

HEALTH

HEALTH

Catholic Diocese of Cleveland

HEALTH CARE PLANS

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PLANS

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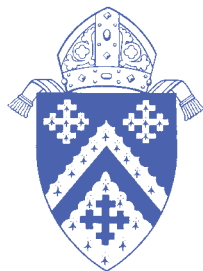
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The Diocese of Cleveland Employee Benefits Office is committed to providing you with quality health care benefits and with the information you need to make wise choices and get the most from your health care dollar. The Catholic Diocese of Cleveland 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, choice of physicians, convenience of facilities to you and your family, and costs – all of which you should carefully consider.

The Diocese offers the following Health Care Plan options for your physician and hospital coverage. The first plan is a preferred provider organization (PPO) and the other two are health maintenance organizations (HMOs):

Medical Mutual SuperMed PPO
Medical Mutual SuperMed HMO
Kaiser Permanente HMO

If you choose SuperMed PPO, you receive maximum benefits and pay the least out of your pocket 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.

Participants in the SuperMed PPO 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.

Each HMO plan requires that you use the HMO’s network physicians and hospitals in order to receive benefits.

Medicare HMO policies are offered for our Medicare primary participants and include Kaiser Permanente, SummaCare Secure, Secure Horizons (AARP Medicare Complete) and Anthem Senior Advantage. Medicare participants who choose an HMO option are no longer involved in any type of claim filing and pay less in premiums. 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, including the PPO and HMOs (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. The SuperMed PPO network is based on the Cleveland Clinic Foundation. 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, 90% after the deductible. Covered benefits received from non-network providers are reimbursed at a lower rate which is generally 70% after the deductible.

KAISER PERMANENTE:

Kaiser Permanente is a group-practice health maintenance organization (HMO). Once you enroll in Kaiser Permanente HMO, you and your family members select a Primary Care Physician (PCP) from their provider list. Depending on your personal health care needs, you may choose a physician specializing in family practice, internal medicine or pediatrics.

When you need medical care from your primary care physician, simply call his or her member service center to schedule an appointment. For answers to medical questions, you may call an emergency advice hotline which is available 24 hours a day. A Primary Care Team – including your physician and other qualified allied health professionals – coordinates all of your care from one of Kaiser Permanente's conveniently located medical offices or from an affiliated community physician. For more information please use the Kaiser Permanente website at www.kp.org.

SUPERMED HMO:

SuperMed HMO is a Medical Mutual of Ohio Health Maintenance Organization that utilizes both a hospital and physician network. Each member of your family selects a Primary Care Physician (PCP) who provides most of your health care services. To receive the highest level of benefits provided by this Plan, 100% in most cases, you must use the HMO physicians. Except for authorized referrals and emergencies, no coverage is provided for services received outside the network.

DENTAL PLANS:

Dental coverage is provided by MetLife to those participants enrolled in any Diocesan Medical Plan, with the exception of Medicare HMOs. Medicare HMOs 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 19 for additional information).

[Your Health Plan Options cont.]

CLAIM FILING/BALANCE BILLINGS:

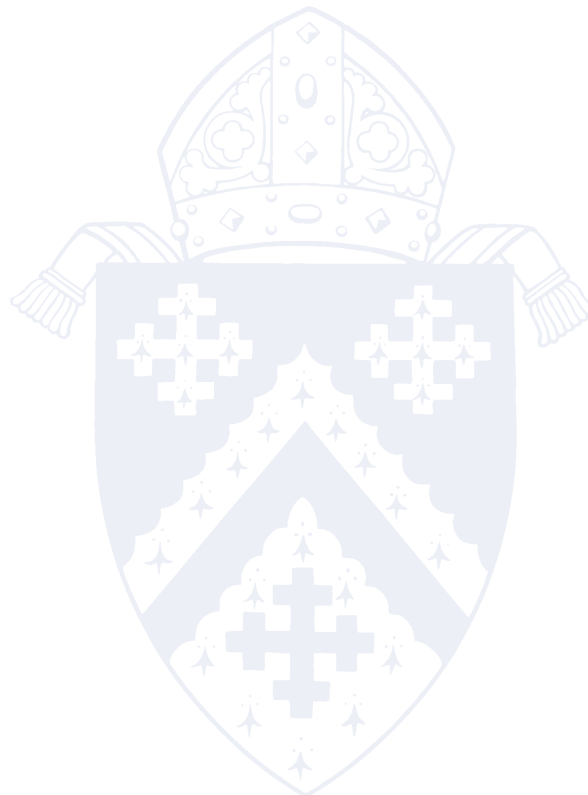
All network providers will file claims for you. Also, they have agreed to accept the network payment as payment in full and will not balance bill you for charges which are above and beyond your required co-payments and deductibles.

