

**MEDICAL PLAN COMPARISON**

<b>IN- NETWORK</b> (see page 2 for Non-Network)	<b>Medical Mutual - PPO</b> (Preferred Provider Organization)	<b>Medical Mutual - HDHP</b> (High Deductible Health Plan)	<b>Medical Mutual – MetroHealth Select EPO</b> (Exclusive Provider Organization)
<b>DEDUCTIBLE</b>			
Per Individual	\$300	\$1500	\$400
Family Maximum	\$900	\$3000	\$800
<b>OUT-OF-POCKET MAXIMUM</b> (excludes deductible)			
Per Individual	\$1750	\$1500	\$1600
Family Maximum	\$3500	\$3000	\$3200
<b>MEMBER COSTS</b>			
Office Visit Co-Pay (Preventative / Primary Care)	\$15	20% After deductible is met	\$15
Office Visit Co-Pay (Specialist)	\$30	20% After deductible is met	\$30
Preventative Services	20% Coinsurance Deductible does not apply (See benefits booklet for included services)	0% (See benefits booklet for included services)	0% (See benefits booklet for included services)
Urgent Care	\$30	20% After deductible is met	\$15
Emergency Room	\$75 then 0%	20% After deductible is met	\$100 then 0%
Non-emergency use of Emergency Room	Deductible and coinsurance apply	20% After deductible is met	20% After deductible is met
Coinsurance	20% After deductible is met	20% After deductible is met	20% After deductible is met

**SEE RATE SHEET FOR MONTHLY PREMIUMS**

For detailed information about networks, please go to the provider website at [www.medmutual.com](http://www.medmutual.com) or at [www.mhselect.com](http://www.mhselect.com)

**MEDICAL PLAN COMPARISON**

<b>NON- NETWORK</b> (see page 1 for In-Network)	<b>Medical Mutual - PPO</b> (Preferred Provider Organization)	<b>Medical Mutual - HDHP</b> (High Deductible Health Plan)	<b>Medical Mutual – MetroHealth Select EPO</b> (Exclusive Provider Organization)
<b>DEDUCTIBLE</b>			As an EPO, services must be received through the Metro Health System. There are no non-network benefits.
Per Individual	\$500	\$3000	
Family Maximum	\$1000	\$6000	
<b>OUT-OF-POCKET MAXIMUM</b> (excludes deductible)			
Per Individual	\$2500	\$3000	
Family Maximum	\$5000	\$6000	
<b>MEMBER COSTS</b>			
Office Visit Co-Pay (Preventative / Primary Care)	Deductible and coinsurance apply	40% After deductible is met	
Office Visit Co-Pay (Specialist)	Deductible and coinsurance apply	40% After deductible is met	
Preventative Services	40% After deductible is met	40% After deductible is met	
Urgent Care	40% After deductible is met	40% After deductible is met	
Emergency Room	\$75 then 0%	20% After deductible is met	
Non-emergency use of Emergency Room	Deductible and coinsurance apply	40% After deductible is met	
Coinsurance	40% After deductible is met	40% After deductible is met	

**SEE RATE SHEET FOR MONTHLY PREMIUMS**

**HealthSmartRx PRESCRIPTION DRUG PLANS**
**RETAIL – 30 DAY**

	<b>Medical Mutual - PPO</b> (Preferred Provider Organization)	<b>Medical Mutual - HDHP</b> (High Deductible Health Plan)	<b>Medical Mutual – MetroHealth Select EPO</b> (Exclusive Provider Organization)
<b>MEMBER COSTS</b>			
Generic	\$10	20% After deductible is met	\$10
Formulary	\$25	20% After deductible is met	\$35
Non-Formulary	\$50	20% After deductible is met	\$70
Specialty	Available through mail order only- \$100 per 30 day supply	20% After deductible is met	Available through mail order only- \$100 per 30 day supply

