Simmons University FY21 BCBSMA Medical Plans

	HMO	PPO With HSA (HDHP)	
Plan Limits	**In-Network**	**In-Network**	**Out-of-Network**
Plan Year Deductible • Employee • Employee + One • Family	$500 $1,000 $1,000 Note: The individual deductible applies to each member up to the family maximum.	$1,500 $3,000 $3,000 Note: There is no individual deductible on the family tiers. The full $3,000 deductible must be met (by 1 member or a combination of several) before the plan pays.	$2,500 $5,000 $5,000
Simmons HSA Contribution • Employee • Employee + One • Family	NA	$500 $1,000 $1,000	
Coinsurance	10%	10%	30% (for most services)
Lifetime Maximum Benefit	Unlimited	Unlimited	
Plan Year Out-of-Pocket Maximum (Includes RX – all plans) • Employee • Employee + One • Family	$3,000 $6,000 $6,000 Note: The individual OOP max applies to each member up to the family maximum.	$3,000 $6,000 $6,000 Note: There is no individual OOP max on the family tiers. The full $6,000 (for in-network) and/or $8,000 (for out of network) must be met by 1 member or a combination of several.	$4,000 $8,000 $8,000
Office Visits (Diagnostic) • Primary Care • Specialist • Telehealth visit via Well Connection	$20 copay per visit $35 copay per visit $10 copay per visit	10% after deductible 10% after deductible 10% after deductible	30% after deductible 30% after deductible 30% after deductible
Preventive Care • Annual Physical Exams and Screenings • Well Child	no cost	no cost	20% after deductible
Emergency Room Visits	$150 (copay waived if admitted)	$150 after deductible (copay waived if admitted)	$150 after deductible (copay waived if admitted)
Inpatient Hospitalization	10% after deductible	10% after deductible	30% after deductible
Day Surgery	10% after deductible	10% after deductible	30% after deductible
Mental Health • Inpatient • Outpatient	10% after deductible $20 copay	10% after deductible 10% after deductible	30% after deductible 30% after deductible
Substance Abuse • Inpatient • Outpatient	10% after deductible $20 copay	10% after deductible 10% after deductible	30% after deductible 30% after deductible
Diagnostic X-Rays/Lab Tests, Allergy Injections (Inpatient)	10% after deductible	10% after deductible	30% after deductible
Chiropractic Care	$35 copay	10% after deductible	30% after deductible
Durable Medical Equipment	10% after deductible	10% after deductible	30% after deductible
Prescription Drugs Retail (up to 30-day supply) Mail Order (31 to 90-day)	$15/$30/$50 $30/$60/$150 For a listing of free preventive drugs & mail order value drugs, visit Benefits Intranet.	After deductible (except for preventive*) $10/$25/$45 $20/$50/$135 *For a listing of preventive drugs & mail order value drugs excluded from the plan deductible, visit Benefits Intranet.	After deductible (except for preventive*) $20/$50/$90 No out-of-network mail order benefit *For a listing of preventive drugs & mail order value drugs excluded from the plan deductible, visit Benefits Intranet.

Exclusions and limitations may apply. It is important to understand that this information is not a legal document. It is meant to provide a general overview of the medical plans named above for eligible employees and their dependents, as of July 1, 2020. Plan provisions and coverage available will be governed by the respective plan document. Should there be any conflict between this overview and the plan document and agreements, the plan document and agreements will govern.