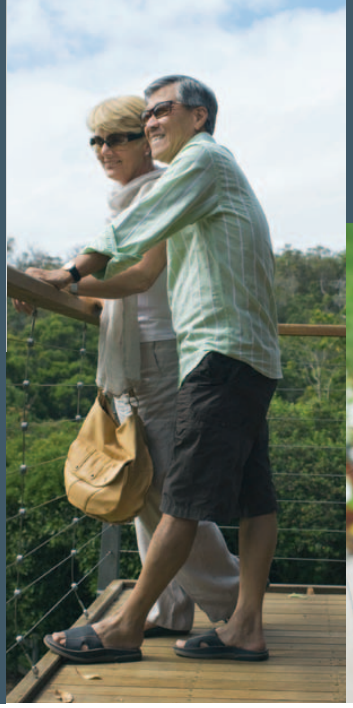

Cleveland Clinic

2011 Benefit Program Summary

INFORMATION ABOUT YOUR BENEFITS

INSIDE THIS SUMMARY

Cleveland Clinic offers a comprehensive and competitive benefits program that recognizes the needs of a diverse workforce, provides individuals and families with meaningful choices and lets employees change work locations without experiencing interruptions in benefit coverage.

Eligibility

Employees

In general, the benefits described in this summary are offered to:

- Regular full-time employees scheduled to work 72 to 80 hours per pay period, and
- Regular part-time/weekender employees scheduled to work 40 to 71 hours per pay period.

Eligible Dependents for Coverage under the Cleveland Clinic Medical Plan

1. Your lawful spouse (not divorced nor legally separated).
2. Your dependent children who are: your natural children, stepchildren, legally adopted children, or children under an officially court-appointed guardianship who are under age 26.
3. Your unmarried children age 26 or older who are disabled as determined by the Social Security Administration. Proof of disability must be provided to HR within 31 days after the determination of disability.

Eligibility

(continued)

Ineligible dependents include:

- Employee's parents
- Grandchildren
- Nieces
- Nephews
- Ex-Spouses
- Common-law marriage partners (after the year 1991)
- Foster children who have not been legally adopted

Eligible Dependents for Coverage under the Dental and Vision Plans

1. Your lawful spouse (not divorced nor legally separated).
2. Your dependent children who are: your natural children, stepchildren, legally adopted children, or children under an officially court-appointed guardianship who are age 23 or younger.
3. Your unmarried children age 23 or older who are disabled as determined by the Social Security Administration. Proof of disability must be provided to HR within 31 days after the determination of disability.

Ineligible dependents include:

- Employee's parents
- Grandchildren
- Nieces
- Nephews
- Ex-Spouses
- Common-law marriage partners (after the year 1991)
- Foster children who have not been legally adopted

Domestic Partners*

If you participate in the Health, Dental or Vision plan(s), your same-gender domestic partner also is eligible to participate in the plan(s) if **all** of these criteria are met:

- You both are of the same gender.
- You both are age 18 or older and mentally competent to enter into contracts.
- You both reside in the same household.
- You and your partner have been in a committed relationship with one another for at least six months and intend to remain in the relationship solely and indefinitely with one another.
- You have joint responsibility for one another's welfare and financial obligations.
- You are not related by blood to a degree that would prohibit marriage under the law of the state in which you reside.
- You are not currently married to any other person under either statutory or common law.

Please note: Domestic Partner Benefits are not available to Marymount Hospital employees.

*Dependent children of domestic partners also are eligible for coverage as long as they meet the eligibility requirements for dependents outlined above.

BeneFlex Program

Cleveland Clinic's Flexible Benefits Program — BeneFlex — lets **you** select benefits that meet your and your family's needs, including Health, Dental, Vision, Flexible Spending Accounts, Supplemental and Dependent Life insurance, and in some instances, disability insurance. You pay a portion of the cost of your coverage, based on who you decide to cover. The BeneFlex coverage you select begins on your date of hire.

Make your BeneFlex selections carefully because you can change them only once a year – during Open Enrollment, which usually takes place in October.

The following are Cleveland Clinic Tier 1 Network Hospitals:

- Cleveland Clinic
- Cleveland Clinic Children's Hospital for Rehabilitation
- Ashtabula County Medical Center
- Euclid Hospital
- Fairview Hospital
- Hillcrest Hospital
- Huron Hospital
- Lakewood Hospital
- Lutheran Hospital
- Marymount Hospital
- Medina Hospital
- South Pointe Hospital
- Cleveland Clinic Florida
- Cleveland Clinic Nevada

Qualifying Life Events

The only other time(s) it is permissible to make certain changes to BeneFlex selections is within 31 days of a **qualifying life event**, which the IRS defines as:

- Changes in legal marital status, including marriage, death of a spouse, divorce, legal separation or annulment.
- Changes in the number of dependents for reasons that include birth, adoption, placement for adoption, the assumption of legal guardianship, or death.
- Employment status changes, meaning an employee, spouse or dependent starts a new job or loses a current job.
- Work schedule changes, meaning a reduction or increase in hours of employment for the employee, spouse, or dependent, including a switch between part-time and full-time, a strike or lockout, or the beginning or end of an unpaid leave of absence.
- Changes in work location, meaning a change in the place of residence or work of an employee, spouse, or dependent.
- A dependent satisfies – or no longer satisfies – the plan requirements for unmarried dependents because of age, job status or other circumstances.
- A qualified medical child support court order (QMCSO), or other similar order, that requires health coverage for an employee's child.
- The employee, spouse or dependent qualifies for Medicare or Medicaid. (If this happens, Health Plan coverage may be cancelled for that individual.)

