HOW TO USE THIS DOCUMENT

The Table of Contents provides an overview of the detailed information in this Summary Plan Description. For a quick link, place your cursor on the page number and left click with your mouse — this action takes you to the details of the topic selected.

You will find a glossary of terms used in this document.

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

Mayo Clinic sponsors the Mayo Clinic Accidental Death & Dismemberment plan (the “Plan”), which has two components: Employer Paid Accidental Death and Dismemberment (“Employer Paid AD&D”) and Voluntary Accidental Death and Dismemberment Insurance Plan (“Voluntary AD&D”).

Effective January 1, 2018, this document sets forth a summary of the Plan benefits for eligible employees and serves as the Summary Plan Description (“SPD”). This SPD is intended to be easy to use and understand. It contains only highlights of the insurance policy (discussed below), which, together with the SPD, constitute the official plan document for the Plan.

The benefits are insured, meaning they are paid from an insurance policy or Group Contract, and any applicable documents (collectively, the “Policy”) issued to Mayo Clinic by the Insurance Company.

The benefits offered under the Plan are governed by the Policy. The terms of the Policy, not the SPD, are used by the Insurance Company to administer the Plan. The Plan is administered by, and all claims are decided by, the Insurance Company in its sole discretion, not by Mayo Clinic or any participating employer. If you have a dispute concerning the Insurance Company’s decision about the Plan, you must pursue that dispute with the Insurance Company, not Mayo Clinic; and Mayo Clinic will have no role in resolving the dispute. In the case of a conflict between this SPD and the Policy, the Policy will control. You should also not rely on oral descriptions of the Plan provisions, as the written terms of the Plan document will always govern. Mayo Clinic reserves the right to amend, modify, or terminate the Plan at any time and for any reason.

**Important Information For Residents Of Certain States:** There are state-specific requirements that may change the provisions under the Coverage(s) described in this Group Insurance Certificate. If you live in a state that has such requirements, those requirements will apply to your Coverage(s) and are made a part of your Group Insurance Certificate. Prudential has a website that describes these state-specific requirements. You may access the website at www.prudential.com/etonline. When you access the website, you will be asked to enter your state of residence and your Access Code. Your Access Code is 45200.

Please review this entire document so that you understand fully what your benefits and responsibilities are under the Plan. If you have questions, see the contact information in the next section.
CONTACT INFORMATION

For enrollment or general eligibility questions, please contact Mayo Clinic’s HR Connect. HR Connect is your human resources office for the Plan.

<table>
<thead>
<tr>
<th>General 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>507-266-0330 (TDD)</td>
</tr>
<tr>
<td>M – F, 5 a.m. to 6 p.m., Saturday/Sunday 5 a.m. to 9 a.m. CT</td>
</tr>
<tr>
<td>(excluding holidays)</td>
</tr>
</tbody>
</table>

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

El presente Resumen del Plan de Descripción, que también sirve como documento del plan, está redactado en inglés y ofrece detalles sobre sus derechos y beneficios. Si tiene alguna dificultad para entender cualquier parte de este documento, por favor comuníquese con el Centro para Servicios al Empleado a los números que constan abajo.

For questions about claims, see the sections on Claim Procedures and Claims Administration.
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</tbody>
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ELIGIBILITY AND PARTICIPATION

You are eligible for coverage under both components of the Plan (Employer Paid AD&D and Voluntary AD&D) if you are classified as (1) Consultant, (2) Voting Staff or (3) Allied Health Staff at either a Mayo Clinic or Mayo Clinic Health System location. (See Plan Information for list of participating employers).

In addition, if you are classified as a Mayo School of Graduate Medical Education Appointee, Mayo School of Health Sciences Resident or Fellow, or Research Appointee you are eligible for Voluntary AD&D only. To be eligible, you must be 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. Regularly scheduled means your schedule on file with your employer is 0.5 FTE or more. A 0.4 FTE working extra hours does not qualify as regularly scheduled to work 0.5 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.

Effective Date of Coverage

Employer Paid AD&D
There is no waiting period to receive Employer Paid AD&D coverage. Employer paid coverage will be effective automatically on the first day that you are actively at work.

