PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

Mayo Long Term Disability Plan

January 2017
Mayo Long Term Disability Plan

January 2017
HOW TO USE THIS DOCUMENT

The Table of Contents on page 6 provides you with an overview of the detailed information in the Plan.

Also, the glossary beginning on page 37 provides additional detailed definitions.

To quickly search for a specific word or phrase simply press your “Ctrl” and “F” keys simultaneously to open the search function.
INTRODUCTION

Mayo Clinic sponsors the Mayo Long Term Disability Plan ("Long Term Disability Plan" or "Plan") to provide benefits for eligible employees of Mayo Clinic and other participating employers. This Plan Document sets forth the Plan benefits for eligible employees who are classified as Allied Health Staff or as Consultants/Voting Staff. Because this document is intended to give employees an easily understood explanation of the Plan, it also serves as the summary plan description.

Many of the provisions in the Plan are interrelated. Therefore, please review this entire document so that you understand fully what your benefits and responsibilities are under this Plan. See the administrative section of this summary plan description to learn about the right of Mayo Clinic to amend or terminate this Plan. If you have questions, see the contact information in the next section.

Please note that Mayo Clinic sponsors a separate long term disability plan, called the Mayo Voluntary Long Term Disability Plan ("Voluntary Plan"). The Voluntary Plan is entirely separate from this Plan, has different eligibility and benefit rules and has a separate summary plan description and plan document. Claims under the Voluntary Plan are decided by Prudential Insurance.
Recovery and Claims Services is the Claims Administrator for the Long Term Disability Plan. Recovery and Claims Services processes claims and answers claim questions for the Plan.

For enrollment or eligibility questions, please contact HR Connect. HR Connect is your human resources office for this Plan.

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<tr>
<th>Questions about Claims</th>
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<tr>
<td>Mayo Clinic</td>
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<td>Recovery and Claims Services</td>
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<tr>
<td>Rosa Parks Pavilion PB-4</td>
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<tr>
<td>Rochester, MN 55905</td>
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<tr>
<td>Attn: LTD Claims Administrator</td>
</tr>
<tr>
<td>Phone:</td>
</tr>
<tr>
<td>(507) 266-0484 (local)</td>
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<tr>
<td>(800) 583-3390 (toll-free)</td>
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<tr>
<th>Questions about Enrollment/Eligibility</th>
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<tr>
<td>HR Connect</td>
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<tr>
<td>200 First Street SW</td>
</tr>
<tr>
<td>Rochester, MN 55905</td>
</tr>
</tbody>
</table>

507-266-0440 (local)
1-888-266-0440 (toll free)
M-F 5 a.m. to 6 p.m., Saturday/Sunday 5 a.m. to 9 a.m.
CT (excluding holidays)

HR Connect has access to translation services to meet the needs of many non-English speaking persons.

El presente Resumen del Plan de Descripción, que también sirve como documento del plan, está redactado en inglés y ofrece detalles sobre sus derechos y beneficios bajo el Plan Médico de Mayo. Si tiene alguna dificultad para entender cualquier parte de este documento, por favor comuníquese con el Centro para Servicios al Empleado o con el Servicio de Atención al Cliente de Mayo Clinic Health Solutions, a los números que constan abajo.
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LONG TERM DISABILITY BENEFITS

Subject to all of the terms and limitations set forth in this Plan, Mayo Clinic sponsors the Plan to provide long term income replacement benefits in the event you are disabled from illness or injury. In general, the Plan applies to disabilities lasting longer than thirteen weeks for eligible Allied Health Staff and to disabilities lasting longer than twenty six weeks for eligible Consultants/Voting Staff.

You may also be eligible for short term disability benefits. Review your employer’s policy to determine your eligibility and the amount of coverage available to you.
ELIGIBILITY AND PARTICIPATION

Eligibility for Mayo Clinic and Mayo Clinic Health System Locations
You are eligible if (1) you are classified as either Allied Health Staff or Consultants/Voting Staff and (2) you are classified by a participating employer (listed in the “Plan Information” section, subsection “Participating Employers”) for payroll and personnel purposes as an employee who is regularly scheduled to work at least half-time (forty (40) hours or more per pay period) for the employer. You are eligible to participate in the Long Term Disability Plan on the first day of employment provided you are at work on that day. Regularly scheduled means your schedule on file with your employer is .5 FTE or more. A .4 FTE working extra hours does not qualify as regularly scheduled to work .5 FTE. In addition to the classification as an eligible employee, you must also not have elected coverage under the Mayo Voluntary Long Term Disability Plan, if that option is available to you as an alternative to coverage under this Plan.

Please note: This Plan has a pre-existing condition limitation that may affect your eligibility.

An employer’s classification is conclusive and binding for purposes of determining benefit eligibility under the Plan. Please note that your eligibility as Consultant/Voting Staff is determined in accordance with a participating employer’s payroll and personnel requirements and procedures. No reclassification of an employee’s or non-employee’s status for any reason by a third party, whether by a court, governmental agency or otherwise, and without regard to whether or not the employer agrees to the reclassification, shall make the employee retroactively or prospectively eligible for benefits. Any uncertainty regarding an employee’s classification will be resolved by excluding that person from eligibility. Students, Residents and Research Appointees are excluded from this LTD Plan.

Please note: In order to receive long term disability benefits under this Plan, your disability must have commenced at a time when you were covered by this Plan. For example, if you were not covered by the Mayo Long Term Disability Plan prior to January 1, 2015, your disability must have commenced on or after January 1, 2015 in order to be eligible for disability benefits under this Plan.

MCHS in Waycross. Due to the fact that MCHS in Waycross ceased being a participating employer in this Plan, disabilities commenced on or after July 1, 2016 will not be covered by this Plan.

Actively at Work Requirement
Actively at work means physically present to work .5 FTE or more at the employee’s regular worksite or at an alternative employer worksite at the request of the employer. If you are not actively at work on the day your automatic coverage is scheduled to begin, your coverage will not begin until the first day you begin or return to your employment.

FMLA Covered Persons
Family Medical Leave Act leaves of absence will be administered according to applicable law and policies established by the employer. Copies of FMLA policies are available from the employer.

Personal, USERRA or Parental Leaves of Absence
Long term disability income coverage continues in force based on the salary in effect at the beginning of your approved personal, USERRA or parental leave for up to 90 days of authorized leave, measured from the commencement of the leave. Note however, that the Plan does not cover disabilities caused by war or acts of war while in active military service, including USERRA leaves. If your personal, USERRA or parental leave of absence extends beyond 90 days, your long term disability coverage ends on the 90th day of your leave.
**Other Benefits While on LTD**

For information on how your other benefits are affected during a period of long term disability, see the summary plan descriptions describing those benefit plans. Your rights to other benefits are subject to the terms of those plans; the Long Term Disability Plan provides no benefits other than disability pay.

