HEALTH CARE PLANS

*Catholic Diocese of Cleveland*

# HEALTH CARE PLANS

2018-2019

Medical Mutual • CVS Caremark • MetLife • MetroHealth • VSP

Catholic Diocese of Cleveland

# [Table of Contents]


Introduction ..... 1

Your Health Plan Options ..... 2-3

Questions & Answers ..... 4-7

## Hospital & Physician Coverage

General Information ..... 7-9

Hospital Coverage ..... 7-9

Physician Coverage ..... 9

Questions & Answers ..... 10-11

Health Coverage Benefit Comparison Chart ..... 12-19

## Dental Coverage ..... 20

## Health Care Plan Monthly Rates ..... 21

## Vision Service Plan® ..... 22

## CVS Caremark ..... 23

## MetroHealth Locations ..... 24

## Telephone Service Guide ..... 25

The Diocese of Cleveland Employee Benefits Office is committed to providing you with quality health care benefits and with the information you need to make wise choices and get the most from your health care dollar. The Catholic Diocese of Cleveland currently sponsors three (3) basic medical plans — one which covers Clergy Members, one which covers members of Religious Orders and one which covers Lay Employees (together they are referred to in this booklet as the "Medical Plans," the "Health Care Plans," or the "Plans"). The Medical Plans offered are regularly reviewed to insure that they provide comprehensive coverage and remain cost-effective. In this booklet you will find useful information about plan provisions, along with answers to your most commonly asked questions.

While the Health Care Plans have some similarities, there are some important differences among them. These differences involve benefit levels and costs – all of which you should carefully consider.

The Diocese offers three Health Care Plan options for your physician and hospital coverage. The first plan is a preferred provider organization (PPO), the second is a plan compatible with a Health Savings Account (HSA) and the third plan (new this year) is an Exclusive Provider Network (EPO).

***Medical Mutual SuperMed PPO***
***Medical Mutual SuperMed PPO/HSA***
***MetroSelect EPO***

If you choose either of the Medical Mutual plans, you receive maximum benefits when you use network physicians and hospitals. Benefits are available if you choose doctors and hospitals not part of the provider network, but at a reduced level.

If you choose the SuperMed PPO/HSA Plan you will use the same network of hospitals and providers used in the SuperMed PPO Plan. The only difference is that the SuperMed PPO/HSA is a high-deductible health plan as defined by the Internal Revenue Service. The plan is compliant with Federal Regulations that permit you to open a tax advantaged health savings account and offers the lowest employee contributions.

Medical Mutual has an online tool called My Care Compare. Different facilities and providers charge different amounts for the same medical services. The My Care Compare tool allows members to determine the cost for services depending on where you choose to see your doctor – at a hospital, community-based clinic or standalone office. Members can access their secure My Health Plan account and access this tool at **member.medmutual.com/user/login.aspx**

The MetroSelect EPO provides medical benefits only from MetroHealth providers and hospitals. The lone exception to this design are those services received resulting from an emergency; emergency claims will be processed as if they were incurred at a MetroHealth facility. Members selecting this plan can obtain prescription drugs from either MetroHealth pharmacies or any pharmacies in the CVS/Caremark network. Members electing this plan will pay lower prescription drug co-pays if they use the MetroHealth pharmacies.

The Diocese also offers a Medicare supplement plan called Medifil. Participants in the Medifil Plan who have Medicare as their primary health care coverage will not be limited to SuperMed providers to receive maximum benefits. In addition, claim filing is simplified because Medicare provides automatic electronic transfer of claims to Medical Mutual of Ohio for coordination of benefits.

Medicare HMO policies are offered for our Medicare primary participants and include SummaCare Secure and Anthem Senior Advantage. Medicare participants who choose an HMO option are no longer involved in any type of claim filing. Medicare pays the HMOs to provide care instead of reimbursing the doctors and hospitals for each service provided. Medicare participants interested in the Medicare HMO options should contact the Employee Benefits Office for more details. These HMOs do not automatically include Diocesan dental benefits.

Coverage for necessary dental care is automatically included for those enrolled in any Health Care Plan offered by the Diocese of Cleveland (except Medicare HMOs). You must choose between the Standard Dental Plan and the PPO Dental Plan. A high level PPO Dental Plan can also be purchased at the option of the participant. Eligible employees not enrolled in one of the Diocesan Medical Plans may choose to be covered under any dental plan on a stand-alone basis.

Long-term care insurance and vision insurance are offered as optional programs. These programs are totally voluntary and fully paid by the participant.

This booklet is neither a Summary Plan Description nor a Plan document. If there is any discrepancy between the information contained in this booklet and the official Plan document, the Plan document will govern.

## Medical Mutual SuperMed PPO Health Plan:

**SuperMed PPO** utilizes a broad network of hospitals and physicians who provide services at a special rate for the carrier. A complete listing of area hospitals is provided in this booklet.

The network includes physicians in general practice, family practice, internal medicine, pediatrics and obstetrics/gynecology. In addition, specialists in cardiovascular services, neuroscience, neonatal care, radiology, cancer treatment and others are included in the network.

As a PPO member, you have the freedom to choose and self-refer to any of the network providers. In doing so, you will receive the highest level of benefits provided by your Plan, in most cases, 80% after the deductible. Covered benefits received from non-network providers are reimbursed at a lower rate which is generally 60% after the deductible.

## Medical Mutual SuperMed PPO/HSA Health Plan (MMO PPO/HSA):

The MMO PPO/HSA uses the same network of hospitals and providers used in the SuperMed PPO Plan. Also, like the SuperMed PPO Plan, you have the freedom to choose and self-refer to any of the network providers. The same services covered under the SuperMed PPO Plan are covered under the MMO PPO/HSA. The only differences are that the MMO PPO/HSA is a high-deductible health plan and the benefits you receive under the Plan are provided, in most cases, at 80% after the deductible. Covered benefits received from non-network providers are reimbursed at a lower rate which is generally 60% after the deductible.

MMO PPO/HSA Plan enrollees will automatically be enrolled in a MetLife *"Critical Illness"* policy. There is no additional cost to the participant in the MMO PPO/HSA Plan for this benefit as it is now a stated element of that health plan. This is coverage that can help cover the extra expenses associated with a covered serious illness. When a covered serious illness happens to you or a loved one, this coverage provides you with a lump-sum payment up to $12,000 in Initial Benefits upon diagnosis. Payment you receive will be made in addition to any other insurance you may have and may be spent as you see fit.

## MetroSelect EPO Health Plan:

The MetroSelect EPO Health Plan covers the same services as the other two plans offered through Medical Mutual of Ohio. A difference from the other two plans is that medical services are only available from MetroHealth providers and hospitals. That is, medical services obtained from providers and hospitals that are not part of the MetroHealth network are not covered.

Fees for services from MetroHealth providers are generally lower than those for the same services obtained from providers in the MMO network. Members enrolling in this plan will have lower deductibles, out-of-pocket maximums and copayments than the other two plans. Additionally, this plan will pay 90% of medical expenses incurred after the deductible is satisfied. Members can obtain their prescriptions using pharmacies that are part of the MetroHealth or CVS/Caremark networks. Members enrolled in this plan will have lower copayments if they use MetroHealth pharmacies.

## Dental Plans:

Dental coverage is provided by MetLife to those participants enrolled in any Diocesan Medical Plan, with the exception of Medicare HMOs. Medicare HMO enrollees may, however, elect a dental plan at an additional cost.

**The Standard Dental Plan*** includes coverage for services such as fillings, extractions, crowns, bridges and orthodontia. Preventive services are covered at 80%, not subject to the annual deductible. Services can be obtained from any dental provider.

**The PPO Dental Plan** is another option available to those participants enrolled in any Diocesan Medical Plan. This plan utilizes providers in the MetLife Dental Network, who have agreed to accept reduced fees for dental services. Members who use a network provider receive a higher level of benefits. Preventive care for check-ups and bitewing x-rays are payable at 100%, not subject to the deductible when network providers are utilized. All other dental services are covered at a higher level of benefits than the Standard Dental Plan when received from a network provider. Benefit levels are reduced when services are received outside the MetLife network.

**The High Option PPO Plan**, which requires an additional cost to the participant, provides higher levels of benefits compared to the PPO Dental Plan described above.

*MetLife providers are also available under the Standard Dental Plan for those who wish to take advantage of discounted charges and no balance billing (see Page 20 for additional information).

## Claim Filing/Balance Billings:

All network providers will file claims for you. Also, they have agreed to accept the network payment as payment in full and will not balance bill you for charges which are above and beyond your required co-payments and deductibles.

## Vision Service Plan®:

**Vision Service Plan® (VSP)** is an optional program for which you pay the full premium cost. VSP is a comprehensive, prepaid vision plan designed to cover vision care expenses not covered by a medical insurance plan. High level benefits are available through VSP's extensive network of doctors. Benefits are also available for services received from non-network providers but at a reduced level. For more information please use the Vision Service Plan website at **www.vsp.com**.