Voluntary AD&D
If you enroll within the first 31 days of initial eligibility, your coverage will be effective on the first day you are eligible.

If you do not enroll within 31 days of initial eligibility, you may enroll anytime on or after the first day you are actively at work. Your coverage will be effective on the day your enrollment is received by HR Connect, provided you are actively at work on that day.

Evidence of Insurability
There is no evidence of insurability required.

Actively at Work Requirement
Actively at work means you are physically present to work 0.5 FTE or more at the employee’s regular worksite or at an alternative employer worksite at the request of the employer. If you are not actively at work on the day your coverage (or a change in coverage) is scheduled to begin, your coverage will not begin until the first day you begin or return to your employment.

You are considered actively at work during normal vacation if you are actively at work during your last normally scheduled work day.
Naming a Beneficiary
You have the right to choose a beneficiary for this coverage as long as the beneficiary is not Mayo Clinic, a Participating Employer or a subsidiary of Mayo Clinic that has adopted the Plan. If you choose more than one beneficiary, they will receive equal amounts of the benefit unless you request otherwise in writing.

You may change your beneficiary designation at any time by accessing the Employee Self-Service tool found on the HR Connect page by or you may call HR Connect at (507) 266-0440 or toll free at 1-888-266-0440.

In the event of your death, if there is no beneficiary designation on record, benefits will be paid in the following successive order: (a) surviving spouse, (b) surviving child(ren) in equal shares, (c) surviving parent(s) in equal shares, (d) surviving sibling(s) in equal shares, (e) your estate. This is also true if you name a beneficiary who dies before you and you do not choose a new beneficiary before your death. If you have more than one beneficiary and one of them dies before you, benefits will be divided among the remaining beneficiaries if you do not choose a new beneficiary before your death.

Personal, Disability, USERRA, FMLA or Parental Leaves of Absence
Your benefits continue in force based on the salary in effect at the beginning of your authorized employer-approved, personal, disability, USERRA, FMLA, or parental leave for the duration of the authorized leave. If the leave ends and you do not return to work, your coverage ends. You will be billed the appropriate premiums for any Voluntary AD&D coverage in which you are enrolled.

When Coverage Ends
Your coverage will end on the day on which the earliest of the following events occurs:

- The last day of your employment or the day you cease to be an eligible employee
- The day the employer terminates the Plan or its participation in these Plan
- The effective date of an amendment to the Plan causing you to lose coverage
- The last day of an authorized employer-approved, personal, disability, USERRA, FMLA, or parental leave if you do not return to work at the end of the leave
- The day before the first day of any leave other than an authorized employer-approved, personal, disability, USERRA, FMLA, or parental leave
- The date on which you are no longer actively at work unless you are on an authorized employer-approved personal, disability, USERRA, FMLA, or parental leave
- The date of your death
- The date you (for Voluntary AD&D) or Mayo Clinic fails to pay, when due, any premium required for your coverage

Cost of Coverage
Your employer pays the cost of the Employer Paid AD&D component of the Plan. You pay the cost of the Voluntary AD&D component of the Plan on an after-tax basis. Additional details are provided in the Plan Benefits section that follows.
PLAN BENEFITS

Employer Paid AD&D

The full value of your coverage under Employer Paid AD&D is equal to the amount of your annual salary, up to a maximum of $650,000 of annual salary unless you are eligible for and enrolled in the Group Variable Universal Life coverage under the Voluntary Group Term and Universal Life plan sponsored by Mayo Clinic (“Group Variable Universal Life”). If you are enrolled in Group Variable Universal Life, your Employer Paid AD&D coverage is equal to the amount of your annual salary up to a maximum of $1,750,000 of annual salary. Salaries not in even thousands are rounded to the next higher thousand for benefit purposes.

Voluntary AD&D

In addition to your Employer Paid AD&D coverage, you may purchase up to $225,000 in Voluntary AD&D coverage. Coverage must be purchased in multiples of $10,000 or $25,000.

