

Section Six

HBP MEMBERS' RIGHTS AND RESPONSIBILITIES

This section of the *Summary Plan Description (SPD)* includes information about Health Benefit Program (HBP) members' rights and responsibilities. You will find information about:

- Benefit Determination for Claims
- Filing a Complaint
- Appeals Process
- Reimbursement and Subrogation Rights of the HBP
- The Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- Employee Retirement Income Security Act of 1974 (ERISA)
- Statement of Your Rights Under ERISA

Benefit Determination for Claims

Urgent Care Claims

An **Urgent Care Claim** is a claim for Medical Care or treatment where applying the timeframes for non-urgent care could:

1. seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or
2. in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Determination of **urgent** can be made by:

1. an individual acting on behalf of the Benefit Program and applying the judgment of a prudent lay person who possesses an average knowledge of medicine; or
2. any physician with knowledge of the claimant's medical condition can determine that a claim involves urgent care.

If you file an Urgent Care Claim in accordance with the Benefit Program's claim procedures and all of the required information is received, the Benefit Program will notify you of its benefit determination, whether adverse or not, as soon as possible but not later than 72 hours after the Benefit Program's receipt of the claim.

If you do not follow the Benefit Program's procedures or we do not receive all of the information necessary to make a benefit determination, the Benefit Program will notify you within 24 hours of receipt of the Urgent Care Claim of the specific deficiencies. You will have 48 hours to provide the requested information. Once the Benefit Program receives the requested information, we will notify you of the benefit determination as soon as possible but not later than 48 hours after receipt of the information.

The Benefit Program may notify you of its benefit determination decision orally and follow with written or electronic notification not later than three days after the oral notification.

Concurrent Care Claims

A **Concurrent Care Claim** is any claim for ongoing treatment, including the Benefit Program's approval for a number of treatments. The decision is adverse if the Benefit Program decided to reduce or terminate benefits for the ongoing treatment (unless it's due to a health benefit program amendment or health benefit program termination).

A request for an extension to an ongoing course of treatment must be filled in accordance with the Benefit Program's claim procedures and must be made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. The Benefit Program will notify you of any benefit determination concerning the request to extend the course of treatment within 24 hours after its receipt of the claim.

If the Benefit Program reduces or terminates a course of treatment before the end of the course previously approved, the reduction or termination is considered an adverse benefit determination. The Benefit Program will notify you, in advance, of the reduction or termination so that you may appeal and obtain an answer on the appeal before the benefit is reduced or terminated.

Pre-Service Claims

A **Pre-Service Claim** is a claim for a benefit which requires some form of preapproval or precertification by the Benefit Program.

If you file a Pre-Service Claim in accordance with the Benefit Program's claim procedures and all the required information is received, the Benefit Program will notify you of its benefit determination within 15 days after receipt of the claim. The Benefit Program may extend this time period for up to an additional 15 days if such an extension is necessary due to circumstances beyond the control of the Benefit Program. The Benefit Program will notify you of such an extension and date by which it expects to render a decision.

If an extension is needed because you did not provide all the necessary information to process your claim, the Benefit Program will notify you in writing, within the initial 15 day response period and will specifically describe the missing information. You will then have 45 days to provide the additional information. If you do not provide the information, your claim may be denied.

Post-Service Claims

A **Post-Service Claim** is any claim that is not a Pre-Service Claim.

If you file a Post-Service Claim in accordance with the Benefit Program's claim procedures and all of the required information is received, the Benefit Program will notify you of its benefit determination within 30 days after receipt of the claim. The Benefit Program may extend this time period for up to an additional 15 days if such an extension is necessary due to circumstances beyond the control of the Benefit Program. The Benefit Program will notify you of such an extension and date by which it expects to render a decision.

If an extension is needed because you did not provide all of the necessary information to process your claim, the Benefit Program will notify you, in writing, within the initial 30 day response period and will specifically describe the missing information. You will then have 45 days to provide the additional information. If you do not provide the information, your claim may be denied.