**When Long Term Disability Income Coverage Ends**

Your coverage under the Long Term Disability Plan will end at midnight of the day on which the earliest of the following events occurs:

- The last day of your employment or the day you cease to be an eligible employee.
- The day the employer terminates the Plan or its participation in the Plan.
- The effective date of an amendment to the Plan causing you to lose coverage.
- The 90th day of an authorized personal, USERRA or parental leave.
- The day before the first day of any leave other than an authorized personal, USERRA or parental leave.
- The date on which you are no longer actively at work unless you are on an authorized personal, USERRA or parental leave.
- The date of your death.

**Cost of Coverage**

Your employer pays the full cost of the Long Term Disability Plan coverage. Any benefits you receive from the Plan are taxable at the time you receive them.

**Claimant’s Responsibilities**

You have an obligation to cooperate with the Plan. You are responsible for providing the Claims Administrator with your current address. Any notices required or permitted to be given to you hereunder shall be deemed given if directed to the address most recently provided by you and mailed by first class United States mail. The Claims Administrator has no obligation or duty to locate you.

If you fail to keep the Claims Administrator informed of any changes in your address, the Plan may temporarily suspend the long term disability benefits until you provide the Claims Administrator with your current contact information.
PLAN BENEFITS

Benefits under the Plan are different for eligible employees classified as Allied Health Staff and those classified as Consultants/Voting Staff.\(^1\) The first part of this section on Plan Benefits provides separate information for each of these two groups. The remainder of the section applies to both Allied Health Staff and Consultants/Voting Staff.

Allied Health Staff Benefits

- **Elimination Period.** The Long Term Disability Plan pays benefits for qualifying disabilities that extend beyond 13 calendar weeks.

- **Amount of Benefit.** For the purpose of determining the amount of long term disability income benefits available to eligible employees who are classified as Allied Health Staff, the Plan uses your Annual Benefit Salary. Annual Benefit Salary means your basic salary, as determined by your employer, at the time your disability begins and the Elimination Period commences (based on your regularly scheduled hours) and does not include bonuses, incentive pay, commissions, overtime pay, shift pay or any other extra compensation. The Monthly Benefit you are eligible to receive is 65\% of your annual salary at the time your disability commences, converted to a Monthly Benefit, which is paid every two weeks. This benefit is taxable income to you and is paid to you through your employer’s payroll system.

- **Partial-month Disabilities.** If you are disabled for a portion of a month, the benefit you receive from the Long Term Disability Plan will be based on the number of working days you are absent because of the disability.

- **Partial Disability Benefits.** If you qualify for partial disability (discussed below), your benefit will be reduced by 80\% of the income you earn through your partial disability/work. Partial Disability employment status is available for up to 52 weeks.

\(^1\) A small number of Allied Health Staff employees are classified as “special status” on payroll and personnel records and receive benefits at the Consultant/Voting Staff levels. These employees are individually notified of this special status.
Consultants/Voting Staff Benefits

- **Elimination Period.** The Long Term Disability Plan pays benefits for qualifying disabilities that extend beyond twenty six calendar weeks.

- **Amount of Benefit.** For the purpose of determining the amount of long term disability income benefits available to eligible employees who are classified as Consultants/Voting Staff, the Plan uses your Annual Benefit Salary. Annual Benefit Salary means your basic salary, as determined by your employer, at the time your disability begins and the Elimination Period commences (based on your regularly scheduled hours) and does not include bonuses, incentive pay, commissions, overtime pay, shift pay or any other extra compensation. The Monthly Benefit you are eligible to receive is based on 84% of your annual salary at the time your disability commences or 84% of your wage loss if partially disabled, converted to a Monthly Benefit which is paid every two weeks. This benefit is taxable income to you and is paid to you through your employer’s payroll system. There is an annual cost of living adjustment for total disabilities that extend beyond one calendar year. The amount of the monthly disability benefits increases by 2% on April 1 of each subsequent calendar year of disability, if you were disabled under the Plan and receiving long term disability benefits on the preceding October. In no event, however, will the Monthly Benefit exceed 1/12 of your pre-disability annual salary.

- **Partial-month Disabilities.** If you are disabled for a portion of a month, the benefit you receive from the Long Term Disability Plan will be based on the number of working days you are absent because of the disability.

- **Partial Disability.** If you are partially disabled and earning at least 20% of your pre disability annual salary, converted to a monthly amount, but less than your pre disability salary, your benefit will be based on 84% of your wage loss. Your wage loss is the difference between your pre disability salary and your current gross earnings based on your employment, converted to monthly amounts, at Mayo Clinic or another employer. If you are earning less than 20% of your predisability annual salary, converted to a monthly amount, you are not considered partially disabled and your benefit will be based on Total Disability and any other Plan provisions including the reductions outlined in the next section. If you are earning equal to or more than your pre disability annual salary, your LTD benefits will be terminated.

- **Partial Disability Example.** Assume a $240,000 pre disability annual salary and current annual earnings of $120,000. Your annual wage loss is $120,000 ($240,000-$120,000) and monthly wage loss is $10,000. Your annual partial disability benefit is $100,800 (84% of $120,000). This annual benefit is pro-rated for 26 pay periods per year.

- **Partial Disability Example with other Reductions.** Assume a $240,000 pre disability annual salary and current annual earnings of $120,000, as well as $2,000 monthly Social Security Disability Benefits (SSDI). SSDI is pro-rated over 26 pay periods, so a $2,000 monthly award results in a $923.07 per pay period reduction ($2,000 x 12 = $24,000 annual SSDI award, then divided by 26 to arrive at a per pay period reduction of $923.07). Your annual wage loss is $120,000 ($240,000-
$120,000). Your annual partial disability benefit is $76,800 (84% of $120,000), less $24,000 in annual SSDI benefits).
Reduction of Benefits for Other Income

The benefit from the Long Term Disability Plan will be reduced by the amount of (1) any other income and/or (2) a benefit for loss of income for which you, your family or a third party on your behalf is paid or is eligible to receive as a result of the period of total disability for which you claim benefits under the Plan (“other income”). These reduction in benefits rules for other income apply to all disability payments to both Allied Health Staff and Consultants/Voting Staff, except as provided for in the Partial Disability section for Consultants/Voting Staff.