## Long-Term Care:

**UNUM Long-Term Care** is offered to participants as an optional benefit. Evidence of Insurability (medical underwriting) is required for any participant electing coverage as a late enrollee or after their original eligibility period. Information regarding benefits, premium costs and enrollment materials can be obtained by contacting the Diocese of Cleveland Employee Benefits Office.

# [Your Health Care Options - Q&A]

## 1. Who is eligible for coverage?

- All active, full-time employees of a covered employer and persons who are hired by a covered employer as temporary employees regularly scheduled to work on a full-time basis after being employed for a 90-day period. Part-time employees who work a minimum number of hours are eligible for coverage at their own expense. Persons who are contract or leased employees and persons who have entered into a written agreement not to participate in the plan are not eligible. Persons who are seasonal employees, whose employment is expected to last less than 6 months, are not eligible.
- An eligible employee's spouse who is the lawful husband or wife of the opposite sex from that of the employee.
- Children (up to age 26) of eligible employees including his or her biological and adopted children, the biological and adopted children of an eligible spouse of the opposite sex, and such children who are required to be covered under the Plan by court order of decree.
- Anyone selecting family medical coverage will need to produce proof for their dependents. Employees covering dependent children will need to provide a birth certificate or applicable court/legal documents. Employees covering a spouse will have to produce a marriage certificate, current tax returns and a Working Spouse Employment Verification Form.
- Retirees.
- Clergy and members of religious organizations participate in separate plans with similar coverages.

***Note: You must enroll within 30 days of eligibility and pay any required premiums for coverage.***

## 2. Do I pay anything for my coverage?

If you are a full-time employee you are responsible for a portion of the cost of your coverage. If you are a part-time employee working on a regular basis, you can participate in a Health Care Plan at your own expense. The **normal** employer and full-time employee costs are shown on page 21 of this booklet. This can be paid on a pre-tax basis through payroll reductions.

## 3. Will I have to pay a surcharge if I elect family coverage and my spouse works?

A $650 monthly surcharge will apply if your spouse works and has access to medical coverage through their employer and elects to enroll in the Diocesan Health Care Plan for primary coverage. This surcharge does not apply to a spouse who does not have heath care available from their employer.

## 4. Can my spouse enroll in their employer's plan for primary coverage and also enroll in the Diocesan Plan for secondary coverage?

No, secondary coverage is not available for spouses where an employee selects a family plan that covers the employee and dependents.

## 5. Can I reduce the cost of my coverage by earning incentives?

Yes, there are two incentives that can be earned to reduce your premium costs. Incentives can be earned by being tobacco-free and/or by being current with your preventive care (also known as an annual physical). You can receive an incentive of $15 for single coverage or $30 for family coverage for each category. Family medical coverage requires both the Employee and Spouse to participate.

## 6. How do I earn the preventive care incentive?

Your physician needs to certify that you are current with your age, and gender appropriate preventive care by May 1, 2018 by completing the 2018 Annual Physical and Tobacco Attestation Form (APTA Form). If you are current with your preventive care, then you may not need to complete another physical to qualify for the incentive this year. (Note: Even if you submitted a form for a physical after May 1, 2017 to receive an incentive in the current year, a new form for the 2018-2019 plan year must be submitted by May 1, 2018.)

Remember, if your spouse is enrolled in family medical coverage, then both of you must have your physical exams certified in order to earn the preventive care incentive. The incentive rate will be effective July 1, 2018.

If you need a copy of the APTA Form, there is a downloadable PDF available at: **www.MyDOCBenefits.com** or contact the Employee Benefits Office.

## 7. How do I earn the tobacco-free incentive?

To earn the tobacco-free incentive, you must sign the Tobacco Attestation section of the Annual Physical and Tobacco Attestation Form (APTA Form). You must complete this section of the APTA Form by May 1, 2018. If you are NOT a tobacco user, then your incentive rate will be effective July 1, 2018.

If you ARE a tobacco user and ready to be tobacco-free, enrolling in the Medical Mutual of Ohio QuitLine tobacco cessation program by calling (866) 845-7702 by May 1, 2018 will also earn you the incentive effective on July 1, 2018. Regardless of your tobacco use, you still must complete the tobacco-use certification portion of your APTA Form and indicate your tobacco use by May 1, 2018. Once you have enrolled in the QuitLine program, you must complete the program within 90 days of enrollment. The QuitLine will report your completion of the tobacco cessation program directly to the Diocese.

Remember, if your spouse is enrolled in family medical coverage, then both of you must be tobacco-free or have enrolled in the QuitLine program and complete the program in order to earn the tobacco-free incentive.

## 8. Can I ever change the Health Care Plan I initially enrolled in?

You have the opportunity to change your Health Care Plan once a year during open enrollment which is typically held in April or May. Coverage under your open enrollment elections will be effective July 1.

## 9. Can I change my Health Care Plan elections during a coverage period?

Your elections generally must remain in effect for the entire coverage period. Under the Plans, however, you may change your elections during a coverage period upon the occurrence of certain events called "Change Events." Change Events include a change in your legal marital status, birth of a child, adoption or death of a dependent, change in your employment status or your spouse's or dependent's employment status, changes in your dependent's satisfaction of the Plan's eligibility requirements (for example, attainment of the maximum age), a significant change in coverage options or cost of the Plans, you or your dependent first become entitled to coverage under Medicare or Medicaid, you first become covered by a qualified medical child support order which requires you to provide coverage for your dependent child, or you first become entitled to coverage under your spouse's plan. If you have a Change Event and you wish to make a new coverage election during a coverage period, you must complete a new enrollment/change form within 30 days of the effective date for any of these Change Events. If you do not complete a new enrollment/change form within 30 days, you will not be able to make a change in your coverage until the next open enrollment. The extent to which you may make a change is limited by and must be consistent with the Change Event which occurred.

## 10. What if I can no longer afford coverage because I have had a change in employment status to part-time but under the stability period I am still treated as full-time?

You may elect to revoke your Health Care Plan election (but not a health FSA election) and drop your medical coverage only if:

- You had been reasonably expected to work on average 30 hours or more per week as a full-time employee and, after the change to part-time, you are reasonably expected to work on average less than 30 hours per week; and
- You represent that either you are already enrolled, or you intend to enroll (including any dependents if you had elected family coverage), in other healthcare coverage providing minimum essential coverage effective no later than the first day of the second month after the month in which your Health Care Plan coverage is revoked.

## 11 . What if I want to enroll in the Marketplace Exchange?

You may elect to revoke your Health Care Plan election during the Marketplace Exchange open enrollment period which typically starts in November with coverage starting January 1. Your Health Care Plan coverage would remain in effect through December and your Marketplace Exchange coverage would need to be effective immediately thereafter on January 1. Generally, your Health Care Plan coverage is affordable minimum essential coverage, so if you elect to drop it in order to obtain coverage on the Marketplace Exchange, you would not be eligible for the tax credit.

## 12. Does my medical plan contain a pre-existing condition clause?

No, none of the Health Plans contain pre-existing condition clauses.

## 13. Can I enroll for dental benefits only?

An employee can opt to enroll for dental benefits only. If you are full-time, you can choose single or family dental under the Standard or PPO Dental Plans and your employer will pick up the entire cost. You can do so by completing an enrollment/change form when you are first hired or during the open enrollment. Elected coverage under the High Option PPO Dental Plan may require a contribution on the part of the participant (see page 21).

## 14. When is coverage under the health plan terminated?

You are covered for the full month in which you terminate your employment. Health coverage will cease to be effective at 12:00 midnight at the end of the last day of the month in which you terminate.

## 15 . Can I continue coverage after I terminate my employment?

You can continue your current health care coverage after you terminate your employment for up to a maximum of eighteen (18) months at your own expense under certain conditions.

## 16. What happens to my coverage when I retire?

Upon retirement, you may elect to continue coverage at your own expense if you have been employed and a participant under a Diocese Health Care Plan for the five years immediately preceding retirement and have attained age 55.

## 17. Can I waive participation in a health care plan?

If you are a full-time employee and covered under your spouse's plan or another health plan, you may waive participation in a health care program by completing and signing a release form. The release/waiver form indicates you have been offered health benefits and choose not to participate.

## 18. If I elect not to participate in a health care plan now, can I join later?

If you remain eligible, you can elect to participate in a Health Care Plan at a later date only in the event your spouse's coverage for you is involuntarily terminated, your other plan is involuntarily terminated, your coverage in the other plan is dropped during the other plan's open enrollment, your status changes from part-time to full-time, you have an addition of a new dependent through marriage, birth of a child or adoption, or during the annual open enrollment period.

## 19. What if I have questions regarding the different plans? Whom do I contact?

You are welcome to stop in the Employee Benefits Office located on the eighth floor of the Cathedral Square Plaza Building. You can also call the Employee Benefits Office at (216) 696-6525, (800) 869-6525 (In Ohio), ext. 5040 or (216) 621-3700.

## 20. What if I am a lay person over 65 and still working?

You may choose either Medicare or the Diocese Health Care Plan as your primary source for medical expense benefit payments. If you choose coverage under the Diocese Health Care Plan you will be enrolled for full coverage and if you are also enrolled in Medicare, Medicare will become the secondary payer of benefits. If you choose Medicare as primary, your coverage under the Diocese Health Care Plan will be cancelled in accordance with federal law.

