward your out-of-pocket maximum, except balance billed amounts.
All copays and other eligible out-of-pocket pharmacy costs are due at the time of service and are not eligible for financing.

Pharmacy Plan Feature	In-Network Pharmacies	Out-of-Network Pharmacies	Description
Retail Pharmacy			
Generic Drugs (Up to a 30-day supply)	$12	No Coverage	Generic drugs are covered at this copay level.
Preferred Brand Drugs (Up to a 30-day supply)	$60	No Coverage	All preferred drugs are covered at this copay level.
Non-Preferred Brand Drugs	$80	No Coverage	Non-preferred brand drugs on this copay level are not on the Preferred Drug List. Discuss using alternatives with your physician or pharmacist.
Optum Specialty Exclusive Drug Program			
Generic Drugs (Up to a 30-day supply)	$12	No Coverage	
Preferred Brand Drugs (Up to a 30-day supply)	$60	No Coverage	
Non-Preferred Brand Drugs	$80	No Coverage	
Mail Order (90 Day Supply)			
Generic Drugs	$30	Maintenance drugs of up to a 90-day supply is available for twice the in-network copay through Mail Service Pharmacy.	
Preferred Brand Drugs	$150		
Non-Preferred Brand Drugs	$200		

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