



Summary Plan Description

Mayo Clinic Health & Welfare Benefits Plan — January 2022

General Information Booklet

IMPORTANT NOTICE

This General Information Booklet for the Mayo Clinic Health & Welfare Benefits Plan (the “Plan”) provides information that is applicable to all benefit programs offered under the Plan. This General Information Booklet addresses eligibility for coverage under the Plan, how to enroll, opportunities to make mid-year changes, when coverage ends and how you and your covered family members may be able to continue coverage under certain benefit programs if it ends. It also contains information such as who provides coverage, who administers the benefit programs offered under the Plan, who decides claims for benefits, your rights under the Employee Retirement Income Security Act of 1974, as amended (“ERISA”) and who has the right to amend and terminate the Plan and the benefit programs offered under the Plan.

The benefits booklets, benefits summaries, certificates of coverage and other documents provided in connection with this General Information Booklet (collectively, the “Incorporated Documents”) describe the benefits provided by the benefit programs offered under the Plan, including deductible, co-pay and co-insurance information, as applicable, coverage levels, how to submit a claim for benefits and other important information about your benefit programs.

This General Information Booklet, together with the Incorporated Documents provided in connection with this General Information Booklet, constitutes the Summary Plan Description for the Plan as of January 1, 2022 and replaces all prior descriptions of the Plan. It is intended to provide a summary of your benefits available under the Plan. If there are any discrepancies between the Summary Plan Description and the governing plan documents and insurance policies, the plan documents and insurance policies will control.

INTRODUCTION

Mayo Clinic maintains the Plan for the exclusive benefit of eligible employees of Mayo Clinic and its affiliates that participate in the Plan (collectively referred to with Mayo Clinic as “Mayo”), eligible retirees and their eligible family members. The Plan provides benefits through the following benefit programs:

- Mayo Medical Plan
- Mayo Expatriate Medical Plan
- Mayo Dental Plan
- Mayo Vision Plan
- Health Care Flexible Spending Account Plan (offered under the Mayo Cafeteria Plan)
- Dependent Care Flexible Spending Account Plan (offered under the Mayo Cafeteria Plan)
- Pre-Tax Health Savings Account
- Mayo Clinic Employee Assistance Plan
- Group Life Insurance Plan (Employer Paid)
- Voluntary Group Term and Universal Life Plan
- Short-Term Disability Policy
- Mayo Paid Disability Income Plan
- Fellows Group Term Life Insurance & Disability Income Plan
- Mayo Clinic Accidental Death & Dismemberment Plan
- Mayo Accident Insurance Plan
- Mayo Critical Illness Insurance Plan
- Mayo Hospital Indemnity Insurance Plan
- Mayo Travel Accident Plan
- Mayo Business Travel Medical Plan
- Mayo Legal Plan

All of the above benefit programs are described in this General Information Booklet and in the Incorporated Documents provided in connection with this General Information Booklet.

Note: The Dependent Care Flexible Spending Account Plan, the Pre-Tax Health Savings Account and the Short-Term Disability Policy are not part of the Plan and are not subject to the requirements of ERISA, but information about these benefits programs is included in this General Information Booklet for ease of reference.

CONTACT INFORMATION

For enrollment or eligibility questions, please contact Mayo's HR Connect. HR Connect is your human resources office for the Plan and the benefit programs offered under the Plan.

QUESTIONS ABOUT ENROLLMENT/ELIGIBILITY
HR Connect 200 First Street SW Rochester, MN 55905 507-266-0440 (local) 1-888-266-0440 (toll free) M – F, 7 a.m. to 6 p.m. CT (excluding holidays)

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

El presente Resumen del Plan de Descripción está redactado en inglés y ofrece detalles sobre sus derechos y beneficios bajo el Plan y los programas de beneficios ofrecidos bajo el Plan. Si tiene alguna dificultad para entender cualquier parte de este documento, por favor comuníquese con el Centro para Servicios al Empleado al número que se encuentra arriba.

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OVERVIEW OF THE PLAN'S BENEFIT PROGRAMS

The following is a brief description of the benefit programs offered to eligible employees, eligible retirees and their eligible family members under the Plan.

Benefit	Description
Mayo Medical Plan (the "Medical Plan")	<ul style="list-style-type: none"> • Provides medical, prescription drug, mental health and chemical dependency benefits • The Medical Plan includes a high deductible health plan ("HDHP") coverage option - the Mayo Custom Coverage option - and two non-HDHP coverage options - the Mayo Select and Mayo Premier options • The Medical Plan also includes the Mayo Medicare Supplement option for Medicare-eligible individuals on long-term disability, eligible retirees who are Medicare-eligible and their Medicare-eligible family members • All Medical Plan options are designed to help you pay for eligible health care expenses • You must enroll in the Medical Plan to participate • Eligible retirees and their eligible family members also can enroll in accordance with and subject to the Medical Plan's retiree coverage rules
Mayo Dental Plan (the "Dental Plan")	<ul style="list-style-type: none"> • Provides coverage for diagnostic and preventive services, basic dental services and major restorative dental services • The Dental Plan is designed to encourage regular checkups and preventive care to correct minor dental problems before they become serious, and to help cover the cost of more expensive dental procedures • The Dental Plan includes two Delta Dental of Minnesota coverage options - the Standard Option and the Deluxe Option - and a Mayo Reimbursement Account coverage option • The Dental Plan also includes a Retiree Mayo Reimbursement Account coverage option and a Dental Assistance Plan coverage option for eligible retirees and their eligible family members • Coverage is provided for orthodontia only once per person per lifetime under all of the Dental Plan's coverage options combined • You must enroll in the Dental Plan to participate
Mayo Vision Plan (the "Vision Plan")	<ul style="list-style-type: none"> • Provides vision benefits for vision examinations, contact lenses, eyeglass lenses and frames for eligible employees and their eligible dependents • The Vision Plan is designed to help you pay for eligible vision expenses • You must enroll in the Vision Plan to participate

Benefit	Description
Health Care Flexible Spending Account Plan (the "Health FSA")	<ul style="list-style-type: none"> • You may elect to contribute, on a pre-tax basis through payroll deductions, to the Health FSA to help pay for eligible health care expenses for you and your eligible family members • You must be enrolled in the Mayo Select or Mayo Premier option under the Medical Plan, or not enrolled in the Medical Plan at all, to contribute to the Health FSA • Each year, you may contribute up to the annual limit communicated to you in open enrollment materials (\$2,750 for 2022)
Dependent Care Flexible Spending Account Plan (the "Dependent Care FSA")	<ul style="list-style-type: none"> • You may elect to contribute, on a pre-tax basis through payroll deductions, to the Dependent Care FSA to help pay for eligible dependent care expenses to allow you and your spouse to work or attend school full-time • You may contribute up to \$5,000 per year per household (or up to \$2,500 if you are married and file separate tax returns)
Pre-Tax Health Savings Account (the "Pre-Tax HSA")	<ul style="list-style-type: none"> • If you are enrolled in the Mayo Custom Coverage option under the Medical Plan and satisfy all other applicable requirements, you may elect to contribute, on a pre-tax basis through payroll deductions, to the Pre-Tax HSA • You may contribute up to the annual limit communicated to you in open enrollment materials (for 2022, \$3,650 for single coverage and \$7,300 for family coverage under the Mayo Custom Coverage option)
Mayo Clinic Employee Assistance Plan ("EAP")	<ul style="list-style-type: none"> • Provides employees and eligible family members help to address and manage life issues and concerns • Mayo automatically provides EAP coverage at no cost to you
Group Life Insurance Plan (Employer Paid) (the "Basic Life Insurance Plan")	<ul style="list-style-type: none"> • Provides a monetary benefit to your beneficiaries if you die equal to three times your annual salary, up to the maximum salary limit specified in the applicable Incorporated Documents • Mayo automatically provides Basic Life Insurance Plan coverage at no cost to you • Eligible retirees also are provided with coverage in accordance with and subject to the Basic Life Insurance Plan's retiree coverage rules
Voluntary Group Term and Universal Life Plan (the "Voluntary Life Insurance Plan")	<ul style="list-style-type: none"> • You may choose to pay for supplemental (voluntary) life insurance, which provides an additional monetary benefit to your beneficiaries if you die and/or a monetary benefit to you if an enrolled eligible family member dies • You must enroll in the Voluntary Life Insurance Plan to participate

Benefit	Description
Short-Term Disability Policy (the “STD Policy”)	<ul style="list-style-type: none"> • Provides short term income replacement benefits in the event you are disabled from illness or injury for up to 13 weeks for eligible Allied Health Staff or for up to 26 weeks for eligible Consultants/Voting Staff • Mayo automatically provides short-term disability coverage at no cost to you
Mayo Paid Disability Income Plan (the “LTD Plan”)	<ul style="list-style-type: none"> • Provides long term income replacement benefits in the event you are disabled from illness or injury for more than 13 weeks for eligible Allied Health Staff or for more than 26 weeks for eligible Consultants/Voting Staff • Mayo automatically provides long-term disability coverage at no cost to you
Fellows Group Term Life Insurance & Disability Income Plan (the “Fellows Life & LTD Plan”)	<ul style="list-style-type: none"> • Provides basic, optional and dependent term life insurance and long-term disability insurance for eligible residents, fellows and research appointees • You must enroll in the Fellows Life & LTD Plan to participate • If you enroll in basic life insurance coverage, you also are automatically enrolled in long-term disability coverage, and vice versa
Mayo Clinic Accidental Death & Dismemberment Plan (the “AD&D Plan”)	<ul style="list-style-type: none"> • Accidental death & dismemberment (“AD&D”) coverage provides monetary benefits if you die or are dismembered as the result of a covered accident • Mayo automatically provides basic AD&D Plan coverage at no cost to you • You may choose to pay for voluntary AD&D Plan coverage, which provides additional coverage if you die or are dismembered as a result of a covered accident • You must enroll in voluntary AD&D Plan coverage to participate
Mayo Travel Accident Plan (the “MTA Plan”)	<ul style="list-style-type: none"> • Provides monetary benefits if you die or suffer a covered loss in a Mayo business travel-related accident • Mayo automatically provides MTA Plan coverage at no cost to you
Mayo Business Travel Medical Plan (the “WorldTraveler Plan”)	<ul style="list-style-type: none"> • Provides coverage for urgent and emergency care while you are traveling outside your home country on an approved business trip, which cannot be more than 180 days for any one trip, or related business sojourn (not to exceed 270 travel days in any 12-month period) • Mayo automatically provides WorldTraveler Plan coverage at no cost to you

Benefit	Description
Mayo Expatriate Medical Plan (the “Expat Medical Plan”)	<ul style="list-style-type: none"> • Provides medical, prescription drug, vision, mental health and chemical dependency benefits • You must enroll in the Expat Medical Plan to participate • The Expat Medical Plan is designed to help you pay for eligible health care expenses
Mayo Accident Insurance Plan (the “Accident Insurance Plan”)	<ul style="list-style-type: none"> • Provides a monetary benefit when you and/or your enrolled eligible dependent experience a covered accident as described in the Incorporated Documents • The Accident Insurance Plan is designed to help you pay for any costs (including non-medical costs) associated with a covered accident • You must enroll in the Accident Insurance Plan to participate
Mayo Critical Illness Insurance Plan (the “Critical Illness Insurance Plan”)	<ul style="list-style-type: none"> • Provides a monetary benefit if you and/or your enrolled eligible dependent experience the initial occurrence or recurrence of a covered illness as described in the Incorporated Documents • The Critical Illness Insurance Plan is designed to help you pay for any costs (including non-medical costs) associated with catastrophic illness • You must enroll in the Critical Illness Insurance Plan to participate
Mayo Hospital Indemnity Insurance Plan (the “Hospital Indemnity Insurance Plan”)	<ul style="list-style-type: none"> • Provides a monetary benefit upon your and/or your enrolled eligible dependent’s hospital admission, and for each day of a covered hospital stay, up to applicable limits as described in the Incorporated Documents • The Hospital Indemnity Insurance Plan is designed to help you pay for any costs (including non-medical costs) associated with a hospital stay • You must enroll in the Hospital Indemnity Insurance Plan to participate
Mayo Legal Plan (the “Legal Plan”)	<ul style="list-style-type: none"> • Provides access to free or discounted legal services through in-network attorneys • You must enroll in the Legal Plan to participate

The benefits provided by each of the benefit programs are described in detail in the applicable benefits booklets, certificates of coverage and other Incorporated Documents. Refer to the applicable Incorporated Documents for information about the coverage provided by each of the benefit programs.