VISION SERVICE PLAN®:

Vision Service Plan® (VSP) is an optional program for which you normally 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.



1. Who is eligible for coverage?

- All active, full-time employees of a covered employer who are regularly scheduled to work 35 or more hours per week (20 classroom hours if such employees are teachers). Part-time employees are eligible for coverage at their own expense if they are regularly scheduled to work 20 hours per week. Persons who are contract or leased employees, persons who are temporary or seasonal employees whose employment is expected to last less than 6 months, and persons who have entered into an oral written agreement not to participate in the plan are not eligible.
- Lawful husbands and wives of eligible employees.
- Unmarried children of eligible employees including stepchildren and adopted children, who are eligible as dependents for income tax purposes, and children who are required to be covered under the Plan by court order or decree.
- Retirees, clergy and religious.

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 physician and hospital 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 employee costs are shown on page 20 of this booklet. This can be paid through payroll deductions on a pre-tax basis.

3. 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. An open enrollment for covered employees to change health plans is held in June. Coverage under your new Plan will be effective July 1.

4. 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.

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

The HMO Plans do not contain this clause. SuperMed PPO contains a pre-existing clause; however, a certificate of creditable coverage from a prior employer’s medical plan may offset any applicable waiting period. See Plan document for details.

6. 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 requires a contribution on the part of the participant (see page 20).

7. 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 on the last day of the month in which you terminate.

8. Can I continue coverage after I terminate my employment?

You can continue your current health care coverage after you terminate your employment for a maximum of eighteen (18) months at your own expense under certain conditions. Conversion plans are available after eighteen months from your HMO or PPO by applying directly with the carrier. Conversion plans are not the same as your current coverage in benefit or in cost.

9. 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 insured for the five years immediately preceding retirement and have attained age 55.

10. 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.

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

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 and you are left without coverage, your status changes from part-time to full-time or during the open enrollment period. The Plan's pre-existing condition clause may apply to you and/or your covered family members.

12. 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. 4640 or (216) 621-3700.

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

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

14. 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 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. Clergy may also elect a Medicare HMO option. Under this option, the HMO agrees to assume the full responsibility of paying benefits under the program. Details regarding the Medicare HMOs are available from the Employee Benefits Office.

15. 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 Plan as a result of your membership in your religious order you would be covered regardless of where you work, Medicare will provide primary benefits and the Diocese will become the secondary payer. If you are working outside the order for another employer and you receive medical plan coverage through your employer, your employer's plan will provide primary benefits and Medicare will become the secondary payer. Religious may also elect a Medicare HMO option. Under this option, the HMO agrees to assume the full responsibility of paying benefits under the program. Details regarding the Medicare HMOs are available from the Employee Benefits Office.

16. 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. In addition, Kaiser and SuperMed HMO offer routine eye exams as part of their benefit package.

General Information Regarding Hospital & Physician Services

Depending on the health care option you choose, coverage for physician services is provided by the Medical Mutual of Ohio (MMO) SuperMed PPO Network or one of the Health Maintenance Organizations (HMOs). 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 an HMO, you must use the HMO Hospitals to receive coverage for hospital services. Except for specific referral cases, you will receive no coverage for services provided by hospitals outside of the HMO.

If you enroll in the SuperMed PPO Plan, you can use any hospital you choose. However, the Plan provides higher benefits, 90% after the deductible in most cases, when you use hospitals that are part of the Plan's network. A listing of 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.

[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 shown below.

