HOW TO USE THIS DOCUMENT

The Table of Contents provides an overview of the detailed information in the Plan.

You will find a glossary of terms used in this document. To quickly search for a specific word or phrase, simply press the “Ctrl” and “F” keys simultaneously to open the search function.
INTRODUCTION

Mayo Clinic sponsors the Mayo Flexible Spending Account Plan. The Health Care Flexible Spending Account is a component of this plan, which reimburses eligible employees of Mayo Clinic and other participating employers for eligible health care expenses on a pre-tax basis. This component will be referred to in this document as the Plan. Effective January 1, 2018, this document sets forth the benefits under the Plan. There are separate summaries for the Dependent Care Flexible Spending Account and the Pre-Tax Health Savings Account Plan which are certain other components of the Mayo Flexible Spending Account Plan. This document replaces all previous Plan statements and descriptions.

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

The Plan is a general purpose health care flexible spending account funded by participant contributions. Mayo Clinic does not contribute to the Plan. 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.

The pre-tax contributions to the Plan are permitted under Section 125 of the Internal Revenue Code, subject to certain rules and limitations, including the requirement of a written plan document. This document includes the written Pre-Tax Premium Payment Rules for this Plan (“Pre-Tax Premium Rules”). The Plan will be administered in accordance with these rules and limitations and with any subsequent amendment to or clarification of the rules and limitations. The Pre-Tax Premium Rules are not subject to ERISA. The plan year for the Premium Payment Rules is the calendar year.

You should also consider the fact that an adult dependent child who may be eligible for coverage under the Mayo Medical Plan is not an eligible family member under this Plan unless that adult child is your tax dependent for Federal income tax purposes. If you have any questions about whether your child is a tax dependent, please consult your tax advisor.

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.
Mayo Clinic Health Solutions is the claims administrator for the Plan and processes claims and answers claim questions for the Plan.

Mayo Clinic Health Solutions customer service representatives are available to answer any questions or concerns regarding Plan. For enrollment or eligibility questions, please contact Mayo Clinic’s HR Connect. HR Connect is your contact for this Plan.

<table>
<thead>
<tr>
<th>QUESTIONS ABOUT PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mayo Clinic Health Solutions</td>
</tr>
<tr>
<td>4001 41 Street NW</td>
</tr>
<tr>
<td>Rochester, MN 55901-8901</td>
</tr>
<tr>
<td>507-266-5580 (local)</td>
</tr>
<tr>
<td>1-800-635-6671 (toll free)</td>
</tr>
<tr>
<td>TDD at 1-800-407-2442 (toll free)</td>
</tr>
<tr>
<td>M – F, 7 a.m. to 7 p.m. CT (excluding holidays)</td>
</tr>
<tr>
<td><a href="http://www.MayoClinicHealthSolutions.com">www.MayoClinicHealthSolutions.com</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>QUESTIONS ABOUT ENROLLMENT/ELIGIBILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>HR Connect</td>
</tr>
<tr>
<td>200 First Street SW</td>
</tr>
<tr>
<td>Rochester, MN 55905</td>
</tr>
<tr>
<td>507-266-0440 (local)</td>
</tr>
<tr>
<td>1-888-266-0440 (toll free)</td>
</tr>
<tr>
<td>M – F, 5 a.m. to 6 p.m., Saturday/Sunday 5 a.m. to 9 a.m. CT (excluding holidays)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COBRA ADMINISTRATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discovery Benefits, Inc.</td>
</tr>
<tr>
<td>PO Box 2079</td>
</tr>
<tr>
<td>Omaha, NE 68108-2079</td>
</tr>
<tr>
<td>1-866-451-3399</td>
</tr>
<tr>
<td>M-F, 7 a.m. – 7 p.m. CST</td>
</tr>
</tbody>
</table>

HR Connect and Mayo Clinic Health Solutions Customer Service have access to translation services to meet the needs of non-English speaking persons.

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

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>HOW TO USE THIS DOCUMENT</td>
<td>3</td>
</tr>
<tr>
<td>INTRODUCTION</td>
<td>4</td>
</tr>
<tr>
<td>CONTACT INFORMATION</td>
<td>5</td>
</tr>
<tr>
<td>ELIGIBILITY AND PARTICIPATION</td>
<td>8</td>
</tr>
<tr>
<td>Who is eligible for coverage?</td>
<td>8</td>
</tr>
<tr>
<td>When can you elect?</td>
<td>9</td>
</tr>
<tr>
<td>How do I pay for the cost of coverage I elect?</td>
<td>9</td>
</tr>
<tr>
<td>Can I change or cancel my enrollment during the year?</td>
<td>10</td>
</tr>
<tr>
<td>How do I cancel or reduce my coverage level?</td>
<td>10</td>
</tr>
<tr>
<td>What if I have questions about enrolling or changing my election after</td>
<td>12</td>
</tr>
<tr>
<td>a change in status?</td>
<td>12</td>
</tr>
<tr>
<td>When does my coverage become effective?</td>
<td>12</td>
</tr>
<tr>
<td>What happens to my Plan coverage at retirement?</td>
<td>12</td>
</tr>
<tr>
<td>If I die, what happens to coverage for my dependents at my death?</td>
<td>13</td>
</tr>
<tr>
<td>WHEN DOES COVERAGE END</td>
<td>14</td>
</tr>
<tr>
<td>Employee Coverage Ends</td>
<td>14</td>
</tr>
<tr>
<td>Effect of Termination of Coverage</td>
<td>14</td>
</tr>
<tr>
<td>Additional Termination of Coverage Rules</td>
<td>15</td>
</tr>
<tr>
<td>CONTINUATION OF HEALTH CARE COVERAGE UNDER COBRA</td>
<td>16</td>
</tr>
<tr>
<td>COBRA Eligibility</td>
<td>16</td>
</tr>
<tr>
<td>Notification of COBRA Continuation Coverage Election</td>
<td>17</td>
</tr>
<tr>
<td>You Must Give Notice of Certain Qualifying Events</td>
<td>17</td>
</tr>
<tr>
<td>How is COBRA Coverage Provided?</td>
<td>17</td>
</tr>
<tr>
<td>What is the Length of COBRA Continuation Coverage</td>
<td>17</td>
</tr>
<tr>
<td>Election of COBRA Continuation Coverage</td>
<td>18</td>
</tr>
<tr>
<td>Procedures to Elect COBRA Continuation Coverage</td>
<td>18</td>
</tr>
<tr>
<td>Cost of COBRA Continuation Coverage</td>
<td>18</td>
</tr>
<tr>
<td>Payment for COBRA Continuation Coverage</td>
<td>18</td>
</tr>
<tr>
<td>Termination of COBRA Continuation Coverage Before the End of the Maximum</td>
<td>19</td>
</tr>
<tr>
<td>Coverage Period</td>
<td>19</td>
</tr>
<tr>
<td>Keep Your Plan Informed of Address Changes</td>
<td>19</td>
</tr>
<tr>
<td>HEALTH CARE FLEXIBLE SPENDING ACCOUNT</td>
<td>20</td>
</tr>
<tr>
<td>Annual Contributions</td>
<td>20</td>
</tr>
<tr>
<td>Employee Contributions</td>
<td>20</td>
</tr>
<tr>
<td>Reimbursement Information</td>
<td>20</td>
</tr>
<tr>
<td>Tax Benefits</td>
<td>21</td>
</tr>
<tr>
<td>Definition of Dependent</td>
<td>21</td>
</tr>
<tr>
<td>Information Regarding Your Account</td>
<td>21</td>
</tr>
<tr>
<td>Roll-over of Unused FSA Funds</td>
<td>21</td>
</tr>
<tr>
<td>ELIGIBLE EXPENSES</td>
<td>22</td>
</tr>
<tr>
<td>INELIGIBLE EXPENSES</td>
<td>26</td>
</tr>
<tr>
<td>CLAIM PAYMENT AND APPEAL PROCEDURES</td>
<td>29</td>
</tr>
<tr>
<td>STANDARD CLAIM PROCEDURE</td>
<td>30</td>
</tr>
<tr>
<td>Filing an Initial Claim</td>
<td>30</td>
</tr>
<tr>
<td>Time for Filing a Claim</td>
<td>30</td>
</tr>
<tr>
<td>Filing a Claim</td>
<td>30</td>
</tr>
<tr>
<td>Special Rules for Filing Orthodontia Claims</td>
<td>30</td>
</tr>
<tr>
<td>Claim Decision</td>
<td>31</td>
</tr>
</tbody>
</table>

