BENEFITS BOOKLET

Mayo Clinic Employee Assistance Plan
Offered under the Mayo Clinic Health & Welfare Benefits Plan

Mayo Clinic Rochester
Mayo Clinic Health System - SWWI

January 2019
INTRODUCTION

This benefits booklet for the Mayo Clinic Employee Assistance Plan provides information that is applicable to certain employee assistance benefits offered under the Mayo Clinic Health & Welfare Benefits Plan for employees in Rochester and Mayo Clinic Health System – SWWI, effective as of January 1, 2019 (the “Plan” or “EAP”). Other portions of the Mayo Clinic Employee Assistance Plan that apply to employees working at other locations are described in a separate document.

The General Information Booklet for the Mayo Clinic Health & Welfare Benefits Plan (the “General Information Booklet”) provides information such as who has the right to amend and terminate the Plan. This benefits booklet, together with the General Information Booklet, constitutes the Summary Plan Description for the Plan as of January 1, 2019, and replaces all prior descriptions of the Plan. It is intended to provide a summary of your benefits available under the Plan. If there are any discrepancies between the Summary Plan Description and the governing documents, the plan documents will control.

Mayo Clinic sponsors the Plan to help address and manage life issues and concerns, and also provide confidential and professional counseling meant to help you and your family members deal with personal problems. The Plan’s staff consists of trained, experienced, licensed clinical professionals within Mayo Clinic with expertise in counseling individuals with personal issues and concerns.

We all have problems at some time in our lives. Usually we are able to handle them ourselves, but sometimes a personal problem gets out of hand. When this happens, it can interfere with relationships, job performance, and physical health. That is why Mayo Clinic provides a special service under the Plan that can be used by you, your spouse, and your eligible family members.
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PARTICIPATION

Who is Eligible

If you are classified by a participating employer for payroll and personnel purposes as an employee, you are eligible to use EAP services. The benefits described in this benefits booklet apply to Rochester and Mayo Clinic Health System – SWWI employees only. In addition, your eligible family members (spouse and your child or children who are under the age of 26) are eligible for services.

How to Enroll

As an eligible employee of a participating employer, you are automatically eligible for services provided through the EAP.
EAP BENEFITS

How the EAP Works

The EAP is a confidential and voluntary assessment, counseling, and referral service that is designed to help you and your family resolve personal problems. The EAP provides short-term assistance by offering problem identification and short-term problem resolution counseling when indicated by Mayo Clinic EAP. All Mayo Clinic EAP Counselors are experienced and have special training in all phases of EAP practice, including mental health issues and drug and alcohol concerns.

Your Right to Confidentiality

All interactions between you and the EAP are strictly confidential and will not be noted in any official company record, clinical record, or in your personnel file. Information from the EAP may be released only with your written permission, in response to state or federal statute/regulation, or from a court or other legal order. The law may require the release of specific information when the life or safety of a person is seriously threatened.

How to Obtain Covered Services

Rochester Employees:

You and your eligible family members may call the EAP at 507-266-3330 to request information or schedule an appointment with an EAP Counselor. You can access EAP services at any time, 24 hours a day, seven days a week. When you call, the EAP receptionist will ask you for your complete name, LAN ID, and contact phone number. Most appointments are offered within 1-3 days.

Mayo Clinic Health System – SWWI Employees:

You and your eligible family members may call the EAP at 608-392-9530 to request information or schedule an appointment with an EAP Counselor. You may be eligible for different benefits than those listed below. Please contact the Employee Assistance Center at 608-392-9530 for more information.

Covered Services

The EAP’s counseling services include:

- Problem assessment
- Short-term counseling
- Referrals to appropriate resources

Examples of personal problems the EAP can help with are:

- Marital or family problems
- Relationship issues
- Child or elder care issues
- Drug or alcohol concerns
- Interpersonal conflicts
- Emotional problems such as depression, anxiety, or stress-related issues
- Occupational problems
- Phase of life problems (leaving school, entering college, starting a new career, marriage, divorce, retirement)
- Bereavement
- Financial or credit concerns
• Legal questions

This is not intended to be an all-inclusive list. Please contact the EAP if you have an issue with which you need assistance.

