

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:

- Appeals Process
- Reimbursement and Subrogation Rights of the Plan
- The Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- Employee Retirement Income Security Act of 1974 (ERISA)
- Statement of Your Rights Under ERISA

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 UMR 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

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:

Claims Appeals Unit

UMR

P.O. Box 30546

Salt Lake City, UT 84130-0546

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 UMR 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 UMR may not reduce or eliminate coverage of ongoing treatment until your appeal is exhausted.

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 Department 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.

Adverse Benefit Determination (Denied Claims)

Adverse Benefit Determination means a denial, reduction or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination or failure to provide or make payment that is based on a determination that the member is no longer eligible to participate in the Health Benefit Program.

If a claim is being denied in whole or in part, and the member will owe any amount to the provider, the member will receive an initial claim denial notice, usually referred to as an Explanation of Benefits (EOB) form. The EOB form will:

- Explain the specific reason for the denial.
- Provide a specific reference to pertinent Plan provisions on which the denial was based.
- Provide a description of any material or information that is necessary for the member to perfect the claim, along with an explanation of why such material or information is necessary, if applicable.
- Provide appropriate information as to the steps the member can take to submit the claim for appeal (review).
- If an internal rule or guideline was relied upon, or if the denial was based on not meeting Clinical Appropriateness for coverage or experimental treatment, the TPA will notify the member of that fact. The member has the right to request a copy of the rule/guideline or clinical criteria that was relied upon, and such information will be provided free of charge.

Appeals Procedure for Denied Benefit Determinations

If a member disagrees with the denial of a claim or a rescission of coverage determination, the member or his/her Personal Representative can request that the TPA review its initial determination by submitting a written request to the TPA as described on the next page. An appeal filed by a provider on the member's behalf is not considered an appeal under the Health Benefit Program unless the provider is a Personal Representative.

First Level of Appeal

This is a mandatory appeal level and is filed with UMR. The member must exhaust the following internal procedures before any outside action is taken.

Note: Pharmacy appeals are not subject to the mandatory appeal level. Pharmacy appeals should start at the second appeal level.

- Members must file the appeal within 180 days of the date they received the EOB form from the TPA showing that the claim was denied. The Health Benefit Program will assume that the member received the EOB form five days after the TPA mailed the EOB form.
- Members or their Personal Representative will be allowed reasonable access to review or copy pertinent documents, at no charge.
- Members may submit written comments, documents, records and other information relating to the claim to explain why they believe the denial should be overturned. This information should be submitted at the same time the written request for a 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 review will take into account all comments, documents, records and other information submitted that relates to the claim. This would include comments, documents, records and other information 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 and are not under the supervision of the person who originally denied the claim.
- If the benefit denial was based in whole or in part on a medical judgment, the TPA 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, nor be supervised by the healthcare professional who was involved. If the TPA has obtained medical or vocational experts in connection with the claim they will be identified upon the member's request, regardless of whether the TPA 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. The notification will provide members with the information outlined under the Adverse Benefit Determination section on page 51. 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*.

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 54.

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 60 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 the above voluntary appeal level, 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 above. 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 effect 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 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
 UMR
 Claims Appeal Unit
 P.O. Box 30546
 Salt Lake City, UT 84130-0546

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

Send Pharmacy Appeals to:

Note: Pharmacy Appeals are not subject to the mandatory appeal level.

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 Health 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

Following completion of the internal appeals process, you may be eligible to submit a request for external review, which will be conducted by an independent physician external review group. Your request for external review will have no effect on other benefits available under your Health Benefit Program. Your request must be submitted within four months of the last adverse determination.

If you wish to pursue an external review, please send a written request to the following address:

UMR

External Review

Appeal Unit

P.O. Box 8048

Wausau, WI 54402-8048

Your written request should include: (1) your specific request for an external review; (2) the Employees' name, address, and member ID number; (3) your designated representative's name and address, when applicable; (4) the service that was denied; and (5) any new, relevant information that was not provided during the internal appeal. You will be provided more information about the external review process at the time we receive your request.

Contact UMR at the telephone number shown on your ID card for more information on the Federal external review program.

Reimbursement and Subrogation Rights of the Plan

The Plan has a right to subrogation and reimbursement. References to "You" or "Your" in this Right of Subrogation, Reimbursement, and Offset section include You, Your estate, Your heirs, and Your beneficiaries unless otherwise stated.