If you enroll for Voluntary AD&D when you are first eligible but for less than the maximum amount, you must **wait one year before you may increase the coverage**. If you do not enroll when you are first eligible, you may enroll at any time for any level of coverage available. Any subsequent increases also are subject to a one-year waiting period. If coverage is revoked for any reason, you must wait at least one year before re-enrollment is allowed. You may enroll and increase coverage by contacting HR Connect. The effective date of the increase will be the date your enrollment is received by HR Connect. However, if you are not actively working on that day, the increase will be effective on the day you return to active work.

You may decrease or cancel coverage at any time by contacting HR Connect.

Benefits Payable in the Event of Death

In the event of your death from accidental bodily injury, the full value of your coverage under Employer Paid AD&D and any Voluntary AD&D coverage in which you are enrolled is paid to your beneficiary. Benefits are not payable if death results from any of the causes listed under **When Benefits Are Not Payable Under Employer Paid AD&D and Voluntary AD&D**.
**Benefits Payable for Loss or by Reason**

The amount payable depends on the type of Loss as shown below. All benefits are subject to the Limits below. If a limb or appendage is Surgically Replanted the amount payable will be 25% of the amount which would have been paid for a Loss of such limb or appendage. If the Surgical Replantation fails to provide you with adequate use of the limb or appendage, the Amount of Insurance for the Loss will be paid, less any amount paid for the Surgical Replantation. Surgical Replantation means the surgical reattachment of an arm, leg, hand, foot, finger, or toe that has been severed from your body.

<table>
<thead>
<tr>
<th>Loss of or by Reason of</th>
<th>Percent of Your Amount of Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td>100%</td>
</tr>
<tr>
<td>Sight of Both Eyes</td>
<td>100%</td>
</tr>
<tr>
<td>Speech and Hearing in Both Ears</td>
<td>100%</td>
</tr>
<tr>
<td>Both Hands</td>
<td>100%</td>
</tr>
<tr>
<td>Both Feet</td>
<td>100%</td>
</tr>
<tr>
<td>One Hand and One Foot</td>
<td>100%</td>
</tr>
<tr>
<td>One Hand and Sight of One Eye</td>
<td>100%</td>
</tr>
<tr>
<td>One Foot and Sight of One Eye</td>
<td>100%</td>
</tr>
<tr>
<td>Quadriplegia</td>
<td>100%</td>
</tr>
<tr>
<td>Triglegia</td>
<td>75%</td>
</tr>
<tr>
<td>One Arm</td>
<td>75%</td>
</tr>
<tr>
<td>One Leg</td>
<td>75%</td>
</tr>
<tr>
<td>Paraplegia</td>
<td>75%</td>
</tr>
<tr>
<td>Sight of One Eye</td>
<td>50%</td>
</tr>
<tr>
<td>Speech</td>
<td>50%</td>
</tr>
<tr>
<td>Hearing in Both Ears</td>
<td>50%</td>
</tr>
<tr>
<td>One Hand</td>
<td>50%</td>
</tr>
<tr>
<td>One Foot</td>
<td>50%</td>
</tr>
<tr>
<td>Hemiplegia</td>
<td>50%</td>
</tr>
<tr>
<td>Critical Burns covering 25% or more of the</td>
<td>50%</td>
</tr>
<tr>
<td>Uniplegia</td>
<td>25%</td>
</tr>
<tr>
<td>Thumb and Index Finger of the Same Hand (permanent loss)</td>
<td>25%</td>
</tr>
<tr>
<td>Four Fingers of the Same Hand (permanent</td>
<td>25%</td>
</tr>
<tr>
<td>Hearing in One Ear</td>
<td>25%</td>
</tr>
<tr>
<td>All Toes on One Foot (permanent loss)</td>
<td>25%</td>
</tr>
<tr>
<td>Big Toe (permanent loss)</td>
<td>13%</td>
</tr>
<tr>
<td>Coma</td>
<td>1% of the Principal Sum per month, less any other dismemberment benefits paid, up to 100 months after one month of continuous coma</td>
</tr>
</tbody>
</table>
Loss of sight, hearing, and speech means entire loss with no possibility of recovery. Loss of hands and feet means the loss by complete severance through or above the wrist or ankle. Loss of thumb and index finger means loss by actual severance through or above the metacarpophalangeal joints. Benefits are not payable for losses incurred as a result of any of the causes listed under When Benefits Are Not Payable Under Employer Paid AD&D and Voluntary AD&D.