Such other income includes, without limitation, any of the following:

- **Employment Income.** Any income you receive or are entitled to receive for any employment that you perform while eligible for disability benefits will reduce your disability benefits, regardless of the source or characterization of the income and including, but not limited to, any type of wage, bonus, commission, incentive pay, stock option and/or deferred compensation. All such income must be promptly reported to Recovery and Claims Services. **Note** that special rules apply to the reduction in benefits relating to income received by Allied Health Staff if eligible for partial disability benefits.

- **Severance or Separation Payments.** Any payments you receive upon separation from service from an employer as severance pay, separation pay or pursuant to an employment agreement.

- **Social Security Benefits.** Social Security benefits because of your total disability (including the primary benefit applicable to you, and one half the Social Security benefit applicable to your spouse and children).

- **Benefit under a Workers’ Compensation Law or Similar Law.** Additionally note that receipt of workers’ compensation benefits excludes you from eligibility to benefit under this Plan.

- **Employer Disability Benefits.** Benefits under another total disability plan provided by a participating employer or any other employer, regardless of whether the premiums or cost of coverage are paid by the employer or by you.

- **No Fault Automobile Plan Benefits.**

- **Government Benefits.** Benefits from any federal, state, county or municipal Government disability, disability retirement and/or loss of time plans or laws.

- **Benefits under any Other Individual or Group Long Term Disability Policy.**

- **Benefits under compulsory benefit laws or law or any other act or law of like intent (for example Veterans Administration disability benefits)**

- **Social Security Retirement Benefits.** Social Security retirement benefits that commence after you become totally disabled.
• **Settlement or Judgment of a Lawsuit.** Any portion of a settlement or judgment of a lawsuit related to your disability and/or its cause, regardless of whether the settlement or judgment is characterized as reimbursement for loss of earnings, medical expenses, disability, pain and suffering or some other loss.

• **Retirement payments under your Employer’s retirement plan.**

**Special Rules for Social Security Benefits and other Federal, State, County or Municipal Benefits**
If you become disabled, you must contact the Social Security Administration (and any other federal, state, county or municipal source of disability benefits) as soon as possible to apply for disability benefits. When you know the amount of your Social Security benefit or when your claim is denied, you must notify Recovery and Claims Services.

Generally, until you know the amount of your Social Security benefit, no Social Security reduction will be made from your Plan benefit. However, it is important you make a reasonable attempt to obtain Social Security (or other federal, state, county or municipal) benefits, including, if necessary, any step in the appeal process. The Plan Administrator will reduce your benefit under this Plan by the estimated amount of any Social Security disability benefits as well as any federal, state, county or municipal programs you would be eligible for if you are unwilling to take the necessary steps to obtain (including applying for and pursuing available appeals) Social Security or other federal, state, county or municipal benefits.

After you notify Recovery and Claims Services of the final benefit from the Social Security Administration or any other sources, your long term disability benefits from the Plan will be recalculated. As further described in the next section, if there is an overpayment of the long term disability benefits from the Plan, you will be responsible for paying back the amounts of overpayment. Your failure to repay the amounts of overpayment constitutes misconduct and is grounds for termination of your eligibility for benefits under this Plan.

**How the Plan Reduces Benefits Because of Other Income**
All sources of other income described above (including, but not limited to, Social Security and/or other governmental disability benefits) are offset against disability benefits under this Plan. If you receive a retroactive payment of other income, any other type of lump sum payment and/or any other type of other income that will be paid to you on a periodic basis, you must report the other income immediately to Recovery and Claims Services.

You will likely owe some or all of a lump sum or retroactive payment for disability benefits you have already received under this Plan. If you fail to repay Mayo Clinic from the lump sum or retroactive payment, your disability benefits under this Plan will be reduced to zero until the offset is fully satisfied.

If you receive other income (including, but not limited to, Social Security) going forward, your payments under this Plan will be reduced by those other income payments on a going-forward basis.

If, at the end of your eligibility for disability benefits under this Plan, you have been overpaid long term disability benefits under this Plan because of other income you have received, you will be responsible for paying back the amounts of overpayment.

Failure to report other income to Recovery and Claims Services is a basis to terminate eligibility for benefits under this Plan.

**Disability Benefits Example – Consultants/Voting Staff**
**Assumptions:**

a. Annual salary: $150,000. $150,000/12 = $12,500 monthly.
b. Your Social Security disability benefits plus one-half of the benefit your spouse is eligible to receive if you are disabled is equal to $900. This is the only “other income” benefit you are receiving.

Under these assumptions, your Monthly Benefit from the Plan would be calculated as follows:

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<th>Payment Example</th>
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<tr>
<td>Monthly Salary</td>
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<tr>
<td>Rate of Reimbursement</td>
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<td>Monthly Taxable Benefit</td>
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<td>Offset for Social Security Benefits</td>
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<td>Received</td>
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<tr>
<td>Monthly Taxable Benefit after Reduction</td>
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</table>

Example of Disability Benefits – Allied Health Staff

Assumptions:

c. Annual salary: $84,000. $84,000/12 = $7,000 monthly.

d. You are eligible for partial disability benefits and earn $1,500 per month. This is the only “other income” benefit you are receiving.

Under these assumptions, your Monthly Benefit from the Plan would be calculated as follows:

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<th>Payment Example</th>
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<tbody>
<tr>
<td>Monthly Salary</td>
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<tr>
<td>Rate of Reimbursement</td>
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<td>Monthly Taxable Benefit</td>
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<tr>
<td>Offset for 80% of Monthly Partial</td>
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<tr>
<td>Disability Benefits</td>
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<tr>
<td>Monthly Taxable Benefit after Reduction</td>
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</table>
QUALIFYING DISABILITIES

The Plan has different definitions of qualifying disabilities, depending on whether eligible employees are classified as Allied Health Staff or as Consultants/Voting Staff. Benefits are payable for your period of disability only if the period of disability began while you were covered under the Plan.

Allied Health Staff Qualifying Disabilities
Eligible employees who are classified as Allied Health Staff are eligible for long term disability benefits if they have a total disability, as defined in this section below.

Total Disability—Allied Health Staff
Total disability for eligible Allied Health Staff, for the first two years and 13 weeks of a disability, means that the Plan Administrator determines that you are completely unable to perform the duties of your regular occupation and you are not engaged in some other occupation (except as provided by the partial disability benefit rules of this Plan) due to illness or injury, and you are under the regular care of a physician. Your regular occupation refers to any occupation with duties similar to the occupation you were in when you became disabled.

After the initial two-year and 13 calendar week period, your total disability ends unless the Plan Administrator determines that you are completely unable to engage in any gainful occupation for which you are fitted by education, training or experience due to illness or injury (except as provided by the partial disability benefit provisions of this Plan), and you are under the regular care of a physician.

Consultants/Voting Staff Qualifying Disabilities
Eligible employees who are classified as Consultants/Voting Staff are eligible for long term disability benefits if they have a total disability or partial disability, as defined below.