SUPERMED PLUS	
Ashland County	Samaritan Regional Health Ctr.
Ashtabula County	Ashtabula County Medical Ctr.
	Glenbeigh Hospital
	UH Conneaut Medical Center
	UH Geneva Medical Center
Cuyahoga County	Cleveland Clinic Children's Hospital for Rehabilitation
	Cleveland Clinic Foundation
	Euclid Hospital
	Fairview Hospital
	Grace Hospital- Fairview Campus
	Grace Hospital-Huron Campus
	Grace Hospital-Lakewood Campus
	Grace Hospital-Main Campus
	Hillcrest Hospital
	Huron Hospital
	Kindred Hospital
	Lakewood Hospital
	Lutheran Hospital
	Marymount Hospital
	MetroHealth Center for Rehabilitation
	MetroHealth Medical Center
	Parma Community General Hospital
	Regency Hospital of Cleveland East
	South Pointe Hospital
	Southwest General Health Center
	St. John West Shore Hospital
	St. Vincent Charity Hospital
	Stella Maris Inc.
	UHHS Richmond Heights Hospital
Geauga County	UH Geauga Medical Center
	UH Extended Care Campus
Lake County	UHHS Laurelwood Hospital
	Lake East Hospital
	Lake West Hospital
Lorain County	Allen Medical Center
	Community Health Partners-East Campus
	Community Health Partners-West Campus
	EMH Amherst Hospital
	EMH Regional Medical Center
	Grace Hospital-Amherst Campus
	Specialty Hospital of Lorain
Medina County	Lodi Community Hospital
	Medina General Hospital
	Wadsworth-Rittman Hospital
Portage County	Robinson Memorial Hospital
	Regency Hospital of Ravenna
Stark County	Affinity Medical Center Doctors
	Affinity Medical Center Massillon
	Alliance Community Hospital
	Mercy Medical Center
	Select Specialty Hospital-Northeast OH Canton Campus
Summit County	Akron General Medical Center
	Akron General Health & Wellness
	Akron General Tallmadge Health
	Children's Hospital Medical Center of Akron
	Cuyahoga Falls General Hospital
	Edwin Shaw Rehabilitation Center
	Regency Hospital of Akron
	Select Specialty Hospital-Akron General Medical Center
	Summa Barberton Citizens Hospital
	Summa Health System-Akron City Hospital
	Summa Health System-St. Thomas Medical Center
Wayne County	Dunlap Memorial Hospital
	Wooster Community Hospital

SUPERMED PPO 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 an **HMO**, you must use the HMO physicians to receive coverage for physician services. Except for authorized referral cases, you will receive no coverage for services provided by doctors outside of the HMO.

If you enroll in the **SuperMed PPO Plan** for physician coverage, you can choose to use any qualified physician you wish. But the Plan provides higher benefits when you use doctors who are in the Plan's network of providers. Here's how it works:

In Network: When you use a physician who is in the PPO network, you pay \$15 for each 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 \$250 per person and \$500 per family.

Out-of-Network: Charges for out-of-network physician services are subject to a \$500 per person and \$1000 per family annual deductible and then are paid at 70% of the traditional amount.

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 Plan provides health care coverage through a comprehensive network of hospitals and physicians. This Plan gives 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 PPO Plan, simply use the services of any hospital or physician listed in the provider directory for the Plan. 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.

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 traditional amount.

[SuperMed PPO Health Plan]

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

You can obtain a directory for the SuperMed PPO network by calling the Diocesan Employee Benefits Office at 1-800-869-6525 (in Ohio), extension 4640. Directories can also be obtained by contacting the carrier directly as follows:

Medical Mutual: (888) 241-2583 24 hour toll free • www.medmutual.com (website)

2. What happens if I use a doctor or hospital that is not in the network?

You will receive the out-of-network coverage. Charges will be subject to the higher annual deductible, and then paid at 70% of the traditional amount. The annual deductibles and coinsurance amounts you pay for covered expenses apply toward your annual out-of-pocket maximum.

3. 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, but to receive maximum benefits, you should see a specialist in the network.

4. What if 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 a network provider.

5. What benefit levels are available to me or my dependents who live out of state?

Dependents who live out-of-state should use the out-of-state network listed on the back of your ID card for the highest level of benefits.