ELIGIBILITY AND PARTICIPATION

Who is Eligible

Eligible Employees

Generally, you are an eligible employee who is eligible for coverage under the Plan and the benefit programs offered under the Plan if you are classified by a participating employer for payroll and personnel purposes as an employee who is regularly scheduled to work at least 40 hours per pay period for the employer. “Regularly scheduled” means that you are on file with Human Resources as having a 0.5 full-time equivalent (“FTE”) or higher status. For example, a 0.4 FTE working extra hours does not qualify as “regularly scheduled” to work 0.5 FTE, even if the hours worked may occasionally reflect a 0.5.

If you are not regularly scheduled to work at least 40 hours per pay period, you generally are not eligible for coverage under the Plan or the benefit programs offered under the Plan. However, you are eligible for EAP and MTA Plan coverage as described in the applicable Incorporated Documents, even if you are not regularly scheduled to work at least 40 hours per pay period. In addition, you may become eligible for Medical Plan or Expat Medical Plan coverage if you are considered a “full-time employee” as defined under the Shared Responsibility provisions of the Affordable Care Act (“ACA”), and as determined by Mayo in its sole discretion in accordance with policies and procedures established by Mayo in compliance with applicable legal requirements. If you become eligible for Medical Plan coverage under this ACA-related eligibility rule, you will be notified of your enrollment period.

Important Note: The Medical Plan and Expat Medical Plan have elected to adopt the Internal Revenue Service (“IRS”) safe harbor look-back method to comply with the ACA’s shared responsibility provisions. For more information regarding the ACA, please visit www.IRS.gov.

You generally are not eligible to participate in the Plan or any benefit program offered under the Plan if you:

- are included within a unit of employees covered by a collective bargaining agreement unless such agreement expressly provides for your coverage under the Plan and/or a benefit program offered under the Plan;
- are a nonresident alien who receives no earned income from Mayo from sources within the United States;
- are employed by a Mayo Clinic affiliate that is not a participating employer under the Plan;
- are working at a specific division, department or other business unit (which may include acquired operations) to which the Plan and/or a benefit program offered under the Plan has not been extended;
- are a leased employee or are classified by your employer as a temporary employee, seasonal employee, supplemental employee or non-benefit eligible employee for the period during which you are so classified, whether or not you are on your employer’s payroll or are determined by the IRS or others to be a common-law employee of your employer;
- are a party to an employment agreement that states that you are not eligible for the Plan and/or a benefit program offered under the Plan;
- are not treated as a common law employee on your employer’s payroll records, including but not limited to situations in which you perform services for your employer pursuant to a contract or agreement (whether verbal or written) which provides that you are an independent contractor or

consultant, whether or not you are determined by the IRS or others to be a common-law employee of your employer;

- are a member of any other special classification of employee that is not eligible for the Plan and/or a benefit program offered under the Plan, as determined by Mayo; or
- perform services for your employer through, and are paid by, a third-party (including but not limited to an employee leasing or staffing agency) for the period during which you are paid by such third-party, whether or not you are determined by the IRS or others to be a common-law employee of your employer.

An employer's classification is conclusive and binding for purposes of determining benefit eligibility under the Plan and the benefit programs offered 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 your employer agrees to the reclassification, shall make such employee or non-employee retroactively or prospectively eligible for benefits. Any uncertainty regarding an employee's classification will be resolved by excluding that person from eligibility.

Note that you are ineligible for coverage under the Medical Plan if you are eligible for coverage under the Expat Medical Plan. Similarly, in the event of repatriation, Expat Medical Plan participants cease to be eligible for coverage under the Expat Medical Plan (but may be eligible to resume coverage under the Medical Plan).

Additional eligibility requirements and eligibility exclusions for particular benefit programs offered under the Plan are addressed in the applicable Incorporated Documents. Please review the applicable Incorporated Documents in connection with this General Information Booklet to determine if you are eligible to participate in a particular benefit program offered under the Plan.

Eligible Retirees

Coverage is available for eligible retirees and their eligible family members under the Medical Plan, the Dental Plan and the Basic Life Insurance Plan. Eligibility and enrollment rules for retirees are separately addressed in the applicable Incorporated Documents. Please review the applicable Incorporated Documents in connection with this General Information Booklet to determine whether you are eligible for retiree coverage. Note that you may be able for retiree coverage under the Medical Plan if you retire while participating in the Expat Medical Plan. Please call HR Connect for more information.

Waiting Period

There is no waiting period for coverage under the Plan. An eligible employee is eligible for coverage on the first day of employment or change to eligible status with the employer, subject to any enrollment and/or actively at work requirements that apply to certain benefit programs offered under the Plan as described in the applicable Incorporated Documents.

FMLA Covered Persons

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

Military Leave Covered Persons

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

Leave of Absence

An employee who would normally be working as a regular employee for the employer for at least the required number of hours per pay period to qualify as an eligible employee, but who is on an employer-approved leave of absence (such as approved personal, disability, parental and/or military leave), generally remains an eligible employee for the duration of the approved leave. Refer to the applicable Incorporated Documents for any additional restrictions on your ability to continue benefit program coverage while on an approved leave, such as LTD Plan coverage only continuing during the first 90 days of leave and MTA Plan and WorldTraveler Plan coverage not continuing during any leave.

Eligible Family Members

When you enroll in coverage under certain benefit programs, you may elect to cover your eligible family members. Eligible family members include your eligible spouse and your eligible child or children as described in this section.

Except as otherwise provided in the applicable benefits booklets, certificates of coverage and other Incorporated Documents, your spouse and/or child must satisfy the eligibility requirements described below to participate in the Plan and/or a particular benefit program offered under the Plan.

Spouse Eligibility

Your spouse, eligible for coverage as a family member under the Plan and the benefit programs that provide for spousal coverage, is a person to whom you are legally married under the law of the domestic state or foreign jurisdiction having legal authority to sanction the marriage. Your spouse ceases to be your spouse on the date your marriage is legally terminated by divorce or annulment. Your spouse does not include a person in another formal relationship with you, such as a common law marriage, registered domestic partnership or marriage-equivalent civil union. You may be required to provide evidence of your marriage to Mayo (e.g., by providing a marriage license upon request).

Child Eligibility

A child or children, eligible for coverage as a family member under the Plan and the benefit programs that provide for child coverage, include your or your spouse's biological children, stepchildren, legally adopted children or children legally placed with you for adoption, up to age 26.

An eligible child of any age who is unmarried and physically or mentally incapable of self-support continues to be an eligible child at and after age 26, provided that such incapacity arose prior to age 26 and resulted in the child being approved to receive Social Security Disability Insurance ("SSDI") benefits as demonstrated by an SSDI approval letter dated prior to the child's 26th birthday. New hires and newly benefit-eligible employees are required to provide such SSDI approval letter as proof of incapacity in order to enroll children who are age 26 or older when they first enroll in coverage. Benefits-eligible employees who wish to continue an incapacitated child's coverage after the child reaches age 26 must provide such SSDI approval letter as proof that the child is receiving SSDI benefits prior to age 26. An incapacitated child's coverage will end if your own coverage ends or if the child marries or is no longer incapacitated.

A child whose coverage is required under a Qualified Medical Child Support Order ("QMCSO") will be eligible to participate in the Medical Plan, the Expat Medical Plan, the Dental Plan, the Vision Plan, the Health FSA and the EAP. The Plan Administrator or its designee will review a child support order and determine whether it is qualified. Upon written request to HR Connect, you may obtain a copy of the procedures governing QMCSOs at no charge.

Employee Couples

No one may be considered a family member of more than one employee for purposes of eligibility to participate in the Plan or any benefit program offered under the Plan. In addition, no individual may be covered as both an employee and as a family member of another employee for purposes of eligibility to participate in the Plan or any benefit program offered under the Plan. However, these dual coverage rules do not apply to the Mayo Reimbursement Account component of the Dental Plan.

Verification of Family Member Status

By enrolling your family member in a benefit program, you are affirmatively representing that your family member is eligible for coverage under that benefit program. You may be required to provide evidence of family member eligibility, such as, but not limited to, tax returns, marriage license, birth certificate, court order or adoption papers following the date of enrollment.

Affirmation of Eligibility

By enrolling your family member in the Plan and/or a particular benefit program offered under the Plan, you are affirmatively representing that your family member is eligible for coverage under the benefit program and the Plan. Failure to drop your family member from coverage constitutes a continuous affirmation of your family member's eligibility. Any failure to drop coverage for your family member after your family member ceases to be eligible will be considered a misrepresentation of your family member's eligibility.

If you or an enrolled family member knowingly submit false information when enrolling in, changing or claiming health and insurance benefits, or if you fail to report that an enrolled family member is no longer eligible for coverage, participation for you and your family members may be immediately and permanently canceled. In addition, your coverage may be denied. Pending claims may not be paid, and you must reimburse the Plan and the benefit program for any previous claims incurred that should not have been paid. You also may be subject to disciplinary action by your employer, up to and including termination of employment.

If a Family Member Becomes Ineligible

If a covered family member becomes ineligible for coverage during the year (for example, if you and your spouse divorce), the individual(s) who become(s) ineligible for coverage will be dropped from your coverage.

You must report any family members who should be dropped from coverage due to a loss of eligibility within 31 calendar days of the loss of eligibility. When you report a family member's loss of eligibility within 31 calendar days of the loss of eligibility:

- the family member's coverage ends at midnight on the last day of the month in which the family member ceases to be an eligible family member under each benefit program; and
- changes to your contribution amounts will be made as soon as administratively practicable after the date on which you provide notice that your family member is no longer eligible.

If you do not provide notice of a covered family member's ineligibility within 31 calendar days of the loss of eligibility:

- the family member's coverage ends at midnight on the last day of the month in which the family member ceases to be an eligible family member under each benefit program;
- changes to your contribution amounts will be made as soon as administratively practicable after the date on which you provide notice that your family member is no longer eligible;

- with respect to a benefit program that is a group health plan subject to the Consolidated Omnibus Budget Reconciliation Act (“COBRA”), the coverage provided while your family member is ineligible will be considered as part of the individual’s COBRA coverage period (this period begins on the first day of the month following the month in which eligibility is lost); and
- COBRA contributions (102% of the total cost) will be required to pay for the coverage received since the end of the month in which eligibility was lost if the individual elects continuation of coverage under COBRA.

If you do not report a covered family member’s ineligibility within 60 calendar days after the date the family member’s coverage would be lost due to becoming ineligible, such family member will not be offered COBRA continuation coverage.

To drop coverage for ineligible family members, contact HR Connect.

Mayo reserves the right to seek recovery of any benefits paid to or for your ineligible family members.

Note that if you are participating in either the Medical Plan or the Expat Medical Plan at the time of your death, coverage may be available for your family members after your death under the Medical Plan if you satisfy certain years of service requirements. Please refer to the Incorporated Documents for the Medical Plan or call HR Connect for more information.

When You Can Enroll

The following paragraphs describe enrollment. Please note that in order for your eligible family members to be enrolled, you must be enrolled or enrolling.