If you experience a qualifying life event and wish to change your coverage, you must contact the Benefits Department within 31 days of the event and provide the necessary supporting documentation. Any adjustment to coverage must be consistent with the changes resulting from the qualifying life event.

Health Plans

Choosing the right medical coverage is one of the most important benefit decisions you will make. You have several choices, and each offers a comprehensive network of medical providers, including primary care physicians (PCPs), specialists, hospitals and allied healthcare providers. (Health Plan options are the same throughout Cleveland Clinic, except for the choice of Kaiser Permanente HMO, which is an option only at Cleveland Clinic, Cleveland Clinic Children's Hospital for Rehabilitation, Cleveland Clinic Home Care Services, Fairview Hospital, Lakewood Hospital, Lutheran Hospital, Marymount Hospital and Medina Hospital.)

Cleveland Clinic's Health Plans provide valuable financial assistance for costs associated with serious illness and injury, as well as help in maintaining good health through preventive care. **None of the Health Plans offered by Cleveland Clinic excludes pre-existing conditions.** Following are brief descriptions and charts summarizing the Health Plans.

Cleveland Clinic Employee Health Plan Total Care

Total Care provides its members with comprehensive healthcare coverage through a two-tier network of providers. The tier of providers you select determines the amount of coverage you will receive.

Tier 1 includes all Cleveland Clinic and system hospital providers who are credentialed through Community Physician Partnership (CPP). Using this tier of providers gives you maximum coverage.

Tier 2 providers include the following three provider networks:

- Cleveland Health Network (CHN) – a regional network of hospitals, physicians, and other healthcare providers in northern Ohio and western Pennsylvania – Web site: www.chnetwork.com.
- Medical Mutual Traditional Network – a network of providers within the state of Ohio. Web site: www.supermednetwork.com and click on "Traditional".
- USA Managed Care Organization (USAMCO) – a network of providers outside the state of Ohio. Web site: www.usamco.com.

Tier 2 benefits are often used by members for non-routine services such as treatment and/or follow-up for sprains, diabetes, hypertension, or any chronic condition, rehab therapies, colds, wounds, and follow-up treatment for emergency/urgent care services (usually used for students outside the Tier 1 network or if a member is on vacation and requires care).

The chart on page 6 provides a comparison of key plan features and coverage under the two tiers.

Total Care Wellness Program

This program helps Total Care member employees focus on three areas: smoking cessation, weight management and physical activity. If the member employee completes the Total Care application at sign-up, these services are offered free of charge. The Total Care Wellness Program Application requires an original signature that authorizes Total Care to collect specific data, including height, weight, waist and hip circumference, smoking status at six months and one year, and participation rates for tracking program success.

Total Care Medical Management

Total Care Medical Management offers robust coordinated care and pharmacy programs that help Total Care members address chronic conditions such as diabetes, high blood pressure and asthma, and it provides reimbursement for physician office visit co-payments and prescription co-insurance as long as Total Care members comply with specific care criteria.

Total Care Claims Processing

Antares Management Solutions serves as the Third-Party Administrator (TPA) for Total Care. Antares processes claims for all medical and behavioral health services received by Total Care members (Total Care Behavioral Health coverage is described on page 7).

EHP Total Care Health Plan Summary

		Tier 1 Cleveland Clinic Provider Network	Tier 2 CHN, MMO* and USAMCO* Provider Networks
Annual Deductible	Individual Family	None None	$500 $1,500
Out-of-Pocket Maximum	Individual Family	$1,500 $3,000	$5,000 $15,000
PCP Office Visit	Family Practice, Gynecology, Internal Medicine, Obstetrics and Pediatrics	100% of Allowed Amount	$25 co-pay, then 70% of allowed amount, after deductible
Specialist Office Visits		100% of Allowed Amount after $35 co-pay (No referral required)	$50 co-pay, then 70% of allowed amount, after deductible
Maternity Care		100% of Allowed Amount after one time $50 co-pay	One time $100 co-pay, then 70% of allowed amount, after deductible
Routine (Annual) Physical Examination by PCP		100% of Allowed Amount	Not Covered
Routine (Annual) Vision Examination		100% of Allowed Amount after $25 co-pay (No referral required)	Not Covered
Inpatient Hospital Services		100% of Allowed Amount	70% of Allowed Amount
Outpatient Hospital Services		100% of Allowed Amount	70% of Allowed Amount
Laboratory/Diagnostics Tests		100% of Allowed Amount	70% of Allowed Amount
Emergency Department	Emergency Care Urgent Care	100% after $50 co-pay 100% after $50 co-pay	100% after $50 co-pay 100% after $50 co-pay
Medical Supplies and Durable Medical Equipment		80% of Allowed Amount (does NOT accumulate to out-of-pocket max)	80% of Allowed Amount (does NOT accumulate to out-of-pocket max)
Extended Care/Skilled Nursing Care – 180 Days per Benefit Year		100% of Allowed Amount	70% of Allowed Amount
Long-Term Acute Care – 180 Days Lifetime Maximum		100% of Allowed Amount	Not Covered
Hospice Respite Care – 10 Days per Benefit Year		100% of Allowed Amount 100% of Allowed Amount	100% of Allowed Amount 100% of Allowed Amount
Home Health Care – 100 Visits per Benefit Year		100% of Allowed Amount	70% of Allowed Amount
Chiropractic – Maximum of 20 Visits per Benefit Year		First 10 visits: 100% of Allowed Amount after $10 co-pay Second 10 visits: 50% of Allowed Amount (Children under 16 require pre-certification by the EHP Medical Management Department)	Not Covered
Therapy Services	Occupational/Speech/Physical –Maximum of 26 Visits per Therapy per Benefit Year	100% of Allowed Amount after $10 co-pay per visit	100% of Allowed Amount after $10 co-pay per visit (does NOT accumulate to out-of-pocket max)
Dental - Surgical extractions for soft/bony impactions, or Dental implants for certain medical conditions or recent accidents/injuries		100% of Allowed Amount	Not Covered
Family Planning†		100% of Allowed Amount	Not Covered
Infertility	Diagnostic Only	100% of Allowed Amount	Not Covered
Hearing Aids		50% of Charge up to $2,000/Ear Limited to one aid per Ear every 3 years	Not Covered
Organ Transplant Transplant Lifetime Maximum Out-of-Pocket Maximum		100% of Allowed Amount Unlimited See Above	70% of Allowed Amount Unlimited Unlimited