Once you are enrolled in Medicare benefits, you are no longer eligible to contribute funds into your HSA account if you previously selected the MMO PPO/HSA. The funds in your HSA remain available for your use.

## 21. What if I am a priest over 65?

You should apply for Medicare at your local Social Security Office as soon as possible. Medicare will provide primary benefits because priests are considered to be self-employed and covered by a Plan that is not treated as a "Group Health Plan" under Medicare regulations. The Diocese Health Care Plan for Clergy

will become the secondary payer. When you become eligible for Medicare, you may receive a questionnaire from Medicare or its agent asking about other coverage available to you through your employer. In order to receive the proper coverage, you must indicate on this form that you are not eligible for coverage under a "Group Health Plan" offered by your employer. If you would like assistance with completion of the Medicare questionnaire, please call the Employee Benefits Office.

Once you are enrolled in Medicare benefits, you are no longer eligible to contribute funds into your HSA account if you previously selected the MMO PPO/HSA. The funds in your HSA remain available for your use.

### 22. What if I am a religious over 65?

You should apply for Medicare at your local Social Security Office as soon as possible. If you receive coverage under the Diocese Health Care Plan for Members of Religious Orders, you would be covered regardless of where you work and Medicare would provide primary benefits and the Diocese Health Care Plan for Members of Religious Orders would become the secondary payer.

### 23. Is vision coverage available?

The Diocese offers vision care coverage through Vision Service Plan® (VSP). The Plan pays a substantial portion of the cost of eye exams, frames, lenses and contact lenses for employees and eligible dependents. In order to receive full benefits from the Plan, employees must use VSP panel doctors. A reduced benefit will be paid if a non-panel provider is used. Vision care is voluntary. If coverage is elected, the premium will be fully paid by the employee.

If you are a full-time employee, waive medical coverage and enroll for vision coverage, your employer may pick up the cost of your vision benefit.

## *Regarding Hospital and Physician Services*

Coverage for physician services is provided by the Medical Mutual of Ohio (MMO) SuperMed PPO and MetroHealth networks. Your hospital and physician coverage under these options is summarized in this section of the handbook.

Some of the most common services covered under your health care plan include:

**Hospital Services:** Inpatient Services; Room and Board; X-Ray, EEG, EKG; Lab; Ancillaries; Emergency Room; Hospice Care; Skilled Nursing Care; Chemotherapy; Radiation Therapy; Speech Therapy; Home Health Care; Mental Health and Substance Abuse Services; Anesthesia / Medicines / Drugs.

**Physician Services:** Office Visits; Prescriptions; Surgical Procedures; Anesthesia; Physical Examinations; Allergy Injections; Physician Maternity Services; Outpatient Lab and X-Ray; Assistant Surgeon; Inpatient Consultations / Daily Visits; Prenatal and Postnatal Care; Immunizations.

## *Hospital and Physician Coverage:*

### HOSPITALS:

If you enroll in the SuperMed PPO or MMO PPO/HSA Plans, you can use any hospital you choose. However, these Plans provide higher benefits when you use hospitals that are part of the Plan's network. A listing of the SuperMed PPO network Hospitals in the eight-county area of the Diocese of Cleveland is provided in this book. Also, you can receive a complete list of SuperMed PPO Hospitals by contacting the Diocesan Employee Benefits Office or on Medical Mutual's website at **www.medmutual.com**.

If you enroll in the MetroSelect EPO, hospital benefits are provided only from MetroHealth hospitals. The lone exception to this design are those services received resulting from an emergency; emergency claims will be processed as if they were incurred at a MetroHealth hospital. A list of MetroHealth hospitals and outpatient facilities is provided in this book on page 24.

# [General Information cont.]

## SuperMed PPO Hospitals

You will receive the highest level of benefits when receiving care from a network hospital. The SuperMed PPO hospitals in the Diocese of Cleveland area are listed here.

Members should check with MMO to confirm network status.

| | SuperMed PPO |
|---|---|
| **Ashland County** | Samaritan Regional Health Ctr. |
| **Ashtabula County** | Ashtabula County Medical Ctr. |
| | UH Conneaut Medical Center |
| | UH Geneva Medical Center |
| **Cuyahoga County** | Cleveland Clinic Children's Hospital for Rehabilitation |
| | Cleveland Clinic Foundation |
| | Euclid Hospital |
| | Fairview Hospital |
| | Hillcrest Hospital |
| | Lakewood Hospital |
| | Lutheran Hospital |
| | Marymount Hospital |
| | MetroHealth Medical Center |
| | Rainbow Babies and Children's Hospital |
| | RB&C Ahuja Medical Center |
| | South Pointe Hospital |
| | Southwest General Health Center |
| | St. John West Shore Hospital |
| | St. Vincent Charity Hospital |
| | UH Ahuja Medical Center |
| | UH Bedford Medical Center |
| | UH Cleveland Medical Center |
| | UH MacDonald Women's Hospital |
| | UH Parma Medical Center |
| | UH Seidman Cancer Center |
| | UHHS Richmond Heights Hospital |
| **Geauga County** | UH Geauga Medical Center |
| **Lake County** | Lake Health |
| | Lake Health Tripoint Med Center |
| | Lake Hospital Systems West |
| **Lorain County** | EMH Regional Medical Center |
| | EMH Regional Medical Center Avon |
| | Mercy Allen Hospital |
| | Mercy Regional Medical Center |
| **Medina County** | Lodi Community Hospital |
| | Medina General Hospital |
| | Summa Health System |
| **Portage County** | Robinson Health Center Streetsboro |
| | Robinson Memorial Hospital |
| **Stark County** | Alliance Community Hospital |
| | Mercy Medical Center |
| | Navarra Affinity Therapy |
| **Summit County** | Akron General Medical Center |
| | Akron General Health & Wellness |
| | Akron General Tallmadge Health |
| | Children's Hospital Medical Center of Akron |
| | Crystal Clinic Orthopaedic Center |
| | Summa Barberton Citizens Hospital |
| | Summa Health System |
| | Summa Health System-Western Reserve Hospital |
| **Wayne County** | Aultman Orrville Hospital |
| | Wooster Community Hospital |

## SuperMed PPO and MMO PPO/HSA Hospitals cont.

If you or a family member are scheduled for a non-emergency hospital admission, the carrier must be contacted, or for mental and nervous or substance abuse reviews, call the following numbers:

**Medical Mutual of Ohio:** **(800) 338-4114** (Non-Emergency Admission)
**(800) 258-3186** (Mental/Nervous/Substance Abuse)

It is the hospital's responsibility to call when your admission is to a network hospital. Although some non-network hospitals may call on behalf of the member, it is the member's responsibility to make sure the carrier is notified of non-network hospital admissions. In the case of an emergency or maternity admission, the carrier must be contacted within 24 hours after the admission by the responsible party.

## Physicians:

If you enroll in the **SuperMed PPO or the MMO PPO/HSA Plans** for physician coverage, you can choose to use any qualified physician you wish. But the Plans provide higher benefits when you use doctors who are in the Plan's network of providers. Here's how the Plans work:

**SuperMed PPO**

**In Network:** When you use a primary care physician who is in the PPO network, you pay $25 for each office visit; there is a $50 co-pay for each specialist office visit. Any services related to the office visit for which the provider bills separately for, will be paid at 80% after an annual deductible of $1,000 per person and $2,000 per family. The maximum out-of-pocket expense (includes co-pays, co-insurance and prescription drugs) you will pay in a calendar year under this plan is $3,000 for single and $6,000 for family coverage.

**Out-of-Network:** Charges for out-of-network physician services are subject to a $2,000 per person and $4,000 per family annual deductible and then are paid at 60% of the allowed amount. The maximum out-of-pocket expense you will pay in a calendar year is $6,000 for single and $12,000 for family coverage.

**MMO PPO/HSA**

**In Network:** When you use a physician who is in the PPO network for non-preventive services, you pay the full cost of each office visit and any services related to the office visit until the deductible is met. Visits to physicians in the PPO network for preventive services are not subject to the deductible and covered at 100%. After the annual deductible of $3,000 per person and $6,000 per family has been met, any office visits or other services will be paid at 80%. The maximum out-of-pocket expense (includes co-pays, co-insurance and prescription drugs) you will pay in a calendar year under this Plan is $4,000 for single and $8,000 for family coverage.

**Out-of-Network:** Charges for out-of-network physician services are subject to a $6,000 per person and $12,000 per family annual deductible and then are paid at 60% of the allowed amount. The maximum out-of-pocket expense you will pay in a calendar year is $8,000 for single and $16,000 for family coverage.

You should check with your physician to make sure he or she has admitting privileges at a network hospital to receive the highest benefit from your Health Care Plan.

The SuperMed PPO and MMO PPO/HSA Plans provide health care coverage through a comprehensive network of hospitals and physicians. These Plans give you the freedom to choose any network hospital, physician or specialist, for each member of your family, without prior approval.