Initial Enrollment

Eligible employees¹: An eligible employee has 31 days from the date he/she first satisfies the definition of eligible employee to enroll in coverage under the Plan and/or any benefit program offered under the Plan. This is called the initial enrollment period. Enrollment instructions will be provided by a designated representative of the employer. Enrollment materials must be completed and submitted electronically to HR Connect within the 31-day period. Alternatively, you may call HR Connect to complete your enrollment within the 31-day period. If enrollment does not occur within this initial period, the eligible employee may enroll in the Plan and/or any benefit program offered under the Plan only if a permitted mid-year election change event or special enrollment event occurs or during the next open enrollment period, unless otherwise provided in the applicable Incorporated Documents.

Eligible family members: An eligible family member must be enrolled within 31 days of the date he/she first satisfies the definition of eligible family member. If enrollment does not occur within this initial enrollment period, the eligible family member may enroll in the Plan and/or any benefit program offered under the Plan only if a permitted mid-year election change event or special enrollment event occurs or during the next open enrollment period, and only if the eligible family member continues to satisfy the eligibility rules at that time, unless otherwise provided in the applicable Incorporated Documents.

¹ For employees who transition from Medical Plan to Expat Medical Plan coverage, Expat Medical Plan coverage will be based on elections in place under the Medical Plan (e.g., a single employee coverage election in Mayo Premier results in single employee coverage under the Expat Medical Plan). Participants in the Expat Medical Plan have 31 days to change this default coverage or completely opt out and waive coverage altogether.

If you are not enrolled in the Medical Plan at the time you become eligible for Expat Medical Plan coverage, Expat coverage must be elected within 31 days of becoming eligible. Please call HR Connect for more information.

Open Enrollment

Prior to the start of a coverage year, the Plan has an open enrollment period. The terms of the open enrollment period, including, but not limited to, the duration of the election period, are determined by Mayo and communicated prior to the start of the open enrollment period. During the open enrollment period, you have the opportunity to enroll in coverage, make changes to your coverage, or continue your previous coverage election for the following year, if available. Your open enrollment elections will become effective on the next January 1 and will remain in effect until the next December 31, unless you experience a permitted mid-year election change event or special enrollment event as described below or you are otherwise permitted to make a mid-year election change under the benefit program in accordance with the provisions of the applicable Incorporated Document.

Open enrollment each year will be either active or passive. Active enrollment means you must make an affirmative election for coverage for yourself and your eligible family members during the open enrollment period, or you will be deemed to have waived coverage. Passive enrollment means your current coverage will roll over to the next calendar year if the benefit program is still offered and you do not make any change. The open enrollment materials you receive each year will describe which benefit programs require your affirmative election for coverage and which benefit program coverage will automatically continue if you do not take any action. After the open enrollment deadline, you must wait until the next open enrollment period to make a new election, unless you experience a permitted mid-year election change event or special enrollment event as described below or you are otherwise permitted to make a mid-year election change under the benefit program in accordance with the terms of the applicable Incorporated Document.

Who Pays the Costs of the Plan

Mayo contributes toward the cost of your coverage under the benefit programs. In some cases, Mayo pays the full cost of your coverage under the benefit programs. In other cases, you share the cost of your coverage under the benefit programs with Mayo, or pay the full cost.

Who Pays the Cost	Benefit
Mayo pays the full cost	<ul style="list-style-type: none"> • Basic Life Insurance Plan coverage • AD&D Plan basic coverage • MTA Plan coverage • WorldTraveler Plan coverage • STD Policy coverage • LTD Plan coverage • EAP coverage
You and Mayo share the cost	<ul style="list-style-type: none"> • Medical Plan coverage • Expat Medical Plan coverage • Dental Plan coverage

<p>You pay the full cost</p>	<ul style="list-style-type: none"> • Vision Plan coverage • Health FSA • Dependent Care FSA • Pre-Tax HSA • Voluntary Life Insurance Plan coverage • Fellows Life & LTD Plan coverage • AD&D Plan voluntary coverage • Accident Insurance Plan coverage • Critical Illness Insurance Plan coverage • Hospital Indemnity Insurance Plan coverage • Legal Plan coverage
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The cost of coverage depends on the type(s) of coverage you elect and, if applicable, which family members you elect to cover. Mayo will determine and periodically communicate your share of the cost of coverage under the benefit programs, and Mayo may change your share of the cost at any time.

Mayo will make its contributions in an amount that (in Mayo’s sole discretion) is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by your contributions. Mayo will pay its contribution and your contributions to an insurance carrier or, with respect to benefits that are self-insured, will use these contributions to pay benefits directly to or on behalf of you and your eligible family members from Mayo’s general assets. Your contributions toward the cost of a particular benefit program will be used in their entirety prior to using Mayo contributions to pay for the cost of such benefit program.

See the section titled *Contributions and Funding* for more detail.

How You Pay for Coverage and Pre-Tax Premium Payment Program

All employees electing coverage under the Medical Plan, the Expat Medical Plan, the Dental Plan and/or the Vision Plan pay their share of the cost of coverage through pre-tax salary reductions from the first two pay periods per month, 24 times per year, except if on an unpaid leave of absence. All employees electing to contribute to the Health FSA, Dependent Care FSA and/or Pre-Tax HSA pay their contributions through pre-tax salary reductions each pay period, except if on an unpaid leave of absence. All employees electing voluntary AD&D Plan coverage, Voluntary Life Insurance Plan coverage, Fellows Life & LTD Plan, Accident Insurance Plan coverage, Critical Illness Insurance Plan coverage, Hospital Indemnity Insurance Plan coverage and/or Legal Plan coverage pay the cost of coverage through after-tax salary deductions from the first two pay periods per month, 24 times per year, except if on an unpaid leave of absence. If your pay for a pay period is insufficient to cover your benefits coverage cost for that pay period, you will be sent an invoice which you must pay on an after-tax basis via check or direct debit from your bank account. Employees on an unpaid leave of absence during which benefit program coverage can continue must make arrangements to continue to pay their required contributions on an after-tax basis while on leave, in accordance with procedures established by Mayo. All retirees pay their share of the cost of coverage on an after-tax basis every month via check or direct debit from their bank account.

Eligible employees pay their share of the cost of coverage elected under the Medical Plan, the Expat Medical Plan, the Dental Plan and/or the Vision Plan on a pre-tax basis for themselves, their spouses, and their children who are their tax dependents. Eligible employees also pay elected Health FSA, Dependent Care FSA and/or Pre-Tax HSA contributions on a pre-tax basis. Such pre-tax payments are permitted under Section 125 of the Internal Revenue Code, subject to certain rules and limitations. This document includes a description of the Pre-Tax Premium Payment Program (“Pre-Tax Premium Rules”) for these benefit programs under the Mayo Cafeteria Plan. These benefit programs under the Plan will be administered in accordance with these rules and limitations and with any subsequent amendment to or clarification of the rules and limitations. The Pre-Tax Premium Rules under the Mayo Cafeteria Plan are not subject to ERISA. The plan year for the Pre-Tax Premium Rules under the Mayo Cafeteria Plan is the calendar year. Pre-Tax Premium Rules continue to apply to employees who are on an approved paid leave of absence, but do not apply to employees who are on an approved unpaid leave of absence.

Federal law limits the circumstances under which you can make changes to your pre-tax elections during the plan year (other than your Pre-Tax HSA elections). Unless you experience a permitted mid-year election change event or special enrollment event as described below, you will not be able to make changes to your pre-tax elections (other than your Pre-Tax HSA elections) until the next open enrollment period.

Mid-Year Election Changes

You can change your pre-tax contribution elections under the Pre-Tax HSA, your after-tax coverage elections under the Voluntary Life Insurance Plan, the Fellows Life & LTD Plan, the Accident Insurance Plan, Critical Illness Insurance Plan and/or the Hospital Indemnity Insurance Plan and/or your after-tax coverage elections for voluntary coverage under the AD&D Plan, as applicable, at any time during the year and for any reason by contacting HR Connect.

Note that for coverage under the Legal Plan, elections are only permitted upon new hire, open enrollment, or becoming newly benefits eligible mid-year.

You can only change your pre-tax coverage elections under the Medical Plan, the Expat Medical Plan, the Dental Plan, the Vision Plan, the Health FSA and/or the Dependent Care FSA during the year, including who you choose to cover as eligible family members, as applicable, if you experience a permitted mid-year election change event as discussed below.

Events Permitting Changes in Pre-tax Elections during the Year

Because you pay your share of Medical Plan, Expat Medical Plan, Dental Plan and/or Vision Plan coverage with pre-tax dollars and because you contribute to your Health FSA and/or Dependent Care FSA on a pre-tax basis, you can only change your elections under those benefit programs mid-year if you and/or your eligible family member experience a permitted mid-year election change event. This means that once you make your pre-tax elections at initial or open enrollment, those elections are ordinarily in effect for the remainder of the calendar year.

If your mid-year election change request is approved, the requested change in your coverage will be effective as of the date of your permitted mid-year election change event. If your cost of coverage changes as a result of your permitted mid-year election change event, Mayo will automatically increase or decrease your cost of coverage, as applicable, on a prospective basis as soon as administratively practical after your election change is approved.

The chart below describes the permitted mid-year election change events and the consistency requirements that must be met in order to make an election change mid-year.

Under certain circumstances, your enrollment elections will change automatically (for example, if you terminate employment, your coverage ends and your pre-tax elections are automatically stopped). The

events leading to automatic changes to your coverage are included in the chart below, even though they will occur automatically.

Permitted Mid-Year Election Change Events

The rules in the chart below apply only to coverage under the Medical Plan, Expat Medical Plan, Dental Plan and Vision Plan. These mid-year election change rules may apply slightly differently to your Health FSA and/or Dependent Care FSA elections. Refer to the applicable Incorporated Documents for those benefit programs for a description of any unique rules that apply to your FSA elections.

Event	Permitted Election Change	Employee Requirements for Election Change
<p>Marriage</p>	<p>If you are not already enrolled:</p> <p>May enroll yourself and your new spouse and any other eligible family member (even if they were previously not enrolled before you married). You must enroll yourself to cover your spouse or any other eligible family member.</p> <p>If you are already enrolled:</p> <p>May add your new spouse and any other eligible family member (even if they were previously not enrolled before you married).</p> <p>If you or any eligible family member become eligible under your spouse’s group health plan and elect such coverage, may drop the corresponding Mayo coverage.</p>	<p>Within 31 calendar days from the date of marriage, you must contact HR Connect to request a change.</p> <p><i>But see special rules regarding this deadline related to COVID-19 below under the “Special Enrollment Rights” section.</i></p>
<p>Birth, adoption or placement for adoption</p>	<p>If you are not already enrolled:</p> <p>May enroll yourself, your spouse and any other eligible family member (even if they were previously not enrolled before you acquired the new child). You must enroll yourself to cover your spouse or any other eligible family member.</p> <p>If you are already enrolled:</p> <p>May enroll your spouse and any other eligible family member (even if they were previously not</p>	<p>Within 31 calendar days from the date of birth, adoption or placement for adoption, you must contact HR Connect to request a change.</p> <p><i>But see special rules regarding this deadline related to COVID-19 below under the “Special Enrollment Rights” section.</i></p>

Event	Permitted Election Change	Employee Requirements for Election Change
	enrolled). <i>Note: You must affirmatively and timely add a new child, even if your coverage level does not change.</i>	
Death of a child	Must remove child from coverage.	Within 31 calendar days from the date of the child’s death, you must contact HR Connect to request a change.
Your child becomes eligible for Mayo coverage (for example, if you gain a stepchild)	May add child and any other eligible family member to your coverage. <i>Note: You must affirmatively and timely add a newly eligible family member, even if your coverage level does not change.</i>	Within 31 calendar days from the date of eligibility, you must contact HR Connect to request a change.
Divorce, annulment or death of spouse	<p>If spouse has Mayo coverage: Must remove spouse</p> <p><i>Note: You must affirmatively and timely remove your spouse from coverage, even if your coverage level does not change. Failure to do so is considered fraud against the Plan.</i></p> <p>If you or any eligible family member were covered by your spouse’s plan and lose eligibility: May elect Mayo coverage for yourself and any eligible family member.</p>	Within 31 calendar days from date of divorce, annulment or death of spouse, you must contact HR Connect to request a change.
Your covered child loses eligibility for Mayo coverage due to age	Coverage ends on the last day of the month in which the child reaches age 26	Not applicable because Mayo will automatically make this change.

