INTRODUCTION

The Mayo Travel Accident Plan (“the Plan”) provides benefits if you die or suffer a covered loss in a business travel-related accident. The benefits under the Plan are referred to throughout this document as “MTA Insurance.” You are enrolled automatically if you are employed in a position at a participating employer (as listed on page 26) classified as covered under the Plan. Mayo Clinic provides this coverage at no cost to you.

This Summary Plan Description (SPD) is intended to be easy to use and understand. This SPD and the underlying insurance policy constitute the official plan document for the Plan. The Plan document governs the Plan and is the final authority regarding the Plan’s benefits and administration. You should also not rely on oral descriptions of the Plan provisions, as the written terms of the Plan document will always govern. In all cases, benefits will be paid according to the terms of the Plan in effect at the time the expense is incurred. Mayo Clinic reserves the right to amend, modify, or terminate the Plan at any time and for any reason.
TABLE OF CONTENTS

INTRODUCTION ................................................................. 2

TABLE OF CONTENTS .................................................... 3

ELIGIBILITY AND PARTICIPATION ........................................... 5

Who is Eligible ........................................................................ 5
How to Enroll ........................................................................ 5
When Coverage Begins .......................................................... 5
Coverage during a Leave of Absence ....................................... 5
When Coverage Ends ............................................................. 5
Cost of Coverage .................................................................... 6

MAYO TRAVEL ACCIDENT INSURANCE BENEFITS .................. 7

MTA Insurance Coverage Amount .......................................... 7
What the Plan Covers ............................................................ 8
Accidental Death and Dismemberment Benefits ................. 10

EXCLUSIONS ........................................................................ 14

BENEFICIARY AND ASSIGNMENT PROVISIONS ............... 16

Naming a Beneficiary ............................................................ 16
Loss of Life Benefits ............................................................ 16
Assignment of Benefits ......................................................... 16

CLAIMS ADMINISTRATION .................................................. 17

Notice of Claim ...................................................................... 17
Claim Submission .................................................................... 17
Initial Determination .............................................................. 17
Procedures for Claims Not Requiring Determination of Disability .... 19
Time of Claim Payment ........................................................ 20
Legal Action ........................................................................ 20

YOUR RIGHTS UNDER ERISA .......................................... 21

Receive Information about Your Plan and Benefits ............... 21
Prudent Actions by Plan Fiduciaries ....................................... 21
Enforce Your Rights ............................................................. 21
Assistance with Your Questions ........................................ 22

PLAN ADMINISTRATION ....................................................... 23

Powers and Duties of the Plan Administrator ......................... 23
Records ................................................................................ 23
Allocation of Responsibilities ................................................................. 23
Amendment and Termination of Plan....................................................... 24
PLAN ADMINISTRATIVE INFORMATION .............................................. 25
Employers Participating in the Mayo Travel Accident Plan...................... 26
ELIGIBILITY AND PARTICIPATION

Who is Eligible

You are eligible for MTA Insurance coverage if you are employed in a position at Mayo Clinic or a Participating Employer, as listed on page 23 of this document and classified as covered under the policy. Covered classes of employees are:

- Class 1: All Physicians, Residents, Fellows and Voting Staff
- Class 2: All Allied Health Staff employees, except when traveling in the United States on an organ procurement basis and trauma run basis
- Class 3: All Allied Health employees who are an employee of the Minnesota location while traveling in the United States on an organ procurement basis**
- Class 4: All Allied Health employees who are an employee of the Arizona or Florida locations while traveling in the United States on an organ procurement basis**
- Class 5: All Physicians, Residents, and Fellows who are an employee of the Arizona, Florida, Minnesota or Wisconsin locations while traveling in the United States on an organ procurement basis **
- Class 6: All Allied Health employees of the Minnesota and Wisconsin locations while traveling in the United States on a trauma run basis**
- Class 7: All Physician, Residents, and Fellows of the Minnesota and Wisconsin locations while traveling in United States on a trauma run basis**
- Class 8: All non-benefits eligible physicians who are employees of Mayo Clinic on an organ procurement run**

**U.S. Territories include coverage in American Samoa, Guam, Puerto Rico, and Virgin Islands.

How to Enroll

As an eligible employee, you are automatically enrolled in MTA Insurance.

