MAYO CLINIC

Plan Document and Summary Plan Description

Mayo Universal

A Component of Mayo Medical Plan

Mayo Clinic in Arizona, Florida, and Rochester

January 2014

benefits
TO BUILD ON

HOW TO USE THIS DOCUMENT

The Table of Contents beginning on page 5 provides an overview of the detailed information in the Plan.

You will find definitions of terms throughout this medical plan document, typically adjacent to the first reference for that term. Also, the glossary beginning on page 95 provides additional detailed definitions.

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

INTRODUCTION

Mayo Clinic sponsors the Mayo Medical Plan to provide medical and prescription drug benefits for eligible employees of Mayo Clinic and other participating employers. This Plan is "self-insured" and benefits are paid from the Employers' general assets. Plan benefits vary depending on the employer, location, and specific option selected by the eligible employee. Effective January 1, 2014, this document sets forth the benefits for employees who are eligible under the portion of the Mayo Medical Plan known as the Mayo Universal, referred to in this document as the "Plan."

Because this document is intended to give employees an easily understood explanation of the Plan, it also serves as the Summary Plan Description. Privacy rules required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) are part of this Plan and are stated in a separate document that is available upon request from the Plan Administrator and available online with the Summary Plan Descriptions. Other portions of the Mayo Medical Plan that apply to other employees working at other locations or covered by other options are described in separate documents that are listed in the administrative section of this document.

Under this Plan, an eligible employee may be offered a choice of various benefit options. Covered medical services, prescription drug availability, and the cost to the employee (called cost sharing) vary between options. Cost sharing is reflected in different levels of employee contributions (called premiums), employer contributions, copayments, deductibles, and coinsurance. The options available in this Plan are listed in the plan administration section of this document. The option you elected will be shown on your member ID card.

Many of the provisions in the Plan are interrelated. Therefore, please review this entire document so that you understand fully what your benefits and responsibilities are under this Plan. The right of Mayo Clinic to amend or terminate this Plan is explained in the administrative section of this document. If you have questions, see the *Contact Information* in the next section.

Rescission of Coverage Rules

Under this Plan, coverage may be retroactively cancelled or terminated if you act fraudulently or make material misrepresentations of fact. It is your responsibility to provide accurate information and to make accurate and truthful statements including information and statements regarding familial status, age, relationships, etc. In addition, it is your responsibility to update previously provided information and statements. Failure to do so may result in your coverage, including the coverage of those provided coverage through you, being cancelled and such cancellation may be retroactive.

Grandfathered Health Plan Status

The Mayo Medical Plan is a "grandfathered plan" under the Patient Protection and Affordable Care Act (Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. As a grandfathered health plan, the Mayo Medical Plan is not required to comply with all consumer protections of the Affordable Care Act that apply to other plans. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at the Employee Service center. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

CONTACT INFORMATION

Mayo Clinic Health Solutions is the Claim Administrator for the Mayo Medical Plan and will process claims, manage the Mayo Clinic Health Solutions network of health care providers, and answer medical benefit and claim questions for the Plan.

Mayo Clinic Health Solutions customer service representatives are available to answer any questions or concerns regarding the Plan. Phone lines are open from 7 a.m. to 7 p.m. (Central Time) Monday through Friday (excluding holidays).

For enrollment or eligibility questions, please contact the Mayo Clinic Employee Service Center. The Employee Service Center is your human resources office for this Plan. Phone lines are open from 7 a.m. to 6 p.m. (Central Time) Monday through Friday (excluding holidays).

QUESTIONS ABOUT PLAN
Mayo Clinic Health Solutions 4001 41 Street NW Rochester, MN 55901-8901 507-266-5580 (local) 1-800-635-6671 (toll free) TDD at 1-800-407-2442 (toll free)
QUESTIONS ABOUT ENROLLMENT/ELIGIBILITY
Mayo Clinic Employee Service Center 200 First Street SW Rochester, MN 55905 507-266-0440 (local) 1-888-266-0440 (toll free)
COBRA ADMINISTRATION
Mayo Clinic Health Solutions ATTN: COBRA Membership 4001 41 Street NW Rochester, MN 55901-8901 507-266-5580 (local) 1-800-635-6671 (toll free) TDD at 1-800-407-2442 (toll free)

The Employee Service Center and Mayo Clinic Health Solutions Customer Service have access to translation services to meet the needs of many non-English speaking persons.

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

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ELIGIBILITY AND PARTICIPATION

Who is Eligible

If you are classified by a participating employer for payroll and personnel purposes as an employee who is regularly scheduled to work at least half-time (40 hours or more per pay period) for the employer, you are considered an eligible employee and eligible to enroll for single or family coverage on the first day of employment and during the annual open enrollment. Eligible family members are described below.

"Regularly scheduled" means your schedule on file with your employer is .5 FTE or more. A .4 FTE working extra hours does not qualify as regularly scheduled to work .5 FTE.

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

All employees who are eligible for coverage under the Plan are also eligible to participate in the Pre-Tax Premium Rules. Any employee who elects medical and prescription drug coverage under a Mayo Medical Plan will automatically pay his or her share of the cost of such coverage through the Pre-Tax Premium Payment Rules, except to any extent the employee is covering a same-sex domestic partner (or child of a same-sex domestic partner) who is not the employee's tax dependent or if the employee is on an unpaid medical leave such as FMLA.

Note that eligibility and enrollment rules for retirees are different and are addressed separately in the *Medical Coverage in Retirement* section. Also, retirees do not pay their share of the cost of coverage pre-tax.

Waiting Period

There is no waiting period. An eligible employee is eligible for coverage on the first day of employment or change to eligible status with the employer.

FMLA Covered Persons

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

Military Leave Covered Persons

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

Leave of Absence

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 (including approved personal, disability, parental, and/or military leave), remains an eligible employee for the duration of the approved leave.

Dual Employment

If you are a benefit eligible employee that works at multiple Mayo Clinic sites you may participate in the benefit plans available through the primary site location (based on hours worked). Should an employee work the same hours at multiple locations, the employee is required to select all benefits from one site location. Dual coverage or benefits from multiple locations is not permitted by the plan(s).

Eligible Family Members

Eligible family members include your spouse, same-sex domestic partner, and your child or children who are under the age of 26, even if they are eligible for medical coverage through another plan. Please note that not all same-sex domestic partners will be eligible under the Plan as specified in the definition below.

A child or children include an employee's biological children, stepchildren, legally adopted children, or children legally placed with you for adoption. In addition, children of a same-sex domestic partner who are under the age of 26 and may be eligible for coverage but only if your same-sex domestic partner's child is wholly financially dependent upon you as the employee. You must submit and obtain approval of a financial responsibility statement and may contact the Employee Service Center for the appropriate form and procedure.

A child who is physically or mentally incapable of self-support at age 26 and beyond may continue coverage under the Plan. Effective January 1, 2014, new hires and newly benefit-eligible employees will require proof of disability as defined by Social Security Disability Insurance (SSDI) for children who are age 26 or older. The employee must provide proof that the child has been declared disabled and is receiving SSDI prior to age 26. 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 Plan. The Plan Administrator will review a child support order and determine whether it is qualified. Upon written request to the Plan Administrator, you may obtain a copy of the procedures governing QMCSOs at no charge.

"Include," "includes" or ***"including"*** in this document generally mean "including, but not limited to."

"Child" or ***"children***" include biological children, stepchildren, adopted children, and children legally placed with you for adoption who are under the age of 26.

"Covered person" is an eligible employee and his/her eligible family members whose enrollment form has been accepted, whose coverage is in force, in whose name the member ID card is issued, and whose coverage has not terminated. This includes a former employee or eligible family member that is otherwise entitled to coverage and properly enrolled under any of the Plan options. "Covered person" may also be referred to as you/your.

"Same-sex domestic partner" is an individual who qualifies for membership under this Plan in accordance with each of the five requirements below:

- Is in a committed relationship with an eligible employee
- Is not related to the eligible employee
- Resides in a state that does not permit same-sex marriage
- Is the same-sex as the eligible employee
- The eligible employee has completed and submitted the Certificate of Domestic Partnership that has been approved by the Plan Administrator

There is one exception to the residency rule related to same-sex domestic partners through December 31, 2014 based on the States that currently permit same-sex marriage.

> Same-sex domestic partners who (1) reside in a state that permits same-sex marriage and (2) who were actually enrolled in the Plan as of August 1, 2013 based on a Certificate of Domestic Partnership, remain eligible as a same-sex domestic partner through December 31, 2014 subject to all other Plan terms and limitations. After this date, same-sex domestic partners residing in a State that permits same-sex marriage must be legally married and meet the definition of a spouse to maintain eligibility under the Plan. If additional States amend their laws and permit same-sex marriages, same-sex domestic partners enrolled at that time will have the later of 180 days from the laws effective date or until December 31, 2014 to enter a legal marriage in order to maintain the domestic partners eligibility.

A Certificate of Domestic Partnership must be completed and approved by the Plan Administrator before coverage begins for same-sex domestic partners.

"Spouse" is an individual who is legally married to an eligible employee under the law of the domestic state or foreign jurisdiction having legal authority to sanction the marriage.

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

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 period, the eligible family member may enroll in the Plan only if a "special enrollment" situation occurs or during the annual open enrollment provided they otherwise satisfy the eligibility rules.

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 duration of the election period, shall be determined by the Plan Administrator and communicated prior to the start of the open enrollment period. The open enrollment effective date of coverage is January 1.

"Coverage year" is the time period, not to exceed 12 months, from the effective date of the Plan to the anniversary date. All subsequent coverage years shall begin on the anniversary date and consist of a period of not more than 12 months. The Plan's coverage year is January 1 through December 31.

Who Pays the Costs of the Plan

The Plan costs are shared by you and Mayo Clinic. See the section titled *Contributions and Funding* for more detail.

How You Pay for Coverage

All employees electing coverage under the Plan pay their share of the cost of coverage through salary reductions each payroll except if on an unpaid leave of absence.

Subject to special rules for same-sex domestic partner coverage, eligible employees pay their share of the cost of coverage elected under the Plan on a pre-tax basis for themselves, their spouses, their children and their same-sex domestic partners (or children of same-sex domestic partners) who are their tax dependents. Such pre-tax payments are permitted under Section 125 of the Internal Revenue Code, subject to certain rules and limitations, including the requirement of a written plan document. This document includes the written Pre-Tax Premium Payment Rules for the Mayo Medical Plan ("Pre-Tax Premium Rules"). The Plan will be administered in accordance with these rules and limitations and with any subsequent amendment to or clarification of the rules and limitations. The Pre-Tax Premium Rules are not subject to ERISA. The plan year for the Premium Payment Rules is the calendar year.

Because you pay your share of the cost of coverage pre-tax, federal law limits the circumstances under which you can make changes to your pre-tax election during the plan year. Unless you have a special enrollment or change in status event (as discussed in the next sub-section entitled "Mid-Year Coverage Changes") you will not be able to make changes until the next open enrollment period.

