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Cleveland Clinic Short Term Disability Benefits

SUMMARY

Definition of Disability

“Disability” means the employee’s inability to perform the essential duties of the employee’s own occupation or an equivalent occupation by reason of any medically determinable physical or mental impairment.

Eligibility/Enrollment

To be eligible, the employee must be classified as an active, regular, full-time employee and must have completed one continuous year of regular, full-time employment immediately prior to the onset of the illness or injury. Employees on Personal or Military Leave of Absence at the time of the illness or injury are not considered “active” for the purpose of benefit payment.

When Benefits Are Payable

Benefit payments begin with the 8th calendar day of any non-occupational illness or injury including hospital admission and ambulatory surgery. Only full days of absence will be counted toward the seven calendar day waiting period. The employee is required to utilize Paid Time Off (PTO), or accumulated sick days, to the extent that it has been banked and/or accrued during the waiting period. The authorized Medical Leave of Absence also begins on the 8th calendar day of an illness or injury.

The payment of benefits will be processed by the Payroll Department upon receipt of approved paperwork from the Cleveland Clinic Absence Management Office. It is the responsibility of the employee to ensure initial completion of the Request Form.

The actual length of the benefit payment period is dependent upon the diagnosis and the customary recovery time associated with that condition. The customary recovery time is derived from a disability schedule that was determined by the Physician Group at the Cleveland Clinic, in addition to cross-referencing “The Medical Disability Advisor” by Presley Reed, M.D. After the seven calendar day waiting period, the benefit provides 60% of one’s base salary for up to twenty six weeks of approved disability.

Benefits will be paid to a maximum period of twenty six weeks (1040 hours) for any one period of disability.

When an employee meets the aforementioned eligibility criteria, has worked for less than 90 calendar days of full duty since the last period of disability, benefit payment starts immediately for the same or related illness or injury.

When an employee meets the aforementioned eligibility criteria, has worked less than 90 days of full duty since the last period of disability for an unrelated illness or injury, the seven calendar day waiting period is imposed.

When an employee meets the aforementioned eligibility criteria, has worked for 90 calendar days or more of full duty since the last period of disability for an unrelated illness or injury, the seven calendar day waiting period is imposed. Note: The employee must have returned to full duty for 90 calendar days for these provisions to apply. The Restricted Duty benefit does not apply to the 90 calendar day renewal period.

The Cleveland Clinic Absence Management Office will make the final determination and indicate whether or not the current disability is related to a previous disability. The Office will hold discretionary authority to determine eligibility for benefits and/or to construe the terms of the Program.
Restricted Duty

Restricted Duty provides the employee with temporary relief from performing identified functions of his/her position consistent with the physical limitations designated by his/her physician. Depending on the nature of the disability, the requirements of the regular position and the operational needs of the department, an employee may continue to work in his/her position while observing the documented restrictions. In no event will Restricted Duty extend beyond twelve full weeks (480 hours) in a disability period.

Regardless of the position, the employee will continue to receive his/her regular pay rate as of the date that he/she was approved and placed in a Restricted Duty assignment. If an employee cannot be placed in a Restricted Duty assignment, the employee will be placed on an unpaid FMLA or medical leave, as appropriate. Overtime pay is not available to employees during Restricted Duty. The Cleveland Clinic Absence Management Office shall make the final determination as to whether or not the employee is capable of performing Restricted Duty functions based on medical documentation provided by the employee’s physician. Employees who refuse to work in a Restricted Duty assignment will be placed on an unpaid FMLA or medical leave and, where applicable, have their Workers’ Compensation benefits terminated.

Limitations Which Apply to Short Term Disability Benefits Coverage

Short Term Disability Benefits do not cover any disability that:

- Is for elective cosmetic surgery.
- During any period of time that the employee performs any work and/or service external to Cleveland Clinic for remuneration or profit which is inconsistent with his/her medical restrictions.
- An employee attempts to secure a Medical Authorization under fraudulent and/or misrepresented conditions.
- Is due to self-inflicted injury (while sane or insane; unintentional or intentional).
- Results from your committing, or attempting to commit an assault, battery, or felony.
- Is due to war or any act of war (declared or not declared).
- Is due to insurrection, rebellion, or taking part in a riot or civil commotion.
- Is not a non-occupational disease.
- Is not a non-occupational injury.

