SimplePay Health Benefits Summary - Copay Plan
Client Name: Immanuel
Plan Year: January 1, 2026 - December 31, 2026

Medical Benefits				
Plan Year Deductible				
Single	None			
Family	None			
Out-of-Pocket Maximum (includes medical copays combined with prescriptions copays)				
Single	$3,500			
Family	$7,000			
OOP Max applies to in-network services only; Only services through In-Network providers are covered				
Preventative Services & Routine Care	(see plan document for specific coverage based on age/necessity)			
Well-Child Care (including exams and immunizations)	No Charge			
Adult Physical Examination (including routine GYN visit)	No Charge			
COVID 19 Vaccine	No Charge			
Breast Cancer Screening	No Charge			
Pap Test	No Charge			
Prostate Cancer Screening	No Charge			
Colorectal Cancer Screening	No Charge			
Medical Services	**In-Network**			**Out-of-Network**
	Tier 1	**Tier 2**	**Tier 3**	
Physician Services				
Primary Care Physician	$25	$40	$60	Not Covered
Specialist	$50	$70	$120	Not Covered
Teladoc™ (General Medicine / Behavioral Health)	No Charge			N/A
Maternity				
Initial Prenatal Office Visit	$25	$40	$60	Not Covered
Routine Ongoing Prenatal Office Visit	Included with Delivery Copay			Not Covered
Delivery & Postnatal Care	$2,700	$3,000	$3,500	Not Covered
Hospital Expenses or Long-Term Acute Care Facility/Hospital (Facility Charges)				
Inpatient Hospital	$2,700	$3,000	$3,500	Not Covered
Outpatient Hospital	$880	$1,170	$1,950	Not Covered
Skilled Nursing / Rehabilitation Facility (160 days combined max per plan year)	$2,700	$3,000	$3,500	Not Covered
Ambulatory Surgical Center	$800	$1,170	$1,950	Not Covered
Home Health Care (60 visits per plan year)	$55	$80	$120	Not Covered
Home Infusion	$55	$80	$120	Not Covered
Hospice Care	$245	$330	$550	Not Covered

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Medical Services	In-Network			Out-of-Network
	Tier 1	Tier 2	Tier 3	
Radiology Services				
Diagnostic X-Rays	$50	$70	$120	Not Covered
Advanced Imaging (MRI, MRA, CAT & PET Scans)	$230	$400	$600	Not Covered
Laboratory Services				
Routine Basic Labs	$20	$30	$40	Not Covered
Advanced Diagnostic Labs	$50	$70	$120	Not Covered
Emergency Services/Urgent Care				
Emergency Services / Emergency Room		$450		
Ambulance Services		$650		
Urgent Care Facility		$55		Not Covered
Mental Disorders & Substance Use Disorders				
Office Visit	$25	$40	$60	Not Covered
Inpatient	$2,700	$3,000	$3,500	Not Covered
Outpatient	$880	$1,170	$1,950	Not Covered
Therapy Services				
Chiropractic Care/Spinal Manipulation (20 visits per plan year)	$55	$80	$120	Not Covered
Outpatient Therapies (PT, OT, ST) (60 combined visits per plan year)	$55	$80	$120	Not Covered
Durable Medical Equipment**				
Durable Medical Equipment (DME) / Item	$100	$135	$230	Not Covered
Other Healthcare Facilities/Services				
Allergy Injections, Serum & Testing	$55	$80	$120	Not Covered
Acupuncture (10 visits per plan year)	$55	$80	$120	Not Covered
Temporomandibular Joint Dysfunction (TMJ)		Not Covered		
Weight ControlServices / Bariatric Surgery		Not Covered		
Transplants - Aetna IOE Program* (Travel/lodging $10,000 per transplant)	$2,700	$3,000	$3,500	Not Covered

*Please refer to the Aetna Institute of Excellence (IOE) Program section in the plan document for a more detailed description of this benefit, including travel and lodging maximums. No charge for travel and lodging.

**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 and Price Care".

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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SimplePay Health Benefits Summary - Copay Plan
Client Name: Immanuel
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Pharmacy Drug Vendor: MedOne Rx

Pharmacy Benefits

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

Pharmacy Plan Feature	In-Network Retail Pharmacies	CVS	Walgreens
Retail Pharmacy			
Generic Drugs (Up to a 30-day supply)	$0	$15	$20
Preferred Brand Drugs (Up to a 30-day supply)	$40	$60	$80
Non-Preferred Brand Drugs (Up to a 30-day supply)	$60	$80	$120
Specialty Drug Program			
Specialty Drugs	Not covered under the basic pharmacy benefit. For specialty drugs, contact the RxAlly patient care team at 1-877-794-2218		
Mail Order (90 Day Supply)**			
Generic Drugs (Tier 1)		$0	
Preferred Brand Drugs (Tier 2)		$70	
Non-Preferred Brand Drugs (Tier 3)		$120	

**90-day Prescriptions must be filled via mail order in order to receive the savings of a 90-day supply.

Drug Descriptions	
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: Log into your member portal at www.simplepayhealth.com and click on “Find and Price Care".

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.