Benefit Determination Notices

You will receive notice of a benefit determination, orally as allowed, or in writing. All notices of a denial of a benefit will include the following:

- The specific reason for the denial;
- Sufficient information to identify the claim involved, including the date of services, the healthcare provider, and the claim amount, if applicable;
- Reference to the specific Benefit Program provision on which the denial is based;
- A description of any additional material or information necessary to process the claim and an explanation of why such information is necessary;
- A description of the Benefit Program's appeal procedures, applicable timeframes, including the expedited appeal process, if applicable;
- Your right to bring a civil action under Federal law following the denial of a claim after review on appeal, if your group is subject to the Employee Retirement Income Security Act of 1974 (ERISA);
- If an internal rule, guideline, protocol or similar criteria was relied upon in making the benefit determination, then that information will be provided free of charge upon written request; and

- If the claim was denied based on Medical Necessity or Experimental treatment or a similar exclusion or limit, then an explanation of the scientific or clinical judgment used for the determination applying the terms of the Benefit Program to your circumstances will be provided free of charge upon request.

Filing a Complaint

If you have a complaint, please call or write to Customer Service at the telephone number or address listed on your Explanation of Benefits (EOB) form and/or identification card. To expedite the processing of an inquiry, the employee should have the following information available:

- Name of patient
- Identification number
- Claim number(s) (if applicable)
- Date(s) of service

If your complaint is regarding a claim, a Mutual Health Services (MHS) Customer Service representative will review the claim for correctness in processing. If the claim was processed according to terms of the Group Contract, the Customer Service representative will telephone the employee with the response. If attempts to telephone the employee are unsuccessful, a letter will be sent explaining how the claim was processed. If an adjustment to the claim is required, the employee will receive a check, Explanation of Benefits or letter explaining the revised decision.

If you are not satisfied with the results, you may continue to pursue the matter through the appeal process.

Appeals Process

Expedited Review Process

A request for an expedited review must be certified by your Provider that your condition could, without immediate medical attention, result in any of the following:

1. Seriously jeopardize your life or health or your ability to regain maximum function; or
2. In the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The appeal does not need to be submitted in writing. You or your physician should call the Medical Management telephone number on your identification card as soon as possible.

Expedited reviews will be resolved within 72 hours after you have submitted the request.

The expedited review process does not apply to prescheduled treatments, therapies, surgeries or other procedures that do not require immediate action.

When you request an internal review for an urgent care claim or for a concurrent care claim that is urgent, you may also file a request at the same time for an expedited external review.

Filing an Appeal

If you are not satisfied with any of the following:

- A benefit determination decision;
- A Medical Necessity determination decision;
- A determination of your eligibility to participate in the Benefit Program or health insurance coverage; or
- A decision to rescind your coverage (a rescission does not include a retroactive cancellation for failure to timely pay required premiums); then you may file an appeal.

To submit an appeal, call the Customer Service telephone number on your identification card. You may also write a letter with the following information: employee's full name; patient's full name; identification number; claim number if a claim has been denied; the reason for the appeal; date of services; the provider/facility name; and any supporting information or medical records, dental X-rays or photographs you would like considered in the appeal. Send the letter and records to:

Mutual Health Services
Member Appeals Unit
P.O. Box 89472
Cleveland, OH 44101-6472
Fax: 440.878.5451

The request for review must come directly from the patient unless he/she is a minor or has chosen an authorized representative. You can choose another person to represent you during the appeal process, as long as MHS has a signed and dated statement from you authorizing the person to act on your behalf.

You will receive continued coverage pending the outcome of the appeals process. This means that the Benefit Program may not reduce or eliminate coverage of ongoing treatment until your appeal is exhausted.

First Level Mandatory Appeal

The Benefit Program offers all members a first level **mandatory** appeal. You must complete this first level of appeal before any additional action is taken.