6. What happens if I am out of town or one of my dependents is away at school and needs care?

If 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 in other areas of Ohio. Medical Mutual of Ohio also contracts with a national network called First Health Network for services rendered outside Ohio. While traveling outside the state, you can access these networks 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.

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

You will not have any traditional amount issues if you use network hospitals and physicians. The only time the traditional 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. Do my prescription expenses count toward the deductible and the out-of-pocket maximums?

No. Your prescription co-payments do not apply to your deductible or to your maximum out-of-pocket.

Other charges that do not apply to your out-of-pocket maximum include charges in excess of the traditional amounts out-of-network, any services not covered under the plan at all, co-payments for office visits and emergency room visits.

12. 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 name and a 40% co-pay with a \$40 minimum and a \$150 maximum co-pay for non-formulary brand name 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 name and a 40% co-pay with a \$90 minimum and a \$300 maximum co-pay for non-formulary brand name 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 in network and 70% after the deductible for non-network.

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

Yes, for example, authorization is required for drugs utilized to treat narcolepsy, retina-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.

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

CVS Caremark contracts with over 59,000 pharmacies nationwide. Walgreens is not a participating pharmacy under the CVS Caremark program. 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.

[Catholic Diocese of Cleveland Health Plans]

GENERAL INFO		MEDICAL MUTUAL OF OHIO SUPERMED PPO PLAN	
PLAN PROVISIONS	IN-NETWORK	OUT-OF-NETWORK	
Annual Deductible*	\$250/Person \$500/Family	\$500/Person \$1000/Family	
Your Share of Covered Expenses	Plan pays 90% for most services, you pay 10% after deductible.	Plan pays 70% of traditional amount for most services, you pay 30% after deductible and any charges in excess of traditional amount.	
Your annual maximum out-of-pocket expenses* (excludes network office & ER co-payments)	\$1250/Person \$2500/Family	\$2500/Person \$5000/Family	

* SuperMed PPO in-network and out-of-network deductibles and out-of-pocket maximums accumulate simultaneously.

Emergency Care			
Urgent Care Centers		100% after \$15 co-pay	70% after deductible
Miscellaneous			
Enrollment of Dependent Children		Age 25 removal upon birthday	Age 25 removal upon birthday
Claim Form Required		One per person, per submission	One per person, per submission
Hospital Coverage			
Semi-private room & board		90% after deductible up to 365 days	70% after deductible up to 365 days
Operating Room/Recovery Room		90% after deductible	70% after deductible
Birthing Rooms		90% after deductible	70% after deductible
Inpatient Psychiatric		90% after deductible	70% after deductible
Inpatient/Outpatient Lab, X-Rays, Diagnostic Procedures		90% after deductible	70% after deductible

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 Summary Plan Descriptions issued by each plan and are available upon request to all interested persons.

continued on page 13

KAISER PERMANENTE HMO PLAN	MEDICAL MUTUAL SUPERMED HMO
None	\$250 per inpatient admission
100% after \$25 co-pay per visit for most outpatient services.	100% after \$25 co-pay per visit for most outpatient services.
\$2000/Person \$6000/Family	\$1250/Person \$2500/Family (Applies to inpatient services only)

100% after \$25 co-pay	100% after \$25 co-pay
Age 23 month end	Age 23 removal upon birthday
For emergency; non-plan services	None
\$250 co-pay per admission then 100% unlimited days	\$250 co-pay per admission then 90% (\$1250 Max/Ind or \$2500/Family) unlimited days
100%	90% after co-pay
100%	90% after co-pay
\$250 co-pay per admission, then 100%	\$250 co-pay per admission then 90% (\$1250 Max/Ind or \$2500/Family)
100%	100% for outpatient, 90% after co-pay for inpatient

[Catholic Diocese of Cleveland Health Plans cont.]