Member ID Card

A member ID card is issued by the Claim Administrator to eligible employees or eligible family members pursuant to the Plan and is used for identification purposes only. Possession of a member ID card confers no right to services or benefits under the Plan, and misuse of such card may be grounds for termination of coverage under the Plan.

To be eligible for services or benefits under the Plan, the holder of the member ID card must be an eligible employee or eligible family member. Any person receiving services or benefits which he/she is not entitled to receive pursuant to the provisions of the Plan will be charged for such services or benefits at prevailing rates. If any participant permits the use of his/her member ID card by any other person, the card may be retained by the Plan and all rights of the participant to benefits under the Plan may be terminated.

Mid-Year Coverage Changes

You can only change your coverage election, including who you choose to cover as an eligible family member, under the Plan if you have either a special enrollment event or change in status event as discussed below.

Change in Status Events Permitting Cancellation or Reduction of Coverage During the Year

Because you pay your share of Mayo Medical Plan coverage with pre-tax dollars, you can only change your coverage election under the Plan mid-year if you, your spouse (and in some cases, your same-sex domestic partner), and/or eligible family member experience a change in status event This means that once you elect coverage at initial or open enrollment, that coverage is ordinarily in effect until December 31 of the year in question.

If your cost of coverage changes as a result of your permitted coverage change, Mayo will automatically increase or decrease your cost of coverage, as applicable, on the next payroll after your election change is approved.

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

Some of the changes, as indicated, are "Special Enrollment" rights subject to special protections under federal law. See the *Special Enrollment* section below for more information.

Under certain circumstances, your enrollment election will change automatically (for example, if you terminate employment, your Mayo Medical Plan coverage ends and your pre-tax election is automatically stopped). The events leading to automatic changes to the Mayo Medical Plan coverage are included in the Permitted Med-Year Election Change Event chart that follows, even though they will occur automatically.

Permitted Mid-Year Election Change Event

Event	Permitted Election Change	Employee Requirements for Election Change
Marriage (Special Enrollment)	**If you are not already enrolled**: - 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 eligible family member. **If you are already enrolled:** - May add your new spouse and any eligible family member (even if they were previously not enrolled before you married). - If you or eligible family member become eligible under your spouse's group health plan and elect such coverage, corresponding premium decreases under the Mayo Medical Plan may be made.	Within 31 calendar days from date of marriage, you must contact the Employee Service Center to request a change.
Birth, adoption, placement for adoption (Special Enrollment)	**If you are not already enrolled:** 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 eligible family member.	Within 31 calendar days from date of birth, adoption, placement for adoption, you must contact the Employee Service Center to request a change.

Event	Permitted Election Change	Employee Requirements for Election Change
	If you are already enrolled: May enroll your spouse and any other eligible family member (even if they were previously not enrolled). ***Note: You must affirmatively and timely add a new child, even if your coverage level does not change.***	
Death of a child	**If your child was covered under The Mayo Medical Plan:** Must remove child from Plan.	Within 31 calendar days from date of death of child, you must contact the Employee Service Center to request a change.
Your child becomes eligible under the terms of The Mayo Medical Plan (for example, if you add a stepchild)	May add child to your coverage. ***Note: You must affirmatively and timely add a newly eligible family member, even if your coverage level does not change.***	Within 31 calendar days from date of eligibility, you must contact the Employee Service Center to request a change.
Divorce, annulment or death of spouse	**If spouse is covered under The Mayo Medical Plan:** - Must remove spouse ***Note: You must affirmatively and timely remove your spouse, even if your coverage level does not change. Failure to do so is considered fraud on the Plan.*** **If you or any eligible family member were covered by spouse's plan and lose eligibility:** - May elect coverage under The Mayo Medical Plan for yourself and any eligible family member also losing coverage.	Within 31 calendar days from date of divorce, annulment or death of spouse, you must contact the Employee Service Center to request a change.
Your covered eligible family member loses eligibility under The Mayo Medical Plan (for example, your child exceeds the maximum	Must remove ineligible family member. ***Note: You must affirmatively and timely remove your child, even if***	Within 31 calendar days, you must contact the Employee Service Center to request a change.

Event	Permitted Election Change	Employee Requirements for Election Change
age of child coverage)	***your coverage level does not change. Failure to do so is considered fraud on the Plan.***	
Your employment status changes so that you gain eligibility under The Mayo Medical Plan	May elect coverage for yourself, your spouse and any eligible family member.	Within 31 calendar days, you must contact the Employee Service Center to request enrollment.
Your employment status changes so that you lose eligibility under The Mayo Medical Plan (for example, you move from full-time to a non-benefit eligible employment status)	**Coverage ends.**	Not applicable because Mayo will automatically make this change.
Your spouse gains eligibility under another employer's plan	**If your spouse, any covered eligible family member or you will become covered under spouse's plan:** May make corresponding premium decreases to your coverage under the Mayo Plan.	Within 31 calendar days, you must contact the Employee Service Center to request a change.
Your eligible family member gains eligibility under another employer's plan (for example, your child is hired)	If your eligible family member will become covered under his/her employer's plan, you may drop the eligible family member from your coverage under The Mayo Medical Plan.	Within 31 calendar days, you must contact the Employee Service Center to request a change.
Your spouse loses eligibility under another employer's plan because of an employment status change (for example, your spouse is terminated)	**If you are covered under The Mayo Medical Plan:** - May add your spouse as well as any eligible family member who were also covered under your spouse's plan. **If you were covered under your spouse's plan:** - May elect coverage under The Mayo Medical Plan for yourself, your spouse and any	Within 31 calendar days, you must contact the Employee Service Center to request a change.

Event	Permitted Election Change	Employee Requirements for Election Change
	eligible family member losing coverage under spouse's plan.	
Your eligible child loses eligibility under another employer's plan because of an employment status change	May add eligible family member, if eligible, to your coverage under The Mayo Medical Plan.	Within 31 calendar days, you must contact the Employee Service Center to request a change.
You are rehired by Mayo within 30 days of termination by Mayo	If you are rehired into a benefits eligible position, the Medical Plan election you had in place at your termination of employment is reinstated.	Not applicable because Mayo will automatically make this change.
You are rehired by Mayo more than 30 days after termination by Mayo and in the same year	If you are rehired into a benefits eligible position, you may make a new Medical Plan election.	You will have the same time frame to elect new coverage as other new hires.
You are covered under The Mayo Medical Plan, 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 The Mayo Medical Plan and you decide to change to your spouse's plan	If you, your spouse, or any 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) coverage under The Mayo Medical Plan.	Within 31 calendar days, you must contact the Employee Service Center to request a change.
You are covered under your spouse's employer's plan which has a different plan year (and annual enrollment period) than The Mayo Medical Plan and you want to drop coverage under your spouse's plan and become covered under The Mayo Medical Plan	If you drop coverage under your spouse's plan, you, your spouse and any covered family members can become covered under The Mayo Medical Plan.	Within 31 calendar days, you must contact the Employee Service Center to request a change.

Event	Permitted Election Change	Employee Requirements for Election Change
You, your spouse or your eligible family member experience a loss of other coverage that is a Special Enrollment that is an event not covered elsewhere on this chart	Under federal law, you have the right to elect coverage under The Mayo Medical Plan if you experience a "Special Enrollment" event. Special enrollments can include gaining new dependents through marriage, birth or adoption or loss of other coverage. There is more information about Special Enrollments in the Special Enrollment Rights section below. Special Enrollments involving gaining new dependents are covered above in this chart as are most Special Enrollments involving loss of coverage. Some Special Enrollment events related to losses of other coverage are not covered elsewhere, however. If you, a spouse or eligible family member were previously eligible but not enrolled in The Mayo Medical Plan and subsequently lose coverage due to any of the following, you, your spouse or eligible family member has such a Special Enrollment opportunity: - incurring a claim that would meet or exceed a lifetime limit on all benefits. - employer contributions toward the cost of coverage terminate. - the Plan is changed so that you, your spouse or your eligible family member is no longer eligible. - you, your spouse or eligible family member exhaust COBRA coverage (that you, your spouse or eligible family member were enrolled in when you last declined coverage under The Mayo Medical Plan). See *Special Enrollment Rights* section below for more information.	Within 31 days from loss of other coverage, you must contact the Employee Service Center to request a change.

Event	Permitted Election Change	Employee Requirements for Election Change
Your child is employed and the child's plan is improved mid-year or has a different plan year (and annual enrollment period) than the Mayo Medical Plan	**If your child moves to his or her employer's plan:** You may reduce your coverage under The Mayo Medical Plan by dropping the child.	Within 31 calendar days, you must contact the Employee Service Center to request a change.
You, your spouse or eligible family member become entitled to Medicare, Medicaid	You can decrease premium or cancel your Mayo coverage to the extent consistent with the Medicare or Medicaid entitlement.	Within 60 calendar days from date of Medicare or Medicaid eligibility, you must contact the Employee Service Center to request a change.
<u>You</u>, your spouse or eligible family member loses eligibility for Medicare, Medicaid or a state Children's Health Insurance Program ("CHIP")	You can increase premium or add coverage to The Mayo Medical Plan to the extent the change corresponds with the loss of Medicare, Medicaid or CHIP entitlement. Additionally, if you lose Medicaid eligibility, you can add yourself, your spouse and any eligible family members to The Mayo Medical Plan.	Within 60 calendar days from loss of eligibility for Medicare, Medicaid or CHIP coverage, you must contact the Employee Service Center to request a change.
You or your children become eligible for a premium assistance subsidy under Medicaid or CHIP	You may either enroll yourself or enroll yourself, your spouse and your eligible family member(s) in The Mayo Medical Plan.	Within 60 calendar days after date on which eligibility for premium assistance subsidy is determined, you must contact the Employee Service Center to request a 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 The Mayo Medical Plan	If you already have coverage under The Mayo Medical Plan, you may add the child who is the subject of the QMCSO. If your coverage level changes, your cost of coverage will increase. If you do not have coverage under The Mayo Medical Plan, both you and the child who is the subject of the QMCSO will be enrolled in coverage.	Contact the Employee Service Center within 31 days and submit QMCSOs as soon as possible.
Another person, such as your former spouse, is required to provide health coverage to a eligible family member you currently cover under The Mayo	Notify Mayo of the order. The eligible family member will be dropped from coverage and, if your coverage level changes, your cost of coverage will decrease.	Submit QMCSO as soon as possible to the Employee Service Center.

Event	Permitted Election Change	Employee Requirements for Election Change
Medical Plan		
Your share of the cost of your Mayo coverage increases or decreases (because the cost of coverage charged by Mayo changes mid-year)	If Mayo increases or decreases the cost of health plan coverage for employees during the year, your share will be automatically adjusted.	Not applicable, because Mayo will automatically make these changes.