**MAIL ORDER – 90 DAY**

	<b>Medical Mutual - PPO</b> (Preferred Provider Organization)	<b>Medical Mutual - HDHP</b> (High Deductible Health Plan)	<b>Medical Mutual – MetroHealth Select EPO</b> (Exclusive Provider Organization)
<b>MEMBER COSTS</b>			
Generic	\$20	20% After deductible is met	\$25
Formulary	\$50	20% After deductible is met	\$87.50
Non-Formulary	\$100	20% After deductible is met	\$175
Specialty	Available through mail order only- \$100 per 30 day supply	20% After deductible is met	Available through mail order only- \$100 per 30 day supply

**PRESCRIPTION DRUG PLAN IS INCLUDED IN THE MONTHLY MEDICAL PREMIUMS**

**Medical Mutual – FLEXIBLE SPENDING ARRANGEMENT (FSA)**

Available ONLY if you're enrolled in the PPO or Metro Health Select plans

Coverage Level	Healthcare FSA Maximum Annual Contribution*
All	\$2650.00
	Dependent Care FSA Maximum Annual Contribution*
N/A	\$5000.00

\*Account balances do not roll over year to year. See plan document for details. [FSA Plan Document](#)

**Optum Bank – HEALTH SAVINGS ACCOUNT (HSA)**

Available ONLY if you're enrolled in the High Deductible Health Plan

COVERAGE LEVEL	University Annual HSA Contribution*
Employee Only	\$500.00
Employee + Spouse	\$1000.00
Employee + Child(ren)	\$1000.00
Family	\$1500.00

\*University contributions are prorated your first year enrolled and deposited in a lump sum. Deposits are made monthly after the first year.  
 NOTE: 2019 HSA contribution limits (employer + employee): Self: \$3,500, Family: \$7,000

**DENTAL PLAN COMPARISON**

CIGNA DENTAL (www.cigna.com)	Cigna Dental Care HMO	Cigna Dental PPO	
		IN-NETWORK	NON-NETWORK
<b>DEDUCTIBLE</b>			
Per Individual	None	\$50	\$50
Family	None	\$150	\$150
<b>MAXIMUMS</b>			
Maximum coverage per individual per calendar year	None	Year 1: \$1200	Year 1: \$1200
		Year 2: \$1450	Year 2: \$1450
		Year 3: \$1700	Year 3: \$1700
		Year 4: \$1950	Year 4: \$1950
Orthodontia	See Co-Pay Schedule	\$1000 per member	\$1000 per member
<b>MEMBER COSTS</b>			
Preventative & Diagnostic Care (Oral Exams, Routine Cleanings, X-Rays, Fluoride, Sealants, Space Maintainers)	\$5 Co-Pay only	100%	10%
Basic Restorative Care (Fillings, Root Canal, Simple Extraction, Anesthetic)	See Co-Pay Schedule	20%	30%
Major Restorative Care (Crowns, Dentures, Bridges, Orthodontia)	See Co-Pay Schedule	50%	60%
<b>EMPLOYEE MONTHLY RATE</b>			
Single	\$18.40		\$36.67
2-Person	\$28.93		\$71.09
Family	\$46.50		\$105.05

<b>VISION PLAN COMPARISON</b>		
<b>IN-NETWORK</b>	<b>VSP Vision Care</b> ( <a href="http://www.vsp.com">www.vsp.com</a> )	<b>EyeMed</b> ( <a href="http://www.eyemed.com">www.eyemed.com</a> )
	<b>POINT OF SERVICE</b>	<b>POINT OF SERVICE</b>
Eye Exam (Every 12 months)	\$10	\$10
Frames (Every 24 months)	\$120 allowance 20% discount off balance after \$120	\$120 allowance 20% discount off balance after \$120
Lenses (Every 12 months)	\$25	\$10
Contacts (In lieu of glasses)	\$120 allowance 20% discount off balance after \$120	\$135 allowance 15% discount off balance after \$135
<b>NON-NETWORK</b>	<b>VSP Vision Care</b>	<b>EyeMed</b>
	<b>REIMBURSEMENT</b>	<b>REIMBURSEMENT</b>
Eye Exam (Every 12 months)	Up to \$34	Up to \$35
Frames (Every 24 months)	Up to \$38.25	Up to \$48
Lenses (Every 12 months)	Up to \$17, \$30, \$43, \$64	Up to \$25, \$40, \$60
Contacts (In lieu of glasses)	Up to \$100	Up to \$95
<b>EMPLOYEE MONTHLY RATE</b>	<b>VSP Vision Care</b>	
Employee Only	\$6.53	
Employee + Spouse	\$10.99	
Employee + Child(ren)	\$11.22	
Family	\$18.10	
<b>EMPLOYEE MONTHLY RATE</b>	<b>EyeMed</b>	
Employee Only	\$8.36	
Employee + One	\$15.86	
Family	\$23.32	

