Cuyahoga County 2026 Medical and Prescription Drug Plan Options

This summary of benefits is designed to provide a high-level overview of Cuyahoga County's 2026 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		
	Covers 100% of preventive care services provided In- Network (according to age and gender)		Covers 100% of preventive care services provided In-Network (according to age and gender)		Covers 100% of preventive care services provided In-Network (according to age and gender)			Covers 100% of preventive care services provided In-Network (according to age and gender)		
	In-Network coverage available through MetroHealth Select Network only		In-Network coverage available through MetroHealth Select Network only		In- Network coverage through MetroHealth Select and Medical Mutual SuperMed Network			In-Network coverage through MetroHealth Select and Medical Mutual SuperMed Network		
	Medical and Prescription Drug costs are out-of-pocket until the deductible is met		Requires you to Pay 100% for Out-of-Network services		Requires that you pay 100% for Out-of- Network services			Out-of-Network coverage available		
	Requires you to pay 100% for Out-of-Network services		Prescription Drug coverage through a MetroHealth Pharmacy and CVS CareMark Network		Prescription Drug coverage through a MetroHealth Pharmacy and CVS CareMark Network			Prescription Drug coverage through a MetroHealth Pharmacy and CVS CareMark Network		
	Prescription Drugs are required to be filled at a MetroHealth Pharmacy or Express Scripts		Option to participate in Medical Flexible Spending Account for eligible health care expenses		Option to participate in Medical Flexible Spending Account for eligible health care expenses			Option to participate in a Medical Flexible Spending Account for eligible health care expenses		
	Option to open and contribute to a tax-favored Health Savings Account to pay for healthcare expenses									
					Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3
	MetroHealth Select Network	**Out-of-Network**	**MetroHealth Select Network**	**Out-of-Network**	**MetroHealth Select Network**	**Medical Mutual SuperMed Network**	**Out-of-Network**	**MetroHealth Select Network**	**Medical Mutual SuperMed Network**	**Out-of-Network**
Deductible (Individual/Family)	$2,800/ $5,250	Not Covered	$0/$0	Not Covered	$0/$0	$1,000/$2,000	Not Covered	$750/$1,500	$1,000/$2,000	$1,500/$3,000
Coinsurance	20% After Deductible	Not Covered	0%, No Deductible	Not Covered	10%, No Deductible	20% After Deductible	Not Covered	0% After Deductible	10% After Deductible	30% After Deductible
Coinsurance Limit – Medical Only (Individual/Family) – Excludes Deductible	$3,850/$7,950	Not Covered	N/A	N/A	$1,250/$2,500	$6,000/$12,000	Not Covered	$1,750/$3,500	$4,000/$8,000	$2,000/$4,000
Inpatient Facility Services	20% After Deductible	Not Covered	$250 Copay	Not Covered	$250 + 10%	20% After Deductible	Not Covered	0%, No Deductible	10% After Deductible	30% After Deductible
Outpatient Facility & X-Ray/Lab Services	20% After Deductible	Not Covered	0%, No Deductible	Not Covered	0%, No Deductible	20% After Deductible	Not Covered	0%, No Deductible	10% After Deductible	30% After Deductible
Preventive Care Office Visit	0%, No Deductible	Not Covered	$0 Copay, No Deductible	Not Covered	$0 Copay, No Deductible	$0 Copay, No Deductible	Not Covered	$0 Copay, No Deductible	$0 Copay, No Deductible	30% After Deductible
Office Visit – Primary Care Physician	20% After Deductible	Not Covered	$20 Copay	Not Covered	$20 Copay	$30 Copay	Not Covered	$25 Copay	$25 Copay	30% After Deductible
Office Visit – Specialist	20% After Deductible	Not Covered	$40 Copay	Not Covered	$40 Copay	$50 Copay	Not Covered	$50 Copay	$50 Copay	30% After Deductible
Urgent Care Visit	20% After Deductible	Not Covered	$40 Copay	Not Covered	$40 Copay	$60 Copay	Not Covered	$75 Copay	$75 Copay	30% After Deductible
Emergency Room Visit – Emergency *(Not subject to deductible, Copay waived if admitted)	20% After Deductible		$150 Copay*		$150 Copay*			$150 Copay*		
Emergency Room Visit – Non- Emergency	20% After Deductible	Not Covered	$200 Copay	Not Covered	$200 Copay		Not Covered	$200 Copay		30% After Deductible
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**	**MetroHealth Pharmacy or Medical Mutual Express Script Network (Mail Order is only available through Express Scripts Network)**	**Out-of-Network**	**MetroHealth Pharmacy**	**CVS CareMark**	**MetroHealth Pharmacy**	**CVS CareMark**	**Out-of-Network**	**MetroHealth Pharmacy**	**CVS CareMark**	**Out-of-Network**
Retail Generic	20% After Deductible	Not Covered	$10 Copay	$20 Copay	$10 Copay	$10 Copay	Not Covered	$10 Copay	$10 Copay	Not Covered
Retail Preferred Brand	20% After Deductible	Not Covered	$25 Copay	$50 Copay	$40 Copay	$40 Copay	Not Covered	$40 Copay	$40 Copay	Not Covered
Retail Non-Preferred Brand	50% After Deductible	Not Covered	$50 Copay	$100 Copay	$60 Copay	$60 Copay	Not Covered	$60 Copay	$60 Copay	Not Covered
Retail Specialty	50% After Deductible	Not Covered	20% to $750	20% to $750	20% to $750	20% to $750	Not Covered	20% up to $750	20% up to $750	Not Covered
Mail Order Generic	20% After Deductible	Not Covered	$10 Copay	$20 Copay	$10 Copay	$10 Copay	Not Covered	$10 Copay	$10 Copay	Not Covered
Mail Order Preferred Brand	20% After Deductible	Not Covered	$50 Copay	$80 Copay	$80 Copay	$80 Copay	Not Covered	$80 Copay	$80 Copay	Not Covered
Mail Order Non-Preferred Brand	50% After Deductible	Not Covered	$80 Copay	$120 Copay	$120 Copay	$120 Copay	Not Covered	$120 Copay	$120 Copay	Not Covered
Mail Order Specialty	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Maximum Out-of-Pocket – Includes Medical and Prescription (Individual/ Family)	$6,650 / $13,200	N/A	$6,600/ $13,200	N/A	$6,600/ $13,200	$7,000/$14,000	N/A	$2,500/ $5,000	$5,000/$10,000	$6,000/$12,000

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.