Procedure and Deadline for Making Change in Status Event Changes

If you satisfy the requirements in this section for a Permitted Mid-Year Election Change Event, you must notify the Employee Service Center within 31 days of the date you experience a change in status event or special enrollment that allows you to make an election change. Under federal law, however, you have 60 days from either (i) loss of coverage under Medicaid or CHIP, or (ii) becoming eligible for a Medicaid or CHIP premium assistance subsidy to make your change. See the Special Enrollment Rights section below for more information.

The Consistency Rule

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

Please Note

You may need to provide proof of your change in status event or special enrollment event and the date the event occurred. Failure to do so may result in denial of your change request.

If you have questions about changing your benefit elections during the year, please contact the Employee Service Center.

Special Enrollment Rights

Special Enrollment Due to Loss of Other Health Coverage

Under certain circumstances, an eligible employee or his/her eligible family member(s) who did not enroll during the initial enrollment period (or at annual enrollment or when a change in status event occurred) may enroll in the Plan during the Plan year. These circumstances warrant "special enrollment." Special enrollment will be allowed for any of the following:

(a) The eligible employee or eligible family member satisfies all of the following criteria:

- Was covered under another group health plan or other health insurance coverage (this prior coverage does not include continuation coverage required under federal and state law) at the time the eligible employee or eligible family member was previously eligible to enroll under the Plan.
- Declined Mayo coverage for the reason described above.

- Presents to the Employee Service Center evidence of loss of prior coverage due to loss of eligibility for that coverage, or evidence of the termination of employer contributions toward that coverage.
- Loss of eligibility is not due to the eligible employee's or eligible family member's failure to pay premiums on a timely basis or termination for cause but is due to:
    - Legal separation
    - Divorce
    - Death
    - Cessation of eligible family member status
    - Loss of HMO or similar coverage because you change your residence or work place and as a result coverage is no longer available
    - The Plan is changed so that you, your spouse, or your eligible family member are no longer eligible
    - Employer contributions toward the coverage terminate
    - Termination of employment
    - Reduction in the number of hours of employment
    - Incurring a claim that would meet or exceed a lifetime limit on all benefits
- Notifies the Employee Service Center, in writing, within 31 days of the date of the loss of coverage or the date the employer's contribution toward that coverage terminates.

(b) The eligible employee or eligible family member satisfies all of the following criteria:

- Was covered under benefits available under COBRA
- Declined coverage for that reason
- Presents to the Employee Service Center, evidence that the eligible employee has exhausted such COBRA coverage and has not lost such coverage due to the failure of the eligible employee or eligible family member to pay premiums on a timely basis or termination of coverage for cause. COBRA would therefore be deemed to be exhausted if it ended for any of these reasons:
    - Another employer or responsible entity fails to remit premiums for the coverage as a whole (but not if you or an eligible family member lose coverage for your or your eligible family member's non-payment)
    - Loss of HMO or similar coverage because of change in residence or work place that makes coverage available
    - Incurring a claim that would meet or exceed a lifetime limit on all benefits
- Notifies the Employee Service Center, in writing, within 31 days of the date of the loss of coverage.

(c) The eligible employee or eligible family member satisfies all of the following criteria:

- An eligible employee or eligible family member with coverage under a state Medicaid plan or The Children's Health Insurance Program (CHIP) loses such eligibility.
- Loss of eligibility is not due to the eligible employee's or eligible family member's failure to pay premiums on a timely basis or termination for cause.

- Notifies the Employee Service Center, in writing, within 60 days of the date of the loss of coverage.

Special Enrollment Due to Medicaid or CHIP Premium Assistance

If an eligible employee or his/her eligible family member(s) who did not enroll during the initial enrollment (or at annual enrollment or when a change in status event occurred) become eligible for premium assistance under a state Medicaid or Children's Health Insurance Program (CHIP), then an eligible employee or his/her eligible family member(s) may enroll in the Plan during the Plan year if the eligible individual notifies the Employee Service Center, in writing within 60 days of the date of becoming eligible for such premium assistance.

Special Enrollment Due to Addition of Eligible Family Member

You may add coverage for yourself and any eligible family members following:

- Marriage
- Committed relationship with a same-sex domestic partner
- Birth, adoption, or placement for adoption of an eligible employee's child
- Birth, adoption, or placement for adoption of a same-sex domestic partner's child

Non-Participating Employees May Also Enroll

The addition of a new eligible family member triggers enrollment rights for an eligible employee even if he/she does not participate in the Plan at the time of the event. For example, upon the birth of an eligible employee's child, the eligible employee (assuming that he/she did not previously enroll), his/her spouse, and his/her newborn child may all enroll because of the child's birth. The same rule applies to the other special enrollment events if the eligible employee had not previously enrolled in the Plan.

Time Period for Special Enrollment

The eligible employee must request special enrollment in the Plan within 31 days of the marriage or birth, adoption or placement for adoption of his/her child. **Please note** that in the event of loss of other coverage under Medicaid or CHIP or eligibility in the Plan based on premium assistance under Medicaid or CHIP, the eligible individual must request special enrollment within 60 days of the event. If the Employee Service Center does not receive the eligible employee's completed request for enrollment within this deadline, the eligible employee and his/her eligible family member lose special enrollment rights for that event.

Effective Date of Special Enrollment

Enrollment in the Plan under this special enrollment provision will be the date of the event. **Please note** that you can only pay for this coverage on a pre-tax basis retroactively for the birth, adoption, and placement of a child for adoption and only if you satisfy the 31 day deadline to enroll the child.

Adding Child Coverage Due To Court Order

Although the Plan normally does not permit you to add coverage mid-year absent a special enrollment event, you may add health coverage during the year for a child if a judgment, decree, or order (i.e., a *Qualified Medical Child Support Order*) requires that your child be covered under the Mayo Medical Plan.

Changing Your Coverage Election

Some changes to your health coverage will happen automatically. For example, if you terminate or are no longer eligible for coverage under the Plan, your coverage (and your spouse's, same-sex domestic partner's, and eligible family members' coverage) will automatically be terminated.

In cases not related to your Mayo employment, however, you need to notify the Plan of the occurrence of the change in status event to stop your pre-tax premium payments, even if coverage is lost under the terms of the Plan. For example, if you divorce, your spouse loses coverage as of the date of the divorce. You must still notify the Plan of the divorce if you want to change your coverage level and reduce your pre-tax employee contributions.

If you experience a special enrollment event and want to add coverage, you should contact the Employee Service Center within the time period specified in the Special Enrollment event section above.

If you experience one of the change in status events listed above and want to cancel or reduce the level of coverage, contact the Employee Service Center within 31 days of the occurrence of the event.

If you are an eligible employee and are required by a Qualified Medical Child Support Order to provide coverage for health expenses of a child, you will be enrolled in the Plan, if necessary, or your contribution will be increased as specified in the Order, and the entire cost to you for such coverage will be deducted from your pay automatically on a pre-tax basis. Submit Child Support Orders to the Employee Service Center at your earliest convenience so that they can be processed.

Change in Status Rules If You Are Retired

If you are retired, you pay for your benefits with after-tax dollars and these 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 eliminate your retiree coverage at any time, you and your eligible family members will never have the opportunity to re-enroll to obtain coverage in this Plan or any other component of the Mayo Medical Plan. Please review the other sections in this document regarding medical coverage in retirement.

Change in Status Rules If You Have a Same-sex Domestic Partner

If you pay for your same-sex domestic partner's coverage with pre-tax dollars (including coverage for any children of a same-sex domestic partner) then the change in status rules apply.

If you pay for your same-sex domestic partner's coverage with after-tax dollars (including coverage for any children of a same-sex domestic partner), then you can cancel the coverage prospectively at any time during the year. If you cancel coverage, you will be required to wait until the next open enrollment period to add a same-sex domestic partner (including children of a same-sex domestic partner).

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 new eligible family member becomes eligible for coverage under the Plan, provided the employee completes a change form and submits it to the Plan Administrator 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 "special enrollment" situation occurs. The effective date of coverage would be the first day of the coverage year for which the open enrollment period was held.

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 proof of Creditable Coverage and the COBRA letter are in the Employee Service Center within 31 days of the loss of such other coverage. 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. **Change in Status Event.** When an election changes as the result of a change in status event as described above, the effective date of coverage is the date of the event. For example, coverage for your spouse would start on the day you got married.

Medical Coverage in Retirement

Requirements

In order to continue coverage under the Mayo Medical Plan during retirement, you must be in a benefit eligible position and meet the following age and continuous service requirements.

Retirement Age	Required Years of Service
62 and over	10 continuous years
60 and 61	15 continuous years
55 through 59	20 continuous years
Under age 55	30 continuous years

Continuous Service

Continuous service is defined as a period of unbroken service from hire date to termination date with the employer or an affiliated company by an employee who is classified as a regular employee and is scheduled to work at least half-time (.5 FTE). Vacations and approved leaves of absence are not breaks in service except for educational leaves of more than six months for a non-critical employment need. Transfers between the employer and affiliated companies are not breaks in service as long as the employee continues to be classified as a regular employee and continues to be scheduled to work at least half-time. A break in service occurs upon termination of employment, transfer to a non-regular classification, or change to a schedule that is less than half-time. A regular employee classification does not include temporary, supplemental, or casual employees or residents, research fellows or health-related science students. Continuous service is used to determine the eligibility for retiree medical benefits. In the context of eligibility for retiree coverage after an approved disability leave, the disability rules of the Mayo Pension Plan shall apply.

Enrollment

Eligible retirees will be given an open enrollment period within 31 days of retirement to enroll in the Plan. Subject to the next section, effective January 1, 2012, retirees who decide not to enroll at the time of retirement will waive their rights and rights of eligible family members to retiree medical coverage and will not have any option or ability to participate in the Mayo Medical Plan at any time based on retiree

status. In other words, you have a one-time election for retiree coverage unless the circumstances of the next section apply. In addition, if you elect or previously elected retiree medical coverage, but later eliminate, drop or lose the retiree coverage at any time and for any reason, you and your eligible family members will not have the opportunity to re-enroll to obtain coverage in this Plan or any other component of the Mayo Medical Plan based on retiree status.

Retirement and Re-hire at Mayo Clinic Site

If you retire from a Mayo Clinic site that participates in the Mayo Medical Plan and that offers retiree coverage and you have satisfied the above eligibility rules for retiree coverage, you may defer electing retiree coverage but only if you are re-hired by another Mayo Clinic site in a benefit eligible position and enroll and remain enrolled in that site's medical plan. Upon terminating employment at the other Mayo Clinic site or reducing your hours so that you are no longer benefit eligible, you must immediately notify Mayo Clinic. You will be given an open enrollment period of 31 days from the date of termination or reduction in hours to enroll in the Mayo Medical Plan as a retiree. If you do not to enroll at this time, you will not be eligible for any ongoing retiree medical coverage as described above. If you do enroll as a retiree, you will be subject to all of the terms and limitations described in this Plan.

If you retire from a Mayo Clinic site that offers retiree coverage and you have satisfied the eligibility rules for retiree coverage and you are re-hired at a Mayo Clinic site in a non-benefit eligible position, you must elect retiree coverage as described above in the prior section. If you do not elect retiree coverage within the required timeframe, you and your eligible family members will no longer be eligible at any time for retiree coverage under the Mayo Medical Plan.