To be eligible for coverage, the loss of life, sight, hearing, speech, limbs, or loss of use must occur within 365 days of the accidental injury. Any benefits unpaid at the time of your death are payable to your beneficiary.

Not all such Losses are covered. See When Benefits Are Not Payable Under Employer Paid AD&D and Voluntary AD&D.

Benefits Payable for More Than One Loss

No more than 100 percent of your coverage will be paid for more than one loss resulting from the same accidental injury.

Additional Benefits

Additional benefits may be payable from the Employer Paid AD&D and any Voluntary AD&D coverage in which you are enrolled. Please review a copy of the Prudential Certificate of Coverage for a list of additional benefits payable.

When Benefits Are Not Payable Under Employer Paid AD&D

Benefits under Employer Paid AD&D are not payable for losses resulting from the following:

- Suicide or attempted suicide, while sane or insane
- Sickness, whether the loss results directly or indirectly from the sickness
- Medical or surgical treatment of sickness, whether the loss results directly or indirectly from the treatment.
- Any bacterial or viral infection, but does not include:
  - a pyogenic infection resulting from an accidental cut or wound
  - a bacterial infection result from accidental ingestion of a contaminated substance.
- War or any act of war, except as provided by the War Risk Hazard Provision as defined below. “War” means declared or undeclared war and includes resistance to armed aggression. Terrorism is not considered an act of war.
  - Terrorism means the deliberate use of violence or the threat of violence against civilians to create an emotional response through the suffering of victims or to achieve military, political, religious or social objectives.
- Commitment of or attempt to commit a felony

When Benefits Are Not Payable Under Voluntary AD&D

Benefits under Voluntary AD&D are not payable for losses resulting from the following:
• Suicide or attempted suicide, while sane or insane
• Sickness, whether the loss results directly or indirectly from the sickness
• Medical or surgical treatment of sickness, whether the loss results directly or indirectly from the treatment.
• Any bacterial or viral infection, but does not include:
  o a pyogenic infection resulting from an accidental cut or wound
  o a bacterial infection result from accidental ingestion of a contaminated substance.
• War or any act of war, except as provided by the War Risk Hazard Provision as defined below. “War” means declared or undeclared war and includes resistance to armed aggression. Terrorism is not considered an act of war.
  Terrorism means the deliberate use of violence or the threat of violence against civilians to create an emotional response through the suffering of victims or to achieve military, political, religious or social objectives.
• Committment of or attempt to commit a felony
• Travel or flight in any vehicle used for aerial navigation, except as provided by any Hazard provision, if any of these apply
  o You are riding as a passenger in any aircraft not intended or licensed for the transportation of passengers.
  o You are performing as a pilot or a crew member of any aircraft.
  o You are riding as a passenger in an aircraft owned, operated, controlled or leased by or on behalf of the Mayo Clinic or any of its subsidiaries or affiliates.
    This includes getting in, out, on or off any such vehicle.
• Operation of a motor vehicle by a person while that person has a blood-alcohol level in excess of the state legal limit.
• Being under the influence of or taking non-prescription drug, medication, narcotic, stimulant, hallucinogen, barbiturate, amphetamine, gas, fumes or inhalants, poison, or any other substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless prescribed by and administered in accordance with the advice of the insured’s Doctor.

Hazard Provisions For Employer Paid and Voluntary AD&D
Benefits are payable when you are participating in, or practicing in any volunteer work that is performed for any recognized humanitarian agency, including church groups, such as, Doctors without Borders or the American Red Cross, while you are actively working for Mayo Clinic.

War Risk Hazard
During an *authorized business trip* for Mayo Clinic, you are traveling to a Designated War Risk Area. These locations include those areas listed *except* the United States of America and your permanent country of residence.

Coverage against Acts of War is provided if the Contract Holder provides Prudential with either: (1) the travel data being provided to the Insurance Company for business travel accident coverage; or (2) the number of authorized business trips to each of the countries listed below, at least annually in arrears.

