

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

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EpiphanyRx 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

Medical Mutual – FLEXIBLE SPENDING ARRANGEMENT (FSA)

Available ONLY if you're enrolled in the PPO or MetroHealth 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](#)

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: 2022 HSA contribution limits (employer + employee): Single: \$3,650, Family: \$7,300

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

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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	\$6.55	
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 - \$0.147 per \$1000 Covered Salary	N/A	N/A	N/A
	Basic Life - \$0.119/\$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	\$0.273 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.

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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)	$\$0.136 (\$4,333.33 / \$100)$	= \$5.89