**LIFE INSURANCE, ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)**

 Unum ([www.unum.com](http://www.unum.com))

	<b>Employee Basic Life Benefit (includes AD&amp;D)</b>	<b>Supplemental Life</b>	<b>Spousal Life</b>	<b>Child Life</b>
Benefit Amount	1 x Salary – Max \$250,000	Option A: 1 x Salary – Max \$250,000	\$10,000	\$5,000
	2 x Salary (10 yrs. + Svc) – Max \$350,000	Option B: 2 x Salary – Max \$500,000		
Monthly Employee Share of Premium	N/A	See age banded rates below	See age banded rates below	\$1.095 per family
Monthly Employer Share of Premium	Total - \$0.203 per \$1000 Covered Salary	N/A	N/A	N/A
	Basic Life - \$0.175/\$1000			
	AD&D - \$0.028/\$1000			

An evidence of insurability questionnaire is required if the amount of your life coverage (basic plus supplemental) exceeds \$250,000 OR if you are enrolling at a time other than at the time of hire, regardless of the amount of coverage requested.

Total Maximum Coverage Amounts are equal to the basic maximum plus the supplemental maximum.

**AGE BANDED RATE TABLE**

<b>Age Band</b>	<b>Employee Supplemental Life Monthly Rate</b>	<b>Spousal Life Monthly Rate</b>
<25	\$0.05 / \$1000	\$0.0672 / \$1000
25-29	\$0.06 / \$1000	\$0.0576 / \$1000
30-34	\$0.08 / \$1000	\$0.0614 / \$1000
35-39	\$0.09 / \$1000	\$0.0826 / \$1000
40-44	\$0.10 / \$1000	\$0.1171 / \$1000
45-49	\$0.15 / \$1000	\$0.1824 / \$1000
50-54	\$0.23 / \$1000	\$0.2861 / \$1000
55-59	\$0.43 / \$1000	\$0.4416 / \$1000
60-64	\$0.66 / \$1000	\$0.7613 / \$1000
65-69	\$1.27 / \$1000	\$1.3123 / \$1000
>70	\$2.06 / \$1000	\$3.0557 / \$1000

### LONG TERM DISABILITY\*

 Unum ([www.unum.com](http://www.unum.com))

	Long Term Disability
Benefit Amount	60% of monthly earnings
Total Maximum Coverage Allowed	\$7,500 per month
Elimination Period	180 days
Total Monthly Premium	\$0.305 per \$100 of covered salary
Monthly Employee Share of Premium	\$0.155 per \$100 of covered salary
Monthly Employer Share of Premium	\$0.15 per \$100 of covered salary

\*Individuals utilizing the Long Term Disability benefit should note 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.

\*An evidence of insurability questionnaire is required if you are enrolling at a time other than at the time of hire.

### SAMPLE CALCULATIONS

Product	Age	Salary	Coverage Amount	Calculation	Monthly Rate
Employee Supplemental Life – 1x Salary	37	\$42,000	\$42,000	$(\$42,000 / \$1000) \$0.09$	= \$3.78
Employee Supplemental Life – 2x Salary	45	\$64,000	\$128,000	$(\$128,000 / \$1000) \$0.15$	= \$19.20
Spousal Life	43 (spouse)	n/a	\$10,000	$(\$10,000 / \$1000) \$0.1171$	= \$1.71
Long Term Disability	n/a	\$52,000	60% of covered monthly salary (\$4,333.33)	$\$0.155 (\$4,333.33 / \$100)$	= \$6.71