First level mandatory appeals related to a claim decision must be filed within 180 days from your receipt of the notice of denial of benefits. All requests for appeal may be made by calling Customer Service or in writing as described on page 57.

Under the appeal process, there will be a full and fair review of the claim in accordance with applicable law for this benefit program. The internal appeal process is a review of your appeal by an Appeals Coordinator, a physician consultant and/or other licensed healthcare professional. The review of an appeal will take into account all comments, documents, medical records and other information submitted by you and the Provider relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. All determinations based on Medical Necessity and appropriateness, experimental treatment, or that are based in whole or in part on a medical judgment, are made by healthcare professionals who have the appropriate training and experience in the field of medicine involved in the medical judgment. The healthcare professionals who review the appeal will not have made any prior decisions about your claim and will not be a subordinate of the professional who made the initial determination on your claim. These healthcare professionals act independently and impartially. Decisions to hire, compensate, terminate, promote or retain these professionals are not based in any manner on the likelihood that these professionals will support a denial of benefits.

You may submit written comments, documents, records, testimony and other information relating to the claim that is the basis for the appeal. These documents should be submitted by you at the time you send in your request for an appeal. Upon written request, you may have reasonable access to and copies of documents, records and other information used to make the decision on your claim for benefits that is the subject of your appeal.

If, during the appeal, the Benefit Program considers, relies upon or generates any new or additional evidence, you will be provided free of charge with copies of that evidence before a notice of denial is issued. You will have an opportunity to respond before our timeframe for issuing a notice of denial expires. Additionally, if the Benefit Program decides to issue a final denial based on a new or additional rationale, you will be provided that rationale free of charge before the final notice of denial is issued. You will have an opportunity to respond before our timeframe for issuing a notice of denial expires.

The appeal procedures are as follows:

Urgent Care Appeal

- You, your authorized representative or your Provider may request an appeal for urgent care. Urgent care claim appeals are typically those claims for Medical Care or treatment where withholding immediate treatment could seriously jeopardize the life or health of a patient, or could affect the ability of the patient to regain maximum functions. The appeal must be decided within 72 hours of the request. When you request an internal appeal for an urgent care claim, at the same time you may also file a request for an expedited external appeal as described below.

Pre-Service Claim Appeal

- You or your authorized representative may request a pre-service claim appeal. Pre-service claim appeals are those requested in advance of obtaining Medical Care for approval of a benefit, as it relates to the terms of the Benefit Program. The pre-service claim appeal must be decided within 30 days of the request and must be requested within 180 days of the date you received notice of denial.

Post-Service Claim Appeal

- You or your authorized representative may request a post-service claim appeal. Post-service claim appeals are those requested for payment or reimbursement of the cost for Medical Care that has already been provided. As with pre-service claims, the post-service claim appeal must be decided within 30 days of the request and must be requested within 180 days of the date you received notice of the denial.

Appeal Denial Notices

All notices of a denial of benefits relative to appeals will include the following:

- The specific reasons for the denial;
- Sufficient information to identify the claim involved, including the date(s) of service, the healthcare provider, and the claim amount, if applicable;
- Reference to the specific benefit program provisions on which the denial is based;
- Statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits;
- If an internal rule, guideline, protocol or similar criteria was relied upon in making the determination, then that information will be provided free of charge upon written request;
- If the claim was denied based on a Medical Necessity, Experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment used for the determination applying the terms of the Benefit Program to your circumstances will be disclosed, or you will be advised that this explanation will be provided free of charge upon request; and
- A statement of your right to bring civil action under Federal law following the denial of a claim upon review, if your group is subject to the Employee Retirement Income Security Act of 1974 (ERISA).

Second Level of Appeal

This is a **voluntary** appeal level and is filed with the Health Benefit Program to be reviewed by the Health Plan Advisory Committee (HPAC). The member is not required to follow this internal procedure before going to the External Review Process on page 61.