Employer Subsidized Retiree Medical Premiums

You may be eligible for an employer subsidized retiree medical premium. Please note that not all participating employers offer retiree medical coverage and for those that do, not all offer a subsidized premium. In order to receive a subsidized retiree medical premium, the general requirements are that you (1) must have a continuous service hire date prior to January 1, 2002, and (2) must have been eligible for or accruing eligibility for a subsidized Mayo Medical Plan retiree option on 12/31/2001. Please note that there are additional rules with respect to individuals who transfer between Mayo Clinic affiliated sites.

Subsidy Eligibility for Transfers between Mayo Clinic Affiliated Sites

1) Staff that did not have rights to a subsidized retiree medical premium as of December 31, 2012 will not receive such rights by transferring to a subsidy Mayo site on or after January 1, 2013.
2) Staff that have rights to a subsidized retiree medical premium as of December 31, 2012 will not lose those rights by transferring to a non-subsidy Mayo Site on or after January 1, 2013. Subsidy sites include Rochester, Arizona, Florida, Gold Cross sites, Decorah and Lake City. All other Mayo sites/employers are "non-subsidy sites." To be eligible for a subsidized retiree premium, the first basic requirement is that the continuous service hire date be before January 1, 2002.

In addition, the following rules apply:

Transfer from a non-subsidy site to a subsidy site:

<u>Before January 1, 2013:</u>
Such employee will be entitled to the subsidized retiree medical premium in place at the subsidy site at the time of retirement.

<u>On or after January 1, 2013:</u>

Such employee will not be entitled to a subsidized retiree medical premium.

Transfers from a subsidy site to a non-subsidy site:

Before January 1, 2013:
Such employees are not entitled to a subsidized retiree medical premium.

On or after January 1, 2013:

Such employees are entitled to the subsidized retiree medical premium in place at the time of retirement at the subsidy site they transferred from.

Transfers from a subsidy site to another subsidy site:

Before January 1, 2013:
Such employees are entitled to a subsidized retiree medical premium at the site at which they retired from.

On or after January 1, 2013:

Such employees are entitled to the subsidized retiree medical premium in place at the time of retirement at the subsidy site they transferred from.

Mayo Clinic reserves the right to amend or terminate retiree medical coverage and any applicable subsidized premium at any time. You do not have vested benefits in the Mayo Medical Plan.

Attaining Medicare Eligibility

If You Are Retired

If you are enrolled in the Plan on the first day of the month in which your 65th birthday or your eligible family member's 65th birthday falls, you are considered to have enrolled in Medicare Part B with the Social Security Administration, and the coverage will be moved to the Mayo Medicare Supplement (regardless of the Mayo Medical Plan enrollment at that time). If you or your eligible family member's birthday is the first of the month, you are eligible for Medicare on the first day of the previous month. For example, your birthday is April 1; you are Medicare eligible on March 1.

Medicare will become the primary payer of claims for you if you are age 65 or older and retired. Medicare is also the primary payer of claims for your spouse if age 65 or older and you are retired. The Mayo Medicare Supplement benefit will be reduced by the amount Medicare pays or would have paid if Medicare coverage had been in effect. In other words, even if you do not apply for Medicare when eligible, your Mayo Medicare Supplement will pay only for the portion of expense Medicare coverage would not pay.

If you marry or remarry during retirement and are enrolled in the Plan, your spouse and any newly eligible family members are eligible for coverage on the date of your marriage. You must notify the Employee Service Center within 31 days of the date of marriage to add your spouse and eligible family members to your coverage. The effective date of coverage is the date of marriage.

If you are retired (but less than age 65) and eligible for Medicare due to end-stage renal disease, after 30 months of Medicare eligibility or entitlement or Medicare eligible for any disability after two years, the Plan will pay secondary to Medicare.

If You Are Still Working

Medicare benefits are available to anyone who reaches age 65, even if not retired. However, if you are age 65 or older and you are still working, your Mayo coverage will continue and will be primary, and you may not need to purchase Medicare Part B. Instead, you can wait until you are no longer working and enroll at that time. You have 31 days from your last day of work to enroll in Medicare Part B. If you are still working, and your spouse is 65 or older and not working, your Mayo coverage will remain primary and your spouse may not need to purchase Medicare Part B. Instead, the spouse can wait until you are no longer working and enroll at that time. Contact your local Social Security Office for additional information regarding Medicare eligibility and enrollment as there may be a late enrollment penalty if you or your spouse miss a deadline.

Coverage for Family Members after Your Death

If you met the required years of service listed above under *Medical Coverage in Retirement* for retiree coverage and if your spouse and eligible family members were enrolled in the Plan at the time of your death, coverage for your spouse may be continued indefinitely upon payment of any required charges. Coverage for your eligible family member may be continued as long as they meet the definition of eligible family members. Coverage will not be available for any spouse or eligible family member not enrolled at the time of your death. A spouse and other eligible family members covered under this provision will not be eligible to participate in the annual open enrollment.

If you had not met the required years of continuous service for retiree coverage and if your spouse and eligible family members were enrolled in the Plan at the time of your death, coverage for your eligible family members will continue until they no longer meet the definition of eligible family member. Coverage for your spouse may be continued for a minimum period of 60 days. Coverage for your spouse will continue beyond the minimum 60-day period until your spouse is gainfully employed, remarried, or age 65. Coverage will not be available for any spouse or eligible family member not enrolled at the time of your death. A spouse and other eligible family members covered under this provision will not be eligible to participate in annual open enrollment.

If your spouse is eligible for coverage as an employee under the Plan, contact the Employee Service Center for enrollment details.

"Gainfully employed" means that an individual is employed in a benefit-eligible position and his or her earnings are subject to FICA tax.

WHEN COVERAGE ENDS

When Employee Coverage Ends

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

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

When Eligible Family Member Coverage Ends

Your eligible family member's participation under the Plan will terminate immediately upon termination of the Plan or at midnight on the occurrence of the earliest of:

1. The last day of the month the individual ceases to be an eligible family member as defined in the Plan. Premiums must be paid until the end of the month of termination.
2. The day before a child's 26th birthday.
3. The last day of the month of the date the final decree for dissolution of marriage is entered or on the last day of the month the formal termination of partnership agreement is signed for a former spouse, former same-sex domestic partner, and stepchildren.
4. The date the eligible employee loses coverage under the Plan. See *Coverage for Family Members after Your Death* for information regarding coverage after the death of an employee.
5. The date eligible family member coverage is discontinued under the Plan or the Plan is amended so that the eligible family member loses eligibility.
6. The date ending the period for which the 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 Plan.
8. The date your eligible family member is discharged from the hospital, if he/she is hospitalized on the day coverage would otherwise end.

When Retiree Coverage Ends

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

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 date the employer terminates the Plan or its participation in the Plan.
4. If the Plan is amended so that you lose coverage, the effective date of the amendment.
5. The date you are discharged from the hospital, if you are hospitalized on the day coverage would otherwise end.
6. The last day of the month if you eliminate, drop or lose coverage as a retiree.

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 eligible family members with the same member ID card. 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 *Member ID Card* subsection above.
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 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.

Certification of Creditable Coverage

Federal law requires that group health plans provide a Certificate of Creditable Coverage if you or an eligible family member loses coverage under the Plan. In some circumstances the certificate will be sent to you automatically. Upon request, the Plan will provide the certificate as long as the request is made while you, your spouse, or your eligible family member is covered under the Plan or within 24 months after coverage under the Plan terminates. The request can also be made by someone else on behalf of you, your spouse, or your eligible family member. For example, you, your spouse, or eligible family members that were previously covered under the Plan may authorize a new plan in which you, your spouse, or your eligible family members enroll to request a Certificate of Creditable Coverage relating to prior coverage under the Plan. You, your spouse, and your eligible family members are entitled to receive a Certificate of Creditable Coverage upon request even if the Plan has previously provided a Certificate of Creditable Coverage to you, your spouse, or your eligible family members.

If you, your spouse, or your eligible family members would like to request a Certificate of Creditable Coverage, the request should be directed to Mayo Clinic Health Solutions as specified in the *Plan Administration Information* section of this document.

The request must include the following information:

- The name of the individual for whom the certificate of Creditable Coverage is requested
- The last day the individual was covered under the Plan, if relevant
- The name of the participant that enrolled the individual in the Plan
- The name of the person making the request and, if applicable, evidence of authority to request and receive the Certificate of Creditable Coverage on behalf of another individual
- The address to which the Certificate of Creditable Coverage should be sent
- The requester's signature

CONTINUATION OF HEALTH CARE COVERAGE UNDER COBRA

This section contains detailed information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan after you or your eligible family members lose coverage in certain circumstances. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). If you have questions about your COBRA continuation coverage rights, please contact the COBRA Administrator at the address or number listed in the *Contact Information* 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.

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 or same-sex domestic partner, and your eligible family member 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 or same-sex domestic partner of an employee, you will become a qualified beneficiary if you lose coverage under the Plan because any of the following qualifying events occur:

- Your spouse or same-sex domestic partner dies.
- Your spouse's or same-sex domestic partner's hours of employment are reduced.
- Your spouse's or same-sex domestic partner's employment ends for any reason other than his or her gross misconduct.
- You become divorced or you officially terminate your same-sex domestic partnership relationship.

Your eligible family member (including your same-sex domestic partner's children who are eligible under the terms of the Plan and 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 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 or officially terminate their same-sex domestic partnership.
- 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 Clinic 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 or same-sex domestic partner, surviving spouse or same-sex domestic partner, and eligible family member 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 official termination of a same-sex domestic partner relationship, or an eligible family member losing eligibility for coverage), a COBRA election will be available only if you, your spouse or same-sex domestic partner, or eligible family member notify the COBRA Administrator of the qualifying event by sending written notice to the address listed in the *Contact Information* 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, same-sex domestic partner, or 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 this Plan,
- The type of qualifying event (e.g., divorce),
- The date of the event, and
- Your name and the names of your spouse or same-sex domestic partner and your eligible family member.

Verbal notice, including notice by telephone, is not sufficient. You may deliver your written notice by mail, 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 that day. If you, your spouse or same-sex domestic partner, or your eligible family member fail to provide notice to the COBRA Administrator during this 60-day notice period, your spouse, same-sex domestic partner, or your eligible family member 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 first day of the month following 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 loss of coverage) according to the directions on the form. If you, your spouse or same-sex domestic partner, and your eligible family member do not elect continuation coverage within this period, you will not receive continuation coverage. If mailed, your election form must be postmarked no later than the last day of the 60-day election period. Otherwise it must be actually received by the entity indicated on the election form no later than that day.