521.MC5500-41rev01012018  Page 6 of 51
Claim Payment .................................................................................................................................31

**APPEAL PROCEDURE FOR STANDARD CLAIMS** ........................................................................32
  - Filing First Level Appeal (Standard Claim Process) .................................................................32
  - Time for Filing First Level Appeal ............................................................................................32
  - Filing of First Level Appeal ........................................................................................................32
  - Appeal Decision ............................................................................................................................32
  - Filing Second Level Appeal (Standard Claim Process) ...............................................................32
  - Time for Filing Second Level Appeal ........................................................................................33
  - Filing of Second Level Appeal ..................................................................................................33
  - Appeal Decision .........................................................................................................................33
  - Special Rule for Claims Related to a Course of Treatment .......................................................33

**GENERAL RULES APPLICABLE TO ALL CLAIM PROCEDURES** ..................................34
  - Authority ......................................................................................................................................34
  - Time Limits for Commencing Legal Action ...............................................................................34
  - Exhaustion of Administrative Remedies ..................................................................................34

**CLAIM ADMINISTRATION AND COMMITTEE CONTACTS FOR APPEAL PROCESS** ....35

**GENERAL PROVISIONS** ...........................................................................................................36
  - Applicable Law ............................................................................................................................36
  - Conformity with Governing Law ................................................................................................36
  - Construction of Terms ...............................................................................................................36
  - HIPAA Privacy Rules ..................................................................................................................36
  - Assignment Prohibited ..............................................................................................................36
  - No Guarantee of Employment ...................................................................................................36
  - Non-Discrimination Policy ........................................................................................................36
  - Plan Provisions Binding ............................................................................................................37
  - Section Titles ...............................................................................................................................37

**PLAN ADMINISTRATION** ..........................................................................................................38
  - Powers and Duties of the Plan Administrator ..........................................................................38
  - Records .....................................................................................................................................38
  - Release of Medical Information ...............................................................................................38
  - Assignment of Benefits ..............................................................................................................38
  - Amendment and Termination of Plan.......................................................................................39

**ERISA STATEMENT OF RIGHTS** .........................................................................................40
  - Receive Information About Your Plan and Benefits .................................................................40
  - Continue Group Health Plan Coverage ....................................................................................40
  - Prudent Actions by Plan Fiduciaries ..........................................................................................40
  - Enforce Your Rights ..................................................................................................................40
  - Assistance with Your Questions ...............................................................................................41

**NON-DISCRIMINATION NOTICE** .............................................................................................42
  - Discrimination is Against the Law ............................................................................................42

**PLAN ADMINISTRATIVE INFORMATION** .............................................................................44

**GLOSSARY** .................................................................................................................................48
ELIGIBILITY AND PARTICIPATION

Who is eligible for coverage?

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

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

**Impact of Mayo Basic Coverage.** Because Mayo Basic is a High Deductible Health Plan which allows you to make contributions toward a Health Savings Account (HSA), you and your family members are not eligible for the Health Care Flexible Spending Account.

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

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

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

**Leave of Absence.** Employees who would normally be working as a regular employee for the employer for at least the required number of hours per pay period to qualify as an eligible employee, but who are on an employer approved leave of absence, such as approved personal, disability, parental, and/or military leave, remain eligible employees for the duration of the approved leave. Any contributions, however, that are made during unpaid or third-party paid leaves have to be made with after-tax dollars.
When can you elect?

The following paragraphs describe enrollment.

**Initial Enrollment**

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

1. **Open Enrollment**

Prior to the start of a coverage year, the Plan has an open enrollment period. **If you wish to participate, you must enroll each year.** At the time of open enrollment, you may elect to enroll, increase, decrease your contributions, or drop coverage. 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. Once your elections are effective, you may not change them until the next annual enrollment period unless you experience a “special enrollment.” The open enrollment effective date of coverage is January 1.

2. **Special Enrollment Due to a Change in Status Event**

Under certain circumstances, an eligible employee who did not enroll during the initial enrollment period may enroll in the Plan during the Plan year. These circumstances warrant "special enrollment." Special enrollment shall be permitted as identified in the Change in Status Events chart below.

**Time Period for Special Enrollment Period.** The eligible employee must request special enrollment in the Plan within 31 days of the event. If the HR Connect or its designee does not receive the eligible employee’s completed request for enrollment within this deadline, the eligible employee loses special enrollment rights for that event.

**How do I pay for the contributions I elect?**

Eligible employees electing coverage under the Plan solely contribute to the Plan through pre-tax salary reductions. This reduces taxable income reported by Mayo on your W-2. Therefore if you elect coverage under the Plan, you will contribute to the Plan through pre-tax salary reductions each payroll. Your taxable compensation from Mayo will be correspondingly reduced by the amount of annual contributions you elect. Because you pay your contributions pre-tax, however, federal law limits the circumstances under which you can make changes to your pre-tax election during the plan year. Unless you have a special enrollment or change in status event (as discussed in the next sub-section entitled “Can I change or cancel my enrollment during the year?”) you will not be able to make changes to your elected contribution amount until the next open enrollment period.
Can I change or cancel my election during the year?

Because you contribute to the Plan on a pre-tax basis, federal law limits your ability to change your benefit elections during the year. This means that once you make your election, you cannot change or cancel your election unless you experience a change in status event. Your change must be both on account of and consistent with the change in status event. Change in status events and consistency requirements that apply to the Plan are described in the chart below. You may be asked to provide proof of your Change in Status Event and the date the event occurred. Failure to do so may result in denial of your change request.

