

MEDICAL PLAN COMPARISON

IN- NETWORK (see page 2 for Non-Network)	Medical Mutual - PPO (Preferred Provider Organization)	Medical Mutual – MetroHealth Select/Skyway 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

MEDICAL PLAN COMPARISON

NON- NETWORK <small>(see page 1 for In-Network)</small>	Medical Mutual - PPO <small>(Preferred Provider Organization)</small>	Medical Mutual – MetroHealth Select/Skyway EPO <small>(Exclusive Provider Organization)</small>
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 <small>(excludes deductible)</small>		
Per Individual	\$2500	
Family Maximum	\$5000	
MEMBER COSTS		
Office Visit Co-Pay <small>(Preventative / Primary Care)</small>	Deductible and coinsurance apply	
Office Visit Co-Pay <small>(Specialist)</small>	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

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 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	\$2750.00
	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](#)

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	Cigna Dental Care HMO	Cigna Dental PPO	
Single	\$19.28	\$38.50	
2-Person	\$30.31	\$74.64	
Family	\$48.72	\$110.30	

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

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	\$0.147 per \$1000 covered salary	n/a
Monthly Employee Share of Premium	\$0.0735 per \$1000 covered salary	See age banded rates below
Monthly Employer Share of Premium	\$0.0735 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

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	\$0.273 per \$100 of covered salary
Monthly Employee Share of Premium	\$0.136 per \$100 of covered salary
Monthly Employer Share of Premium	\$0.135 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 post 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)	\$0.136 (\$4,333.33 / \$100)	= \$5.89