Event	Permitted Election Change	Employee Requirements for Election Change
<p>Your employment status changes so that you gain eligibility for Mayo coverage (for example, you move from a non-benefit eligible position to a benefit eligible position)</p>	<p>May elect Mayo coverage for yourself, your spouse and any other eligible family member.</p>	<p>Within 31 calendar days from the date of your employment status change, you must contact HR Connect to request enrollment.</p>
<p>Your employment status changes so that you lose eligibility for Mayo coverage (for example, you move from a benefit eligible position to a non-benefit eligible position)</p>	<p>Coverage ends unless you are covered under the Medical Plan or Expat Medical Plan as a full-time employee as defined by the ACA and are in a Stability Period, in which case you can continue only your Medical Plan or Expat Medical Plan coverage through the end of the last Stability Period for which you are a full-time employee as defined by the ACA.</p>	<p>Mayo will automatically make this change unless you are in a Stability Period under the Medical Plan or Expat Medical Plan.</p>
<p>Your employment status changes so that you are working less than a .50 FTE but are in a Stability Period and you do not lose eligibility under the Medical Plan or Expat Medical Plan</p>	<p>You may elect to end coverage for yourself and all eligible family members under the Medical Plan or Expat Medical Plan if you intend to enroll in another plan providing minimum essential coverage with coverage effective no later than the first day of the second month following the month in which you drop coverage under the Medical Plan or Expat Medical Plan.</p>	<p>Within 31 calendar days from the date of your employment status change, you must contact HR Connect to request a change.</p>
<p>You become eligible for Special Enrollment or Open Enrollment in a Qualified Health Plan through a Marketplace Exchange and enroll in such a Qualified Health Plan with coverage effective immediately following your election to revoke coverage under the Medical Plan or Expat Medical Plan</p>	<p>You may elect to end coverage for yourself and all eligible family members covered under the Medical Plan or Expat Medical Plan.</p>	<p>Within 31 calendar days from the date of your enrollment in a Qualified Health Plan through a Marketplace Exchange, you must contact HR Connect to request a change.</p>

Event	Permitted Election Change	Employee Requirements for Election Change
<p>Your spouse gains eligibility under another employer’s plan</p>	<p>If you, your spouse or any other covered family member will become covered under your spouse’s plan: May drop the corresponding Mayo coverage.</p>	<p>Within 31 calendar days from the date of your spouse’s gain of eligibility, you must contact HR Connect to request a change.</p>
<p>Your eligible family member gains eligibility under another employer’s plan (for example, your child is hired)</p>	<p>If your eligible family member becomes covered under the other employer’s plan, you may drop the eligible family member from the corresponding Mayo coverage.</p>	<p>Within 31 calendar days from the date of your family member’s gain of eligibility, you must contact HR Connect to request a change.</p>
<p>Your spouse loses eligibility under another employer’s plan because of an employment status change (for example, your spouse’s employment is terminated)</p>	<p>If you have Mayo coverage: May add your spouse as well as any other eligible family member to the applicable Mayo coverage. If you or any eligible family member were covered under your spouse’s plan: May elect coverage under the applicable Mayo coverage for yourself, your spouse and any other eligible family member.</p>	<p>Within 31 calendar days from the date of your spouse’s loss of eligibility, you must contact HR Connect to request a change.</p>
<p>Your eligible child loses eligibility under another employer’s plan because of an employment status change (for example, your child is terminated)</p>	<p>May elect coverage under the applicable Mayo coverage for yourself, your eligible child and any other eligible family member.</p>	<p>Within 31 calendar days from the date of your child’s loss of eligibility, you must contact HR Connect to request a change.</p>
<p>You are rehired by Mayo within 30 days of termination by Mayo</p>	<p>If you are rehired into a benefits eligible position, the coverage elections you had in place at your termination of employment are reinstated.</p>	<p>Not applicable because Mayo will automatically make this change.</p>
<p>You are rehired by Mayo more than 30 days after termination by Mayo</p>	<p>If you are rehired into a benefits eligible position, you may make new coverage elections.</p>	<p>You will have the same time frame to elect new coverage as other new hires.</p>

Event	Permitted Election Change	Employee Requirements for Election Change
<p>You have Mayo coverage, your spouse is employed by another employer, and either (i) your spouse’s plan is improved mid-year or (ii) your spouse’s plan has a different plan year (and annual enrollment period) than your Mayo coverage and you decide to change to your spouse’s plan</p>	<p>If you, your spouse, or any other covered family member moves to your spouse’s plan, you can drop (if all of you are changing coverage) or reduce (for those covered persons who are moving to the spouse’s plan) your corresponding Mayo coverage.</p>	<p>Within 31 calendar days from the date coverage under your spouse’s plan begins, you must contact HR Connect to request a change.</p>
<p>You are covered under your spouse’s employer’s plan which has a different plan year (and annual enrollment period) than Mayo coverage and you want to drop coverage under your spouse’s plan and elect Mayo coverage</p>	<p>If you drop coverage under your spouse’s plan, you may enroll yourself, your spouse and any other eligible family members in the corresponding Mayo coverage.</p>	<p>Within 31 calendar days from the date coverage under your spouse’s employer’s plan ends, you must contact HR Connect to request a change.</p>
<p>Your child is employed and the child’s plan is improved mid-year or has a different plan year (and annual enrollment period) than Mayo coverage</p>	<p>If your child moves to his or her employer’s plan, you may drop your child from the corresponding Mayo coverage.</p>	<p>Within 31 calendar days from the date your child gains coverage under his or her employer’s plan, you must contact HR Connect to request a change.</p>
<p>You, your spouse or other eligible family member become entitled to Medicare or Medicaid</p>	<p>You can decrease or drop your Mayo coverage to the extent consistent with the Medicare or Medicaid entitlement.</p>	<p>Within 60 calendar days from date of Medicare or Medicaid eligibility, you must contact HR Connect to request a change.</p>
<p>You, your spouse or other eligible family member loses eligibility for a premium assistance subsidy under Medicaid or a state Children’s Health Insurance Program (“CHIP”)</p>	<p>You can add or increase your Medical Plan or Expat Medical Plan coverage to the extent the change corresponds with the loss of eligibility for a premium assistance subsidy under Medicaid or CHIP.</p>	<p>Within 60 calendar days from the loss of eligibility for a premium assistance subsidy under Medicaid or CHIP, you must contact HR Connect to request a change.</p>
<p>You, your spouse or other eligible family member becomes eligible for a premium assistance subsidy</p>	<p>You may enroll yourself, your spouse and any other eligible family member in Medical Plan or Expat Medical Plan coverage.</p>	<p>Within 60 calendar days after the date on which eligibility for premium assistance subsidy is determined, you must contact HR Connect to request a</p>

Event	Permitted Election Change	Employee Requirements for Election Change
under Medicaid or CHIP		change.
You are required to provide health plan coverage under a Qualified Medical Child Support Order (“QMCSO”) for a child you do not currently cover under Mayo’s group health plans	<p>If you already have coverage, you may add the child who is the subject of the QMCSO. If your coverage level changes, your cost of coverage will increase.</p> <p>If you do not have coverage, both you and the child who is the subject of the QMCSO will be enrolled in the coverage required by the QMCSO.</p>	Contact HR Connect within 31 days of receiving the QMCSO and submit the QMCSO as soon as possible.
Another person, such as your former spouse, is required by a QMCSO to provide health coverage to an eligible family member currently enrolled in Mayo coverage	Notify Mayo of the QMCSO. The eligible family member will be dropped from your Mayo coverage and, if your coverage level changes, your cost of coverage will decrease.	Contact HR Connect within 31 days of receiving the QMCSO and submit the QMCSO as soon as possible.
Your share of the cost of your Mayo coverage increases or decreases insignificantly (because the cost of coverage charged by Mayo changes by an insignificant amount mid-year)	If Mayo increases or decreases the cost of Mayo coverage for employees during the year by an insignificant amount, as determined by Mayo in its sole discretion, your share will be automatically adjusted.	Not applicable, because Mayo will automatically make these changes.

Moving to and from International Assignment

Pursuant to the permitted mid-year status change events above, in the event you leave the U.S. for international assignment of six months or more, you will cease to be eligible for coverage under the Medical Plan, but will become eligible for coverage under the Expat Medical Plan. In the event you “repatriate” and return to the U.S. following international assignment, you will cease to be eligible for Expat Medical Plan coverage, but will become eligible for coverage under the Medical Plan.

Procedure and Deadline for Making Mid-Year Election Changes

If you satisfy the requirements in this section for a permitted mid-year election change event, you must notify HR Connect within 31 days of the date you experience an event that allows you to make a mid-year election change. Under federal law, however, you have 60 days from either (i) termination of Medicaid or CHIP coverage due to loss of eligibility for that coverage, or (ii) becoming eligible for a Medicaid or CHIP premium assistance subsidy to make your mid-year election change on account of one of those two events. See the *Special Enrollment Rights* section below for more information, including special rules related to COVID-19’s impact on certain reporting deadlines.

As previously noted, some changes to your coverage will happen automatically. For example, if you terminate or are no longer eligible for coverage, your coverage (and your spouse's, and eligible family members' coverage) will automatically be terminated.

In cases not related to your Mayo employment, however, you need to notify HR Connect of the occurrence of the event in order to stop your pre-tax employee contributions, even if coverage is lost under the terms of the applicable benefit program. For example, if you divorce, your spouse loses coverage on the last day of the month in which the dissolution of marriage date occurs. You must still notify HR Connect of the divorce if you want to change your coverage level and reduce your pre-tax employee contributions.

If you are an eligible employee and are required by a QMCSO to provide health coverage for a child, you will be enrolled in the applicable group health plan coverage under the Plan, if necessary, or your existing coverage level and required contributions will be increased as specified in the QMCSO. The entire cost to you for such coverage will be deducted from your pay automatically on a pre-tax basis. Submit medical child support orders to HR Connect at your earliest convenience so that they can be processed.

The Consistency Rule

Also note that federal tax rules applicable to pre-tax benefits under the Plan require that your changes satisfy certain "consistency rules." This means that the permitted mid-year election change event generally must affect eligibility for coverage under an employer's plan and the requested mid-year election change must be on account of and consistent with the event. If, in the Plan Administrator's judgment, the requested mid-year election change does not satisfy these rules, it will not be permitted.

Important Note: You may need to provide proof of your permitted mid-year election change event and the date the event occurred. Failure to do so may result in denial of your mid-year election change request.

If you have questions about changing your benefit elections during the year, please contact HR Connect.

Permitted Mid-Year Election Change Rules If You Are Retired

If you are retired, you pay for your benefits with after-tax dollars and the Pre-Tax Premium Rules do not apply. Retired employees can make changes in coverage prospectively at any time during the year to eliminate or reduce their coverage. However, if you drop your retiree coverage under a benefit program at any time, you and your eligible family members will not have the opportunity to re-enroll in that benefit program or any option under that benefit program at any future date. Please review the applicable Incorporated Documents for additional information about benefit program coverage in retirement.

Special Enrollment Rights

You can enroll yourself and your eligible family members for coverage under the Medical Plan or Expat Medical Plan, as applicable, during the year if:

- you or your family member had other coverage under another health plan or health insurance at the time the Medical Plan or Expat Medical Plan, as applicable, was previously offered to you; and
- you or your eligible family member, as applicable, did not enroll in the Medical Plan or Expat Medical Plan, as applicable; and
- you or your family members lose such other coverage and are otherwise eligible for coverage under the Medical Plan or Expat Medical Plan.

