

Cuyahoga County 2024 Medical and Prescription Drug Plan Options

This summary of benefits is designed to provide a high-level overview of Cuyahoga County's 2024 Employee Benefits. Should there be any conflict between the explanation in this summary and the actual terms and provisions of the plan documents, the terms of the plan documents and contracts will govern in all cases. You will not gain any new benefits because of a misstatement or omission in this overview.

	MetroHealth Select High Deductible	MetroHealth Select	Medical Mutual SuperMed EPO Plan	Medical Mutual SuperMed PPO Plan																																																		
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| | Covers 100% of preventive care services provided In-Network (according to age and gender)
In-Network coverage available through MetroHealth Select Network only
Medical and Prescription Drug costs are out-of-pocket until the deductible is met
Requires you to pay 100% for Out-of-Network services
Prescription Drugs are required to be filled at a MetroHealth Pharmacy or Express Scripts
Option to open and contribute to a tax-favored Health Savings Account to pay for healthcare expenses | Covers 100% of preventive care services provided In-Network (according to age and gender)
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Prescription Drug coverage through a MetroHealth Pharmacy and CVS CareMark Network
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| Prescription Drug Benefits
Retail - Up to 30 days supply (3 Fill Limit) Mail Order - Up to 90 day supply
All Specialty- Up to 30 day supply | <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="background-color: #f4a460;">MetroHealth Pharmacy or Medical Mutual Express Script Network (Mail Order is only available through Express Script Network)</th> <th style="background-color: #f4a460;">Out-of-Network</th> </tr> </thead> <tbody> <tr> <td style="background-color: #f4a460;">Retail Generic</td> <td style="background-color: #f4a460;">20% After Deductible Not Covered</td> </tr> <tr> <td style="background-color: #f4a460;">Retail Preferred Brand</td> <td style="background-color: #f4a460;">20% After Deductible Not Covered</td> </tr> <tr> <td style="background-color: #f4a460;">Retail Non-Preferred Brand</td> <td style="background-color: #f4a460;">50% After Deductible Not Covered</td> </tr> <tr> <td style="background-color: #f4a460;">Retail Specialty</td> <td style="background-color: #f4a460;">50% After Deductible Not Covered</td> </tr> <tr> <td style="background-color: #f4a460;">Mail Order Generic</td> <td style="background-color: #f4a460;">20% After Deductible Not Covered</td> </tr> <tr> <td style="background-color: #f4a460;">Mail Order Preferred Brand</td> <td style="background-color: #f4a460;">20% After Deductible Not Covered</td> </tr> <tr> <td style="background-color: #f4a460;">Mail Order Non-Preferred Brand</td> <td style="background-color: #f4a460;">50% After Deductible Not Covered</td> </tr> <tr> <td style="background-color: #f4a460;">Mail Order Specialty</td> <td style="background-color: #f4a460;">Not Covered Not Covered</td> </tr> <tr> <td style="background-color: #f4a460;">Maximum Out-of-Pocket – Includes Medical and Prescription (Individual/ Family)</td> <td style="background-color: #f4a460;">\$6,650 / \$13,200 N/A</td> </tr> </tbody> </table> | MetroHealth Pharmacy or Medical Mutual Express Script Network (Mail Order is only available through Express Script Network) | Out-of-Network | Retail Generic | 20% After Deductible Not Covered | Retail Preferred Brand | 20% After Deductible Not Covered | Retail Non-Preferred Brand | 50% After Deductible Not Covered | Retail Specialty | 50% After Deductible Not Covered | Mail Order Generic | 20% After Deductible Not Covered | Mail Order Preferred Brand | 20% After Deductible Not Covered | Mail Order Non-Preferred Brand | 50% After Deductible Not Covered | Mail Order Specialty | Not Covered Not Covered | Maximum Out-of-Pocket – Includes Medical and Prescription (Individual/ Family) | \$6,650 / \$13,200 N/A | | | | | | | | | | |
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| Emergency Room Visit – Emergency *(Not subject to deductible, Copay waived if admitted) | \$150 Copay* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Prescription Drug Benefits
Retail - Up to 30 days supply (3 Fill Limit) Mail Order - Up to 90 day supply
