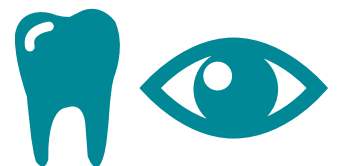




PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

Retiree Mayo Reimbursement Account
and Dental Assistance Plan



January 2018

***Retiree Mayo Reimbursement Account
and Dental Assistance Plan***
(A Component of the Mayo Dental Plan)

January 2018

HOW TO USE THIS DOCUMENT

The Table of Contents provides an overview of the detailed information in the Mayo Reimbursement Account (MRA) and Dental Assistance Plan (DAP).

You will also find a glossary of terms used in the MRA and DAP document.

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 Retiree Mayo Reimbursement Account (MRA) and Dental Assistance Plan (DAP) are separate components of this plan that will be referred to in this document collectively as the Plan, or individually as MRA or DAP. MRA and DAP are available to certain retirees who retired on or before December 31, 2010.

The MRA and DAP are retiree-only limited purpose health reimbursement arrangements that provide reimbursements of certain dental, orthodontic, and vision expenses for eligible retirees 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 or DAP.

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. The Plan is not funded by a trust or individual bank account. Instead, Mayo allocates annual “credits” to you. All Plan 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 (MRA only) 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. The Plan is provided by Mayo at no cost to you. 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 Plan, you are also eligible for the orthodontia component of the Mayo Dental Plan, which is also described in this Summary Plan Description.

Benefits under the Plan 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 Claims Administrator for the Plan and will process claims and answer dental and vision benefit and claim questions.

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
<p>Mayo Clinic Health Solutions Dental Services 4001 41 St NW Rochester, MN 55901-8901</p> <p>507-266-5580 (local) 1-800-635-6671 (toll free) 1-800-407-2442 (TDD)</p> <p>M – F, 7 a.m. to 7 p.m. CT (excluding holidays) www.mayoclinichealthsolutions.com</p>
QUESTIONS ABOUT ENROLLMENT/ELIGIBILITY
<p>HR Connect 200 First Street SW Rochester, MN 55905</p> <p>507-266-0440 (local) 1-888-266-0440 (toll free)</p> <p>M – F, 5 a.m. to 6 p.m., Saturday/Sunday 5 a.m. to 9 a.m. CT (excluding holidays)</p>
COBRA ADMINISTRATION
<p>Discovery Benefits, Inc. PO Box 2079 Omaha, NE 68108-2079</p> <p>1-866-451-3399</p> <p>M-F, 7 a.m. – 7 p.m. CT</p>

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.

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ELIGIBILITY AND PARTICIPATION

Who is Eligible

To qualify for retiree coverage under the MRA or DAP, you (and any eligible family member) must have been (1) enrolled in a component of the Mayo Dental Plan when you retired; (2) retired on or before December 31, 2010; and (3) have met the following age and continuous service requirements. If you satisfy these rules and if you retired before the age of 65 (Medicare eligibility) the only component of the Plan that will be available to you will be the MRA until age 65 and then you will convert to DAP at the age of 65. If you retired at age 65 or older, the only component of the Plan that will be available to you will be the DAP. If you are enrolled in the MRA at retirement, any MRA credits you have at retirement will transfer to your MRA or DAP if you are eligible for and enroll in retiree coverage. Coverage under any component of the Plan is not available to any individual or their spouse or other family members if the employee retires after December 31, 2010. Please note retiree MRA and DAP coverage is not offered by every participating employer in the Mayo Dental Plan. See listed participating employers in *Plan Administrative Information* for more information.

Age at Retirement	Continuous Years of Benefit-Eligible Service
62 and over	10 continuous years
60 and 61	15 continuous years
55 through 59	20 continuous years
Under age 55	30 continuous years

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). Vacations and approved leaves of absence are not breaks in service except for educational leaves of more than 6 months for a non-critical employment need. Transfers between the eligible employer and eligible affiliated companies are not breaks in service as long as the employee continues to be classified as a regular employee and continues to be scheduled to work at least half-time. A break in service occurs upon termination of employment, upon transfer to a non-regular classification, or upon change to a schedule that is less than half-time. A regular employee classification does not include temporary, supplemental, or casual employees or residents, research fellows or health-related science students. Continuous service is used to determine the eligibility for retiree medical benefits. In the context of eligibility for retiree coverage after an approved disability leave, the disability rules of the Mayo Pension Plan shall apply.

