Mayo Reimbursement Account
(A Component of the Mayo Dental Plan)

January 2018
HOW TO USE THIS DOCUMENT

The Table of Contents on page 6 provides an overview of the detailed information in the Mayo Reimbursement Account (MRA).

You will also find a glossary of terms used in the MRA document beginning on page 57.

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 Dental Plan. The Mayo Reimbursement Account (MRA) is one component of this plan. This component of the Mayo Dental Plan will be referred to in this document as the Plan or MRA. This document summarizes the MRA. You must enroll in the Plan in order to obtain coverage. You can enroll in only one component of the Mayo Dental Plan and if you are enrolled in the MRA, you cannot enroll your eligible family members in a different component of the Mayo Dental Plan, such as Delta Dental of MN.

The MRA is a limited purpose health reimbursement arrangement that provides reimbursement of certain dental, orthodontic, and vision expenses for eligible employees of Mayo Clinic and other participating employers. Effective January 1, 2018, this document sets forth the benefits for employees who are eligible under the MRA.

Because this document is intended to give employees an easily understood explanation of the Plan, it also serves as the Summary Plan Description. Privacy rules required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) are part of this Plan and are stated in a separate document that is available from the Plan Administrator and available online with the Summary Plan Descriptions. Simply go to HR Connect, Summary Plan Descriptions, and you will find the HIPAA Privacy Notices.

The MRA is not funded by a trust or individual bank account. Instead, Mayo allocates annual “credits” to you. All MRA reimbursements are made from the general assets of the employer. Mayo will allocate annual credits to you, and you can receive reimbursements for amounts paid by you based on your available credits for certain dental, orthodontic, and vision expenses incurred while you and your eligible dependents are covered by the Plan. The credits (including those already allocated) are subject to Mayo’s generally reserved right to amend and or terminate the Plan. See the Administrative Information section of this document for the amount of your coverage. 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. The right of Mayo Clinic to amend or terminate this Plan is explained in the administrative section of this document. If you have questions, see the contact information in the next section.

If you are eligible for the MRA, you are also eligible the orthodontia benefit component of the Mayo Dental Plan, which is also described in this Summary Plan Description.

Benefits under the MRA are “excepted benefits” as defined in Section 732(c) of ERISA and Sections 9831(c)(1) and 9832(c)(2) of the Code.
CONTACT INFORMATION

Mayo Clinic Health Solutions is the Claim Administrator for the MRA and will process claims and answer dental and vision benefit and claim questions for the Plan.

Mayo Clinic Health Solutions customer service representatives are available to answer questions regarding the Plan. For enrollment or eligibility questions, please contact Mayo Clinic’s HR Connect.

QUESTIONS ABOUT PLAN

Mayo Clinic Health Solutions Dental Services
4001 41 St NW
Rochester, MN 55901-8901
507-266-5580 (local)
1-800-635-6671 (toll free)
1-800-407-2442 (TDD)
M-F, 7 a.m. to 7 p.m. CT (excluding holidays)
www.mayoclinichealthsolutions.com

QUESTIONS ABOUT ENROLLMENT/ELIGIBILITY

HR Connect
200 First Street SW
Rochester, MN 55905
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)

COBRA ADMINISTRATION

Discovery Benefits, Inc.
PO Box 2079
Omaha, NE 68108-2079
1-866-451-3399
M-F, 7 a.m. – 7 p.m. CT

HR Connect and Mayo Clinic Health Solutions Customer Service have access to translation services to meet the needs of 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.
# TABLE OF CONTENTS

- **HOW TO USE THIS DOCUMENT** ................................................................................................. 3
- **INTRODUCTION** ............................................................................................................................... 4
- **CONTACT INFORMATION** ............................................................................................................... 5
- **TABLE OF CONTENTS** ................................................................................................................... 6
- **ELIGIBILITY AND PARTICIPATION** .................................................................................................. 9
  - Who is Eligible .................................................................................................................................. 9
  - Eligible Family Members .................................................................................................................. 10
  - When You Can Enroll ....................................................................................................................... 10
  - Permitted Mid-Year Election Change Event .................................................................................... 11
  - Procedure and Deadline for Making Change in Status Event Changes ........................................ 16
  - The Consistency Rule ....................................................................................................................... 17
  - Special Enrollment Rights ................................................................................................................ 17
  - What Happens to My MRA Balance If I Enroll in Another Component of the Mayo Dental Plan . . 19
  - When Does My Coverage Become Effective .................................................................................. 19
  - Coverage for Family Members after Your Death .............................................................................. 20
- **WHEN DOES COVERAGE END** ...................................................................................................... 21
  - Employee Coverage Ends ................................................................................................................ 21
  - Eligible Family Member Coverage Ends ........................................................................................ 21
  - Account Credit Balances When Employee Plan Coverage Ends .................................................. 22
  - Additional Termination of Coverage Rules ..................................................................................... 22
  - Effect of Return to Employment ..................................................................................................... 22
- **CONTINUATION OF HEALTH CARE COVERAGE UNDER COBRA** ........................................ 23
  - Introduction ....................................................................................................................................... 23
  - COBRA Eligibility .............................................................................................................................. 23
  - Notification of COBRA Continuation Coverage Election: You Must Give Notice of Some Qualifying Events .................................................................................................................................................. 24
  - You Must Give Notice for Certain Qualifying Events ...................................................................... 24
  - Who May Elect COBRA Continuation Coverage ........................................................................... 25
  - How to Elect COBRA Continuation Coverage ................................................................................ 25
  - Special Considerations in Deciding Whether to Elect COBRA ....................................................... 25
  - Duration of COBRA Continuation Coverage .................................................................................. 25
  - Cost of COBRA Continuation Coverage ......................................................................................... 27
  - Payment for COBRA Continuation Coverage ................................................................................ 27
  - First Payment for COBRA Continuation Coverage ........................................................................ 27
  - Periodic Payments for COBRA Continuation Coverage .................................................................. 28
  - Grace Periods for Periodic Payments ............................................................................................... 28
  - Termination of COBRA Continuation Coverage Before the End of the Maximum Coverage Period .................................................................................................................................................. 28
  - Keep Your Plan Informed of Address Changes ................................................................................ 28
  - Continuation of Health Coverage Under USERRA .......................................................................... 29
- **MAYO REIMBURSEMENT ACCOUNT** ............................................................................................... 30
  - Choice of Providers ............................................................................................................................ 29
- **CONTRIBUTIONS AND MAXIMUM ACCOUNT BALANCES** .................................................. 31
  - Annual Credits .................................................................................................................................. 31
  - Maximum Account Balance ............................................................................................................. 31
  - Orthodontia Credits .......................................................................................................................... 31
- **SCHEDULE OF BENEFITS** .............................................................................................................. 32
  - Dental Services .................................................................................................................................. 32
<table>
<thead>
<tr>
<th>Section Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision Services</td>
<td>33</td>
</tr>
<tr>
<td>Orthodontia Services</td>
<td>34</td>
</tr>
<tr>
<td>EXCLUSIONS</td>
<td>35</td>
</tr>
<tr>
<td>COORDINATION OF BENEFITS</td>
<td>36</td>
</tr>
<tr>
<td>Coordination of Group Coverage or Individual Coverage</td>
<td>36</td>
</tr>
<tr>
<td>Workers’ Compensation</td>
<td>36</td>
</tr>
<tr>
<td>SUBROGATION AND REIMBURSEMENT</td>
<td>37</td>
</tr>
<tr>
<td>CLAIM PAYMENT AND APPEAL PROCEDURES</td>
<td>39</td>
</tr>
<tr>
<td>Important Notes</td>
<td>39</td>
</tr>
<tr>
<td>Standard Claim Procedure</td>
<td>40</td>
</tr>
<tr>
<td>Filing an Initial Claim</td>
<td>40</td>
</tr>
<tr>
<td>Time for Filing a Claim</td>
<td>40</td>
</tr>
<tr>
<td>Filing a Claim</td>
<td>40</td>
</tr>
<tr>
<td>Claim Decision</td>
<td>40</td>
</tr>
<tr>
<td>Appeal Procedure For Standard Claims</td>
<td>42</td>
</tr>
<tr>
<td>Filing First Level Appeal (Standard Claim Process)</td>
<td>42</td>
</tr>
<tr>
<td>Time for Filing First Level Appeal</td>
<td>42</td>
</tr>
<tr>
<td>Filing First Level Appeal</td>
<td>42</td>
</tr>
<tr>
<td>Appeal Decision</td>
<td>42</td>
</tr>
<tr>
<td>Filing Second Level Appeal (Standard Claim Process)</td>
<td>43</td>
</tr>
<tr>
<td>Time for Filing Second Level Appeal</td>
<td>43</td>
</tr>
<tr>
<td>Filing of Second Level Appeal</td>
<td>43</td>
</tr>
<tr>
<td>Appeal Decision</td>
<td>43</td>
</tr>
<tr>
<td>Special Rule for Claims Related to a Course of Treatment</td>
<td>43</td>
</tr>
<tr>
<td>General Rules for Claim Procedures</td>
<td>44</td>
</tr>
<tr>
<td>Authority</td>
<td>44</td>
</tr>
<tr>
<td>Time Limit for Commencing Legal Action</td>
<td>44</td>
</tr>
<tr>
<td>Exhaustion of Administrative Remedies</td>
<td>44</td>
</tr>
<tr>
<td>Claim Administration And Committee Contacts For Appeal Process</td>
<td>45</td>
</tr>
<tr>
<td>GENERAL PROVISIONS</td>
<td>46</td>
</tr>
<tr>
<td>Applicable Law and Venue</td>
<td>46</td>
</tr>
<tr>
<td>Conformity with Governing Law</td>
<td>46</td>
</tr>
<tr>
<td>Construction of Terms</td>
<td>46</td>
</tr>
<tr>
<td>HIPAA Privacy Rules</td>
<td>46</td>
</tr>
<tr>
<td>No Guarantee of Employment</td>
<td>46</td>
</tr>
<tr>
<td>Non-Discrimination Policy</td>
<td>46</td>
</tr>
<tr>
<td>Plan Provisions Binding</td>
<td>47</td>
</tr>
<tr>
<td>Section Titles</td>
<td>47</td>
</tr>
<tr>
<td>PLAN ADMINISTRATION</td>
<td>48</td>
</tr>
<tr>
<td>Powers and Duties of the Plan Administrator</td>
<td>48</td>
</tr>
<tr>
<td>Operating Expenses for the Plans</td>
<td>48</td>
</tr>
<tr>
<td>Records</td>
<td>48</td>
</tr>
<tr>
<td>Release of Dental Vision Information</td>
<td>48</td>
</tr>
<tr>
<td>Assignment of Benefits</td>
<td>48</td>
</tr>
<tr>
<td>Amendment and Termination of Plan</td>
<td>49</td>
</tr>
<tr>
<td>Payment of Benefits After Plan Termination</td>
<td>49</td>
</tr>
<tr>
<td>ERISA STATEMENT OF RIGHTS</td>
<td>50</td>
</tr>
<tr>
<td>Receive Information About Your Plan and Benefits</td>
<td>50</td>
</tr>
<tr>
<td>Continue Group Dental Plan Coverage</td>
<td>50</td>
</tr>
<tr>
<td>Prudent Action by Plan Fiduciaries</td>
<td>50</td>
</tr>
<tr>
<td>Enforce Your Rights</td>
<td>51</td>
</tr>
<tr>
<td>Section</td>
<td>Page</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>Assistance with Your Questions</td>
<td>51</td>
</tr>
<tr>
<td>NON-DISCRIMINATION NOTICE</td>
<td>51</td>
</tr>
<tr>
<td>Discrimination is Against the Law</td>
<td>51</td>
</tr>
<tr>
<td>PLAN ADMINISTRATIVE INFORMATION</td>
<td>53</td>
</tr>
<tr>
<td>GLOSSARY</td>
<td>57</td>
</tr>
</tbody>
</table>
ELIGIBILITY AND PARTICIPATION

Who is Eligible

If you are classified by a participating employer for payroll and personnel purposes as an employee who is regularly scheduled to work at least 40 hours or more per pay period for the employer, you are considered an eligible employee and eligible to enroll for single or family coverage on the first day of employment and during the annual open enrollment. Regularly scheduled means your schedule on file with your employer is .5 FTE or more. An employee regularly scheduled to work .4 FTE who works extra hours does not qualify as regularly scheduled to work .5 FTE even if the hours worked may occasionally reflect a .5 FTE.