**Supervisor Referral**

You may be referred to the EAP by a supervisor or manager. If you receive such a referral, it is your choice whether to call the EAP or decline this option.

**Referral to Outside Resources**

Once you have completed an EAP assessment, your EAP Counselor may:

• Refer you to a health care provider. It will be your responsibility to verify coverage with your health plan or pay for charges not reimbursed by your plan.

• Refer you to other community resources.

**Exclusions**

Coverage is not provided for services other than those described in “Covered Services,” above.

If your EAP Counselor refers you to another resource for assistance (such as an attorney for legal problems, a financial advisor for money problems, or an external counselor or therapist for treatment), you must pay for those charges yourself. (Note that mental health treatments may be covered under your Medical Plan.). It is your responsibility to verify coverage with your health plan or pay for charges not paid or reimbursed by your plan. The EAP does not cover and does not pay claims submitted by any health care provider or other third party that is not a participating provider or that provides services outside the scope of the EAP, and it is your responsibility to determine whether any referral may be covered by your health plan.

**Employee Discounts**

Mayo Clinic and Mayo Clinic Health Systems may provide a variety of discounts on services or products. The discounts are only available to those eligible for the EAP. For example, employees and eligible dependents may be eligible to receive discounts on purchases of eyeglasses and materials at Mayo Clinic Optical Shops. Discounts may vary based upon location and materials. Any discounts are made available directly from Mayo Clinic or a Mayo Clinic Health System practice site and are not accessible by calling the EAP. Please contact Mayo Clinic or a Mayo Clinic Health System practice directly for more information regarding such discounts.

**Additional Services**

The Plan contains a wellness program component called the Well-Being Index, which is a web-based tool that evaluates multiple dimensions of distress via a questionnaire in an effort to end employment “burnout” for Plan participants, and also provides several other resources. For more information regarding the Well-Being Index, please contact HR Connect at 507-266-0440.
CLAIMS ADMINISTRATION

You (or your authorized representative) may make a claim for benefits under the Plan by providing notice of your claim to the Claims Administrator. The Claims Administrator has the authority to review certain claims and, in connection with this review, to interpret the plan and decide claims-related questions. Because the Plan is a group health plan (as defined under ERISA), special rules apply to claims filed and appealed under the Plan, as described further in this document.

Claims must be submitted in writing. Your claim is not considered submitted until you provide all information that is necessary for determination of your claim.

Notification of Initial Determination

After you make your claim for benefits, you will be notified of the benefit determination within 30 days after receipt of the claim by the Claims Administrator. The Claims Administrator may extend this period for up to 15 days, if necessary. If extra time is needed to process your claim, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. If additional information is needed because necessary information is missing from the request, the notice will specify what information is needed. You must provide the specified information to the Claims Administrator within 45 days after receiving the notice. The determination period will be suspended on the date the Claims Administrator sends a notice of missing information and the determination period will resume on the date you respond to the notice.

Content of Initial Notification

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”).

Appeal of Determination

If you receive an adverse benefit determination, you have 180 days to appeal the decision. Your appeal must be in writing and state that a formal appeal is being requested and include all pertinent information regarding the claim in question. You should describe the reasons why you think the decision on your claim was incorrect.

Appeals should be directed to the Claims Administrator with which you filed your initial claim. You or your authorized representative will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information related to your claim.

If you do not file an appeal within the time permitted, your claim will be deemed abandoned and you may not reassert it under these procedures or in a court or any other venue. If you fail to raise issues or present evidence on
appeal, you may not be able to raise those issues present that evidence in any later proceeding or judicial review of your claim.

**Content of Appeal Notification**

If your appeal is denied, you will be notified in writing or electronically within 60 days. The denial will tell you 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.

**Legal Action**

You may not bring a civil action for benefits unless you have exhausted your administrative review rights under the internal claims procedures for the Plan. No civil action may be brought more than one year after the date on which your claim is denied on final appeal.