On any day during a period of disability that a person is confined in a penal or correctional institution for conviction of a criminal or other public offense:

- The person will not be deemed to be disabled; and no benefits will be payable.

Temporary and part-time employees are not eligible for Short Term Disability Benefits.

Appeal of Short Term Disability Benefit

The Cleveland Clinic Absence Management Office following review of the documented medical condition will determine eligibility of payment of Short Term Disability Benefit and an authorized Medical Leave of Absence. The Medical Right of Review Committee process, whose determination will be final, will resolve difference of medical opinion.
**Short Term Disability Benefit**  
**During a Scheduled PTO Period**

If an employee becomes injured or ill after completing the last scheduled work day before a scheduled PTO, Short Term Disability Benefit payment shall be applied in the following manner:

- If the employee is granted a Medical Leave of Absence, then the employee will use the subsequent scheduled PTO days as part of the seven calendar day waiting period or he/she may use accumulated sick days.
- If a Designated Holiday occurs during the Short Term Disability Benefit period, PTO is used for that holiday.

**Short Term Disability Benefit**  
**Vis A Vis Other Leave of Absence Benefit Periods**

If an employee becomes injured or ill after completing the last scheduled work day before a Bereavement leave, Short Term Disability Benefit payment shall be applied in the following manner:

- If the employee is granted a Medical Leave of Absence, then the employee will use the subsequent Bereavement days as part of the seven calendar day waiting period.
- If the Bereavement days occur during the Short Term Disability Benefit period, Bereavement benefit will be used instead of Short Term Disability Benefit.

If an employee becomes injured or ill after completing the last scheduled work day before Jury Duty, Short Term Disability benefit payments will not be applied or will cease when Jury Duty begins.

**Termination of Coverage**

Coverage under this benefit program terminates at the first to occur of:

- When employment ceases.
- When the employee is no longer in an Eligible Class.
Cleveland Clinic Long Term Disability Benefits

SUMMARY

Definition of Disability

“Disability” means an employee’s inability to perform the essential duties of their own occupation or an equivalent occupation by reason of any medically determinable physical or mental impairment. After a period of two years, inclusive of the approved six-month Short Term Disability period, “Disability” means the inability to perform the essential duties of any occupation for which an individual is reasonably suited by reason of education, training or experience.

Definition of Benefit Program Administrator

For the purposes of this Summary of Coverage, the following definitions of “Benefit Program Administrator” apply. The Long Term Disability (LTD) program for Cleveland Clinic is self-insured. As a result, the “Benefit Program Administrator” for Cleveland Clinic is the Long Term Disability Review Committee. The remaining hospitals in Cleveland Clinic have a fully-insured Long Term Disability program. As a result, their “Benefit Program Administrator” is Unum.

Eligibility

To be eligible, the employee must be classified as an active, regular, full-time employee and must have completed one continuous year of regular, full-time employment immediately prior to the onset of the illness or injury.

Enrollment

An employee will automatically be enrolled in core coverage if they are a regular full-time employee who has completed one continuous year of regular, full-time employment. Coverage becomes effective on their one-year anniversary of continuous full-time employment.

It is important to note that benefits will not be payable for any disability due to a pre-existing condition.

Benefits Payable

Waiting Period: The first 26 weeks of an approved Medical Leave of Absence, as defined under the Short Term Disability Plan.

Scheduled Monthly LTD Benefit:

Core: 60% of the claimant’s monthly pre-disability earnings.

(Any benefit actually payable may be reduced by “other income benefits.” This Summary of Coverage has definitions of “other income benefits,” “adjusted pre-disability earnings” and “pre-disability earnings.”)

Maximum Monthly Benefit:

Under this Benefit Program (together with all other income benefits)

Core: $15,000
Pre-Disability Earnings

This is the amount of salary or wages an employee was receiving from an employer participating in this Benefit Program on the day before a period of disability started, calculated on a monthly basis.

It will be figured from the rule below that applies to the employee.

If an employee is paid on an hourly basis, the calculation of their monthly wages is based on their hourly pay rate multiplied by the number of hours they are regularly scheduled to work per month, based on 2080 hours per year (40 hours per week). This may be prorated if the employee is regularly scheduled to work less than 40 hours per week.