To enroll for Medical Plan or Expat Medical Plan coverage, as applicable, in such a circumstance, the following conditions must be satisfied:

- The other coverage was:
 - under a federal continuation provision (COBRA) and the continuation period for the other coverage was exhausted. (COBRA coverage is considered exhausted when it ceases for any reason other than either failure of the individuals to pay contributions on a timely basis or for cause (fraudulent or intentional misrepresentation)); or
 - not under COBRA and the other coverage terminated as a result of (i) loss of eligibility (such as loss of eligibility due to divorce, death, termination of employment or reduction in the number of hours of employment), or (ii) employer contributions toward the other coverage end.

In any case, the other coverage must not have terminated because you failed to pay timely contributions, or for cause (such as filing fraudulent claims).

You also can enroll yourself, your eligible spouse and/or your newly eligible child in Medical Plan or Expat Medical Plan coverage, as applicable, if you acquire an eligible family member through marriage, birth, adoption or placement for adoption.

If you need to enroll for coverage under the Medical Plan or Expat Medical Plan, as applicable, as a result of one of these events (such as loss of other coverage, or because you acquire an eligible family member through marriage, birth, adoption or placement for adoption), you must enroll by notifying HR Connect, in writing, within 31 calendar days of the event. Otherwise, unless a subsequent permitted mid-year election change event occurs as described above, you must wait until the next open enrollment.

You also can enroll yourself and your eligible family members for coverage under the Medical Plan or Expat Medical Plan, as applicable, during the year if:

- you or your eligible family members lose Medicaid or Children’s Health Insurance Program (“CHIP”) coverage because you or your eligible family members, as applicable, are no longer eligible; or
- you or your eligible family members become eligible for premium assistance under a Medical Plan or Expat Medical Plan option, as applicable, through a state’s premium assistance program under Medicaid or CHIP.

If you need to enroll for coverage under the Medical Plan or Expat Medical Plan as a result of one of these two events, you must enroll by notifying HR Connect, in writing, within 60 calendar days of the event. Otherwise, unless a subsequent permitted mid-year election change event occurs as described above, you must wait until the next open enrollment.

If HR Connect does not receive your completed request for enrollment by the applicable deadline, you and your eligible family member(s) lose special enrollment rights for that event.

Enrollment in the Medical Plan or Expat Medical Plan, as applicable, following a special enrollment right event is effective as of the date of the event.

Special COVID-19 Rules Related to Special Enrollment Rights. The period beginning on the date of your special enrollment event and ending on the earlier of (1) the one-year anniversary of your special enrollment event and (2) the date that is 60 days after the announced end of the national emergency related to the COVID-19 pandemic, or such other date announced by the federal agencies is disregarded

in determining the deadline for notifying HR Connect of any HIPAA special enrollment event, in accordance with applicable legal guidance.

When Coverage Becomes Effective

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

- a. **Enrollment within Initial Enrollment Period.** The effective date of coverage for eligible employees who enroll during the initial enrollment period is the first day of employment or change to eligible status with the employer. The effective date of coverage for eligible family members is the date of the eligible employee's enrollment. If eligible family member status is acquired after the eligible employee's initial eligibility, the effective date of coverage will be the date on which the family member becomes eligible for coverage, provided the employee completes a change form and submits it to HR Connect within 31 days after the attainment of eligible family member status.
- b. **Open Enrollment Period.** If an eligible employee or eligible family member does not enroll within the initial enrollment period, he or she must wait until the next open enrollment period unless a permitted mid-year election change event occurs. The effective date of coverage would be the first day of the coverage year for which the open enrollment period was held.
- c. **Special Enrollment.** When enrollment occurs as the result of special enrollment due to loss of other health coverage as described above, the effective date of coverage is the day after the end date of the other health coverage as long as the request for special enrollment is submitted to HR Connect by the applicable deadline. When enrollment occurs as the result of special enrollment due to addition of an eligible family member as described above, the effective date of coverage is the date of the event.
- d. **Other Permitted Mid-Year Election Change Event.** When an election changes as the result of a permitted mid-year election change event as described above, the effective date of coverage is the date of the event. For example, if you enroll in the Plan upon dropping coverage under your spouse's employer's plan during a non-calendar year open enrollment period, your Plan coverage would start on the date your coverage under your spouse's employer's plan ended.

WHEN COVERAGE ENDS

When Employee Coverage Ends

Your coverage *under the Plan* ends on the earliest to occur of the following events:

1. The date on which the Plan is terminated.
2. The date on which you cease to be an eligible employee under all of the benefit programs offered under the Plan and your coverage under each benefit program expires as set forth in the benefit programs.
3. The end of the period for which you made the last required contribution for coverage under all of the benefit programs offered under the Plan.
4. The effective date as of which Mayo informs the applicable insurer(s)/Claims Administrator(s) that you are canceling coverage under all of the benefit programs offered under the Plan.

Your coverage *under a particular benefit program* offered under the Plan ends on the earliest of the following dates (or on any other date specified in the applicable benefits booklets, certificates of coverage and other Incorporated Documents):

1. Except in the case of coverage under the Basic Life Insurance Plan, Voluntary Life Insurance Plan and AD&D Plan, the last day of the month in which you terminate employment with the employer. You are required to pay premiums until the end of the month of termination. Coverage under the Basic Life Insurance Plan, Voluntary Life Insurance Plan and AD&D Plan ends on the date you terminate employment with the employer.
2. Except in the case of coverage under the Basic Life Insurance Plan, Voluntary Life Insurance Plan and AD&D Plan, the last day of the month in which your employment position or status changes such that you are no longer an eligible employee, or the last day of the month in which you otherwise no longer satisfy the eligibility requirements. Coverage under the Basic Life Insurance Plan, Voluntary Life Insurance Plan and AD&D Plan ends on the date on which your employment position or status changes such that you are no longer an eligible employee, or on the date on which you otherwise no longer satisfy the eligibility requirements.
3. The date ending the period for which the last contribution is made if you fail to make any required contributions when due.
4. The date you drop coverage under the benefit program in connection with a mid-year election change.
5. The first day of the next plan year after you elect during open enrollment to drop your coverage under the benefit program.
6. The effective date of termination of the benefit program or your employer's participation in the benefit program.
7. The effective date of termination of the Plan or your employer's participation in the Plan.
8. The date of your death.
9. If the Plan is amended so that you lose coverage, the effective date of the amendment.
10. The date you are discharged from the hospital, if you are hospitalized on the day coverage would otherwise end.

When Retiree Coverage Ends

Retiree coverage *under the Plan* ends on the earliest to occur of the following events:

1. The date on which the Plan is terminated.
2. The date on which you cease to be an eligible retiree under all of the benefit programs offered to retirees under the Plan and your coverage under each benefit program expires as set forth in the benefit programs.
3. The end of the period for which you made the last required contribution for coverage under all of the benefit programs offered to retirees under the Plan.
4. The effective date as of which Mayo informs the applicable insurer(s)/Claims Administrator(s) that you are canceling coverage under all of the benefit programs offered to retirees under the Plan.

Retiree coverage *under a particular benefit program* offered under the Plan ends on the earliest of the following dates (or on any other date specified in the applicable benefits booklets, certificates of coverage and other Incorporated Documents):

1. The date of your death.
2. The date ending the period for which the last contribution is made if you fail to make any required contributions when due.
3. The effective date of termination of the benefit program or your former employer's participation in the benefit program.
4. The effective date of termination of the Plan or your former employer's participation in the Plan.
5. If the Plan is amended so that you lose coverage, the effective date of the amendment.
6. The date you are discharged from the hospital, if you are hospitalized on the day coverage would otherwise end.
7. The last day of the month if you eliminate, drop or lose coverage as a retiree.

When Eligible Family Member Coverage Ends

Coverage of your eligible family member *under the Plan* ends on the earliest to occur of the following events:

1. The date on which your coverage ends for any reason other than your death.
2. The last day of the month in which you die.
3. The date that your family member ceases to be an eligible family member under all of the benefit programs and your family member's coverage expires under each of the benefit programs as set forth in the benefit programs.
4. The last day of the period during which you made the last required contribution for your family member's coverage under all benefit programs.
5. The date your family member dies.
6. The date on which you cancel coverage for your family member under all benefit programs.

Coverage of your eligible family member *under a particular benefit program* offered under the Plan ends on the earliest of the following dates (or on any other date specified in the applicable benefits booklets, certificates of coverage and other Incorporated Documents):

1. Except in the case of dependent coverage under the Voluntary Life Insurance Plan, the last day of the month the individual ceases to be an eligible family member as defined in the Plan for any reason other than the individual's death. Premiums must be paid until the end of the month of termination. Dependent coverage under the Voluntary Life Insurance Plan ends on the date the individual ceases to be an eligible family member as defined in the Voluntary Life Insurance Plan for any reason other than the individual's death.
2. Except in the case of dependent coverage under the Voluntary Life Insurance Plan, the last day of the month in which your child's 26th birthday occurs. Dependent coverage under the Voluntary Life Insurance Plan ends on your child's 26th birthday.
3. Except in the case of dependent coverage under the Voluntary Life Insurance Plan, the last day of the month of the date of the final decree for dissolution of marriage due to divorce or annulment. Dependent coverage under the Voluntary Life Insurance Plan ends on the date of the final decree for dissolution of marriage due to divorce or annulment.
4. The date the eligible employee or retiree, as applicable, loses coverage under the benefit program for any reason other than death. See the applicable Incorporated Documents for information regarding coverage after the death of a covered employee or retiree.
5. The date eligible family member coverage is discontinued under the benefit program or the benefit program is amended so that the eligible family member loses eligibility.
6. The date ending the period for which the last required contribution is made if you cease to make the required contributions for the eligible family member.
7. The date coverage is no longer required under the terms of a QMCSO or the benefit program.
8. The first day of the next plan year after you elect during open enrollment to terminate your family member's coverage under the benefit program.
9. The date you drop your family member's coverage under the benefit program in connection with a mid-year election change.
10. The date your family member dies.
11. The effective date of termination of the benefit program or your employer's participation in the benefit program.
12. The effective date of termination of the Plan or your employer's participation in the Plan.
13. The date your eligible family member is discharged from the hospital, if he/she is hospitalized on the day coverage would otherwise end.

Additional Termination of Coverage Rules

Your participation under the Plan will terminate immediately upon termination of the Plan or at midnight upon the occurrence of the earliest of:

1. The date you do not cooperate with (1) the Plan Administrator, as that term is defined in Section 3(16)(A) of ERISA with respect to the administration of the Plan and/or (2) the employer. Failure to cooperate may result in a loss of eligibility for you and all your eligible family members. Such determination shall be made at the discretion of the Plan Administrator provided such determination is consistent with and in fulfillment of the Plan Administrator's fiduciary duties as described in Section 404 of ERISA.

2. The date on which you allow persons not covered under the Plan to obtain Plan benefits for themselves. See the applicable Incorporated Documents for additional information regarding the use of member ID cards.
3. The date you provide fraudulent information to obtain Plan benefits or coverage, including falsifying information on your applications for coverage and/or submitting fraudulent, altered, or duplicate billings for personal gain. If any claims are mistakenly paid for expenses incurred due to fraudulent information, the employee or retiree will be required to reimburse the Plan.
4. The date you do not reimburse the Plan for any claims mistakenly paid.
5. If a covered person is hospitalized on the day coverage is to end, coverage will be extended until the person has been discharged from the hospital.

Rescission

Coverage under the Medical Plan and Expat Medical Plan may be rescinded (retroactively terminated) under certain circumstances. A determination by the Medical Plan or Expat Medical Plan that a rescission is warranted due to fraud or an intentional misrepresentation of a material fact will be considered an Adverse Benefit Determination for purposes of review and appeal. If your and/or your eligible family member's coverage is rescinded due to fraud or intentional misrepresentation, you or your eligible family member, as applicable, will be provided a 30 day notice period as described under the Affordable Care Act and regulatory guidance. Such notice shall be considered an Adverse Benefit Determination. At the conclusion of the 30 day notice period, coverage shall be terminated retroactive to the date identified in the notification. Claims incurred after the retroactive date of termination shall not be further processed and/or paid under the Medical Plan or Expat Medical Plan. Claims incurred after the retroactive date of termination that were paid under the Medical Plan or Expat Medical Plan will be treated as erroneously paid claims according to the provision "Erroneous Payments" under the *General Provisions* section below. Your (and/or your family member's) coverage also may be terminated retroactively for failure to pay required contributions on a timely basis, or in certain other limited circumstances, without the 30 days advance written notice having to be provided.