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. To continue coverage under these conditions, the Plan Administrator must receive proof of incapacity within 31 days after the child's coverage would otherwise end because the child turns 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

Eligible retirees will be given an open enrollment period to enroll for coverage in the Plan option (e.g., MRA if retired before age 65; DAP if retired on or after age 65) available to them at the location from where they retired, provided retirement occurred on or before December 31, 2010. If you do not elect retiree coverage at that time, you will not be eligible for any coverage under any component of the Plan. Following retirement, retirees also have an annual open enrollment until age 65. Enrollment rights as described in this *Eligibility and Participation* section apply to retiree dental and vision plan coverage, subject to the limitation of Plan options as noted above.

If you marry or remarry during retirement, you may enroll your spouse and any newly eligible family members for coverage in the Plan if you notify HR Connect within 31 days of the date of marriage or eligible family member eligibility. The effective date of coverage is the date of marriage or, if applicable, the date of eligible family member eligibility.

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

As a HIPAA excepted benefit, there are no HIPAA special enrollment rights under the Plan. However, the Plan will allow mid-year coverage changes as outlined below.

Mid-Year Coverage Change Due to Loss of Other Health Coverage

Under certain circumstances, an eligible retiree 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 a mid-year change. Enrollment shall be allowed for any of the following:

- a. The eligible retiree 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 retiree or eligible family member was previously eligible to enroll under the Plan.
 - Declined Mayo coverage for the reason described above.
 - Presents to the Plan Administrator, or its designee, 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 retiree's or eligible family member's failure to pay premiums on a timely basis or termination for cause but is due to:
 - Cessation of dependent status
 - Death
 - Divorce
 - Employer contributions toward the coverage terminate
 - Incurring a claim that would meet or exceed a lifetime limit on all benefits (note that benefits paid under one Mayo medical plan option count as benefits paid under all other options for purposes of determining whether the lifetime maximum is reached)
 - Legal separation
 - Loss of HMO or similar coverage because you change your residence or work place and as a result coverage is no longer available
 - Reduction in the number of hours of employment
 - Termination of employment
 - The Plan is changed so that you, your spouse or eligible family member are no longer eligible
 - Notifies the Plan Administrator, or its designee, 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 retiree or eligible family member satisfies all of the following criteria:
- Was covered under benefits available under COBRA
 - Declined coverage for that reason
 - Presents to the Plan Administrator, or its designee, evidence that the eligible retiree family member has exhausted such COBRA coverage and has not lost such coverage due to the failure of the eligible retiree or dependent 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 a 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 the Plan Administrator, or its designee, in writing within 31 days of the date of the loss of coverage.
- c. The eligible retiree or eligible family member satisfies all of the following criteria:
- Effective April 1, 2009, an eligible retiree or eligible family member with coverage under a state Medicaid plan or Children's Health Insurance Program (CHIP) loses such eligibility.
 - Loss of eligibility is not due to the eligible retiree's or eligible family member's failure to pay premiums on a timely basis or termination for cause.

- Notifies the Plan Administrator or its designee, in writing within 60 days of the date of the loss of coverage.

Who Can Enroll After Mid-Year Coverage Change Events That Are Loss of Other Coverage?

If your eligible family member loses coverage as explained above, and that eligible family member is eligible for coverage under the Plan, you can add that eligible family member. You will not be able to add your family member to the Plan if you are not enrolled in the Plan.

Who Can Enroll After Mid-Year Coverage Change Events That Are Addition of Family Member?

The addition of a new family member triggers special enrollment rights for an eligible retiree and the spouse. Even if the retiree does not participate in the Mayo Dental Plan at the time of the event, the employee could add Plan coverage. For example, upon the birth of an eligible retiree's child, the eligible retiree (assuming he/she did not previously enroll), his/her spouse and his/her newborn may all enroll because of the child's birth.