Total Disability—Consultants/Voting Staff
Total disability for eligible Consultants/Voting Staff means the Plan Administrator determines that you are completely unable to perform the material and substantial duties of your regular occupation due to illness or injury, and you are under the regular care of a physician. Your regular occupation refers to any occupation with duties similar to the occupation you were in when you became disabled.

Partial Disability—Consultants/Voting Staff
Partial disability for eligible Consultants/Voting Staff means that the Plan Administrator determines that all of the following conditions are met:

- You are not able to perform the duties of your regular occupation due to illness or injury on a full-time basis. Your regular occupation refers to any occupation with duties similar to the occupation you were in when you became disabled.

- You are working for wage or profit:
  - at your regular occupation, but you are not able to perform your duties on a full-time basis; or
  - at another occupation.
• Your partial disability earnings are at least 20% but not equal to or more than your pre-disability earnings. Your pre-disability earnings are the amount of your annual salary before your period of total disability began.

• You are under the regular care of a physician.
PAYMENTS FOR TOTAL AND PARTIAL DISABILITIES

Elimination Period
The elimination period is counted from the first day you are totally (or, for Consultants/Voting Staff, partially) and continuously disabled from an onset of a non-occupational illness or injury. In addition, any time lost from work in the preceding 13 weeks (for Allied Health Staff) or 26 weeks (for Consultants/Voting Staff) which is as a result of this same illness will be counted toward the elimination period.

Benefits for Total Disability
If you have a total disability, your Monthly Benefit will begin on the first day after the elimination period and will continue until you are no longer eligible for benefits under the Plan. If you are disabled for a portion of a month, the benefits you receive from the Long Term Disability Plan will be based on the number of working days you are absent because of the disability.

While eligible, you will receive disability benefits through biweekly payroll payments.

Partial Disability Benefits (Allied Health Staff Only)
If you are an Allied Health Staff employee attempting to return to work at Mayo Clinic (or with another participating employer in the Plan) while you are disabled, you may be able to continue your long term disability benefits from the Plan for a limited period of time of 52 calendar weeks from the date you are released to return to work (under Partial Disability provision of this Plan). Note that only employment with Mayo Clinic or another participating employer in the Plan qualifies you for this program.

Once you are qualified for return to work and your total disability ends, you may be eligible for partial long term disability benefits if you are released to return to work with restrictions and are not able to work your previous FTE, or if you attempt to return to work but need intermittent time off work due to the disabling condition. In total, your partial disability benefits may not last beyond a 52-week period. While you are on an approved partial disability status, you will receive your long term disability benefits reduced by 80% of any pay you earn during your partial disability status.

Benefits for Partial Disability (Consultants/Voting Staff Only)
If you have a partial disability (available to Consultants/Voting Staff only), your Monthly Benefit will begin on the first day after the elimination period (if you are not then receiving benefits for total disability) and will continue until you are no longer eligible for benefits. If you are disabled for a portion of a month, the benefit you receive from the Long Term Disability Plan will be based on the number of working days you are absent because of the disability. The elimination period does not apply to a partial disability that starts while you are receiving benefits under this Plan for total disability. While eligible, you will receive disability benefits through biweekly payroll payments.
DISABILITIES NOT COVERED AND LIMITATIONS AND EXCLUSIONS ON PLAN BENEFITS

Disabilities will not be covered by the Long Term Disability Plan if they are caused by, or contributed to by:

- Intentionally self-inflicted bodily injury or attempted suicide.
- Pre-existing Condition (any medical condition for which an employee had expenses or received treatment, consultation, care, diagnostic services, or had taken prescription drugs or medicines) for which the employee has treated for within three months prior to becoming covered by the Plan. After 120 days of employment the pre-existing condition exclusion expires. This exclusion does not apply to pregnancy related conditions.
- The commission or attempt to commit a felony or you were engaged in an illegal act or occupation.
- An illness or injury that occurs while on active duty in the military service if such illness or injury is caused by or arises out of such military service, including but not limited to war or acts of war (whether declared or not declared). Note that if you are on military leave, including USERRA leave, coverage ends after 90 days and no illness or injury is covered after that date. Disabilities that commence before you become covered or after you are no longer covered under the Plan.
- Occupationally related illness or injury.

You will also not be eligible for disability benefits and/or disability benefits will immediately terminate if any of the following exclusions apply:

- You are confined in a penal institution or other house of correction as a result of conviction for a criminal or other public offense.
- You are not under the regular care of physician and/or you are not following a recommended course of medical and/or vocational treatment for the disabling condition (including pain management and/or work hardening programs).
- You do not provide the necessary claim information or authorization to review any records or documents including your medical records.
- You refuse to cooperate with the Claims Administrator’s request that you have a medical examination by a physician selected by the Claims Administrator or a vocational examination with the examiner selected by the Claims Administrator.
- You fail to actively participate in a program of rehabilitation approved by the Medical Director for mental, psychoneurotic or personality disorders, alcoholism or drug addiction. Active participation means compliance with the all treatment and vocational requirements of the program and cooperating with Recovery and Claims Services and the Medical Director’s review of the program.
• You do not participate in or follow any recommendations with respect to vocational rehabilitation.

• You commit fraud or misconduct with respect to the benefits sought or received under the Plan or you intentionally misrepresent the facts of your situation. **Please note** that your failure to repay the amounts of overpayment constitutes misconduct as described in **Subsection Special Rules for Social Security Benefits and other Federal, State, County or Municipal Benefits**. You fail to report other income to Recovery and Claims Services.

• You commit fraud or misconduct in your employment relationship with your participating employer regardless of whether the fraud or misconduct occurs at work and regardless of whether it occurs before or after the commencement of the period of disability and regardless of when it is discovered.

• In the case of fraud or misconduct, the Plan Administrator reserves the right to recoup disability benefits that would not have been paid had the fraud or misconduct been known to the Plan Administrator, to the full extent permitted by applicable law.

• The Plan terminates and provides that benefits end.