CONTINUATION OF HEALTH CARE COVERAGE UNDER COBRA

This section contains detailed information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Medical Plan, Expat Medical Plan, Dental Plan, Vision Plan and Health FSA (each referred to in this section as simply the “Plan”) after you or your eligible family members lose coverage in certain circumstances. Note that special COBRA rights apply to the EAP. For further information regarding EAP and COBRA, please reference the Incorporated Documents for EAP. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). If you have questions about your COBRA continuation coverage rights, please contact the COBRA Administrator at the address or phone number provided at the end of this section.

COBRA continuation coverage can become available when you and/or your family members would otherwise lose health coverage under the Plan due to certain events. This notice generally explains COBRA continuation coverage, when it may become available to you and your family members, and what you need to do to protect the right to receive it.

Special COVID-19 Rules Related to COBRA Deadlines. The period beginning on the date of your COBRA qualifying event, initial or ongoing COBRA premium payment deadline or deadline for providing notice of a COBRA qualifying event or disability determination, as applicable, and ending on the earlier of (1) the one-year anniversary of your COBRA qualifying event, initial or ongoing COBRA premium payment deadline or deadline for providing notice of a COBRA qualifying event or disability determination, as applicable and (2) the date that is 60 days after the announced end of the national emergency related to the COVID-19 pandemic, or such other date announced by the federal agencies, is disregarded for purposes of determining (1) the COBRA election period; (2) the initial COBRA premium payment deadline; (3) the ongoing COBRA premium payment deadline; and (4) the deadline for providing notice of a COBRA qualifying event or disability determination, all in accordance with applicable legal guidance.

COBRA Eligibility

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” After a qualifying event (and any required notice of that event has been properly provided), COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse and your other eligible family members could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for that coverage.

If you are an employee, you will become a qualified beneficiary if you lose coverage under the Plan because either one of the following qualifying events occurs:

- Your hours of employment are reduced.
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse, you will become a qualified beneficiary if you lose coverage under the Plan because any of the following qualifying events occur:

- Your spouse dies.
- Your spouse’s hours of employment are reduced.
- Your spouse’s employment ends for any reason other than his or her gross misconduct.

- You become divorced.

Your other eligible family members (including children participating under a Qualified Medical Child Support Order) will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events occur:

- Parent/employee/retiree dies.
- Parent/employee's hours of employment are reduced.
- Parent/employee's employment ends for any reason other than his or her gross misconduct.
- Parents become divorced.
- Child stops being eligible for coverage under the Plan.

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Mayo and results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse and other eligible family members will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

Notification of COBRA Continuation Coverage Election

When the qualifying event is the end of employment, reduction of hours of employment, or death of the employee, the Plan will offer COBRA continuation coverage to qualified beneficiaries. You need not notify the COBRA Administrator of any of these three qualifying events.

For the other qualifying events (divorce or an eligible family member losing eligibility for coverage), a COBRA election will be available only if you, your spouse or your other eligible family member notify the COBRA Administrator of the qualifying event by sending written notice to the address listed at the end of this section. Your written notice must be postmarked no later than 60 days after the later of:

- The date of the qualifying event, and
- The date on which your spouse or your other eligible family member loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event.

You do not need to complete a specific form, but you need to provide certain information. Your written notice must include:

- The name of the Plan,
- The type of qualifying event (e.g., divorce),
- The date of the event, and
- Your name and the names of your spouse and your other eligible family members.

Verbal notice, including notice by telephone, is not sufficient. You may deliver your written notice by mail, by facsimile, or by hand.

You must provide notice in a timely manner. If mailed, a notice must be postmarked no later than the last day of the 60-day notice period described above. If not mailed, it must be received no later than the last day of the 60-day notice period described above. If you, your spouse or your other eligible family members fail to provide notice to the COBRA Administrator during this 60-day notice period, your spouse or your other eligible family members who lose coverage will not be offered the option to elect continuation coverage.

Who May Elect COBRA Continuation Coverage

Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees and covered spouses may elect COBRA continuation coverage on behalf of all qualified beneficiaries in the family, and parents may elect COBRA continuation coverage on behalf of their children. You (and any qualified beneficiary) will have 60 days after the date of the COBRA election notice (or if later, 60 days after the date coverage is lost) to decide whether you want to elect COBRA under the Plan. For each qualified beneficiary who elects COBRA continuation coverage, coverage will begin the day after the loss of coverage resulting from the qualifying event.

How to Elect COBRA Continuation Coverage

After proper notice of a qualifying event, you will be sent an election form. To elect COBRA continuation coverage, you must complete the election form and furnish it (within 60 days from the date of the election notice or, if later, the date of the loss of coverage) according to the directions on the form. If you, your spouse and your other eligible family members do not elect continuation coverage within this period, you will not receive continuation coverage. If mailed, your election form must be postmarked no later than the last day of the 60-day election period. Otherwise it must be actually received by the entity indicated on the election form no later than the last day of the 60-day election period.

Special Considerations in Deciding Whether to Elect COBRA

There may be other coverage options available to you and your family through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of a qualifying event. You will also have the same special enrollment right at the end of COBRA continuation coverage if you remain covered under COBRA continuation coverage for the maximum time available to you.

Duration of COBRA Continuation Coverage

COBRA continuation coverage is temporary continuation of coverage. COBRA coverage elected under the Health FSA does not extend beyond the last day of the calendar year in which the qualifying event occurred. The maximum COBRA coverage period under the Medical Plan, Expat Medical Plan, Dental Plan and Vision Plan is described below.

When the qualifying event is your death or divorce or an eligible family member losing eligibility, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of your employment or reduction in your hours of employment, COBRA continuation coverage generally lasts for up to 18 months.

There are three ways in which the 18-month period of COBRA continuation coverage can be extended.

1. Disability extension of 18-month period of continuation coverage

If a qualified beneficiary in your family is determined by the Social Security Administration to be disabled and you notify the COBRA Administrator in a timely fashion, all qualified beneficiaries in your

family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started some time before the 61st day after termination of employment or reduction in hours, and must last at least until the end of the 18-month period of COBRA continuation coverage.

To obtain the 11-month extension, you must notify the COBRA Administrator in writing of the Social Security Administration's determination within 60 days of the latest of:

- The date of the disability determination,
- The date of the qualifying event, or
- The date on which you lose (or would lose) coverage under the terms of the Plan as a result of the qualifying event. You must also provide the notice before the end of the 18-month period of COBRA continuation coverage. If notice is not made within the required period, there will be no disability extension of COBRA continuation coverage.

To obtain the 11-month disability extension, you must notify the COBRA Administrator that you are requesting the extension by sending written notice to the address listed at the end of this section. Your written notice must be postmarked no later than the 60-day deadline described above. You do not need to complete a specific form, but you need to provide certain information. Your written notice must include:

- The name of the Plan,
- The date of the Social Security disability determination, and
- Your name and the names and addresses of your spouse and your other eligible family members.

You may be required to submit a copy of the Social Security Awards Determination letter or other evidence of the Social Security disability determination. You also must notify the COBRA Administrator immediately if the Social Security Administration determines that you are no longer disabled.

2. Second qualifying event extension of 18-month period of continuation coverage

If your qualified beneficiaries experience another qualifying event while receiving 18 months of COBRA continuation coverage, your spouse and other eligible family members who are qualified beneficiaries can receive up to 18 additional months of COBRA continuation coverage, up to a maximum of 36 months (including the initial 18-month period), if notice of the second qualifying event is properly given to the Plan. This extension may be available to your spouse and other eligible family members receiving COBRA continuation coverage if you die or divorce or if your eligible family member otherwise ceases to be an eligible family member. In all of these cases, the extension is available only if the event would have caused your spouse or your other eligible family members to lose coverage under the terms of the Plan had the first qualifying event not occurred. If you or a qualified beneficiary experiences a second qualifying event, you must notify the COBRA Administrator within 60 days of its occurrence.

If you do not notify the COBRA Administrator in accordance with the procedures below, your qualified beneficiaries will not receive an extension of COBRA continuation coverage.

If you experience a second qualifying event, you or your qualified beneficiary should notify the COBRA Administrator that you are requesting the extension based on the second qualifying event by sending written notice to the COBRA Administrator at the address listed at the end of this section. Your written notice must be postmarked no later than the 60-day deadline described above. You do not need to complete a specific form, but you need to provide certain information. Your written notice must include:

- The name of the Plan,
- The qualifying event that has occurred,

- The date of the second qualifying event, and
- Your name and the names and addresses of your spouse and your other eligible family members.

You may be required to submit a copy of your divorce decree or other evidence of the second qualifying event.

3. Medicare Extension for Spouse and Other Eligible Family Members

If (1) you experience a qualifying event that is either termination of employment or a reduction of hours, and (2) that qualifying event occurs within 18 months after you become entitled to Medicare, then the maximum coverage period for your spouse and other eligible family members who are qualified beneficiaries receiving COBRA continuation coverage will end 36 months from the date you became entitled to Medicare. For example, if you become entitled to Medicare eight months before the date on which you terminate employment, COBRA continuation coverage for your spouse and other eligible family members can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months). Note that your coverage period is not extended by Medicare entitlement. Instead, your maximum COBRA continuation coverage will be the 18-month period (unless extended under the disability extension described above). If you believe your spouse or your other eligible family members qualify for this Medicare extension, you or your qualified beneficiary should contact the COBRA Administrator.

Cost of COBRA Continuation Coverage

Each qualified beneficiary may be required to pay the entire cost of COBRA continuation coverage (including both employee/retiree and employer contributions) plus a 2% administrative fee. The amount of your COBRA premiums can be increased from time to time during your period of COBRA continuation coverage.

YOU WILL NOT BE CONSIDERED TO HAVE MADE ANY PAYMENT IF YOUR CHECK IS RETURNED DUE TO INSUFFICIENT FUNDS OR OTHERWISE.

First Payment for COBRA Continuation Coverage

If you elect COBRA continuation coverage, you do not have to send payment with the COBRA Continuation Coverage Election Form. However, you must make your first payment for COBRA continuation coverage no later than 45 days after the date of your election. (This is the date the election form is postmarked, if mailed.) If you do not make your first payment for COBRA continuation coverage in full by 45 days after the date of your election, you will lose all COBRA continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the COBRA Administrator to confirm the correct amount of your first payment.

Your first payment for COBRA continuation coverage should be sent to the COBRA Administrator at the address listed at the end of this section.

Periodic Payments for COBRA Continuation Coverage

After you make your first payment for COBRA continuation coverage, you will be required to make payments for each subsequent month of coverage. Under the Plan, these periodic payments for COBRA continuation coverage are due on the first of each month. If mailed, payment must be postmarked on or before the first of the month. If you make a periodic payment on or before the first day of the month to which it applies, your coverage under the Plan will continue for that month without a break. The Plan will not send periodic notices of payments due each month. Periodic payments for COBRA continuation coverage should be sent to the same address as the first payment.

Grace Period for Periodic Payments

Although periodic payments are due on the first of each month, you will be given a grace period of 30 days to make each periodic payment. Your COBRA continuation coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. If mailed, payment must be postmarked on or before the end of the grace period.

If you fail to make a periodic payment before the end of the grace period for that month, you will lose all rights to COBRA continuation coverage under the Plan. If COBRA continuation coverage is cancelled for nonpayment, coverage will not be reinstated, and you will have no further rights to COBRA continuation coverage.