Mid-Year Coverage Change Enrollment Due to Addition of Eligible Family Member

The following events for an eligible retiree trigger special enrollment rights:

- Birth, adoption, or placement for adoption of an eligible retiree's child
- Marriage

Rules and Procedures for Mid-Year Coverage Changes

Time Period for Mid-Year Coverage Changes

The eligible retiree must request a mid-year coverage change in the Plan within 31 days of the marriage or birth, adoption or placement for adoption of his/her child.

Effective Date of Mid-Year Coverage Change

Enrollment in the Plan under this mid-year coverage provision will be the date of the event.

Can I Cancel My MRA/DAP Coverage?

Because your MRA/DAP is funded solely with employer contributions and you make no pre-tax contributions, you are not limited by the same rules that limit your ability to change or cancel other health plan elections which are paid for on a pre-tax basis. You can cancel your own or your eligible family member's MRA/DAP coverage at any time. However, if you do so, you will lose your right to renew or re-establish any MRA/DAP coverage for you or your eligible family members at any time and for any reason. You should contact HR Connect before canceling your coverage.

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 retirees who enroll during the initial enrollment period is the first day of retirement. The effective date of coverage for eligible family members is at the time of the eligible retiree's enrollment. If eligible family member status is acquired after the eligible retiree'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 retiree 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 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. **Mid-year Enrollment.** When enrollment occurs as the result of a mid-year 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 mid-year 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 your spouse and eligible family members were enrolled in the Plan at the time of your death, MRA/DAP 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 reaches 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 are not eligible and do not 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 Plan, including the MRA/DAP 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.

Who Pays the Costs of the Plan?

The Plan is funded by participating employers with no retiree contributions. All claims for benefits are paid from the employer’s general assets. See the section titled Contributions for more detail.

WHEN DOES COVERAGE END

Retiree Coverage Ends

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

1. The date the employer terminates the Plan or its participation in the Plan.
2. The date of your death.
3. The effective date of the amendment, if the Plan is amended so that you lose coverage.
4. The date you cancel coverage.

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.
2. The last day of the month after your child's 26th birthday.
3. The last day of the month of the date of the final decree for dissolution of marriage.
4. The date your eligible family member becomes eligible for benefits at Mayo Clinic or an affiliate as an employee.
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 your eligible family member was discharged from the hospital, if he/she is hospitalized on the day coverage would otherwise end.
7. The date coverage is no longer required under the terms of a QMCSO or the Plan.

Account Credit Balances When Retiree Plan Coverage Ends

In the event that you lose coverage as described above, any and all MRA/DAP account credit balance is forfeited at the time of the loss of coverage unless you are eligible and elect COBRA continuation coverage as described in the *Continuation of Healthcare Coverage Under COBRA Section*.

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.

CONTINUATION OF HEALTHCARE 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 in the *Contact Information* section.

COBRA continuation coverage can become available when you and/or your eligible family would otherwise lose 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 Plan, 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 Plan, 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 Plan 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 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

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.

For the other qualifying events (divorce, 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* section. Your written notice must be postmarked no later than 60 days after the later of:

- The date of the qualifying event, and
- 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:

- The name of this Plan,
- The type of qualifying event (e.g., divorce),
- The date of the event, and
- Your name and the names of your spouse and your eligible family member.
- 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 may 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 61st 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, or
- 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.

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 Plan 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 Plan Administrator.

MAYO REIMBURSEMENT ACCOUNT (MRA)

The total annual employer credit contribution to your MRA account is \$1,100. 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.

DENTAL ASSISTANCE PLAN (DAP)

If you are covered by the MRA, upon turning age 65, you become ineligible for MRA coverage and your dental and vision coverage will be changed automatically to the DAP component of the Mayo Dental Plan effective on the first of the month in which you reach age 65. The credit balance of your MRA account will be transferred to the DAP. No further credit contributions will be made to your DAP account after that transfer until your account balance at the end of the year falls below the maximum account balance for the DAP plan that applies to you.

The total annual employer credit contribution to your DAP account is \$475. 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 DAP. At no time will you be reimbursed for expenses that exceed your account credit balance.

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 as noted below, 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/retiree who is covered under MRA or DAP, you will each receive separate annual or pro-rated credit contributions and separate credit maximums.

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 maximums.

Maximum Account Balances	
MRA	\$5,000
DAP	\$1,900

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 \$1,100 because the full contribution will not cause your credit balance to exceed the credit maximum of \$5,000.