• You were receiving Partial LTD benefits but you begin to earn or are capable of earning an amount equal to or more than your pre disability income as determined by the Plan and Claims Administrator.
WHEN LONG TERM DISABILITY BENEFITS END

If you become disabled on or before age 60, benefits under the Long Term Disability Plan are payable, as long as you continue to be eligible for Plan benefits, up to age 65 (the maximum benefit duration). If, however, you become disabled at or after age 60, a combination of both short term and long term disability benefits will continue, as long as you continue to be eligible for Plan benefits, according to the following schedule:

<table>
<thead>
<tr>
<th>Age at Disablement</th>
<th>Maximum Benefit Duration (STD/LTD Combined)</th>
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</thead>
<tbody>
<tr>
<td>60</td>
<td>60 months</td>
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<tr>
<td>61</td>
<td>48 months</td>
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<tr>
<td>62</td>
<td>42 months</td>
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<tr>
<td>63</td>
<td>36 months</td>
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<tr>
<td>64</td>
<td>30 months</td>
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<tr>
<td>65</td>
<td>24 months</td>
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<tr>
<td>66</td>
<td>21 months</td>
</tr>
<tr>
<td>67</td>
<td>18 months</td>
</tr>
<tr>
<td>68</td>
<td>15 months</td>
</tr>
<tr>
<td>69-74</td>
<td>12 months</td>
</tr>
<tr>
<td>75 &amp; over</td>
<td>6 months</td>
</tr>
</tbody>
</table>

If you become disabled, benefits will be paid for your period of total disability or partial disability (Consultants/Voting Staff only) or the maximum benefit duration, whichever period is shorter.

Recurrent Disability

If your total disability benefits end based on the terms of this Plan and you are no longer employed by Mayo or a participating employer, you have no additional coverage under the Plan. If your total disability benefits end and you return to work at a participating employer as an eligible employee, but then become disabled again, that disability will be considered a continuation of the first, you must satisfy the following:

- The periods of disability are related to the same disability and are separated by an interval during which you have performed all the important duties of a job less than the length of the elimination period applicable to you. This is considered the “Monitoring Period,” however, there is no Monitoring Period if you have exhausted the Partial Disability benefit (Allied Health Staff) provision.

Special Rules for Combined Total and Partial Disabilities (Consultants/Voting Staff Only)

Periods of disability of Consultants/Voting Staff that include times when you are totally disabled as well as times when you are partially disabled, including any part of the elimination period, are one period of disability unless:

- The period meets the conditions for separate periods of disability described above.
- The disability is not treated as continuous under the waiting period in the schedule of benefits.

Benefits for one such period of disability are not payable for more than the maximum benefit duration.
The benefits are payable for your period of partial disability only if the period of disability began while you were covered under the Plan.
SITUATIONS AFFECTING PLAN BENEFITS

Disabilities Due to Mental, Psychoneurotic or Personality Disorders, Alcoholism or Drug Addiction
To receive long term disability benefits for disabilities resulting from mental, psychoneurotic or personality disorders, alcoholism or drug addiction, you must actively participate in a program of rehabilitation approved by the Medical Director of Recovery and Claims Services. For mental, psychoneurotic or personality disorders, alcoholism or drug addiction, active participation means compliance with all treatment and vocational requirements of the program and cooperating with Mayo Clinic’s review of the program.

Continuing Proof of Disability
From time to time during your disability, your employer may request that you have a medical examination by physicians they select. The purpose of the examination is to provide further evidence of your disability and to consider treatment recommendations. You are also required to follow a recommended course of treatment for the disabling condition.

Periodically you will be required to provide appropriate financial records, such as Federal income tax returns including schedules and other attachments necessary to substantiate your income.

Mental Health Claims
Mental Illness is a psychiatric or psychological condition classified in the Diagnostic and Statistical Manual of Mental Health Disorders (DSM), published by the American Psychiatric Association, most current as of the start of a disability. If the DSM is discontinued or replaced, these disorders will be those classified in the diagnostic manual then used by the American Psychiatric Association as of the start of a disability.

The Mayo LTD plan recognizes the potential severity of mental health diagnoses and provides a comprehensive LTD benefit aligned with industry standards. When a medical condition affects the ability to work on a regular basis getting appropriate medical care from a health care provider specializing in the condition is important. In serious mental health conditions, that expert is usually a psychiatrist who can guide diagnosis and treatment including hospitalization, outpatient programs, medication, behavioral/psychotherapy, group therapy, and ongoing specialized testing, and follow up.

For mental health claims, active participation means:
• You are being treated by a physician trained in assessment and management of mental health conditions;
• You are regularly and actively complying with treatment recommendations and participating in all aspects of your treatment program – medication, therapy, testing, and follow up;
• Your physician is using the most appropriate treatment and care which conforms with generally accepted medical standards for your disability condition.

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 who is:

• Specialized in psychiatry; or
• Trained or experienced to evaluate and treat a mental condition
For the purpose of this Mental Health Claims section, Mental Illness does not include the following mental disorders outlined in the Diagnostic and Statistical Manual of Mental Disorders:

1) Mental Retardation;

2) Pervasive Developmental Disorders;

3) Motor Skills Disorder;

4) Substance-Related Disorders;

5) Delirium, Dementia, and Amnesic and Other Cognitive Disorders. This Mental Health Claims Section will not be applied to dementia if it is a result of:
   • stroke;
   • trauma;
   • viral infection;
   • Alzheimer's disease; or
   • other conditions not listed which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment.

6) Narcolepsy and Sleep Disorders related to a General Medical Condition;

7) Primary personality disorders (e.g., antisocial personality disorder and borderline personality disorder).

**Note** that LTD benefits for the above disorders will be administered in accordance with the main provisions of this Plan.
HOW TO RECEIVE BENEFITS AND CLAIM FILING DEADLINE

If your disability is expected to continue beyond 13 weeks (for Allied Health Staff) or 26 weeks (for Consultants/Voting Staff), notify the Claims Administrator as soon as possible. You must submit a written application on a long term disability claim form along with medical documentation to the Claims Administrator in order for your claim to be considered.

Time Limit to File the Initial Claim

You must file your written claim for long term disability benefits with the Claims Administrator, Recovery and Claim Services, no later than one year (365 days) from the date that you satisfied the Elimination Period. Any claim received after this date is not covered and/or compensable under this Plan.
SUBROGATION AND REIMBURSEMENT

There may be situations in which you have a legal right to recover damages or losses including loss of income as a result of an injury or illness caused by or the responsibility of a third party. For example, if you are injured in a store, the owner may be responsible for your illness or injury. If you become sick or injured in the course of your job, your employer or workers’ compensation insurer may be responsible for your loss of income or other expenses from the illness or injury. If someone else or an entity is legally responsible or agrees to compensate you for your injury or illness, the Plan has the right to recover any and all benefits it has paid in connection with the accident, illness or injury. Of course, this applies only if you receive any form of payment from any source through an award, judgment, damages, settlement or compromise as a result of the accident, illness or injury caused by, attributable to or otherwise the responsibility of a third party or entity.