You must contact HR Connect within 31 days of the event to request a change

<table>
<thead>
<tr>
<th>Change in Status Events</th>
<th>Permitted Election Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marriage</td>
<td><strong>Enroll or increase coverage</strong> because of new dependent(s).</td>
</tr>
<tr>
<td></td>
<td><strong>Cancel or decrease coverage</strong> if you and/or any dependent(s) will be covered by spouse’s Health Care Flexible Spending Account.</td>
</tr>
<tr>
<td>Divorce or Annulment</td>
<td><strong>Enroll or increase coverage</strong> if you or any dependent(s) lost coverage under spouse’s Health Care Flexible Spending Account.</td>
</tr>
<tr>
<td></td>
<td><strong>Decrease coverage</strong> in anticipation of reduced expenses because of spouse’s loss of coverage.</td>
</tr>
<tr>
<td>Death of Spouse</td>
<td><strong>Enroll or increase coverage</strong> if you and/or any dependent lost coverage under spouse’s plan.</td>
</tr>
<tr>
<td></td>
<td><strong>Decrease coverage</strong> in anticipation of reduced expenses because of spouse’s death.</td>
</tr>
<tr>
<td>Change in Number of Dependents (birth, adoption, death, etc.)</td>
<td><strong>Enroll or increase coverage</strong> for new dependent.</td>
</tr>
<tr>
<td></td>
<td><strong>Decrease coverage</strong> in the event of the death of a dependent.</td>
</tr>
<tr>
<td>Dependent Loses Eligibility</td>
<td><strong>Decrease coverage</strong> but only relating to anticipated expenses of dependent losing eligibility.</td>
</tr>
<tr>
<td>Dependent Gains Eligibility</td>
<td><strong>Add or increase coverage</strong> but only relating to anticipated expenses of dependent gaining</td>
</tr>
<tr>
<td>Change in Status Events</td>
<td>Permitted Election Changes</td>
</tr>
<tr>
<td>------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td><strong>Employment Status Changes of Spouse</strong>&lt;br&gt;You or dependents gain or lose eligibility under another flexible benefit plan</td>
<td><strong>Enroll or increase coverage</strong> because of loss of other coverage (e.g., if you were covered under your spouse’s health care flexible spending account plan and your spouse loses coverage, you, your spouse, and any other dependents covered on your spouse’s plan can make or increase an election in the Plan.  &lt;br&gt;<strong>Cancel or decrease coverage</strong> if you and/or any dependent(s) will be covered by spouse’s or dependent’s health care flexible spending account because of gaining eligibility for coverage.</td>
</tr>
<tr>
<td><strong>Your Employment Status Changes</strong>&lt;br&gt;You gain or lose Eligibility under the Mayo Clinic Flexible Spending Account</td>
<td><strong>Enroll coverage</strong> if you have gained eligibility.  &lt;br&gt;If you have lost eligibility in an employment related change, such as termination or moving from a benefit eligible to benefit ineligible job classification, your coverage will be automatically canceled, as well as your pre-tax election. You can continue to submit any expenses you incurred before your coverage was canceled until March 31 of the following year.</td>
</tr>
<tr>
<td><strong>Residence Change</strong></td>
<td><strong>No change permitted</strong></td>
</tr>
<tr>
<td><strong>Certain Changes under Spouse’s Employer’s Plan.</strong>&lt;br&gt;If they are due to and correspond with a permitted change made under your spouse’s employer’s plan (for example, if your spouse’s employer adds a new health option mid-year and your spouse can elect and elects coverage under the new option) or during the annual enrollment period of your spouse’s employer’s plan, if it (and the plan year) is different from Mayo’s annual enrollment and Plan year.</td>
<td><strong>Enroll or increase coverage</strong> if you are dropping coverage under spouse’s health care flexible spending account.  &lt;br&gt;<strong>Cancel or decrease coverage</strong> if you and/or any dependent(s) will be covered by spouse’s health care flexible spending account.</td>
</tr>
<tr>
<td><strong>Medicare or Medicaid Eligibility Change</strong></td>
<td><strong>No change permitted</strong></td>
</tr>
<tr>
<td><strong>Qualified Medical Child Support Order (QMCSO)</strong></td>
<td><strong>Enroll or increase coverage</strong> if QMCSO requires that you provide coverage and if you provide more than half the financial support for the child.</td>
</tr>
</tbody>
</table>
Change in Status Events | Permitted Election Changes
--- | ---
Change to Cost or Coverage Needs | No change permitted

### How do I cancel coverage or reduce my coverage level?

Some changes to your health coverage will happen automatically. For example, if you terminate or are no longer eligible for coverage under the Plan, your coverage will automatically be terminated. If you return to work to a benefit eligible position within 30 days of your termination, your benefits are automatically reinstated at the previous election level. If you are rehired or otherwise become benefit eligible after 30 days, you are treated as a new hire.

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

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

### What if I have questions about enrolling or changing my election after a change in status?

Mayo Clinic administers the Plan according to the rules and retains the discretion to determine whether you can make the desired cancellation or reduction of coverage. If you have further questions, contact HR Connect.

### When does my coverage become effective?

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

- **Enrollment Within Initial Enrollment Period.** The effective date of coverage for eligible employees who enroll during the initial enrollment period is the first day of employment or change to eligible status with the employer.

  **Open Enrollment Period** If an eligible employee 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.

- **Special Enrollment.** When enrollment occurs as the result of a special enrollment described above, your new elections will be effective the first payroll period following the date your completed election change is approved.

### What happens to my Plan coverage at retirement?

At the time of retirement, you are able to continue the Plan for a limited period under COBRA coverage. Please refer to the section titled *Continuation of Health care Coverage Under COBRA* for more details.
If I die, what happens to coverage for my dependents at my death?

In the event of your death, the person entitled to receive payment under applicable law can submit claims for expenses incurred prior to your death to the extent those claims would have been eligible for reimbursement to you. You will only be reimbursed for eligible health care expenses you incurred while you are making contributions during the Plan Year. No expenses incurred after your participation ends will be reimbursed.

Your dependents may be able to continue coverage for a limited period after your death. Please see the COBRA continuation coverage section for more details.
WHEN DOES COVERAGE END

Employee Coverage Ends

Coverage ends at midnight of the earliest of the following dates:

1. The date in which you terminate employment with the employer.
2. The date your employment position or status changes such that you are no longer an eligible employee.
3. The date ending the period for which the last contribution is made if you fail to make any required contributions when due.
4. The date the employer terminates the Plan or its participation in the Plan.
5. The date of your death.
6. If the Plan is amended so that you lose coverage, the effective date of the amendment.
7. The last day of the Plan year for which you have a benefit election in effect.
8. The last day of the pay period following the date you request your benefit election be terminated as a result of, and consistent with, a change in status event or leave of absence rule.
9. The date your elected coverage under the Mayo Basic medical plan option becomes effective.

Effect of Termination of Coverage

On the date your participation ends, no further reductions in pay will be contributed to your accounts. All claims incurred during the period of coverage (i.e., the calendar year) must be submitted for reimbursement by March 31 following the year in which your participation terminated. Any amount remaining in your account after eligible expenses have been reimbursed will be forfeited unless you return to employment within 30 days or you elect COBRA continuation coverage, if available.

In the event of your death, the person entitled to receive payment under applicable law can submit claims for expenses incurred prior to your death to the extent those claims would have been eligible for reimbursement to you.

