



**SimplePay Benefits Summary: HireRight - Enhanced HDHP**

**Plan Year: January 1<sup>st</sup>, 2022 – December 31<sup>st</sup>, 2022**

| <b>MEDICAL BENEFITS</b>   |               |               |               |   |
|---|---------------|---------------|---------------|---|
| <b>Medical Services</b>   | <b>Tier 1</b> | <b>Tier 2</b> | <b>Tier 3</b> | <b>Out-of-Network</b>                         |
| <b>Calendar Year Deductible</b>   |               |               |               |   |
| Single  |               |               |               | \$1,500                                       |
| Family  |               |               |               | \$3,000                                       |
| <b>Out-Of-Pocket Maximum*</b> (includes Copays – combined with Prescription Drug Card)    |               |               |               |   |
| Single  |               |               | \$3,350       | Unlimited                                     |
| Family  |               |               | \$6,700       | Unlimited                                     |
| <b>*OOP Max applies to In-Network services only; Out-of-Network OOP Max is unlimited*</b> |               |               |               |   |
| <b>Medical Services</b>   | <b>Tier 1</b> | <b>Tier 2</b> | <b>Tier 3</b> | <b>Out-of-Network</b>                         |
| <b>COVID-19 Services</b>  |               |               |               |   |
| COVID-19 Testing  |               |               |               | No Charge                                     |
| COVID-19 Vaccine (Moderna, Pfizer, Johnson & Johnson)                                     |               |               |               | No Charge                                     |
| <b>Durable Medical Equipment</b>  |               |               |               |   |
| Durable Medical Equipment (DME)   | \$65          | \$85          | \$140         | \$170   |
| <b>Emergency Services/Urgent Care</b>   |               |               |               |   |
| Emergency Services/Emergency Room Services  |               |               |               | \$265 per visit                               |
| Urgent Care Facility  | \$30          | \$40          | \$65          | \$80  |
| <b>Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)</b>     |               |               |               |   |
| Inpatient Hospital  | \$1,300       | \$1,600       | \$1,750       | \$2,500                                       |
| Outpatient Hospital   | \$465         | \$615         | \$1,030       | \$1,240                                       |
| Infertility Treatment   |               |               |               | Not Covered                                   |
| Skilled Nursing Facility (160 visit limit)  | \$1,200       | \$1,450       | \$1,750       | \$2,500                                       |
| Ambulance Services  |               |               |               | \$265 per visit                               |
| Ambulatory Surgical Center  | \$465         | \$615         | \$1,030       | \$1,240                                       |
| Home Health Care (50 visit limit)   | \$30          | \$40          | \$65          | \$80  |
| Hospice Care  | \$155         | \$205         | \$345         | \$420   |
| <b>Laboratory Services</b>  |               |               |               |   |
| Routine Diagnostic Labs   | \$10          | \$15          | \$20          | \$30  |
| Diagnostic Labs   | \$40          | \$55          | \$90          | \$110   |
| <b>Maternity</b>  |               |               |               |   |
| Initial Office Visit  | \$30          | \$40          | \$65          | \$80  |
| Preventive & On-going Prenatal Care   |               |               |               | No Charge (included in global delivery copay) |
| Delivery & Postnatal Care   | \$1,300       | \$1,600       | \$1,750       | \$2,500                                       |
| <b>Mental Disorders &amp; Substance Use Disorders</b>                                     |               |               |               |   |
| Office Visit  | \$15          | \$20          | \$30          | \$40  |
| Inpatient   | \$1,300       | \$1,600       | \$1,750       | \$2,500                                       |
| Outpatient  | \$465         | \$615         | \$1,030       | \$1,240                                       |
| <b>Physician Services</b>   |               |               |               |   |
| Primary Care Physician  | \$15          | \$20          | \$30          | \$40  |
| Specialist  | \$30          | \$40          | \$65          | \$80  |
| Teladoc   |               |               |               | No Charge                                     |
| <b>Preventive Services and Routine Care</b>   |               |               |               |   |
| Well-Child Care (including exams & immunizations)   |               |               |               | No Charge                                     |
| Adult Physical Examination (including routine GYN visit)                                  |               |               |               | No Charge                                     |
| Breast Cancer Screening (any age)   |               |               |               | No Charge                                     |

