



SimplePay Health Benefits Summary - HDHP Plan

Client Name: Metro Fire

Plan Year: January 1, 2026 - December 31, 2026

Medical Benefits	
Plan Year Deductible - embedded	
Single	\$3,400
Family	\$6,800
Out-of-Pocket Maximum (includes medical copays combined with prescriptions copays) - embedded	
Single	\$6,800
Family	\$13,600

Deductible and OOP Maximum apply to in-network services only; Out-of-Network OOP Max is unlimited

All copays are applied after the deductible has been met

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	✓ Tier 1	⊕ Tier 2	❗ Tier 3	Out-of-Network
Physician Services				
Primary Care Physician	\$20	\$25	\$40	\$50
Specialist	\$35	\$50	\$80	\$95
Teladoc™ (General Medicine / Behavioral Health / Dermatology)		\$20		N/A

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

Maternity				
Initial Prenatal Office Visit	\$20	\$25	\$40	\$50
Routine/Ongoing Prenatal Office Visit		Included in Delivery Copay		\$50
Delivery & Postnatal Care	\$1,640	\$2,180	\$3,690	\$4,425
Hospital Expenses or Long-Term Acute Care Facility/Hospital (Facility Charges)				
Inpatient Hospital	\$1,640	\$2,180	\$3,690	\$4,425
Outpatient Hospital	\$535	\$715	\$1,205	\$1,445
Skilled Nursing /Rehabilitation Facility (180 days combined max per plan year)	\$1,445	\$1,920	\$3,250	\$3,900
Ambulance Services		\$305		
Ambulatory Surgical Center	\$535	\$715	\$1,205	\$1,445
Home Health Care (up to 6 hours/day)	\$35	\$50	\$80	\$95
Home Infusion	\$35	\$50	\$80	\$95
Hospice Care	\$180	\$240	\$405	\$485

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Medical Services	✓ Tier 1	In-Network	Out-of-Network	
	⊖ Tier 2	❗ Tier 3		
Radiology Services				
Diagnostic X-Rays	\$50	\$65	\$105	\$125
Advanced Imaging (MRI, MRA, CAT & PET Scans)	\$165	\$215	\$365	\$435
Laboratory Services				
Routine Basic Labs	\$10	\$15	\$30	\$35
Advanced Diagnostic Labs	\$50	\$65	\$105	\$125
Emergency Services/Urgent Care				
Emergency Services/Emergency Room		\$305		
Urgent Care Facility		\$35		\$95
Mental Disorders & Substance Use Disorders				
Office Visit	\$20	\$25	\$40	\$50
Inpatient	\$1,640	\$2,180	\$3,690	\$4,425
Outpatient	\$535	\$715	\$1,205	\$1,445
Therapy Services				
Chiropractic Care/Spinal Manipulation (60 visits per plan year)	\$35	\$50	\$80	\$95
Outpatient Therapies (PT, OT, ST) (120 combined visits per plan year)	\$35	\$50	\$80	\$95
Durable Medical Equipment**				
Durable Medical Equipment (DME) / Item	\$75	\$100	\$170	\$205
Other Healthcare Facilities/Services				
Allergy Injections, Serum & Testing	\$35	\$50	\$80	\$95
Hearing Aids (see plan document for benefit details)	\$75	\$100	\$170	\$205
Transplants - Aetna IOE Program* (Travel/lodging \$10,000 per transplant)	\$1,640	\$2,180	\$3,690	\$4,425

*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**Meritain Health**
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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. All copays are applied after the deductible has been met								
Pharmacy Plan Feature	In-Network Retail Pharmacies	CVS	Walgreens					
Retail Pharmacy								
Generic Drugs (Up to a 31-day supply)	\$5	\$10	\$15					
Preferred Brand Drugs (Up to a 31-day supply)	\$15	\$20	\$25					
Non-Preferred Brand Drugs	\$20	\$25	\$40					
Specialty Drug Program								
Specialty Drugs (Up to a 31-day supply. Specialty meds are required to go through mail order.)	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)	\$12.50							
Preferred Brand Drugs (Tier 2)	\$37.50							
Non-Preferred Brand Drugs (Tier 3)	\$50							
**90-day Prescriptions must be filled via mail order or through Tier 1 pharmacies 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.