In addition, you will be reimbursed only for eligible health care expenses you incurred while you are making contributions during the Plan year. No expenses incurred after your participation ends will be reimbursed.

Effect of Return to Employment

The following special rules apply when you return to work for the employer:

Thirty (30) Days or Less

If you return to work within 30 days of the date you terminated employment, your prior elections will be reinstated automatically for the remainder of the Plan Year.
After 30 Days

If you return to work more than 30 days from the date you terminated employment, you will be treated as a newly hired employee and the initial enrollment rules will apply. Refer to the Initial Enrollment section for more information.

Dependent Coverage Ends

You can submit expenses of eligible dependents for reimbursement that are incurred while you are covered under the Plan. Eligible dependents include your spouse and children who are your 152 tax dependents. See “Definition of Dependent” for more information about eligible dependents.

Additional Termination of Coverage Rules

Your participation under the Plan will terminate immediately upon termination of the Plan or will terminate at midnight 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. 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 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 for any claims mistakenly paid.

3. The date you do not reimburse the Plan for any claims mistakenly paid.
CONTINUATION OF HEALTH CARE COVERAGE UNDER COBRA

This section contains detailed information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan after you or your eligible dependents 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). COBRA continuation coverage can become available to you and your dependents who are covered under the Plan when you or your dependents would otherwise lose health coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your dependents, and what you need to do to protect the right to receive it.

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 dependent children 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 your expenses can no longer be reimbursed under the Plan because any of the following qualifying events occur:

- Your spouse
- 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.

Your dependent children (including children participating under a qualified medical child support order (QMSCO)) will become qualified beneficiaries if their expenses can no longer be reimbursed 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.
Notification of COBRA Continuation Coverage Election

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been timely notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or commencement of a proceeding in bankruptcy with respect to the employer, the employer must notify the COBRA Administrator of the qualifying event.

You Must Give Notice of Certain Qualifying Events

For the other qualifying events (divorce or legal separation or an eligible family member losing eligibility for coverage), you or your dependents must notify Human Resources. Verbal notice, including notice by telephone, is not sufficient. You may deliver your written notice by mail, facsimile, or by hand.

You must submit written notice within 60 days after the later of (1) the date of the qualifying event, or (2) the date on which you lose, or would lose, coverage under the terms of the Plan as a result of the qualifying event, that states the type of qualifying event permitting you to elect COBRA continuation coverage. You do not need to complete a specific form, but you need to provide certain information. Your written notice must include (i) the name of this Plan, (ii) the type of qualifying event (e.g., divorce), (iii) the date of the event, and (iv) your name and the names of the other qualified beneficiaries.

You must provide notice in a timely manner. If mailed, your notice must be postmarked no later than the last day of the 60-day election period described above. Otherwise it must be received no later than that day. If you or your dependent fails to provide notice to the Plan Administrator during this 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. As long as the employee is a qualified beneficiary, however, there can only be one Health Care Flexible Spending Account election for the entire family. In case of divorce, there can only be one Health Care Flexible Spending Account election for the former spouse and any dependent children who have lost coverage as a result of the divorce. A qualified beneficiary must elect coverage within 60 days of being provided a COBRA election notice. Failure to do so will result in loss of the right to elect COBRA continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of COBRA continuation coverage any time until the end of the 60-day election period.

What is the Length of COBRA Continuation Coverage

COBRA continuation coverage is a temporary continuation of coverage. The maximum COBRA period for a Plan ends on the last day of the Plan year in which the qualifying event occurred.
Election of COBRA Continuation Coverage

To elect COBRA continuation coverage, you must complete an election form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. As long as the employee is a qualified beneficiary, however, there can only be one Health Care Flexible Spending Account election for the entire family. In case of divorce, there can be only one Health Care Flexible Spending Account election for the former spouse and any dependent children who have lost coverage as a result of the divorce. A qualified beneficiary must elect coverage within 60 days of being provided a COBRA election notice. Failure to do so will result in loss of the right to elect COBRA continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of COBRA continuation coverage any time until the end of the 60-day election period.

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 member 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.

Cost of COBRA Continuation Coverage

Generally each qualified beneficiary may be required to pay 102 percent of the entire cost of COBRA continuation coverage on an after-tax basis.

Payment for COBRA Continuation Coverage

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 no 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 your first payment for COBRA continuation coverage in full no 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 correct 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.

Periodic payments for COBRA continuation coverage

After you make your 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 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 period 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 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 (i) any required premium is not paid on time, (ii) after electing COBRA continuation coverage a qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary, (iii) after electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare, or, (iv) the employer ceases to provide any 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 our COBRA continuation coverage.

**Keep Your Plan Informed of Address Changes**

In order to protect your 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.
HEALTH CARE FLEXIBLE SPENDING ACCOUNT

The Health Care Flexible Spending Account section details the eligible expenses under the Plan.

Annual Contributions

Effective January 1, 2018, due to limits set under the Patient Protection and Affordable Care Act and IRS, you are allowed to contribute up to $2,600 pre-tax to a Health Care Flexible Spending Account to pay for eligible out-of-pocket health care expenses such as deductibles, copayments and coinsurance, and other such expenses which are not covered by any other source. Your pre-tax contribution is made through the Pre-Tax Premium Rules.

You or your Dependents do not need to be covered by the employer’s health programs in order for you to contribute money to your account. Please note that any individual who is an eligible dependent or eligible family member under the Mayo Medical Plan may not be an eligible Dependent under this Plan. Dependents under this Plan must be tax dependents under section 152 of the Internal Revenue Code.

Employee Contributions

You must carefully plan the amount you wish to contribute because the Plan is governed by federal regulations and restrictions.

Important points to remember are:

- **No Tax Deduction.** You cannot take a tax deduction on your federal income tax return for expenses reimbursed from your Health Care Flexible Spending Account.
- **No Change to Election.** During the year you cannot change your contribution election except under certain conditions, see Change in Status Events for details.
- **Filing Deadline.** Even if you incur eligible expenses for the year, if you do not file a claim for reimbursement of those expenses before the filing deadline, you will forfeit the amount remaining in your accounts. The filing deadline for the year is March 31 of the following year.

The minimum employee contribution is $5 per payroll, and the maximum employee contribution is $2,600 annually.

Reimbursement Information

You may be reimbursed under the Health Care Flexible Spending Account for expenses for “medical care” as defined by section 213(d) of the Internal Revenue Code incurred by you, your spouse, or your eligible family members.

In administering the Account, the employer may, in its sole discretion, consult various Internal Revenue Service publications, rulings, notices, and other authorities to determine if an expense is eligible.

To be eligible for reimbursement the expense **must be incurred during the Plan year while you are a participant** and **must not be reimbursed** by any insurance, other reimbursement accounts, or an HMO. Generally, expenses are incurred when services are provided, not when you are billed for or pay for the services.
At any time during the year you can be reimbursed for your eligible expenses up to the annual amount you elected to contribute to your account for that year, even if that amount has not yet been contributed to your account.