<table>
<thead>
<tr>
<th>Algeria</th>
<th>Saudi Arabia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angola</td>
<td>Yemen</td>
</tr>
<tr>
<td>Afghanistan</td>
<td>Pakistan</td>
</tr>
<tr>
<td>Jammu &amp; Kashmir</td>
<td>Burundia</td>
</tr>
<tr>
<td>Israel</td>
<td>Dem. Republic of Congo</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>Somalia</td>
</tr>
<tr>
<td>Columbia</td>
<td>Egypt</td>
</tr>
<tr>
<td>Mali</td>
<td>Chechnya</td>
</tr>
<tr>
<td>Kuwait</td>
<td>Nigeria</td>
</tr>
<tr>
<td>Chad</td>
<td>Iraq</td>
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<td>Iran</td>
<td>Syria</td>
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<tr>
<td>North Korea</td>
<td>Cuba</td>
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<tr>
<td>Myanmar</td>
<td>Sudan</td>
</tr>
<tr>
<td>Lebanon</td>
<td>Venezuela</td>
</tr>
<tr>
<td></td>
<td>Ukraine</td>
</tr>
</tbody>
</table>
Specified Aircraft Hazard:

During an *authorized business trip* for your Employer, you are: boarding; leaving; riding as a passenger or crew member in; or struck by a Specified Aircraft.

Specified Aircraft means any of the aircraft described below which is owned, operated, controlled or leased by or on behalf of Mayo Clinic or any of its subsidiaries or affiliates or its customers, if such aircraft is: (a) Certified (as defined in the Policy); and (b) operated by a pilot who has a Certificate of Competency (as defined in the Policy) and who has logged the applicable minimum number of hours of flying time in aircraft of similar design. But the term does not include any aircraft used for: (a) firefighting; (b) exploration; (c) pipe or powering work; or (d) aerial photography.

<table>
<thead>
<tr>
<th>Aircraft Model Type</th>
<th>FAA Tail Number</th>
<th>Crew Seats</th>
<th>Passenger Seats</th>
</tr>
</thead>
<tbody>
<tr>
<td>Messerschmitt BK 117</td>
<td>N 217MC</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Eurocopter EC 145</td>
<td>N145 MC</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Eurocopter EC 145</td>
<td>N 145 EC</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Eurocopter EC 145</td>
<td>N145SM</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

An *authorized business trip* is defined as follows:

- A bona fide trip during which you are on assignment or at the direction of Mayo Clinic to conduct business for the Mayo Clinic,
  - Beginning when you leave your residence or place of employment, whichever occurs last, for the purpose of beginning the Business Trip, and
  - Ending when you return to your residence or the place of regular employment, whichever occurs first.

- Commuting between your residence and place of regular employment by automobile or other conveyance on a regularly scheduled workday if you are using a mode of transportation you don’t normally use, because a strike, power failure, major breakdown, or similar event results in the interruption of one or more public transportation systems that you regularly use.

- During a sojourn or personal deviation from a business trip not exceeding seven days in length. For example, while on a business trip you may wish to extend
COST OF COVERAGE

Employer Paid AD&D
Your employer pays the full cost of Employer Paid AD&D coverage. There is no cost to you.

Voluntary AD&D
You pay the full cost of any coverage you enroll in for Voluntary AD&D on an after-tax basis. The monthly cost is $0.15 per $10,000 of coverage. The premiums are set by the Insurance Company. In general, they are determined by the number of people in the Plan and the amount paid in benefit claims in the preceding Plan year.

An Example
Assume you enrolled for $200,000 of Voluntary AD&D coverage. Your monthly contribution would be calculated by first dividing $200,000 by $10,000 ($200,000 ÷ $10,000), which is 20. Then 20 is multiplied by the monthly cost per $10,000 of coverage, which is $0.15. The monthly cost for $200,000 of coverage in Voluntary AD&D is $3.00 ($0.15 x 20).
COVERAGE WHILE DISABLED

Your coverage under the Employer Paid AD&D and any Voluntary AD&D in which you enroll will continue while you are on approved disability under a Mayo sponsored disability plan. Your coverage will end if your disability ends and you do not return to work for a participating employer.

Cost of Coverage for Employer Paid AD&D during Disability

During approved disability, the employer will continue to pay the cost of Employer Paid AD&D.