continued from page 12

GENERAL INFO	MEDICAL MUTUAL OF OHIO SUPERMED PPO PLAN	
	PLAN PROVISIONS	IN-NETWORK
Anesthesia/Medicines/Drugs	90% after deductible	70% after deductible
Hospital Emergency Room Services (Outpatient)	\$50 co-pay then 100% if accident-related or life-threatening; otherwise 90% after deductible	\$50 co-pay then 100% if accident-related or life-threatening; otherwise 70% after deductible
Nursing Services in the Home	90% after deductible	70% after deductible
Skilled Nursing Care Facility	90% after deductible (limited to 120 days per calendar year)	70% after deductible (limited to 120 days per calendar year)
Hospice Care	100% limited to \$150 per day; \$2500 lifetime maximum	70% after deductible limited to \$150 per day; \$2500 lifetime maximum
Chemotherapy	90% after deductible	70% after deductible
Speech Therapy (Outpatient)	90% after deductible (20 visits per calendar year) if illness/accident related	70% after deductible (20 visits per calendar year) if illness/accident related
Physical/Occupational Therapy (Outpatient)	90% after deductible (40 visits per calendar year) if illness/accident related	70% after deductible (40 visits per calendar year) if illness/accident related
Radiation Therapy	90% after deductible	70% after deductible
Routine Office Calls	100% after \$15 co-pay	70% after deductible
Diagnostic Office Calls	100% after \$15 co-pay	70% after deductible
Specialist Office Calls	100% after \$15 co-pay	70% after deductible
Surgical Procedures	90% after deductible	70% after deductible
Assistant Surgeon	90% after deductible	70% after deductible
Inpatient Consultations	90% after deductible	70% after deductible
Inpatient Daily Visits	90% after deductible	70% after deductible
Allergy Testing	90% after deductible	70% after deductible

continued on page 15

KAISER PERMANENTE HMO PLAN	MEDICAL MUTUAL SUPERMED HMO
100%	90% after co-pay
\$50 co-pay per visit. (Waived if admitted.)	100% subject to \$50 co-pay. (Waived if admitted.)
100% when medically necessary & approved by Plan Physician	100%
100 days per calendar year when medically necessary & arranged by Physician	\$250 co-pay per admission (\$500 Max/Ind or \$1250/ Family) then 90% up to 100 days
100%	100%
100%	100%
100% after \$25 co-pay (30 visit limit) if illness/accident related	\$25 co-pay (10 visits per year) if illness/accident related
100% after \$25 co-pay (30 visit limit) if illness/accident related	\$25 co-pay (20 visits per year) if illness/accident related then 100%
100%	100%
100% after \$25 co-pay	100% after \$25 co-pay
100% after \$25 co-pay	100% after \$25 co-pay
100% after \$25 co-pay	100% after \$25 co-pay
100% after \$25 co-pay for outpatient, 100% for inpatient	100% for outpatient, 90% after co-pay for inpatient
100%	90% after co-pay for inpatient; otherwise 100%
100%	90% after co-pay
100%	90% after co-pay
\$25 co-pay	100% after \$25 co-pay

[Catholic Diocese of Cleveland Health Plans cont.]

continued from page 14

GENERAL INFO		MEDICAL MUTUAL OF OHIO SUPERMED PPO PLAN	
PLAN PROVISIONS	IN-NETWORK	OUT-OF-NETWORK	
Maternity Services			
Prenatal & Postnatal Care	90% after deductible	70% after deductible	
Delivery Charges	90% after deductible	70% after deductible	
Well Baby Care In Hospital	90% after deductible	70% after deductible	
Mental Health Care & Substance Abuse			
Outpatient Psychiatric Testing	90% after deductible	70% after deductible	
Outpatient Psychiatric Service	100% after \$15 co-pay	70% after deductible	
Inpatient Psychiatric	90% after deductible	70% after deductible	
Outpatient Diagnostic Procedures			
Laboratory Test	90% after deductible	70% after deductible	
Diagnostic X-Rays	90% after deductible	70% after deductible	
Surgical Pathology	90% after deductible	70% after deductible	
Preventive Services			
Immunizations	100%	70% after deductible	
Sterilization	Not Covered	Not Covered	
Annual Physical Exam	100% after \$15 co-pay	70% after deductible	
Well Baby Care (Doctor's Office Call)	100% after \$15 co-pay	70% after deductible	
Pap Test	100%	70% after deductible	
Mammogram	100%	70% after deductible	
Routine Colonoscopy	90% after deductible (Age 50 and older)	70% after deductible (Age 50 and older)	
<i>continued on page 17</i>			