Special Considerations in Deciding Whether to Elect COBRA

If you experience a qualifying event, in considering whether to elect COBRA continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of COBRA continuation coverage may help you avoid such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not elect and remain covered under COBRA continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. 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. When the qualifying event is the death of the employee, your divorce (or termination of a same-sex domestic partnership), or an eligible family member losing eligibility, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's 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 in the *Contact Information* 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 this Plan,
- The date of the Social Security disability determination, and
- Your name and the names and addresses of your spouse or same-sex domestic partner and your eligible family member.

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, the spouse and eligible family member 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 the spouse or same-sex domestic partner and eligible family member receiving COBRA continuation coverage if the employee or former employee dies, gets divorced, or officially terminates a same-sex domestic partnership, or if your eligible family member child stops being eligible under the Plan as an eligible family member. In all of these cases, the extension is available only if the event would have caused your spouse or same-sex domestic partner or your eligible family member to lose coverage under the terms of the Plan had the first qualifying event not occurred. If you or a qualified beneficiary experience 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 in the *Contact Information* 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 or same-sex domestic partner and your eligible family member.

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

3. Medicare Extension for Spouse and Eligible Family Member

If a covered employee (1) experiences a qualifying event that is either termination of employment or a reduction of hours, and (2) that qualifying event occurs within 18 months after the covered employee becomes entitled to Medicare, then the maximum coverage period for the spouse or same-sex domestic partner and eligible family member who are qualified beneficiaries receiving COBRA continuation coverage will end 36 months from the date the employee became entitled to Medicare. For example, if a covered employee becomes entitled to Medicare eight months before the date on which the employee terminates employment, COBRA continuation coverage for the employee's spouse or same-sex domestic partner and 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 the covered employee's coverage period is not extended by Medicare entitlement, rather the employee's maximum COBRA continuation coverage will be the 18-month period (unless extended under the disability extension described above). If you believe your spouse or same-sex domestic partner or your eligible family member 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 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 in the *Contact Information* section.

Periodic Payments for COBRA Continuation Coverage

After you make your first payment for COBRA continuation coverage, you will be required to make payments for each subsequent month of coverage. Under the Plan, these periodic payments for COBRA continuation coverage are due on the first of each month. If 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 (but only after any pre-existing condition exclusions of the other plan for a pre-existing condition of the qualified beneficiary have been exhausted),
- After electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare, or
- The employer ceases to provide a group health plan for its employees.

COBRA continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA continuation coverage (such as fraud). COBRA continuation coverage may also be terminated if you recover from a disability that extended 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 this Plan, (2) the type of event, and (3) the date of the event. You, your spouse or same-sex domestic partner, or your eligible family member should contact the COBRA Administrator.

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.

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 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 lasts 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.

MAYO UNIVERSAL

The *Schedule of Benefits* section contains detailed information on coverage levels for the different categories of health care providers and offers information on the level of coverage available under the Plan. Cost sharing of the options is located in the section entitled *Cost Sharing and Benefits*.

"Health care provider" is any institutional or professional health care provider furnishing health care services to you. Each health care provider must be licensed, registered, or certified by the appropriate state agency where the health care services are performed. Where there is no appropriate state agency, the health care provider must be registered or certified by the appropriate professional body. Health care providers include those listed below:

- **Advanced Practice Registered Nurse** – including a Clinical Nurse Specialist, Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife, and Nurse Practitioner.
- **Ambulatory Surgical Facility** – a facility with an organized staff of physicians that:
    - Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis.
    - Provides treatment by or under the direct supervision of a physician or other health care provider.
    - Does not provide inpatient accommodations.
    - Is not, other than incidentally, a facility used as an office or clinic for the private practice of a physician or dentist.
- **Chiropractor** – a Doctor of Chiropractic (DC).
- **Dentist** – a Doctor of Dental Surgery (DDS), Oral Pathologist, Oral Surgeon, or Doctor of Dental Medicine (DMD).
- **Home Health Agency** – an agency that provides home health care and is Medicare certified and licensed or approved under state or local law.
- **Hospice** – a Medicare certified organization or agency that primarily provides services for pain relief, symptom management, and supportive services to terminally ill persons and their families.
- **Hospital** – a licensed institution operated pursuant to law that is engaged in providing inpatient and outpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of sick and injured persons by or under the direct supervision of physicians or other health care providers.
- **Licensed Practical Nurse** (LPN)
- **Licensed Registered Dietitian**
- **Occupational Therapist**
- **Ophthalmologist** – Doctor of Ophthalmology
- **Optometrist** – Doctor of Optometry
- **Physical Therapist**
- **Physician** – Doctor of Medicine (MD) or Doctor of Osteopathy (DO)
- **Physician Assistant** – an individual licensed by the medical examining board to provide medical

care with physician supervision and direction.

- **Podiatrist** – a Doctor of Podiatry (DP), Doctor of Surgical Chiropody (DSC), Doctor of Podiatric Medicine (DPM), or Doctor of Surgical Podiatry (DSP)
- **Psychologist**
- **Radiation Therapist**
- **Registered Nurse (RN)**
- **Respiratory Therapist**
- **Skilled Nursing Facility** – an institution or a distinct part of an institution providing skilled care and related services to persons on an inpatient basis.
- **Social Worker** – an individual who is qualified through education, training, and experience to provide services in relation to the treatment of emotional disorders, psychiatric conditions, or substance abuse when employed by, or under the supervision of, an MD, DO, or PhD.
- **Speech Therapist**
- **Urgent Care Facility** – an ambulatory care facility or walk-in clinic with Urgent care hours or walk-in clinic hours providing treatment for minor conditions.

Choice of Providers

You have free choice of any legally qualified health care provider, and the health care provider-patient relationship will be maintained. If you choose to receive covered services out-of-network, you may receive a lower level of benefits as described in the *Schedule of Benefits* section. **Please note**: Mayo reserves the right to exclude specific out-of-network providers from coverage under the Plan for any reason not prohibited by applicable law, even if the services received from the excluded provider are generally covered by the Plan. For information about a specific out-of-network provider that has been excluded from coverage, contact Mayo Clinic Health Solutions at 507-266-5580 (local) or 1-800-635-6671 (toll free). You may choose to see either an in-network or out-of-network provider. Establishing a Primary Care Physician is encouraged to better coordinate your care.

Please also note that there may be instances where you receive services at an in-network facility like a hospital where out of network providers may render some services to you or others covered by the Plan. Before receiving such services, you should ask the hospital or other facility whether or not any out of network providers will provide services to you or an eligible family member.

In-network providers under Mayo Universal based on your work location:

Florida

- Mayo Medical Plan Network (MC6213-19)
- Private Healthcare Systems (PHCS)-custom network in the states of FL and GA
- National Health Benefits Corporation (NHBC)-National Access Program-outside the states of FL and GA
- Catamaran pharmacy network (includes Mayo Clinic Health System pharmacies)

Rochester

- Mayo Medical Plan Network (MC6213-19)

- First Health Network (excluding state providers for Rochester members)
- Catamaran pharmacy network (includes Mayo Clinic Health System pharmacies)

Arizona

- Mayo Medical Plan Network (MC6213-19)
- Blue Cross Blue Shield of Arizona (BCBSAZ) an independent licensee of the Blue Cross Blue Shield Association does not provide administrative or claims payment services. Mayo Clinic has assumed all liability for claims payment. No provider network benefits are available outside of Arizona and this applies to Mayo Clinic employees, retirees, and their eligible family members covered by the Mayo Medical Plan.
- CIGNA Medical Group Network in Arizona; to find a provider in Arizona, call Mayo Clinic Health Solutions Customer Service 1-800-635-6671
- First Health Network (excludes AZ state providers for AZ members which is considered out-of-network)
- Catamaran pharmacy network (includes Mayo Clinic Health System pharmacies)

"Covered services" are health care services provided by a health care provider and as described in the Mayo Medical Plan Schedule of Benefits section for which Mayo Medical Plan benefits will be provided, unless limited or excluded in any Exclusions section. A covered service is incurred on the date the health care service is received.

"In-network" includes Mayo facilities, the Mayo Clinic Health Solutions network, Blue Cross and Blue Shield of Arizona for staff working in Arizona, and PHCS Exclusive Network/NHBC for staff working in Florida. For the prescription drug benefit, "in-network" means Mayo Pharmacies and the Catamaran Network.

"Out-of-network" means any health care provider who is not in-network, as defined above.

"Prior authorization" means authorization from the Plan that is required for specific covered services before they are received. If authorization is not obtained before such services are received, coverage will be reduced or denied. For a list of services that require prior authorization, see the *Utilization Management* section. For a description of how to obtain prior authorization and how to appeal if authorization is not given, see the *Claim Payment and Appeal Procedure* section.

Cost Sharing and Benefits

This *Cost Sharing and Benefits* section and the *Schedule of Benefits* section detail the covered services and related costs to you under the Plan. You will generally pay a cost sharing amount for covered services. The amount you pay is dependent upon your choice of provider and/or provider location.

Mayo Universal is a component of the Mayo Medical Plan available to a number of participating employers.

The *Schedule of Benefits* section is limited by the express exclusions and limitations set out in the *Exclusions* section. Some covered services are subject to prior authorization requirements, as indicated in the *Utilization Management* section.

"Allowed amount" is the maximum dollar amount eligible for payment of a procedure or service as determined by the Mayo Medical Plan. This includes billed charges, contracted amounts, or Usual, Customary and Reasonable rates, depending on the physician's relationship with Mayo Medical Plan and/or the services provided.

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

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

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

"Cost sharing amount" is the dollar amount you are responsible for paying when covered services are received from a health care provider. Cost sharing amounts include coinsurance, copayment, and deductible amounts. Applicable cost sharing amounts are identified in the *Schedule of Benefits* section. Health care providers may bill you directly or request payment of cost sharing amounts at the time covered services are provided.

"Deductible" is the aggregate amount for certain covered services that are your responsibility each coverage year before Mayo Medical Plan will begin to pay for covered services (with the exception of preventive services). Prior authorization penalties and charges in excess of allowed amounts, including charges in excess of Usual, Customary and Reasonable rates for out-of-network services, do not count toward the deductible.

"Annual out-of-pocket maximum," unless specifically excluded, means the total deductible and coinsurance amounts for certain covered services that are your responsibility during a coverage year. The following amounts are not considered or taken into account:

- Charges that are not covered services under Mayo Medical Plan (e.g.; charges which exceed the Mayo Clinic Health Solutions fee schedule for out-of-network services and amounts paid by you as a result of your failure to comply with prior authorization requirements);
- Charges for out-of-network services in excess of Usual, Customary and Reasonable rates;
- Charges in excess of Mayo Medical Plan benefit maximums or charges exceeding allowed amount for non-formulary prescription drugs; and
- Charges that are not covered services under Mayo Medical Plan (e.g.; the difference in price between the generic drug and the brand name drug if a brand name drug is dispensed when a generic drug is available).

When the annual out-of-pocket maximum is met, Mayo Medical Plan will pay 100% of the allowed amount for certain eligible covered services incurred during the remainder of the coverage year. The Plan will pay 100% of the allowed amount for formulary prescription drugs after the annual out-of-pocket maximum. The annual out-of-pocket maximum renews each January 1.