For Tier 1, all co-payments and co-insurance listed on this chart accumulate to your out-of-pocket maximum with the exception of co-payments for durable medical equipment.

For Tier 2 ancillaries (services such as dialysis, ambulance transportation, home health, skilled nursing facilities and hospice), co-payments and co-insurance do **NOT** accrue to the out-of-pocket maximum.

* MMO Traditional for the state of Ohio and USAMCO outside the state of Ohio.

† Marymount employees are subject to family planning exclusions including abortion, vasectomy, Norplant, Depo Provera, IUD, tubal ligation, and oral contraceptives, except if medically necessary.

Total Care/SummaCare EPO Prescription Drug Benefit

Total Care/SummaCare EPO Prescription Drug Benefit is administered through CVS/Caremark, the nation's largest provider of prescriptions and related healthcare services.

There is a front-end deductible of $100 for each member, with a maximum deductible of $300 per family. **This deductible is waived if members fill prescriptions with generic medications from Cleveland Clinic Pharmacies.** Total Care and SummaCare members also receive enhanced benefits for other prescriptions filled at Cleveland Clinic pharmacies. In addition, the plan covers prescriptions for oral contraceptives – *except for Marymount plan participants, unless the prescriptions are medically necessary.* Note: Kaiser Permanente administers its own pharmacy program.

The chart on page 9 highlights the features of the Total Care/SummaCare EPO Prescription Drug Benefit.

EHP Total Care Behavioral Health Benefits

Total Care behavioral health and substance abuse services are administered through the Total Care Medical Management Department. To receive maximum benefits for inpatient behavioral health and/or substance abuse services, plan members must obtain prior authorization from Medical Management. The chart below highlights plan benefits.

	Tier 1 – Cleveland Clinic Provider Network	Tier 2 – CHN, MMO* and USAMCO* Provider Networks
Annual Deductible†		
Individual	$0	$500
Family	$0	$1,500
Out-of-Pocket Maximum	Unlimited	Unlimited
Outpatient Coverage •		
35 Outpatient (OP) Visits in a Calendar Year for Mental Health and/or Substance Abuse‡	100% of Allowed Amount after $35 co-pay	$50 co-pay (after deductible) with 100% of Allowed Amount
Psychological and Neuro-Psychological Testing §	100% of Allowed Amount after $35 co-pay	Not Covered
(See Benefits and Coverage Clarification)		
Inpatient Coverage‡		
Up to 30 Inpatient (IP) Days in a Calendar Year for Mental Health and/or Substance Abuse	100%	70%
Inpatient Lifetime Maximum for Mental Health	None	None
Inpatient Lifetime Maximum for Substance Abuse	None	None
Intensive Outpatient (IOP)‡		
24 Visit Limit per Calendar Year for Mental Health and/or Substance Abuse	100%	70%
Partial Hospitalization Programs (PHP)‡		
24 Visit Limit per Calendar Year for Mental Health and/or Substance Abuse	100%	70%
Emergency Department Coverage		
Emergency Care	100% of Allowed Amount after $50 co-pay	100% of Allowed Amount after $100 co-pay
Urgent Care	100% of Allowed Amount after $50 co-pay	100% of Allowed Amount after $50 co-pay
Note: Any *UNAUTHORIZED* programs, services, or visits will not be covered by EHP Total Care under any circumstances and the subsequent charges will be the financial responsibility of the member. This applies to any unauthorized out-of-network and out-of-area providers and facilities, with the only exception being for emergency care. The 35 visit Outpatient Coverage INCLUDES any outpatient services provided by a behavioral health practitioner for chronic pain management, sleep disorder, aftercare groups for substance abuse, and/or pre and post gastric surgery visits. There is NO COVERAGE for telephone counseling services or school meetings by outpatient behavioral health practitioners.		