To receive the maximum amount of coverage from the MMO PPO and MMO PPO/HSA Plans, simply use the services of any hospital or physician listed in the provider directory for the Plans. If you choose to receive services from a hospital or physician who is not listed in the directory and is not part of the network, you will still receive partial coverage for medically necessary services. As always, in the case of a life-threatening emergency, seek care at the nearest facility.

**MetroSelect EPO**

The MetroSelect EPO provides medical benefits only from MetroHealth providers and hospitals. The lone exception to this design are those services received resulting from an emergency; emergency claims will be processed as if they were incurred at a MetroHealth facility. When you use a primary care physician who is in the MetroHealth network, you pay $20 for each office visit; there is a $40 co-pay for each specialist office visit. Any services related to the office visit for which the provider bills separately for, will be paid at 90% after an annual deductible of $500 per person and $1,000 per family. The maximum out-of-pocket expense (includes co-pays, co-insurance and prescription drugs) you will pay in a calendar year under this plan is $2,000 for single and $4,000 for family coverage.

With all Plans, network providers will file claims on your behalf. Also, by contract agreement, these network providers have agreed not to balance bill you for services above the allowed amount.

# [Health Plans – Questions & Answers]

## 1. How do I know if my physician or hospital is in the network?

For the two medical plans using the Medical Mutual Network, you can search for a provider or hospital by going to Medical Mutual's website at **www.medmutual.com** and click on "Find a Doctor." Then select "Looking for an Employer Plan" and choose the SuperMed PPO Network.

You can also download the mobile app to search for a provider.

Medical Mutual representatives are available to help and can be reached at **(800) 610-2583**.

You can search for a MetroHealth provider at https://www.metrohealth.org/physiciandirectory/
You can search for a MetroHealth hospital at https://www.metrohealth.org/locations/
MetroHealth representatives are available to help and can be reached at **(216) 778-7800**.

## 2. What happens if I elect one of the MMO Plans and I use a doctor or hospital that is not in the MMO network?

You will receive the out-of-network coverage. Charges will be subject to the higher annual deductible, and then paid at 60% of the allowed amount. The annual deductibles and coinsurance amounts you pay for covered expenses apply toward your annual out-of-pocket maximum. Charges in excess of the allowed amount will not be applied to your maximum out-of-pocket.

## 3. What happens if I elect the MetroSelect plan and I use a doctor or hospital that is not in the MetroHealth network?

The cost of your services will not be covered.

## 4. What happens if I need to see a Specialist?

Physicians who specialize in a particular field of medicine are listed in your provider directory according to their specialty. You do not need a referral from another physician to see a specialist.

## 5. What if I elect one of the MMO Plans and my physician refers me to a non-network hospital or physician?

You may choose to accept your physician's referral to a non-network hospital or physician and receive a reduced level of benefits. However, you should first discuss your alternatives. In most cases, your physician will be able to refer you to an MMO network provider.

## 6. What happens if I and/or one of my dependents are out of town and need care?

If you elect one of the MMO Plans and you or your dependent is in an area of Ohio with access to network hospitals and physicians, you can still receive the maximum in-network benefits by using those hospitals or physicians. If you or your dependent is admitted to a hospital for emergency care, you will receive the in-network benefits even if it is not a network hospital. Directories are also available that list all the physicians and hospitals that make up the SuperMed PPO network. Medical Mutual of Ohio also contracts with a national network called First Health Network for services rendered outside of Medical Mutual's proprietary network. While traveling outside of Medical Mutual's proprietary network, you can access First Health by calling the phone number on back of your ID card. When using a hospital or physician within the First Health Network, you will receive in-network level of benefits for all covered services.

If you elect the MetroSelect plan, medical expenses are covered only when obtained by a MetroHealth provider, outpatient facility or hospital. The lone exception to this plan provision is for emergency services; these are covered as if they were incurred using the MetroHealth network.

## 7. Will I be responsible for any costs I incur that are above the allowed amount limit?

You will not have any allowed amount issues if you use network hospitals and physicians. The only time the allowed amount applies is when you or a dependent uses an out-of-network provider.

## 8. What happens in cases of an emergency?

In the event of an accident or life-threatening emergencies, you should always go to the nearest medical facility. You will not be penalized for using a non-network hospital; you will receive the normal in-network benefit.

## 9. What services require pre-certification and who is responsible for completing the process?

All inpatient admissions, acute rehabilitation admissions, skilled nursing facility admissions and home health care services require pre-certification. In addition, some imaging and surgical procedures require pre-certification including, but not limited to, MRI/MRA, PET scans, sclerotherapy and blepharoplasty. Durable medical equipment may also require pre-certification. All network providers are responsible to complete these pre-certification requirements on your behalf. Should services be accessed from non-network providers, members must verify that pre-certification has been completed or services could be denied and may be the member's responsibility.

## 10. Does my coverage apply to any other facilities besides hospitals?

Yes. In addition to regular hospitals, the program includes coverage of skilled nursing facilities, surgical centers, home health agencies and mental health hospitals. For specific information about your benefit coverage, contact the Diocesan Employee Benefits Office.

### 11. If I enroll in the SuperMed PPO or MetroSelect EPO, what expenses count toward the deductible and the out-of-pocket maximums?

Prescription co-payments do apply to your maximum out-of-pocket, but not to your deductible. Charges that do not apply to your out-of-pocket maximum or deductible include charges in excess of the allowed amounts out-of-network and any services not covered under the plan at all.

### 12. If I enroll in the MMO PPO/HSA, do my prescription expenses count toward the deductible and the out-of-pocket maximums?

If the prescription expense is for a non-preventive medication, you would pay the entire cost of the medication until your deductible is met, then your co-payments will count towards your out-of-pocket maximum.

If the prescription expense is for a preventive medication, then your co-payment will count towards your out-of-pocket maximum, but not towards the deductible.

### 13. If I enroll in a MMO plan, what is my prescription drug program?

Under the SuperMed PPO Plan, your prescription drug plan is managed by CVS Caremark and has a $10 co-pay for generic, a 20% co-pay with a $25 minimum and a $75 maximum co-pay for formulary brand and a 40% co-pay with a $40 minimum and a $150 maximum co-pay for non-formulary brand prescriptions when purchased at the retail network pharmacies, for a 30-day supply. For mail order, the co-pay is $25 for generic, a 20% co-pay with a $60 minimum and a $150 maximum co-pay for formulary brand and a 40% co-pay with a $90 minimum and a $300 maximum co-pay for non-formulary brand prescriptions, for a 90-day supply. Diabetic supplies fall under the medical equipment/supplies benefit, under major medical, and are paid at 80% after the deductible has been satisfied in network and 60% after the deductible for non-network. Mail order is mandatory for all maintenance medications. Generic medications are also mandatory when an equivalent is available. **Please note that a 90-day supply is alo available at your local CVS Pharmacy.*

Under the MMO PPO/HSA Plan, prescriptions for drugs that are considered preventive medications (see Preventive Drug List at **www.MyDOCBenefits.com**) have the same co-payments shown above for the SuperMed PPO Plan. You pay the full cost of prescriptions that are not considered preventive until the annual deductible has been met. After the annual combined medical and prescription drug deductible of $3,000 per person and $6,000 per family has been met, any prescription drugs will have the normal prescription co-payments apply until the out-of-pocket maximum is met, then paid at 100%. The maximum combined in-network medical and prescription drug out-of-pocket expense you will pay in a calendar year under this plan is $4,000 for single coverage and $8,000 for family coverage.

### 14. If I enroll in the MetroSelect plan, what is my prescription drug program?

Under the MetroSelect Plan, you can obtain your prescription drugs using either a MetroHealth pharmacy or pharmacies included in the CVS/Caremark network.

The MetroHealth pharmacies have a $10 co-pay for generic, a $20 co-pay for formulary brand and a $40 co-pay for non-formulary brand prescriptions when purchased at the retail level, for a 30-day supply. For mail order, the co-pay is $10 for generic, a $50 co-pay for formulary brand and an $80 co-pay for non-formulary brand prescriptions, for a 90-day supply. Diabetic supplies fall under the medical equipment/supplies benefit, under major medical, and are paid at 90% after the deductible has been satisfied. Mail order is mandatory for all maintenance medications. Generic medications are also mandatory when an equivalent is available. **Please note that a 90-day supply is also available at your local MetroHealth locations.*

Prescriptions filled using the CVS Caremark network have a $10 co-pay for generic, a 20% co-pay with a $25 minimum and a $75 maximum co-pay for formulary brand and a 40% co-pay with a $40 minimum and a $150 maximum co-pay for non-formulary brand prescriptions when purchased at the retail network pharmacies, for a 30-day supply. For mail order, the co-pay is $25 for generic, a 20% co-pay with a $60 minimum and a $150 maximum co-pay for formulary brand and a 40% co-pay with a $90 minimum and a $300 maximum co-pay for non-formulary brand prescriptions, for a 90-day supply. Diabetic supplies fall under the medical equipment/supplies benefit, under major medical, and are paid at 90% after the deductible has been satisfied. Mail order is mandatory for all maintenance medications. Generic medications are also mandatory when an equivalent is available. **Please note that a 90-day supply is also available at your local CVS Pharmacy.*

### 15. Do any of my medications require authorization before they are considered covered?

Yes, for example, authorization is required for drugs utilized to treat narcolepsy, Retin-A and oral contraceptives when prescribed for a medical condition. Have your doctor call to complete the process for these medications to your carrier at the following number: **CVS Caremark: 1-800-626-3046**

The request must include the patient's name, identification number, name of medication and reason (diagnosis) for using the prescription.