**Tax Benefits**

You will save money when you use pre-tax dollars to reimburse your eligible health care expenses. In most cases, you will not pay Federal Income Tax (approx. 10 to 35 percent), State Income Tax (approx. 3 percent), or Social Security (FICA) Tax (approx. 7.65 percent) on the amount you contribute to or are reimbursed from the Plan.

Because your contributions are deducted before your social security taxes are calculated, your social security benefit may be affected. In addition, for expenses reimbursed under Health Care Flexible Spending Account, you may not claim a health care expense deduction on your federal income taxes. For some employees, it may be preferable to use the health care expense deduction rather than to participate in the Plan. The tax savings when you participate in the Plan will vary from taxpayer to taxpayer based on personal circumstances, exemptions, deductions, and filing status. You may want to discuss these issues with your tax advisor.

**Definition of Dependent**

Eligible Dependents (as defined by Section 152 of the IRS) may include your spouse, biological, legally adopted children, or children placed for adoption, siblings, or grandchildren through age 18 (or age 24 if a full-time student) or for whom you provide over half the support. Eligible dependent also includes any person who resides with you, is a member of your household and for whom you provide over half the support. This does not include an individual who is not a U.S. citizen or national, unless the individual is a resident of the U.S. or a country contiguous to the United States.

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

**Information Regarding Your Account**

Detailed information about your contributions and reimbursements from your account are available by accessing the Self-Service Tools on Mayo Clinic Health Solutions website (www.MayoClinicHealthSolutions.com). Account information may also be obtained by calling the Mayo Clinic Health Solutions.

**Roll-over of Unused FSA Funds**

At the end of the year, if you have funds of $500 or less in your FSA, those funds will automatically be rolled over to the next plan year if you take action during Open Enrollment to re-enroll in FSA. You will be able to use those roll-over funds for qualified medical expense reimbursement the following year. Any amount over $500 will be forfeited at the end of the plan year.

To be eligible for roll-over, you must re-enroll in the health care FSA during Open Enrollment for the following year. The roll-over is in addition to the maximum employee contribution of $2,600 annually.
ELIGIBLE EXPENSES

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

Following is a list of common items used for reimbursement from this account; however this is not an exhaustive list as there are some expenses which potentially qualify for reimbursement. Please contact Mayo Clinic Health Solutions Customer Services to discuss.

Medical

- Ambulance expenses
- Artificial limbs and prosthetics
- Reconstructive surgery (due to a congenital defect, accident, or medical treatment, including mastectomy)
- Coinsurance, copays, and deductibles
- Dietary supplements when prescribed by a physician to treat a specific medical condition
- Hearing aids and batteries
- Smoking cessation programs

Dental

- Coinsurance, copays, and deductibles
- Dental treatment, included but not limited to:
  - X-rays
  - Fillings
  - Ex Extractions
  - Dentures and denture adhesives
- Fluoridation device or services
- Occlusal guards to prevent teeth grinding
- Toothache and teething pain relievers when prescribed by a physician
- Orthodontia (unless the care is for cosmetic procedures)

Vision

- Eye exams
- Contact lenses care
- Vision correction procedures
  - Laser eye surgery
  - Lasik
  - Radial keratotomy
- Prescription eyeglasses, prescription sunglasses, and contact lenses

Medications/Prescriptions

- Acne medications when prescribed by a physician
• Allergy medicine when prescribed by a physician
• Prescription drugs unless otherwise identified as not covered
• Glucosamine/Chondroitin when prescribed by a physician
• Hormone replacement therapy when prescribed by a physician
• Insulin
• Over the counter medications with a prescription and prescribed by a physician to treat a medical condition
• Smoking cessation medicines when prescribed by a physician
  o Nicotine patches
  o Nicotine gums

Medical Supplies
• Air purifier/humidifier (if prescribed by a physician for a specific medical condition)
• Bandages, elastic, band aids
• Blood pressure monitoring devices
• Breast pumps and lactation supplies
• Diabetic supplies:
  o Blood sugar test kit and test strips
  o Glucose monitoring equipment
  o Insulin
• Carpal tunnel wrist supports
• Cold/hot packs (if sold as medical supplies)
• Crutches (whether purchased or rented)
• First aid kits
• Hearing aids and batteries
• Orthopedic shoes (custom made), only if used to treat a specific medical condition
• Orthopedic inserts or lift
• Oxygen
• Thermometers
• Walker
• Wheelchairs

Pregnancy/Fertility
• Medical expenses incurred before adoption is finalized if child is a Section 152 IRS code tax dependent at the time expenses are incurred
• Contraceptives
  o Condoms
  o Spermicidal foams (when prescribed by a physician)
  o Norplant insertion or removal
Egg donor fees

- Fertility treatments
  - IVF (In vitro fertilization) will qualify to the extent procedures are performed on the participant, spouse or another individual whose expenses are eligible for tax-free reimbursement
  - Temporary storage of eggs or sperm
  - Reversal surgery
  - Shots
  - Treatments
  - GIFT (gamete intrafallopian transfer)

- Infertility treatments
- Pregnancy testing kit
- Ovulation monitor
- Prenatal vitamins (if taken during pregnancy)

Treatment/Therapy

- Acupuncture (to treat a medical condition)
- Alcoholism and drug addiction treatment
- Allergy treatments (when prescribed by a physician)
- Chelation (EDTA) therapy (if used to treat a medical condition such as lead poisoning)
- Chiropractors
- Christian Science Practitioners fees (for medical care)
- Smoking cessation programs

Miscellaneous

- Adoption, pre-adoption medical expenses incurred before an adoption is finalized if the child qualifies as your tax dependent when the services/items are provided
- Automobile modifications for physically handicapped persons (when prescribed by a physician)
- Braille books and magazines (for visually impaired person)
- Guide dog or animal aide (including purchase, training, and care of animals used by vision impaired or hearing impaired person).
- Lodging not at a hospital or similar institution, up to $50 per night and the following conditions are met:
  - Lodging is primarily for and essential to medical care
  - Medical care is provided by a physician in a licensed hospital or medical care facility related to (or equivalent to) a licensed hospital
  - Lodging isn’t lavish or extravagant
  - No significant element of personal pleasure, recreation, or vacation in the travel
- Lodging of a companion if accompanying patient for medical reasons, up to $50 per night (if patient is a child, up to $100 per night, $50 per person) and the above four conditions are satisfied.
• Medical alert bracelet or necklace (if recommended by a medical practitioner in connection with treating a medical condition)
• Medical record charges
• Nursing services (including nurse’s board, wages, or other nursing services)
• Shipping and handling fees incurred to obtain an item that constitutes medical care
• Taxes on medical services and products including local, sales, service, and other taxes
• Telephone for hearing-impaired person (purchase and repair)
• Television for hearing-impaired person. Amount that qualifies is limited to the excess of the cost over the cost of the regular model
• Travel expense (amounts paid for transportation primarily for and essential to medical care based on IRS guidelines)
• Weight loss programs/drugs (must be prescribed by a physician to treat a specific medical condition; i.e., heart disease, obesity, diabetes, etc.)
INELIGIBLE EXPENSES