When Coverage Begins

Your coverage begins on your first day of employment in a covered position, whether you are a newly hired employee or an employee who has moved from a non-covered to a covered position.

If you are not actively at work on the date coverage would otherwise begin, coverage begins on the first day you return to work and assume your normal duties.

Coverage during a Leave of Absence

Since MTA Insurance provides coverage only while you are traveling on business for Mayo Clinic, you will not be covered during any leave of absence, such as family, medical, military, and other approved leaves.

When Coverage Ends

Your coverage will end on the earliest of the following:
• The date you cease to be in an eligible class of employees covered under the Plan
• The date the group policy ends
• The date the Plan terminates

Termination of the Plan will not affect any claim for loss due to an accident that occurs before the effective date of the termination.

**Cost of Coverage**

Mayo Clinic pays all of the cost of your MTA Insurance coverage.
## MAYO TRAVEL ACCIDENT INSURANCE BENEFITS

### MTA Insurance Coverage Amount

<table>
<thead>
<tr>
<th>Coverage Class</th>
<th>Coverage Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 1 All Physicians, Residents, Fellows, and Voting Staff</td>
<td>$1,000,000</td>
</tr>
<tr>
<td>Class 2 Allied Health Staff employees excluding Allied Health employees while traveling in the United States on an organ procurement basis and trauma run basis</td>
<td>$250,000</td>
</tr>
<tr>
<td>Class 3 All Allied Health employees who are an employee of the Minnesota location while traveling in the United States on an organ procurement basis</td>
<td>7 times salary* to a maximum of $400,000 plus and additional $250,000**</td>
</tr>
<tr>
<td>Class 4 All Allied Health employees who are an employee of the Arizona or Florida locations while traveling in the United States on an organ procurement basis</td>
<td>7 times salary* to a maximum of $400,000 plus an additional $250,000*</td>
</tr>
<tr>
<td>Class 5 All Physicians, Residents, and Fellows who are an employee of the Arizona, Florida, Minnesota or Wisconsin location while traveling in the United States on an organ procurement basis</td>
<td>$4,000,000**</td>
</tr>
<tr>
<td>Class 6 All Allied Health employees of the Minnesota and Wisconsin locations while traveling in the United States on a trauma run basis</td>
<td>7 times salary* to a maximum of $400,000 plus and additional $250,000**</td>
</tr>
<tr>
<td>Class 7 All physicians, Residents, and Fellows of the Minnesota and Wisconsin locations while traveling in the United States on a trauma run basis</td>
<td>$4,000,000**</td>
</tr>
<tr>
<td>Class 8 All non-benefit eligible physicians who are employees of Mayo Clinic on an organ procurement run</td>
<td>$4,000,000**</td>
</tr>
</tbody>
</table>

* “Salary” means the covered person’s base annual salary on the date of the accident, excluding overtime pay, bonuses, commissions, and any other types of incentives.

If you qualify in more than one coverage class on the date of a covered accident, your benefit will be based on the class that provides the largest benefit amount.

**Note:** For those insured’s located in Minnesota and Wisconsin who are also covered under the LifeSource policy the maximum benefit they will receive will be a total of $4 million for Classes 5, 7 & 8 and $650,000 for Classes 3 & 6.**
Aggregate Limitation
The Plan will pay no more than $17,000,000 in total benefits for all covered losses for all covered employees as a result of any one covered accident.

If two or more covered persons are injured as a result of any one accident and the total of all amounts payable exceeds the aggregate limitation shown above, the benefit amount for each person will be proportionately reduced so that the total equals the aggregate amount.

