SimplePay Benefits Summary: Jim Ellis Atlanta, Inc
Plan Year: January 1st, 2022 – December 31st, 2022

Services	Tier 1	Tier 2	Tier 3	Out-of-Network
LIFETIME MAXIMUM BENEFIT	Unlimited			Not Covered
CALENDAR YEAR MAXIMUM BENEFIT	Unlimited			Not Covered
CALENDAR YEAR DEDUCTIBLE				
Single	N/A			Not Covered
Family	N/A			Not Covered
OUT-OF-POCKET MAXIMUM (Includes Copays – combined with Prescription Drug Card)				
Single	$8,150			Not Covered
Family	$16,300			Not Covered
MEDICAL BENEFITS				
Acupuncture	Not Covered			
Allergy Injections, Serum & Testing	$20	$85	$250	Not Covered
Ambulance Services	$500 per visit			
Ambulatory Surgical Center	$500	$2,500	$5,000	Not Covered
Chiropractic Care/Spinal Manipulation (20 visit limit)	$20	$85	$250	Not Covered
Routine Diagnostic Labs	$10	$30	$65	Not Covered
Diagnostic Radiology	$50	$150	$500	Not Covered
Diagnostic Labs	$50	$150	$500	Not Covered
Advanced Imaging MRI, MRA, CAT & PET Scans	$200	$425	$1,500	Not Covered
Outpatient Therapies (PT, OT, ST) (20 visit limit each)	$20	$85	$250	Not Covered
Durable Medical Equipment (DME)*	$65	$200	$425	Not Covered
Emergency Services/Emergency Room Services	$500 per visit			
Gender Reassignment Surgery	$1,500	$4,500	$6,000	Not Covered
Hearing Aids (One per ear, every 3 years, $3,000 limit)	$65	$200	$425	Not Covered
Home Health Care (50 visit limit)	$20	$85	$190	Not Covered
Hospice Care	$150	$465	$1,030	Not Covered
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)				
Inpatient	$1,500	$4,500	$6,000	Not Covered
Outpatient	$500	$2,500	$5,000	Not Covered
Infertility Treatment	Not Covered			
Maternity				
Initial Office Visit	$20	$85	$250	Not Covered
Preventive & On-going Prenatal Care	No Charge (included in global delivery copay)			Not Covered
Delivery & Postnatal Care	$1,500	$4,500	$6,000	Not Covered
Mental Disorders & Substance Use Disorders				
Office Visit	$10	$45	$95	Not Covered
Inpatient	$1,500	$4,500	$6,000	Not Covered
Outpatient	$500	$2,500	$5,000	Not Covered
Physician Services				
Primary Care Physician	$10	$45	$95	Not Covered
Specialist	$20	$85	$250	Not Covered
Preventive Services and Routine Care				
Well-Child Care (Including exams & immunizations)	No Charge			Not Covered
Adult Physical Examination (Including routine GYN visit)	No Charge			Not Covered
Breast Cancer Screening (any age)	No Charge			Not Covered

AV: 78%

Pap Test	No Charge			Not Covered
Prostate Cancer Screening	No Charge			Not Covered
Colorectal Cancer Screening	No Charge			Not Covered
Routine Eye Exam	Not Covered			
Skilled Nursing Facility (160 visit limit)	$1,200	$4,000	$6,000	Not Covered
Teladoc	No Charge			Not Covered
Temporomandibular Joint Dysfunction ($5,000 Lifetime Maximum Benefit)	$500	$2,500	$5,000	Not Covered
Transplants (Aetna IOE Program)	$1,500	$4,500	$6,000	Not Covered
Urgent Care Facility	$20	$85	$190	Not Covered
Weight Control/Bariatric Surgery	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).

For Questions about your SimplePay Health Plan, please contact your SimplePay Health Pro.
Email: HealthPro@simplepayhealth.com
Phone: 800-606-3564

PRESCRIPTION DRUG SCHEDULE OF BENEFITS

Plan Feature	All other In-Network Pharmacies	CVS	Description
NOTE: There is no coverage under the Plan for Prescription Drugs obtained from a Non-Participating Provider.			
OUT-OF-POCKET MAXIMUM (Includes Copays – combined with Major Medical Out-of-Pocket)			
Single Family	$8,150 $16,300		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 deductibles, copays, coinsurance and other eligible out-of-pocket costs count toward your out-of-pocket maximum, except balance billed amounts.
Retail Pharmacy			
Generic Drugs (Tier1) (Up to a 31-day supply)	$5	$15	Generic drugs are covered at this copay level.
Preferred Brand Drugs (Tier 2) (Up to a 31-day supply)	$20	$80	All preferred brand drugs are covered at this copay level.
Non-Preferred Brand Drugs (Tier 3) (Up to a 31-day supply)	$40	$120	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)	Not Covered		
Mail Order Pharmacy (90-day supply)			
Generic Drugs (Tier1)	$20		Maintenance drugs of up to a 90-day supply is available for twice the copay through Mail Service Pharmacy.
Preferred Brand Drugs (Tier 2)	$80		
Non-Preferred Brand Drugs (Tier 3)	$160		

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.

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