Termination of COBRA Continuation Coverage before the End of the Maximum Coverage Period

COBRA continuation coverage will be terminated before the end of the maximum period if any of the following occurs:

- Any required premium is not paid on time,
- After electing COBRA continuation coverage a qualified beneficiary becomes covered under another group health plan,
- After electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare, or
- The employer ceases to provide a group health plan for its employees and retirees.

COBRA continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA continuation coverage (such as fraud). COBRA continuation coverage may also be terminated if you recover from a disability that extended your COBRA continuation coverage.

If you or a qualified beneficiary becomes covered under any other group health plan, enroll in Medicare, or recover from disability, you must notify the COBRA Administrator immediately and provide (1) the name of the Plan, (2) the type of event, and (3) the date of the event. You, your spouse or your other eligible family member should contact the COBRA Administrator.

Enrolling in Medicare in Lieu of Electing COBRA Continuation Coverage

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if

secondary to Medicare, even if you are not enrolled in Medicare. For more information visit <https://www.medicare.gov/medicare-and-you>.

Keep Your Plan Informed of Address Changes

In order to protect your rights and your family's rights, you should keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy for your records of any notices you send to or receive from the Plan Administrator.

COBRA ADMINISTRATOR
Discovery Benefits, Inc. PO Box 2079 Omaha, NE 68103-2079 1-866-451-3399 M-F, 7 a.m. – 7 p.m. CT (excluding holidays)

Continuation of Health Coverage under USERRA

The Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”) provides an additional basis for the continuation of health coverage if you are absent from employment due to service in the uniformed services, including the U.S. Armed Forces (including the Coast Guard), the Army National Guard, and the Air National Guard (when engaged in active or inactive duty training or full-time National Guard duty). USERRA provides that each qualified beneficiary may be required to pay the entire cost of continuation coverage (including both employee/retiree and employer contributions) plus a 2% administration fee (unless your period of service in the uniformed services is less than 32 days).

USERRA continuation coverage can last for up to 24 months, although the period is shortened to the day after the date on which you could return to or apply to return to employment. The USERRA continuation coverage period begins on the day after you lose coverage under the Plan. USERRA does not provide for extension of the USERRA continuation coverage period beyond 24 months.

In general, if you wish to elect to continue coverage under USERRA, you must comply with the policies and procedures outlined above with respect to COBRA. The continuation coverage periods under COBRA and USERRA run concurrently (at the same time). You are not able to continue coverage under USERRA after the COBRA continuation coverage period.

BENEFIT RESOURCES

The following is a chart identifying the third parties to whom the Plan Administrator has delegated certain of its duties and authority under the Plan:

Resource/Claims Administrator	Benefits Provided	Website	Telephone Number(s)
Medica (and Medica ONESource for reimbursement plans)	Medical, Mayo Reimbursement Account under the Dental Plan, Health FSA and Dependent Care FSA	www.medica.com/MemberSite	866-839-4015
Alluma	Prescription drug	www.allumaco.com	833-789-5310
Aetna	Expat medical coverage	https://www.aetnainternational.com/members/login-page/cx/login.do	International Toll-free: 800-231-7729 Direct/Collect: 813-775-0190 TDD (Hearing impaired): 800-325-6273
Aetna	Business travel medical insurance	http://www.aetnainternational.com	International Toll-free: 877-301-5042 Direct/Collect: 813-775-0239
Delta Dental of Minnesota	Dental	www.deltadentalmn.org	800-448-3815
Avesis	Vision	www.avesis.com	800-828-9341
Fidelity Investments	Pre-Tax HSA	www.NetBenefits.com	800-343-0860
Prudential	Life insurance, AD&D insurance, Fellows' long-term disability insurance, accident, critical illness and hospital indemnity	https://mybenefits.prudential.com	844-656-6296

Resource/Claims Administrator	Benefits Provided	Website	Telephone Number(s)
Mayo Clinic, Recovery and Claims Services	Short-term disability coverage Long-term disability coverage	http://intranet.mayo.edu/charlie/recovery-and-claims-services/	833-522-7857 or 507-284-3211
Hartford	Business travel accident insurance	https://www.hartford.com	888-563-1124
VITAL WorkLife	Employee assistance program	www.VITALWorkLife.com	800-383-1908
Mayo Clinic	Employee assistance program	Rochester Employees: http://intranet.mayo.edu/charlie/employee-assistance-rst/	Rochester Employees: 507-266-3330
ARAG	Free or discounted legal services with in-network attorneys	www.ARAGlegal.com	800-247-4184

CLAIM AND APPEAL PROCEDURES

All claims for benefits under the benefit programs must be submitted to the applicable benefit program and all claims reviews will comply with any rules and procedures required by law, as applicable. If you do not file a claim or follow the claim procedures, you are giving up important legal rights.

The information included in the chart on the next page provides a high level overview of the timeline and notification requirements under the claims and appeals processes that are required under ERISA. Specific instructions about submitting claims and specific information about appeal processes are included in each benefit program's benefits booklet, certificate of coverage and/or other Incorporated Documents. Refer to the applicable Incorporated Documents for a description of each benefit program's claims and appeals process.

Special COVID-19 Rules Related to Deadlines for Filing Claims and Appeals. The period beginning on the deadline for filing your claim or appeal and ending on the earlier of (1) the one-year anniversary of the deadline for filing your claim or appeal and (2) the date that is 60 days after the announced end of the national emergency related to the COVID-19 pandemic, or such other date announced by the federal agencies, is disregarded for purposes of determining the deadlines for filing claims and appeals under any benefit program offered under the Plan, in accordance with applicable legal guidance.

General Rules Applicable to All Claim Procedures

Authority

The Mayo Clinic Salary and Benefits Committee is the Plan Administrator and has delegated the authority to decide benefit claims and appeals as described in each benefit program's claim procedures. Each Claims Administrator listed in the Benefit Resources chart above has the discretion, authority, and responsibility to make final decisions on all factual and legal questions under each respective benefit program, to interpret and construe the benefit program and any ambiguous or unclear terms, and to determine whether a participant is eligible for benefits and the amount of the benefits. The Claims Administrator may rely on any applicable statute of limitations as a basis to deny a claim. The Claims Administrator's decisions are conclusive and binding on all parties.

Time Limit for Commencing Legal Action

If you file your initial claim within the required time, and the Claims Administrator denies your claim and appeal, you may sue over your claim (unless you have executed a release on your claim). You must, however, commence suit within one year after the date on which your claim is denied on final appeal.

Exhaustion of Administrative Remedies

You may not bring a legal action to recover benefits or to enforce or clarify your rights to benefits under the Plan or any benefit program offered under the Plan unless you have exhausted your administrative review rights under the internal claims and appeals procedure. If a benefit program provides for binding arbitration of any controversy between you or your beneficiary and the benefit program, including, as applicable, its agents, employees, providers and staff physicians, then any such controversy is subject to binding arbitration.

Timeline and Notification Requirements

Time Limits	Urgent Care Claims	Pre-Service Care Claims	Post-Service Claims	Disability Determinations	Other Claims
<i>To make initial claim determination</i>	72 hours	15 days	30 days	45 days	90 days
<i>Extension (if proper notice is given and delay is beyond the Plan's control)</i>	None	15 days	15 days	30 days (plus up to an additional 30 days)	90 days
<i>To request missing information from claimant</i>	24 hours	5 days	30 days	45 days	N/A
<i>For claimant to provide missing information</i>	48 hours	45 days	45 days	45 days	N/A
<i>For claimant to request appeal</i>	180 days	180 days	180 days	180 days	60 days
<i>To make determination on appeal</i>	72 hours	30 days (or 15 days for each appeal, if benefit program provides two levels of appeal)	60 days (or 30 days for each appeal, if benefit program provides two levels of appeal)	45 days (plus up to an additional 45 days)	60 days (plus up to an additional 60 days)

NOTE: For all claims for benefits under a benefit program, if you or any other person entitled to benefits under the benefit program does not comply with the benefit program's claims review procedures, or does not do so in a timely manner, you or such person will have failed to exhaust the administrative remedies under the benefit program and may not commence any legal or equitable action in court claiming benefits under the benefit program.

CONTRIBUTIONS AND FUNDING

Allocation of Plan Cost

Prior to each coverage year, the Plan Administrator will determine the aggregate cost to employers necessary to provide the benefits under the Plan and the benefit programs offered under the Plan and shall determine each employer's share of the aggregate cost.

Employee Contributions

Each coverage year the Plan Administrator will determine the amount of contributions, if any, that you or any subgroup will be required to pay for coverage under the Plan and the benefit programs offered under the Plan.

Employee and retiree contributions for benefit program coverage are determined by the Plan Administrator and announced during open enrollment. Your contribution amount varies based on factors such as the benefit program options you elect, your assigned full-time employee status and the coverage levels you choose. The Plan Administrator reserves the discretion and right to change the amounts of employee and retiree contributions during the Plan year.

The portion of the cost of coverage for which you are responsible under the Medical Plan, Expat Medical Plan, Dental Plan, Vision Plan, Health FSA and Dependent Care FSA as an employee is paid on a pre-tax basis through the Pre-Tax Premium Rules. Your contributions to your Pre-Tax HSA also are paid on a pre-tax basis through the Pre-Tax Premium Rules, but are not subject to the Pre-Tax Premium Rules' restrictions on midyear election changes. The portion of the cost of coverage for which you are responsible under the other benefit programs offered under the Plan and of retiree coverage under the Plan are paid for on an after-tax basis.

The cost of coverage under the Plan for you and your covered eligible family members will be deducted from your payroll deposit or check if you are the eligible covered employee. If you do not receive a payroll deposit or check, you will receive a bill for the cost of coverage under the Plan for you and your covered eligible family members.

Operating Expenses for the Plan

Operating expenses may be paid out of the Plan assets, if any, in the employers' sole discretion, or by the employers.

Plan Assets

To the extent the Plan has assets, such assets shall be used for the sole and exclusive purpose of providing benefits under the Plan and defraying reasonable administrative costs of the Plan (including disposition of Plan assets upon termination of the Plan or any benefit program under the Plan).

No Trust

There is no trust. Benefits under and expenses of the Plan are paid from the general assets of the employer.

GENERAL PROVISIONS

Applicable Law and Venue for Legal Action

The Plan is intended to be construed, and all rights and duties hereunder are to be governed, in accordance with the laws of the State of Minnesota, except to the extent such laws are preempted by the laws of the United States of America.

All litigation, in any way related to the Plan (including but not limited to any and all claims brought under ERISA, such as claims for benefits and claims for breach of fiduciary duty) must be filed in a United States District Court for the District of Minnesota.

Conformity with Governing Law

If any provision of the Plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto.

Construction of Terms

Words of sex will include persons and entities of any sex. The plural will include the singular, and the singular will include the plural.

HIPAA Privacy Rules

The group health plans offered under the Plan are subject to federal privacy requirements under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). As a participant you will receive a Notice of Privacy Practices describing your rights under these regulations. The privacy requirements are contained in the Plan document and permit Mayo as Plan Sponsor to obtain your protected health information for certain limited purposes, such as operation of the Plan. However, these provisions require Mayo to agree to various safeguards to protect your health information from impermissible uses and disclosures. You may obtain a copy of the privacy requirements by contacting the Plan Administrator.

No Guarantee of Employment

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

Non-Discrimination Policy

The Medical Plan, Expat Medical Plan, Dental Plan, Vision Plan, Health FSA and EAP (collectively referred to in this section as the “Plans”) comply with applicable Federal civil rights laws and will not discriminate against you or your eligible family members based on race, color, religion, national origin, disability, sex, or age. The Plans will not establish rules for eligibility based on health status, medical condition, claim experience, receipt of health care, medical history, evidence of insurability, genetic information, or disability.

In compliance with Section 1557 of the Affordable Care Act, the Non-discrimination Notice below describes how to obtain free qualified sign and language interpreters, obtain the Notice in large print, audio and electronic formats and language services for those whose primary language is not English. You may obtain an electronic copy of the Non-discrimination Notice on the Mayo Intranet. In the HR Connect tool, search on key words “non-discrimination”. Click on the article titled Legal Notice from Benefits.