Age Reductions in Coverage
When you reach ages 70, 75, 80, and 85, your coverage amount will be reduced to a percentage of the original coverage amount shown in the table above, as follows:

<table>
<thead>
<tr>
<th>Your Age</th>
<th>Percent of Original Coverage Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 70 to 74</td>
<td>65%</td>
</tr>
<tr>
<td>Age 75 to 79</td>
<td>45%</td>
</tr>
<tr>
<td>Age 80 to 84</td>
<td>30%</td>
</tr>
<tr>
<td>Age 85 and older</td>
<td>15%</td>
</tr>
</tbody>
</table>

What the Plan Covers
Business Trip
MTA Insurance covers different types of travel and the Plan breaks your coverage into different covered “hazards”. Most commonly, you are covered when you are traveling on an authorized business trip for Mayo Clinic in the course of performing Mayo Clinic business. Such travel begins when you leave your primary place of work or your home, whichever is last, and ends when you return to your primary place of work or your home, whichever is first.

“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
your travel for personal reasons unrelated to the business for which you are traveling, your MTA Insurance coverage will continue as long as that travel extension does not last for more than seven days.

MTA Insurance provides coverage 24 hours a day, anywhere in the world, while you are traveling on Mayo Clinic business. It includes coverage for injuries resulting from accidents that occur while you are a passenger on, boarding, or alighting from a civil aircraft or military transport aircraft. It also covers you for injuries resulting from being struck by an aircraft. However, you are not covered if you are piloting your own airplane or any other aircraft.

**Specified Aircraft Coverage**

MTA Insurance also provides coverage for an injury resulting from an accident which occurs anywhere in the world while you are on a Business Trip as a passenger, pilot, operator, or member of the crew on, boarding or alighting from, or being struck by:

- 2013 American Eurocopter EC-145 FAA No. N145SZ
- Or any other fix-winged or rotary-winged aircraft used in the organ procurement or trauma run process which is owned, leased, chartered, or operated on behalf of Mayo Clinic and which aircraft is being operated at the time with the consent of Mayo Clinic and piloted by a certified pilot holding a current and valid certificate of competency of a rating authorizing him or her to pilot the aircraft and who has logged a minimum of 1,000 hours as a pilot, at least 500 hours of which were logged in a single or multi-engine aircraft of like and basic design.

**Commutation Coverage**

Commuting to and from work is not considered a Business Trip, and you are normally not covered in this situation. However, if certain circumstances are met, 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 normally would not use, due to a strike, power failure, major breakdown, or similar event results in the interruption of one or more public transportation systems that you regularly use.

**Hijacking Benefit**

MTA Insurance covers injury resulting from an accident that occurs during a hijacking anywhere in the world while you are on a Business Trip. Hijacking coverage continues while you are subject to the control of the hijacker(s) and during travel directly to your residence or original destination.

“Hijacking” means the unlawful seizure or wrongful exercise of control of an aircraft or other conveyance, or the crew thereof, in which you are traveling as a passenger.
Accidental Death and Dismemberment Benefits

If you suffer accidental death or bodily injury resulting in any of the losses described below, MTA Insurance will pay the benefits stated. The loss must occur:

- During covered travel, as described above, and
- Within 365 calendar days of the accident.

<table>
<thead>
<tr>
<th>Covered Loss</th>
<th>Benefit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td>100% of the Coverage Amount</td>
</tr>
<tr>
<td>Both hands or both feet or sight of both eyes</td>
<td></td>
</tr>
<tr>
<td>One hand and one foot</td>
<td></td>
</tr>
<tr>
<td>Speech and hearing</td>
<td></td>
</tr>
<tr>
<td>Either hand or foot and sight of one eye</td>
<td></td>
</tr>
<tr>
<td>Quadruplegia (movement of both upper and lower limbs)</td>
<td></td>
</tr>
<tr>
<td>Paraplegia (movement of both lower limbs)</td>
<td>75% of the Coverage Amount</td>
</tr>
<tr>
<td>Hemiplegia (movement of both upper and lower limbs of one side of the body)</td>
<td>50% of the Coverage Amount</td>
</tr>
<tr>
<td>Either hand or foot</td>
<td></td>
</tr>
<tr>
<td>Sight of one eye</td>
<td></td>
</tr>
<tr>
<td>Speech or hearing</td>
<td></td>
</tr>
<tr>
<td>Thumb and index finger of either hand</td>
<td>25% of the Coverage Amount</td>
</tr>
</tbody>
</table>

“Loss of hand or foot” means actual severance through or above wrist or ankle joints.