An employer’s classification is conclusive and binding for purposes of determining benefit eligibility under the Plan. 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.

All employees who are eligible for coverage under the Plan are also eligible to participate in the Pre-Tax Premium Rules. Any employee who elects MRA coverage under the Mayo Dental Plan will automatically pay his or her share of the cost of such coverage through the Pre-Tax Premium Payment Rules or if the employee is on an unpaid medical leave such as FMLA.

Impact of Mayo Basic Coverage. If you have coverage under or become covered by the Mayo Basic medical plan option (a High Deductible Health Plan that allows you to make contributions toward a Health Savings Account (HSA), you and any eligible family member automatically lose coverage under and become ineligible for the MRA. Any MRA account credit balance is forfeited on a permanent basis and you will not be entitled to any additional credits towards an MRA at Mayo while you are covered under Mayo Basic. When you lose coverage under Mayo Basic, you may become eligible for coverage under the MRA.

Waiting Period. There is no waiting period. An eligible employee is eligible for coverage on the first day of employment or change to eligible status with the employer.

FMLA Covered Persons. Family Medical Leave Act (FMLA) 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.

Military Leave Covered Persons. Military leaves of absence will be administered according to applicable law and policies established by the employer. Copies of military leave policies are available from the employer.

Leave of Absence. An employee who would normally be working as a regular employee for the employer for at least the required number of hours per pay period to qualify as an eligible employee, but who is on an employer approved leave of absence, such as, approved personal, disability, parental, and/or military leave, remains an eligible employee for the duration of the approved leave.
Eligible Family Members

Eligible family members include your spouse, and your child or children who are under the age of 26. A child or children include an employee’s biological children, stepchildren, legally adopted children, or children legally placed with you for adoption. A child who is physically or mentally incapable of self-support at age 26 and beyond may continue coverage under the Plan. New hires and newly benefit-eligible employees will require proof of disability as defined by Social Security Disability Insurance (SSDI) for children who are age 26 or older. The employee must provide proof that the child has been declared disabled and is receiving SSDI prior to age 26. Coverage will end if your own coverage ends or if the child marries or is no longer incapacitated.

A child whose coverage is required under a Qualifying Medical Child Support Order (QMCSO) will be eligible to participate in the Plan. The Plan Administrator will review a child support order and determine whether it is qualified. Upon written request to the Plan Administrator, you may obtain a copy of the procedures governing QMCSOs at no charge.

When You Can Enroll

To be covered by the Plan you must enroll yourself and any eligible family members. Please note that in order for your eligible family members to be enrolled, you must be enrolled or enrolling. The Plan reimburses only expenses incurred while you and your eligible family members are covered by the Plan. The following paragraphs describe enrollment. You cannot enroll in the MRA and switch to another component of the Mayo Dental Plan other than during open enrollment.

Initial Enrollment

Eligible employees. An eligible employee has 31 days from the date he/she first satisfies the definition of eligible employee to enroll for coverage in the Plan. This is called the initial enrollment period. Enrollment instructions will be provided by a designated person of the employer. Enrollment materials must be completed and submitted (electronically or on paper) to the Plan Administrator, or its designee, within the thirty-one (31) day period. If enrollment does not occur within this initial period, the eligible employee may enroll in the Plan only if a “special enrollment” situation occurs or during the annual open enrollment.

Eligible family members. An eligible family member must be enrolled within thirty-one (31) days of the date he/she first satisfies the definition of eligible family member. If enrollment does not occur within this initial period, the eligible family member may enroll in the Plan only if a “special enrollment” situation occurs or during the annual open enrollment.

Open Enrollment

Prior to the start of a coverage year, the Plan has an open enrollment period. The terms of the open enrollment period, including duration of the election period, shall be determined by the Plan Administrator and communicated prior to the start of the open enrollment period. The open enrollment effective date of coverage is January 1.

Mid-Year Coverage Changes

You can only change your coverage election, including who you choose to cover as an eligible family member, under the Plan if you have either a special enrollment event or change in status event as discussed below.

Change in Status Events Permitting Change, Cancellation or Reduction of Coverage during the Year

Because you pay your share of Plan coverage with pre-tax dollars, you can only change your coverage election under the Plan mid-year if you, your spouse, and/or eligible family member experience a change
in status event. This means that once you elect coverage at initial or open enrollment, that coverage is ordinarily in effect until December 31 of the year in question.

If your cost of coverage changes as a result of your permitted coverage change, Mayo will automatically increase or decrease your cost of coverage, as applicable, on the next payroll after your election change is approved.

The chart below describes the change in status events and the consistency requirements that must be met in order to make a change mid-year.

Some of the changes, as indicated, are “Special Enrollment” rights subject to special protections under federal law. See the Special Enrollment section below for more information.

Under certain circumstances, your enrollment election will change automatically (for example, if you terminate employment, your Plan coverage ends and your pre-tax election is automatically stopped). The events leading to automatic changes to the Plan coverage are included in the Permitted Med-Year Election Change Event chart that follows, even though they will occur automatically.

**Permitted Mid-Year Election Change Event**

<table>
<thead>
<tr>
<th>Event</th>
<th>Permitted Election Change</th>
<th>Employee Requirements for Election Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marriage (Special Enrollment)</td>
<td><strong>If you are not already enrolled:</strong> - May enroll yourself and your new spouse and any other eligible family member (even if they were previously not enrolled before you married). You must enroll yourself to cover your spouse or any eligible family member. <strong>If you are already enrolled:</strong> - May add your new spouse and any eligible family member (even if they were previously not enrolled before you married). - If you or eligible family member become eligible under your spouse’s group health plan and elect such coverage, corresponding premium decreases under the Plan may be made.</td>
<td>Within 31 calendar days from date of marriage, you must contact HR Connect.</td>
</tr>
<tr>
<td>Birth, adoption, placement for adoption (Special Enrollment)</td>
<td><strong>If you are not already enrolled:</strong> May enroll yourself, your spouse and any other eligible family member (even if they were previously not enrolled before you acquired the new child). You must enroll yourself to cover your spouse or any eligible family member.</td>
<td>Within 31 calendar days from date of birth, adoption, placement for adoption, you must contact HR Connect.</td>
</tr>
<tr>
<td>Event</td>
<td>Permitted Election Change</td>
<td>Employee Requirements for Election Change</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td>Member</td>
<td>If you are already enrolled:</td>
<td>Within 31 calendar days from date of</td>
</tr>
<tr>
<td></td>
<td>May enroll your spouse and any other eligible family member (even if they were previously not enrolled).</td>
<td>death of child, you must contact HR</td>
</tr>
<tr>
<td></td>
<td>Note: You must affirmatively and timely add a new child, even if your coverage level does not change.</td>
<td>Connect.</td>
</tr>
<tr>
<td>Death of child</td>
<td>If your child was covered under the Plan:</td>
<td>Within 31 calendar days from date of</td>
</tr>
<tr>
<td></td>
<td>Must remove child from Plan.</td>
<td>death of child, you must contact HR</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Connect.</td>
</tr>
<tr>
<td>Your child becomes eligible under the terms of the Plan (for example, if you add a stepchild)</td>
<td>May add child to your coverage.</td>
<td>Within 31 calendar days from date of</td>
</tr>
<tr>
<td></td>
<td>Note: You must affirmatively and timely add a newly eligible family member, even if your coverage level does not change.</td>
<td>eligibility, you must contact HR</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Connect.</td>
</tr>
<tr>
<td>Divorce, annulment or death of spouse</td>
<td>If spouse is covered under the Plan:</td>
<td>Within 31 calendar days from date of</td>
</tr>
<tr>
<td></td>
<td>- Must remove spouse</td>
<td>divorce, annulment or death of spouse, you must contact HR Connect.</td>
</tr>
<tr>
<td></td>
<td>Note: You must affirmatively and timely remove your spouse, even if your coverage level does not change. Failure to do so is considered fraud on the Plan.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If you or any eligible family member were covered by spouse’s plan and lose eligibility:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- May elect coverage under the Plan for yourself and any eligible family member also losing coverage.</td>
<td></td>
</tr>
<tr>
<td>Your covered child loses eligibility under the Plan due to age</td>
<td>Coverage ends the last day of the month of child’s 26th birthday</td>
<td>Within 31 calendar days, you must</td>
</tr>
<tr>
<td></td>
<td></td>
<td>contact HR Connect.</td>
</tr>
<tr>
<td>Your employment status changes so that you gain eligibility under the Plan (for example, you move from a non-benefit eligible position to a benefit eligible</td>
<td>May elect coverage for yourself, your spouse and any eligible family member.</td>
<td>Within 31 calendar days, you must</td>
</tr>
<tr>
<td></td>
<td></td>
<td>contact HR Connect.</td>
</tr>
<tr>
<td>Event</td>
<td>Permitted Election Change</td>
<td>Employee Requirements for Election Change</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Your employment status changes so that you lose eligibility under The Plan (for example, you move from full-time to a non-benefit eligible employment status)</td>
<td><strong>Coverage ends.</strong></td>
<td>Not applicable because Mayo will automatically make this change.</td>
</tr>
</tbody>
</table>
| Your spouse gains eligibility under another employer’s plan          | If your spouse, any covered eligible family member or you will become covered under spouse’s plan:  
|                                                                     | May make corresponding premium decreases to your coverage under the Mayo Plan.          | Within 31 calendar days, you must contact HR Connect.                          |
| Your eligible family member gains eligibility under another employer’s plan. | If your eligible family member will become covered under his/her employer’s plan, you may drop the eligible family member from your coverage under the Plan. | Within 31 calendar days, you must contact HR Connect.                          |
| Your spouse loses eligibility under another employer’s plan because of an employment status change (for example, your spouse is terminated) | If you are covered under the Plan:  
|                                                                     | - May add your spouse as well as any eligible family member who were also covered under your spouse’s plan.  
|                                                                     | If you were covered under your spouse’s plan:  
<p>|                                                                     | - May elect coverage under the Plan for yourself, your spouse and any eligible family member losing coverage under spouse’s plan. | Within 31 calendar days, you must contact HR Connect.                          |
| Your eligible child loses eligibility under another employer’s plan because of an employment status change | May add eligible family member, if eligible, to your coverage under the Plan. | Within 31 calendar days, you must contact HR Connect.                          |
| You are rehired by Mayo within 30 days of termination by Mayo       | If you are rehired into a benefit eligible position, the Plan election you had in place at your termination of employment is reinstated. | Not applicable because Mayo will automatically make this change.               |
| You are rehired by Mayo                                              | If you are rehired into a benefit                                                        | You will have the same time frame to                                             |</p>
<table>
<thead>
<tr>
<th>Event</th>
<th>Permitted Election Change</th>
<th>Employee Requirements for Election Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>more than 30 days after termination by Mayo and in the same year</td>
<td>eligible position, you may make a new Medical Plan election.</td>
<td>elect new coverage as other new hires.</td>
</tr>
<tr>
<td>You are covered under the Plan, your spouse is employed by another</td>
<td>If you, your spouse, or any covered family member moves to your spouse’s plan, you can</td>
<td>Within 31 calendar days, you must contact HR Connect.</td>
</tr>
<tr>
<td>employer, and either (i) your spouse’s plan is improved mid-year or</td>
<td>drop (if all of you are changing coverage) or reduce (for those covered persons who are</td>
<td></td>
</tr>
<tr>
<td>(ii) your spouse’s plan has a different plan year (and annual</td>
<td>moving to the spouse’s plan) coverage under the Plan.</td>
<td></td>
</tr>
<tr>
<td>enrollment period) than the Plan and you decide to change to your</td>
<td></td>
<td></td>
</tr>
<tr>
<td>spouse’s plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>You are covered under your spouse’s employer’s plan which has a</td>
<td>If you drop coverage under your spouse’s plan, you, your spouse and any covered family</td>
<td>Within 31 calendar days, you must contact HR Connect.</td>
</tr>
<tr>
<td>different plan year (and annual enrollment period) than the Plan</td>
<td>members can become covered under the Plan.</td>
<td></td>
</tr>
<tr>
<td>and you want to drop coverage under your spouse’s plan and become</td>
<td></td>
<td></td>
</tr>
<tr>
<td>become covered under the Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>You, your spouse or your eligible family member experience a loss of</td>
<td>Under federal law, you have the right to elect coverage under the Plan if you experience a</td>
<td>Within 31 days from loss of other coverage, you must HR Connect.</td>
</tr>
<tr>
<td>other coverage that is a Special Enrollment that is an event not</td>
<td>“Special Enrollment” event. Special enrollments can include gaining new dependents through</td>
<td></td>
</tr>
<tr>
<td>covered elsewhere on this chart</td>
<td>marriage, birth or adoption or loss of other coverage. There is more information about</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Special Enrollments in the Special Enrollment Rights section below. Special Enrollments</td>
<td></td>
</tr>
<tr>
<td></td>
<td>involving gaining new dependents are covered above in this chart as are most Special</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Enrollments involving loss of coverage. Some Special Enrollment events related to losses</td>
<td></td>
</tr>
<tr>
<td></td>
<td>of other coverage are not covered elsewhere, however. If you, a spouse or eligible family</td>
<td></td>
</tr>
<tr>
<td></td>
<td>member were previously eligible but not</td>
<td></td>
</tr>
<tr>
<td>Event</td>
<td>Permitted Election Change</td>
<td>Employee Requirements for Election Change</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Your child is employed and the child’s plan is improved mid-year or has a different plan year (and annual enrollment period) than the Plan | If your child moves to his or her employer’s plan:  
You may reduce your coverage under the Plan by dropping the child.  
You can decrease premium or cancel your Mayo coverage to the extent consistent with the Medicare or Medicaid entitlement. | Within 31 calendar days, you must contact HR Connect to request a change.  
Within 60 calendar days from date of Medicare or Medicaid eligibility, you must contact HR Connect. |
| You, your spouse or eligible family member become entitled to Medicare, Medicaid |                                                                 |                                                                                                          |
| You, your spouse or eligible family member loses eligibility for Medicare, Medicaid or a state Children’s Health Insurance Program (“CHIP”) | You can increase premium or add coverage to The Plan to the extent the change corresponds with the loss of Medicare, Medicaid or CHIP entitlement.  
Additionally, if you lose Medicaid eligibility, you can add yourself, your spouse and any eligible family members to The Plan. | Within 60 calendar days from loss of eligibility for Medicare, Medicaid or CHIP coverage, you must contact HR Connect. |
| You or your children become eligible for a | You may either enroll yourself or enroll yourself, your spouse and | Within 60 calendar days after date on which eligibility for premium |

