



City of Twinsburg 2019 Health Insurance Plan Options



IMPORTANT - If you are keeping the same coverage or are simply switching from one plan to the other, you do not need to complete a MMOH change form, but if **you are coming off of opt-out or if you are switching family to single or single to family, you will need to complete a Medical Mutual Enrollment form** - available from HR.

The Medical Mutual network is exactly the same for both plans

Service Categories	PPO Plan		HSA Plan	
	Employee Pays a percentage of the COBRA rate based on applicable CBA or Chap. 147		No Employee Premium Contribution is Required	
Deductible	Network \$500/\$1,000	Non-Network \$500/\$1,000	Network \$2,700 / \$5,400	Non-Network \$5,000 / \$10,000
Office Visit	\$20	60%	100% after Deductible	60%
Annual Physical	\$0	60%	\$0	60%
Coinsurance %	80%	60%	100% after Deductible	60%
Emergency Room	80%	80%	100% after Deductible	100% after Deductible
Urgent Care	\$20	60%	100% after Deductible	60%
Coinsurance Limit	\$1,000/\$2,000	\$1,500/\$3,000	\$0	\$5,000/\$10,000
Prescription Drug	\$5/\$20/\$40		100% after Deductible	
Mail Order Drug	\$15/\$60/\$120		100% after Deductible	
	<u>COBRA Rates</u>	<u>Employee's Cost</u>	<u>COBRA Rates</u>	<u>Employee's Cost</u>
Single:	\$1,129.74	\$113	\$840.63	\$0
Family:	\$2,770.52	\$277	\$2,121.29	\$0

Dental & Vision Coverage

	Dental	Vision	Employee Cost:
Single	\$38.79	\$8.35	\$0
Family	\$120.10	\$17.97	\$0

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

Select Medical Plan Option(s)	Select Dental Plan Option(s)	Select Vision Plan Option(s)
<input type="checkbox"/> Family PPO Plan <input type="checkbox"/> Family HSA Plan <input type="checkbox"/> Single PPO Plan <input type="checkbox"/> Single HSA Plan	<input type="checkbox"/> Dental Family <input type="checkbox"/> Dental Single	<input type="checkbox"/> Vision Family <input type="checkbox"/> Vision Single
<input type="checkbox"/> Opt-Out of Family Medical Coverage ¹ <input type="checkbox"/> Opt-Out of Single Medical Coverage ²	<input type="checkbox"/> Opt Out of Family ³ <input type="checkbox"/> Opt Out of Single (S) ⁴	<input type="checkbox"/> Opt Out of Vision (F) ⁵ <input type="checkbox"/> Opt Out of Vision (S) ⁶

- 1 Means that employee has eligible family members, but elects no medical coverage for them
- 2 Means that employee is single and elects no medical coverage
- 3,4 Means that employee and/or family will have no dental coverage
- 5,6 Means that employee and/or family will have no vision coverage

Health Insurance Opt-Out Agreement

If I elect to opt out of medical coverage, I understand that I may receive monthly payments in lieu of coverage which is 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 do not enroll at this time, I will have to wait until the open enrollment period unless a qualifying event occurs that results in a loss of my alternate coverage.

Print Name

Department

Signature

Date