* MMO Traditional for the state of Ohio and USAMCO outside the state of Ohio.
† The Behavioral Health Tier 2 deductible does NOT apply to other health plan provisions.
• No pre-certification required for Tier 1, pre-certification IS required for Tier 2.
‡ Pre-certification and medical necessity required.
§ Pre-certification required.
Note: Pre-certification, prior authorization, predetermination and prior approval are often used interchangeably.

BeneFlex Program

(continued)

SummaCare Health Plan EPO*

The SummaCare Health Plan Exclusive Provider Organization (EPO) offers access to providers in the SummaCare Network, which includes Cleveland Clinic providers. When they enroll, employees and their dependents are encouraged to select a Primary Care Physician (PCP) to receive coverage. The PCP coordinates all care. Following is a chart that highlights benefits you can receive from the SummaCare Health Plan EPO:

	SummaCare Health Plan EPO Customer Service: 1.800.753.8429
Facilities	**SummaCare Hospitals**
Annual Deductible – Individual or Family	None
Out-of-Pocket Maximum – Individual or Family	None
Covered Services	
PCP Requirement	No
PCP Office Visits	$15 co-pay
Preventive Office Visits	None
Specialist Office Visits	$15 co-pay
Routine Physical Examination	$15 co-pay
Routine Vision Examination	$15 co-pay
Maternity Hospital Services Office Visits Pre- and Post-Partum Care	 100% $15 co-pay (initial visit only) 100%
Infertility Diagnostic Treatment	 $15 co-pay Subject to Medical Policy
All Therapy Services Physical/Occupational – 30 Visits Combined per Calendar Year Speech – 30 Visits per Calendar Year	 $15 co-pay $15 co-pay
Emergency Department *(Emergency and/or Urgent Care)*	$50 co-pay
Durable Medical Equipment	100%
Inpatient Hospital Services	100%
Outpatient Services Lab, X-Rays and Outpatient Surgery	100%
Extended Care/Skilled Nursing Care – 100 Day Maximum	100%
Home Health Care – 30 Visits Maximum	100%
Dental Services Dental Treatment to Stabilize After an Accidental Injury	 $15 co-pay
Hearing Aid	Not Covered
Mental Health and Substance Abuse Services Inpatient – 21 Days per Calendar Year Outpatient – 20 Visits per Calendar Year	 100% $20 co-pay
Organ Transplant Transplant Lifetime Maximum Out-of-Pocket Maximum	100% None None

* The benefits listed above are only a summary. Detailed benefit information and exclusions are available on request.

EHP Total Care / SummaCare EPO Prescription Drug Benefit Administered Through CVS Caremark

	Tier 1 Generic Rx	Tier 2 Preferred Brands (Formulary)	Tier 3 Non-Preferred Brands (Non-Formulary)	Tier 4 Specialty Drugs (Hi-Tech)	Drugs & Items at Discounted Rate	Non-Covered Drugs & Items
Annual Deductible	$100 Individual $300 Family	*(Waived for generic prescriptions if obtained from a Cleveland Clinic Pharmacy)*			No	No
Employee % Co-pay Cleveland Clinic Pharmacies - Outpatient – 30 Day Supply Home Delivery – Up to 90 Day Supply	15%	25%	45%	20%	Employee Pays 100% of the Discounted Price	Not Available through Rx Plan
Employee % Co-pay CVS Caremark Retail – 30 Day Supply Mail Service Program – 90 Day Supply	20%	30%	50%	20%	Employee Pays 100% of the Discounted Price	Not Available through Rx Plan
Is there a Minimum or Maximum to the Rx % Co-pay – Cleveland Clinic Pharmacies (including Home Delivery)?	Yes $3 Minimum/ $50 Maximum per Month Supply	Yes $3 Minimum/ $50 Maximum per Month Supply	No	Yes No Minimum/$75 Maximum per Month Supply	No	No
Is there a Minimum or Maximum to the Rx % Co-pay – Retail?	Yes $5 Minimum/ $50 Maximum per Month Supply	Yes $5 Minimum/ $50 Maximum per Month Supply	No	NA	No	No
Is there a Minimum or Maximum to the Rx % Co-pay – CVS Caremark Mail Service Program?	Yes $15 Minimum/ $150 Maximum 90 Day Supply	Yes $15 Minimum/ $150 Maximum 90 Day Supply	No	Yes No Minimum/$300 Maximum 90 Day Supply	No	No
Is there an Annual Out-of-Pocket Max?	Individual – $1,500 / Family – $4,500 Combined Maximums for Retail and Home Delivery				No	No
Components of Each Category	**Generic Drugs**	**Brand Drugs – See Formulary Guide**		**Specialty Drugs*** Antirejection Therapies, Antivirals, Blood Modifying Agents, Cystic Fibrosis Therapies, Gn RH Analog, Growth Hormone, Hemophilia Therapies, Interferons, Multiple Sclerosis Therapies, Oncology Therapies, Psoriasis Therapies, Pulmonary Hypertension Therapies, Rheumatoid Arthritis Therapies, Other Medications: • Cimzia • Forteo • Regranex • Restasis • Rilutek • Sensipar • Syprine • Tracleer • Vfend • Zyvox	**Life Style Drugs** • Benzoyl Peroxide Only Agents • Caverject • Cialis • Cosmetic Agents • Denavir Cream • Edex • Fertility Agents • Levitra • Muse • Non-controlled Cough and Cold Agents • Oral Allergy Medication • Penlac • Propecia • Topical Androgen Products • Viagra • Weight Control Products • Zovirax Ointment	**Over-the Counter** • Alcohol Swabs • DME (Durable Medical Equipment) • Medical Devices • Medical Supplies **Prescription Drugs** • Oral contraceptives (brand name products) • Proton Pump Inhibitors (brand name products)
Prior Authorization Required	• Acne Treatments > 21 Years Old • Actemra • Boniva IV • Botox • Cimzia • Cinryze • Enbrel • Exjade • Forteo • Growth Hormone • Humira • Kineret • Letairis • Lupron • Myobloc • Orencia • Psoriasis Therapies • Reclast • Remicaid • Simponi • Synagis • Tracleer • Vimovo • Xolair • Zemplar				No	NA
Diabetic Supplies† and Asthma Delivery Devices†	Co-pay 20%			No	No	NA
Major Chains‡ in the Retail Network	ACME, Cleveland Clinic Pharmacies, Costco, CVS, Discount Drug Mart, Giant Eagle, K-Mart, Marc's, Medicine Shoppe, Rite Aid, Target, Walgreens, Wal-Mart, plus other chains and independent pharmacies.					