|  |             |         |         |         |
|--|-------------|---------|---------|---------|
| Pap Test   | No Charge   |         |         |         |
| Prostate Cancer Screening  | No Charge   |         |         |         |
| Colorectal Cancer Screening  | No Charge   |         |         |         |
| Routine Eye Exam   | Not Covered |         |         |         |
| <b>Radiology Services</b>  |             |         |         |         |
| Diagnostic X-Rays  | \$40        | \$55    | \$90    | \$110   |
| Advanced Imaging<br>MRI, MRA, CAT & PET Scans  | \$140       | \$190   | \$315   | \$400   |
| <b>Other Healthcare Facilities/Services</b>  |             |         |         |         |
| <b>Therapy Services</b>  |             |         |         |         |
| Chiropractic Care/Spinal Manipulation<br>(20 visit limit)  | \$30        | \$40    | \$65    | \$80    |
| Outpatient Therapies (PT, OT, ST)<br>(20 visit limit each)   | \$30        | \$40    | \$65    | \$78    |
| <b>Other Healthcare Facilities/Services</b>  |             |         |         |         |
| Temporomandibular Joint Dysfunction<br>(\$5,000 Lifetime Maximum Benefit)  | \$1,300     | \$1,600 | \$1,750 | \$2,500 |
| Allergy Injections, Serum & Testing  | \$30        | \$40    | \$65    | \$80    |
| Acupuncture (20 visit limit)   | \$30        | \$40    | \$65    | \$80    |
| Transplants (Aetna IOE Program) *  | \$1,300     | \$1,600 | \$1,750 | \$2,500 |
| *Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit, including travel and lodging maximums. No charge for travel and lodging |             |         |         |         |
| Weight Control/Bariatric Surgery<br>(\$75,000 Lifetime Limit)  | \$1,300     | \$1,600 | \$1,750 | \$2,500 |

\*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 (Open Access)

**How to Find a Provider:** Log in to your member portal at [www.simplepayhealth.com](http://www.simplepayhealth.com) and find the “Find A Doctor and Compare Costs” under the “Benefits” tab

**For Questions about your SimplePay Health Plan, please contact your SimplePay Health Pro.**

Email: [HealthPro@simplepayhealth.com](mailto:HealthPro@simplepayhealth.com)

Phone: 800-606-3564

## PHARMACY BENEFITS

**NOTE:** There is no coverage under the Plan for Prescription Drugs obtained from a Non-Participating Provider.

|                  |                    |  |
|------------------|--------------------|--|
| Single<br>Family | \$3,350<br>\$6,700 | If you reach your out-of-pocket maximum, SimplePay Health will pay 100% of the applicable allowed benefit for most covered services for the remainder of the year. All copays and other eligible out-of-pocket costs count toward your out-of-pocket maximum, except balance billed amounts. |
|------------------|--------------------|--|

| Pharmacy Plan Feature | All other In-<br>Network<br>Pharmacies | CVS | Walgreens | Description |
|-----------------------|--|-----|-----------|-------------|
|-----------------------|--|-----|-----------|-------------|

### Retail Pharmacy

|  |      |      |      |   |
|--|------|------|------|---|
| <b>Generic Drugs (Tier1)</b><br><br>(Up to a 31-day supply)              | \$5  | \$5  | \$10 | Generic drugs are covered at this copay level.  |
| <b>Preferred Brand Drugs (Tier 2)</b><br><br>(Up to a 31-day supply)     | \$10 | \$15 | \$25 | All preferred brand drugs are covered at this copay level.  |
| <b>Non-Preferred Brand Drugs (Tier 3)</b><br><br>(Up to a 31-day supply) | \$15 | \$20 | \$30 | All non-preferred brand drugs on this copay level are not on the Preferred Drug List. * Discuss using alternatives with your physician or pharmacist. |

### Specialty Drug Program

|   |      |   |
|---|------|---|
| Specialty Drugs (Tier 4)<br><br>(Up to a 31-day supply) | \$15 | Specialty medications are required to be filled through Mail Order. |
|---|------|---|

### Mail Order Pharmacy (90-day supply)

|                                    |      |  |
|------------------------------------|------|--|
| Generic Drugs (Tier 1)             | \$10 | Maintenance drugs of up to a 90-day supply is available for twice the copay through Mail Service Pharmacy. |
| Preferred Brand Drugs (Tier 2)     | \$25 |  |
| Non-Preferred Brand Drugs (Tier 3) | \$30 |  |



**Pharmacy Drug Vendor:** Medone RX

**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". Please refer to the "MedOne Preventative Drug List 2021" found on the *Employer Benefit Page* within the *SimplePay Health Member Portal* for all preventative medications covered at 100% with a \$0 cost to you.

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

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.