Annual Deductible

A deductible will apply for out-of-network services only. The deductible amount applies to each calendar year for each person covered by the Plan. However, there is a family deductible limit per calendar year. This means that one covered family member must satisfy a deductible and the remainder of the covered family members together would satisfy the remainder of the family deductible.

	In-Network	Out-of-Network
Per person	none	$250
Per family	none	$500

Once the deductible has been satisfied, you will continue to pay coinsurance and/or copayments for the remainder of the year for most covered services. Also, you will continue to be responsible for Charges in excess of Usual, Customary and Reasonable rates for out-of-network benefits. Copayments and prior authorization penalties also do not count toward deductibles.

For example, you, your spouse, and two children are covered under the Plan. During the Plan year, you incur eligible expenses out-of-network totaling $250. Your spouse and two children would then need to incur $250 to meet the remaining family deductible of $500. If you incur $100 and each member of your family incurs $100, then none of you meets the deductible for the calendar year.

Annual Out-of-Pocket Maximum

The medical covered services and prescription drug annual out-of-pocket maximums are independent of each other. That means that cost sharing amounts applied toward the annual out-of-pocket maximum for medical will not apply toward the annual out-of-pocket maximum for prescription drug expenses, and cost sharing amounts that are applied toward the annual out-of-pocket maximum for prescription drug expenses will not apply toward the annual out-of-pocket maximum for medical.

Plan out-of-pocket maximums for covered medical services:

	In-Network	Out-of-Network
Per person	$1,100	$2,200
Per family	$2,200	$4,400

Here’s an example of how it works: You are traveling and receive medical care from an out-of-network provider. You incur out-of-pocket expenses totaling $1,300. Upon your return, it is necessary for you to follow-up with your in-network care provider and your expenses total $300. The $300 will apply to your in-network, out-of-pocket maximum. Your out-of-network expenses of $1,300 WILL NOT apply to your in-network, out-of-pocket maximum of $1,100.

The following do not contribute to your annual medical out-of-pocket maximum:

- Charges for any services that are not covered services under the Plan

- Copayments
- Deductibles
- Amounts you pay in excess of any maximum benefits
- Infertility treatment
- Hospice care (non-Mayo)
- Prescription drugs (subject to separate out-of-pocket maximum discussed below)
- Payments in excess of allowed amounts, such as payments in excess of Usual, Customary and Reasonable rates
- Organ transplants at an out-of-network or a non-Mayo facility

Pharmacy and prescription drug out-of-pocket maximums for covered pharmaceuticals:

	In-Network
Per person	$1,500
Per family	$3,000

When you reach the maximum out-of-pocket amount of $1,500 per person ($3,000 per family) per year for prescription drugs, you will pay nothing for your coinsurance and copayment at Mayo Pharmacies. This includes formulary prescription drugs only and will not be coordinated with medical out-of-pocket maximums.

The following do not contribute to your annual pharmacy and prescription drug out-of-pocket maximum:

- Charges for any prescriptions that are not covered under the Plan
- Cost of brand name drugs in excess of cost of generic when generics are available
- Charges that exceed allowed amount for prescription drugs not listed on the Mayo Clinic Formulary
- Amounts you pay in excess of maximum benefits
- Fertility drugs
- Medications purchased in excess of dispensing limit

Coinsurance

Coinsurance is your share of what you must pay for certain covered health care services after any applicable deductibles and copayments have been paid and until the annual out-of-pocket maximum has been reached. Covered services subject to coinsurance and the amount of coinsurance are listed in the *Schedule of Benefits* section. Coinsurance is a percentage of the allowed amount. The coinsurance may differ based on whether the provider is in-network or out-of-network.

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

Copayments

Copayments apply for specific covered services under the Plan. See the *Schedule of Benefits* section to determine what you will pay.

Maximum Benefits

The Plan has established limits on the amount of benefits it will pay for certain covered services. These specific services and their applicable limits are identified in the *Schedule of Benefits* section.

Premium

The appropriate premium will be deducted on a pre-tax basis from your payroll deposit. If you do not receive a payroll deposit, you will receive a bill for the appropriate premium. See *Contributions and Funding* section for more details.

Usual, Customary, and Reasonable

Unless otherwise indicated, you and your eligible family members will be responsible for any charges above Usual, Customary, and Reasonable rates when receiving covered services out-of-network, and such payments will not count toward your deductible and/or out-of-pocket maximum.

SCHEDULE OF BENEFITS

The following section outlines what you would pay for covered services under Mayo Universal. Benefits for covered services are subject to the definitions, exclusions, conditions, and limitations of the Plan as well as cost sharing amounts and annual maximums.

In addition to cost sharing amounts, you will be responsible for charges above Usual, Customary and Reasonable rates when receiving covered services out-of-network. For out-of-network covered services, all coinsurance percentages are percentages of the Usual, Customary and Reasonable rate. If the amount charged exceeds the Usual, Customary and Reasonable rate, you are responsible for the difference in addition to the required coinsurance amount.

If you receive services outside the United States, its territories, or Canada, benefits will be provided for the charges to the extent the services rendered are included as covered services under the Plan.

It is important to note that only medically necessary services are covered under the Plan.

Continued Care Services

Service	In-Network Cost to You	Out-of-Network Cost to You Coinsurance after Deductible
Home Health Care	10%	30%
	90-day limit per year	
Home Infusion Therapy	10%	30%
Hospice Care-Inpatient	10%	30%
Hospice Care-Outpatient	10%	30%
Skilled Nursing Care Facility	10%	30%
	30-day limit per year	

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

"Injury" refers to a non-occupational accidental bodily injury caused directly and exclusively by external, violent, and purely accidental means. The term "injury" does not include injury with respect to which benefits are payable under any Workers' Compensation, occupational disease, or similar law.

"Inpatient" means a person who occupies a hospital bed, crib, or bassinet while under observation, care, diagnosis, or treatment for at least 24 hours.

"Medically necessary" means health care services that are appropriate in terms of type, frequency, level, setting, and duration to your diagnosis or condition, and diagnostic testing and preventive services that are not otherwise excluded under the Mayo Medical Plan. Medically necessary care must:

- Be consistent with generally accepted parameters as determined by health care providers in the same or similar general specialty as typically manage the condition, procedure, or treatment at

issue.

- Help restore or maintain your health.
- Prevent deterioration of your condition.
- Prevent the reasonably likely onset of a health problem or detect an incipient problem.

"Outpatient" means a person who visits a clinic or health care facility and receives health care without being admitted as an overnight patient.

Prior Authorization

Prior authorization is required before receiving care at a skilled nursing care facility. Each time prior authorization is required but not obtained in connection with a covered service, the charges related to the service will not be covered. The cost to you will be 100% of the charges. For information on how to obtain prior authorization, see the *Accelerated Claim Procedure* subsection of the *Claims Payment and Appeal Procedures* section.

Maximum Benefits

The Plan covers non-Mayo home health care for a maximum of 90 days (combined) per year. The Plan also covers a maximum of 30 days, regardless whether the services are provided in-network (including Mayo owned facilities) or out-of-network..

"Continued care" refers to certain specified hours of service per day provided by a registered nurse, licensed practical nurse, or home health care aide during a period of skilled care needed in order to maintain your illness at home.

"Custodial care" is a type of care designed to assist an individual to meet the activities of daily living. The care is of a nature that does not require the continuing attention of trained medical or paramedical personnel. Custodial care is not skilled care. These services can be provided by persons without professional skills or training. Custodial care includes assistance in walking, getting in and out of bed, bathing, dressing, preparation of meals (including special diets), supervision of medication that can be self-administered, and care that does not require the continuing attention of licensed medical personnel. Custodial care also includes rest cures and home care provided by eligible family members.

"Extended care facility" is a health care facility offering skilled nursing care, rehabilitation, and convalescent services for patients no longer needing hospital care.

"Home health care" is skilled care for the treatment of homebound illness or injury requiring only intermittent care.

"Intermittent care" is a medically predictable need for skilled care at least once every 60 days.

"Respite care" is care provided while you are receiving covered services for hospice care, for the purpose of giving your uncompensated primary caregivers relief when necessary at your home.

"Skilled care" is nursing or rehabilitative services requiring the skills of technical or professional medical personnel to develop, provide, and evaluate care and assess your changing condition.

"Skilled nursing facility" is a nursing facility with the staff and equipment to provide skilled nursing care and/or skilled rehabilitation services and other related health services.

Covered Continued Care Services

Home Health Care — Home health care is covered only when rendered as rehabilitative, and not as maintenance, custodial care, or respite care. Home health care is not provided as a substitute for a primary caregiver in the home or as relief (respite) for a primary caregiver in the home.

For purposes of home health care under this Plan option, a service shall not be considered skilled care merely because it is performed by or under the direct supervision of a licensed nurse. Where a service such as tracheotomy suctioning, ventilator monitoring, or like services can be safely and effectively performed by a non-medical person or self-administered without the direct supervision of a licensed nurse, the service shall not be regarded as skilled care, whether or not a skilled nurse actually provides the service. The unavailability of a competent person to provide a non-skilled service shall not make it a skilled service when a skilled nurse provides it. Only the skilled care component of so-called "blended" services (i.e., services that include skilled and non-skilled components) are covered under this Plan component.

- Skilled care by a registered nurse or licensed practical nurse
- Laboratory services
- Therapies
    - Habilitative physical therapy
    - Habilitative speech therapy
    - Habilitative occupational therapy
    - Intravenous (IV) antibiotic therapy
    - Infusion therapy
    - Chemotherapy
    - Anticoagulant therapy
- Parenteral or enteral nutrition as required for treatment of phenylketonuria (PKU) and parenteral or enteral nutrition when it is the only source of nutrition to meet adequate caloric needs to maintain or improve health. Food pumps are covered when used for enteral or parenteral feeding
- Complex wound care (including wound packing and debridement)
- Administration of injectable

Hospice Care — Covered services are described below for those who are terminally ill and accepted as hospice program participants. You must meet the eligibility requirements of the program and elect to receive services through the hospice program. Services will be provided in your home or on an inpatient basis. Those who elect to receive hospice services do so in lieu of curative treatment for their terminal illness for the period they are enrolled in the hospice program.

- Part-time care provided in your home by an interdisciplinary hospice team
- Continued care in your home or in a setting which provides day care for pain or symptom management
- Inpatient care
- Skilled nursing care by a registered nurse or licensed practical nurse

Ineligible Continued Care Service:

Home Health Care

- Home infusion services that do not involve direct contact, such as delivery charges and recordkeeping
- Financial or legal counseling services
- Housekeeping or meal services in your home
- Custodial care
- Respite care
- Services provided by a home health care aide
- Room and board

Hospice Care

- Any charges or services billed for room and board
- Financial or legal counseling services
- Housekeeping or meal services in your home
- Custodial care
- Outpatient respite care

Dental Services

Service	In Network Coinsurance	Out of Network Coinsurance after Deductible
Accident related treatment	10%	30%

Covered Dental Services (except as listed as ineligible dental services below)

- Dental diagnosis and treatment in conjunction with a medical illness
- Treatment of teeth, jaws, or mouth as a result of injury

Service	Mayo Clinic Department of Dentistry and PHCS Exclusive Network (Florida participants only) Coinsurance after deductible
Medical consultation	$25
Medically necessary dental services	10%

Important Note: Not all dental services are covered under the Mayo Reimbursement Account. Dental services not listed in the Covered Dental Services Section may be covered under Mayo Reimbursement Account. Please refer to the Mayo Reimbursement Account Summary Plan Description that applies to your coverage to determine covered dental services under that plan.