Cost of Coverage for Voluntary AD&D during Disability

During approved disability, to continue your coverage under Voluntary AD&D you must continue to pay the premiums for any Voluntary AD&D insurance in which you are enrolled. You will be billed for the cost of coverage or it will be deducted from your disability payment. Your coverage will end if you fail to make a timely payment.
OTHER INFORMATION ABOUT THE PLAN

Conversion to an Individual Policy
There is no option to convert Employer Paid AD&D or Voluntary AD&D coverage to an individual policy.

Continuation of Coverage
There is no option to continue coverage under Employer Paid AD&D or Voluntary AD&D.
How to Receive Benefits

In the event of a covered loss including death HR Connect should be contacted as soon as possible. They can provide assistance in filing a claim for benefits.

Determination of Benefits

The Insurance Company shall notify you of the claim determination within 45 days of the receipt of your claim. This period may be extended by 30 days if such an extension is necessary due to matters beyond the control of the Plan. A written notice of the extension, the reason for the extension, and the date by which the Plan expects to decide your claim shall be furnished to you within the initial 45-day period. This period may be extended for an additional 30 days beyond the original 30-day extension if necessary due to matters beyond the control of the Plan. A written notice of the additional extension, the reason for the additional extension, and the date by which the Plan expects to decide on your claim shall be furnished to you within the first 30-day extension period if an additional extension of time is needed. However, if a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination by the Insurance Company will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If your claim for benefits is denied, in whole or in part, you or your authorized representative will receive a written notice from the Insurance Company. The notice will be written in a manner calculated to be understood by you and shall include:

- The specific reason(s) for the denial
- References to the specific Plan provisions on which the benefit determination was based
- A description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary
- A description of the Insurance Company’s appeal procedure and applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA following your appeals
- If an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request
Appeals of Adverse Determination

If your claim for benefits is denied, you or your representative may appeal your denied claim in writing to the Insurance Company within 180 days of receipt of the written notice of denial. Your appeal should describe the decision you are appealing and state the reasons why you think the decision on your claim was incorrect. You may submit with your appeal any written comments, documents, records, and other information relating to your claim. Upon your request, you will have access to, and the right to obtain copies of, all documents, records, and information relevant to your claim free of charge.

A full review of the information in the claim file and any new information submitted to support the appeal will be conducted by the Insurance Company utilizing individuals not involved in the initial benefit determination. This review will not afford any deference to the initial benefit determination.

The Insurance Company shall make a determination on your claim appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if the Insurance Company determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension, and the date that the Insurance Company expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If the claim on appeal is denied in whole or in part, you will receive a written notification from the Insurance Company of the denial. The notice will be written in a manner calculated to be understood by the applicant and shall include:

- The specific reason(s) for the adverse determination
- References to the specific plan provisions on which the determination was based
- A statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents, and other information relevant to your benefit claim upon request
- A description of the Insurance Company’s review procedures and applicable time limits
- A statement that you have the right to obtain upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination
- A statement describing any appeals procedures offered by the Plan, and your right to bring a civil suit under ERISA

If the appeal of your benefit claim is denied, you or your representative may make a second voluntary appeal of your denial in writing to the Insurance Company within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. You may submit with your second appeal any written comments, documents, records, and other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records, and information relevant to your claim free of charge.
The Insurance Company shall make a determination on your second claim appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if the Insurance Company determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension, and the date by which the Insurance Company expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

Your decision to submit a benefit dispute to the voluntary second level of appeal has no effect on your right to any other benefits under this Plan. If you elect to initiate a lawsuit without submitting to a second level of appeal, the Plan waives any right to assert that you failed to exhaust administrative remedies. If you elect to submit the dispute to the second level of appeal, the Plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that the appeal is pending.

If the claim on appeal is denied in whole or in part for a second time, you will receive a written notification from the Insurance Company of the denial. The notice will be written in a manner calculated to be understood by the applicant and shall include the same information that was included in the first adverse determination letter. If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

**Claim Rules**

These rules apply to payment of benefits under all components of the Plan.