Note: Plan Includes: generic oral contraceptives – *covered for Marymount plan participants for medical necessity only.*

*There are 3 options for obtaining medications in the category listed above. The options are: 1. Cleveland Clinic Pharmacies in Cleveland and Cleveland Clinic Weston Pharmacy, 2. Cleveland Clinic Home Infusion Pharmacy (injectables only), and 3. CVS Caremark Specialty Drug Program.

† Diabetic Supplies – Insulin and all diabetic supplies covered. Includes: needles purchased separately, test strips, lancets, glucose meters, syringes and injection pens. Asthma Delivery Devices – Includes spacers used with asthma inhalers.

‡ Members can utilize the CVS Caremark Retail Pharmacy Network for obtaining acute care prescriptions (e.g., single course of antibiotic therapy) and for the first fill of maintenance medications but must use a Cleveland Clinic Pharmacy or CVS Caremark Mail Service Program for all maintenance medications.

BeneFlex Program

(continued)

Kaiser Permanente HMO*

Employees at Cleveland Clinic, Cleveland Clinic Children's Hospital for Rehabilitation, Cleveland Clinic Home Care Services, Fairview Hospital, Lakewood Hospital, Lutheran Hospital, Marymount Hospital and Medina Hospital can choose to receive healthcare coverage through Kaiser Permanente HMO. Following is a chart that summarizes Kaiser benefits:

Customer Service Telephone Number	**1.800.686.7100**
FACILITIES	**Kaiser Permanente**
Annual Deductible – Individual or Family **Out-of-Pocket Maximum – Individual or Family**	None $2,000 / $6,000
COVERED SERVICES	
Outpatient Care Preventive Care Office Visits including: Physician exams, allergy testing, well-child care, hearing tests Minor surgery Specialist's Treatment Vision exams available through affiliated providers **Prenatal Care** **Urgent Care:** At Kaiser Permanente facilities or outside the service area **Urgent Care:** Inside service area **Short Term Physical, Speech and Occupational Therapy** *(up to two months or 30 visits per therapy, whichever is greater, per medical episode)*	 No charge $15 co-pay $15 co-pay $15 co-pay $15 co-pay No charge $35 co-pay, waived if admitted Not covered if received at non-plan facility $15 co-pay
Diagnostic Services: Laboratory and Diagnostic testing, X-rays	No charge
Hospital Inpatient Care No limit on covered days, including: physician and surgeon services, room and board, anesthesia, operating and recovery rooms, laboratory and diagnostic testing, x-rays	 No charge
Alternate Care: Home Health Services Hospice Home Care / Respite Care Extended Care in a Skilled Nursing Facility *(up to 100 days per calendar year)*	No charge No charge No charge
Emergency Department Visits Only when required by medical condition and transportation in any other vehicle would endanger your health If provided at plan facility *(charges waived if admitted)* *(Available 24 hours a day at Kaiser Permanente Emergency Facilities at the Cleveland Clinic and Parma Medical Center)* *(Emergency medical advice is available 24 hours a day)* If provided at other facility *(charges waived if admitted)*	 $50 co-pay $50 co-pay $50 co-pay
Ambulance Services *(Only when transportation in any other vehicle would endanger your health)*	$50 co-pay
Mental Health Services Inpatient: 30 days of hospital care per calendar year Outpatient: 20 visit maximum Individual *(each visit counts as one visit against maximum)* Group *(each visit counts as one-half of a visit against maximum)*	 No charge $15 co-pay $7 co-pay
Chemical Dependency Services Inpatient: Detoxification in general hospital Detoxification in a specialized facility (One Admit Per Year) Outpatient: Detoxification Individual Therapy Group Therapy	 No Charge No Charge $15 co-pay $15 co-pay $5 co-pay
Infertility Services Inpatient Outpatient	 30% of total charges 30% of total charges
Additional Benefits and Services Prescription Drugs: covered formulary drugs and accessories up to a 31-day supply at Kaiser Permanente and affiliated network facilities; 62-day supply of maintenance drugs by mail order from the Kaiser Permanente mail order pharmacy Durable Medical Equipment: Medicare approved equipment	 $15 co-pay generic/ $30 co-pay brand No charge

* The benefits listed above are only a summary. Detailed benefit information and exclusions are available on request.

