John Carroll University
2014 Staff Benefits Summary
Available To All Full-Time Staff

Medical

	Medical Mutual of Ohio – PPO SuperMed			Kaiser Permanente (HealthSpan) - HMO
	www.medmutual.com			www.kaiserpermanente.org
	Traditional PPO			HMO
	In-Network	*Non-Network*		*In-Network*
Deductible	$500/$1,000	$1,000/$2,000		N/A
Out-of-Pocket Max (excl. Deductible)	$2,000/$4,000	$2,500/$4,500		N/A
Office Visit Co-pay Preventative/Primary Care Specialist	$20 $35	Deductible and coinsurance apply		$10 (includes Urgent Care, Mental Health, Chemical Dependency)
Emergency Room	$100 then 100%	$100 then 100%		$35
Non-emergency use of Emergency Room	Deductible and coinsurance apply	Deductible and coinsurance apply		$35
Coinsurance	80% after deductible	60% after deductible		N/A
Preventative Services	80% coinsurance (deductible does not apply)	60% after deductible		$10 per visit per covered child under 24 months of age; no charge for immunizations
Prescription Drugs Generic Formulary Non-Formulary Specialty	**RETAIL (30 day)** $10 ($5 Align) $35 $70 $100	**MAIL-ORDER (90 day)** $25 $87.50 $175 N/A		$15 co-pay
For monthly cost see salary based rate sheet				**See salary based rate sheet**

Medical Mutual of Ohio High Deductible Health Plan – SuperMed

	www.medmutual.com		
	High Deductible Health Plan (HDHP) & Health Savings Account (HSA)		
	In-Network		*Non-Network*
Deductible	$1,500/$3,000		$3,000/$6,000
Out-of-Pocket Max (excl. Deductible)	$1,500/$3,000		$3,000/$6,000
Physician/Office Services Office Visit (Illness/Injury) Urgent Care Office Visit	80% after deductible 80% after deductible		60% after deductible 60% after deductible
Emergency Room	80% after deductible		80% after deductible
Non-emergency use of Emergency Room	80% after deductible		60% after deductible
Coinsurance	80%		60%
Preventative Services	100%		60% after deductible
Prescription Drugs Generic Formulary Non-Formulary	**RETAIL (30 day)** 80% after deductible		**MAIL-ORDER (90 day)** 80% after deductible
University Annual HSA Contribution	Single	$500	
	Employee + spouse	$1000	
	Employee+ child(ren)	$1000	
	Family	$1500	
For monthly cost see salary based rate sheet			

Dental

CIGNA Dental (www.cigna.com)

	Dental Care (HMO)	Dental PPO	
		In-Network	Out-of-Network
Deductible	None	$50 individual / $150 family	$50 individual / $150 family
Calendar Year Maximum	None	$1,000 (each member)	$1,000 (each member)
Orthodontia Maximum	See co-pay schedule	$1,000 (each member)	$1,000 (each member)
Preventative & Diagnostic Care (Oral Exams, Routine Cleanings, X-Rays, Fluoride, Sealants, Space Maintainers)	No charge ($5 office visit co-pay)	100%	90%/10%
Basic Restorative Care (Fillings, Root Canal, Simple Extractions, Anesthetics)	See co-pay schedule	80%/20%	70%/30%
Major Restorative Care (Crowns, Dentures, Bridges, Orthodontia)	See co-pay schedule	50%/50%*	40%/60%*
	Employee Monthly Rate	Employee Monthly Rate	
Single Plan	$18.19	$36.79	
2-Person Plan	$28.59	$71.33	
Family Plan	$45.96	$105.39	
*Waiting Periods Apply			

Vision

VSP Vision Care (www.vsp.com)

	In-Network (at point of service)	Non-Network (reimbursement)
Eye Exam (Every 12 months)	$10	Up to $34
Frames (Every 24 months)	$120 allowance, 20% discount over $120	Up to $38.25
Lenses (Every 12 months)	$25	Up to $17, $30, $43 or $64
Contacts (in lieu of glasses)	$120 allowance, 20% discount over $120	Up to $100
	Employee Monthly Rate	
Employee	$6.25	
Employee + Spouse	$10.52	
Employee + Child(ren)	$10.74	
Employee, Spouse + Children	$17.31	

Vision

EyeMed (www.eyemedvisioncare.com)

	In-Network (at point of service)	Non-Network (reimbursement)
Eye Exam (Every 12 months)	$10	Up to $35
Frames (Every 24 months)	$120 allowance, 20% discount over $120	Up to $48
Lenses (Every 12 months)	$10	Up to $25, $40, $60
Contacts (in lieu of glasses)	$135 allowance, 15% off balance over $135	Up to $95
	Employee Monthly Rate	
Single Plan	$8.36	
2-Person Plan	$15.86	
Family Plan	$23.32	

Employee Life, Accidental Death & Dismemberment and Long Term Disability

	Unum (www.unum.com)	
	Life and AD&D	**Long Term Disability**
Basic Benefit (Life & AD&D)	1x salary to a max of $250,000 2x salary to max of $350,000 (10yrs+ service)	60% of monthly earnings
	Monthly Rate for Basic and AD&D	Monthly Rate
Employee share of premium	N/A	$0.190 per $100 of covered salary
University share of premium	$0.32 per $1,000	$0.180 per $100 of covered salary
	Supplemental Life	
Supplemental Life only Benefit	Option A - 1x salary Option B - 2x Salary to a maximum of $250,000	N/A
Employee premium	See age-banded rates below	N/A
Total Maximum Coverage Allowed	$500,000 (combined basic and supplemental)	$7,500 per month maximum

Spouse and Child Life Insurance

	Unum (www.unum.com)	
	Spouse Life	**Child Life**
Benefit Amount	$10,000.00	$5,000.00
	Monthly Rate for Spousal Life	Monthly Rate
Employee Premium	See age banded rates below	$1.14 per family

(1) An Evidence of Insurability questionnaire is required if the amount of your life coverage (basic and supplemental) exceeds $250,000; or if you did not enroll at the time of hire and are doing so at the open enrollment period regardless of the amount of coverage requested.

(2) Individuals utilizing the Long Term Disability benefit must remember that the portion of the benefit they
receive that is attributable to the employer will be subject to taxes; only the employee portion of the premium is paid utilizing pre tax dollars. Please consult with the Unum representative processing your claim and your tax advisor.

Age Banded Rate Table

Coverage	Age Band	Current Employee Rate	Current Spousal Rate
LTD	**	0.37/$100	**
Basic Life	**	0.29/$1,000	**
Supplemental Life	<25	0.08/$1,000	0.070/$1,000
	25-29	0.08/$1,000	0.060/$1,000
	30-34	0.08/$1,000	0.064/ $1,000
	35-39	0.10/$1,000	0.086/$1,000
	40-44	0.14/$1,000	0.122/$1,000
	45-49	0.23/$1,000	0.190/$1,000
	50-54	0.35/$1,000	0.298/$1,000
	55-59	0.55/$1,000	0.460/$1,000
	60-64	0.80/$1,000	0.793/$1,000
	65-69	1.39/$1,000	1.367/$1000
	>70	3.11/$1,000	3.183/$1000
AD&D	**	0.03/$1,000	**