The HPAC members include the HBP Chief Medical Officer, Senior Director, Legal Counsel, Cleveland Clinic Medical Director, Director of Health and Welfare Benefits, Director of Retirement/Voluntary Benefit Plan, Director of Medical Management, Pharmacy Director, and Behavioral Health representatives.

- Members who are not satisfied with the decision following the first appeal have the right to appeal the denial a second time.
- Members or their Personal Representative must submit a written request for a second review within 180 calendar days following the date they received the TPA's decision regarding the first appeal. The HBP will assume that the member received the determination letter regarding the first appeal five days following the date the TPA sends the determination letter.

- Members may submit written comments, documents, records and other pertinent information to explain why they believe the denial should be overturned. This information should be submitted at the same time the written request for a second review is submitted.
- Members have the right to submit evidence that their claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The second review will take into account all comments, documents, records and other information submitted that related to the claim that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision or the first appeal, and are not under the supervision of those individuals.
- If the benefit denial was based in whole or in part on a medical judgment, the HBP will consult with a healthcare professional with training and experience in the relevant medical field. This healthcare professional may not have been involved in the original denial decision or first appeal, nor be supervised by the healthcare professional who was involved. If the HBP has obtained medical or vocational experts in connection with the claim, they will be identified upon the member's request, regardless of whether the HBP relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the member will receive written notification letting them know if the claim is being approved or denied. It will also notify them of their right to file suit under ERISA after they have completed all mandatory appeal levels described in this *SPD*.

Regarding voluntary appeal level on page 58, the HBP agrees that any statutory limitations that are applicable to pursuing the claim in court will be put on hold during the period of this voluntary appeal process. The voluntary appeal process is available only after the member has followed the mandatory appeal level as required on page 58. The HBP also agrees that it will not charge the member a fee for going through the voluntary appeal process, and it will not assert failure to exhaust administrative remedies if a member elects to pursue a claim in court before following this voluntary appeal process. A member's decision about whether to submit a benefit dispute through this voluntary appeal level will have no affect on their rights to any other benefits under the HBP. For any questions regarding the voluntary level of appeal including applicable rules, a member's right to representation (Personal Representative) or other details, please contact the HBP. Refer to the ERISA Statement of Rights section on page 65 of this *SPD* for details on a member's additional rights to challenge the benefit decision under section 502(a) of ERISA.

Appeals should be sent within the prescribed time period as stated above.

Send Medical Appeals to:

First Level **Mandatory** Appeals
 Mutual Health Services
 Member Appeals Unit
 P.O. Box 89472
 Cleveland, OH 44101-6472
 Fax: 440.878.5451

Second Level **Voluntary** Appeals
 Cleveland Clinic Health Benefit Program
 3050 Science Park Drive / AC332B
 Beachwood, OH 44122
 Fax: 216.448.2053

Send Pharmacy Appeals to:

Health Benefit Program
 Pharmacy Appeals
 6000 Westcreek, Suite 10
 Independence, OH 44131
 Phone: 216.986.1050 (option 4)
 or toll-free at 888.246.6648 (option 4)

Time Periods for Making Decision on Appeals

After reviewing a claim that has been appealed, the TPA/HBP will notify the member of its decision within the following timeframes, although members may voluntarily extend these timelines. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the Benefit Program will provide it to you free of charge and sufficiently in advance of the due date of the response to the Adverse Benefit Determination.

The timelines below only apply to the mandatory appeal level. The voluntary appeal level will not be subject to specific timelines.

- **Pre-Service Claim:** Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 calendar days after the Benefit Program receives the request for review.
- **Post-Service Claim:** Within a reasonable period of time but not later than 30 calendar days after the Benefit Program receives the request for review.
- **Concurrent Care Claim:** Before treatment ends or is reduced.