Dental Plans

You can choose one of three dental options administered by Cigna for yourself and your eligible dependents:

- The Dental Care Plan HMO
- The Traditional Plan
- The Preventive Plan

The Dental Care Plan HMO charges nothing for most preventive services, including no deductibles and no annual or lifetime maximums. If you elect this coverage, you must use CIGNA Dental Care HMO network providers, and each covered family member is required to select a general dentist.

The Traditional Plan covers all types of dental services, and the Preventive Plan is designed for individuals who only want preventive and basic services. If you're covered under the Traditional Plan or the Preventive Plan, you may choose any dental provider, but by using CIGNA network providers your co-payments will be lower because of the discounted rates these providers have agreed to accept.

The following charts summarize the benefits provided under the dental plans.

Dental Care Plan HMO	
COVERED SERVICES	YOUR CHARGE
Preventive Care Oral exams, routine cleanings, x-rays	 No Charge
Restorative Services Amalgam (silver) fillings Resin-based composite crown, anterior	 No Charge $80
Major Services Crown – porcelain fused to high noble metal Full upper or lower denture	 $440 $590
Orthodontia Pre-orthodontic treatment visit Orthodontic treatment: children (up to 19th birthday) adults	 $61 $1,872 $2,184

Covered Services	**Traditional Plan**		**Preventive Plan**
	In-Network	**Out-of-Network**	
Preventive Care Oral exams, cleanings, x-ray, etc.	100%*	100% R&C	100% R&C
Basic Services Fillings, oral surgery, extractions, etc.	80%* (after deductible)	70% R&C (after deductible)	80% R&C (after deductible)
Major Services Dentures, crowns, etc.*	50%* (after deductible)	50% R&C (after deductible)	Not Covered
Orthodontia (subject to lifetime max. benefit of $1,250 per eligible covered dependent under age 23)	50% R&C (after deductible)	50% R&C (after deductible)	Not Covered
Annual Deductible (individual/family)	$50/$150	$50/$150	$50 /$150
Annual Benefit Maximum	$1,250 per Person	$1,000 per Person	$500 per Person

* Negotiated fee

BeneFlex Program

(continued)

Vision Plan

If you participate in the EyeMed Vision Care Plan, you can purchase eyewear from any provider, but you will maximize your benefits by using EyeMed Vision Care network providers. Participants can also take advantage of discounts for additional pairs of eyeglasses and contact lenses. The following chart summarizes the benefits of this plan.

EyeMed Vision Care Plan	Member Cost	Out-of-Network Allowance
Frames *Any available frame at provider location*	$120 Allowance	$30
Standard Plastic Lenses		
Single Vision	$0 co-pay	$25
Bifocal	$0 co-pay	$40
Trifocal	$0 co-pay	$50
Lens Options		
UV Coating	$15	Not Covered
Tint *(Solid and Gradient)*	$15	Not Covered
Standard Scratch-Resistance	$15	Not Covered
Standard Polycarbonate	$40	Not Covered
Standard Progressive *(Add-on to Bifocal)*	$65	Not Covered
Standard Anti-Reflective Coating	$45	Not Covered
Other Add-Ons and Services	20% off retail price	Not Covered
Contact Lenses *Allowance covers materials only*		
Conventional	$0 co-pay, $100 Allowance	$70
Disposable	$0 co-pay, $100 Allowance	$70
Laser Vision Correction		
Lasik or PRK	15% off retail price or 5% off promotional price	Not Covered
Frequency		
Frames	Once each calendar year	
Lenses or Contact Lenses	Once each calendar year	

Flexible Spending Accounts

BeneFlex offers two Flexible Spending Accounts that can help you save money on out-of-pocket healthcare costs and on the cost of providing dependent day care:

- one for qualified medical expenses not covered by the Health, Dental and Vision Plans
- one for qualified dependent/child care expenses

You can use the accounts to set aside pre-tax pay to reimburse yourself for qualified expenses incurred during the calendar year. Claims for reimbursement must be submitted by no later than March 31 following the end of the calendar year.

You should consider these points when making decisions about contributing to the Flexible Spending Accounts:

- You can make pre-tax contributions to either or both accounts.
- The minimum pre-tax contribution to the Medical Flexible Spending Account is $100 per calendar year (unless you are depositing leftover PTO trade-in dollars during the annual open enrollment period). The maximum is $5,000 per calendar year.
- The minimum pre-tax contribution to the Dependent Care Flexible Spending Account is $100 per calendar year – unless you are depositing leftover PTO trade-in dollars during the annual open enrollment period. The maximum is $5,000 per calendar year if you are single or you are married and filing a joint tax return. If

you are married and you and your spouse file separate tax returns, the maximum amount you can contribute is $2,500 per calendar year.