Covered Dental Services (when services are provided at locations listed above)

- Craniofacial anomalies including cleft lip or cleft palate
- Periodontal surgery
- Hospital charges including emergency room care
- Oral surgery and surgical procedures
- Surgical root canal
- Teeth extractions excluding simple adult and child extractions

Ineligible Dental Services

- Routine dental exams, treatment, and x-rays
- Treatment for damage to teeth as a result of biting or chewing
- Orthodontic treatment regardless of medical diagnosis. See *Orthodontic Services* subsection of the *Mayo Reimbursement Account Summary of Benefits* section
- Replacement retainers
- Periodontal
    - Scaling and root planning
    - Prophylaxis
- Simple adult and child tooth extractions
- Crowns, amalgams, composites
- Endodontics
- Osseo prosthesis (implant)
- Titanium screw or fixture/implant
- Abutments
- Dentures
- Local anesthesia with routine dental services
- Pontics
- Veneers

Emergency Services

Service	In-Network Cost to You	Out-of-Network Cost to You Coinsurance after Deductible
Emergency transportation	0	0
Emergency room–facility / professional (physicians, nurses, etc.)	$50	30%
Diagnostic tests and labs	10%	30%

Important Note: In case of an emergency, go to the nearest qualified emergency care facility. You and your eligible family members will **not** be responsible for any charges above Usual, Customary and Reasonable rates when receiving covered emergency transportation services out-of-network.

"Emergency" is any condition requiring immediate care to preserve life, to prevent serious impairment to bodily functions, organs, or parts, or to prevent placing your physical or mental health in serious jeopardy.

Covered Emergency Services

- Licensed emergency transportation for an emergency to the nearest facility qualified to provide care.
- Fixed wing air Ambulance or medical escort when authorized. Call Ask Mayo Clinic toll free to request a transport at 1-888-288-1881.
- Transportation services for an emergency even if not transported.
- Transportation services that are medically necessary.

Ineligible Emergency Services

- Non-emergency transportation services.
- Travel to a non-qualified facility or beyond nearest qualified facility (except when travel is to a Mayo Clinic facility) or between health care facilities.

Infertility Services

Service	Mayo Facility* Coinsurance
Office visits	50% for eligible services
Outpatient or hospital procedures	50% for eligible services

***Important Note:** Infertility services are covered only at a Mayo Clinic facility. However, for Florida members using PHCS custom network and Arizona members using Blue Cross Blue Shield of Arizona, providers are covered at the same level as Mayo facilities.

Maximum Benefit

The maximum lifetime benefit for infertility services is $15,000.

Covered Infertility Services

- Diagnostic tests
- In-vitro fertilization
- Gamete intrafallopian transfer
- Frozen embryo transfer
- Therapeutic donor insemination
- Artificial insemination by spouse
- Intrauterine insemination
- Charges related to or in connection with the reversal of a sterilization procedure
- Any other fertility treatment

Ineligible Infertility Services

- Charges for donor ova or sperm
- Charges for cryopreservation or storage of cryopreserved embryos, sperm, and/or ova
- Gestational carrier or surrogacy services

Inpatient Hospital Services

Service	In-Network Cost to You	Out-of-Network Cost to You Coinsurance after Deductible
Facility - if applicable	10%	30%
Semiprivate room	10%	30%
Anesthesia	10%	30%
Operating room	10%	30%
Professional (physicians, nurses, etc.)	10%	30%
Diagnostic x-ray and lab	10%	30%
Medications and supplies	10%	30%
Bariatric surgery (only at Mayo)	10%	not covered

Prior Authorization: Prior authorization is required for out-of-network inpatient admissions. Each time prior authorization is required but not obtained in connection with a covered service, the charges related to the service will not be covered. The cost to you will be 100% of the charges. For information on how to obtain prior authorization, see the *Accelerated Claim Procedure* subsection of the *Claims Payment and Appeal Procedures* section.

Important Note: Bariatric surgery available at a Mayo provider only.

Important Note: Take-home drugs may be covered under the *Pharmacy and Prescription Drug* subsection of the *Schedule of Benefits.*

Covered Inpatient Hospital Services

- Diagnosis, surgery, and office treatment
- Nutritional counseling
- Room, board, and general nursing service in semi-private room
- Operating room and related facilities
- Phase I and Phase II cardiac rehabilitation
- Laboratory and other diagnostic tests
- Therapies:
    - Habilitative physical speech therapy
    - Habilitative speech therapy
    - Habilitative occupational therapy

  - Inhalation therapy
  - Radiation therapy
  - Chemotherapy
- Inpatient medications
- Biological and disposable supplies for in-hospital use
- In-hospital use of medical equipment
- Patient education
- Take home drug dispensed at the time of dismissal
- Anesthesia in conjunction with a covered surgical or medical procedure
- Processing and administration of blood or blood components
- Blood transfusion services including the cost of blood, blood plasma, and other blood products not donated or replaced by a blood bank or otherwise
- Oxygen and other gases and their administration
- Dialysis
- Mastectomy related services including all stages of reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and physical complications of mastectomy (including lymphedemas)
- Elective sterilization
- Corneal grafts
- For aphakic patients, soft lenses or sclera shells intended for use as corneal bandages
- Surgical interventions for the following foot conditions
  - Metatarsalgia
  - Bunions
  - Corns
  - Calluses
  - Toenails when at least part of the nail root is removed or due to metabolic or peripheralvascular disease
- Medical care and reconstructive or cosmetic surgery for a child under the age of 16 for the treatment of a congenital disease or anomaly which has resulted in a functional defect
- Sleep study

"Cardiac Rehabilitation Phase I" is a medically supervised multidisciplinary program covered under the inpatient hospital benefit.

"Cardiac Rehabilitation Phase II" is an outpatient rehabilitation and risk factor modification program usually beginning upon dismissal from the hospital. It is physician directed and closely supervised by paramedical personnel. The program components include carefully prescribed exercise, education, counseling, and risk factor modification.

"Cardiac Rehabilitation Phase III" applies to patients who no longer need medical supervision while exercising.

"Cardiac Rehabilitation Phase IV" is a maintenance program consisting of efforts to modify risk factors with a routine program of physical activity.

Ineligible Inpatient Hospital Services

- Private or special duty nursing services
- Charges for a private room, unless medically necessary
- Personal convenience items
- Guest trays
- Cosmetic surgery/non-functional surgery and any subsequent surgery related to such surgery

Maternity Care Services

Service	In-Network Cost to You	Out-of-Network Cost to You Coinsurance after Deductible
Prenatal and postnatal visits	0	30%
Delivery and Inpatient services	10%	30%

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).

Covered Maternity Care Services

- Routine prenatal and postnatal visits
- Inpatient maternity services including delivery
- The following benefits are available for the newborn from the moment of birth as long as the newborn is enrolled in accordance with the Plan Eligibility and Participation section:
    - Elective circumcision
    - Routine pediatric care for a healthy newborn child while in the hospital immediately following birth
    - Newborn hearing exams
    - If the baby is ill, suffers an injury, premature birth, congenital abnormality, or requires care other than routine care, benefits will be provided on the same basis as for any other covered service provided coverage is in effect

Ineligible Maternity Care Services:

- Services of a doula
- Delivery services of a certified nurse midwife when performed at an unlicensed, unaccredited facility
- Prenatal classes or education

Mental Health and Chemical Dependency Services

Service	In-Network Cost to You	Out-of-Network Cost to You Coinsurance after Deductible
Specialty care visit	$0	30%
Inpatient Service	10%	30%
Outpatient Services	10%	30%
Nonresidential structured treatment program	10%	30%
Residential structured treatment program	10%	30%

Prior Authorization: Prior authorization is required for out-of-network mental health or chemical dependency inpatient admissions. Each time prior authorization is required but not obtained in connection with a covered service, the charges related to the service will not be covered. The cost to you will be 100% of the charges. For information on how to obtain prior authorization, see the *Accelerated Claim Procedures* subsection of the *Claims Payment and Appeal Procedures* section.

Prior authorization can be obtained by contacting Mayo Clinic Health Solutions. For more information on how to obtain prior authorization, see the *Utilization Management* section.

Covered Mental Health and Chemical Dependency Services

- Outpatient treatment coverage: Individual or group visits to a mental health or chemical dependency physician's office.
- Non-residential structured treatment coverage: Day or evening treatment programs that provide a planned therapeutic program for those who do not require hospitalization but who need broader programs that are not possible from single outpatient visits.
- Residential structured treatment coverage: A licensed skilled nursing program in a facility or distinct part of a facility for children and adult psychiatric and chemical dependency care that provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
- Inpatient treatment coverage: Acute inpatient treatment services for mental health and chemical dependency providing psychiatric diagnosis and treatment of mental illness requiring medical management and skilled care.

