2026-2027 Cleveland State University's Medical and Prescription Drug Plans Comparison

This summary of benefits is designed to provide a high-level overview of Cleveland State University's Medical and Prescription Drug benefits. Should there be a conflict between 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 an omission in this overview.

Cleveland State University

	MetroHealth Select (Skyway)		Medical Mutual Value Plan		Medical Mutual Traditional Plan	
	Lowest monthly employee contribution and lowest deducitble and out of pocket maximums		Highest Deductible and Out of Pocket Maximum		Most expensive monthly employee contribution	
	Covers 100% of preventive care services provided In network*		Covers 100% of preventive care services provided In-Network*		Covers 100% of preventive care services provided In-Network*	
	In-network coverage through MetroHealth ONLY		In-network and non-network coverage available		In-network and non-network coverage available	
	Requires you to Pay 100% for most Non-Network services		Option to participate in Health Care Flexible Spending Account		Option to participate in Health Care Flexible Spending Account	
	Option to participate in Health Care Flexible Spending Account					
	Benefit Period January 1st to December 31st*		**Benefit Period January 1st to December 31st***		**Benefit Period January 1st to December 31st***	
	MetroHealth Select (Skyway) Network	**Non-Network**	Medical Mutual SuperMed Network	**Non- Network**	Medical Mutual SuperMed Network	**Non-Network**
Deductible (Individual/Family)	$350/$1,050	Not Covered	$1,100/$3,300	$2,200/$6,600	$600/$1,800	$1,200/$3,600
Coinsurance After Deductible	20%, After Deductible	Not Covered	20% After Deductible	40% After Deductible	25% After Deductible	40% After Deductible
Inpatient Facility Services	20% After Deductible	Not Covered	20% After Deductible	40% After Deductible	25% After Deductible	40% After Deductible
Outpatient Facility & X-Ray/Lab Services	20% After Deductible	Not Covered	20% After Deductible	Not Covered	25% After Deductible	40% After Deductible
Preventive Care Office Visit	$0 Copay, No Deductible	Not Covered	$0 Copay, No Deductible	40% After Deductible	$0 Copay, No Deductible	40% After Deductible
Office Visit – Primary Care Physician	$20 Copay	Not Covered	$35 Copay	40% After Deductible	$25 Copay	40% After Deductible
Office Visit – Specialist	$40 Copay	Not Covered	$50 Copay	40% After Deductible	$50 Copay	40% After Deductible
Urgent Care Visit	$50 Copay	Not Covered	$75 Copay	40% After Deducible	$75 Copay	40% After Deductible
Emergency Room Visit (Copay Waived If Admitted)	0% after $250 Copay	0% after $250 Copay	$350 Copay + 20% After Deductible	**$350 Copay + 20% After Deductible**	$300 Copay + 25% After Deductible	$300 Copay + 25% After Deductible
Emergency Room Visit – Non- Emergency	$250 Copay + 20% After Deductible	Not Covered	$350 Copay + 20% After Deductible	$350 Copay + 40% After Deductible	$300 Copay + 25% After Deductible	$300 Copay + 40% After Deductible
Prescription Drug Benefits	**MetroHealth (Skyway) Pharmacy**	**Medical Mutual Express Scripts**	**Medical Mutual Express Scripts**	**Non-Network**	**Medical Mutual Express Scripts**	**Non-Network**
Retail Drug (30 day supply) Mandatory Generic Non-Maintenance, Non-Specialty Drugs						
Retail Generic (30 day supply)	$0 Copay	$10 Copay	$15 Copay	Not Covered	$15 Copay	Not Covered
Retail Preferred Brand Name (30 day supply)	$30 Copay	$45 Copay	$50 Copay	Not Covered	$50 Copay	Not Covered
Retail Non-Preferred Brand (30 day supply)	$60 Copay	$90 Copay	$95 Copay	Not Covered	$95 Copay	Not Covered
Mail Order Non-Specialty (90 Day Supply) Mandatory Generic Maintenance Drugs						
Mail Generic	$10 Copay	$20 Copay	$30 Copay	Not Covered	$30 Copay	Not Covered
Mail Preferred Brand	$60 Copay	$90 Copay	$100 Copay	Not Covered	$100 Copay	Not Covered
Mail Non-Preferred Brand	$120 Copay	$180 Copay	$190 Copay	Not Covered	$190 Copay	Not Covered
Specialty Drugs (Accredo Specialty Pharmacy only)	Accredo Pharmacy Only		Accredo Pharmacy Only		Accredo Pharmacy Only	
30 Day Supply	10% up to $100	10% up to $100	10% up to $200 max per prescription	Not Covered	10% up to $200 max per prescription	Not Covered
Out of Pocket Maximum (Individual/Family) - Includes Deductible, Copay, and Coinsurance for medical and prescription drugs.	$3,500/$7,000	Unlimited	$5,000/$10,000	Unlimited	$4,000/$8,000	Unlimited

The Benefit Period is based on a calendar year and it is the period of time during which covered services are rendered and Benefit Maximums, Deductibles, and Out of Pocket Maximums are accumulated.

*According to age and gender