If an employee is paid on a salaried basis, the calculation of their monthly wages is based on 2080 hours per year (40 hours per week). This may be prorated if the claimant is regularly scheduled to work less than 40 hours per week.

Included in salary or wages are:

• Gross base salary

Not included in salary or wages are:

• Awards and bonuses
• Overtime pay
• Contributions made by the Employer to any deferred compensation arrangement or pension plan.

A retroactive change in the claimant’s rate of earnings will not result in a retroactive change in coverage.

Other Income Benefits

They are:

• 50% of any award provided under The Jones Act or The Maritime Doctrine of Maintenance, Wages and Cure.
• Disability, retirement, or unemployment benefits required or provided for under any law of a government. Examples are:
  − Unemployment compensation benefits
  − Temporary or permanent, partial or total disability benefits under any state or federal workers’ compensation law or any other like law, which are meant to compensate the worker for any one or more of the following: loss of past and future wages; impaired earning capacity; lessened ability to compete in the open labor market; any degree of permanent impairment; and any degree of loss of bodily function or capacity.
  − Automobile no-fault wage replacement benefits to the extent required by law.
  − Statutory disability benefits
  − Benefits under the Federal Social Security Act, the Railroad Retirement Act, the Canada Pension Plan, and the Quebec Pension Plan
  − Veterans’ benefits
• Disability or unemployment benefits under:
  − Any group insurance plan
  − Any other type of coverage for persons in a group. This includes both plans that are insured and those that are not.
• Disability payments which result from the act or omission of any person whose action caused your disability. These payments may be from insurance or other sources.

Other income benefits include those, due to a disability, which are payable to: the claimant, their spouse, their children, or their dependents.
The Benefit Program Administrator will determine other income benefits as follows:

- **Lump Sum Payments From Workers’ Compensation Or Which Result From The Act Or Omission Of Any Person Who Caused The Disability:**
  - That part of the lump sum payment that is for disability will be counted, even if it is not specifically apportioned or identified as such. This will be done if it is or is not the result of a compromise, settlement, award or judgment. If there is no proof acceptable to the Benefit Program Administrator as to what that part is, 50% will be deemed to be for disability.
  - This amount will be broken down to a period of time equal to the lesser of: (a) the remaining benefit duration; and (b) 60 months. If the lump sum payment is tied to a specific period, the period of time will start on the same date as the period for which the lump sum payment is made. If the lump sum payment is not tied to a specific period, the period of time will start on the first day of the calendar month following the date that the lump sum payment is made.

- **Other Payments:**
  - Payments In A Lump Sum: These will be broken down to a period of time equal to the lesser of: (a) the remaining benefit duration; and (b) 60 months. These will include periodic payments that could have been chosen in a lump sum.
  - Periodic Payments: These will be broken down to monthly periods. These will include amounts, which are an accumulation of past due periodic payments.
  - Any of these “Other Payments” that date back to a prior date may be allocated on a retroactive basis.

**Estimated Payments**

The amount of other income benefits for which the claimant appears to be eligible will be estimated, unless they have signed and returned a reimbursement agreement to the Benefit Program Administrator. This agreement contains the claimant’s promise to repay the Benefit Program Administrator for any overpayment of benefits made to them.

If other income benefits are estimated, the monthly benefit will be adjusted when we receive proof:

- Of the exact amount awarded; or
- That benefits have been denied after review at the highest administrative level.

The Benefit Program Administrator will pay the claimant if any underpayment in their monthly benefit results. The claimant will have to repay the Benefit Program Administrator if any overpayment results. When the Benefit Program Administrator has to take legal action against the claimant to recover any overpayment, they will also have to pay the Benefit Program Administrator’s reasonable attorney’s fees and court costs, if the Benefit Program Administrator prevails.

**Effect of Increases in Other Income Benefits on Monthly Benefits**

Increases in the level of other income benefits due to the following will be considered “other income benefits:”

- A change in the number of family members;
- A re-computation or recalculation to correct or adjust the benefit level as first established for the period of total disability; or
- A change in the severity of the disability.