### 16. What if I am away from home and need a pharmacy?

CVS Caremark contracts with over 59,000 pharmacies nationwide. You can call the number located on the back of your prescription ID card or go to **www.caremark.com** for information regarding the name and location of a convenient network pharmacy near you.

| General Info | MMO PPO/HSA Plan | |
|---|---|---|
| **Plan Provisions** | **In-Network** | **Out-of-Network** |
| Annual Deductible* | $3,000/Person<br>$6,000/Family | $6,000/Person<br>$12,000/Family |
| Your Share of Covered Expenses | Plan pays 80% for most services, you pay 20% after the deductible. | Plan pays 60% of traditional amount for most services, you pay 40% after deductible and possibly any charges in excess of allowed amount |
| Your annual maximum out-of-pocket expenses* (includes deductible, co-pays, co-insurance and prescription drugs) | $4,000/Person<br>$8,000/Family | $8,000/Person<br>$16,000/Family |
| | *In-network and out-of-network deductibles and out of pocket maximums accumulate simultaneously. | |
| **Emergency Care** | | |
| Urgent Care Centers | 80% after deductible | 60% after deductible |
| **Miscellaneous** | | |
| Enrollment of Dependent Children | Age 26 removal month end | Age 26 removal month end |
| Claim Form Required | One person, per submission | One person, per submission |
| **Hospital Coverage** | | |
| Semi-private room & board | 80% after deductible up to 365 days | 60% after deductible up to 365 days |
| Operating Room/Recovery Room | 80% after deductible | 60% after deductible |
| Birthing Rooms | 80% after deductible | 60% after deductible |
| Inpatient Psychiatric | 80% after deductible | 60% after deductible |
| Inpatient/Outpatient Lab, X-Rays, Diagnostic Procedures | 80% after deductible | 60% after deductible |
| | Maximum allowable cost applies: members are responsible for charges in excess of the maximum allowable cost for outpatient lab and diagnostic procedures. | |

*continued on page 14*

These comparison forms describe the essential features of the health plans in general terms. They are not intended to be full descriptions of coverages. The complete plans are described in the Certificate of Coverage and Summary of Benefits and Coverage (SBC) issued by each plan and are available upon request to all interested persons.

| MMO PPO Plan | | MetroSelect EPO Plan |
|---|---|---|
| **In-Network** | **Out-of-Network** | **In-Network Benefits Only** |
| $1,000/Person<br>$2,000/Family | $2,000/Person<br>$4,000/Family | $500/Person<br>$1,000/Family |
| Plan pays 80% for most services, you pay 20% after deductible. | Plan pays 60% of traditional amount for most services, you pay 40% after deductible and possibly any charges in excess of allowed amount. | Plan pays 90% for most services, you pay 10% after. |
| $3,000/Person<br>$6,000/Family | $6,000/Person<br>$12,000/Family | $2,000/Person<br>$4,000/ Family |
| *In-network and out-of-network deductibles and out of pocket maximums accumulate simultaneously. | | |
| 100% after $30 co-pay | 60% after deductible | 100% after $25 co-pay |
| Age 26 removal month end | Age 26 removal month end | Age 26 removal month end |
| One person, per submission | One person, per submission | One person, per submission |
| 80% after deductible up to 365 days | 60% after deductible up to 365 days | 90% after deductible up to 365 days |
| 80% after deductible | 60% after deductible | 90% after deductible |
| 80% after deductible | 60% after deductible | 90% after deductible |
| 80% after deductible | 60% after deductible | 90% after deductible |
| 80% after deductible | 60% after deductible | 90% after deductible |
| Maximum allowable cost applies: members are responsible for charges in excess of the maximum allowable cost for outpatient lab and diagnostic procedures. | | |

# [Catholic Diocese of Cleveland Health Plans cont.]

*continued from page 13*

| General Info | MMO PPO/HSA Plan | |
|---|---|---|
| **Plan Provisions** | **In-Network** | **Out-of-Network** |
| Anesthesia/Medicines/Drugs | 80% after deductible | 60% after deductible |
| Hospital Emergency Room Services | 80% after deductible | 60% after deductible |
| Nursing Services in the Home | 80% after deductible | 60% after deductible |
| Skilled Nursing Care Facility | 80% after deductible (limited to 120 days per calendar year) | 60% after deductible (limited to 120 days per calendar year) |
| Hospice Care | 80% after deductible | 60% after deductible |
| Chemotherapy | 80% after deductible | 60% after deductible |
| Speech Therapy (Outpatient) | 80% after deductible (20 visits per calendar year) if illness/accident related | 60% after deductible (20 visits per calendar year) if illness/accident related |
| Physical/Occupational Therapy (Outpatient) | 80% after deductible (40 visits per calendar year) if illness/accident related | 60% after deductible (40 visits per calendar year) if illness/accident related |
| Radiation Therapy | 80% after deductible | 60% after deductible |
| Diagnostic Office Calls | 80% after deductible | 60% after deductible |
| Specialist Office Calls | 80% after deductible | 60% after deductible |
| Surgical Procedures | 80% after deductible | 60% after deductible |
| Assistant Surgeon | 80% after deductible | 60% after deductible |
| Inpatient Consultations | 80% after deductible | 60% after deductible |
| Inpatient Daily Visits | 80% after deductible | 60% after deductible |
| Allergy Testing | 80% after deductible | 60% after deductible |

*continued on page 16*

| MMO PPO Plan | | MetroSelect EPO Plan |
|---|---|---|
| In-Network | Out-of-Network | In-Network Benefits Only |
| 80% after deductible | 60% after deductible | 90% after deductible |
| $150 co-pay then 100% if accident-related or life-threatening; otherwise $500 co-pay, then 60% after deductible | $150 co-pay then 100% if accident-related or life-threatening; otherwise $500 co-pay, then 60% after deductible | $150 co-pay then 100% if accident-related or life-threatening; otherwise $500 co-pay, then 60% after deductible † |
| 80% after deductible | 60% after deductible | 90% after deductible |
| 80% after deductible (limited to 120 days per calendar year) | 60% after deductible (limited to 120 days per calendar year) | 90% after deductible (limited to 120 days per calendar year) |
| 100% | 60% after deductible | 100% |
| 80% after deductible | 60% after deductible | 90% after deductible |
| 80% after deductible (20 visits per calendar year) if illness/accident related | 60% after deductible (20 visits per calendar year) if illness/accident related | 90% after deductible (20 visits per calendar year) if illness/accident related |
| 80% after deductible (40 visits per calendar year) if illness/accident related | 60% after deductible (40 visits per calendar year) if illness/accident related | 90% after deductible (40 visits per calendar year) if illness/accident related |
| 80% after deductible | 60% after deductible | 90% after deductible |
| 100% after $25 co-pay | 60% after deductible | 100% after $20 co-pay |
| 100% after $50 co-pay | 60% after deductible | 100% after $40 co-pay |
| 80% after deductible | 60% after deductible | 90% after deductible |
| 80% after deductible | 60% after deductible | 90% after deductible |
| 80% after deductible | 60% after deductible | 90% after deductible |
| 80% after deductible | 60% after deductible | 90% after deductible |
| 80% after deductible | 60% after deductible | 90% after deductible |
| | | † *Please go to any medical facility in the event of an emergency; claims will be processed as if they were incurred at a MetroHealth facility.* |

*continued from page 15*

| General Info | MMO PPO/HSA Plan | |
|---|---|---|
| **Plan Provisions** | **In-Network** | **Out-of-Network** |
| **Maternity Services** | | |
| Prenatal & Postnatal Care | 80% after deductible | 60% after deductible |
| Delivery Charges | 80% after deductible | 60% after deductible |
| Well Baby Care In Hospital | 80% after deductible | 60% after deductible |
| **Mental Health Care & Substance Abuse** | | |
| Outpatient Psychiatric Testing | 80% after deductible | 60% after deductible |
| Outpatient Psychiatric Service | 80% after deductible | 60% after deductible |
| Inpatient Psychiatric | 80% after deductible | 60% after deductible |
| **Outpatient Diagnostic Procedures** | | |
| Laboratory Test | 80% after deductible | 60% after deductible |
| Diagnostic X-Rays | 80% after deductible | 60% after deductible |
| Surgical Pathology | 80% after deductible | 60% after deductible |
| **Preventive Services** | | |
| Immunizations | 100% | 60% after deductible |
| Sterilization | Not Covered | Not Covered |
| Annual Physical Exam | 100% | 60% after deductible |
| Well Child Care to Age 21 | 100% | 60% after deductible |
| Pap Test | 100% | 60% after deductible |
| Mammogram | 100% | 60% after deductible |
| Routine Colonoscopy | 100% (Age 45 and older) | 60% after deductible (Age 45 and older) |
| Nutritional Counseling/ Diabetes Education/Smoking Cessation | 100%, Smoking Cessation covered at 80% after deductible | 60% after deductible |