enrolled in the Plan and subsequently lose coverage due to any of the following, you, your spouse or eligible family member has such a Special Enrollment opportunity:  
- Incurring a claim that would meet or exceed a lifetime limit on all benefits.  
- Employer contributions toward the cost of coverage terminate.  
- The Plan is changed so that you, your spouse or your eligible family member is no longer eligible.  
- You, your spouse or eligible family member exhaust COBRA coverage (that you, your spouse or eligible family member were enrolled in when you last declined coverage under the Plan). See Special Enrollment Rights section below for more information.
<table>
<thead>
<tr>
<th>Event</th>
<th>Permitted Election Change</th>
<th>Employee Requirements for Election Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>premium assistance subsidy under Medicaid or CHIP</td>
<td>your eligible family member(s) in the Plan.</td>
<td>assistance subsidy is determined, you must contact HR Connect.</td>
</tr>
<tr>
<td>You are required to provide health plan coverage under a Qualified Medical Child Support Order (“QMCSO”) for a child you do not currently cover under the Plan</td>
<td>If you already have coverage under the Plan, you may add the child who is the subject of the QMCSO. If your coverage level changes, your cost of coverage will increase. If you do not have coverage under the Plan, both you and the child who is the subject of the QMCSO will be enrolled in coverage.</td>
<td>Contact HR Connect within 31 days and submit QMCSOs as soon as possible.</td>
</tr>
<tr>
<td>Another person, such as your former spouse, is required to provide health coverage to an eligible family member you currently cover under the Plan</td>
<td>Notify Mayo of the order. The eligible family member will be dropped from coverage and, if your coverage level changes, your cost of coverage will decrease.</td>
<td>Submit QMCSO as soon as possible to HR Connect.</td>
</tr>
<tr>
<td>Your share of the cost of your Mayo coverage increases or decreases (because the cost of coverage charged by Mayo changes mid-year)</td>
<td>If Mayo increases or decreases the cost of health plan coverage for employees during the year, your share will be automatically adjusted.</td>
<td>Not applicable, because Mayo will automatically make these changes.</td>
</tr>
</tbody>
</table>

**Procedure and Deadline for Making Change in Status Event Changes**

If you satisfy the requirements in this section for a Permitted Mid-Year Election Change Event, you must notify HR Connect within 31 days of the date you experience a change in status event or special enrollment that allows you to make an election change. Under federal law, however, you have 60 days from either (i) loss of coverage under Medicaid or CHIP, or (ii) becoming eligible for a Medicaid or CHIP premium assistance subsidy to make your change. See the Special Enrollment Rights section below for more information.

**The Consistency Rule**

Also note that federal tax rules applicable to pre-tax health care require that your changes satisfy certain “consistency rules.” This means that the change in status event must affect eligibility for coverage under an employer’s plan and the requested election change must be on account of and consistent with the event. If, in Mayo’s judgment, the requested change does not satisfy these rules, it will not be permitted.
You may need to provide proof of your change in status event or special enrollment event and the date the event occurred. Failure to do so may result in denial of your change request.

If you have questions about changing your benefit elections during the year, please contact HR Connect.

Special Enrollment Rights

**Special Enrollment Due to Loss of Other Health Coverage**

Under certain circumstances, an eligible employee or his/her eligible family member(s) who did not enroll during the initial enrollment period (or at annual enrollment or when a change in status event occurred) may enroll in the Plan during the Plan year. These circumstances warrant "special enrollment."

Special enrollment will be allowed for any of the following:

(a) The eligible employee or eligible family member satisfies all of the following criteria:
   - Was covered under another group health plan or other health insurance coverage (this prior coverage does not include continuation coverage required under federal and state law) at the time the eligible employee or eligible family member was previously eligible to enroll under the Plan.
   - Declined Mayo coverage for the reason described above.
   - Presents to HR Connect evidence of loss of prior coverage due to loss of eligibility for that coverage, or evidence of the termination of employer contributions toward that coverage.
   - Loss of eligibility is not due to the eligible employee’s or eligible family member’s failure to pay premiums on a timely basis or termination for cause but is due to:
     - Legal separation
     - Divorce
     - Death
     - Cessation of eligible family member status
     - Loss of HMO or similar coverage because you change your residence or work place and as a result coverage is no longer available
     - The Plan is changed so that you, your spouse, or your eligible family member are no longer eligible
     - Employer contributions toward the coverage terminate
     - Termination of employment
     - Reduction in the number of hours of employment
     - Incurring a claim that would meet or exceed a lifetime limit on all benefits
   - Notifies HR Connect in writing, within 31 days of the date of the loss of coverage or the date the employer’s contribution toward that coverage terminates.

(b) The eligible employee or eligible family member satisfies all of the following criteria:
   - Was covered under benefits available under COBRA
   - Declined coverage for that reason
   - Presents to HR Connect evidence that the eligible employee has exhausted such COBRA coverage and has not lost such coverage due to the failure of the eligible employee or eligible
family member to pay premiums on a timely basis or termination of coverage for cause. COBRA would therefore be deemed to be exhausted if it ended for any of these reasons:

- Another employer or responsible entity fails to remit premiums for the coverage as a whole (but not if you or an eligible family member lose coverage for your or your eligible family member’s non-payment)
- Loss of HMO or similar coverage because of change in residence or work place that makes coverage available
- Incurring a claim that would meet or exceed a lifetime limit on all benefits

- Notifies HR Connect in writing, within 31 days of the date of the loss of coverage.

(c) The eligible employee or eligible family member satisfies all of the following criteria:

- An eligible employee or eligible family member with coverage under a state Medicaid plan or The Children’s Health Insurance Program (CHIP) loses such eligibility.
- Loss of eligibility is not due to the eligible employee’s or eligible family member’s failure to pay premiums on a timely basis or termination for cause.
- Notifies HR Connect in writing, within 60 days of the date of the loss of coverage.

Special Enrollment Due to Medicaid or CHIP Premium Assistance

If an eligible employee or his/her eligible family member(s) who did not enroll during the initial enrollment (or at annual enrollment or when a change in status event occurred) become eligible for premium assistance under a state Medicaid or Children’s Health Insurance Program (CHIP), then an eligible employee or his/her eligible family member(s) may enroll in the Plan during the Plan year if the eligible individual notifies HR Connect, in writing within 60 days of the date of becoming eligible for such premium assistance.

Special Enrollment Due to Addition of Eligible Family Member

You may add coverage for yourself and any eligible family members following:

- Marriage
- Birth, adoption, or placement for adoption of an eligible employee’s child

Non-Participating Employees May Also Enroll

The addition of a new eligible family member triggers enrollment rights for an eligible employee even if he/she does not participate in the Plan at the time of the event. For example, upon the birth of an eligible employee’s child, the eligible employee (assuming that he/she did not previously enroll), his/her spouse, and his/her newborn child may all enroll because of the child's birth. The same rule applies to the other special enrollment events if the eligible employee had not previously enrolled in the Plan.

Time Period for Special Enrollment

The eligible employee must request special enrollment in the Plan within 31 days of the marriage or birth, adoption or placement for adoption of his/her child. **Please note** that in the event of loss of other coverage under Medicaid or CHIP or eligibility in the Plan based on premium assistance under Medicaid or CHIP, the eligible individual must request special enrollment within 60 days of the event. If HR Connect does not receive the eligible employee’s completed request for enrollment within this deadline, the eligible employee and his/her eligible family member lose special enrollment rights for that event.
Effective Date of Special Enrollment

Enrollment in the Plan under this special enrollment provision will be the date of the event. Please note that you can only pay for this coverage on a pre-tax basis retroactively for the birth, adoption, and placement of a child for adoption and only if you satisfy the 31 day deadline to enroll the child.

Adding Child Coverage Due To Court Order

Although the Plan normally does not permit you to add coverage mid-year absent a special enrollment event, you may add health coverage during the year for a child if a judgment, decree, or order (i.e., a Qualified Medical Child Support Order) requires that your child be covered under the Plan.

Changing Your Coverage Election

Some changes to your health coverage will happen automatically. For example, if you terminate or are no longer eligible for coverage under the Plan, your coverage (and your spouse's and eligible family members’ coverage) will automatically be terminated.

In cases not related to your Mayo employment, however, you need to notify the Plan of the occurrence of the change in status event to stop your pre-tax premium payments, even if coverage is lost under the terms of the Plan. For example, if you divorce, your spouse loses coverage as of the date of the divorce. You must still notify the Plan of the divorce if you want to change your coverage level and reduce your pre-tax employee contributions.

If you experience a special enrollment event and want to add coverage, you should contact HR Connect within the time period specified in the Special Enrollment event section above.

If you experience one of the change in status events listed above and want to cancel or reduce the level of coverage, contact HR Connect within 31 days of the occurrence of the event.

If you are an eligible employee and are required by a Qualified Medical Child Support Order to provide coverage for health expenses of a child, you will be enrolled in the Plan, if necessary, or your contribution will be increased as specified in the Order, and the entire cost to you for such coverage will be deducted from your pay automatically on a pre-tax basis. Submit Child Support Orders to HR Connect at your earliest convenience so that they can be processed.

What Happens to My MRA Balance If I Enroll in Another Component of the Mayo Dental Plan?

If you are enrolled in the MRA and switch to Delta Dental of MN during Open Enrollment, any MRA account credit balance will be forfeited.

When Does My Coverage Become Effective?

The date on which coverage becomes effective depends upon when enrollment occurs.

a. Enrollment within Initial Enrollment Period. The effective date of coverage for eligible employees who enroll during the initial enrollment period is the first day of employment or change to eligible status with the employer. The effective date of coverage for eligible family members is at the time of the eligible employee’s enrollment. If eligible family member status is acquired after the eligible employee’s initial eligibility, the effective date of coverage shall be the date on which the new eligible family member becomes eligible for coverage under the Plan, provided the employee completes a change form and submits it to the Plan Administrator within 31 days after the attainment of eligible family member status.
b. **Open Enrollment Period.** If an eligible employee or eligible family member does not enroll within the initial enrollment period, he or she must wait until the next open enrollment period unless a “special enrollment” situation occurs. The effective date of coverage would be the first day of the coverage year for which the open enrollment period was held. Additional information is available on page 10 in the paragraph titled open enrollment.

c. **Special Enrollment.** When enrollment occurs as the result of a special enrollment due to loss of other health coverage as described above, the effective date of coverage is the day after the end date of the other health coverage as long the COBRA letter is in the Human Resources office or filed with HR Connect within 31 days of the loss of such other coverage. When enrollment occurs as the result of a special enrollment due to addition of an eligible family member as described above, the effective date of coverage is the date of the event.