There may be cost of living increases in the level of other income benefits received from a governmental source during a period of total disability. These increases will not be deemed to be “other income benefits.”

There may be cost of living or general increases in the level of other income benefits from a non-governmental source during a period of total disability. These increases will not be considered other income benefits to the extent they are based on the annual average increase in the Consumer Price Index.
Other Income Benefits Which Do Not Reduce Monthly Benefits

The amount of any retirement or disability benefits the claimant was receiving from the following sources before the date they became disabled under this LTD Benefit Program will not reduce the monthly benefits:

- Military and other government service pensions;
- Retirement benefits from a prior employer; and
- Veterans’ benefits for service related disabilities.

Also, the amount of any income or other benefits the claimant receives from the following sources will not reduce their monthly benefits:

- Profit sharing plans;
- Thrift plans;
- 401(k)/403(b) plans;
- Keogh plans;
- Employee stock option plans; or
- Tax sheltered annuity plans.

- Disability benefits under any group mortgage or group credit disability plan funded by the claimant’s after-tax contributions.

A Period of Total Disability

A period of total disability starts on the first day the claimant is totally disabled as a direct result of a significant change in their physical or mental condition occurring while they are insured under this Benefit Program. The claimant must be under the care of a physician. (The claimant will not be deemed to be under the care of a physician more than 31 days before the date he or she has seen and treated you in person for the disease or injury that caused the total disability.)

The period of total disability ends on the first to occur of:

- The date the claimant is not disabled, as defined under the Benefit Program.
- The date the claimant starts work at a reasonable occupation.
- The date the claimant fails to give proof that they are still disabled, as defined under the Benefit Program.
- The date the claimant refuses to be examined.
- The date the claimant ceases to be under the care of a physician.
- The date the claimant reaches the expiration of the Maximum Benefit Duration shown in this Summary of Coverage.
- The date the claimant performs any work and/or service for remuneration or profit, except rehabilitative employment approved by the Cleveland Clinic LTD Benefit Program Administrator.
- The date of the claimant’s death.
- The day after the Benefit Program Administrator determines the claimant is able to participate in an Approved Rehabilitation Program and refuses to do so.
- Also, a period of disability will end after 24 monthly benefits are payable, if it is determined that the disability is, at that time, caused to any extent by a mental condition (including conditions related to alcoholism or drug abuse) described in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.
**Maximum Benefit Duration**

- If the claimant’s period of total disability starts prior to the date they reach age 62, it will end with the calendar month in which they reach Normal Retirement Age.
- If the claimant’s period of total disability starts on or after the date they reach age 62, it will end with the expiration of the number of months of total disability, after the waiting period is met, as figured from the following Schedule:

<table>
<thead>
<tr>
<th>Age When Period of Total Disability Starts</th>
<th>Months of Total Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>62 but less than 63</td>
<td>To Normal Retirement Age or 42 months, if greater</td>
</tr>
<tr>
<td>63 but less than 64</td>
<td>To Normal Retirement Age or 36 months, if greater</td>
</tr>
<tr>
<td>64 but less than 65</td>
<td>30 months</td>
</tr>
<tr>
<td>65 but less than 66</td>
<td>24 months</td>
</tr>
<tr>
<td>66 but less than 67</td>
<td>21 months</td>
</tr>
<tr>
<td>67 but less than 68</td>
<td>18 months</td>
</tr>
<tr>
<td>68 but less than 69</td>
<td>15 months</td>
</tr>
</tbody>
</table>
| 69 and over                                | 12 months                 

Normal Retirement Age means the Social Security Normal Retirement Age as stated in the 1983 revision of the United States Social Security Act. It is determined by your date of birth as follows:

<table>
<thead>
<tr>
<th>Year of Birth</th>
<th>Normal Retirement Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>1937 or before</td>
<td>65</td>
</tr>
<tr>
<td>1938</td>
<td>65 + 2 months</td>
</tr>
<tr>
<td>1939</td>
<td>65 + 4 months</td>
</tr>
<tr>
<td>1940</td>
<td>65 + 6 months</td>
</tr>
<tr>
<td>1941</td>
<td>65 + 8 months</td>
</tr>
<tr>
<td>1942</td>
<td>65 + 10 months</td>
</tr>
<tr>
<td>1943 through 1954</td>
<td>66</td>
</tr>
<tr>
<td>1955</td>
<td>66 + 2 months</td>
</tr>
<tr>
<td>1956</td>
<td>66 + 4 months</td>
</tr>
<tr>
<td>1957</td>
<td>66 + 6 months</td>
</tr>
<tr>
<td>1958</td>
<td>66 + 8 months</td>
</tr>
<tr>
<td>1959</td>
<td>66 + 10 months</td>
</tr>
<tr>
<td>1960 or after</td>
<td>67</td>
</tr>
</tbody>
</table>