***continued on page 18***

| MMO PPO Plan | | MetroSelect EPO Plan |
|---|---|---|
| In-Network | Out-of-Network | In-Network Benefits Only |
| 80% after deductible | 60% after deductible | 90% after deductible |
| 80% after deductible | 60% after deductible | 90% after deductible |
| 80% after deductible | 60% after deductible | 90% after deductible |
| 80% after deductible | 60% after deductible | 90% after deductible |
| 100% after $25 co-pay | 60% after deductible | 100% after $20 co-pay |
| 80% after deductible | 60% after deductible | 90% after deductible |
| 80% after deductible | 60% after deductible | 90% after deductible |
| 80% after deductible | 60% after deductible | 90% after deductible |
| 80% after deductible | 60% after deductible | 90% after deductible |
| 100% | 60% after deductible | 100% |
| Not Covered | Not Covered | Not Covered |
| 100% | 60% after deductible | 100% |
| 100% | 60% after deductible | 100% |
| 100% | 60% after deductible | 100% |
| 100% | 60% after deductible | 100% |
| 100% (Age 45 and older) | 60% after deductible (Age 45 and older) | 100% (Age 45 and older) |
| 100% | 60% after deductible | 100% |

# [Catholic Diocese of Cleveland Health Plans cont.]

*continued from page 17*

| General Info | MMO PPO/HSA Plan | |
|---|---|---|
| **Plan Provisions** | **In-Network** | **Out-of-Network** |
| **Other Outpatient Services** | | |
| Routine Eye Exams | Not Covered | Not Covered |
| Durable Medical Equipment | 80% after deductible | 60% after deductible |
| Prescriptions (excluding birth control pills, devices and vitamins) | **Subject to deductible and coinsurance then**: **Retail (up to 30-day supply):** Generic: $10 co-pay, Formulary Brand: 20% w/$25 min. & $75 max. co-pay, Non-Formulary Brand: 40% w/$40 min. & $150 max. co-pay **Mail Order (up to 90-day supply):** Generic: $25 co-pay, Formulary Brand: 20% w/$60 min. & $150 max., Non-Formulary Brand: 40% w/$90 min. & $300 max. **(Provider: CVS Caremark) Preventive Drugs: not subject to deductible** | **Retail (up to 30-day supply):** 25% of the drug plus applicable co-pay **(Provider: CVS Caremark)** |
| Ambulance | 80% after deductible only when medically necessary | 60% after deductible only when medically necessary |
| Allergy Injections | 80% after deductible | 60% after deductible |
| Skilled Nursing Care | 80% after deductible | 60% after deductible |
| Chemotherapy | 80% after deductible | 60% after deductible |
| Radiation Therapy | 80% after deductible | 60% after deductible |
| **Hearing** | | |
| **Benefit Description** | **Dollar Maximum** | **Frequency** |
| Benefit Period | January 1 through December 31 | |
| Coinsurance | **Subject to medical deductible and coinsurance** | |
| Audiometric Exam | 100% after deductible | Unlimited |
| Hearing Aid Evaluation | 100% after deductible | Unlimited |
| Conformity Evaluation | 100% after deductible | Unlimited |
| Hearing Aids (includes dispensing fee) | 100% after deductible | 1 per ear every 36 months |

| MMO PPO Plan | | MetroSelect EPO Plan |
|---|---|---|
| **In-Network** | **Out-of-Network** | **In-Network Benefits Only** |
| Not Covered | Not Covered | Not Covered |
| 80% after deductible | 60% after deductible | 90% after deductible |
| **Retail (up to 30-day supply):** Generic: $10 co-pay Formulary Brand: 20% w/$25 min. & $75 max. co-pay Non-Formulary Brand: 40% w/$40 min. & $150 max. co-pay **Mail Order (up to 90-day supply):** Generic: $25 co-pay Formulary Brand: 20% w/$60 min. & $150 max. Non-Formulary Brand: 40% w/$90 min. & $300 max. **(Provider: CVS Caremark)** | **Retail (up to 30-day supply):** 25% of the drug plus applicable co-pay **(Provider: CVS Caremark)** | **MetroHealth Pharmacies – Retail (up to 30-day supply):** Generic: $10 co-pay Formulary Brand $20 co-pay Non-Formulary Brand: $40 co-pay **Mail Order (up to 90-day supply):** Generic: $10 co-pay Formulary Brand $50 co-pay Non-Formulary Brand: $80 co-pay<br>**CVS Caremark Pharmacies – Retail (up to 30-day supply):** Generic: $10 co-pay Formulary Brand 20% w/$25 min. & $75 max. co-pay Non-Formulary Brand: 40% w/$40 min. & $150 max. co-pay **Mail Order (up to 90-day supply):** Generic: $25 co-pay Formulary Brand 20% w/$60 min. & $150 max. co-pay Non-Formulary Brand: 40% w/$90 min. & $300 max. co-pay |
| 80% after deductible only when medically necessary | 60% after deductible only when medically necessary | 90% after deductible only when medically necessary |
| 80% after deductible | 60% after deductible | 90% after deductible |
| 80% after deductible | 60% after deductible | 90% after deductible |
| 80% after deductible | 60% after deductible | 90% after deductible |
| 80% after deductible | 60% after deductible | 90% after deductible |

| Dollar Maximum | Frequency | Dollar Maximum | Frequency |
|---|---|---|---|
| January 1 through December 31 | | January 1 through December 31 | |
| Plan pays 100% traditional amount | | Plan pays 100% traditional amount | |
| 100% traditional amount | Unlimited | 100% traditional amount | Unlimited |
| 100% traditional amount | Unlimited | 100% traditional amount | Unlimited |
| 100% traditional amount | Unlimited | 100% traditional amount | Unlimited |
| 100% traditional amount | 1 per ear every 36 months | 100% traditional amount | 1 per ear every 36 months |

# [Dental]

Coverage for necessary dental care is automatically included for those enrolled in any Health Care Plan offered by the Diocese of Cleveland. The coverage is also available as a stand-alone benefit for eligible participants. Participants can choose between the Standard Dental, PPO or High Option PPO Plans.

**The Standard Dental Plan** is NOT a preferred provider program and allows you to use any licensed dental provider. As an added feature of this Plan, MetLife provides advantages when using one of their network providers, including negotiated discounts for non-covered services or after your annual/lifetime maximums have been reached (subject to state approval). Additionally, you are guaranteed not to be balance billed for charges in excess of the negotiated fee when using a MetLife network provider. To locate a participating MetLife provider, you can call 1-800-942-0854 or access the MetLife Provider Finder at www.metlife.com.

**The PPO Dental Plan** is a preferred provider dental program which allows you to receive a higher level of benefits when utilizing a dentist in the MetLife network. You are not required to sign up with a Primary Care Dentist (PCD) in order to receive services, and no ID card is required. However, you must use a dentist in the MetLife network in order to receive the highest level of benefits. This program also provides you with no balance billing from the MetLife network providers.

**The High Option PPO Dental Plan** provides benefits in the same manner as the PPO Dental Plan. Members are able to purchase a higher level of benefits for a monthly contribution (see Page 21).

Note: Certain procedures are considered to be surgical, such as impacted wisdom teeth and osseous surgery, and may be covered under your medical plan rather than the dental plan.

*Diocese of Cleveland*
## Dental Benefit Comparison

| | Standard Plan | PPO Plan | | High Option PPO Plan (Buy-Up) | |
|---|---|---|---|---|---|
| | | In-Network | Out-of-Network | In-Network | Out-of-Network |
| Annual Maximum | $750 | $1000 | | $1250 | |
| Deductible | $50 Individual<br>$150 Family | $100 per Individual | | $50 Individual<br>$150 Family | |
| Dependent Child Maximum Age | Age 26 removal month end | Age 26 removal month end | | Age 26 removal month end | |
| Emergency Palliative Treatment | 80% traditional amount | 100% | | 100% | |
| Preventive Services (Annual Cleanings, Exams & Bitewing X-Rays, etc.) | 80% traditional amount (No Deductible) | 100% (No Deductible) | 50% traditional amount | 100% (No Deductible) | 50% traditional amount |
| Essential Services (Fillings, Root Canals, Extractions) | 50% traditional amount | 70% | 50% traditional amount | 80% | 50% traditional amount |
| Periodontal Surgery | 50% traditional amount | 70% | 50% traditional amount | 60% | 50% traditional amount |
| Complex Services (Crowns, Partials) | 50% traditional amount | 60% | 50% traditional amount | 60% | 50% traditional amount |
| Orthodontia (dependent Children only to the age of 18) | 50% traditional amount ($100 Deductible) | 60% (No Deductible) | 50% ($100 Deductible) | 60% (No Deductible) | 50% ($100 Deductible) |
| Orthodontia Lifetime Max | $750 | $750 | | $750 | |

Please note: This is not intended to represent a complete listing of all benefits, limitations and exclusions.