**Coverage for Family Members after Your Death**

If you had not met the required years of Continuous Service coverage for retiree coverage as provided under the Mayo Dental Plan, and if your spouse, and eligible family members were enrolled in the Plan at the time of your death, MRA coverage for your eligible family members will continue until they no longer meet the definition of eligible family member. Coverage for your spouse will continue until he/she is gainfully employed, remarried, or age 65. Coverage will not be available for any eligible family member not enrolled at the time of your death. Eligible family members covered under this provision will not be eligible to participate in annual open enrollment.

If your spouse is eligible for coverage as an employee under the Plan, contact HR Connect for enrollment details.

**NOTE:** Mayo has reserved the right to amend the terms of any component of the Mayo Dental Plan, including the MRA described herein, in any respect, at any time, and for any reason, including provisions of coverage for surviving spouses, and eligible family members. See the subsection *Amendment and Termination* of the Plan in the *Plan Administration* section for additional information.
WHEN DOES COVERAGE END

Employee Coverage Ends

Your participation in the Plan will terminate upon the occurrence of the earliest of:

1. The last day of the month in which you terminate employment with the employer. You are required to pay premiums until the end of the month of termination.
2. The last day of the month in which your employment position or status changes such that you are no longer an eligible employee, or the last day of the month in which you otherwise no longer satisfy the eligibility requirements.
3. The date your elected coverage under the Mayo Basic medical plan option becomes effective.
4. The date the employer terminates the Plan or its participation in the Plan.
5. The date of your death.
6. The effective date of the amendment, if the Plan is amended so that you lose coverage.
7. The date you retire.

Eligible Family Member Coverage Ends

Your eligible family member’s participation in the Plan will terminate immediately upon termination of the Plan or at midnight upon the occurrence of the earliest of:

1. The last day of the month the family member ceases to be an eligible family member as defined in the Plan. Premiums must be paid until the end of the month of termination.
2. The last day of the month after your child’s 26th birthday.
3. The last day of the month of the date the final decree for dissolution of marriage.
4. The date the eligible employee loses coverage under the Plan.
5. The date eligible family member coverage is discontinued under the Plan or the Plan is amended so that the eligible family member loses eligibility.
6. The date ending the period for which the contribution is made if you cease to make the required contributions for the eligible family member.
7. The date coverage is no longer required under the terms of a QMCSO or the Plan.
8. The date your eligible family member is discharged from the hospital, if he/she is hospitalized on the day coverage would otherwise end.
9. The date the eligible family member becomes eligible and enrolls in coverage under Mayo Basic medical plan option.
Account Credit Balances When Employee Plan Coverage Ends

In the event that you lose coverage as described above, any and all MRA account credit balance is forfeited at the time of the loss of coverage, unless (1) you and your eligible family members have and elect COBRA continuation rights and are entitled to continue the Plan coverage, or (2) your employment is terminated but you return to work at the employer within 30 days.

You should note the fact that losing eligibility under the Plan due to gaining coverage under Mayo Basic is not a “qualifying event” that entitles you to COBRA continuation coverage. (NOTE: If you gain coverage under Mayo Basic, you will forfeit any balance you had in your MRA)

Additional Termination of Coverage Rules

In addition to the occurrences listed above, your participation in the Plan will terminate upon the occurrence of the earliest of:

1. The date you do not cooperate with (1) the Plan Administrator, as that term is defined in Section 3(16)(A) of ERISA, with respect to the administration of the Plan and/or (2) the employer. Failure to cooperate may result in a loss of eligibility for you and all eligible family members with the same member card. Such determination shall be made at the discretion of the Plan Administrator provided such determination is consistent with and in fulfillment of the Plan Administrator’s fiduciary duties as described in Section 404 of ERISA.

2. The date on which you allow persons not covered under the Plan to obtain Plan benefits.

3. The date you provide fraudulent information to obtain Plan benefits or coverage, including falsifying information on your applications for coverage and/or submitting fraudulent, altered, or duplicate billings for personal gain. If any claims are mistakenly paid for expenses incurred due to such fraudulent information, the employee will be required to reimburse the Plan.

4. The date you do not reimburse the Plan for any claims mistakenly paid.

Effect of Return to Employment

Special rules apply when you return to work after previously working for the participating employer. Your participation in the Plan will depend on the length of time between when your employment terminated and when you return to work for the Employer.

Thirty 30 Days or Less. If you return to work within 30 days of the date you terminated employment, your coverage and prior account credit balance will be reinstated automatically; however, you will not receive an additional contribution for that Plan year. Covered expenses you incurred during the period you were terminated will not be reimbursed from your account.

After 30 Days. If you return to work more than 30 days from the date you terminated employment, you will be treated as a newly hired employee, and the initial enrollment rules will apply. Refer to the Enrollment section for more information. Your prior balance will not be reinstated unless you elected COBRA continuation coverage as described in the COBRA Continuation Coverage section.
CONTINUATION OF HEALTH CARE COVERAGE UNDER COBRA

This section contains detailed information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan after you or your eligible family members lose coverage in certain circumstances. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). If you have questions about your COBRA continuation coverage rights, please contact the COBRA Administrator at the address or number listed below.

COBRA ADMINISTRATION

<table>
<thead>
<tr>
<th>Discovery Benefits, Inc.</th>
</tr>
</thead>
<tbody>
<tr>
<td>PO Box 2079</td>
</tr>
<tr>
<td>Omaha, NE 68103-2079</td>
</tr>
<tr>
<td>1-866-451-3399</td>
</tr>
<tr>
<td>M-F, 7 a.m. – 7 p.m. CT</td>
</tr>
</tbody>
</table>

COBRA continuation coverage can become available when you and/or your eligible family would otherwise lose health coverage under the Plan due to certain events. This notice generally explains COBRA continuation coverage, when it may become available to you and your eligible family members, and what you can do to protect the right to receive it.

Introduction

If you are eligible to elect COBRA continuation coverage under the MRA, you will be able to elect this coverage separately from any other Mayo health plan coverage you have, such as coverage under a Mayo Medical Plan option. If you are eligible for and elect COBRA under the MRA, you will have continued access to the balance in your account (if any) at the time you would otherwise lose coverage (less any reimbursements) and you will receive annual employer contributions. You will however be required to pay 102% of the cost of coverage to maintain MRA coverage under COBRA. Read this section for additional information about your COBRA rights.

COBRA Eligibility

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” After a qualifying event (and any required notice of that event has been properly provided), COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your eligible family members could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose coverage under the Plan because either one of the following qualifying events occurs:

- Your hours of employment are reduced
- Your employment ends for any reason other than your gross misconduct
• If you are the spouse of an employee, you will become a qualified beneficiary if you lose coverage under the Plan because any of the following qualifying events occur:
  • Your spouse dies
  • Your spouse’s hours of employment are reduced
  • Your spouse’s employment ends for any reason other than his or her gross misconduct
  • You become divorced from your spouse (Also, if an employee eliminates coverage for his or her spouse in anticipation of a divorce, and a divorce later occurs, the ex-spouse may still be entitled to COBRA continuation coverage even though he or she lost coverage before the divorce. It is therefore important for the ex-spouse to notify the COBRA Administrator of the divorce even if coverage had been eliminated earlier. The ex-spouse will need to follow the procedures outlined below for providing such notice.)

Your eligible family members (including your children participating under a qualified medical child support order (QMCSO) will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events occur:
  • Parent/Employee dies
  • Parent/Employee’s hours of employment are reduced
  • Parent/Employee’s employment ends for any reason other than his or her gross misconduct
  • Parents become divorced
  • Child stops being eligible for coverage under the Plan

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Mayo Clinic and results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee’s spouse, surviving spouse and eligible family members will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

Notification of COBRA Continuation Coverage Election: You Must Give Notice of Some Qualifying Events

When the qualifying event is the end of employment, reduction of hours of the employment, or death of the employee, the Plan will offer COBRA continuation coverage to qualified beneficiaries. You need not notify THE COBRA ADMINISTRATOR of any of these three qualifying events.

You Must Give Notice for Certain Qualifying Events

For the other qualifying events (divorce of the employee and spouse or an eligible family member losing eligibility for coverage), a COBRA election will be available only if you, your spouse or eligible family member notify the COBRA Administrator of the qualifying event by sending written notice to the address listed in the Contact Information on page 5. Your written notice must be postmarked no later than 60 days after the later of (i) the date of the qualifying event and (ii) the date on which your spouse, or eligible family member loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event. You do not need to complete a specific form, but you need to provide certain information.

Your written notice must include (i) the name of this plan, (ii) the type of qualifying event (e.g., divorce), (iii) the date of the event, (iv) your name, the name of your spouse and the names of your eligible family members.
Verbal notice, including notice by telephone, is not sufficient. You may deliver your written notice by mail, facsimile, or by hand.

You must provide notice in a timely manner. If mailed, a notice must be postmarked no later than the last day of the 60-day notice period described above. If not mailed, it must be received no later than that day. If you, your spouse or your eligible family member fails to provide notice to the COBRA Administrator during this 60-day period, your spouse, or dependent children who lose coverage will not be offered the option to elect continuation coverage.

Who May Elect COBRA Continuation Coverage

Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees and covered spouse may elect COBRA continuation coverage on behalf of all qualified beneficiaries in the family, and parents may elect COBRA continuation coverage on behalf of their Children. You (and any qualified beneficiary) will have 60 days after the date of the COBRA election notice (or if later, 60 days after the date coverage is lost) to decide whether you want to elect COBRA under the Plan. For each qualified beneficiary who elects COBRA continuation coverage, COBRA coverage will begin the first day of the month following the qualifying event.

How to Elect COBRA Continuation Coverage

After proper notice of a qualifying event, you will be sent an election form. To elect COBRA continuation coverage, you must complete the election form and furnish it (within 60 days from the date of the election notice or, if later, the loss of coverage) according to the directions on the form. If you, your spouse and your eligible family members do not elect continuation coverage within this period, you will not receive continuation coverage. If mailed, your election form must be postmarked no later than the last day of the 60-day election period. Otherwise it must be actually received by the entity indicated on the election form no later than that day.

Special Considerations in Deciding Whether to Elect COBRA

There may be other coverage options for you and your family through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

You may have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse’s employer) within 30 days after your group health coverage ends because of a qualifying event. You will also have the same special enrollment right at the end of COBRA continuation coverage if you remain covered under COBRA continuation coverage for the maximum time available to you.

Duration of COBRA Continuation Coverage

COBRA continuation coverage is temporary continuation of coverage. When the qualifying event is the death of the employee, your divorce or a family member losing eligibility, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee’s hours of employment, COBRA continuation coverage generally lasts for up to 18 months.

There are three ways in which the 18-month period of COBRA continuation coverage can be extended.

1. Disability extension of 18-month period of continuation coverage
If a qualified beneficiary in your family is determined by the Social Security Administration to be
disabled and you notify the COBRA Administrator in a timely fashion, all qualified beneficiaries in your
family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a
total maximum of 29 months. The disability would have to have started some time before the sixty-first
day after termination of employment or reduction in hours and must last at least until the end of the 18-
month period of COBRA continuation coverage.

To obtain the 11-month extension, you must notify the COBRA Administrator in writing of the Social
Security Administration’s determination within 60 days of the latest of

- The date of the disability determination
- The date of the qualifying event
- The date on which you lose (or would lose) coverage under the terms of the Plan as a result of
  the qualifying event. You must also provide the notice before the end of the 18-month period
  of COBRA continuation coverage. If notice is not made within the required period, there will
  be no disability extension of COBRA continuation coverage.

To obtain the 11-month disability extension, you must notify the COBRA Administrator that you are
requesting the extension by sending written notice to the address listed in the Contact Information section
on page 5. Your written notice must be postmarked no later than the 60-day deadline described above.
You do not need to complete a specific form, but you need to provide certain information. Your written
notice must include:

- The name of this Plan
- The date of the Social Security disability determination, and
- Your name and the names and addresses of your spouse and your eligible family members.

You may be required to submit a copy of the Social Security Awards Determination letter or other
evidence of the Social Security disability determination.

You also must notify the COBRA Administrator immediately if the Social Security Administration
determines that you are no longer disabled.