“Loss of sight, speech or hearing” means entire and irrecoverable loss of those faculties.

“Loss of thumb and index finger” means actual severance through or above the metacarpophalangeal joints.

“Loss of movement of limbs” means complete and irreversible paralysis of the limbs.

“Injury” means a bodily injury resulting directly and independently of all other causes from a covered accident. (Loss resulting from sickness or disease, or medical or surgical treatment of a sickness or disease, is not covered, unless it is an infection which occurs through a wound incurred in a covered accident.)
Exposure

Exposure to the elements will be presumed to be injury if:

- It results from the forced landing, stranding, sinking, or wrecking of a conveyance in which you were traveling at the time of the accident, and
- The MTA Insurance would have covered injury resulting from the accident.

Disappearance

In the case of your disappearance while on covered travel, you will presumed to have suffered loss of life if:

- Your remains have not been found within one year after the disappearance of a conveyance in which you were traveling at the time of its disappearance,
- The disappearance of the conveyance was due to its accidental forced landing, stranding, sinking, or wrecking, and
- The MTA Insurance would have covered injury resulting from the accident.

Seat Belt and Airbag Benefit

If your injury results in a covered loss while you are a passenger in, or the licensed operator of, an automobile, and at the time of the accident you were properly wearing a seat belt as verified on the police report, then the coverage amount will be increased by 10% (up to a maximum of $25,000).

If the seat belt benefit is payable, your benefit will be increased by another 5% of the coverage amount (up to a maximum of $10,000) if you were positioned in a seat equipped with a factory-installed airbag, you were properly strapped in the seat belt when the airbag inflated, and the police report established that the airbag inflated properly upon impact.

“The Automobile” means a duly registered, four-wheeled, private passenger car, pick-up truck, van, self-propelled motor home, or sport utility vehicle that is not being used as a common carrier (i.e., a vehicle operated by a concern organized and licensed for transportation of passengers for hire and operated by an employee of that concern).

“The Seat belt” means an unaltered belt, lap restraint, or lap and shoulder restraint installed by the manufacturer of the automobile or proper replacement parts as required by the manufacturer’s specifications.

“The Air bag” means an inflatable supplemental passive restraint system installed by the manufacturer of the automobile, or proper replacement parts as required by the manufacturer’s specifications, that inflate upon collision to protect an individual from injury or death. An airbag is not considered a seat belt.

The seat belt and airbag benefit does not cover injury to you if you are operating the automobile and you are under the influence of any intoxicant, excitant, hallucinogen, or any narcotic or other drug, or similar substance as verified in the police report (unless administered under the advice of a physician).
Rehabilitation Benefit

If your injury results in any covered loss other than loss of life, MTA Insurance will pay a benefit equal to the lesser of:

a) The expense of rehabilitative training (any training required due to your injury that prepares you for an occupation in which you would not have engaged except for the injury), or

b) 10% of your coverage amount, up to a maximum of $25,000.

The expense (the actual cost of the training and materials needed for training) must be incurred within two years of the date of the accident.

Adaptive Home and Vehicle Benefit

If your injury results in any covered loss other than loss of life, MTA Insurance will pay a benefit equal to the lesser of:

a) 10% of your coverage amount, up to a maximum of $25,000, or

b) The actual one-time cost of alterations performed within two years of the date of the accident to your principal residence (to make the residence accessible) and/or your private automobile (to make the automobile drivable or rideable for you).

This benefit will be payable only if:

- Any home alterations are made by a person or persons with experience in this type of alteration and recommended by a recognized organization associated with the specific loss, and
- Any automobile alterations are made by an experienced person and approved by the Motor Vehicle Department.

Coma Benefit

MTA Insurance will pay a monthly benefit of 1% of your coverage amount if you become comatose within 31 days of a covered accident and remain in a coma for at least 30 days.

“Coma” means complete and continuous unconsciousness and the inability to respond to external or internal stimuli.