By enrolling and accepting coverage in any of the Mayo Clinic disability plans, you agree to the following:

- The entire amount collected by you or your family members will be considered to be a first recovery of benefits paid under this Plan regardless of the terms of any award, agreement, regulation, statute, etc., to the contrary. The fact that only a part of the payment, settlement or recovery is allocated to loss of income or disability expenses does not affect the Plan’s rights to recover all the benefits paid in connection with your injury. The Plan shall have a lien and a security in all such claims.

- The Plan will be reimbursed 100% from any and all recovery before any payment of any existing claims including any claim made by you or your covered family members for general damages.

- The Plan may collect the proceeds of any settlement or judgment recovered by you or your covered family members or your legal representative regardless of whether you have been fully compensated or made whole.

- You have an obligation to cooperate completely with the Plan. You must sign all documents that may be required and take any other action necessary to secure these Plan rights. You also have an obligation to notify the Plan in writing immediately any time the Plan may have rights against another person or entity.

- If you fail to immediately repay amounts owed to the Plan under this rule, the Plan may withhold future payments from the Plan to satisfy your obligation.

- If you voluntarily accept a lump sum or other settlement from any source without the Plan’s consent and this causes the Plan to lose its subrogation or reimbursement rights, the Plan will have no obligation to pay any past, present or future benefits or expenses relating to the injury or illness caused by, attributable to in any degree or otherwise the responsibility of another person, party or entity.

- You may not assign any rights or causes of action you have or may have without the express written consent of the Plan.

Subrogation and reimbursement also applies to coverage under workers’ compensation plans, disability and lost time coverage, other substitute coverage, any other right of recovery or any claim payment received from any motor vehicle insurance including no-fault or med-pay insurance, underinsured and uninsured insurance and liability insurance. In addition, it applies in the event you fail to obtain any mandated insurance coverage. The
Plan reserves the right to recover expenses incurred on your behalf even if a family member makes the recovery if that recovery is based on your injuries. At all times, the Plan represents itself in subrogation and intervention interests. Therefore, no reduction for attorney fees, costs or expenses will be withheld from the Plan’s recovery. The common fund doctrine will not govern the allocation of attorney’s fees incurred by you or your dependents.

**Modification or Termination of the Plan**
Mayo Clinic reserves the right to change or terminate the Long Term Disability Plan in whole or in part at any time and in its sole discretion. Any disability benefits being paid at the time the Plan is amended continue based on the provisions of the Long Term Disability Plan at the time the disability commences, unless the amendment specifically provides otherwise. Any disability benefits being paid at the time the Plan terminates would continue based on the provisions of the Long Term Disability Plan applicable to the disabled participant at the time of the Plan termination, unless the amendment specifically provides otherwise.
**CLAIMS AND APPEAL PROCEDURES**

Claims under the Mayo Long Term Disability Plan are handled according to the claims procedure outlined in this section.

Unless specifically noted, time periods are in calendar days, not business days, and oral inquiries about coverage and benefits are not considered claims.

**Authorized Representative**

For the purpose of this Plan’s claims and appeal procedures, an Authorized Representative may act on your behalf with respect to any aspect of a claim or appeal.

In order to determine whether an individual has been authorized to act on your behalf, an “Authorized Representative” form must be received by the Plan in order for a person to be recognized as your Authorized Representative for both claims and appeals. Such forms are available by calling or writing the Claims Administrator’s office at:

Mayo Clinic

Recovery and Claims Services

Rosa Parks Pavilion, PB-4

200 First Street SW

Rochester, MN  55905

Attn:  LTD Claims Administrator

(800) 583-3390

Once an Authorized Representative is recognized, the Plan will direct all information, notification, etc. regarding the claim to the Authorized Representative, unless you provide specific written direction otherwise.

**Initial Claim and Decision**

If you believe you are eligible to receive long term disability benefits, you must file a written claim with the Claims Administrator (see address below). Your initial claim must be submitted by written application which may be obtained from the Claims Administrator, and you must provide medical support from a physician for your claim. Additional information may be requested by the Claims Administrator.

The written application to be completed is entitled ‘Claim for Long Term Disability Benefits’ and is available from the Claims Administrator.

Claims must be filed no later than one year (365 days) from the date that the Claims Administrator determines that you satisfied the applicable Elimination Period under this Plan.

You may, upon request and free of charge, receive copies of documents and information relevant to your claim. The Claims Administrator may require a medical examination or additional information regarding the claim. If a medical examination is required, the Claims Administrator will notify you of the date and time of the examination and the physician’s name and address. The Claims Administrator has 45 days to decide your claim and to notify...
you if your claim is denied in whole or in part. If your claim is denied, the notice will include all information required by federal regulations.

**Adverse Benefit Determination**

If your claim is denied, you will receive a Notice of an Adverse Determination in written form no later than 45 days after the receipt of the claim by the Plan. The notice will include the following:

- The specific reason(s) for the denial
- Reference to the specific Plan provision(s) on which the determination is based
- Description of any additional material or information necessary to process the claim and an explanation of why such information is necessary
- Description of the Plan procedures and time limits for appeal of the Adverse Benefit Determination and the right to sue in federal court
- Disclosure of any internal rule, guideline, protocol or similar criteria that was used when making the Adverse Benefit Determination or a statement that such information was relied upon when making the Adverse Benefit Determination. Such information will be provided free of charge upon request
- If the decision involves a scientific or clinical judgement, an explanation of the scientific or clinical judgement applying the terms of this Plan to your medical circumstances or a statement that such information was involved will be provided free of charge upon request

**1st Level Appeal and Decision**

If you disagree with the denial of your claim, you may appeal that decision. Your appeal must be in writing to the Claims Administrator (see address below). The appeal must state the reason you disagree with the denial of your claim and must be filed within 180 days after you received the notice denying your claim. You should submit all documents and written arguments you want considered at the review. The Claims Administrator will identify any medical or vocational experts it consults. The Claims Administrator has 30 days to make a decision on your appeal and to notify you if the denial of your claim is upheld. Your notice of denial will contain the information required by federal regulations.

**2nd Level Appeal and Decision**

If you disagree with the denial of your 1st level appeal, you may appeal that decision. Your 2nd level appeal must be in writing to the Plan Review Committee (see address below), must state the reason you disagree with the denial of your appeal and must be filed within 60 days after you received the notice denying your 1st appeal. You should submit all documents and written arguments you want considered at the 2nd appeal. The Plan Review Committee has 15 days to make a decision on your 2nd appeal and to notify you if the denial of your claim is upheld. Your notice of denial will contain the information required by federal regulations.