External Review Process

In accordance with Federal law, the HBP has also established an external review process to examine coverage decisions under certain circumstances. The request for External Review must be made within 120 days from your receipt of the notice of denial from the first-level mandatory internal appeal. You may be eligible to have a decision reviewed through the external review process if you meet the following criteria:

1. For claims for which external review is initiated:
 - a. Before September 20, 2011, the adverse benefit determination does not relate to your failure to meet the requirements of eligibility under the Benefit Program;
 - b. On or after September 20, 2011, the adverse benefit determination involves medical judgment or a rescission of coverage;
2. You have exhausted the mandatory internal appeal process unless under applicable law you are not required to exhaust the internal appeal process;
3. You are or were covered under the Benefit Program at the time the service was requested or, in the case of retrospective review, were covered under the Benefit Program when the service was provided; and
4. You have provided all of the information and forms necessary to process the external review.

External Review will be conducted by Independent Review Organizations (IRO). You will not be required to pay for any part of the cost of the external review. All IROs act independently and impartially and are assigned to review your claim on a rotational basis or by another unbiased method of selection. The decision to use an IRO is not based in any manner on the likelihood that the IRO will support a denial of benefits.

The Benefit Program is required by law to provide to the independent review organization conducting the review, a copy of the records that are relevant to your medical condition and the external review.

External Review for Non-Urgent Care Claim Appeals

A request for an external review for a non-expedited or non-urgent claim must be in writing and should be addressed to MHS's Member Appeals Unit at the address listed on page 58.

If your request for external review is complete and you are eligible for external review, an IRO will conduct the review. The IRO will notify you and give you 10 business days to submit information for its consideration. The IRO will issue a written decision within 45 days after it receives the request for external review. This written decision will include the main reasons for the decision, including the rationale for the decision. If the IRO reverses the adverse benefit determination, the Benefit Program will provide coverage, subject to other terms, limitations and conditions of your benefit program.

Expedited External Review for Urgent Care Claim Appeals

A request for an external review for urgent or expedited claims may be requested orally or in writing. A request for an expedited review should be made by contacting Mutual Health Services at the number on the back of your identification card. You may also request an external review for urgent or expedited claims at the same time you request an expedited internal review of your claim.

An expedited review may be requested if your condition, without immediate medical attention, could result in any of the following:

1. Seriously jeopardize your life or health or your ability to regain maximum function; or
2. In the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If your request for external review is complete and you are eligible for external review, an IRO will conduct the review. The IRO will issue a decision within 72 hours after the IRO receives the request for external review. If the decision is not in writing, within 48 hours after providing that notice, the IRO will provide a written confirmation. This decision will include the main reasons for the decision, including the rationale for the decision. If the IRO reverses the adverse benefit determination, the Benefit Program will provide coverage, subject to other terms, limitations and conditions of your *Summary Plan Description*.

Reimbursement and Subrogation Rights of the Plan

This Section of this *Summary Plan Description* addresses the Cleveland Clinic Health Benefit Program's (referred to as the "Benefit Program") "subrogation" and "reimbursement" rights. The terms "Covered Person," "Third Party," "Claim," and "Claim Proceeds" are defined at the end of this section.

First, this Benefit Program does not provide any benefits to a Covered Person to the extent that there is any other type of non-healthcare insurance coverage that would provide reimbursement for a Covered Person's medical expenses (including auto insurance that provides underinsured and non-insured motorist coverage, and insurance maintained by Cleveland Clinic or its affiliates on employees and insurance maintained by other employers).