Monthly payments under this benefit will end on the first of the following:

- The end of the month in which you die
- The end of the month in which you recover from the coma
- When the total payment equals the maximum allowed under this benefit (your coverage amount less all other payments under MTA Insurance for the injury)

Therapeutic Counseling Benefit

If your injury results in any covered loss other than loss of life and you require therapeutic counseling within 90 days of the injury, MTA Insurance will pay a benefit equal to the lesser of:

a) Reasonable expenses incurred for therapeutic counseling in excess of any other Plan, or
b) 10% of your coverage amount (up to a maximum of $25,000).

The counseling services must be performed within one year of the date of loss.

| “Therapeutic counseling” means treatment or counseling provided by a licensed therapist or counselor registered or certified to provide psychological treatment or counseling. |
| “Reasonable expenses” means fees and prices that do not exceed those generally charged for similar counseling in your local area. Hartford Life and Accident Insurance Company ("the Insurer") reserves the right to determine reasonable expenses. |

| “Plan” means any of the following: |
| a) A group or blanket or franchise health insurance |
| b) Group hospital, medical service, or pre-payment plan |
| c) Labor-management trustee, union welfare, employer organization, or employee benefit organization plan |
| d) Governmental program or coverage required or provided by any statute except Medicare |
| e) Automobile insurance medical payments benefit or automobile reparations insurance (no-fault) |
| f) Workers’ Compensation or similar law |

Bereavement Counseling Benefit

If you lose your life in a covered accident and your coverage amount is payable to your beneficiaries, MTA Insurance also will pay for bereavement counseling for your dependent spouse and child or children. The benefit pays up to $100 per session and a maximum of $500 per covered person.

In order to be covered, bereavement counseling must begin within 90 days of your death. Proof of counseling expenses must be provided to the insurer within one year of the death.

| “Bereavement counseling” means treatment or counseling for the grief reaction resulting from your loss of life. Counseling must be provided by a licensed therapist, counselor, or psychiatrist who is registered or certified to provide psychological treatment or counseling. |
| “Spouse” means your wife or husband who is not legally separated or divorced from you at the time of the accident. |
| “Child”, for purposes of this benefit, means your unmarried child, an unmarried grandchild who resides with you and is in your legal custody, a stepchild, a legally adopted child in your home, or a foster child who is under 26 years of age and primarily dependent on you for support and maintenance. |
EXCLUSIONS

MTA Insurance does not cover any loss resulting from the following:

- An intentionally self-inflicted injury, suicide, or attempted suicide, while sane or insane

- War or act of war, whether declared or undeclared, occurring within the geographical limits, the territorial waters, or the airspace above the United States, and any country in which you are a permanent resident (“permanent resident” means you are a resident of or regularly employed in a country for three months or longer)

- Injury sustained while in the armed forces of any country or international authority

- Injury sustained while on any aircraft, unless, and only to the extent, there is such coverage described in the Policy.

- Injury sustained while voluntarily taking drugs which federal law prohibits dispensing without a prescription, including sedatives, narcotics, barbiturates, amphetamines, or hallucinogens, unless the drug is prescribed or administered by a licensed physician

- Injury sustained while committing or attempting to commit a felony

- Injury sustained while operating a motor vehicle while legally intoxicated from the use of alcohol

- Injury sustained when you are piloting your own airplane or any other aircraft.

- Injury sustained while the aircraft is carrying passengers for hire

- The Plan does not cover injury resulting from an accident that occurs while an aircraft is engaged in an extra-hazardous aviation activity
“Extra-hazardous aviation activity” includes the following:

- Acrobatics or stunt flying
- Racing or any endurance test
- Crop dusting or seeding
- Spraying
- Exploration
- Pipe or power line inspection
- Any form of hunting or bird/fowl herding
- Aerial photography or banner towing
- Any test or experiment
- Firefighting
- Any flight requiring a special permit or waiver from the FAA, even though granted
BENEFICIARY AND ASSIGNMENT PROVISIONS

Naming a Beneficiary

You may name a beneficiary or change a revocably named beneficiary by submitting a written request. Your request takes effect on the date you execute it, regardless of whether you are living when it is received by the Plan. The Plan will be released from further responsibility to the extent of any payment made in good faith before your request was received.