- You cannot transfer funds from one account to the other.
- You should carefully consider the amounts you plan to contribute to these accounts, because you will forfeit any account balances that are not claimed for reimbursement.
- Since contributions to the Flexible Spending Accounts are made with pre-tax pay, you do not pay Social Security taxes on the contributions. This means that you are paying less into Social Security, and your future Social Security benefits may be somewhat smaller than if you had not made pre-tax contributions to the accounts. That said, the reduction in future Social Security benefits is generally very small and may be outweighed by the tax advantages of participating in the accounts.

Medical Flexible Spending Account

Eligible dependents for the Medical Flexible Spending Account are the same as those defined at the beginning of this summary. Medically necessary expenses eligible for reimbursement* include medical or dental co-payments, prescription drugs, durable medical equipment, eyeglasses and contact lenses. Expenses that are **not** reimbursable include premiums for insurance coverage, cosmetic surgery and dietary supplements such as vitamins and herbs.

*Healthcare reform legislation has impacted how over-the-counter (OTC) drugs and medicines are treated with respect to the Medical Flexible Spending Account (FSA). Beginning January 1, 2011, OTC drugs and medicines will be considered ineligible expenses unless you have a prescription from your physician. For detailed information, please visit PayFlex's site at www.HealthHub.com.

Dependent Care Flexible Spending Account

Eligible dependents for the Dependent Care Flexible Spending Account are:

- Individuals under age 13 who you claim as dependents on your Federal income tax return
- Individuals (such as parents or children age 13 or older) who reside with you, are physically or mentally incapable of caring for themselves, and can be claimed as dependents on your Federal income tax return
- Spouses who are physically or mentally unable to care for themselves

Qualified expenses eligible for reimbursement include care for dependent adults or children provided by individuals or facilities such as nursery schools and day care centers. For tax reporting purposes, the IRS requires that you provide the name and Social Security number or tax identification number of the person or organization providing the care.

Under certain circumstances, it may be more advantageous for you to receive a tax credit on your Federal income tax than to participate in the Dependent Care Flexible Spending Account. You should consult with your tax advisor if you have questions about which approach best meets your needs.

BeneFlex Program

(continued)

Life Insurance Plans

Basic Life/AD&D

Cleveland Clinic provides full-time employees with no-cost term life insurance coverage at two times annual base pay, up to a maximum of $500,000. Part-time employees receive no-cost coverage of one times annual base pay, up to $200,000. Both full- and part-time employees also receive Accidental Death and Dismemberment coverage equal to the amount of the term life coverage at no additional cost.

Supplemental Life

Under BeneFlex, full- and part-time employees who would like additional life insurance coverage can purchase supplemental term life insurance, up to four times annual base pay, not exceeding $500,000. Evidence of insurability is not required when employees are newly eligible. If you didn't choose the highest level of coverage available to you when you were first eligible and decide to elect it at a later date, you will be asked to provide evidence of insurability.

IRS Requirement. If the amount of your life insurance exceeds $50,000, Cleveland Clinic is required to report the premium on the excess amount as taxable income to you (known as imputed income). Any tax liability will be reported on your annual W-2 Statement.

Dependent Life

Through BeneFlex, full- and part-time employees also can cover their legal spouses and children with term life insurance at group rates and with the convenience of payroll deduction. (The IRS requires that payroll deduction for this coverage be made on an after-tax basis.) You may cover your spouse in the amount of $25,000, and your dependent children in the amount of $10,000 per child. Dependent evidence of insurability is not required when employees are newly eligible. If you choose dependent life insurance, you are automatically the beneficiary under the plan.

Disability Insurance Plans

Short Term Disability

Full-time employees with one continuous year of regular, full-time service are provided with Short Term Disability coverage at no cost to them. If an employee is on an authorized leave of absence, the STD benefit may provide up to 26 weeks of income protection at 70% of base pay through the approved disability period.

Long Term Disability

If a medical condition continues beyond the short term disability period, an employee may be eligible to receive benefits from the Long Term Disability Plan. The LTD benefit, which is paid for by Cleveland Clinic, replaces 60% of base pay, up to $15,000 per month. Following BeneFlex Open Enrollment, part-time employees will be provided with the opportunity to purchase Voluntary Long Term Disability coverage that pays a benefit of up to 60% of base monthly pay.

Additional Valuable Cleveland Clinic Benefits

Paid Time Off (PTO)

The Paid Time Off (PTO) program combines vacation, holidays, personal days and sick days to provide you with flexibility in determining your individual time off schedule. PTO allowances are based on position and length of service. After you complete your new hire period and have your manager's approval, you can begin taking off the time you have accrued.

During BeneFlex Open Enrollment, to offset part or all of your benefit costs, you can trade in up to ten days (or 80 hours) of your total Paid Time Off (PTO) allowance. For each day (eight hours) that you trade in, you will receive an amount equal to your hourly rate of pay times eight hours. For example, if your base rate of pay is ten dollars and you trade in eight hours of PTO, you will receive $80 to apply to the cost of your benefits. For BeneFlex purposes, your PTO trade-in is based on your base hourly rate of pay as of the September 1 just before BeneFlex Open Enrollment (in October).

Please Note: If you elect to trade in PTO and you terminate, retire, change status to PRN or temporary, or experience a qualifying life event during the calendar year, your PTO cannot be returned to you. Here are additional rules about PTO trade-in:

- You cannot change your PTO trade-in amount during the calendar year.
- PTO trade-in does not carry over from one calendar year to another.
- PTO trade-in can only be elected during the annual BeneFlex Open Enrollment.