All Specialty- Up to 30 day supply | <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="background-color: #4f81bd; color: white;">MetroHealth Pharmacy</th> <th style="background-color: #4f81bd; color: white;">CVS CareMark</th> </tr> </thead> <tbody> <tr> <td style="background-color: #4f81bd; color: white;">Retail Generic</td> <td style="background-color: #4f81bd; color: white;">\$10 Copay \$20 Copay</td> </tr> <tr> <td style="background-color: #4f81bd; color: white;">Retail Preferred Brand</td> <td style="background-color: #4f81bd; color: white;">\$25 Copay \$50 Copay</td> </tr> <tr> <td style="background-color: #4f81bd; color: white;">Retail Non-Preferred Brand</td> <td style="background-color: #4f81bd; color: white;">\$50 Copay \$100 Copay</td> </tr> <tr> <td style="background-color: #4f81bd; color: white;">Retail Specialty</td> <td style="background-color: #4f81bd; color: white;">20% to \$750 20% to \$750</td> </tr> <tr> <td style="background-color: #4f81bd; color: white;">Mail Order Generic</td> <td style="background-color: #4f81bd; color: white;">\$10 Copay \$20 Copay</td> </tr> <tr> <td style="background-color: #4f81bd; color: white;">Mail Order Preferred Brand</td> <td style="background-color: #4f81bd; color: white;">\$50 Copay \$80 Copay</td> </tr> <tr> <td style="background-color: #4f81bd; color: white;">Mail Order Non-Preferred Brand</td> <td style="background-color: #4f81bd; color: white;">\$80 Copay \$120 Copay</td> </tr> <tr> <td style="background-color: #4f81bd; color: white;">Mail Order Specialty</td> <td style="background-color: #4f81bd; color: white;">Not Covered Not Covered</td> </tr> <tr> <td style="background-color: #4f81bd; color: white;">Maximum Out-of-Pocket – Includes Medical and Prescription (Individual/ Family)</td> <td style="background-color: #4f81bd; color: white;">\$6,600/ \$13,200 N/A</td> </tr> </tbody> </table> | MetroHealth Pharmacy | CVS CareMark | Retail Generic | \$10 Copay \$20 Copay | Retail Preferred Brand | \$25 Copay \$50 Copay | Retail Non-Preferred Brand | \$50 Copay \$100 Copay | Retail Specialty | 20% to \$750 20% to \$750 | Mail Order Generic | \$10 Copay \$20 Copay | Mail Order Preferred Brand | \$50 Copay \$80 Copay | Mail Order Non-Preferred Brand | \$80 Copay \$120 Copay | Mail Order Specialty | Not Covered Not Covered | Maximum Out-of-Pocket – Includes Medical and Prescription (Individual/ Family) | \$6,600/ \$13,200 N/A | | | | | | | | | | |
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| Emergency Room Visit – Emergency *(Not subject to deductible, Copay waived if admitted) | \$150 Copay* | \$150 Copay* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Emergency Room Visit – Non-Emergency | \$200 Copay | Not Covered | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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 | Not Covered Not Covered | Not Covered | Maximum Out-of-Pocket – Includes Medical and Prescription (Individual/ Family) | \$2,500/ \$5,000 | \$3,500/ \$7,000 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Deductible (Individual/Family) | \$750/ \$1,500 | \$1,500/ \$3,000 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Coinsurance | 0% After Deductible 10% After Deductible | 30% After Deductible | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Coinsurance Limit – Medical Only (Individual/Family) – Excludes Deductible | \$1,750/ \$3,500 | \$2,000/ \$4,000 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Inpatient Facility Services | 0%, No Deductible 10% After Deductible | 30% After Deductible | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Outpatient Facility & X-Ray/Lab Services | 0%, No Deductible 10% After Deductible | 30% After Deductible | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Preventive Care Office Visit | \$0 Copay, No Deductible \$0 Copay, No Deductible | 30% After Deductible | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Office Visit – Primary Care Physician | \$25 Copay \$25 Copay | 30% After Deductible | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Office Visit – Specialist | \$50 Copay \$50 Copay | 30% After Deductible | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Urgent Care Visit | \$75 Copay \$75 Copay | 30% After Deductible | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Emergency Room Visit – Emergency *(Not subject to deductible, Copay waived if admitted) | \$150 Copay* | \$150 Copay* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Emergency Room Visit – Non-Emergency | \$200 Copay | 30% After Deductible | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Prescription Drug Benefits