- Maximum Benefit Duration is 24 months for psychiatric and/or substance abuse disabilities as defined in this Summary of Coverage. All other limitations of the plan will also apply.

*Unless the claimant’s period of total disability ends earlier for one or more of the reasons stated in this Summary of Coverage.*
How Separate Periods of Total Disability Are Treated

Once a period of total disability has ended, any new period of disability will be treated separately. However, two or more separate periods of total disability due to the same or related causes, which are separated by less than six months, will be deemed to be one period of total disability. Only one waiting period will apply.

The first period will not be included if it began while you were not covered under this LTD Benefit Program.

How and When to Report Your Claim

The claimant and their employer must submit the claim to the Benefit Program Administrator in writing on forms supplied by the Benefit Program Administrator. The claim must give proof of the nature and extent of the loss. The Benefit Program Administrator may require copies of documents to support the claim, including data about any other income benefits. The claimant must also provide the Benefit Program Administrator with authorizations to allow it to investigate the claim and their eligibility for and the amount of other income benefits.

The claimant must furnish such true and correct information as the Benefit Program Administrator may reasonably request.

Unless other conditions prevail, as reviewed by the Benefit Program Administrator on a case-by-case basis, any claim must be received within 31 days following the end of the claimant’s waiting period. Claims not received within this time frame are not eligible for LTD review or benefits. In no case, will any claim be accepted later than one year from the end of the claimant’s waiting period, unless they are legally incapacitated.

The Benefit Program Administrator has the right to require proof that:

- The claimant, their spouse, child, or dependent has made application for all other income benefits which they are, or may be, eligible to receive relative to the claimant’s disability and has made a timely appeal of any denial through the highest Administrative level. Timely appeal means making such an appeal as required, but in no case later than 60 days from the latest denial;
- The person has furnished proofs needed to obtain other income benefits;
- The person has not waived any other income benefits without the Benefit Program Administrator’s written consent; and
- The person has sent copies of documents to the Benefit Program Administrator showing the effective dates and the amounts of other income benefits.

The Benefit Program Administrator also requires proof:

- Of income the claimant receives from any occupation for compensation or profit.

In addition to the above, for purposes of Federal Social Security, when a timely application for benefits has been made and denied, a request for reconsideration must be made within 60 days after the denial, unless the Benefit Program Administrator states, in writing, that it does not require the claimant to do so. Also, if the reconsideration is denied, an application for a hearing before an Administrative Law Judge must be made within 60 days of that denial unless the Benefit Program Administrator relieves the claimant of that obligation.

The Claimant does not have to apply for:

- Retirement benefits paid only on a reduced basis; or
- Disability benefits under group life insurance if they would reduce the amount of group life insurance; but, if the claimant does apply for and receive these benefits, they will be deemed to be other income benefits for which proof is required.

If the claimant does not furnish proof of other income benefits, the Benefit Program Administrator reserves the right to suspend or adjust benefits by the estimated amount of such other income benefits.
How Benefits Will Be Paid
Benefits will be paid to the claimant at the end of each calendar month during the period for which benefits are payable. Benefits for a period less than a month will be prorated. This will be done on the basis of the ratio, to 30 days, of the days of eligibility for benefits during the month.

Any unpaid balance at the end of the Benefit Program Administrator’s liability will be paid within 24 days of receipt, by the Benefit Program Administrator of the due written proof.

The Benefit Program Administrator may pay up to $1,000 of any benefit to any of the claimant’s relatives whom it believes fairly entitled to it. This can be done if the benefit is payable to the claimant and the claimant is a minor or not able to give a valid release. It can also be done if a benefit is payable to the claimant’s estate.