2. Second qualifying event extension of 18-month period of continuation coverage

If your qualified beneficiaries experience another qualifying event while receiving 18 months of COBRA
continuation coverage, the spouse and eligible family member who are qualified beneficiaries can receive
up to 18 additional months of COBRA continuation coverage, up to a maximum of 36 months (including
the initial 18-month period), if notice of the second qualifying event is properly given to the Plan. This
extension may be available to the spouse and eligible family member receiving COBRA continuation
coverage if the employee or former employee dies, gets divorced or legally separated or if your child
stops being eligible under the Plan as an eligible family member. In all of these cases, the extension is
available only if the event would have caused your spouse or your eligible family member to lose
coverage under the terms of the Plan had the first qualifying event not occurred. If you or a qualified
beneficiary experiences a second qualifying event, you must notify the COBRA Administrator within 60
days of its occurrence.

If you do not notify the COBRA Administrator in accordance with the procedures below, your qualified
beneficiaries will not receive an extension of COBRA continuation coverage.

If you experience a second qualifying event, you or your qualified beneficiary should notify the COBRA
Administrator that you are requesting the extension based on the second qualifying event by sending
written notice to the COBRA Administrator at the address listed in the Contact Information section on
page 5. Your written notice must be postmarked no later than the 60-day deadline described above. You do not need to complete a specific form, but you need to provide certain information. Your written notice must include:

- The name of the Plan
- The qualifying event that has occurred
- The date of the second qualifying event, and
- Your name and the names and addresses of your spouse and your eligible family member. You may be required to submit a copy of your divorce decree, or other evidence of the second qualifying event.

3. Medicare extension for Spouse and Eligible Family Member

If a covered employee (i) experiences a qualifying event that is either termination of employment or a reduction of hours, and (ii) that qualifying event occurs within 18 months after the covered employee becomes entitled to Medicare, then the maximum coverage period for the spouse and children who are qualified beneficiaries receiving COBRA continuation coverage will end 36 months from the date the employee became entitled to Medicare. For example, if a covered employee becomes entitled to Medicare eight months before the date on which the employee terminates employment, COBRA continuation coverage for the employee’s spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months). Note that the covered employee’s coverage period is not extended by Medicare entitlement, rather the employee’s maximum COBRA continuation coverage will be the 18-month period (unless extended under the disability extension described above). If you believe your spouse or your eligible family member qualify for this Medicare extension, you or your qualified beneficiary should contact the COBRA Administrator.

Cost of COBRA Continuation Coverage

Each qualified beneficiary may be required to pay the entire cost of COBRA continuation coverage (including both employee and employer contributions) plus a two percent administrative fee. The amount of your COBRA premiums can be increased from time to time during your period of COBRA continuation coverage.

Payment for COBRA Continuation Coverage

YOU WILL NOT BE CONSIDERED TO HAVE MADE ANY PAYMENT IF YOUR CHECK IS RETURNED DUE TO INSUFFICIENT FUNDS OR OTHERWISE.

First Payment for COBRA Continuation Coverage

If you elect COBRA continuation coverage, you do not have to send payment with the COBRA Continuation Coverage Election Form. However, you must make your first payment for COBRA continuation coverage not later than 45 days after the date of your election. (This is the date the election form is postmarked, if mailed.) If you do not make the first payment for COBRA continuation coverage in full not later than 45 days after the date of your election, you will lose all COBRA continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the Cobra Administrator to confirm the amount of your first payment.

Your first payment for COBRA continuation coverage should be sent to the Cobra Administrator at the address listed in the Contact Information section on page 5.
Periodic Payments for COBRA Continuation Coverage

After you make the first payment for COBRA continuation coverage, you will be required to make payments for each subsequent month of coverage. Under the Plan, these periodic payments for COBRA continuation coverage are due on the first of each month. If mailed, payment must be postmarked on or before the first of the month to be timely. If you make a periodic payment on or before the first day of the month to which it applies, your coverage under the Plan will continue for that month without any break. The Plan will not send periodic notices of payments due each month. Periodic payments for COBRA continuation coverage should be sent to the same address as the first payment.

Grace Periods for Periodic Payments

Although periodic payments are due on the first of each month, you will be given a grace period of 30 days to make each periodic payment. Your COBRA continuation coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. If mailed, payment must be postmarked on or before the end of the grace period.

If you fail to make a periodic payment before the end of the grace period for that month, you will lose all rights to COBRA continuation coverage under the Plan. If COBRA continuation coverage is cancelled for nonpayment, coverage will not be reinstated, and you will have no further rights to COBRA continuation coverage.

Termination of COBRA Continuation Coverage Before the End of the Maximum Coverage Period

COBRA continuation coverage will be terminated before the end of the maximum period if any of the following occurs:

- Any required premium is not paid on time.
- After electing COBRA continuation coverage a qualified beneficiary becomes covered under another group health plan (but only after any pre-existing condition exclusions of the other plan for a pre-existing condition of the qualified beneficiary have been exhausted).
- After electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare.
- The employer ceases to provide a group health plan for its employees.

COBRA continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA continuation coverage (such as fraud). COBRA continuation coverage may also be terminated if you recover from a disability that extended your COBRA continuation coverage.

If you or a qualified beneficiary becomes covered under any other group health plan, enrolls in Medicare, or recovers from a disability, you must notify the COBRA Administrator immediately and provide (1) the name of this Plan, (2) the type of event, and (3) the date of the event. You, your spouse or your eligible family member should contact the COBRA Administrator.

Keep Your Plan Informed of Address Changes

In order to protect your rights and your family’s rights, you should keep the COBRA Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy for your records of any notices you send to or receive from the COBRA Administrator.
Continuation of Health Coverage Under USERRA

The Uniform Services Employment and Reemployment Rights Act of 1994 (USERRA) provides an additional basis for the continuation of health coverage if you are absent from employment due to service in the uniformed services (the U.S. Armed Forces (including the Coast Guard), the Army National Guard, and the Air National Guard (when engaged in active or inactive duty training or full-time National Guard duty).

USERRA provides that each qualified beneficiary may be required to pay the entire cost of continuation coverage (including both employee and employer contributions) plus a two-percent administration fee (unless your period of service in the uniformed services is less than 32 days).

USERRA continuation coverage lasts for up to 24 months, although the period is shortened to the day after the date on which you could return to or apply to return to employment. The USERRA continuation coverage period begins on the day after you lose coverage under the Plan. USERRA does not provide for extension of the USERRA continuation coverage period beyond 24 months. In general, if you wish to elect to continue coverage under USERRA, you must comply with the policies and procedures outlined above with respect to COBRA. The continuation coverage periods under COBRA and USERRA run concurrently (at the same time). You are not able to continue coverage under USERRA after the COBRA continuation coverage period.
The total annual employer credit contribution to your account is $1,150. You can use your MRA account credit balance to obtain reimbursement for eligible dental and vision expenses incurred by you or your eligible family members while you are covered by the MRA. At no time will you be reimbursed for expenses that exceed your account credit balance. In addition, if you incur expenses after you have exhausted your account credit balance or incur expenses that exceed your account credits in a calendar year, you are not allowed to use future credit to cover such expenses.

NOTE: Effective January 1, 2013, the credit contribution is pro-rated for new employees and/or newly benefits eligible employees. For example, a new employee on January 1, 2013 will receive the total $1,150. That amount will decrease by one-twelfth of the annual credit each month or approximately $95.83 each month thereafter for new hires or an employee that becomes benefit eligible mid-year. For example, an eligible employee hired on July 1st, will receive a $575 MRA credit for the remainder of the calendar year.

Choice of Providers

The Plan will reimburse covered expenses for services of any legally qualified dental or vision care provider of your choice, and the dental or vision care provider/patient relationship will be maintained.
CONTRIBUTIONS AND MAXIMUM ACCOUNT BALANCES

Annual Credits

On the first day of your enrollment and each January 1 thereafter, you will receive the specified credit to your Plan account. However, because you are allowed to carry over any credits in your account from the previous year and because the credits are subject to a maximum equal to $5,000, the annual credits contributed will be reduced as necessary to prevent your balance from exceeding the specified credit maximum. The examples below show how this works.

If your spouse is also an eligible employee who is covered under this MRA option, you will each receive separate annual or pro-rated credit contributions and separate credit maximums of $5,000.

Maximum Account Balance

Because you are allowed to carry over credits left in your account from the previous year and because the credits are subject to a maximum, contributions will be reduced to prevent your total credits from exceeding the specified maximum of $5,000.

The examples below show how this works.

Example #1: You participate in MRA. On December 31 your credit balance is $3,000. Your $3,000 credit balance will be carried forward for use in the next year. On January 1 you will receive the full credit contribution of $1,150 because the full contribution will not cause your credit balance to exceed the credit maximum of $5,000.

Example #2: You participate in MRA. On December 31 your credit balance is $4,200. Your $4,200 credit balance will be carried forward for use in the next year. On January 1 you will receive a credit of an additional $800. The $1,150 annual credit you would otherwise receive must be reduced to $800 to keep your credit balance from exceeding the maximum of $5,000.

Orthodontia Credits

The Mayo Dental Plan has a separate component that provides a one-time orthodontia benefit. You and each of your eligible family members will receive a one-time only $1,500 credit contribution for orthodontia to an orthodontia account at certain participating employers. Benefits are paid from the employers general assets. Once used, this benefit will not be available under any other Mayo benefit plan, including Delta Dental of MN. This contribution is a life-time maximum benefit under the Mayo Dental Plan. This means:

- If you terminate and then return to employment with Mayo, you will not receive another $1,500 contribution
- If you (or your eligible family members) previously exhausted the $1,500 contribution, you will not receive an additional contribution
- If your spouse is also an eligible employee, your joint eligible family members will receive only one $1,500 contribution, not two

The orthodontia credits will be used first to pay qualifying orthodontia expenses under the Mayo Dental Plan. See “Orthodontia Services” for additional information, including information on coinsurance for these services.
SCHEDULE OF BENEFITS

The following section describes services that are reimbursable under the Plan (referred to as “covered services”). Benefits for covered services are subject to the definitions, exclusions, conditions, and limitations of the Plan.

DENTAL SERVICES

Important Note: Not all dental services are covered under the Mayo Dental Plan. Dental services not listed under the covered items may be covered under Plan if you are enrolled in a component of that medical plan. Please refer to your Plan Summary Plan Description to determine eligible expense under that Plan.

Important Note: In administering the Plan, Mayo Clinic Health Solutions and/or Mayo Clinic may, in its sole discretion, consult various Internal Revenue Service publications, rulings, notices, and other authorities to determine if an expense is eligible. Mayo Clinic reserves the right to deny payment for any service it considers ineligible.

Covered Dental Services

You may be reimbursed from your MRA for any covered services that qualify as medical care for dental and vision services as defined by section 213(d) of the Internal Revenue Code, except those listed as exclusions in the following section.

Examples of reimbursable dental expenses:

- Accident related treatment
- Amalgams
- Composites
- Dentures
- Initial orthodontic exam and consult
- Local anesthesia required for dental services
- Oral surgery and surgical procedures
- Osseo prosthesis, abutments, titanium screw, or fixture/implants
- Orthodontic records (x-ray, study casts, and photographs)
  - Initial
  - Progress
- Periodontal scaling and root planning
- Periodontal surgery
- Replacement retainers
- Routine dental x-rays
- Routine preventative dental treatment
- Single crowns
- Surgical root canal
- Teeth extractions, including simple adult and child teeth extractions
- Treatment of teeth, jaws, or mouth as a result of injury or illness

Ineligible Dental Services
- Athletic mouthguard
- Claims received after March 31 filing deadline
- Coinsurance, copayment, or deductible for dental services covered under any medical plan
- Craniofacial anomalies including cleft lip or cleft palate
- Dental diagnosis and treatment in conjunction with a medical illness including x-rays, consultation, and treatment (i.e., oral cancer or jaw injury)
- Dental hygiene products
- Dental treatment that is determined to be unnecessary or not customary
- Desensitizing medicament
- Discounts given by the dental provider
- Fluoride gel carrier
- Hospital charges including emergency room care
- Labial veneers
- Orthodontic treatment regardless of medical diagnosis (other than initial consult and exam, orthodontic records and replacement retainers). See Orthodontic Services subsection of the Schedule of Benefits
- Prescription and nonprescription drugs ordered from dental services
- Snoring nose piece
- Treatment or services for cosmetic purposes including, but not limited to, tooth bleaching and facings on molar crowns or pontics

VISION SERVICES

Covered Vision Services

- Eye refractions
- Routine eye exams
- New prescription lenses including frames, lens, and contact lens
- Surgical eye loupes

Ineligible Vision Services

- Add-ons to existing prescription lenses
- Claims received after March 31 filing deadline
- Eye drops
- Eyewear clip-ons
- Laser procedures
- Lens cleaner/maintenance solutions
- Non-prescription lenses (for example, reading glasses and sunglasses)
- Attachments to prescription lenses to enhance technology (for example, technology to support wearable computer devices)
- Prescription and nonprescription drugs ordered from vision services
- Vision treatment that is determined to be unnecessary or not customary
ORTHODONTIA SERVICES

**Important Note:** You and your eligible family members will be reimbursed from the applicable individual account for eligible orthodontic expenses you incur while a participant, but only up to the available amount of your individual account balance ($1,500 lifetime maximum per participant). In no event will you be reimbursed for expenses that exceed your individual balance. See *Coordination of Benefits* section for details regarding other insurance.