Claims involving loss of life will be paid according to the beneficiary designation on file with the claims administrator (The Hartford) at the time of the covered accident. If there is no beneficiary designation on file, the claim will be paid according to the beneficiary designation applicable to your employer-paid group life insurance.

Loss of Life Benefits

Benefits for your covered loss of life are payable to your beneficiary if that person survives you. If the Plan makes good-faith payment to your beneficiary (as named in your most recent written beneficiary designation on file in your Plan records), the Plan is released from further obligation.

If your beneficiary does not survive you or you do not name a beneficiary, benefits are payable to the surviving persons in the following order:

- Your spouse
- Your children
- Your parents
- Your brothers and sisters
- Your estate

If the benefit is payable to your estate or to a beneficiary who is either a minor or not competent to give valid release for the payment, the Plan may pay up to $1,000 ($3,000 for residents of Florida) of the benefit due to some other person. The other person will be someone related to you or the beneficiary by blood or marriage who the Plan determines is entitled to the payment. The Plan is released from further obligation to the extent of any such payment made in good faith.

Assignment of Benefits

The Plan will recognize any assignment you make under the MTA Insurance policy, provided it is properly executed and a copy is on file with Hartford Life and Accident Insurance Company (“the Insurer”). The Insurer and Mayo Clinic assume no responsibility for the validity or effect of any assignment.
CLAIMS ADMINISTRATION

Mayo Clinic has designated the Hartford Life and Accident Insurance Company (“the Insurer”) as the claims fiduciary for benefits provided under the MTA Insurance. The Insurer has full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the MTA Insurance policy.

Notice of Claim

You (or your beneficiary, in the case of your loss of life), or your representative, must provide written notice of a claim within 30 days after a covered loss occurs. If notice cannot be given within that time, it must be submitted as soon as reasonably possible.

The notice should be sent to:

The Hartford
P.O. Box 2999
Hartford, Ct 06104-2999

It should include your name and the policy number (ETB-112975).

Claim Submission

The Insurer will send claim forms to you or your beneficiary within 15 days of receiving your notice of claim. Complete the claim form in accordance with the instructions and return it to The Hartford with the required proof of loss described in the form. Applicable sections of the form must be completed by you (or your beneficiary), the Plan Administrator, and the attending physician or hospital.

Proof of loss must be submitted in writing within 90 days after the date of the loss. Failure to furnish proof within 90 days will not void or reduce your claim if it was not reasonably possible for you to provide it within that time. Additional time allowed cannot exceed one year, however, except in the event of legal incapacitation.

Physical Examination and Autopsy

The Insurer reserves the right to have the covered employee examined, at the Insurer’s expense, as often as reasonably necessary while a claim is pending. The Insurer also may have an autopsy performed, unless forbidden by law.

Initial Determination

The Insurer will make a decision no more than 45 days after receipt of your properly filed claim. The time for decision may be extended for two additional 30-day periods provided that, prior to any extension period, the Insurer notifies you in writing that an extension is necessary due to matters beyond control of the Plan, identifies those matters, and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim, the time for decision may begin when the additional information is received. If the Insurer approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

If the Insurer denies your claim in whole or in part, notification of the claims decision will be in writing and will include the following:

- The specific reasons for the decision
- Specific references to the Plan provisions on which the decision is based
• A description of any additional material or information necessary for you to validate the claim and an explanation of why that material or information is needed

• A description of the review procedures and their time limits

• A statement that you have the right to bring a civil action under Section 502(a) of ERISA if your claim is denied after an appeal

• If the denial is based on an internal rule, guideline, protocol, or other similar criterion, either (a) the specific criterion on which the denial is based or (b) a statement that such a criterion was relied upon and that a copy of the criterion will be provided to you free of charge upon request

• If the denial is based on medical judgment, either (a) an explanation of the scientific or clinical judgment for the determination, applying the terms of the policy to your medical circumstances, or (b) a statement that the explanation will be provided to you free of charge upon request

Appealing the Initial Determination

To appeal any wholly or partially denied claim, you or your representative must ask the Insurer for a full and fair review, and you must complete the claims appeal process described below before you file any action in court.