Second, if a Covered Person has a Claim against a Third Party, this Benefit Program will provide benefits to, or on behalf of, a Covered Person only under the following terms and conditions:

1. To the extent that benefits are provided under this Benefit Program, the Benefit Program shall be subrogated to all of the Covered Person's Claims against any Third Party. The Covered Person shall execute and deliver instruments and papers and do whatever else is necessary to secure the subrogation rights of the Benefit Program. The Covered Person shall do nothing to prejudice the subrogation rights of the Benefit Program. By submitting a claim for benefits under the Benefit Program, the Covered Person hereby agrees to cooperate with the Benefit Program and/or any representatives of the Benefit Program in completing subrogation forms and in giving such information surrounding any accident or other set of facts and circumstances as the Benefit Program or its representatives deem necessary to fully investigate and enforce the Benefit Program's subrogation rights.
2. The Benefit Program is also granted a right of reimbursement from any Claim Proceeds. This right of reimbursement is cumulative with, and not exclusive of, the subrogation right granted in paragraph 1, but only to the extent of the benefits provided under this Benefit Program.
3. The Benefit Program, by providing benefits hereunder, is hereby granted a lien on any Claim Proceeds intended for, payable to, or received by the Covered Person or his/her representatives, and the Covered Person hereby consents to said lien and agrees to take whatever steps are necessary to help the company secure said lien. The Covered Person agrees that said lien shall constitute a charge upon the Claim Proceeds and the Benefit Program shall be entitled to assert security interest thereon. By the acceptance of benefits under the Benefit Program, the Covered Person and his/her representatives agree to hold the Claim Proceeds in trust for the benefit of the Benefit Program to the extent of 100% of all benefits paid by the Benefit Program on behalf of the Covered Person.
4. By accepting benefits hereunder, the Covered Person hereby grants a lien and assigns to the Benefit Program an amount equal to the benefits paid against any Claim Proceeds. This assignment is binding on an attorney who represents the Covered Person whether or not an agent of the participant and on any insurance company or other financially responsible party against whom a Covered Person may have a claim.

5. The subrogation and reimbursement rights and liens apply to any Claim Proceeds received or payable to the Covered Person, including but not limited to the following:
 - a. Payments made directly by a third party tortfeasor, or any insurance company on behalf of a third party tortfeasor, or any other payments on behalf of a third party tortfeasor.
 - b. Any payments or settlements or judgment or arbitration awards paid by any insurance company under an uninsured or underinsured motorist coverage, whether on behalf of a Covered Person or other person.
 - c. Any other payments from any source designed or intended to compensate a Covered Person for injuries sustained as the result of negligence or alleged negligence of a third party.
 - d. Any workers compensation award or settlement.
 - e. Any recovery made pursuant to no-fault insurance.
 - f. Any medical payments made as a result of such coverage in any automobile or homeowners insurance policy.
6. No adult Covered Person hereunder may assign any rights that such person may have to recover medical expenses from any Third Party to any minor child or children of said adult Covered Person without the prior express written consent of the Benefit Program. The Benefit Program's right to recover (whether by subrogation or reimbursement) shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
7. No Covered Person shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude the benefits provided by the Benefit Program.
8. The Benefit Program's rights of subrogation and reimbursement shall be a prior lien against any Claim Proceeds, and shall not be defeated nor reduced by the application of any so-called "Make-Whole Doctrine," "Rimes Doctrine," or any other such doctrine purporting to defeat the Benefit Program's recovery rights by allocating the proceeds exclusively to non-medical expense damages. Accordingly, the Benefit Program's rights of subrogation and reimbursement provide the Benefit Program with the right to receive the first dollars of any Claim Proceeds, irrespective of whether the Covered Person has been fully compensated or partially compensated for all or any of injuries, damages or other claims of the Covered Person.
9. No Covered Person hereunder shall incur any expenses on behalf of the Benefit Program in pursuit of the Benefit Program's rights hereunder, specifically, no court costs or attorneys fees may be deducted from the Benefit Program's recovery without the prior express written consent of the Benefit Program. This right shall not be defeated by any so-called "Fund Doctrine," or "Common Fund Doctrine," or "Attorney's Fund Doctrine."
10. The Benefit Program shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Covered Person, whether under comparative negligence or otherwise.
11. The benefits under this Benefit Program are secondary to any coverage under no-fault or similar insurance.
12. In the event that a Covered Person shall fail or refuse to honor its obligations hereunder, then the Benefit Program shall be entitled to recover any costs incurred in enforcing the terms hereof including but not limited to attorney's fees, litigation, court costs, and other expenses. The Benefit Program shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Covered Person has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.
13. Any reference to state law in any other provision of this Benefit Program shall not be applicable to this provision if the Benefit Program is governed by ERISA. By acceptance of benefits under the Benefit Program, the Covered Person agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Benefit Program shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the Benefit Program, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

