John Carroll University

2019 BENEFITS SUMMARY
STAFF

MEDICAL PLAN COMPARISON

IN- NETWORK (see page 2 for Non-Network)	Medical Mutual - PPO (Preferred Provider Organization)	Medical Mutual - HDHP (High Deductible Health Plan)	Medical Mutual – MetroHealth Select EPO (Exclusive Provider Organization)
DEDUCTIBLE			
Per Individual	$500	$1500	$400
Family Maximum	$1000	$3000	$800
OUT-OF-POCKET MAXIMUM (excludes deductible)			
Per Individual	$2000	$1500	$1600
Family Maximum	$4000	$3000	$3200
MEMBER COSTS			
Office Visit Co-Pay (Preventative / Primary Care)	$20	20% After deductible is met	$15
Office Visit Co-Pay (Specialist)	$35	20% After deductible is met	$30
Preventative Services	0% (See benefits booklet for included services)	0% (See benefits booklet for included services)	0% (See benefits booklet for included services)
Urgent Care	$35	20% After deductible is met	$15
Emergency Room	$100 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 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 - HDHP (High Deductible Health Plan)	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	$1000	$3000	
Family Maximum	$2000	$6000	
OUT-OF-POCKET MAXIMUM (excludes deductible)			
Per Individual	$2500	$3000	
Family Maximum	$4500	$6000	
MEMBER COSTS			
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	$100 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

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HealthSmartRx PRESCRIPTION DRUG PLANS

RETAIL – 30 DAY

	Medical Mutual - PPO (Preferred Provider Organization)	Medical Mutual - HDHP (High Deductible Health Plan)	Medical Mutual – MetroHealth Select EPO (Exclusive Provider Organization)
MEMBER COSTS			
Generic	$10	20% After deductible is met	$10
Formulary	$35	20% After deductible is met	$35
Non-Formulary	$70	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

	Medical Mutual - PPO (Preferred Provider Organization)	Medical Mutual - HDHP (High Deductible Health Plan)	Medical Mutual - Metro Select EPO (Exclusive Provider Organization)
MEMBER COSTS			
Generic	$25	20% After deductible is met	$25
Formulary	$87.50	20% After deductible is met	$87.50
Non-Formulary	$175	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 IN INCLUDED IN THE MONTHLY MEDICAL PREMIUMS

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2019 BENEFITS SUMMARY
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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**

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

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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			
Single	$18.40	$36.67	
2-Person	$28.93	$71.09	
Family	$46.50	$105.05	

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VISION PLAN COMPARISON		
IN-NETWORK	**VSP Vision Care** (www.vsp.com)	**EyeMed** (www.eyemed.com)
	POINT OF SERVICE	**POINT OF SERVICE**
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
NON-NETWORK	**VSP Vision Care**	**EyeMed**
	REIMBURSEMENT	**REIMBURSEMENT**
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
EMPLOYEE MONTHLY RATE	**VSP Vision Care**	
Employee Only	$6.53	
Employee + Spouse	$10.99	
Employee + Child(ren)	$11.22	
Family	$18.10	
EMPLOYEE MONTHLY RATE	**EyeMed**	
Employee Only	$8.36	
Employee + One	$15.86	
Family	$23.32	

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

Unum (www.unum.com)

	Employee Basic Life Benefit (includes AD&D)	**Supplemental Life**	**Spousal Life**	**Child Life**
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 basic maximum plus the supplemental maximum.

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.

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AGE BANDED RATE TABLE

Age Band	Employee Supplemental Life Monthly Rate	Spousal Life Monthly Rate
<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

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

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