Your appeal must be in writing and received by the Insurer within 180 days after the date you received your claim denial. As part of your appeal, you may request, free of charge, copies of all documents, records, and other information relevant to your claim. You also may submit written comments, documents, records, and other information related to your claim. The Insurer will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether that information was submitted or considered in the initial benefit determination.

The Insurer will make a final decision no more than 45 days after it receives your timely appeal. The time period for a final decision may be extended for one additional 45-day period provided that, prior to the extension, the Insurer notifies you in writing that an extension is necessary due to special circumstances, identifies those circumstances, and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim on appeal, the time period for a decision will begin when the additional information is received.

The individual reviewing your appeal will give no weight to the initial benefit determination and will be neither the individual who made the initial determination nor a subordinate of that individual.

The review process provides for the identification of the medical or vocational experts whose advice was obtained in connection with an initial adverse decision, without regard to whether that advice was relied upon in making the decision. When deciding an appeal that is based on medical judgment, in whole or in part, the Insurer will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual consulted in connection with the initial benefit determination, nor a subordinate of that individual. If the Insurer grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.
If the Insurer denies your appeal, the notification of the decision will be in writing and will include the following:

- The specific reasons for the decision
- Specific references to the Plan provisions on which the decision is based
- A statement that you have the right to bring a civil action under Section 502(a) of ERISA if your claim is denied after an appeal
- A statement that you may request, free of charge, copies of all documents, records, and other information relevant to your claim
- If the denial is based on an internal rule, guideline, protocol, or other similar criterion, either (a) the specific criterion on which the denial is based or (b) a statement that such a criterion was relied upon and that a copy of the criterion will be provided to you free of charge upon request
- If the denial is based on medical judgment, either (a) an explanation of the scientific or clinical judgment for the determination, applying the terms of the policy to your medical circumstances, or (b) a statement that the explanation will be provided to you free of charge upon request
- Any other notice(s), statement(s), or information required by applicable law

**Procedures for Claims Not Requiring Determination of Disability**

If you or your authorized representative want to file a claim for benefits for yourself or your named beneficiary, obtain a claim form from the Plan Administrator. Applicable sections of the form must be completed by you (or your beneficiary), the Plan Administrator, and the attending physician or hospital. Following completion, send the form to the Insurer, who will evaluate your claim and determine if benefits are payable.

The Insurer will make a decision no more than 90 days after receipt of your properly filed claim. However, if the Insurer determines that special circumstances require an extension, the time period for its decision will be extended for an additional 90 days provided that, prior to the beginning of the extension period, the Insurer notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If the time period is extended, a decision will be made no more than 180 days after your claim was received. If the Insurer approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

If the Insurer denies your claim, in whole or in part, notification of the claims decision will be in writing and will include the following:

- The specific reasons for the decision
- Specific references to the Plan provisions on which the decision is based
- A description of any additional material or information necessary for you to validate the claim and an explanation of why that material or information is needed
- A description of the review procedures and their time limits
- A statement that you have the right to bring a civil action under Section 502(a) of ERISA if your claim is denied after an appeal
**Appealing Denials of Claims**

To appeal any wholly or partially denied claim, you or your representative must ask the Insurer for a full and fair review, and you must complete the claims appeal process described below before you file any action in court.

Your appeal must be in writing and received by the Insurer within 60 days after the date you received your claim denial. As part of your appeal, you may request, free of charge, copies of all documents, records, and other information relevant to your claim. You also may submit written comments, document, records, and other information related to your claim. The Insurer will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether that information was submitted or considered in the initial benefit determination.

