

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/Skyway 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

Note: This is only a summary. Detailed plan descriptions can be obtained online at www.jcu.edu/hr or from the JCU Human Resources Department

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/Skyway 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

HealthSmartRx PRESCRIPTION DRUG PLANS

RETAIL – 30 DAY

| | Medical Mutual - PPO (Preferred Provider Organization) | Medical Mutual - HDHP (High Deductible Health Plan) | Medical Mutual – MetroHealth Select/Skyway 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 IS 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 | \$2700.00 |
| 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: 2020 HSA contribution limits (employer + employee): Self: \$3,550, Family: \$7,100 | |

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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 2: \$1450 Year 3: \$1700 Year 4: \$1950 | Year 1: \$1200 Year 2: \$1450 Year 3: \$1700 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 | \$19.28 | | \$38.50 |
| 2-Person | \$30.31 | | \$74.64 |
| Family | \$48.72 | | \$110.30 |

Note: This is only a summary. Detailed plan descriptions can be obtained online at www.jcu.edu/hr or from the JCU Human Resources Department

| 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 | \$6.55 | |
| Employee + Spouse | \$11.04 | |
| Employee + Child(ren) | \$11.27 | |
| Family | \$18.17 | |
| 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 - \$0.188 per \$1000 Covered Salary | N/A | N/A | N/A |
| | Basic Life - \$0.16/\$1000 | | | |
| | AD&D - \$0.028/\$1000 | | | |

An evidence of insurability questionnaire is required if the amount of your life coverage (basic plus supplemental) exceeds \$300,000.
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 | \$0.28 per \$100 of covered salary |
| Monthly Employee Share of Premium | \$0.14 per \$100 of covered salary |
| Monthly Employer Share of Premium | \$0.14 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) | $\$0.14 (\$4,333.33 / \$100)$ | = \$6.07 |