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

**Medical**
- Cosmetic expense (any service deemed not to be medically necessary to improve function)

**Dental**
- Toothpaste, toothbrushes (whether or not prescribed or recommended by a dentist)
- Dental floss
- Teeth whitening/bleaching
- Veneers
- Discounts given by the dental provider
- On-line invisible aligners

**Vision**
- Non-prescription sunglasses
- Clip-on sunglasses
- Warranties

**Medications/Prescriptions**
- Controlled substances in violation of federal law (e.g. medical marijuana)
- Over-the-counter medications unless prescribed by a Physician or is insulin
Cosmetic
- Appearance improvements
- Botox treatment
- Collagen injections
- Electrolysis or hair removal
- Hair transplants
- Face lifts
- Tanning salons and equipment
- Cosmetic and toiletries:
  - Face creams or other skin moisturizers (including hand lotion)
  - Perfume or cologne
  - Lipsticks
  - Chapstick or lip balm
  - Fingernail polish or remover
  - Eye and facial makeup or remover
  - Shampoos and soaps
  - Shaving cream
  - Permanent waves
  - Hair colorants
  - Ear piercing
  - Deodorants
  - Tissues
  - Feminine hygiene products
  - Mouthwash

Pregnancy/Fertility
- Childbirth classes
- Diapers or diaper services (unless used to receive the effects of a diagnosed medical condition)
- Maternity clothes
- Surrogate expenses

Treatment/Therapy
- Dancing lessons
- Swimming lessons
- Marriage counseling
- Massage therapy (unless prescribed by physician to treat a specific injury or trauma)
- Applied Behavioral Analysis or similar interventions
Miscellaneous

- Adoption fees and other non-medical expenses
- Health club dues and fees
- Insurance or COBRA premiums
- Diet foods
- Exercise equipment or programs
- Funeral expenses
- Non-orthopedic or Orthotic Shoes
- Pre-payments for goods or services that have not yet been provided
- Expense for services or products in a prior or future Plan year
- Duplicate prescription drugs, services, or supplies
- Nursing services for a baby

These lists of examples are not intended to be comprehensive. If you have questions about whether an expense is reimbursable, call Mayo Clinic Health Solutions at the number listed in the Contact Information Section.
CLAIM PAYMENT AND APPEAL PROCEDURES

Because the Health Care Flexible Spending Account will not reimburse any expense covered under the Mayo Medical Plan, Mayo Dental Plan, under any group or individual insurance policy, or under any other plan or program (private or governmental), you must first submit your claim to all other plans, policies, or programs before requesting reimbursement under this Plan.

If you have a reimbursement account under the Mayo Dental Plan, that account must be exhausted or the expense must be denied as ineligible under that Plan before you may be reimbursed from your account in this Plan.

**IMPORTANT NOTE**

Oral inquiries about coverage and benefits are not considered claims or appeals. Any claim or appeal must be in writing.

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

If you complete the appropriate form (available from the Claim Administrator), an authorized representative can file claims and appeals on your behalf.

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

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

All claims in the Plan are handled under these standard claim procedure.

Filing an Initial Claim

Time for Filing a Claim

Your claim must be received by the Claim Administrator no later than March 31 following the year in which the expenses were incurred. You will lose any funds over $500, remaining in your Health Care Flexible Spending Account, after all your claims received by the Claims Administrator through March 31, are processed.

Filing a Claim

You must submit a claim through the online portal, mobile app or by submitting a paper Health Care Flexible Spending Account claim form, which is available from Mayo Clinic Health Solutions or on the Mayo intranet. You may also obtain a claim form by calling the Claim Administrator. The claim form must include the six-digit Mayo Employee ID Number to be processed, or it will be returned to you. You must attach to the claim certain information for each item you want reimbursed. The information should include a detailed original itemized statement from your provider that shows:

- Name and address of the provider
- Name, address, and date of birth of person receiving the service or supply
- Date of service
- Detailed description of care, service, or item received
- Amount of the charges
- Explanation of Benefits if insurance covered a portion of the expenses

For pharmacy claims, you may use the “Medication History” printout from Mayo Clinic Health Solutions Services as adequate substantiation.

Special Rules for Filing Orthodontia Claims

If you are using this account to reimburse expenses for orthodontia treatment, an itemized statement and/or a copy of your treatment outlining the treatment plan must accompany your claim. Pursuant to the guidelines for orthodontia services only, you may request and receive reimbursement for orthodontia related services where payment is made in advance of all of the services under the treatment plan even if the treatment is incurred over more than one calendar year under the treatment plan. These orthodontia services are deemed to be incurred at the time of the advance payment.
Claim Decision

The Claims Administrator has 30 days to decide your claim and to notify you if your 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. 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.

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 Claim 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 that information will not count against the time the Claim Administrator has to make its decision.

Claim Payment

Your reimbursement of pre-tax Health Care Flexible Spending monies will be provided to you (not to your provider) through direct deposit or a check mailed to your home. You may set up direct deposit on the online portal at MayoClinicHealthSolution.com or by calling Mayo Clinic Health Solutions.
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 of First Level Appeal

Your written appeal must be submitted to the Claim Administrator and must 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 or 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
- Supporting documentation

Notification of Appeal Decisions

The Claims Administrator has 30 days to make a decision and notify you. For adverse benefit determinations, the notification will include the following:

- The specific reason(s) for the adverse benefit determination;
- Reference to the specific Plan provision(s) on which the determination is based;
- A statement indicating entitlement to receive, upon request, and free of charge, reasonable access to or copies of all documents, records and other information relevant to the claimant’s claim for benefits; and
- A statement regarding additional levels of appeal (if any) and the right to sue in federal court;
- Disclosure of any internal rule, guideline, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request);
- If the decision involves scientific or clinical judgment, an explanation of the scientific or clinical judgment applying the terms of the Plan to the claimant’s medical circumstances, or a statement that such explanation will be provided free of charge upon request.

For decisions that are not adverse, a notice will be provided that informs the claimant the decision has been reversed, and the claim has been approved.
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

If there is an adverse benefit determination by the Claims Administrator on the first level of appeal, the claimant may request a second level appeal with the Plan Administrator. A second level appeal request must be in writing and submitted to:

Mayo Clinic Health Solutions
4001 41st Street NW
Rochester, MN  55901-8901
Attn:  Member Appeals Unit

A second level appeal must include the following information:

- The name of the Plan
- The identity of the claimant, including name, address, and date of birth
- Information regarding the appeal being appealed, such as a copy of the appeal denial letter
- A statement that the claimant is requesting a second appeal
- An explanation of why a second appeal is being requested, including the particular aspect of the adverse benefit determination appeal is being disputed
- Supporting documentation

A second level appeal of an adverse benefit determination must be submitted to the Plan within 60 days following receipt of a notification of an adverse benefit determination at the first level of appeal. If a second level appeal is not requested within these 60 days, the claimant loses the right to appeal.

Appeal Decision

The Plan Review Committee has 30 days to make a decision and to notify you of that decision. If the appeal is denied, the notice will contain the information described under Filing First Level Appeal (Standard Claims Process).