*Catholic Diocese of Cleveland*

## Health Care Plans - Monthly Rates - Effective July 1, 2018

| | MMO PPO/HSA | MMO PPO | MetroSelect EPO | Standard Dental[1] | PPO Dental[1] | High Option PPO Dental[2] | VSP |
|---|---|---|---|---|---|---|---|
| Total Plan Cost (Normal part-time employee rate | | | | | | | |
| Single - no incentive | $589 | $686 | $612 | $27 | $27 | $42 | $9 |
| - one incentive | $574 | $671 | $597 | N/A[4] | N/A[4] | N/A[4] | N/A[4] |
| - two incentives | $559 | $656 | $582 | N/A[4] | N/A[4] | N/A[4] | N/A[4] |
| Family - no incentive | $1,504 | $1,849 | $1,649 | $53 | $53 | $82 | $24 |
| - one incentive | $1,474 | $1,819 | $1,619 | N/A[4] | N/A[4] | N/A[4] | N/A[4] |
| - two incentives | $1,444 | $1,789 | $1,589 | N/A[4] | N/A[4] | N/A[4] | N/A[4] |
| Medicare | N/A | $474 | N/A | $27 | $27 | $42 | $9 |
| Medicare no Rx | N/A | $259 | N/A | $27 | $27 | $42 | $9 |
| Normal Employee Cost - No Incentive | | | | | | | |
| Single | $62 | $159 | $141 | $0 | $0 | $15 | $9 |
| Family | $237 | $582 | $517 | $0 | $0 | $29 | $24 |
| Normal Employee Cost - One Incentive | | | | | | | |
| Single | $47 | $144 | $126 | N/A[4] | N/A[4] | N/A[4] | N/A[4] |
| Family | $207 | $552 | $487 | N/A[4] | N/A[4] | N/A[4] | N/A[4] |
| Normal Employee Cost - Two Incentives | | | | | | | |
| Single | $32 | $129 | $111 | N/A[4] | N/A[4] | N/A[4] | N/A[4] |
| Family | $177 | $522 | $457 | N/A[4] | N/A[4] | N/A[4] | N/A[4] |
| Employer Cost - All Incentives[3] | | | | | | | |
| Single | $527 | $527 | $471 | $27 | $27 | $27 | $0 |
| Family | $1,267 | $1,267 | $1,132 | $53 | $53 | $53 | $0 |
| | A spousal surcharge, where applicable, adds $650 per month to the family plan premiums stated in the table. | | | | | | |

1 Rate paid by employer for participant not selecting a medical plan. PPO and EPO rates include choice of Standard or PPO Dental.

2 Employees covered with a medical plan pay the difference in cost for the High Option PPO Dental.

3 Employer cost remains the same regardless of the incentives earned by the employee.

4 Incentives do not apply to dental only and vision coverage.

# [Vision Service Plan®]

## Your Vision Benefits Summary

Get access to the best in eye care and eyewear with CATHOLIC DIOCESE OF CLEVELAND and VSP® Vision Care.

### Using your VSP benefit is easy.

- **Create an account at vsp.com.** Once your plan is effective, review your benefit information.
- **Find an eye doctor who's right for you.** The decision is yours to make—choose a VSP network doctor, a participating retail chain, or any out-of-network provider. Visit **vsp.com** or call **800.877.7195.**
- **At your appointment, tell them you have VSP.** There's no ID card necessary. If you'd like a card as a reference, you can print one on **vsp.com**.

**That's it! We'll handle the rest**—there are no claim forms to complete when you see a VSP provider.

### Best Eye Care

You'll get the highest level of care, including a WellVision Exam®– the most comprehensive exam designed to detect eye and health conditions. Plus, when you see a VSP provider, you'll get the most out of your benefit, have lower out-of-pocket costs, and your satisfaction is guaranteed.

### Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options. Choose from featured frame brands like bebe®, CALVIN KLEIN, Cole Haan, Flexon®, Lacoste, Nike, Nine West, and more.[1] Visit **vsp.com** to find a Premier Program location that carries these brands. Plus, save up to 40% on popular lens enhancements.[2] Prefer to shop online? Check out all of the brands at **eyeconic.com®**, VSP's preferred online eyewear store.

### Plan Information

**VSP Provider Network:** VSP Signature

CATHOLIC DIOCESE OF CLEVELAND and VSP provide you with an affordable eyecare plan.

Visit **vsp.com** or call **800.877.7195** for more details on your vision coverage and exclusive savings and promotions for VSP members.

1. Brands/Promotion subject to change.
2. Savings based on network doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Available only through VSP network doctors to VSP members with applicable plan benefits. Ask your VSP network doctor for details.



| Benefit | Description | Copay |
|---|---|---|
| **Your Coverage with a VSP Provider** | | |
| **WellVision Exam** | • Focuses on your eyes and overall wellness<br>• Every plan year (July) | $10 |
| **Prescription Glasses** | | $15 |
| **Frame** | • $130 allowance for a wide selection of frames<br>• $150 allowance for featured frame brands<br>• 20% savings on the amount over your allowance<br>• $70 Costco® frame allowance<br>• Every plan year (July) | Included in Prescription Glasses |
| **Lenses** | • Single vision, lined bifocal, and lined trifocal lenses<br>• Polycarbonate lenses for dependent children<br>• Every plan year (July) | Included in Prescription Glasses |
| **Lens Enhancements** | • Tints/Photochromic adaptive lenses<br>• Standard progressive lenses<br>• Premium progressive lenses<br>• Custom progressive lenses<br>• Average savings of 35-40% on other lens enhancements<br>• Every plan year (July) | $0<br>$50<br>$80 - $90<br>$120 - $160 |
| **Contacts (instead of glasses)** | • $130 allowance for contacts; copay does not apply<br>• Contact lens exam (fitting and evaluation)<br>• Every plan year (July) | Up to $60 |
| **Diabetic Eyecare Plus Program** | • Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.<br>• As needed | $20 |
| **Extra Savings** | **Glasses and Sunglasses**<br>• Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details.<br>• 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam. | |
| | **Retinal Screening**<br>• No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam | |
| | **Laser Vision Correction**<br>• Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities<br>• After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor | |

**Your Coverage with Out-of-Network Providers**

Get the most out of your benefits and greater savings with a VSP network doctor. Your coverage with out-of-network providers will be less or you'll receive a lower level of benefits. Visit **vsp.com** for plan details.

| | | | |
|---|---|---|---|
| Exam | up to $50 | Lined Trifocal Lenses | up to $100 |
| Frame | up to $70 | Progressive Lenses | up to $75 |
| Single Vision Lenses | up to $50 | Contacts | up to $105 |
| Lined Bifocal Lenses | up to $75 | Tints | up to $5 |

*Plan year begins in July

# Your Personal Prescription Benefit Program
## CVS Caremark MMO Plans

Welcome to your new prescription benefit plan, managed by CVS Caremark. Your plan is designed to bring you quality pharmacy care that can help you save money.

Following is a brief summary of your prescription benefits. You will find details about Maintenance Choice®, which offers two ways for you to save on your long-term medications. CVS Caremark and the Catholic Diocese Cleveland are confident you will find value with your new prescription benefit program.

| | Network Retail Pharmacy | CVS/pharmacy | Mail Service Pharmacy |
|---|---|---|---|
| **When to Use Your Benefit:** | For immediate and short-term medication needs | For immediate and long-term* medication needs | For long-term medication needs |
| **Where:** | The CVS Caremark Retail Program includes more than 64,000 participating pharmacies nationwide, including independent pharmacies and chain pharmacies. To locate a CVS Caremark participating retail network pharmacy in your area, simply click on "Find a Pharmacy" at www.caremark.com or call toll-free at 1-888-607-4287. | You have the convenience of getting your long-term medications, for a 90-day supply, at one of our 6,900 CVS/pharmacy locations for your mail service copay. You also have the convenience of getting your 30-day prescriptions at your local CVS/pharmacy. To locate a CVS/pharmacy in your area, click on "Find a Pharmacy" at Caremark.com. | Simply mail your original prescription and the mail service order form to CVS Caremark. Your medications will be sent directly to your home, office or a location of your choice. |
| **Copay** up to a 30-Day Supply:** | • **$10** for each generic medication<br>• **20%** (**$25 min, $75 max**) for each brand-name medication on the drug list<br>• **40%** (**$40 min, $150 max**) for each brand-name medication **not** on the drug list | • **$10** for each generic medication<br>• **20%** (**$25 min, $75 max**) for each brand-name medication on the drug list<br>• **40%** (**$40 min, $150 max**) for each brand-name medication **not** on the drug list | Up to a **90**-day supply<br>**$25** for each generic medication<br>• **20%** (**$60 min, $150 max**) for each brand-name medication on the drug list<br>• **40%** (**$90 min, $300 max**) for each brand-name medication **not** on the drug list |
| **Refill Limit:** | One initial fill plus two refills for long-term medications | None | |
| **90-Day Supply:** | **Not Available** | • **$25** for each generic medication<br>• **20%** (**$60 min, $150 max**) for each brand-name medication on the drug list<br>• **40%** (**$90 min, $300 max**) for each brand-name medication **not** on the drug list | |
| **Web Services:** | Register at Caremark.com to access tools that can help you save money and manage your prescriptions. To register, have your Prescription Card ready. | | |
| **Customer Care:** | Visit Caremark.com or call toll-free at 1-844-431-4882 | | |

**When a generic is available, but the pharmacy dispenses the brand-name medication for any reason, you will pay the difference between the brand-name medication and the generic plus the brand copayment.**

*A long-term medication is taken regularly for chronic conditions or long-term therapy. A few examples include medications for managing high blood pressure, asthma, diabetes, or high cholesterol.

