Benefits at Work

Simmons UNIVERSITY

Managing Your Health MEDICAL PLANS COSTS & SUMMARY

	HMO Plan (In-Network Only)	PPO Plan with HSA In-Network	PPO Plan with HSA Out-of-Network
Plan Year Deductible Individual Employee+1 / Family	 $1,000 (medical) $2,000 (medical)	 $2,000 (medical and Rx) $4,000 (medical and Rx)	 $3,000 (medical and Rx) $6,000 (medical and Rx)
Simmons HRA Contribution Individual Employee+1 / Family	 $500 $1,000	 $500 $1,000	 $500 $1,000
Simmons HSA Contribution Individual Employee+1 / Family	 N/A N/A	 $500 $1,000	 $500 $1,000
Coinsurance	10%	10%	30% (for most service)
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited
Plan Year Out-of-Pocket Maximum (Includes Rx) Individual Employee+1 / Family	 $3,000 (includes Rx copays) $6,000 (includes Rx copays)	 $3,000 (includes Rx copays) $6,000 (includes Rx copays)	 $4,000 (includes Rx copays) $8,000 (includes Rx copays)
Office Visits (Diagnostic) Primary Care Specialist	 $20 copay/visit $35 copay/visit	 10% after deductible 10% after deductible	 30% after deductible 30% after deductible
Preventive Care Annual Physical Exams/Screenings Well Child	 No cost No cost	 No cost No cost	 20% after deductible 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/visit	 10% after deductible 10% after deductible	 30% after deductible 30% after deductible
Substance Abuse Inpatient Outpatient	 10% after deductible $20 copay/visit	 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/visit	10% after deductible	30% after deductible
Durable Medical Equipment	10% after deductible	10% after deductible	30% after deductible
Pharmacy Copays Retail (up to 30-day supply) Mail Order (31 to 90-day supply)	Generic/Preferred/Non-Preferred $15 / $30 / $50 $30 / $60 / $150	Generic/Preferred/Non-Preferred $10 / $25 / $45 (after deductible) $20 / $50 / $135 (after deductible)	Generic/Preferred/Non-Preferred $20 / $50 / $90 (after deductible) No Out-of-Network Mail Order benefit
WellConnect Telehealth Visits	$10 copay/visit	10% after deductible	30% after deductible
Accupuncture	$35 copay/visit (up to 12 visits)	10% after deductible (up to 12 visits)	30% after deductible (up to 12 visits)