



**City of Twinsburg
2022 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 and/or Guardian Enrollment/Change 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	
	<u>COBRA Rates</u>	<u>Employee's Cost</u>	<u>COBRA Rates</u>	<u>Employee's Cost</u>
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)
<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 ⁴	<input type="checkbox"/> Opt Out of Family ⁵ <input type="checkbox"/> 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