**Copayment, copay or coinsurance means the amount a plan member is required to pay for a prescription in accordance with a Plan, which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan.

Under the MMO/PPO Plan, once the out-of-pocket of $3,000 (single)/ $6,000 (family) is reached a $0 co-payment will apply.

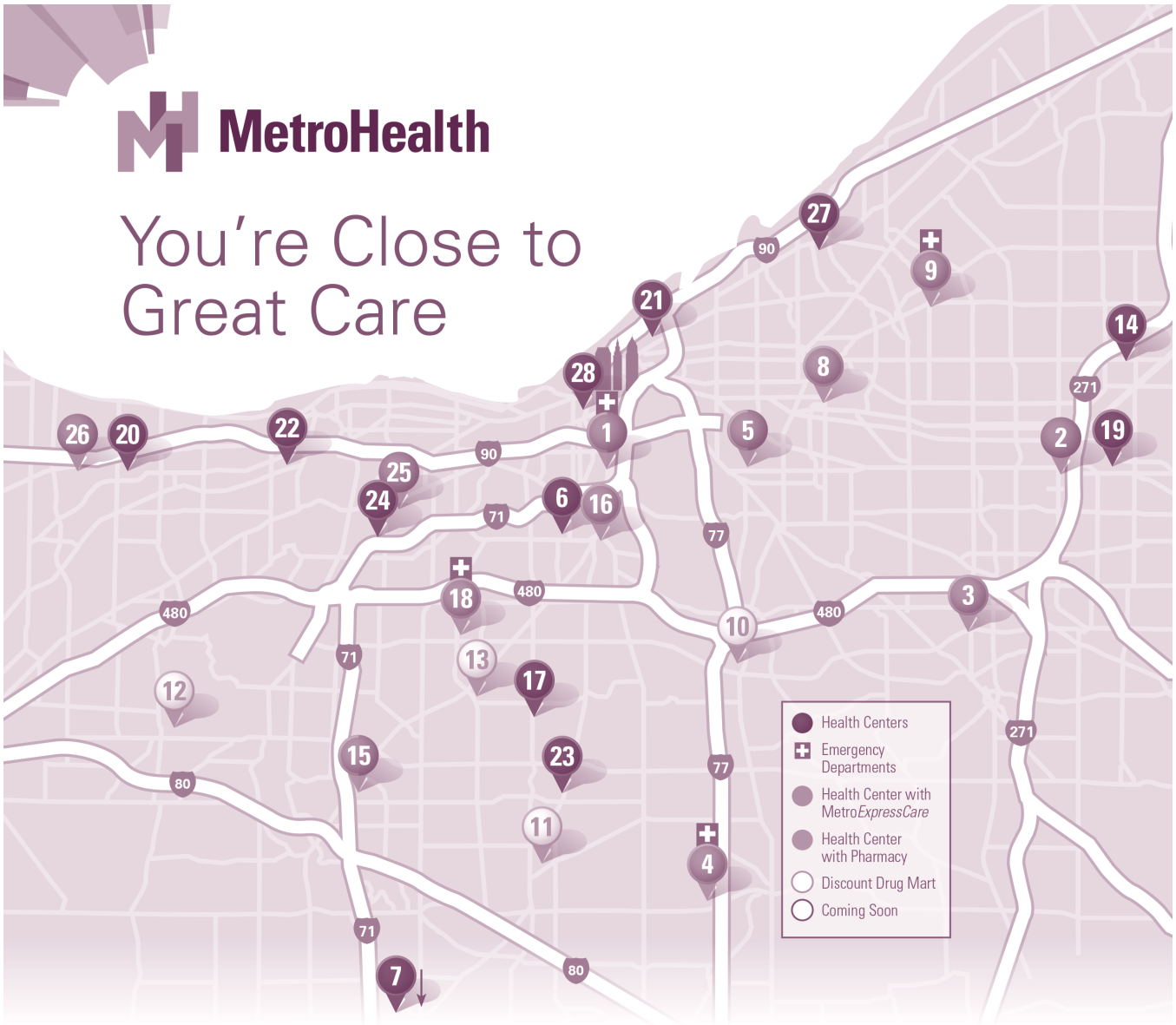
Under the MMO PPO/HSA Plan, prescriptions for drugs that are considered preventive medications (see Preventive Drug List at **www.MyDOCBenefits.com**) have the same co-payments shown above for the SuperMed PPO Plan. You pay the full cost of prescriptions that are not considered preventive until the annual deductible has been met. After the annual combined medical and prescription drug deductible of $3,000 per person and $6,000 per family has been met, any prescription drugs will have the normal prescription co-payments apply until the out-of-pocket maximum is met, then paid at 100%. The maximum combined in-network medical and prescription drug out-of-pocket expense you will pay in a calendar year under this plan is $4,000 for single coverage and $8,000 for family coverage.

Some drugs are formulary exclusions that are subject to prior approval. If not approved, you will be required to pay the full amount. Call CVS Caremark Customer Care at 844-431-4882 to see if a drug is covered.

Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.

MetroHealth

# You're Close to Great Care




1 MetroHealth Medical Center Main Campus
2 Beachwood Health Center
3 Bedford Medical Offices
4 Brecksville Health & Surgery Center
5 Broadway Health Center
6 Brooklyn Health Center
7 Brunswick Health Center
8 Buckeye Health Center
9 Cleveland Heights Medical Offices

**MetroHealth at Discount Drug Mart**
10 Independence
11 North Royalton
12 Olmsted Falls
13 Parma Heights

14 Lyndhurst Health Center
15 Middleburg Heights November Family Health Center
16 Old Brooklyn Health Center
17 Parma Health Center
18 Parma Medical Offices and Ambulatory Surgery Center
19 Pepper Pike Health Center
20 Physical Therapy at West Shore Family YMCA
21 Primary Care at Parker Hannifin Downtown YMCA
22 Rocky River Medical Offices
23 State Road Family Practice
24 West 150th Health and Surgery Center
25 West Park Health Center
26 Westlake Health Center at Crocker Park

*Operating in conjunction with the Cleveland Department of Public Health (in partnership with the city of Cleveland):*
27 J. Glen Smith Health Center
28 Thomas F. McCafferty Health Center

**For a listing of health centers and physicians nearest you, please visit our website: metrohealth.org/locations**

# [Telephone Service Guide]

## *Diocese Of Cleveland*

**Employee Benefits Office**

1404 East 9th Street, 8th Floor • Cleveland, Ohio 44114-1722
www.MyDOCBenefits.com

**Telephone Service Guide**

(216) 621-3700 (Direct Line) or (216) 696-6525 • 1-800-869-6525, ext. 5040 (In Ohio)
Fax Number (216) 621-9622

## Directors

| | | |
|---|---|---|
| Mary Ann Blakeley | Ext. 3930 | mblakeley@dioceseofcleveland.org |
| Donna Speagle | Ext. 8760 | dspeagle@dioceseofcleveland.org |

## Customer Service

| | | |
|---|---|---|
| Millie Gonzalez | Ext. 5060 | mgonzalez@dioceseofcleveland.org |
| Janielle Jones | Ext. 4570 | jjones@dioceseofcleveland.org |
| Eileen Ladden | Ext. 3300 | eladden@dioceseofcleveland.org |
| Elaine Lewis | Ext. 4640 | elewis@dioceseofcleveland.org |
| Mary Vallo | Ext. 1077 | mvallo@dioceseofcleveland.org |

## Additional References

| | |
|---|---|
| **Medical Mutual of Ohio** | **www.medmutual.com** |
| Customer Service Medical | (216) 687-2840 or (800) 610-2583 |
| Preview Managed Care | (800) 338-4114 |
| Mental & Nervous/Substance Abuse | (800) 258-3186 |
| **MetroHealth** | **www.metrohealth.org** |
| Customer Service Medical | (216) 778-7800 |
| **Vision Service Plan® (VSP)** | **www.vsp.com** |
| Customer Service | (800) 877-7195 |
| **MetLife (Dental)** | **www.metlife.com** |
| Customer Service | (800) 942-0854 |
| **CVS Caremark** | **www.caremark.com** |
| Customer Service | (844) 431-4882 |
| Medications Requiring Authorization | (800) 626-3046 |
| **UNUM Long-Term Care Insurance** | **www.unum.com** |
| | (800) 227-4165 |

*Catholic Diocese of Cleveland*

*Diocese of Cleveland Employee Benefits Office*
*1404 East 9th Street, 8th Floor • Cleveland, Ohio 44114-1722*
*(216) 621-3700 or 1-800-869-6525 (In Ohio) • Fax: (216) 621-9622*
*www.MyDOCBenefits.com*