For purposes of this Section:

“Covered Person” includes, individually and collectively, a participant, beneficiary or any other covered person under this Benefit Program. A reference to a Covered Person includes the Covered Person’s estate and any representative of the Covered Person.

“Third Party” refers to any person or entity who, with respect to a claim for benefits of a Covered Person, is not the Covered Person (*e.g.*, a third party tortfeasor). References to a Third Party include, without limitation, any auto or other insurer that provides coverage of any kind (including non-insured or underinsured motorists coverage) to the Covered Person or to any Third Party, including insurers that provide coverage to employees of the Cleveland Clinic or another employer. The term Third Party also may refer to another person who is a Covered Person under this Benefit Program.

“Claim” means any type of legal, equitable, insurance, or other claim that a Covered Person (or any representative of the Covered Person) has against a Third Party, if that claim could, or would, provide any amount of money or other consideration to the Covered Person because of, or in any way attributable to, the Covered Person’s claim for benefits under this Benefit Program, or because of any set of facts and circumstances that are in any way related to the Covered Person’s claim for benefits under the Benefit Program. The reference to a Covered Person’s Claims includes, without limitation, claims of pain and suffering and loss of consortium, as well as claims for consequential, punitive, exemplary or other damages.

“Claim Proceeds” includes any money or other consideration recovered from, or payable by, any Third Party that is attributable to a Claim of a Covered Person. Claim Proceeds includes, without limitation, amounts received by settlement, judgment or otherwise, and any insurance proceeds of any kind, or in satisfaction of any judgment or settlement, insurance claim of any kind, or otherwise. Claim Proceeds includes, without limitation, proceeds received by a Covered Person for claims of pain and suffering, loss of consortium, consequential, punitive, exemplary or other damages.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA)

HIPAA is Federal law that pertains to group health plans. HIPAA has the following three basic provisions:

- It prohibits an employer health plan from imposing pre-existing condition exclusions on employees and dependents, except in limited, specified circumstances and for limited periods of time.
- It prohibits an employer health plan from prohibiting enrollment or charging a higher employee contribution amount or premium because of “health status-related factors.”
- It requires an employer health plan to allow enrollment for employees and dependents who lose coverage under other plans or insurance policies.

Any other questions or issues related to the HIPAA law should be directed to the Total Rewards Department.

A Statement of Your Rights Under ERISA

As a participant in the Cleveland Clinic Welfare Benefits Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) which are described below.

Receive Information about Your Plan and Benefits

ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan and/or this Benefit Program including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated *Summary Plan Description*. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this *Summary Plan Description* and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or Elimination of Exclusionary Periods of Coverage for Pre-existing Conditions Under Your Group Health Plan if You Have Creditable Coverage for Another Plan

You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage or when your COBRA continuation coverage ceases, if you request it before losing coverage or within 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for benefits is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.

If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

ERISA Required Information

This information is provided in compliance with the Employee Retirement Income Security Act of 1974 (ERISA), as amended. While you should not need these details on a regular basis, the information may be useful if you have specific questions about the Plan. The following provides information specific to the Cleveland Clinic Welfare Benefit Plan (the “Plan”), and the Cleveland Clinic Health Benefit Program (the “Benefit Program”) which is a component of the Plan and is a welfare plan that provides benefits to certain employees.