**Covered Orthodontia Services**

You may be reimbursed from your orthodontic account or from the orthodontic accounts of your eligible dependents (depending on which individual has the services), for 100% of any expense incurred for orthodontic services that qualifies as orthodontic care as defined by section 213(d) of the Internal Revenue Code, except those listed as ineligible expenses in the following section.

The following are examples of reimbursable orthodontic expenses:

- Orthodontic appliances including:
  - Banding
  - Braces (date appliance was placed)
  - Habit correct appliance
  - Initial orthodontic retainers
  - Removable appliance treatment
- Orthodontic exam and consult
- Post-treatment records

**Ineligible Orthodontia Services**

- An active appliance which was installed before you or your eligible family member was covered under the Plan
- Treatment or procedures performed while you or your eligible family member was not eligible.
- On-line invisalign aligners

The above lists of ineligible expenses are not intended to be comprehensive. For questions about whether an expense is reimbursable, contact Mayo Clinic Health Solutions.
EXCLUSIONS

Notwithstanding any provision in the Plan to the contrary, the Plan will not provide benefits for the following, dental, hearing, orthodontic or vision procedures, or supplies, regardless of dental/vision/medical necessity or recommendation by a health care provider. You will not receive reimbursement from your Plan account for the following exclusions:

- Cochlear or baha implants (may be covered under your medical plan)
- Claims received after March 31 filing deadline
- Expenses covered under any group or individual insurance policy, or any other plan or program (private or governmental, subject to any applicable Medicare Secondary Payer Rules)
- Expenses due to an accident related to employment or disease covered under Workers’ Compensation or similar law
- Expenses incurred before you or your eligible family member became participants
- Expenses incurred during any year you or your eligible family members are enrolled in another component of the Mayo Dental Plan
- Expenses incurred at a time when you have exhausted your account credit balance or expenses incurred that exceed your account credit balance. You may not use future account credits to cover claims incurred in the prior calendar year
- Expenses incurred while covered by Mayo Basic
- Expenses that exceed your balance at the time submitted
- Hearing aid batteries
- Hearing aids (device)
- Hearing aid fitting
- Repair or rebuild of existing hearing aid device
- Treatment by other than a legally licensed dentist, optometrist or physician, except services by a licensed hygienist under the dentist's supervision
COORDINATION OF BENEFITS

Coordination of Group or Individual Coverage

If you or eligible family members are covered by any group, individual or government sponsored dental and/or vision plan or by no-fault automobile insurance that provides dental and/or vision coverage, you must get payment from those plans first and your MRA coverage is considered secondary coverage. You may submit a claim for reimbursement under the MRA after your primary coverage has processed and paid your claims.

If you or your dental/vision provider submits a claim to your other dental or vision plan and that plan denies your claim, based on the existence of other coverage that may be primary, or, based on a coordination of benefits provision with that other plan, then, the following coordination of benefit rules shall apply to cover up to 100% of your claim. A plan without a coordination of benefits provision always pays first.

(a) The plan covering the person as an employee or retiree pays benefits first.

(b) If a child is covered under both parents’ plans, the plan covering the parent whose birthday comes first during the calendar year is the primary plan. If the birth dates of the parents are the same, the plan that has covered the parent for the longer period of time is the primary plan and pays first. If the parents are divorced, the plans pay in this order:

- If the terms of a court decree have established one parent as financially responsible for the child’s health care expenses, the plan of that parent is primary.
- The plan of the parent with custody of the child pays next.
- The plan of the stepparent married to the parent with custody of the child pays next.
- The plan of the parent without custody of the child pays last.

Coverage under any workers’ compensation act or similar law is primary. Coverage under any no-fault act for auto insurance or similar law is primary.

There is no coordination of benefits between any components of the Mayo Dental Plan other than the Delta Dental plan option which is primary to this Plan if the individual is covered by both.

Workers’ Compensation

Coverage under the Plan does not apply to any work related injury or illness covered by any workers’ compensation program or insurance or any similar state or federal law.
SUBROGATION AND REIMBURSEMENT

There may be situations in which you or your eligible family members have a legal right to recover health care or dental/vision expenses 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 health care or other expenses for that injury; if you are in a motor vehicle accident, another driver may be responsible; if you become sick or injured in the course and scope of employment, your employer or a workers’ compensation insurer may be responsible for health care or other expenses from the illness or injury. If someone else is legally responsible or agrees to compensate you for injuries or an illness suffered by you, the Plan has the right to recover any and all benefits it has paid in connection with the injury or illness.

By enrolling and accepting coverage in the Plan, you and eligible family members agree to the following:

a) The entire amount collected by you from any source will be considered to be a first recovery of benefits paid under the Plan regardless of the terms of any award, agreement, regulation, statute, etc., to the contrary. The fact that only part of the payment or even none of the payment is allocated to dental or vision expenses do not affect the Plan’s rights to recover all the benefits paid in connection with your injury or illness. The Plan shall have a lien and a security in all such claims.

b) Until the Plan has been reimbursed for the full amount of benefits paid under the Plan, you, your eligible family member, or your/their attorney (or other representative) shall hold the payment from any source in constructive trust for the Plan. The term “any source” shall include, but is not limited to, recoveries, settlements, judgments, or other amounts that you or your eligible family members, heirs, guardians, executors, attorneys, or other representatives receive, are awarded, or become entitled to from any plan, person, entity, insurer (first party or third party), and/or insurance policy (including no-fault automobile insurance, an uninsured or underinsured motorists plan, homeowner’s plan, renter’s plan, or liability plan).

c) The Plan will be reimbursed 100% from any and all recovery before payment of any existing claims including any claim made by you for general damages.

d) The Plan may collect the proceeds of any recovery, payment, settlement, or judgment recovered by you or your legal representative regardless of whether you have been fully compensated or “made whole.”

e) You have an obligation to cooperate completely with the Plan. You must complete and sign all documents that may be required by the Plan and take any action necessary to secure the Plan rights. You also have an obligation to notify the Plan immediately in writing any time the Plan may have a reimbursement right and identify any and all parties who may be liable.

f) 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.

g) If you voluntarily accept a lump sum or other settlement from any source without the Plan’s consent which may or may not cause the Plan to lose its subrogation 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, or otherwise the responsibility of the other party. Past payments may be recovered from the dental/vision provider.
The Plan’s subrogation and reimbursement right also applies to your coverage under workers’ compensation plans, disability, lost time coverage, other substitute coverage, any other right of recovery, or any claim payment received from any source. The Plan reserves the right to recover expenses incurred on your behalf (even if the recovery is made by a family member) if the recovery is based on your injuries or illness. At all times the Plan represents itself in subrogation, reimbursement, and intervention interests. Therefore, the Plan claim is not subject to reduction for attorney fees, costs, or expenses will be paid by the Plan or withheld from the Plan’s recovery under the “common fund” doctrine or otherwise.
CLAIMS PAYMENT AND APPEAL PROCEDURES

The standard claims procedure applies to all claims.

Important Notes

Unless specifically noted, oral inquiries about coverage and benefits are not considered claims or appeals.

All time periods described in this section are in calendar days, not business days.

An authorized representative can file claims and appeals on your behalf. For the standard claim procedure, you must complete an authorized representative form, which is available by calling the Claim Administrator. For the accelerated claims procedure, your health care provider or physician will be recognized as your authorized representative unless you direct otherwise.

If you do not file a claim or follow the claims procedures, you are giving up important legal rights.

Except as specifically noted, the claim procedure for prescription drug benefits is the same as for other dental/vision benefits in the Plan. For prescription drug benefits, the pharmacist is considered the health care provider, and the prescription drug is considered the service or supply.

The addresses for Claims Administrator and Committees responsible for deciding claims in the Plan are given in a chart at the end of this section.
STANDARD CLAIMS PROCEDURES

All claims in the Plan except those related to benefits requiring prior authorization are handled under these standard claims procedures.

Filing an Initial Claim

Time for Filing a Claim

Your initial claim must be received by the Claims Administrator no later than March 31 following the year in which you received the service or supply.

Filing a Claim

Your dental or vision care provider may submit your initial claim directly to the Claims Administrator. Your claims may be submitted by using the online portal, mobile app or the MRA paper claim form. You are responsible for paying the dental or health care provider for covered services under the MRA either at the time of the visit or when you are billed for the covered services.

A claim for services or supplies should include the following information:

- Date(s) of service
- Name and address of provider
- Specific ADA Procedure codes and description of treatment
- Itemized charges
- Proof of payment may be submitted if a member has already paid for the service

If you exhaust your current year contribution, you are not able to submit any additional claims that were incurred that year against the next year’s contribution.

Claim Decision

If approved, the reimbursement will be paid to you (not to your provider) after you or your eligible family member has incurred the expenses and as long as you have an available balance in your account. You will be reimbursed by means of a check or direct deposit.

The Claim Administrator has 30 days to decide your claim and notify you if the claim is denied in whole or in part.

If any part of your claim is denied, you will be notified in writing or electronically. This notice will tell you the reason for the denial, including the provisions of the Plan on which the denial is based. It also will describe any additional information that may be needed to change the decision denying your claim and explain why such information is necessary. Also, the notice will describe the procedures for appealing the decision, including the time limits for doing so, and include a statement of your right to bring a civil action for benefits following an adverse determination on appeal.
In addition, the notification also will explain any rule, guideline, protocol or similar criterion relied upon in making the adverse determination, or include a statement that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge upon request (collectively, the “Rule and Guideline Summary”). If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the notification also will contain either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request (collectively, the “Medical Necessity/Experimental Treatment Summary”).

You may be notified that an extension of up to 15 days is needed to decide your claim due to reasons beyond the control of the Claims Administrator. If the extension is required because you need to provide additional information in order for your claim to be decided, you will be given at least 45 days to provide that information. The time it takes you to provide the information will not count against the time the Claims Administrator has to make its decision.
APPEALS PROCEDURES FOR STANDARD CLAIMS

Filing First Level Appeal (Standard Claim Process)

Time for Filing First Level Appeal
You must file an appeal within 180 days after the date you received notice your claim is denied.

Filing First Level Appeal
Your written appeal must be submitted to the Claim Administrator and include the following information:

- Name of plan
- Name, address, and date of birth of patient
- Information regarding the denial of benefits such as the Explanation of Benefits you received, claim number listed on the Explanation of Benefits, or copy of denial letter
- A statement that you are appealing the denial of benefits
- The reason(s) you disagree with the denial of your claims
- Any information, documents, or arguments you want considered in the first appeal

Appeal Decision
The Claims Administrator has 30 days to make a decision and notify you. If your appeal is denied, the notice will contain the reason for the denial, including the provisions of the Plan on which the denial is based. It also will inform you of your right to receive reasonable access to, and copies of, any documents, records and other information related to your appeal. In addition, the notice will tell you about your right to bring a civil action for benefits. Finally, the notice will contain the Rule and Guideline Summary and Medical Necessity/ Experimental Treatment Summary described above.
Filing Second Level Appeal (Standard Claims Process)

Time for Filing Second Level Appeal

You must file an appeal within 60 days after the date you received notice that your first level appeal was denied.

Filing of Second Level Appeal

Your written appeal must be submitted to the Plan Review Committee and include:

- Name, address, and date of birth of patient
- A copy of the previous denial letter
- A statement that you are appealing the denial of benefits
- The reason(s) you disagree with the denial of your claims
- Any information, documents, or arguments that you want considered in the second appeal

Appeal Decision

The Plan Review Committee will decide your second appeal no later than 30 days from the date the second appeal request was received. If the appeal is denied, the notice will contain the reason for the denial, including the provisions of the Plan on which the denial is based. It also will inform you of your right to receive reasonable access to, and copies of, any documents, records and other information related to your appeal. In addition, the notice will tell you about your right to bring a civil action for benefits. Finally, the notice will contain the Rule and Guideline Summary and Medical Necessity/ Experimental Treatment Summary described above.

