Cuyahoga Heights Schools

Employee Medical Benefit Enrollment Form
Effective: January 1, 2024 to December 31, 2024

Utilizing the Medical Mutual Network of Providers	Current Co-Pay Plan		HSA Plan	
	In Network	**Out of Network**	**In Network**	**Out of Network**
Calendar Year Deductible (CYD)	$150 / $300	$300 / $600	$3,200 / $6,400	$7,500 / $15,000
Coinsurance (After CYD)	10% after deductible to $750 / $1,500	30% after deductible to $1500 / $3,000	0% after deductible	50% after deductible
Annual Out of Pocket Maximum (Includes CYD)	$9,100 / $18,200	Unlimited	$3,200 / $6,400	$15,000 / $30,000
Preventive Care Office Visit Copay (PCP)	No Cost	Deductible & Coinsurance	No Cost	Deductible & Coinsurance
Office Visit Copay (PCP)	$20	Deductible & Coinsurance	Deductible then $0	Deductible then $0
Specialist Visit Copay	$20	Deductible & Coinsurance	Deductible then $0	Deductible then $0
Virtual Care Services	$20	Deductible & Coinsurance	Deductible then $0	Deductible then $0
Lab, X-Ray & Diagnostic - Outpatient - Lab Testing	Deductible & Coinsurance	Deductible & Coinsurance	Deductible then $0	Deductible & Coinsurance
Major Diagnostic and Imaging - Outpatient	Deductible & Coinsurance	Deductible & Coinsurance	Deductible then $0	Deductible & Coinsurance
Urgent Care	$20	$20	Deductible then $0	Deductible then $0
Emergency Room Fee	$50 then 10%	$100 then 10%	Deductible then $0	Deductible then $0
Outpatient Services	Deductible & Coinsurance	Deductible & Coinsurance	Deductible then $0	Deductible & Coinsurance
Inpatient Hospital	Deductible & Coinsurance	Deductible & Coinsurance	Deductible then $0	Deductible & Coinsurance
Rehabilitation Services	Deductible & Coinsurance	Deductible & Coinsurance	Deductible then $0	Deductible & Coinsurance
Mental Health & Substance Related and Addictive Disorder Services	Deductible & Coinsurance	Deductible & Coinsurance	Deductible then $0	Deductible & Coinsurance
Prescription Drugs Standard Select Network	Retail Network (Up to 31 day supply) Tier 1 - $10 Tier 2 - $20 Tier 3 - $40	Rx Mail Order (Up to 90 day supply) Tier 1 - $25 Tier 2 - $50 Tier 3 - $100	Retail Network (Up to 31 day supply) Tier 1 - Deductible then $0 Tier 2 - Deductble then $0 Tier 3 - Deductible then $0	Rx Mail Order (Up to 90 day supply) Tier 1 - Deductible then $0 Tier 2 - Deductible then $0 Tier 3 - Deductible then $0
Rx Preferred Specialty Drugs (Up to 31 day supply)	Tier 1 - $10 Tier 2 - $20 Tier 3 - $40		Tier 1 - Deductible then $0 Tier 2 - Deductible then $0 Tier 3 - Deductible then $0	
HSA Employer Funding	$0		$2,240 - Single Coverage/ $4,480 for Family Coverage (please see HSA MOU for prorated funding amounts)	

After you have compared the two plans above, please indicate which plan you choose for your coverage by completing the section below.

Coverage Tiers:	Please Select Medical PPO Coverage Level	Please Select Medical HSA Coverage Level
Employee Only (Single Coverage)	O	O
Employee + Child[ren] and/or Spouse (Family Coverage)	O	O

Print Employee Name: _____

Plan Name: _____ **Coverage Tier:** _____

Employee Signature: _____ **Date:** _____

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