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 APPLICABLE TO ALL CLAIMS PROCEDURES

Authority

Mayo Clinic is the Plan Administrator of the Plan and has delegated the authority to decide benefit claims and appeals as described in these claim procedures. The Plan Review Committee (or HRAS or Mayo Clinic Health Solutions for the accelerated process) 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 Claim 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 Limits for Commencing Legal Action

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

Exhaustion of Administrative Remedies

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

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

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

Assignment Prohibited

You may not pledge or assign your benefits under the Plan to anyone else. You cannot assign your benefits to any provider of health care services.

No Guarantee of Employment

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

Non-Discrimination Policy

The Plan will not discriminate against you or your eligible dependents based on race, color, religion, national origin, disability, sex, or age. The Plan will not establish rules for eligibility based on health status, medical condition, and claims experience, receipt of health care, medical history, evidence of insurability, genetic information, or disability.

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 benefits or eligibility to participate.
Plan Provisions Binding

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

Section Titles

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

Powers and Duties of the Plan Administrator

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

(a) The discretion to determine all factual and legal questions relating to the eligibility of individuals to participate or for you to remain a participant in the Plan and to receive benefits under the Plan. With respect to claims for benefits, the Plan Administrator has delegated authority and discretion as stated in the “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 the proper administration of the Plan as a condition of eligibility for you or eligible dependents to participate under the Plan and to 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. Discretionary authority with respect to claims and appeals is described at page 36.

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

(e) To interpret the provisions of the Plan and make and publish such rules and procedures for regulation of the Plan and to prescribe such forms as the Plan Administrator will deem necessary.

Records

The Plan Sponsor, Plan Administrator, Claim 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 Medical Information

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

Allocation of Responsibilities

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

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

Amendment and Termination of Plan

Mayo Clinic reserves the right to amend or terminate the Plan or any benefit option described in any document for the Plan including this document at any time, for any reason, and in any respect. Mayo Clinic’s right to amend or terminate the Plan or benefit options includes, but is not limited to, changes in the eligibility requirements, employee and employer contributions, 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.
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). The Pre-Tax Premium Rules are not subject to ERISA. ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine without charge at the Plan Administrator’s office and at other specified locations such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the 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, and 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 Health Plan Coverage

Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents 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 Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee 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 and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you 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 this was done, 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 a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. After you exhaust the Plan’s claim 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 these costs and fees; for example, if it finds your claim is frivolous.

**Assistance with Your Questions**

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration. Live assistance is available Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern Time by calling 1-866-4-USA-DOL (1-866-487-2365), or TTY 1-877-889-5627.
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


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）。


አማርኛ: የሚስታወሻት ያለም ከማስታወሻ ከምስመር ከርጉም ይታወቃል፡ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 507-266-0440 (ስተቀቋም ይታወቃል፡ 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。


## PLAN ADMINISTRATIVE INFORMATION

| **Plan Sponsor, Plan Administrator** | Mayo Clinic  
200 First Street SW  
Rochester, MN  55905  
(507) 266-0440 |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan Sponsor EIN</strong></td>
<td>41-6011702</td>
</tr>
</tbody>
</table>
| **Named Fiduciary** | Salary & Benefits Committee  
Mayo Clinic  
200 First Street SW  
Rochester, MN  55905  
(507) 266-0440  
The Plan Administrator may also be served with process |
| **Agent for Service of Legal Process** | Mayo Clinic  
c/o William A. Brown, Assistant Treasurer  
200 First Street SW  
Rochester, MN  55905  
(507) 266-0440 |
<p>| <strong>Plan Year</strong> | January 1 - December 31 |
| <strong>Collectively Bargained Groups</strong> | The Plans are maintained in part pursuant to one or more collective bargaining agreements. A copy of any such agreements may be obtained by you upon written request to the Plan Administrator and is available for examination. |</p>
<table>
<thead>
<tr>
<th><strong>Type of Plan</strong></th>
<th>The health care reimbursement program is a general purpose flexible spending account governed by ERISA.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan Number</strong></td>
<td>521</td>
</tr>
<tr>
<td><strong>Type of Administration</strong></td>
<td>Contract Administration</td>
</tr>
<tr>
<td><strong>Sources of Contributions for the Health Care Flexible Spending Account</strong></td>
<td>This Plan is funded with employee contributions and all benefits are paid from the general assets of Mayo Clinic</td>
</tr>
</tbody>
</table>
| **Claim Administrator** | Mayo Clinic Health Solutions  
PO Box 211698  
Eagan, MN 55121  
1-800-635-6671 (toll free)  
507-266-5580 (local) |
| **Components of Mayo Flexible Spending Account Plan Document** | Dependent Care Flexible Spending Account  
Health Care Flexible Spending Account  
Pre-Tax Health Savings Account  
HIPAA Privacy Rules |
<table>
<thead>
<tr>
<th>Employers Participating in Mayo Flexible Spending Account Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charterhouse</td>
</tr>
<tr>
<td>Franklin Heating Station</td>
</tr>
<tr>
<td>Gold Cross Ambulance Service</td>
</tr>
<tr>
<td>Herman House LLC</td>
</tr>
<tr>
<td>Mayo Clinic</td>
</tr>
<tr>
<td>Mayo Clinic Arizona</td>
</tr>
<tr>
<td>Mayo Clinic Florida (a non-profit corporation)</td>
</tr>
<tr>
<td>Mayo Clinic Health System-Decorah Clinic Physicians</td>
</tr>
<tr>
<td>Mayo Clinic Health System-Fairmont</td>
</tr>
<tr>
<td>Mayo Clinic Health System-Franciscan Medical Center, Inc.</td>
</tr>
<tr>
<td>Mayo Clinic Health System-Lake City Medical Center</td>
</tr>
<tr>
<td>Mayo Clinic Health System-Northwest Wisconsin Region, Inc.</td>
</tr>
<tr>
<td>Mayo Clinic Health System-Pharmacy &amp; Home Medical, Inc.</td>
</tr>
<tr>
<td>Mayo Clinic Health System-Southeast Minnesota Region</td>
</tr>
<tr>
<td>Mayo Clinic Health System-Southwest Minnesota Region</td>
</tr>
<tr>
<td>Mayo Clinic Health System-St. James</td>
</tr>
<tr>
<td>Mayo Clinic Hospital-Rochester</td>
</tr>
<tr>
<td>Mayo Clinic Jacksonville (a non-profit corporation)</td>
</tr>
<tr>
<td>Mayo Collaborative Services, LLC</td>
</tr>
<tr>
<td>Mayo Foundation for Medical</td>
</tr>
<tr>
<td>Education and Research</td>
</tr>
<tr>
<td>------------------------</td>
</tr>
<tr>
<td>Rochester Airport Company</td>
</tr>
</tbody>
</table>
GLOSSARY

After-Tax Dollars
Contribution deducted from an employee’s compensation after taxes have been taken.

Charges
The actual billed cost of services rendered.

Claim Administrator
The Claim Administrator’s responsibilities typically consist of initially determining the validity of claims and administering benefit payments under the Plan.

COBRA
The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time.