Example #2: You participate in DAP. On December 31 your credit balance is \$1,700. Your \$1,700 credit balance will be carried forward for use in the next year. On January 1 you will receive a credit of an additional \$200. The \$475 annual credit you would otherwise receive must be reduced to \$200 to keep your credit balance from exceeding the maximum of \$1,900.

Orthodontia Credits

The Mayo Dental Plan has a separate component that provides a one-time orthodontia benefit, this amount is limited to any unused amount from the Mayo Dental Plan. You and each of your eligible family members will receive a one-time only \$1,500 credit contribution for orthodontia to an orthodontia account. 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 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/retiree under the Mayo Dental Plan with respect to the orthodontia credit, 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 Plan. Dental services not listed under the covered items may be covered under Mayo Medical Plan if you are enrolled in a component of that medical plan. Please refer to your Mayo Medical 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 mouthgard
- Claims received after March 31 filing deadline
- Coinsurance, copayment, or deductible for dental services covered under a 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 (RETIREE MRA ONLY)**Covered Vision Services**

- Eye refractions
- Medical eye exams other than for eye refractions
- 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)
- Prescription and nonprescription drugs ordered from vision services
- Vision treatment that is determined to be unnecessary or not customary
- Warranties

ORTHODONTIA SERVICES

Important Note: You and your eligible family members will be reimbursed from the applicable individual account 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 exam and consult
- Orthodontic appliances including:
 - Braces (date appliance was placed)
 - Banding
 - Removable appliance treatment
 - Habit correct appliance
 - Initial orthodontic retainers
- 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 invisible 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, orthodontic or vision procedures, or supplies, regardless of dental/vision/medical necessity or recommendation by a healthcare provider. You will not receive reimbursement from your 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 incurred before you or your eligible family member became participants
- Expenses due to an accident related to employment or disease covered under Workers' Compensation or similar law
- Expenses incurred on a date that either you or your eligible family members are enrolled in another component of the Mayo Dental Plan
- Expenses that exceed your balance at the time submitted
- Expenses incurred while covered by Mayo Basic
- 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/DAP coverage is considered secondary coverage. You may submit a claim for reimbursement under the MRA/DAP 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 a 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:
 1. If the terms of a court decree have established one parent as financially responsible for the child's healthcare expenses, the plan of that parent is primary.
 2. The plan of the parent with custody of the child pays next.
 3. The plan of the stepparent married to the parent with custody of the child pays next.
 4. 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 healthcare 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 the health care or other expenses of 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 a covered person for Injuries or illness, 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, or withholding 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 claims procedure, you must complete an authorized representative form, which is available by calling the Claims Administrator. For the accelerated claims procedure, your healthcare 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 claims 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 Administrators and Committees responsible for deciding claims in the Plan are given in a chart at the end of this section.

STANDARD CLAIM PROCEDURE

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/DAP paper claim form. You are responsible for paying the dental or health care provider for covered services under the MRA/DAP 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 Claims 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 Claims 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 Claims 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 claims 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 Claims 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 date your final appeal under the Plan's claims procedures was denied.

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

Plan	Claims Administrator
Mayo Reimbursement Account	Mayo Clinic Health Solutions PO Box 211698 Eagan, MN 55121
Dental Assistance Plan	Mayo Clinic Health Solutions PO Box 211698 Eagan, MN 55121

First Level Appeal	Second Level Appeal
Member Appeals Mayo Clinic Health Solutions 4001 41 Street NW Rochester, MN 55901-8901	Member Appeals Plan Review Committee Mayo Clinic Health Solutions 4001 41 Street NW Rochester, MN 55901-8901

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.

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 healthcare, 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 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; Claim 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 state 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 other 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 Claims 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 healthcare provider of services to you. By accepting coverage under the Plan, you agree to sign the necessary authorization directing any healthcare provider that has attended or treated you or your eligible family member, to release to the Plan Administrator and Claims 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 healthcare provider. With respect to any assignment to a healthcare provider, that healthcare 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, Retiree 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 former employer, your former 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 Plans 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, Mayo 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>

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 507-266-0440 (TTY: 1-800-407-2442).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 507-266-0440 (TTY: 1-800-407-2442).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 507-266-0440 (TTY: 1-800-407-2442).