Subrogation applies when the Plan has paid benefits on Your behalf for an Illness or Injury for which any third party is allegedly responsible. The right to subrogation means that the Plan is substituted to and will succeed to any and all legal claims that You may be entitled to pursue against any third party for the benefits that the Plan has paid that are related to the Illness or Injury for which any third party is considered responsible.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for an Illness or Injury for which You receive a settlement, judgment, or other recovery from any third party, You must use those proceeds to fully return to the Plan 100% of any benefits You receive for that Illness or Injury. The right of reimbursement will apply to any benefits received at any time until the rights are extinguished, resolved, or waived in writing.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused You to suffer an Illness, Injury, or damages, or who is legally responsible for the Illness, Injury, or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Illness, Injury, or damages.
- The Plan Sponsor in a Workers' Compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to You, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners', or otherwise), Workers' Compensation coverage, other insurance carriers, or third party administrators.
- Any person or entity against whom You may have any claim for professional and/or legal malpractice arising out of or connected to an Illness or Injury You allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to You on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting the Plan's legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
 - Notifying the Plan, in writing, of any potential legal claim(s) You may have against any third party for acts that caused benefits to be paid or become payable.

- Providing any relevant information requested by the Plan.
- Signing and/or delivering such documents as the Plan or our agents reasonably request to secure the subrogation and reimbursement claim.
- Responding to requests for information about any accident or Injuries.
- Making court appearances.
- Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate or deny future benefits, take legal action against You, and/or set off from any future benefits the value of benefits the Plan has paid relating to any Illness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to You or Your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against a third party before You receive payment from that third party. Further, our first priority right to payment is superior to any and all claims, debts, or liens asserted by any medical providers, including, but not limited to, Hospitals or Emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to You, Your representative, Your estate, Your heirs, or Your beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium, and punitive damages. The Plan is not required to help You to pursue Your claim for damages or personal Injuries and no amount of associated costs, including attorneys' fees, will be deducted from our recovery without the Plan's express written consent. No so-called "fund doctrine" or "common-fund doctrine" or "attorney's fund doctrine" will defeat this right.
- Regardless of whether You have been fully compensated or made whole, the Plan may collect from You the proceeds of any full or partial recovery that You or Your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "made-whole doctrine" or "make-whole doctrine," claim of unjust enrichment, nor any other equitable limitation will limit our subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be benefits advanced.
- If You receive any payment from any party as a result of Illness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, You and/or Your representative will hold those funds in trust, either in a separate bank account in Your name or in Your representative's trust account.
- By participating in and accepting benefits from the Plan, You agree that:
 - Any amounts recovered by You from any third party constitute Plan assets (to the extent of the amount of Plan benefits provided on behalf of the Covered Person);
 - You and Your representative will be fiduciaries of the Plan with respect to such amounts; and
 - You will be liable for and agree to pay any costs and fees (including reasonable attorneys' fees) Incurred by the Plan to enforce its reimbursement rights.
- The Plan's rights to recovery will not be reduced due to Your own negligence.
- Upon the Plan's request, You will assign to the Plan all rights of recovery against third parties, to the extent of the Covered Expenses the Plan has paid for the Illness or Injury.

The Plan may, at its option, take necessary and appropriate action to preserve the Plan's rights under these provisions, including, but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal

representative, or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits You receive for the Illness or Injury out of any settlement, judgment, or other recovery from any third party considered responsible; and filing suit in Your name or Your estate's name, which does not obligate the Plan in any way to pay You part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund benefits as required under the terms of the Plan is governed by a six-year statute of limitations.

- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of Your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to Your estate, the personal representative of Your estate, and Your heirs or beneficiaries. In the case of Your death, the Plan's right of reimbursement and right of subrogation will apply if a claim can be brought on behalf of You or Your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds, or any other recovery, by You, Your estate, the personal representative of Your estate, Your heirs, Your beneficiaries, or any other person or party will be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent Child who incurs an Illness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Illness or Injury, the terms of this subrogation and reimbursement clause will apply to that claim.
- If any third party causes or is alleged to have caused You to suffer an Illness or Injury while You are covered under this Plan, the provisions of this section continue to apply, even after You are no longer covered.
- In the event that You do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate benefits to You, Your Dependents, or the subscriber; deny future benefits; take legal action against You; and/or set off from any future benefits the value of benefits the Plan has paid relating to any Illness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to Your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.
- The Plan and all administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

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 four basic provisions:

- It prohibits an employer health plan from imposing pre-existing condition exclusions on employees and dependents.
- 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.
- It requires employer health plans to establish privacy and security standards to protect the confidentiality and integrity of individually identifiable health information.

Any other questions or issues related to the HIPAA law should be directed to the ONE HR Service Center.

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.

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 at 866.444.3272.

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 MediumBenefits 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 YearJanuary 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 Sponsor34-0714585

Benefit Program Effective DateThe Plan is effective as of January 1, 2013 and the provisions of the Benefit Program are effective January 1, 2021.

Plan DocumentationIf 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 a 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 ResponsibilityThe 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.