Employees who are scheduled to work less than 40 hours per pay period, who are PRN or temporary, and residents/fellows are not eligible to accrue PTO.

Cleveland Clinic Retirement Program

Two plans help eligible employees build savings for their retirement:

The Investment Pension Plan (IPP)
As long as you are at least 21 years old, you are automatically enrolled in the plan on your date of hire. (Students, residents/fellows and research associates are not eligible to participate in the IPP.) Each payroll period, employees enrolled in the plan will receive an Employer Pension Contribution, based on years of service, to an account administered by Fidelity Investments. Employees are responsible for selecting their investment options and managing their IPP account.

Savings & Investment Plan
If you are a full-time, part-time or PRN employee, starting on your first day of service you may participate in the Savings and Investment 403(b) Plan and defer some of your pay on a pre-tax basis. Cleveland Clinic will match 50 cents for every dollar you save, up to 6% of your pay that you contribute to the plan. You are always 100% vested in your contributions, and are vested in the Employer Matching Contributions after two or three years of service, based on your date of hire. Students, resident/fellows, research associates and Lakewood Hospital employees participating in the Public Employees Retirement System are not eligible for matching contributions.

Additional Valuable Cleveland Clinic Benefits

(continued)

CONCERN® Employee Assistance Program (EAP)

CONCERN®, Cleveland Clinic's EAP, is available to assist you and your family members with difficult personal or family issues such as marital or family stress, substance abuse, emotional or health concerns or other issues that can affect well-being. CONCERN provides employees up to 10 free confidential counseling sessions during a calendar year. Employees can call CONCERN 24 hours a day, 7 days a week.

The EAP also offers employees and their immediate family members the benefits of the **WorkLife Services/Family Dependent Care Program**, a comprehensive consultation and resource service that can help with care-giving commitments. Early childhood education and geriatric professionals can help employees find resources for the care of loved ones, including child care, care for older relatives or adoption services, and can also provide guidance about related issues. Services are provided on a strictly confidential basis, and Cleveland Clinic pays the full cost of consultations and referrals.

Tuition Assistance Program

After you complete your new hire period, you are eligible to receive tuition reimbursement after satisfactorily completing approved courses. The following chart shows the annual reimbursement maximums.

Type of Program	Annual Reimbursement Maximum
Undergraduate	$5,000
Graduate	$7,500

Additional supplemental tuition reimbursement or tuition/educational loans may be available to those working to earn certain degrees or certifications. If you have questions about additional tuition programs, check with your manager.

Other Benefits

- Voluntary Long-Term Care Insurance
- College Advantage 529 Savings program
- Retiree Medical Plan
- Adoption Assistance
- Voluntary Auto and Home Insurance
- Voluntary MetLaw Group Legal Plan
- Voluntary Veterinary Pet Insurance

Benefit Contact Information

Cleveland Clinic Benefits Customer Service Center 216.448.0600
Total Care Customer Service 216.448.0800
Tier 1 Providers* ..... www.chnetwork.com
Tier 2 Providers*
Cleveland Health Network ..... www.chnetwork.com
Medical Mutual Traditional Network. ..... www.SuperMedNetwork.com
USA Managed Care Organization (USAMCO) ..... www.usamco.com

Behavioral Health Services 216.986.1050
..... 888.246.6648

Health Plan
Antares Management Solutions Customer Service 800.451.7929

Kaiser Permanente HMO 800.686.7100
www.kaiserpermanente.com

SummaCare Health Plan EPO 800.753.8429
www.summacare.com

CONCERN® Employee Assistance Program 216.445.6970
..... 800.989.8820

Prescription Drug
Caremark 866.804.5876
www.caremark.com

Dental Plans
CIGNA 800.244.6224
www.cigna.com

Vision Plan
EyeMed Vision Care 866.723.0513
www.eyemedvisioncare.com

Life Insurance – Fort Dearborn 800.544.9000

Savings Bonds 800.US.BONDS

Investment Pension Plan
Fidelity Investments 888.388.2247
www.fidelity.com/atwork

Flexible Spending Accounts
PayFlex 800.284.4885
www.HealthHub.com

Short Term Disability (Customer Service) 216.448.0700

Long Term Disability (Customer Service) 216.448.0700
Hartford 800.303.9744

Savings & Investment Plan
Fidelity Investments 888.388.2247
www.fidelity.com/atwork

Long Term Care .....
John Hancock 800.444.3413
http://cchs.jhancock.com: Username: cchs, Password: mybenefit

COBRA Continuation Svcs-Ceridian CobraServ 800.877.7994

Other Benefits .....
MetLife Auto and Home, MetLaw Legal, Vet. Pet Ins. 800.438.6388

College Advantage 800.233.6734

* Hard copy provider directories are not published. To confirm a provider's participation in the Tier 1 or Tier 2 network, or to request a listing of doctors in your geographic area by physician specialty, call Antares Management Solutions Customer Service or Total Care Customer Service.

How to Get More Information About the Plans

You can review summary plan descriptions (spds) on the HRConnect Portal at http://hrconnect.ccf.org.

Cleveland Clinic