

Medical Plans

FY27 Medical Plans At-A-Glance

	HMO Plan (In-Network Only)	PPO Plan with HSA	
		In-Network	Out-of-Network
Plan Year Deductible			
Individual	\$1,000 (medical)	\$2,500 (medical and Rx)	\$4,000 (medical and Rx)
Employee + 1/Family	\$2,000 (medical)	\$5,000 (medical and Rx)	\$8,000 (medical and Rx)
Simmons HSA Contribution			
Individual	N/A		\$500
Employee + 1/Family	N/A		\$1,000
Coinsurance	N/A	N/A	20% (for most services)
Lifetime Maximum Benefit	Unlimited	Unlimited	
Plan Year Out-of-Pocket Maximum (Includes Rx)			
Individual	\$3,000 (includes Rx copays)	\$4,000 (includes Rx copays)	\$5,000 (includes Rx copays)
Employee + 1/Family	\$6,000 (includes Rx copays)	\$8,000 (includes Rx copays)	\$10,000 (includes Rx copays)
Office Visits			
Primary Care	\$30 copay/visit*	No cost after deductible	20% after deductible
Specialist	\$30 copay/visit (Level 1) \$45 copay/visit (Level 2)	No cost after deductible	20% after deductible
Preventive Care			
Annual Physical Exams/Screenings	No cost	No cost	20%
Well Child Exams	No cost	No cost	20%
Emergency Room Visits	\$150 (copay waived if admitted)	\$150 after deductible (copay waived if admitted)	\$150 after deductible (copay waived if admitted)
Urgent Care	\$45 copay/visit	Covered in full after deductible	
Inpatient Hospitalization	No cost after deductible	No cost after deductible	20% after deductible
Day Surgery	No cost after deductible	No cost after deductible	20% after deductible
Mental Health			
Inpatient	No cost	No cost after deductible	20% after deductible
Outpatient	No cost	No cost after deductible	20% after deductible
Substance Use			
Inpatient	No cost	No cost after deductible	20% after deductible
Outpatient	No cost	No cost after deductible	20% after deductible
Diagnostic X-Rays, Lab Tests, Allergy Injections	No cost after deductible	No cost after deductible	20% after deductible
Chiropractic Care	\$45 copay/visit	No cost after deductible	20% after deductible
Durable Medical Equipment	No cost after deductible	No cost after deductible	20% after deductible
Pharmacy Copays			
Retail (up to 30-day supply)	Tier 1/Tier 2/Tier 3/Tier 4/Tier 5 \$10/\$25/\$45/\$70/\$140	Tier 1/Tier 2/Tier 3/Tier 4/Tier 5 \$10/\$25/\$45/\$70/\$140 (after deductible)	No Out-of-Network benefit
Mail Order (Up to 90-day supply)	\$20/\$50/\$90/\$140/\$280	\$20/\$50/\$90/\$140/\$280 (after deductible)	
Telehealth			
Primary Care	\$30 copay/visit*	No cost after deductible	20% after deductible
Specialist	\$30 copay/visit (Level 1) \$45 copay/visit (Level 2)	No cost after deductible	20% after deductible

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