Special Rule for Claims Related to a Course of Treatment

If you are notified that a benefit you were granted for a specified period of time or number of treatments will be reduced from what was previously granted, that notice is considered a claim denial and will be provided to you sufficiently in advance of the benefit reduction to allow you to file first and second level appeals.
General Rules for Claims Procedures

Authority

Mayo Clinic is the Plan Administrator and has delegated authority to decide benefit claims and appeals as described in these claim procedures. The Plan Review Committee 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 and/or applicable committee may rely on any applicable statute of limitations as a basis to deny a claim. The Plan Review Committee’s decisions are conclusive and binding on all parties.

Time Limit for Commencing Legal Action

If you file your initial claim within the required time, and the Claim Administrator and Plan Review Committee deny your claim and appeal, you may sue over your claim (unless you have executed a release on your claim). You must, however, commence the suit within one year from the time your initial claim was submitted.

Exhaustion of Administrative Remedies

Before commencing legal action to recover benefits or to enforce or clarify rights, you must exhaust the claim and review procedures for this Plan.
# CLAIMS ADMINISTRATION AND COMMITTEE CONTACTS FOR APPEAL PROCESS

<table>
<thead>
<tr>
<th>Plan</th>
<th>Claim Administrator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mayo Reimbursement Account</td>
<td>Mayo Clinic Health Solutions</td>
</tr>
<tr>
<td></td>
<td>PO Box 211698</td>
</tr>
<tr>
<td></td>
<td>Eagan, MN 55121</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>First Level Appeal</th>
<th>Second Level Appeal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Appeals</td>
<td>Member Appeals</td>
</tr>
<tr>
<td>Mayo Clinic Health Solutions</td>
<td>Plan Review Committee</td>
</tr>
<tr>
<td>4001 41 Street NW</td>
<td>Mayo Clinic Health Solutions</td>
</tr>
<tr>
<td>Rochester, MN 55901-8901</td>
<td>4001 41 Street NW</td>
</tr>
<tr>
<td></td>
<td>Rochester, MN 55901-8901</td>
</tr>
</tbody>
</table>
GENERAL PROVISIONS

Applicable Law and Venue

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.

Conformity with Governing Law

If any provision of the Plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto.

Construction of Terms

Words of sex will include persons and entities of any sex. The plural will include the singular, and the singular will include the plural.

HIPAA Privacy Rules

Effective April 14, 2003, the Plan was subject to new federal privacy requirements. As a participant, you will receive a Notice of Privacy describing your rights under these regulations. The privacy requirements are contained in a separate document entitled “HIPAA Provisions to Mayo Clinic Group Health Plans,” which is a component of the Plan document. The privacy provisions permit Mayo, as Plan Sponsor, to obtain your protected health information for certain limited purposes, such as operation of the Plan. However, these provisions require Mayo to agree to various safeguards to protect your health information from impermissible uses and disclosures. You may obtain a copy of the privacy provisions by contacting the Plan Administrator.

No Guarantee of Employment

Participation in the Plan will not be construed as giving you any right to continue in the employ of the employer. You will remain subject to discharge by the employer to the same extent had the Plan not been adopted.

Non-Discrimination Policy

The Plan complies with applicable Federal civil rights laws and will not discriminate against you or your eligible family members based on race, color, religion, national origin, disability, sex, or age. The Plan will not establish rules for eligibility based on health status, dental/vision condition, claim experience, receipt of health care, dental/vision history, evidence of insurability, genetic information, or disability.

In compliance with Section 1557 of the Affordable Care Act, the notice describes how to obtain free qualified sign and language interpreters, obtain the written notice in large print, audio, electronic formats and language services for those whose primary language is not English. You may obtain an electronic copy of the Non-discrimination Notice on the Mayo Intranet. In the HR Connect tool, search on key words “non-discrimination”. Click on the article titled Legal Notice from Benefits. You may request a paper copy of the Notice by contacting HR Connect at 507-266-0440 or 1-888-266-0440.
Any portion of the Plan subject to Section 105(h) of the Internal Revenue Code of 1986 shall not discriminate in favor of highly paid Employees as to eligibility to participate or benefits.

Plan Provisions Binding

The provisions of the Plan will be binding upon you; your eligible family members, their respective heirs, and legal representatives; the employer, its successors, and assigns; the Plan Administrator; Claims Administrator; and any other provider of services to the Plan.

Section Titles

Section titles are for convenience only and are not to be considered in interpreting the Plan.
PLAN ADMINISTRATION

Powers and Duties of the Plan Administrator

The Plan Administrator will have the powers and duties of general administration of the Plan including the following:

a) The discretion to determine all factual and legal questions relating to the eligibility of individuals to participate or for you to remain a participant and receive benefits under the Plan. With respect to claims for benefits, the Plan Administrator has delegated authority and discretion as stated in “Claims Administration and Committee Contacts for Appeal Process.”.

b) To require any person to furnish such reasonable information as the Plan Administrator may request for proper administration of the Plan as a condition of eligibility for you or Eligible Family Members to participate and receive any benefits under the Plan.

c) To delegate to other persons authority to carry out any duty or power which under the terms of the Plan or applicable law would otherwise be a responsibility of the Plan Administrator, including but not limited to appointment of and delegation of duties to the Salary and Benefit Committee.

d) To maintain, or to delegate to others the duty of maintaining, all necessary records for the administration of the Plan.

e) To interpret the provisions of the Plan, make and publish such rules and procedures for regulation of the Plan, and prescribe such forms as the Plan Administrator deems necessary.

Operating Expenses for the Plans

Operating expenses may be paid out of the Plan assets, if any, or by employers.

Records

The Plan Sponsor, Plan Administrator, Claims Administrator, and others to whom the Plan Sponsor has delegated duties and responsibilities under the Plan shall keep accurate and detailed records of any matters pertaining to administration of the Plan in compliance with applicable law.

Release of Dental and Vision Information

The Plan Administrator and Claim Administrator are entitled to use and disclose information reasonably necessary to administer the Plan (including the uses and disclosures permitted by the HIPAA privacy rules), subject to all applicable confidentiality requirements as defined in the Plan and as required by law, from any health care provider of services to you. By accepting coverage under the Plan, you agree to sign the necessary authorization directing any health care provider that has attended or treated you or your eligible family member, to release to the Plan Administrator and Claim Administrator upon request such information, records, or copies of records relating to attendance, examination, or treatment rendered to you if necessary to determine whether to pay the claim. If you fail to sign the necessary authorization, the Plan has no obligation to pay claims.
Allocation of Responsibilities

The Named Fiduciaries may designate other persons who are not Named Fiduciaries to carry out such fiduciary responsibilities. The responsibilities imposed by the Plan on each Named Fiduciary are not joint responsibilities with any other fiduciary unless specifically so designated therein. No fiduciary is responsible for the act, or failure to act, of any other fiduciary.

Assignment of Benefits

Your right to receive benefits under the Plan is personal to you and may not be assigned or be subject to anticipation, garnishment, attachment, execution, or levy of any kind, or be liable for your debts or obligations, except for assignment of the right to receive benefits to a health care provider. With respect to any assignment to a health care provider, that health care provider is subject to the same terms and conditions under the Plan as you are.

Amendment and Termination of Plan

Mayo Clinic reserves the right to amend or terminate the Plan, or any benefit option described in any document for the Mayo Dental Plan including this document at any time, for any reason, and in any respect. Mayo Clinic’s right to amend or terminate the Plan or benefit options includes, but is not limited to, changes in the eligibility requirements, Employee and Employer contributions, reducing or eliminating account balances, benefits provided, and termination of all or a portion of any coverage(s) provided under the Plan. If the Plan or any benefit option is amended or terminated, you will be subject to all the changes effective as a result of such amendment or termination, and your rights will be reduced, terminated, altered, or increased accordingly, as of the effective date of the amendment or termination. You do not have ongoing rights to any plan or program benefit, other than payment of any covered expenses you incurred prior to the Plan amendment or termination. You do not have rights to vested benefits in the Plan. The rights with respect to amendment and termination of the Plan have been delegated to the Salary and Benefits Committee.

Payment of Benefits After Plan Termination

In the event of the Plan’s termination, remaining plan assets will be used to pay benefits for remaining Plan Participants.
ERISA STATEMENT OF RIGHTS

As a participant in the Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

**Receive Information About Your Plan and Benefits**

Examine without charge at the Plan Administrator’s office and other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, 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 Employee Benefits Security 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, copies of the latest annual report (Form 5500 Series), and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

**Continue Group Dental Plan Coverage**

Continue dental care coverage for yourself or eligible family members if there is a loss of coverage under the Plan as a result of a qualifying event. You or your eligible family members may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

**Prudent Action by Plan Fiduciaries**

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

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

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such 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 Administrator. After you exhaust the Plan’s claims procedures, if your appeal is denied in whole or in part, you may file suit in a state or Federal court. If it should happen that Plan fiduciaries misuse the Plan’s money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay the costs and fees; for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have questions about your plan, contact the Plan Administrator. If you have questions about this statement or your rights under ERISA, or if you need assistance obtaining documents from the Plan Administrator, 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.
NON-DISCRIMINATION NOTICE

Discrimination is Against the Law

The Mayo Medical Plan, Mayo Flexible Spending Account Plan, Mayo Dental Plan, Mayo Retiree HRA Plan, and Mayo Clinic Employee Assistance Plan, (collectively, the Plans) comply with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plans do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Plan provide:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as: qualified interpreters or information written in other languages.

If you need these services, contact Mayo Clinic, Chair-Total Rewards. If you believe that the Plans have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Mayo Clinic, Chair-Total Rewards 200 First Street SW Rochester, MN 55905, 507-266-0440 or fax-507-538-1856.

You can file a grievance in person, by mail, or fax. If you need help filing a grievance, Clinic, Chair-Total Rewards is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD) Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html


注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-507-266-0440（TTY：507-266-0440）。


版权所有：© Mayo Clinic 2020. 隐私政策 | 条款和条件 | 俄文版 | 网站使用许可 | 507-266-0440 (俄语版：1-800-407-2442)


The information in this section applies to all components of the Mayo Dental Plan.

| Plan Sponsor, Plan Administrator       | Mayo Clinic  
|                                       | 200 First Street SW  
|                                       | Rochester, MN 55905  
|                                       | (507) 266-0440  |
| Plan Sponsor EIN                      | 41-6011702  |
| Named Fiduciary                       | Salary & Benefits Committee  
|                                       | Mayo Clinic  
|                                       | 200 First Street SW  
|                                       | Rochester, MN 55905  
|                                       | (507) 266-0440  |
| Agent for Service of Legal Process    | Mayo Clinic  
|                                       | c/o William A. Brown, Assistant Treasurer  
|                                       | 200 First Street SW  
|                                       | Rochester, MN 55905  
|                                       | (507) 266-0440  
<p>|                                        | <em>The Plan Administrator may also be served with process</em>  |
| Plan Year                             | January 1 - December 31  |
| Collectively Bargained Groups         | The Mayo Dental Plan is maintained in part pursuant to one or more collective bargaining agreements. A copy of any such agreements may be obtained by you upon written request to the Plan Administrator and is available for examination.  |</p>
<table>
<thead>
<tr>
<th><strong>Plan Number</strong></th>
<th>514</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of Administration</strong></td>
<td>Contract Administration</td>
</tr>
<tr>
<td><strong>Type of Plan</strong></td>
<td>Welfare benefit plan</td>
</tr>
<tr>
<td><strong>Sources of Contributions for MRA</strong></td>
<td>This Plan is funded with Employer contributions from its general assets.</td>
</tr>
</tbody>
</table>
| **Claims Administrators** | See “Claims Administration and Committee Contacts for Appeal Process”  
  Mayo Clinic Health Solutions  
  PO Box 211698  
  Eagan, MN 55121  
  1-800-635-6671 (toll free)  
  507-266-5580 (local)  
  Delta Dental of Minnesota  
  National Dedicated Service Center  
  PO Box 59238  
  Minneapolis, MN 55459  
  651-406-5901 or 800-448-3815 |
| **Components of Mayo Dental Plan Document** | Delta Dental of Minnesota  
  Mayo Reimbursement Account  
  Retiree Mayo Reimbursement Account/Dental Assistance Plan  
  Privacy Rules |
### Employers Participating in Mayo Dental Plan

