

	HMO Plan (In-Network Only)	PPO Plan with HSA	
		In-Network	Out-of-Network
<b>Plan Year Deductible</b>			
Individual	\$1,000 (medical)	\$2,000 (medical and Rx)	\$3,000 (medical and Rx)
Employee + 1/Family	\$2,000 (medical)	\$4,000 (medical and Rx)	\$6,000 (medical and Rx)
<b>Simmons HRA Contribution</b>			
Individual	\$250		\$250
Employee + 1/Family	\$500		\$500
<b>Simmons HSA Contribution</b>			
Individual	N/A		\$500
Employee + 1/Family	N/A		\$1,000
<b>Coinsurance</b>	N/A	N/A	20% (for most services)
<b>Lifetime Maximum Benefit</b>	Unlimited		Unlimited
<b>Plan Year Out-of-Pocket Maximum (Includes Rx)</b>			
Individual	\$3,000 (includes Rx copays)	\$3,000 (includes Rx copays)	\$4,000 (includes Rx copays)
Employee + 1/Family	\$6,000 (includes Rx copays)	\$6,000 (includes Rx copays)	\$8,000 (includes Rx copays)
<b>Office Visits</b>			
Primary Care	\$20 copay/visit*	No cost after deductible	20% after deductible
Specialist	\$35 copay/visit	No cost after deductible	20% after deductible
<b>Preventive Care</b>			
Annual Physical Exams/Screenings	No cost	No cost	20%
Well Child Exams	No cost	No cost	20%
<b>Emergency Room Visits</b>	\$150 (copay waived if admitted)	\$150 after deductible (copay waived if admitted)	\$150 after deductible (copay waived if admitted)
<b>Inpatient Hospitalization</b>	No cost after deductible	No cost after deductible	20% after deductible
<b>Day Surgery</b>	No cost after deductible	No cost after deductible	20% after deductible
<b>Mental Health</b>			
Inpatient	No cost	No cost after deductible	20% after deductible
Outpatient	No cost	No cost after deductible	20% after deductible
<b>Substance Use</b>			
Inpatient	No cost	No cost after deductible	20% after deductible
Outpatient	No cost	No cost after deductible	20% after deductible
<b>Diagnostic X-Rays, Lab Tests, Allergy Injections</b>	No cost after deductible	No cost after deductible	20% after deductible
<b>Chiropractic Care</b>	\$35 copay/visit	No cost after deductible	20% after deductible
<b>Durable Medical Equipment</b>	No cost after deductible	No cost after deductible	20% after deductible
<b>Pharmacy Copays</b>	Tier 1/Tier 2/Tier 3/Tier 4	Tier 1/Tier 2/Tier 3/Tier 4	No Out-of-Network benefit
Retail (up to 30-day supply)	\$10/\$25/\$45/\$70	\$10/\$25/\$45/\$70 (after deductible)	
Mail Order (Up to 90-day supply)	\$20/\$50/\$90/\$140	\$20/\$50/\$90/\$140 (after deductible)	
<b>Telehealth</b>			
Primary Care	\$20 copay/visit*	No cost after deductible	20% after deductible
Specialist	\$35 copay/visit	No cost after deductible	20% after deductible
<b>Acupuncture</b>	\$35 copay/visit	No cost after deductible	20% after deductible

\* The first two non-preventive care visits are at no cost