SIMPLEPAY HEALTH

SimplePay Health Benefits Summary

Client Name: Omni Hotels
Plan Year: January 1, 2026 - December 31, 2026
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 (60 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 (90 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 Not Covered)				
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 calendar year)	$125	$140	$230	$275
Outpatient Therapies (PT, OT, ST) (60 visits per calendar 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
Transplants - Aetna IOE Program(see plan documents for further coverage details)	$3,500	$4,745	$6,000	$7,800
TMJ	Not covered			
Bariatric Surgery	Not covered			
Acupuncture	Not covered			

*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: 800-606-93564

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Express Scripts 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
Retail Pharmacy		
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
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	

For help with your prescription or prescription benefit through Express Scripts Pharmacy by Evernorth.

Express Scripts
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Log in to your Express Scripts account, or call.**(800) 282-288- 24 hours a day, 7 days a week.**