<table>
<thead>
<tr>
<th>Employer Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charterhouse</td>
</tr>
<tr>
<td>Franklin Heating Station</td>
</tr>
<tr>
<td>Gold Cross Ambulance Service</td>
</tr>
<tr>
<td>Herman House LLC</td>
</tr>
<tr>
<td>Mayo Clinic</td>
</tr>
<tr>
<td>Mayo Clinic Arizona</td>
</tr>
<tr>
<td>Mayo Clinic Florida (a non-profit corporation)</td>
</tr>
<tr>
<td>Mayo Clinic Health System-Decorah Clinic Physicians</td>
</tr>
<tr>
<td>Mayo Clinic Health System-Fairmont</td>
</tr>
<tr>
<td>Mayo Clinic Health System-Franciscan Medical Center, Inc.</td>
</tr>
<tr>
<td>Mayo Clinic Health System-Lake City Medical Center</td>
</tr>
<tr>
<td>Mayo Clinic Health System-Northwest Wisconsin Region, Inc.</td>
</tr>
<tr>
<td>Mayo Clinic Health System-Pharmacy &amp; Home Medical, Inc.</td>
</tr>
<tr>
<td>Mayo Clinic Health System-Southeast Minnesota Region</td>
</tr>
<tr>
<td>Mayo Clinic Health System-Southwest Minnesota</td>
</tr>
<tr>
<td>Mayo Clinic Health System-St. James</td>
</tr>
<tr>
<td>Mayo Clinic Hospital – Rochester</td>
</tr>
<tr>
<td>Mayo Clinic Jacksonville (a non-profit corporation)</td>
</tr>
<tr>
<td>Mayo Collaborative Services, LLC</td>
</tr>
<tr>
<td>Mayo Foundation for Medical Education and Research</td>
</tr>
<tr>
<td>Rochester Airport Company</td>
</tr>
</tbody>
</table>
GLOSSARY

Abscess
Infection of a tooth, soft tissue, or bone.

Abutment
Tooth or teeth that support a fixed or removable bridge.

Appliance
Anything the orthodontist attaches to the teeth to move them or to change the shape of the jaw.

Arch Wire
A metal wire attached to the brackets to move the teeth.

Band
A metal ring usually placed on the teeth to hold parts of the braces on.

Bitewing
An x-ray that shows upper and lower teeth biting surfaces on the same film. This x-ray shows the portion of the teeth above the gum line.

Bleaching/Whitening
Chemical or laser treatment of natural teeth for whitening effect.

Bracket
A metal or ceramic part glued to a tooth as a means of fastening the arch wire.

Cast/Model
Reproduction of structures made by pouring plaster or stone into a mold.

Cephalometric X-Rays
X-ray of the head that shows teeth alignment and whether they are growing properly.

Child or Children
Biological children, stepchildren, adopted children, and children legally placed with you for adoption that are under the age of 26.

Clasp
Device that retains a removable partial denture to stationary teeth.

Continuous Service
Period of unbroken service from hire date to termination date with the employer or an affiliated company by an employee who is classified as a regular employee and is scheduled to work at least half-time (.5 FTE).

Consultation
A meeting with your orthodontist to discuss your treatment plan.

Covered Person
An eligible employee and his or her eligible family members whose enrollment form has been accepted, whose coverage is in force, in whose name the membership card is issued, and whose coverage has not terminated. This includes a former employee or dependent that is otherwise entitled to coverage and properly enrolled under any of the Plan options. May also be referred to as you/your.

Covered Service
Health care services provided by a health care provider as described in the Mayo Dental Plan Schedule of Benefits section for which Mayo Dental Plan benefits will be provided, unless limited or excluded in any Exclusions section. A covered service is incurred on the date the health care service is received.

Coverage Year
The time period, not to exceed twelve (12) months, from the effective date of the Plan to the anniversary date. All subsequent coverage years shall begin on the anniversary date and consist of a period of not more than twelve (12) months. The Plan coverage year is January 1 through December 31.

Crown
The part of the tooth above the gum. (1) an artificial tooth or (2) an artificial replacement for the covering on a tooth.

Debanding
The removal of cemented orthodontic bands.
Dental/Vision Necessity
Health care services appropriate in terms of type, frequency, level, setting, and duration to your diagnosis or condition, and diagnostic testing and preventive services, that are not otherwise excluded under Mayo Dental Plan. Dental/vision necessary care must:

- Be consistent with generally accepted parameters as determined by health care providers in the same or similar general specialty as typically manage the condition, procedure, or treatment at issue
- Help restore or maintain your health
- Prevent deterioration of your condition
- Prevent the reasonably likely onset of a health problem or detect an incipient problem.

Denture
A synthetic replacement for all of the teeth in either the upper or lower jaw.

Disposable Supplies
Dental/vision supplies necessary for a specific therapeutic purpose in treating an illness or injury that is designed for one use only.

EBSA
Employee Benefits Security Administration (EBSA) formerly known as Pension and Welfare Benefits Administration.

Eligible Employee
The employee eligible for coverage under the Plan. May also include a former employee who is otherwise entitled to coverage and properly enrolled in any of the Plan options.

Eligible Family Member
Your eligible family member who qualifies under this Plan in accordance with the requirements specified below:

- A spouse
- A child (or children) as defined by the Plan

  1) A child who is over the age of 26 and mentally or physically incapable of self-support at age 26 and beyond may continue coverage under the Plan. Effective January 1, 2014, new hires and newly benefit-eligible employees will require proof of disability as defined by Social Security Disability Insurance (SSDI) for children who are age 26 or older. The employee must provide proof that the child has been declared disabled and is receiving SSDI prior to age 26. Adult dependents over the age of 26, currently on the plan, will have until December 31, 2015 to apply and receive a SSDI Designation. Coverage will end if your own coverage ends or if the child marries or is no longer incapacitated.

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-benefits 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 employee of the 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 in the *Plan Administrative Information* section.

**ERISA**
Employee Retirement Income Security Act of 1974, as amended from time to time.

**Expenses Incurred**
When the service or the supply is provided.

**Extraoral Photograph**
Facial photo

**Filling**
Restoration of lost tooth structure with metal, porcelain, or resin materials. *Inlay-indirect* - filling made by a dental laboratory that is cemented or bonded in place, direct placement of dental composite resin restoration at chairside. *Onlay* - laboratory produced restoration covering one or more cusps of a tooth.

**FMLA**
Family and Medical Leave Act of 1993, as amended from time to time.

**Gainfully Employed**
Earnings subject to FICA received by an individual.

**Health Care Provider**
Institutional or professional health care providers furnishing health care services to you. Each health care provider must be licensed, registered, or certified by the appropriate state agency where the health care services are performed. Where there is no appropriate state agency, the health care provider must be registered or certified by the appropriate professional body. Health care provider includes those listed below:

- **Dentist** – Doctor of Dental Surgery (DDS), Oral Pathologist, Oral Surgeon, or Doctor of Dental Medicine (DMD)
- **Hospital** - a licensed institution operated pursuant to law that is engaged in providing inpatient and outpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of sick and injured persons by or under the direct supervision of physicians or other health care providers.
- **Ophthalmologist** – Doctor of Ophthalmology
- **Optometrist** – Doctor of Optometry
- **Physician** – Doctor of Medicine (MD) or Doctor of Osteopathy (DO)

**HIPAA**
Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

**Impacted Tooth**
An unerupted tooth that has gotten stuck and cannot come in.

**Implant**
A replacement for a missing tooth. The implant is different from a bridge in that it is permanently attached to the jaw.

**Impressions**
The first step in making a model of the teeth. An impression of the teeth is taken with algenate, and the algenate hardens to produce a mold of your teeth.

**Including or Includes**
Including, but not limited to.

**Injury**
A non-occupational accidental bodily injury caused directly and exclusively by external, violent, and purely accidental means. The term “injury” does not include an injury with respect to which benefits are payable under any workers’ compensation, occupational disease, or similar law.

**Inpatient**
A person who occupies a hospital bed, crib, or bassinet while under observation, care, diagnosis, or treatment for at least 24 hours.
Malocclusion
Poor positioning of the teeth.

Mayo Clinic Health Solutions
The Claim Administrator for Mayo Reimbursement Account retained by the Plan Administrator and Plan Sponsor. Actual responsibilities of Mayo Clinic Health Solutions are described in the contract between the Plan Administrator, Plan Sponsor, and Mayo Clinic Health Solutions.

Mayo Dental Plan
The Mayo Dental Plan for the provision of limited health care benefits, as amended from time to time.

Occlusal
The chewing or grinding surface of the bicuspid and molar teeth.

Occlusal Plane
The imaginary surface on which upper and lower teeth meet.

Occlusal Radiograph
The only x-ray that is taken without a precision (tm) x-ray holder. The x-ray film for this procedure is shaped like a large oatmeal cookie. You are asked to bite on the x-ray film, and the top of the x-ray machine is positioned over your nose for a maxillary occlusal x-ray or under your chin for a mandibular occlusal film. The x-ray shows the whole arch.

Occlusion
The alignment and spacing of the upper and lower teeth when you bite down.

Open Enrollment Period
The period of time occurring toward the end of the coverage year during which eligible employees may elect to begin coverage for themselves and their eligible family members, if applicable, under the Plan and/or to change options under the Mayo Dental Plan effective the first day of the upcoming coverage year.

Plan
The Mayo Reimbursement Account.

Plan Administrator
The Plan Administrator is Mayo Clinic. The Plan Administrator retains ultimate authority for the Plan including final appeal determinations and is the named fiduciary for purposes of ERISA.

Plan Participant
An eligible employee and dependents whose enrollment form has been accepted, coverage is in force, in whose name the membership card is issued, and whose coverage has not terminated. This includes a former employee or dependent who is otherwise entitled to coverage and properly enrolled under any of the Plan options. May be referred to as you/your.

Plan Sponsor
Mayo Clinic is the Plan Sponsor.

Preventive Care
Services rendered solely for the purpose of health maintenance and not for the treatment of an illness or injury.

Primary Teeth
The first set of teeth that come in. Primary teeth are also called "baby teeth" or deciduous teeth.

Prosthetic
A fixed or removable device that replaces all or part of an extremity or body part including such devices as an artificial limb, intraocular lens, or breast prosthesis.

Pulp
The soft inner structure of a tooth consisting of nerve and blood vessels

Pulp Chamber/Pulp Canal
The very inner part of the tooth containing nerve cells and blood vessels.

Quadrants
The four parts of the mouth; that is, the upper left, the upper right, the lower left, and the lower right.

Qualified Medical Child Support Order (QMCSO)
A judgment, decree, or order that:
• Is issued by a court of competent jurisdiction pursuant to a state domestic relations law or community property law
• Creates or recognizes the right of an alternative recipient to receive benefits under his or her parent’s employer’s group health plan
• Includes certain information relating to the participant and alternate recipient

QMCSO as determined by the Plan Administrator under procedures established by the Plan Administrator. Upon request to the Plan Administrator, you may obtain a copy of the procedures governing QMCSO determinations, which is available at no charge.

Regularly Scheduled
The schedule on file with your employer is your regular schedule. If it is .5 FTE or more you qualify to enroll in certain benefit plans with your employer. A schedule of .4 FTE working additional hours does not qualify as regularly scheduled.

Retainer
A gadget that the orthodontist gives you to wear after removal of your braces. The retainer attaches to the upper teeth and holds them in the correct position. The retainer is worn at night to ensure that none of the teeth move while the jaw hardens and the teeth get strongly attached to the jaw.

Root
The part of the tooth in the gums.

Root Canal
A procedure where the nerve of a heavily decayed tooth is removed from the tooth replaced with a filling material.

Sealants
Thin resin material bonded in the pits and fissures of back teeth for the prevention of decay.

Secondary Teeth
Permanent teeth; i.e., the second group of teeth to come in.

Spouse
An individual who is legally married to an Eligible Employee under the law of the domestic state or foreign jurisdiction having legal authority to sanction the marriage.

Summary Plan Description (SPD)
A written summary of the benefits under an employee welfare benefit plan as required under section 102 of ERISA.

Supernumerary Teeth
Extra teeth.

TMJ/Temporomandibular Joint
The joint where the lower jaw connects to the skull.

Veneer
Plastic or porcelain facing bonded directly to a tooth to improve its appearance.