Recovery of Overpayments
If payments are made in amounts greater than the benefits that the claimant is entitled to receive, the Benefit Program Administrator has the right to do any one or all of the following:
• To require the claimant to return the overpayment on request;
• To stop payment of benefits until the overpayment is recovered;
• To take any legal action needed to recover the overpayment; and
• To place a lien, if not prohibited by law, in the amount of the overpayment on the proceeds of any other income, whether on a periodic or lump sum basis.

Examinations and Evaluations
The Benefit Program Administrator will have the right and opportunity to examine and evaluate any person who is the basis of any claim at all reasonable times while that claim is pending or payable.

Physician
“Physician” means a legally qualified physician. If any part of a period of total disability is caused, to any extent, by a mental condition, “physician” shall mean a legally qualified physician whom:
• Specializes in psychiatry; or
• Is trained or experienced to evaluate and treat a mental condition.

If any part of a period of total disability is caused, to any extent, by a condition related to alcoholism or drug abuse, “physician” shall mean a legally qualified physician who is trained or experienced to evaluate and treat the condition.
Approved Rehabilitation Program

This is a program of physical, mental, or vocational rehabilitation which:
• Is expected to result in maximizing the claimant’s employability; and
• Is approved, in writing, by the Benefit Program Administrator.

A rehabilitation program will cease to be an Approved Rehabilitation Program on the earliest to occur of:
• The date the claimant is able to perform the material duties of their own occupation or work at any other reasonable occupation;
• The date the Benefit Program Administrator withdraws, in writing, its approval of the program.

The Benefit Program Administrator retains the right to evaluate the claimant for participation in an Approved Rehabilitation Program.

If, in the Benefit Program Administrator’s judgment, the claimant is able to participate, the Benefit Program Administrator may, in its sole discretion, require the claimant to participate in an Approved Rehabilitation Program.

This Benefit Program will pay for all services and supplies, approved in advance by the Benefit Program Administrator, needed in connection with such participation; except for those for which the claimant can otherwise receive reimbursement from any third-party payor, including any governmental benefits to which the claimant may be entitled.

Pre-existing Condition Limitations

The LTD Benefit Program does not provide benefits for a disability caused by, contributed to by, or resulting from a pre-existing condition.

A pre-existing condition is any medical condition for which an employee had expenses or received treatment, consultation, care, diagnostic services, or had taken prescription drugs or medicines within the three months prior to becoming covered by the Benefit Program. However, benefits will be provided, if approved by the Benefit Program Administrator:
• For the Core LTD Benefit Program, when that disability begins after one year of continuous active employment, after the employee becomes covered by the Core LTD Benefit Program.

Limitations Which Apply to Long Term Disability Coverage

Long Term Disability Coverage does not cover any disability that:
• Is due to intentionally self-inflicted injury (while sane or insane).
• Results from committing, or attempting to commit an assault, battery, or felony.
• Is due to war or any act of war (declared or not declared).
• Is due to: insurrection; rebellion; or taking part in a riot or civil commotion.

On any day during a period of disability that a person is confined in a penal or correctional institution for conviction of a criminal or other public offense:
• The person will not be deemed to be totally disabled; and
• No benefits will be payable.
• Starts during the first 12 months of the claimant’s current Long Term Disability Coverage, if it is caused or contributed to by a “pre-existing condition.” A disease or injury is a pre-existing condition if, during the three months before the date the claimant last became covered:
  – It was diagnosed or treated; or
  – Services were received for the disease or injury; or
  – The claimant took drugs or medicines prescribed or recommended by a physician for that condition.
**Termination of Coverage**

Coverage under this Benefit Program terminates at the first to occur of:
- When employment ceases.
- When the group contract terminates as to the coverage.
- When the employee is no longer in an Eligible Class.
- When the employee fails to make any required contribution.
- When the employee commences his/her Cleveland Clinic Retirement Benefit Program benefits.

Ceasing active work will be deemed to be cessation of employment. If the employee is not at work due to one of the following, employment may be deemed to continue up to the limits shown below.

If the employee is not at work due to temporary lay-off or leave of absence, their employment will be deemed to cease on their last full day of active work before the start of the lay-off or leave of absence.