**Proof of Loss**

Prudential must be given written proof of the loss for which claim is made under the Plan. This proof must cover the occurrence, character and extent of that loss. It must be furnished within 90 days after the date of the loss. But, if any benefit under the Plan provides for periodic payment of benefits at monthly or shorter intervals, the proof of loss for each such period must be furnished within 90 days after its end.

A claim will not be considered valid unless the proof is furnished within these time limits. However, it may not be reasonably possible to do so. In that case, the claim will still be considered valid if the proof is furnished as soon as reasonably possible, but not later than one year after the time proof is otherwise required, except in the absence of legal capacity.

**When Benefits are Paid**

Benefits are paid when Prudential receives written proof of the loss. But, if the Policy provides that benefits are payable at equal intervals of a month or less, Prudential will not have to pay those benefits more often.

**Physical Exam and Autopsy**

Prudential, at its own expense, has the right to examine the person whose loss is the basis of claim. Prudential may do this when and as often as is reasonable while the claim is pending. Prudential also has the right to arrange for an autopsy in case of accidental death, if it is not forbidden by law.
Legal Action

No action at law or in equity shall be brought as a claim for benefits under the Plan until 60 days after the written proof described above is furnished. No such action shall be brought more than three years after the end of the time within which proof of loss is required.
CLAIMS ADMINISTRATION

Claim Administrators and contacts for the claims/appeals process:

The Prudential Insurance Company of America
Life Claims Management
P.O. Box 8517
Philadelphia, PA 19176

Overnight Mail to:
2101 Welsh Road
Dresher, PA 19025

Phone: (844) 656-MAYO (6296)
Fax: (888) 227-6764

and

Trustmark Insurance Company
400 Field Drive
Lake Forest, IL 60045

Phone: (847) 615-1300
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:

- 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 “Claims Administration.”

- 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 family members to participate under the Plan and to receive any benefits under the Plan.

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

- To maintain or delegate to others the duty of maintaining necessary records for the administration of the Plan.

- To interpret the provisions of the Plan, make and publish such rules and procedures for regulation of the Plan, and prescribe such forms as the Plan Administrator will deem necessary.

Records

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

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.

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 eligibility requirements, employer contributions, benefits provided, and termination of all or a portion of any coverage provided under the Plan. If the Plan or any benefit option is amended or terminated, you will be subject to all the changes effective as a result of such amendment or termination, and your rights will be reduced, terminated, altered, or increased accordingly as of the effective date of the amendment or termination. You do not have ongoing rights to any plan or program benefit other than payment of benefits to which you are entitled prior to the Plan amendment or
termination. You do not have rights to vested benefits in the Plan. The rights with respect to amendment and termination of the Plan have been delegated to the Salary and Benefits Committee.
STATEMENT OF ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all participants shall be entitled to:

**Receive Information About the Plan and Benefits**

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

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.

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

**Prudent Actions by Plan Fiduciaries**

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefits plans. The people who operate the Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in your interest, and that of other plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.
Enforce Your Rights

If your claim for a benefit is denied in whole or in part, you have a right to know why, to obtain copies of documents relating to the decisions without charge, and to appeal any denial, all within certain time schedules. See the Claim Procedure section for more information.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal Court after you have exhausted the Plan claim procedure. If it should happen that Plan fiduciaries misuse Plan money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.