KAISER PERMANENTE HMO PLAN	MEDICAL MUTUAL SUPERMED HMO
Prenatal covered in full Postnatal – 100% after \$25 co-pay	90% after co-pay for inpatient, 100% after \$25 co-pay for postnatal
100% after co-pay	90% after co-pay
100%	90% after co-pay
\$25 co-pay	100% after \$25 co-pay per visit for outpatient Psychiatric testing and services
\$25 co-pay	
100% after \$250 co-pay	\$250 co-pay per admission then 90% (\$1250 Max/Ind or \$2500/Family)
100%	100%
100%	100%
100%	100%
Most Covered 100%	100%
Not Covered	Not Covered
100% after \$25 co-pay	100% after \$25 co-pay
100% after \$25 co-pay	100% after \$25 co-pay
100% after \$25 co-pay	100%
100%	100%
100% after \$25 co-pay (Age 50 -70) (Age 71 and up consult physician)	100% (Authorized outpatient) (Age 50 and older)

[Catholic Diocese of Cleveland Health Plans cont.]

continued from page 16

GENERAL INFO		MEDICAL MUTUAL OF OHIO SUPERMED PPO PLAN	
PLAN PROVISIONS	IN-NETWORK	OUT-OF-NETWORK	
Routine Eye Exams	Not Covered	Not Covered	
Durable Medical Equipment	90% after deductible	70% after deductible	
Prescriptions (excluding birth control pills, devices and vitamins)	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 Provider: CVS Caremark	Retail 30-day supply 25% of the drug plus applicable co-pay Provider: CVS Caremark	
Ambulance	90% after deductible only when medically necessary	70% after deductible only when medically necessary	
Allergy Injections	90% after deductible	70% after deductible	
Skilled Nursing Care	90% after deductible	70% after deductible	
Chemotherapy	90% after deductible	70% after deductible	
Radiation Therapy	90% after deductible	70% after deductible	
Hearing			
BENEFIT DESCRIPTION	DOLLAR MAXIMUM	FREQUENCY	
Benefit Period	January 1 through December 31		
Coinsurance	Plan pays 100% traditional amount		
Audiometric Exam	100% traditional amount	Unlimited	
Hearing Aid Evaluation	100% traditional amount	Unlimited	
Conformity Evaluation	100% traditional amount	Unlimited	
Hearing Aids (includes dispensing fee)	100% traditional amount	1 per ear every 36 months	

KAISER PERMANENTE HMO PLAN	MEDICAL MUTUAL SUPERMED HMO
\$25 co-pay per visit	\$25 co-pay per visit
Limited to infant apnea monitors, traction, bilirubin lights, oxygen & negative pressure wound dressing	Limited to infant apnea monitors, traction, bilirubin lights & oxygen
\$10 per 31-day supply Mail Order - \$10 per 62-day supply	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 Provider: CVS Caremark
100% when medically necessary and approved by plan physician	100% after \$25 co-pay
100%	100% after \$25 co-pay per visit
100%	100%
100%, \$25 co-pay if office visit	100%
100%, \$25 co-pay if office visit	100%

July 1 through June 30	January 1 through December 31
	N/A
\$25 co-pay	100% after \$25 co-pay
Not Covered	Not Covered
Not Covered	Not Covered
Not Covered	Not Covered

Coverage for necessary dental care is automatically included for those enrolled in any Health Care Plan offered by the Diocese of Cleveland, including HMOs and the PPO (except Medicare HMOs). 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 managed-care 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. 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 managed-care 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 20).

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 \$150 Family	\$100 per Individual		\$50 Individual \$150 Family	
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.