In figuring when employment will stop for the purposes of termination of any coverage, the Benefit Program Administrator will rely upon the Employer to notify the Benefit Program Administrator. This can be done by telling the Benefit Program Administrator or by stopping premium payments. Employment may be deemed to continue beyond any limits shown above if the Benefit Program Administrator and the Employer so agree in writing.

**Benefits May Continue After Termination**

If the claimant’s coverage ceases during a period of total disability, which began while they had coverage, benefits will be available as long as their period of total disability continues.
General Provisions
The following additional provisions apply to this coverage.

An employee cannot receive multiple coverage under this Benefit Program because they are connected with more than one Employer.

In the event of a misstatement of any fact affecting an employee’s coverage under this Benefit Program, the true facts will be used to determine the coverage in force.

This document describes the main features of this Program. Additional provisions are described elsewhere in the group contract. If you have any questions about the terms of this Program or about the proper payment of benefits, an employee may obtain more information from their Employer or, if they prefer, from the Home Office of the Benefit Program Administrator. The Employer hopes to continue this Program indefinitely but, as with all group plans, this Benefit Program may be changed or discontinued with respect to all or any class of employees.

Privacy Notice
The information in this Notice is not a part of either the group contract or the Summary of Coverage. It is important to an employee as a covered person under the group contract. The Benefit Program Administrator has bound it into this document only as an aid to an employee in keeping insurance-related material together.

This Notice describes certain aspects of the Benefit Program Administrator's insurance privacy policy, which apply to an employee as a covered person in a plan of group insurance insured by the Benefit Program Administrator. The policy does not apply where a different approach is required by law.

Information Which May Be Collected
The Benefit Program Administrator, in providing insurance services to an employee, relies mainly on the information the employee gives on their group enrollment form and when they file claims.

The Benefit Program Administrator may also collect information about an employee from other sources. This is information necessary for the Benefit Program Administrator to perform its function with regard to the insurance transaction in question. For example, if the amount or type of coverage an employee is entitled to depends on their earnings or job class, the Benefit Program Administrator would obtain that information from the Employer.
Disclosure of Information to Others

All of this information will be treated as confidential. It will not be disclosed to others without the employee's authorization, except in some instances where such disclosure is necessary for the conduct of the Benefit Program Administrator's business. Disclosure cannot be contrary to any law, which applies.

The following sets forth the types of disclosure that may be made:

- Financial information (but not medical information) may be made available to the Employer or his or her representative in connection with the administration of the Program. Information may also be made available in connection with policyholder audits.
- Information may be disclosed to other insurers if there may be duplicate coverage or a need to preserve the continuity of your coverage.
- Information may be disclosed to Peer Review Organizations and other agencies to determine whether health services were necessary and reasonably priced.

In addition, information may be given to regulators of the Benefit Program Administrator's business and to others as may be required by law. It may also be given to law enforcement authorities when needed to prevent or prosecute fraud or other illegal activities.

Your Right of Access and Correction

In general, an employee has a right to learn the nature and substance of any information the Benefit Program Administrator has in its files about them. An employee may also have a right of access to such files, except information, which relates to a claim or a civil or criminal proceeding, and to ask for correction, amendment, or deletion of personal information. This can be done in states which provide such rights and which grant immunity to insurers providing such access. If an employee requests any health information, the Benefit Program Administrator may elect to disclose details of the information the employee requests to their (attending) physician. If an employee of a Cleveland Clinic Regional hospital or Cleveland Clinic Florida wishes to exercise this right or wishes to have more detail on these information practices, please contact:

Unum
2211 Congress Street
Portland, ME 04122

Or for employees of Cleveland Clinic:
Cleveland Clinic
Absence Management Office / AC341
3050 Science Park Drive
Beachwood, OH 44122
Continuation of Coverage During an Approved Leave of Absence Granted to Comply with Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If the Employer grants an employee an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be subject to prior written agreement between the Benefit Program Administrator and the Employer.

If the Employer grants an employee an approved FMLA leave in accordance with FMLA, the Employer may allow an employee to continue coverage for which they are covered under the group contract on the day before the approved FMLA leave starts. However, if a period of disability starts while an employee is on an approved FMLA leave, the waiting period for such period of disability will not be deemed to end until the later of:

• The date an employee completes the waiting period; and
• The date the employee is scheduled to return to active work following the approved FMLA leave.