**Extensions of Time Periods**

If you are notified that special circumstances require an extension and by what date the claim is expected to be decided, the 45-day period for deciding an initial claim may be extended for up to 30 additional days with a further extension of 30 days (for a total of 60 days). The 30-day period for deciding a 1st level appeal may be extended for up to 30 additional days and the 15 day period for deciding a 2nd level appeal may be extended for up to 15 additional days. If the extension of time to decide a claim or an appeal is necessary because you need to submit additional information, you will be given at least 45 days to provide that information, and the time it takes
you to provide that information will not count against the time the Claims Administrator or the Plan Review Committee has to make its decision. Inquiries about the extensions of time periods can be made to the Claims Administrator and Plan Review Committee at the address below.

**In General**
Mayo Clinic is the Plan Administrator of the Plan and has delegated the authority to decide benefit claims and appeals as described in these claims procedures. The Claims Administrator has the discretion, authority and responsibility to make final decisions on all factual and legal questions under the Plan, to interpret and construe the Plan and any ambiguous or unclear terms and to determine whether a participant is eligible for benefits and the amount of the benefits. The Claims Administrator may rely on any applicable statute of limitations as a basis to deny a claim. The Claims Administrator’s decisions are conclusive and binding on all parties. You may, at your own expense, have an attorney or representative act on your behalf, but the Claims Administrator has the right to require a written authorization from you.

**Time Limits for Commencing Legal Action**
If you file your initial claim within the required time and the Claims Administrator denies your claim and appeal or your benefits are terminated, you may sue over your claim (unless you have executed a release on your claim). You must, however, commence that suit within three years after your initial claim was submitted or within three years of your initial appeal of the adverse benefit determination terminating or reducing your benefit.

**Exhaustion of Administrative Remedies**
Before commencing legal action to recover benefits or to enforce or clarify rights, you must completely exhaust the claims procedure for this Plan.

**Applicable Law and Venue for Legal Action**
The Plan is intended to be construed, and all rights and duties hereunder are to be governed, in accordance with the laws of the State of Minnesota, except to the extent such laws are preempted by the laws of the United States of America.

All litigation, in any way related to the Plan (including but not limited to any and all claims brought under ERISA, such as claims for benefits and claims for breach of fiduciary duty) must be filed in a United States District Court for the District of Minnesota.
CLAIMS ADMINISTRATION AND COMMITTEE CONTACTS FOR APPEAL PROCESS

<table>
<thead>
<tr>
<th>Plan</th>
<th>Claims Administrator</th>
</tr>
</thead>
</table>
| Mayo Long Term Disability Plan | Mayo Clinic  
Recovery and Claims Services  
Rosa Parks Pavilion PB-4  
200 First Street SW  
Rochester, MN 55905  
Attn: LTD Claims Administrator|

<table>
<thead>
<tr>
<th>1st Level Appeal</th>
<th>2nd Level Appeal</th>
</tr>
</thead>
</table>
| Mayo Clinic  
Recovery and Claims Services  
Rosa Parks Pavilion PB-4  
200 First Street SW  
Rochester, MN 55905  
Attn: LTD Claims Administrator | Mayo Clinic  
Plan Review Committee  
Rosa Parks Pavilion PB-4  
200 First Street SW  
Rochester, MN 55905 |
STATEMENT OF ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under 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 and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, 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 collective bargaining agreements, 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 each year.

Obtain a statement telling you whether you have a right to receive a benefit under the Plan at normal retirement age and, if so, what your benefits would be at normal retirement age if you stop working under the Plan now. If you do not have a right to a benefit under the Plan, the statement will tell you how many more years you have to work to get a right to a benefit. This statement must be requested in writing and is not required to be given more than once every twelve (12) months. The Plan must provide the statement free of charge.

**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 benefits plan. The people who operate the Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in your interest, and that of 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 a benefit is denied in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decisions without charge and to appeal any denial, all within certain time schedules. See the Claims Procedure section for more information.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 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 medical child support order, you may file suit in Federal Court after you have exhausted the Plan’s claims procedure. 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 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 if, for example, 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. Live assistance is available Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern Time by calling 1-866-4-USA-DOL (1-866-487-2365), or TTY 1-877-889-5627.
# PLAN INFORMATION

| Plan Sponsor and Plan Administrator | Mayo Clinic  
200 First Street SW  
Rochester, MN  55905  
(507) 266-0440 |
<table>
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<tr>
<td>Plan Sponsor EIN</td>
<td>41-6011702</td>
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</table>
| Named Fiduciary                     | Salary and Benefits Committee  
Mayo Clinic  
200 First Street SW  
Rochester, MN  55905  
Plan Review Committee (Claims)  
Mayo Clinic  
200 First Street SW  
Rochester, MN  55905  
(507) 266-0440 |
| Agent for Service of Legal Process  | Mayo Clinic  
200 First Street SW  
Rochester, MN  55905  
(507) 266-0440 |
| Plan Fiscal Year                    | January 1 – December 31                         |
| Type of Plan                        | Self-insured Long Term Disability Plan         |
| Plan Number                         | 505                                              |
| Type of Administration              | Recovery and Claims Services assists Mayo Clinic in the administration of the Plan. Address communications to Recovery and Claims Services:  
Recovery and Claims Services  
Mayo Clinic  
200 First Street SW  
Rochester, MN  55905  
(800) 583-3390 |
<p>| Sources of Contributions            | This Plan is funded solely with employer contributions. All disability benefits are paid from the general assets of participating employers. The Long Term Disability Plan is not insured. |</p>
<table>
<thead>
<tr>
<th>Participating Employers</th>
<th>Mayo Clinic Locations</th>
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<tbody>
<tr>
<td></td>
<td>Franklin Heating Station</td>
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<td>Gold Cross Ambulance Services</td>
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<td>Mayo Clinic</td>
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<td>Mayo Clinic Arizona</td>
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<td>Mayo Clinic Jacksonville</td>
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<td>Mayo Foundation for Medical Education and Research Rochester</td>
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<td>Airport Company</td>
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<td>Mayo Clinic Hospital - Rochester</td>
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<td>St. Luke’s Hospital Association-Jacksonville</td>
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<td>Charterhouse</td>
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<td>MMSI, Inc. d/b/a Mayo Clinic Health Solutions</td>
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<td></td>
<td>Mayo Clinic Methodist Hospital</td>
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<td>Mayo Collaborative Services, LLC</td>
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### Mayo Clinic Health System Locations