Assistance with Your Questions

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

<table>
<thead>
<tr>
<th><strong>Plan Name</strong></th>
<th>Mayo Clinic Accidental Death &amp; Dismemberment</th>
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| **Plan Sponsor and Plan Administrator** | Mayo Clinic  
200 First Street SW  
Rochester, MN 55905  
(507) 266-0440 |
| **Plan Sponsor EIN**   | 41-6011702                                  |
| **Named Fiduciaries**  | Salary and Benefits Committee  
Mayo Clinic  
200 First Street SW  
Rochester, MN 55905  
The Prudential Insurance Company of America  
(named claim fiduciary)  
751 Broad Street  
Newark, NJ 07102  
Trustmark Insurance Company  
400 Field Drive  
Lake Forest, IL 60045 |
| **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  
*The Plan Administrator may also be served with process.* |
<p>| <strong>Plan Year</strong>          | January 1 - December 31                     |</p>
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<tr>
<th><strong>Type of Plan</strong></th>
<th>Accidental Death and Dismemberment</th>
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<tbody>
<tr>
<td><strong>Plan Number</strong></td>
<td>508</td>
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<tr>
<td><strong>Type of Administration</strong></td>
<td>The Plan is insured and administered by The Prudential Insurance Company of America and Trustmark Insurance Company. Address all claim correspondence to Prudential at: The Prudential Insurance Company of America Life Claims Management P.O. Box 8517 Philadelphia, PA 19176 Overnight Mail to: 2101 Welsh Road Dresher, PA 19025 Phone: (844) 656-MAYO (6296) Fax: (800) 778-4797 Address all claims correspondence to Trustmark at: Trustmark Insurance Company 400 Field Drive Lake Forest, IL 60045 Phone (847) 615-1300</td>
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<tr>
<td>Participating Employers</td>
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<tr>
<td>Charterhouse</td>
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<td>Franklin Heating Station</td>
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<td>Gold Cross Ambulance Service</td>
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<td>Herman House LLC</td>
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<td>Mayo Clinic</td>
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<td>Mayo Clinic Arizona</td>
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<td>Mayo Clinic Florida (a non-profit corporation)</td>
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<td>Mayo Clinic Health System – Decorah Clinic Physicians</td>
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<td>Mayo Clinic Health System – Fairmont</td>
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<td>Mayo Clinic Health System – Franciscan Medical Center, Inc.</td>
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<td>Mayo Clinic Health System – Lake City Medical Center</td>
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<td>Mayo Clinic Health System – Northwest Wisconsin Region, Inc.</td>
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<td>Mayo Clinic Health System – Pharmacy &amp; Home Medical, Inc.</td>
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<td>Mayo Clinic Health System – Southeast Minnesota Region</td>
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<td>Mayo Clinic Health System – St. James</td>
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<td>Mayo Clinic Hospital – Rochester</td>
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<td>Mayo Clinic Jacksonville (a non-profit corporation)</td>
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<td>Mayo Collaborative Services, LLC</td>
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<td>Mayo Foundation for Medical Education and Research</td>
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<tr>
<td>Rochester Airport Company</td>
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GLOSSARY

Annual Salary
Your basic salary — does not include bonuses, commissions, overtime pay, shift pay, or other extra compensation. If you receive a draw (because of production-based compensation), your base salary will be your draw for the year in which your death or dismemberment occurs.

Beneficiary
The person or persons (including a trust) that you designate who will receive your life insurance benefits in the event of your death. You may designate more than one beneficiary. You can update your beneficiary by accessing the Employee Self-Service tool found on the HR Connect page or you may call HR Connect at (507) 266-0440 or toll free at 1-888-266-0440.

Continuous Service
Period of unbroken service from hire date to termination date with the employer or an affiliated company by an employee who is classified as a regular employee and is scheduled to work at least half-time (.5 FTE). Vacations and approved leaves of absence are not breaks in service except for educational leaves of more than six months for a non-critical employment need. Transfers between the employer and affiliated companies are not breaks in service as long as the employee continues to be classified as a regular employee and continues to be scheduled to work at least half-time. A break in service occurs upon termination of employment, transfer to a non-regular classification, or change to a schedule that is less than half-time. A regular employee classification does not include temporary, supplemental, casual employees or residents, research fellows, or health-related science students.

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. Employee does not include any person classified by the employer as any of the following:

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

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

Employer
Mayo Clinic and any subsidiary or affiliated entities recognized by Mayo Clinic as eligible to participate and that agree to participate in the Plan. In this document, employer shall mean the participating employers listed in Plan Information.

Insurance Company
The insurance company for your AD&D benefit is The Prudential Insurance Company of America. If, however, you are covered by the Mayo Expense Reimbursement Plan (MERP), the insurance company for the first $100,000 of your employer paid AD&D benefit is Trustmark Insurance Company. Prudential is the insurance company for any benefit over $100,000.

Mayo Clinic Health System Locations
A family of clinics, hospitals and health care facilities serving over 70 communities in Iowa, Wisconsin and Minnesota.