John Carroll University

2019 BENEFITS SUMMARY
FACULTY HIRED PRE-2013

MEDICAL PLAN COMPARISON

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

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MEDICAL PLAN COMPARISON

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

SEE RATE SHEET FOR MONTHLY PREMIUMS

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HealthSmartRx PRESCRIPTION DRUG PLANS

RETAIL – 30 DAY

	Medical Mutual - PPO (Preferred Provider Organization)	**Medical Mutual – MetroHealth Select EPO** (Exclusive Provider Organization)
MEMBER COSTS		
Generic	$10	$10
Formulary	$25	$35
Non-Formulary	$50	$70
Specialty	Available through mail order only- $50 per 30 day supply	Available through mail order only- $100 per 30 day supply

MAIL ORDER – 90 DAY

	Medical Mutual - PPO (Preferred Provider Organization)	**Medical Mutual – MetroHealth Select EPO** (Exclusive Provider Organization)
MEMBER COSTS		
Generic	$20	$25
Formulary	$50	$87.50
Non-Formulary	$100	$175
Specialty	Available through mail order only- $50 per 30 day supply	Available through mail order only- $100 per 30 day supply

PRESCRIPTION DRUG PLAN IN INCLUDED IN THE MONTHLY MEDICAL PREMIUMS

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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**	

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DENTAL PLAN COMPARISON

CIGNA DENTAL (www.cigna.com)	Cigna Dental Care HMO	Cigna Dental PPO	
		IN-NETWORK	NON-NETWORK
DEDUCTIBLE			
Per Individual	None	$50	$50
Family	None	$150	$150
MAXIMUMS			
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
MEMBER COSTS			
Preventative & Diagnostic Care (Oral Exams, Routine Cleanings, X-Rays, Fluoride, Sealants, Space Maintainers)	$5 Co-Pay only	0%	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%
EMPLOYEE MONTHLY RATE	**Cigna Dental Care HMO**	**Cigna Dental PPO**	
Single	$18.40	$36.67	
2-Person	$28.93	$71.09	
Family	$46.50	$105.05	

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EyeMed (www.eyemed.com)	
IN-NETWORK	**POINT OF SERVICE**
Eye Exam (Every 12 months)	$10
Frames (Every 24 months)	$120 allowance 20% discount off balance after $120
Lenses (Every 12 months)	$10
Contacts (In lieu of glasses)	$135 allowance 15% discount off balance after $135
NON-NETWORK	**REIMBURSEMENT**
Eye Exam (Every 12 months)	Up to $35
Frames (Every 24 months)	Up to $48
Lenses (Every 12 months)	Up to $25, $40, $60
Contacts (In lieu of glasses)	Up to $95
EMPLOYEE MONTHLY RATE	**EyeMed**
Employee Only	$8.36
Employee + One	$15.86
Family	$23.32

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2019 BENEFITS SUMMARY
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LIFE INSURANCE, ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

Unum (www.unum.com)

	Employee Basic Life Benefit (includes AD&D)	**Supplemental Life**
Benefit Amount	2 x Salary – Max $250,000 *	Option A: 1 x Salary – Max $250,000
		Option B: 2 x Salary – Max $500,000
Total Maximum Coverage Allowed	$500,000 (Basic + Supplemental)	$500,000 (Basic + Supplemental)
Total Premium	$0.203 per $1000 covered salary	n/a
Monthly Employee Share of Premium	$0.1015 per $1000 covered salary	See age banded rates below
Monthly Employer Share of Premium	$0.1015 per $1000 covered salary	n/a

AGE BANDED RATE TABLE

Age Band	**Employee Supplemental Life** Monthly Rate
<34	$0.08 / $1000
35-39	$0.09 / $1000
40-44	$0.10/ $1000
45-49	$0.15 / $1000
50-54	$0.23 / $1000
55-59	$0.43 / $1000
60-64	$0.66 / $1000
65-69	$1.27 / $1000
>70	$2.06 / $1000

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2019 BENEFITS SUMMARY
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LONG TERM DISABILITY*

Unum (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
Long Term Disability	n/a	$52,000	60% of covered monthly salary ($4,333.33)	$0.155 ($4,333.33 / $100)	= $6.71