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<th>Mayo Clinic Health System Locations</th>
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<tr>
<td>Mayo Clinic Health System - Albert Lea and Austin</td>
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<td>Mayo Clinic Health System - Cannon Falls</td>
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<td>Mayo Clinic Health System – Chippewa Valley, Inc.</td>
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<td>Mayo Clinic Health System - Decorah Clinic Physicians</td>
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<td>Mayo Clinic Health System - Northwest Wisconsin Region, Inc.</td>
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<td>Mayo Clinic Health System - Fairmont</td>
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<td>Mayo Clinic Health System – Franciscan Medical Center, Inc.</td>
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<td>Mayo Clinic Health System – Home Health and Hospice, Inc.</td>
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<td>Mayo Clinic Health System - Lake City</td>
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<td>Mayo Clinic Health System – Mankato Mayo Clinic Health System - New Prague</td>
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<td>Mayo Clinic Health System - Northland, Inc.</td>
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<td>Mayo Clinic Health System - Oakridge, Inc.</td>
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<td>Mayo Clinic Health System - Owatonna</td>
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<tr>
<td>Mayo Clinic Health System – Pharmacy and Home Medical, Inc.</td>
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<td>Mayo Clinic Health System - Red Cedar, Inc.</td>
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<td>Mayo Clinic Health System - Red Wing</td>
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<td>Mayo Clinic Health System – Springfield</td>
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<td>Mayo Clinic Health System – St. James</td>
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<tr>
<td>Mayo Clinic Health System – Supportive HomeCare, Inc.</td>
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<tr>
<td>Mayo Clinic Health System - Waseca</td>
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<tr>
<td>Mayo Clinic Health System in Waycross²</td>
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² MCHS in Waycross ceased being a participating employer in this Plan with respect to disabilities commencing on or after July 1, 2016.
GLOSSARY

Active Participation

For mental, psychoneurotic or personality disorders, alcoholism or drug addiction means compliance with all treatment and vocational requirements of a program of rehabilitation approved by the Medical Director of Recovery and Claims Services and cooperating with Mayo Clinic’s review of the program.

Annual Benefit Salary

Annual benefit salary means your basic salary, as determined by your employer, at the time your disability commenced and does not include bonuses, commissions, overtime pay, shift pay or any other extra compensation.

Adverse Benefit Determination

A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit.

Authorized Representative

An individual or organization that is selected by you to represent your interests in all aspect of your claim and/or appeal process.

Claim

A request for a plan benefit or benefits made by you in accordance with a plan’s reasonable procedure of filing benefit claims. A formal request to the Mayo LTD Plan Administrator asking for a payment of LTD benefits constitutes a Claim under this Plan. The claim is completed by submitting the Mayo LTD Application along with supporting medical documentation.

Disability

Disability means that as a result of illness or injury you are completely unable to perform the duties of your regular occupation and you are under the regular care of a physician. Disability includes the period of time of the Elimination Period.

Elimination Period

The period of time between the beginning of a person’s disability and the start of the long term disability benefits. The elimination period differs for Allied Staff (13 weeks) and Consultants/Voting Staff (26 weeks).

Employee

A person classified by the employer for payroll and personnel purposes as a regular employee, except it shall not include a self-employed individual as described in Section 401(c) of the Internal Revenue Code of 1986. All employees who are treated as employed by a single employer under Subsections (b), (c) or (m) or Section 414 of the Internal Revenue Code of 1986 are treated as employed by a single employer for purposes of the Plan. Employee does not include any person classified by the employer as any of the following:

- Any individual who is a temporary employee.
- Any individual who is a supplemental or non-benefit eligible employee.
• Any individual included within a unit of employees covered by a collective bargaining unit unless such agreement expressly provides for coverage of the employee under the Plan.

• Any individual who is a nonresident alien and receives no earned income from the employer from sources within the United States.

• Any individual who is a leased employee as defined in Section 414(n)(2) of the Internal Revenue Code of 1986.

• Any individual who performs services for the employer through, and is paid by, a third-party (including, but not limited to, an employee leasing or staffing agency) even if such individual is subsequently determined to be a common law employee of the employer.

• Any individual who performs services for the employer pursuant to a contract or agreement (whether verbal or written) which provides that such individual is an independent contractor or consultant, even if such individual is subsequently determined to be a common law employer.

An employer’s classification is conclusive and binding for purposes of determining benefit eligibility under the Plan. No reclassification of a worker’s status, for any reason, by a third party, whether by a court, governmental agency or otherwise, and without regard to whether or not the employer agrees to the reclassification, shall make the worker retroactively or prospectively eligible for benefits. Any uncertainty regarding a worker’s classification will be resolved by excluding that person from eligibility.

**Employer**

Mayo Clinic and any subsidiary or affiliated entities recognized by Mayo Clinic as eligible to participate and that agree to participate in the Plan. In this document, employer shall mean the participating employers listed at the terms in this glossary “Mayo Clinic Locations” and “Mayo Clinic Health System Locations.”

**Illness**

A non-occupational sickness or disease (including pregnancy) that commenced while you are covered under the Plan.

**Injury**

A non-occupational accidental bodily injury caused directly and exclusively by external, violent and purely accidental means. The term injury excludes self-inflicted injury, an injury with respect to which benefits are payable under any workers’ compensation, occupational disease or similar law or, an illegal occupation or during the commission or attempted commission of an assault or any felony.

**Long Term Disability**

A significant period of disability lasting longer than 13 weeks (Allied Health Staff) or 26 weeks (Consultants/Voting Staff or Allied Health Staff – Special Status category).

**Maximum Benefit Duration**

The maximum period a person who is disabled under the terms of the Plan can receive benefits.

**Mayo Clinic Health System Locations**

A family of clinics, hospitals and health care facilities serving over 70 communities in Iowa, Georgia, Wisconsin and Minnesota.
Medical Director
The Medical Director of Recovery and Claims Services, or his or her designee.

Monthly Benefit
The amount of annual salary converted to a “per pay period” amount (26 times per year).

Onset of a Non-Occupational Illness or Injury
Means the first appearance of the signs or symptoms of an illness or injury.

Partial Disability
For Consultants/Voting Staff only, an illness or injury that prevents you from performing the material and substantial duties of your occupation on a full-time basis such that your partial disability earnings are at least 20% but not equal to or more than 100% of your pre-disability earnings.

♦ For Allied Health Staff, an illness or injury that allows you to work with restrictions but prevents you from working your previous FTE, or you need intermittent time off work due to the disability condition. In total, your partial disability benefits may not last beyond a 52-week period.

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 who is:

- Specialized in psychiatry; or
- Trained or experienced to evaluate and treat a mental condition

Regular Care
Means that you:

- Personally visit a physician as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition(s); and
- Are receiving the most appropriate treatment and care which conforms with generally accepted medical standards, for your disabling condition(s) by a physician whose specialty or experience is the most appropriate for your disabling condition(s), according to generally accepted medical standards.

Short Term Disability
A period of disability lasting usually not longer than 13 weeks (Allied Health Staff) or 26 weeks (Consultants/Voting Staff or Allied Health Staff – Special Status category).