Coinsurance
Your share of what you must pay for certain covered health care services after applicable deductibles have been paid and until the annual out-of-pocket maximum has been reached. Coinsurance is based on the initial charge after applicable contractual adjustments are made at in-network providers. Covered services subject to coinsurance and the amounts are listed in the Schedule of Benefits section. Coinsurance is a percentage of the allowed amount. The coinsurance may differ based on whether the provider is in-network or out-of-network. In some instances, you will be responsible at the time and place of service to pay any coinsurance directly to the health care provider. In other instances, you will be billed by the health care provider. These arrangements are between you and the health care provider.

Coinsurance is calculated based on the initial allowed amount for prescription drugs and does not include rebates or discounts that Mayo Clinic receives.

Copayment
A fixed amount (for example, $25) you must pay for a certain covered service, usually when you receive the service. The amount may vary by the type of covered health care service. In some instances, you will be responsible at the time and place of service to pay any copayment directly to the health care provider. In other instances, you will be billed by the health care provider. These arrangements are between you and the health care provider. Covered services subject to a copayment and the amounts are listed in the Schedule of Benefits section. Copayments do not count toward the deductible.

Covered Person
An eligible employee and his dependents 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.

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’s coverage year is January 1 through December 31.

Deductible
The aggregate amount for certain covered services that are your responsibility each coverage year before the Plan begins to pay for covered services. Copayments, prior authorization penalties, and charges in excess of usual and customary rates for out-of-network services do not count toward the deductible.

Dependent
Your dependent as defined under Code § 152. This includes any relative (e.g., children, stepchildren, parents, siblings, grandchildren) for whom you provide over half the support or any person who resides with you and for whom you provide over half their support. The term dependent does not include an individual who is not a U.S. citizen or national, unless the individual is a resident of the U.S. or a country contiguous to the United States.

Disposable Supplies
Medical supplies that are medically necessary for a specific therapeutic purpose in treating an illness or injury and that are designed for one use only.

Durable Medical Equipment
Standard model medical equipment and/or supplies which are medically necessary, prescribed by a health care provider for a specific therapeutic purpose in treating an illness or injury, and designed to be used repeatedly, generally over extended periods of time.
Eligible Employee
The employee eligible for coverage under the Plan. This may also include a former employee who is otherwise entitled to coverage and properly enrolled under any of the Plan options under COBRA.

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

- Any individual who is a temporary employee
- Any individual who is a supplemental or non-benefit eligible employee
- Any individual included within a unit of employees covered by a collective bargaining unit unless such agreement expressly provides for coverage of the employee under the Plan
- Any individual who is a nonresident alien and receives no earned income from the employer from sources within the United States
- Any individual who is a leased employee as defined in Section 414 (n) (2) of the Internal Revenue Code of 1986
- Any individual who performs services for the employer through, and is paid by, a third party (including but not limited to an employee leasing or staffing agency) even if such individual is subsequently determined to be a common law employee of the employer
- Any individual who performs services for the employer pursuant to a contract or agreement (whether verbal or written) which provides that such individual is an independent contractor or consultant, even if such individual is subsequently determined to be a common law 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
An expense is incurred when the service or the supply for which it is incurred is provided.

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

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

Advanced Practice Registered Nurse - Including a Clinical Nurse Specialist, Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife, and Nurse Practitioner.
Ambulatory Surgical Facility - a facility with an organized staff of Physicians that: Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis; and
- Provides treatment by or under the direct supervision of a Physician or other health care provider; and
- Does not provide inpatient accommodations; and
- Is not, other than incidentally, a facility used as an office or clinic for the private practice of a physician or dentist.
Chiropractor - a Doctor of Chiropractic (DC).
Dentist – a Doctor of Dental Surgery (DDS), Oral Pathologist, Oral Surgeon, or Doctor of Dental Medicine (DMD.).
Home Health Agency - an agency that provides home health care and that is Medicare certified and licensed or approved under state or local law.
Hospice - a Medicare certified organization or agency that primarily provides services for pain relief, symptoms management, and supportive services to terminally ill persons and their families.
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.

Licensed Practical Nurse (LPN).

Licensed Registered Dietitian

Occupational Therapist

Ophthalmologist- a Doctor of Ophthalmology

Optometrist – a Doctor of Optometry

Psychiatrist

Physical Therapist

Physician - a Doctor of Medicine (MD) or Doctor of Osteopathy (DO)

Physician Assistant - an individual licensed by the medical examining board to provide medical care with physician supervision and direction.

Podiatrist - a Doctor of Podiatry (DP), Doctor of Surgical Chiropody (DSC), Doctor of Podiatric Medicine (DPM), or Doctor of Surgical Podiatry (DSP).

Psychologist

Radiation Therapist

Registered Nurse (RN)

Respiratory Therapist

Skilled Nursing Facility - an institution or a distinct part of an institution providing skilled care and related services to persons on an inpatient basis.

Social Worker – an individual who is qualified through education, training, and experience to provide services in relation to the treatment of emotional disorders, psychiatric conditions, or substance abuse when employed by, or under the supervision of, an MD, DO, or PhD.

Speech Therapist

Urgent Care Facility – an ambulatory care facility or walk-in clinic with Urgent Care hours or walk-in clinic hours providing treatment for minor conditions.

Health care Services
The provision of all medical treatment, disposable supplies, durable medical equipment, or prosthetics as defined in Mayo Medical Plan.

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

Illness
A non-occupational sickness or disorder, including pregnancy and related conditions. The term “illness” does not include an illness with respect to which benefits are payable under any workers’ compensation, occupational disease, or similar law.

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.

Institutional Health care Provider
Health care providers including an ambulatory surgical facility, home health agency, hospice, hospital, skilled nursing facility, or urgent care facility.

Mayo Clinic Health Solutions
The Claims Administrator for the Plan retained by the Plan Administrator and Plan Sponsor. The actual responsibilities of Mayo Clinic Health Solutions are described in the contract between the Plan Administrator, Plan Sponsor, and Mayo Clinic Health Solutions.

Mayo Flexible Spending Account
The Mayo Flexible Spending Account Plan for the provision of pre-tax to you, as amended from time to time.
Medically Necessary/Medical Necessity
Health care services appropriate, in terms of type, frequency, level, setting, and duration, to your diagnosis or condition, and diagnostic testing and preventive services, that are not otherwise excluded under Mayo Medical Plan. Medically necessary care must:

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

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

Plan
The Mayo Health Care Flexible Spending Account, as amended from time to time, a component of the Mayo Flexible Spending Account Plan

Plan Administrator
The Plan Administrator is Mayo Clinic. The Plan Administrator retains ultimate authority for the Plan including final appeal determinations. The Plan Administrator is also the named fiduciary for purposes of ERISA and has delegated this authority to the Salary & Benefits Committee.

Plan Participant
An eligible employee who has elected to contribute to the Plan in accordance with the Plan Administrator’s rules and procedures. May be referred to as you/your.

Plan Sponsor
Mayo Clinic is the Plan Sponsor.

Professional Health Care Provider
Health care providers including an advanced practice Registered Nurse, Chiropractor, Dentist, Licensed Registered Dietitian, Occupational Therapist, Nurse Practitioner, Physician, Physician Assistant, Podiatrist, Radiation Therapist, Respiratory Therapist, and Speech Therapist.

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

Qualified Medical Child Support Order (QMSCO)
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.

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

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