Official Plan Name Cleveland Clinic Welfare Benefits Plan

Official Benefit Program Name ... Cleveland Clinic Health Benefit Program

Plan Number 530

Type of Administration The Benefit Program is a self-insured benefit plan offering medical benefits. Cleveland Clinic has contracted with Mutual Health Services, a third-party administrator, to administer the Benefit Program.

Contributions to the

Benefit Programs Benefit Program benefits are paid from the general assets of Cleveland Clinic. However, Cleveland Clinic has contracted with a third-party administrator to assist in the a administration of the Benefit Program.

Funding Medium Benefits provided by this Benefit Program are provided through Cleveland Clinic and through employee contributions. The Plan Sponsor shall from time to time determine the amount of contributions payable by Participants.

Plan Sponsor, Plan

Administrator and

Plan Fiduciary

..... Cleveland Clinic
3050 Science Park Drive / AC332B
Beachwood, OH 44122
216.448.CCHR(2247) or toll-free at 877.688.2247

The administration of the Plan, including the Benefit Program, will be under the supervision of the Plan Administrator. To the fullest extent permitted by law, the Plan Administrator will have the discretion to determine all matters relating to eligibility, coverage and benefits under the Plan. The Plan Administrator will also have the discretion to determine all matters relating to the interpretation and operation of the Plan including any portion thereof. Any determination by the Plan Administrator, or any authorized delegate, shall be final and binding.

Agent for

Service of Legal Process

..... Cleveland Clinic
Law Department / AC321
3050 Science Park Drive
Beachwood, OH 44122

Service of legal process may also be made on the Plan Administrator.

Plan Year January 1 – December 31

Records and reports for the Plan, including Benefit Programs contained therein, are kept on a calendar year (January 1 – December 31). The Plan Year is also the Fiscal Year.

Employer Identification

Number of Plan Sponsor 34-0714585

- Benefit Program Effective Date** . . . The Plan is effective as of January 1, 2013 and the provisions of the Benefit Program are effective January 1, 2016.
- Plan Documentation** If there are any discrepancies between this *Summary Plan Description (SPD)* and the provisions of the Cleveland Clinic Welfare Benefits Plan Document, including the contract, the Plan Document will prevail. No oral interpretations can change this Plan. The Plan Sponsor also reserves the right to interpret the Plan’s coverage and meaning in the exercise of its sole discretion. The decisions of the Plan Administrator, Claims Administrator and Appeals Administrator, as applicable, shall be final and conclusive with respect to all questions relating to the Plan.
- Future of the Plan** The Plan Sponsor reserves the right to amend, modify, suspend or terminate the Plan, including this Benefit Program, in whole or in part, at any time, including retroactively, without notice, in such manner as it shall determine regardless of a participant’s status, which may result in the termination or modification of an member’s coverage under the Benefit Program. If the Plan or Benefit Program is amended, modified, or terminated, the rights of members are limited to benefits incurred prior to the Plan’s amendment, modification or termination. However, no participant has a vested right to the continuation of any particular benefit provided by the Plan
- No Employment Contract** This *SPD* does not create any contractual rights to employment nor does it guarantee the right to receive benefits under the Plan or Benefit Program. Benefits are payable under the Plan or Benefit Program only to individuals who have satisfied all of the conditions under the Plan document for receiving benefits.
- Delegation of Responsibility** The Plan Administrator may delegate to other persons responsibilities for performing certain duties of the Plan Administrator under the terms of the Plan. The Plan Administrator, Claims Administrator, and/or Appeals Administrator, as applicable, may seek such expert advice as reasonably necessary with respect to the Plan or Benefit Program. The Plan Administrator, Claims Administrator, and/or Appeals Administrator, as applicable, shall be entitled to rely upon the information and advice furnished by such delegates and experts, unless actually knowing such information and advice to be inaccurate or unlawful. The Plan Administrator may adopt uniform rules for the administration of the Plan from time to time, as it deems necessary or appropriate.