The Insurer will make a final decision no more than 60 days after it receives your timely appeal. However, if the Insurer determines that special circumstances require an extension, the time period for its decision will be extended for an additional 60 days, provided that, prior to the beginning of the extension period, the Insurer notifies you in writing of the special circumstances and give the date by which it expects to render its decision. If the time period is extended, a decision will be made no more than 120 days after your appeal was received. If the Insurer grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

If the Insurer denies your appeal, the notification of the decision will be in writing and will include the following:

- The specific reasons for the decision
- Specific references to the Plan provisions on which the decision is based
- A statement that you have the right to bring a civil action under Section 502(a) of ERISA if your claim is denied after an appeal
- A statement that you may request, free of charge, copies of all documents, records, and other information relevant to your claim
- Any other notice(s), statement(s), or information required by applicable law

**Time of Claim Payment**

The Plan will pay any daily, weekly, or monthly benefit due:

a) On a monthly basis, after receiving proof of loss, while the loss and the Insurer’s liability continue, or

b) Immediately after receiving proof of loss following the end of the Insurer’s liability.

The Plan will pay any other benefit due immediately, but not later than 60 days after receiving proof of loss.

**Legal Action**

No legal action may be taken against the Plan or the Insurer:

a) Before 60 days following the date proof of loss is sent to the Insurer

b) After three years (six years for residents of South Carolina) following the date proof of loss is due (for Florida residents, after the expiration of the applicable statute of limitations following the date proof of loss is due)
YOUR RIGHTS UNDER ERISA

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

Receive Information about Your Plan and Benefits

a) 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.

b) 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.

c) 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.

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. 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. If the Plan requires you to complete administrative appeals prior to filing in court, your right to file suit in state or federal court may be affected if you do not complete the required appeals. 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 (formerly known as the Pension and Welfare Benefits 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 also may 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 ADMINISTRATION

Powers and Duties of the Plan Administrator

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

a) The discretion to determine all factual and legal questions relating to the eligibility of individuals to participate or for you to remain a participant and receive benefits under the Plan. With respect to claims for benefits, the Plan Administrator has delegated authority to the Claims Administrator.

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

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

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

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

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 the eligibility requirements, 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, other than payment of any covered expenses you incurred prior to the Plan amendment or termination. You do not have rights to vested benefits in the Plan. The rights with respect to amendment and termination of the Plan have been delegated to the Salary and Benefits Committee.
The benefits described in this Summary Plan Description are provided under a group insurance policy issued by the Hartford Life and Accident Insurance Company and are subject to the policy’s terms and conditions. The policy is incorporated into, and forms a part of, the official Plan document for the Mayo Travel Accident Plan.

Important Plan administrative information is shown in the following table.

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Mayo Travel Accident Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Number</td>
<td>520</td>
</tr>
<tr>
<td>Plan Sponsor and Plan Administrator</td>
<td>Mayo Clinic 200 1st Street SW Rochester, MN 55905</td>
</tr>
<tr>
<td>Employer Tax Identification Number</td>
<td>41-6011702</td>
</tr>
<tr>
<td>Type of Plan</td>
<td>Welfare benefit plan providing group business travel accident insurance benefits</td>
</tr>
<tr>
<td>Named Fiduciary</td>
<td>Salary &amp; Benefits Committee Mayo Clinic 200 First Street SW Rochester, MN 55905 (507) 266-0440</td>
</tr>
<tr>
<td>Agent for Service of Legal Process</td>
<td>For the Plan: Mayo Clinic c/o William A. Brown, Assistant Treasurer 200 1st Street SW Rochester, MN 55905 Service may also be made on the Plan Administrator</td>
</tr>
<tr>
<td>Sources of Contributions</td>
<td>The Employer pays the premium for the insurance.</td>
</tr>
<tr>
<td>Type of Administration</td>
<td>The Plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the applicable Plan document and insurance policy.</td>
</tr>
<tr>
<td>Claims Administrator</td>
<td>Hartford Life and Accident Insurance Company</td>
</tr>
<tr>
<td>Plan Year</td>
<td>The Plan and its records are kept on a calendar year basis.</td>
</tr>
<tr>
<td>Collectively Bargained Groups</td>
<td>The Plans are maintained in part pursuant to one or more collective bargaining agreements. A copy of any such agreement may be obtained by you upon written request to the Plan Administrator and is available for examination.</td>
</tr>
<tr>
<td>Component of Plan Document</td>
<td>Summary Plan Description Insurance Policy (Hartford Life and Accident Insurance Company)</td>
</tr>
</tbody>
</table>
Employers Participating in the Mayo Travel Accident Plan

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