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 (TTY: 1-800-407-2442))。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 507-266-0440 (телетайп: 1-800-407-2442).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 507-266-0440 (መስማት ለተሳናቸው፡ 1-800-407-2442)።

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 507-266-0440 (TTY: 1-800-407-2442).

ប្រយ័ត្ន: បើសិនអ្នកនិយាយ បារាំង, សេវាជំនួយភាសា ប្រយោជន៍គឺឥតគិតថ្លៃ គឺសេវាសំរាប់ប្រើប្រាស់ ចូរ ទូរស័ព្ទ 507-266-0440 (TTY: 1-800-407-2442)។

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 507-266-0440-1 (رقم هاتف الصم والبكم: 1-800-407-2442).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 507-266-0440 (ATS : 1-800-407-2442).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 507-266-0440 (TTY: 1-800-407-2442)번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 507-266-0440 (TTY: 1-800-407-2442).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。507-266-0440 (TTY:1-800-407-2442) まで、お電話にてご連絡ください。

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 507-266-0440 (TTY: 1-800-407-2442).

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 507-266-0440 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-407-2442).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 507-266-0440 (TTY: 1-800-407-2442).

પ્રયુના: જો તમે ંજરાતી બોલતા હો, તો િનઃબ્લુ ભાષા સહાય સેવાઓ તમારા માટા ઉપલબ્ધ છ. ફોન કરો 507-266-0440 (TTY: 1-800-407-2442).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 507-266-0440 (TTY: 1-800-407-2442).

Wann du [Deutsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 507-266-0440 (TTY: 1-800-402-2442).

PLAN ADMINISTRATIVE INFORMATION

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 <i>The Plan Administrator may also be served with process</i>
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.

Plan Number	514
Type of Administration	Contract Administration
Type of Plan	Welfare benefit plan
Sources of Contributions for MRA and DAP	This Plan is funded with Employer contributions from its general assets.
Claims Administrators for MRA and DAP <i>Please Note:</i> The claims administrators perform claim processing services pursuant to a written contract; they do not insure benefits under the Mayo Dental Plan.	See <i>Claims Administration and Committee Contacts for Appeal Process</i>
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
Retiree MRA and DAP components of Mayo Dental Plan**

Charterhouse

Franklin Heating Station

Mayo Clinic

Mayo Clinic Arizona

Mayo Clinic Florida (a non-profit corporation)

Mayo Clinic Hospital-Rochester

Mayo Collaborative Services, LLC

Mayo Foundation for Medical Education and Research

Rochester Airport Company

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). See page 8.

Consultation

A meeting with your orthodontist to discuss your treatment plan.

Covered Person

An eligible retiree 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 Services

See *Schedule of Benefits* section.

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 Plan. Dental/vision necessary care must:

- Be consistent with generally accepted parameters as determined by healthcare 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.

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 may be eligible as well. The child must have been covered under the Plan immediately prior to reaching the age limitation. For the child to qualify, the Plan Administrator must receive proof of incapacity within thirty-one (31) days after the date the child's coverage would normally end. Additional proof of incapacity may be requested from time to time.

Eligible Retiree

The retiree eligible for coverage under the Plan.

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.

Health Care Provider

Institutional or professional health care providers furnishing healthcare 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 healthcare 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 alginate, and the alginate 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 Claims Administrator for Retiree Mayo Reimbursement Account and Dental Assistance Plan 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.

Open Enrollment Period

The period of time occurring toward the end of the coverage year during which eligible retirees may elect to begin coverage for their eligible family members, if applicable, under the Plan effective the first day of the upcoming coverage year.

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.

Plan

The Mayo Reimbursement Account (MRA) and the Dental Assistance Plan (DAP).

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 retiree and his or her dependents whose enrollment form has been accepted, coverage is in force, and whose coverage has not terminated. 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, intra-ocular 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 retiree under the law of the domestic state or foreign jurisdiction having legal authority to sanction the marriage.

Supernumerary Teeth

Extra teeth.

TMJ/Temporomandibular Joint

The joint where the lower jaw connects to the skull.

Summary Plan Description (SPD)

A written summary of the benefits under an employee welfare benefit plan as required under section 102 of ERISA.

Veneer

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