You may request a paper copy of the Notice by contacting HR Connect at 507-266-0440 or 1-888-266-0440.

Any portion of the Plans subject to Section 105(h) of the Internal Revenue Code of 1986 shall not discriminate in favor of highly paid employees as to benefits or eligibility to participate.

Maternity Length of Stay

Under federal law group health plans may not restrict the hospital length of stay for a new mother or child to less than 48 hours for a normal delivery and 96 hours for Cesarean delivery, nor may they require that a provider obtain authorization in order to prescribe a length of stay not in excess of 48 or 96 hours. However, federal law generally does not prohibit the mother's attending provider or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

Plan Provisions Binding

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

Erroneous Payments

If the Plan or any benefit program makes a payment for benefits in excess of the benefits required by the Plan or benefit program, or makes a payment to or on behalf of an individual who is not covered by the Plan or benefit program, the Plan or benefit program shall be entitled to recover such erroneous payment from the recipient of such erroneous payment, the beneficiary, and/or the employee or retiree.

Women's Health and Cancer Rights Act

Medical and surgical benefits to women who have undergone a mastectomy, a surgical procedure to remove the breast or breast tissue, were expanded under the federal Women's Health and Cancer Rights Act in 1998. That legislation has a provision that requires health plans to provide coverage for certain mastectomy related procedures. As a participant in the Medical Plan or Expat Medical Plan, you receive coverage for all stages of reconstruction of the breast on which the mastectomy was performed, breast prosthesis (artificial substitute), and physical complications of mastectomy including lymphedemas, surgery, and reconstruction of the other breast to produce a symmetrical appearance. Treatments are subject to the same copayments, coinsurance and deductibles, as applicable, as other covered surgical procedures. For more information on copayments, coinsurance and deductibles for surgical procedures, see the applicable Incorporated Documents.

PLAN ADMINISTRATION

Powers and Duties of the Plan Administrator

The Plan Administrator has all necessary powers and duties of general administration of the Plan and the benefit programs offered under the Plan including the following:

- The sole discretion to interpret provisions of the Plan and benefit programs, decide matters of fact in granting or denying claims, determine eligibility and determine the amount of and authorize payments.
- The sole 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/or any benefit program and to receive benefits under the Plan and/or any benefit program. With respect to claims for benefits, the Plan Administrator has delegated authority and discretion as stated in *Delegation of Authority* below.
- To require any person to furnish such reasonable information as the Plan Administrator may request for the proper administration of the Plan and/or any benefit program as a condition of eligibility to participate in the Plan and/or any benefit program and to receive any benefits under the Plan and/or any benefit program.
- By action to delegate to other persons authority to carry out any duty or power which, under the terms of the Plan and/or any benefit program or applicable law, would otherwise be a responsibility of the Plan Administrator, including but not limited to appointment of and delegation of duties to various sub-committees.
- To maintain or delegate to others the duty of maintaining necessary records for the administration of the Plan and/or any benefit program.
- To make and publish such rules and procedures for regulation of the Plan and/or any benefit program, and prescribe such forms as the Plan Administrator may deem necessary.

Delegation of Authority

The Plan Administrator may from time to time delegate to Mayo employees or to other persons or entities certain of its powers, duties, or responsibilities under the Plan and the benefit programs. For example, the Plan Administrator may delegate to a Claims Administrator, a utilization review organization or an insurer certain powers, duties and responsibilities relating to the Plan and the benefit programs. With respect to the benefit programs, the Plan Administrator has delegated to the applicable Claims Administrator all fiduciary authority with respect to payment of benefits, including the initial determination of claims for benefits and the review of denied claims for benefits on appeal.

Records

The Plan Sponsor, Plan Administrator, Claims Administrator and others to whom the Plan Sponsor has delegated duties and responsibilities under the Plan and/or any benefit program shall keep accurate and detailed records of any matters pertaining to administration of the Plan and/or any benefit program 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 and/or any benefit program 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.

Release of Medical Information

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

Assignment of Benefits

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

Amendment and Termination of Plan

Mayo Clinic reserves the right to amend, modify or terminate the Plan and/or any benefit program, or any benefit program option described in any document for the Plan, including this document, in whole or in part at any time, for any reason, and in any respect. Mayo Clinic's right to amend or terminate the Plan and/or any benefit programs includes, but is not limited to, changes in eligibility requirements, employee/retiree and employer contributions, benefits provided, and termination of all or a portion of any coverage provided under the Plan and/or any benefit program, including, but not limited to, retiree coverage. If the Plan or any benefit program or benefit program option is amended or terminated, you will be subject to all of 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 benefit program benefit, other than payment of covered expenses you incurred prior to the amendment or termination. You do not have rights to vested benefits in the Plan and/or any benefit program. Mayo Clinic may delegate its rights with respect to amendment and termination of the Plan and/or any benefit program to a duly authorized delegate.

Mayo Clinic also has the right to amend and/or terminate the Pre-Tax Premium Rules at any time, for any reason and in any respect.

Payment of Benefits after Plan Termination

In the event of the Plan's and/or any benefit program's termination, benefits will be paid only for covered services or other claims incurred prior to the termination date.

ERISA STATEMENT OF RIGHTS

As a participant in the Plan, you are entitled to certain rights and protection under ERISA. The Pre-Tax Premium Rules are not subject to ERISA. ERISA provides that all Plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

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

Obtain upon written request to the Plan Administrator copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, copies of the latest annual report (Form 5500 Series), and updated Summary Plan Description. The 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 the summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse, or other eligible family members if there is a loss of coverage under the Plan's health benefit programs as a result of a qualifying event. You or your eligible family members may have to pay for such coverage. Review this General Information Booklet and the documents governing the Plan and the benefit programs for the rules governing your COBRA continuation coverage rights.

Prudent Action by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan and the benefit programs offered under the Plan. The people who operate the Plan and the benefit programs offered under the Plan, called "fiduciaries" of the Plan and the benefit programs offered under the Plan, have a duty to do so prudently and in the interest of you, other Plan participants, and beneficiaries. No one, including your employer, your union, or any other person, may fire or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored in whole or in part, you have a right to know why, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. After you exhaust the Plan's claim and appeal procedures, if your appeal is denied in whole or in part, you may file suit in a state or federal court. If fiduciaries of the Plan and/or any benefit program misuse the Plan's or benefit program'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 the costs and fees. If you lose, the court may order you to pay the costs and fees; for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have questions about your Plan and/or the benefit programs offered under the Plan, contact the Plan Administrator. If you have questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You 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 ADMINISTRATIVE INFORMATION

The following information applies to all benefit programs under the Plan.

Plan Name	Mayo Clinic Health & Welfare Benefits Plan
Plan Sponsor	Mayo Clinic 200 First Street SW Rochester, MN 55905 (507) 266-0440
Plan Sponsor EIN	41-6011702
Plan Administrator, Named Fiduciary	Salary & Benefits Committee Mayo Clinic 200 First Street SW Rochester, MN 55905 (507) 266-0440
Agent for Service of Legal Process	Mayo Clinic c/o William A. Brown, Assistant Treasurer 200 First Street SW Rochester, MN 55905 (507) 266-0440 <i>The Plan Administrator may also be served with process</i>
Plan Year	January 1 - December 31
Collectively Bargained Groups	The benefit programs under the Plan 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.
Type of Plan	The Plan is a comprehensive welfare benefit plan that provides medical, dental, vision, flexible spending account, long-term disability, life insurance, AD&D insurance, business travel accident insurance, business travel medical insurance, legal insurance, accident, critical illness, hospital indemnity and employee assistance program benefits.
Plan Number	502
Type of Administration	The Medical Plan, Dental Plan, Health FSA, Dependent Care FSA, Pre-Tax HSA, STD Policy, LTD Plan and EAP are self-funded by Mayo. The Expat Medical Plan and WorldTraveler Plan are fully-insured by Aetna. The Vision Plan is fully-insured by Avesis. The Basic Life Insurance Plan, Voluntary Life Insurance Plan, Fellows Life & LTD Plan, AD&D Plan, Accident Insurance Plan, Critical Illness Insurance Plan and Hospital Indemnity Insurance Plan are fully-insured by Prudential. The MTA Plan is fully-insured by Hartford. The Legal Plan is fully-insured by ARAG.
Source of Contributions	This Plan is funded with employer contributions from its general assets and employee contributions.

<p>Claims Administrators</p> <p><i>Please Note:</i> The Claims Administrators for the self-insured benefit programs perform claim processing services pursuant to a written contract; they do not insure benefits under those benefit programs.</p>	<p>See the <i>Benefit Resources</i> section above.</p>
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Incorporated Documents

The following identifies the Incorporated Documents that are provided in connection with this General Information Booklet and that, taken together with this General Information Booklet, constitute the Summary Plan Description for the Plan and the benefit programs offered under the Plan.

Benefit Program	Incorporated Documents
Medical Plan	Mayo Medical Plan Benefits Booklets <ul style="list-style-type: none"> • Mayo Custom Coverage • Mayo Select • Mayo Premier • Mayo Medicare Supplement
Expat Medical Plan	Mayo Expatriate Medical Plan Certificate of Coverage
Dental Plan	Mayo Dental Plan Benefits Booklets <ul style="list-style-type: none"> • Delta Dental of Minnesota • Mayo Reimbursement Account • Retiree Mayo Reimbursement Account and Dental Assistance Plan
Vision Plan	Mayo Vision Plan Certificate of Coverage
Health FSA	Health Care Flexible Spending Account Plan Summary Plan Description
Dependent Care FSA	Dependent Care Flexible Spending Account Plan Summary Plan Description
Pre-Tax HSA	Mayo Pre-Tax Health Savings Account Summary Plan Description
EAP	Mayo Clinic Employee Assistance Plan Benefits Booklets <ul style="list-style-type: none"> • Mayo Clinic Rochester • Offered through VITAL WorkLife
Basic Life Insurance Plan	Group Life Insurance Plan (Employer Paid) Certificates of Coverage <ul style="list-style-type: none"> • Employer Paid Term Life Insurance • Mayo Paid Life
Voluntary Life Insurance Plan	Voluntary Group Term and Universal Life Certificate of Coverage

Benefit Program	Incorporated Documents
STD Policy	Policies and Procedures Documents <ul style="list-style-type: none"> • Short-Term Disability (STD) Policy in the Allied Health Staff Employee Policy Manual • Short- and Long-Term Disability Policy in the Consulting/Voting Staff Policy Manual • Short-Term Disability (STD) Procedure in the Allied Health Staff Employee Policy Manual • Short- and Long-Term Disability Procedure in the Consulting/Voting Staff Policy Manual
LTD Plan	Mayo Paid Disability Income Benefits Booklet
Fellows Life & LTD Plan	Fellows Group Term Life Insurance & Disability Income Certificates of Coverage <ul style="list-style-type: none"> • Mayo Clinic Life Insurance for Residents and Research Appointees • Resident Long Term Disability Plan
AD&D Plan	Mayo Clinic Accidental Death & Dismemberment Certificate of Coverage
MTA Plan	Mayo Travel Accident Plan Certificate of Coverage
WorldTraveler Plan	Mayo Business Travel Medical Plan Certificate of Coverage
Accident Insurance Plan	Mayo Accident Insurance Plan Certificate of Coverage
Critical Illness Insurance Plan	Mayo Critical Illness Insurance Plan Certificate of Coverage
Hospital Indemnity Insurance Plan	Mayo Hospital Indemnity Insurance Plan Certificate of Coverage
Legal Plan	Mayo Legal Plan Certificate of Coverage

Employers Participating in the Plan

Contact HR Connect for information regarding the Mayo Clinic affiliates that participate in the Plan. A reference to “participating employer” or “employer” in this General Information Booklet includes each such affiliate, and such affiliates are collectively referred to with Mayo Clinic as “Mayo” in this General Information Booklet.

mayoclinic.org

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