Retail - Up to 30 days supply (3 Fill Limit) Mail Order - Up to 90 day supply
All Specialty- Up to 30 day supply | <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="background-color: #800000; color: white;">MetroHealth Pharmacy</th> <th style="background-color: #800000; color: white;">CVS CareMark</th> <th style="background-color: #800000; color: white;">Out-of-Network</th> </tr> </thead> <tbody> <tr> <td style="background-color: #800000; color: white;">Retail Generic</td> <td style="background-color: #800000; color: white;">\$10 Copay \$10 Copay</td> <td style="background-color: #800000; color: white;">Not Covered</td> </tr> <tr> <td style="background-color: #800000; color: white;">Retail Preferred Brand</td> <td style="background-color: #800000; color: white;">\$35 Copay \$35 Copay</td> <td style="background-color: #800000; color: white;">Not Covered</td> </tr> <tr> <td style="background-color: #800000; color: white;">Retail Non-Preferred Brand</td> <td style="background-color: #800000; color: white;">\$50 Copay \$50 Copay</td> <td style="background-color: #800000; color: white;">Not Covered</td> </tr> <tr> <td style="background-color: #800000; color: white;">Retail Specialty</td> <td style="background-color: #800000; color: white;">20% up to \$750 20% up to \$750</td> <td style="background-color: #800000; color: white;">Not Covered</td> </tr> <tr> <td style="background-color: #800000; color: white;">Mail Order Generic</td> <td style="background-color: #800000; color: white;">\$10 Copay \$10 Copay</td> <td style="background-color: #800000; color: white;">Not Covered</td> </tr> <tr> <td style="background-color: #800000; color: white;">Mail Order Preferred Brand</td> <td style="background-color: #800000; color: white;">\$70 Copay \$70 Copay</td> <td style="background-color: #800000; color: white;">Not Covered</td> </tr> <tr> <td style="background-color: #800000; color: white;">Mail Order Non-Preferred Brand</td> <td style="background-color: #800000; color: white;">\$100 Copay \$100 Copay</td> <td style="background-color: #800000; color: white;">Not Covered</td> </tr> <tr> <td style="background-color: #800000; color: white;">Mail Order Specialty</td> <td style="background-color: #800000; color: white;">Not Covered Not Covered</td> <td style="background-color: #800000; color: white;">Not Covered</td> </tr> <tr> <td style="background-color: #800000; color: white;">Maximum Out-of-Pocket – Includes Medical and Prescription (Individual/ Family)</td> <td style="background-color: #800000; color: white;">\$2,500/ \$5,000</td> <td style="background-color: #800000; color: white;">\$3,500/ \$7,000</td> </tr> </tbody> </table> | MetroHealth Pharmacy | CVS CareMark | Out-of-Network | Retail Generic | \$10 Copay \$10 Copay | Not Covered | Retail Preferred Brand | \$35 Copay \$35 Copay | Not Covered | Retail Non-Preferred Brand | \$50 Copay \$50 Copay | Not Covered | Retail Specialty | 20% up to \$750 20% up to \$750 | Not Covered | Mail Order Generic | \$10 Copay \$10 Copay | Not Covered | Mail Order Preferred Brand | \$70 Copay \$70 Copay | Not Covered | Mail Order Non-Preferred Brand | \$100 Copay \$100 Copay | Not Covered | Mail Order Specialty | Not Covered Not Covered | Not Covered | Maximum Out-of-Pocket – Includes Medical and Prescription (Individual/ Family) | \$2,500/ \$5,000 | \$3,500/ \$7,000 |
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| Mail Order Specialty | Not Covered Not Covered | Not Covered | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Maximum Out-of-Pocket – Includes Medical and Prescription (Individual/ Family) | \$2,500/ \$5,000 | \$3,500/ \$7,000 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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Medical Mutual SuperMed EPO Plan and Medical Mutual SuperMed PPO Plan: Tier 1 and Tier 2 Coinsurance limits work towards each other.

For all plans, excluding the MetroHealth Select High Deductible: When a generic is available, but the pharmacy dispenses the brand name medication for any reason other than the prescriber indicates "dispense as written," you will pay the difference between the brand name medication and the generic plus the brand copayment.