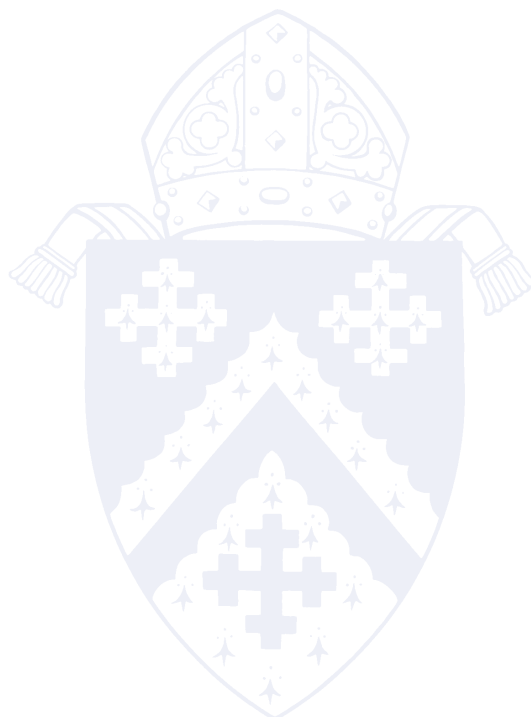
[Health Plan Monthly Rates]

Catholic Diocese of Cleveland HEALTH CARE PLANS - MONTHLY RATES - EFFECTIVE JULY 1, 2010

	PREFERRED PROVIDER (PPO)	HEALTH MAINTENANCE (HMO)		DENTAL ONLY		CONTRIBUTORY OPTIONAL BENEFITS	
	SUPERMED PPO	KAISER	SUPERMED HMO	STANDARD DENTAL ₁	PPO DENTAL ₁	HIGH OPTION PPO DENTAL ₂	VSP
Total Billed Cost							
Single	\$451	\$498	\$451	\$27	\$27	\$42	\$9
Family	\$1,216	\$1,262	\$1,216	\$53	\$53	\$82	\$24
Medicare	\$399	\$301	N/A	\$27	\$27	\$42	\$9
Medicare no Rx	\$207	N/A	N/A	\$27	\$27	\$42	\$9
Normal Employee Cost							
Single	\$67	\$74	\$67	\$0	\$0	\$15	\$9
Family	\$296	\$307	\$296	\$0	\$0	\$29	\$24
Normal Employer Cost							
Single	\$384	\$424	\$384	\$27	\$27	\$27	\$0
Family	\$920	\$955	\$920	\$53	\$53	\$53	\$0

¹ Rate paid by employer for participant not selecting a medical plan. PPO and HMO 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.





Your VSP Vision Benefits

Why enroll in a VSP[®] Vision Care plan? Because we'll help keep you and your eyes healthy with personalized care from a doctor you can trust.

You'll like what you see with VSP:

- **Personalized Care.** Our doctors take the time to get to know you and your eyes. They'll look for vision problems and signs of other health conditions too.
- **Doctor Network.** You'll find the VSP doctor who's right for you at vsp.com or by calling us at 800.877.7195. Our doctors offer flexible hours, a variety of office settings, and eyewear choices you'll love.
- **Value and Savings.** You'll get great savings on your eye exam and eyewear, and discounts on laser vision correction.
- **Satisfaction Guaranteed.** You'll be 100% happy or we'll make it right.

Visit the Eyecare Discovery Center[®] at vsp.com for eye health articles, videos, and interactive games.

Enroll today. You'll be glad you did.

Once enrolled, simply tell your VSP doctor you're a member. We'll handle the rest.

Contact VSP | vsp.com
800.877.7195



11/08 JOB#203CM

Catholic Diocese of Cleveland and VSP provide you with an affordable eyecare plan. Sign up for VSP today.

Your Coverage from a VSP Doctor

WellVision Exam[®] focuses on your eye health and overall wellness

- \$10 copay every plan year (July)

Prescription Glasses

- \$15 copay

Lenses..... every plan year (July)

- Single vision, lined bifocal, lined trifocal lenses and tints
- Polycarbonate lenses for dependent children

Frame..... every plan year (July)

- \$130 allowance for frame of your choice
- 20% off the amount over your allowance

~OR~

Contact Lens Care

- No copay every plan year (July)

\$120 allowance for contacts and the contact lens exam (fitting and evaluation).

Current soft contact lens wearers may qualify for a special program that includes a contact lens exam and initial supply of lenses.