At the time an employee requests the leave, they must agree to make any contributions required by the Employer to continue coverage. The Employer must continue to make premium payments.

Coverage will not be continued beyond the first to occur of:

• The date an employee is required to make any contribution and fails to do so.
• The date the Employer determines the approved FMLA leave is terminated.
• The date the coverage involved discontinues as to an employee’s eligible class.

If an employee returns to work for the Employer, following the date the Employer determines the approved FMLA leave is terminated, an employee’s coverage under the group contract will be in force, as though they had continued in active employment rather than going on an approved FMLA leave, provided they make request for such coverage within 31 days of the date the Employer determines the approved FMLA leave to be terminated. If an employee does not make such request within 31 days, coverage will again be effective under the group contract only if and when the Benefit Program Administrator gives its written consent.

Claim Procedures

This Summary of Coverage contains information on reporting claims. Claim forms may be obtained at the employee’s place of employment. These forms tell the employee how and when to file a claim.

If a claim is denied in whole or in part, the claimant will receive a written notice of the denial from the Benefit Program Administrator. The notice will explain the reason for the denial and the review procedures.

The claimant may request a review of the denied claim. The request must be submitted, in writing, within 60 days after the claimant receives the notice. Include any and all reasons for requesting the review. Submit the request to the office of the Benefit Program Administrator to which the claimant submitted the initial request for benefit payment.

The Benefit Program Administrator will review the claim and ordinarily notify the claimant of its final decision within 60 days of receipt of the request. If special circumstances require an extension of time, the claimant will be notified of such extension during the 60 days following receipt of the request.
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). ERISA provides that all plan participants shall be entitled to:

**Receive Information about Your Plan and Benefits**

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.

**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. This following provides information specific to the Cleveland Clinic Welfare Benefit Plan (the “Plan”), and the Disability Benefit Program (the “Benefit Program”) which is a component of the Plan and provides disability benefits to certain employees.

<table>
<thead>
<tr>
<th><strong>Official Plan Name</strong></th>
<th>Cleveland Clinic Welfare Benefits Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Official Benefit Program Name</strong></td>
<td>Cleveland Clinic Disability Benefit Program</td>
</tr>
<tr>
<td><strong>Plan Number</strong></td>
<td>530</td>
</tr>
<tr>
<td><strong>Type of Administration</strong></td>
<td>The Benefit Program is a combination of a fully-insured and self-insured benefit plan offering Short-Term and Long-Term Disability benefits.</td>
</tr>
<tr>
<td><strong>Contributions to the Benefit Programs</strong></td>
<td>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 administration of the Benefit Program.</td>
</tr>
<tr>
<td><strong>Funding Medium</strong></td>
<td>Benefits provided by this Benefit Program are provided solely through Cleveland Clinic.</td>
</tr>
<tr>
<td><strong>Plan Sponsor, Plan Administrator and Plan Fiduciary</strong></td>
<td>Cleveland Clinic 3050 Science Park Drive / AC341 Beachwood, OH 44122 216.448.0600</td>
</tr>
<tr>
<td><strong>Agent for Service of Legal Process</strong></td>
<td>Cleveland Clinic Law Department / AC321 3050 Science Park Drive Beachwood, OH 44122</td>
</tr>
<tr>
<td><strong>Plan Year</strong></td>
<td>January 1 – December 31</td>
</tr>
<tr>
<td><strong>Employer Identification Number of Plan Sponsor</strong></td>
<td>34-0714585</td>
</tr>
<tr>
<td><strong>Benefit Program Effective Date</strong></td>
<td>The Plan is effective as of January 1, 2013 and the provisions of the Benefit Program are effective January 1, 2015.</td>
</tr>
</tbody>
</table>
Plan Documentation .......... If there are any discrepancies between this Summary Plan Description (SPD) and the provisions of the 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 employee’s coverage under the Benefit Program. If the Plan and/or Benefit Program is amended, modified, or terminated, the rights of employees are limited to benefits incurred prior to the Plan’s or Benefit Program’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 and/or Benefit Program. Benefits are payable under the Plan and/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 and/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.