City of Twinsburg
2021 Healthcare Plan Selection Sheet

IMPORTANT - If you are keeping the exact same coverage, you do not need to complete this form. If you are changing coverage type or going on/off of Opt-Out, you must complete this form as well as 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	
	Network	**Non-Network**	**Network**	**Non-Network**
Deductible	$500/$1,000	$500/$1,000	$2,800 / $5,600	$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	
	COBRA Rates	**Employee's Cost**	**COBRA Rates**	**Employee's Cost**
Single:	$1,129.74	$67.79 per pay	$840.63	$0
Family:	$2,770.52	$166.23 per pay	$2,121.29	$0

Dental & Vision Coverage

	Dental	Vision	Employee's 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)
____Family PPO Plan ____Family HSA Plan ____Single PPO Plan ____Single HSA Plan	____Dental Family ____Dental Single	____Vision Family ____Vision Single
____Opt-Out of Family Medical Coverage[1] ____Opt-Out of Single Medical Coverage[2]	____Opt Out of Family[3] ____Opt Out of Single[4]	____Opt Out of Family[5] ____Opt Out of Single[6]

1 Employee has eligible family members, but elects no medical coverage for them
2 Employee is single and elects no medical coverage
3,4 Employee and/or family will have no dental coverage
5,6 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 _____