City of Twinsburg
2015 Health Insurance Plan Options

MMOH network is exactly the same for all plans:same doctors, hospitals, etc.

	PLAN A		PLAN B		HSA Plan	
Service Categories	Employee Pays 14%		Employee Pays 10%		No Employee Contribution Required	
	Network	**Non-Network**	**Network**	**Non-Network**	**Network**	**Non-Network**
Deductible	$100/$200	$100/$200	$500/$1,000	$500/$1,000	$2,600/$5,200	$5,000/$10,000
Office Visit	$10	60%	$20	60%	100% after Deductible	60%
Annual Physical	$10	60%	$0	60%	$0	60%
Coinsurance %	80%	60%	80%	60%	100% after Deductible	60%
Emergency Room	80%	80%	80%	80%	100% after Deductible	100% after Deductible
Urgent Care	$10	60%	$20	60%	100% after Deductible	60%
Coinsurance Limit	$400/$800	$900/$1,800	$1,000/$2,000	$1,500/$3,000	$0	$5,000/$10,000
Prescription Drug	$5/$20/$40		$5/$20/$40		100% after Deductible	
Mail Order Drug	$15/$60/$120		$15/$60/$120		100% after Deductible	
COBRA Rates		Employee Cost:		Employee Cost:		Employee Cost:
Single	$926.27	**$129.68**	$866.40	**$86.64**	$721.05	**$0**
Family	$2,382.65	**$333.57**	$2,228.21	**$222.82**	$1,840.84	**$0**

* Prescription coverage includes home delivery and generic incentive

	Dental Coverage		Vision Coverage	
		Employee Cost:		Employee Cost:
Single	$39.72	**$0.00**	$8.88	**$0.00**
Family	$120.68	**$0.00**	$19.12	**$0.00**

I have reviewed the above plan options and I choose the following:

Select One Medical Plan
____Plan A Family
____Plan A Single
____Plan B Family
____Plan B Single
____Health Savings Account Plan
____Opt-Out

Select One Dental Plan
____Dental Family
____Dental Single
____Opt-Out

Select One Vision Plan
____Vision Family
____Vision Single
____Opt-Out

Health Insurance Opt-Out Option
I understand that these monthly payments are in lieu of coverage and subject to all applicable taxes. I attest that I have alternative medical coverage in order to qualify for this Opt-Out. Additionally, I understand that if I choose to enroll later, I will have to wait until the open enrollment period in February of each year, unless a qualifying event occurs that results in a loss of my alternate coverage.

____
Print Name

____
Department

____
Signature

____
Date