Extra Discounts and Savings

Glasses and Sunglasses

- Average 35 - 40% savings on all non-covered lens options
- 30% off additional glasses and sunglasses, including lens options, from the same VSP doctor on the same day as your WellVision Exam. Or get 20% off from any VSP doctor within 12 months of your last WellVision Exam

Contacts

- 15% off cost of contact lens exam (fitting and evaluation)

Laser Vision Correction

- Average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities.
- After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor

If you see a non-VSP provider, you'll receive a lesser benefit. Before seeing a non-VSP provider, call us at 800.877.7195 for more details.

Out-of-Network Reimbursement Amounts:

Exam	Up to \$35
Single vision lenses	Up to \$25
Lined bifocal lenses	Up to \$40
Lined trifocal lenses	Up to \$55
Frame	Up to \$45
Contacts	Up to \$105

VSP guarantees service from VSP doctors only. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail.

Your Personal Prescription Benefit Program

CVS Caremark/MMO Plans

	Retail Program	Mail Service Pharmacy
When to Use Your Benefit:	For immediate or short-term medicine needs	For maintenance or long-term medicine needs
Where:	At over 62,000 CVS Caremark participating retail pharmacies nationwide, including over 20,000 independent community pharmacies. To locate a CVS Caremark participating retail network pharmacy in your area, simply click on "Find a Local Pharmacy" at www.caremark.com or call a Customer Care representative toll-free at 1-800-776-1355.	Simply mail your original prescription and the mail service order form to CVS Caremark. Your medicines will be sent directly to your home, office or a location of your choice.
Your Copay*:	<ul style="list-style-type: none"> • \$10 for each generic medicine • 20% (\$25 min, \$75 max) for each brand-name medicine on the drug list • 40% (\$40 min, \$150 max) for each brand-name medicine not on the drug list 	<ul style="list-style-type: none"> • \$25 for each generic medicine • 20% (\$60 min, \$150 max) for each brand-name medicine on the drug list • 40% (\$90 min, \$300 max) for each brand-name medicine not on the drug list
Day Supply Limit:	30-day supply	90-day supply
Refill Limit:	None	None
Web Services:	Register at www.caremark.com to access tools that can help you save money and manage your prescription benefit. To register, have your benefit ID card ready.	
Customer Care:	Call toll-free 1-800-776-1355 or visit www.caremark.com	

*Copayment, copay or coinsurance means the amount a plan participant 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.

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

20906-SUM50-0409



[Notes]

[Telephone Service Guide]

Diocese Of Cleveland

Employee Benefits Office

1404 East 9th Street, 8th Floor • Cleveland, Ohio 44114-1722

Telephone Service Guide

(216) 621-3700 (Direct Line) or (216) 696-6525 • 1-800-869-6525, ext. 4640 (In Ohio)
Fax Number (216) 621-9622

DIRECTOR

Palmira A. Juras	Ext. 4590	pjuras@dioceseofcleveland.org
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CUSTOMER SERVICE

Laurie George	Ext. 5060	lgeorge@dioceseofcleveland.org
Janielle Jones	Ext. 4570	jjones@dioceseofcleveland.org
Elaine Lewis	Ext. 4640	elewis@dioceseofcleveland.org
Debbie Morris	Ext. 3300	dmorris@dioceseofcleveland.org

ADDITIONAL REFERENCES

Medical Mutual of Ohio

Customer Service Medical	(216) 687-2840 or (800) 610-2583
Preview Managed Care	(800) 338-4114
Mental & Nervous/Substance Abuse	(800) 258-3186

Kaiser Permanente

Customer Service	(216) 621-7100 or (800) 686-7100
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Vision Service Plan® (VSP)

Customer Service	(800) 877-7195
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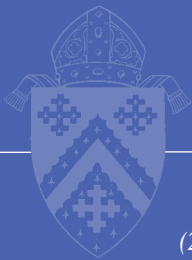
MetLife (Dental)

Customer Service	(800) 942-0854
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CVS Caremark

Customer Service	(800) 776-1355
Medications Requiring Authorization	(800) 626-3046

UNUM Long Term Care Insurance	(800) 227-4165
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Catholic Diocese of Cleveland

*Diocese of Cleveland Employee Benefits Office
1404 East 9th Street, 8th Floor • Cleveland, Ohio 44114-1722
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