- Treatment for eating disorders
- Detox center

Ineligible Mental Health and Chemical Dependency Services

- Anonymous support groups
- Halfway houses
- Wilderness programs
- Group homes
- Summer camps
- Weight loss programs not provided by a health care provider
- Court ordered care without prior authorization

Outpatient Hospital and Ambulatory Services

Service	In-Network Cost to You	Out-of-Network Cost to You Coinsurance after Deductible
Facility - if applicable	10%	30%
Professional (physicians, nurses, etc.)	10%	30%
Operating room and invasive surgery	10%	30%
Anesthesia	10%	30%
Diagnostic x-ray and lab	10%	30%
Medications and supplies	10%	30%

Covered Outpatient Hospital and Ambulatory Services

- Anesthesia in conjunction with a covered surgical or medical procedure
- Diagnostic imaging
- Laboratory and other diagnostic tests
- Pathology
- Processing and administration of blood or blood components
- Blood transfusion services, including the cost of blood, blood plasma, and other blood products not donated or replaced by a blood bank or otherwise
- Oxygen and other gases and their administration
- Dialysis

- Therapies
    - Habilitative physical therapy
    - Habilitative speech therapy
    - Habilitative occupational therapy
    - Radiation therapy
    - Chemotherapy
    - Electro-convulsive therapy
- Mastectomy related services including all stages of reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and physical complications of mastectomy (including lymphedemas)
- Elective sterilization
- Corneal grafts
- For aphakic patients, soft lenses or sclera shells intended for use as corneal bandages
- Surgical interventions for the following foot conditions
    - Metatarsalgia
    - Bunions
    - Corns
    - Calluses
    - Toenails when at least part of the nail root is removed or due to metabolic or peripheralvascular disease
- Medical care and reconstructive or cosmetic surgery for a child under the age of 16 for the treatment of a congenital disease or anomaly which has resulted in a functional defect
- Sleep study

Ineligible Outpatient Hospital and Ambulatory Services

- Cosmetic surgery/non-functional surgery and any subsequent surgery related to such surgery
- Phase III and Phase IV cardiac rehabilitation

Pharmacy and Prescription Drugs

	Mayo Clinic Pharmacy		Catamaran Pharmacy Network
Prescription Drug Coverage	**Mayo Mail Service (Up to 100-Day Supply)**	**Mayo Outpatient Pharmacy (Up to 100-Day Supply)**	**34-Day Supply**
Formulary Generic and Preferred Drug (Tier I)	$10 (maximum)	$10* (maximum per 34-day supply)	$10 (maximum)
Formulary Brand or Injectable Drug (Tier II)	25% ($10 minimum)	30% ($10 minimum)	40% ($15 minimum)
Formulary Non-Preferred Drug (Tier III)	40% ($10 minimum)	40% ($10 minimum)	50% ($15 minimum)
Non-Formulary or Fertility Drug (Tier IV)	50% ($10 minimum)	50% ($10 minimum)	60% ($15 minimum)

*Up to a 34-day supply for one copayment ($10); up to 68-day supply for two copayments ($20); up to 100-day supply for three copayments ($30)

Prior Authorization: Prior authorization is required by the Plan for Lipitor® strength 40mg and 80mg, growth hormones Enbrel®, Simponi®, Phentermine®, Meridia®, Xenical®, Celebrex®, Strattera®, Xolair®, Remicade®, Humira®, Cimzia®, Pulmicort Respules®, Namenda®, and any migraine, erectile dysfunction or diabetic product when a member requires more than the dispensing limit allows. The list of prescription drugs that require prior authorization, the list of prescription drugs with dispensing limitations, and the Mayo Clinic Formulary are continually updated. You may call the Mayo Clinic Health Solutions Customer Service Department at the number listed in the *Contact Information* section of this Plan with questions regarding whether a particular prescription drug requires additional information for coverage, has dispensing limits or is on the Mayo Clinic Formulary. If approved, the drug will be covered based on the product's formulary status. Each time prior authorization is required but not obtained the prescription will not be covered. The cost to you will be 100% of the charges. For information on how to obtain prior authorization, see the *Accelerated Claim Procedure* subsection of the *Claim Payment and Appeal Procedures* section.

Important Note: When a brand name product is filled when a generic product is available, pharmacies are required to fill your prescription with the generic drug. The determination of a drug classification as brand name versus generic is made by external organizations called First Data Bank or Medispan. If you or your physician requests the pharmacies to fill your prescription with the brand name medicine, you pay the difference in cost between the generic and brand name plus the applicable generic copayment or coinsurance. Your coinsurance is calculated on the Catamaran pharmacy payment for your prescription and does not include rebates or discounts that may be available to Mayo.

Important Note: The *Coordination of Benefits* section does not apply to prescription drugs.

Important Note: TNF Inhibitors (such as Cimzia, Enbrel, Humira, Simponi) that can be self-administered subcutaneously must be filled at an outpatient pharmacy through the Catamaran) network provider. Cimzia is the formulary preferred TNF Inhibitor in the class. It must be used prior to any other TNF Inhibitor for patients with arthritis or Crohn's disease.

"Prescription drug" refers to medications and drugs that bear the legend, "Federal law prohibits dispensing without a prescription." This term includes medicines and drugs that contain a legend drug that requires compounding by a pharmacist to the order of a physician or other authorized health care provider and are approved by the U.S. Food and Drug Administration (FDA). Insulin and diabetic supplies (e.g., syringes, lancets, and testing strips) are generally covered as prescription drugs as well. Prescription drugs include:

- **Brand Name Drug** – a patent-protected prescription drug.
- **Generic Drug** – a prescription drug whose patent has expired and is usually manufactured by several pharmaceutical companies. FDA A-rated generic drugs (which are the only type of generic drugs covered under the Mayo Medical Plan) contain the same active ingredient as the brand name drug, are manufactured under the same FDA standards, and are considered equivalent in all respects to the brand name drug.
- **Mayo Clinic Formulary (Formulary**) – an approved, continually updated list of medications and dosage recommendations supplemented with drug monographs or references, policies, and criteria for use. The Mayo Pharmaceutical Formulary Committee develops the Mayo Clinic Formulary based on drug safety, effectiveness, and cost.
- **Specialty Drug** – a prescription medication that requires special handling, administration, or monitoring. These drugs are used to treat complex, chronic, and often costly conditions, including cancer, HIV/AIDS, multiple sclerosis, and rheumatoid arthritis. *Prescriptions for specialty drugs are only covered if filled through the Mayo Specialty Pharmacy.*

Covered Prescription Drugs

- Legend drugs when filled at a participating network pharmacy
- Compounded medication of which at least one ingredient is a prescription legend drug
- Injectable insulin (prescription only)
- Self-injectable low molecular weight heparins (LMWH)
- Diabetic supplies (needles, syringes, chemstrips, and lancets)
- Fertility medications (covered at 50%-60% are considered non-formulary and do not accumulate toward out-of-pocket maximum)
- Legend contraceptives
- Specialty drugs (if filled through the Mayo Specialty Pharmacy)
- Any other drug that under the applicable state law may be dispensed only upon the written prescription of a physician or other lawful prescriber

Ineligible Pharmacy and Prescription Drugs

- Cosmetic medications including anti-wrinkle agents such as Renova® and minoxidil (e.g. Rogaine®) for alopecia, Vaniqua® for excessive hair growth, etc.
- Self-prescribed controlled substances for self and/or eligible family members
- Lipitor® 10mg and 20mg
- Duplicate prescription drugs

- Over-the-counter vitamins
- Prescription drugs dispensed by a health care provider in its office or clinic facility for use outside the office or clinic facility unless the health care provider is part of the Catamaran network
- Prescription drugs labeled investigational or experimental
- Replacement of lost or stolen prescription drugs
- Topical dental preparation fluoride supplements
- Any drugs or medicines that can be purchased as over-the-counter items (even if you have a prescription) except for insulin, and diabetic supplies
- Therapeutic devices or appliances, support garments, and other non-medicinal substances (regardless of intended use, except for diabetic supplies such as needles and syringes)
- Blood or blood plasma
- Charges for the administration or injection of any drug
- Drugs that may be properly received without charge under local, state, or federal programs including Workers' Compensation
- Any prescription refilled in excess of the number specified by the physician or any refill dispenses after one year from the physician's original order
- Any eligible prescription filled at a non-participating pharmacy without prior authorization or in the case of an emergency
- Prescriptions filled prior to allowed refill date

Dispensing Limits

Some prescription drugs have dispensing limits. Prescriptions issued over the specified dispensing limits are not covered, and the costs do not apply toward the out-of-pocket maximum. See table below for dispensing limits for specific drugs.

Prescription Drug (NF=non-formulary)	Dispensing Limit	Supply
Impotency Drugs		
Viagra®, Cialis® [NF], Levitra® [NF]	18 tablets	100 days
Muse®	18 suppositories	100 days
Caverject® or Papaverine®/prostaglandin combination	18 injections	100 days
Nicotine Replacement Therapy		
Nicotine gum (Nicorette® or Nicorette® DS)	1,980 pieces	100 days
Topical nicotine patches	204 patches	100 days
Nicotrol® Nasal Spray	42 bottles	100 days
Nicotrol® Oral Inhaler	1,512 cartridges	100 days
Commit® lozenges	1,944 lozenges	100 days
Migraine		
Sumatriptan®, Amerge®, Maxalt®, Maxalt	54 tablets (all strengths)	100 days

MLT® Relpax®, Axert® [NF], or Zomig® [NF]		
Migranal® spray	6 kits	100 days
Dihydroergotamine injection	20 vials	100 days
Sumatriptan® Injection	6 kits (12 vials)	100 days
Sumatriptan® Nasal Spray	36 sprays	100 days
Diabetic Supplies		
Needles, lancets and syringes	600	100 days
Test Strips	600	100 days
Glucometers	One	Yearly

The Mayo Prescription Drug Plan bases benefits on prescription drugs listed in the Mayo Clinic Formulary. The Formulary is an approved list of drugs recommended for use throughout Mayo Clinic. The amount you pay will depend on the formulary status of the drug and the pharmacy you use to fill your prescription.

You may need to file a claim for reimbursement after filling a prescription without your member ID card. After filling a prescription in an emergency situation, submit a *Prescription Drug Reimbursement Claim Form*, which is available online by visiting the internal Mayo Web site and going to the "For You" home page under prescription drug coverage information or by contacting the Employee Service Center. Complete the form, attach copies of the prescription receipt (s), and mail the claim form to Mayo Clinic Health Solutions at the address listed on the form. The reimbursement you receive may be reduced to the amount that would have been paid by the Plan for the claim had it been processed electronically.

Physician Visits

Service	In-Network Cost to You	Out-of-Network Cost to You Coinsurance after Deductible
Primary care	$0	30%
Mayo Express Care (Rochester Only)	$0	30%
Specialty care	$25	30%
Urgent Care	$40	30%

Important Note: Services provided by the physician are not addressed in the *Physician Visits* section, rather in the *Schedule of Benefits*.

Primary Care

To help protect the health of you and your family, Mayo Universal provides comprehensive coverage for in-network preventive care and primary care visits.

When you visit an in-network provider for a primary care visit, your copayment will be zero. For more information about the cost to you for services provided by your primary care physician, see the *Preventive Care Services* subsection of the *Schedule of Benefits.*

Primary care is offered at various specialty areas at Mayo Clinic. Your coverage for preventive care services is based on your work site and does not provide the same level of coverage if you are visiting one of the other Mayo Clinic facilities.

For example, if you work in Florida and are traveling to Arizona on business or for personal reasons, Obstetrics will not be covered as primary care nor would General Internal Medicine while you are in Arizona.

The following chart shows Mayo Clinic clinical areas that offer primary care based on your work location.

Specialty Area	Florida and Georgia	Rochester	Arizona
Acute Illness			X (Mayo Clinic only)
Primary Care Internal Medicine	X	X	X
Community Pediatric and Adolescent Medicine	X PHCS/NHBC	X	
Mayo Express Care		X	
Family Medicine	X	X	X
General Internal Medicine			X
Gynecology (annual well-woman exam)	X		X
Mayo Clinic Health System - primary care providers		X	
Preventive and Occupational Medicine (includes Employee Health Services)		X	X (Mayo Clinic only)
Obstetrics (for pregnancy)	X		

Preventive Care Services

Service	In-Network Cost to You	Out-of-Network Cost to You
Annual Preventive Service	0	not covered
Well-Baby/Child Care and Immunizations	0	not covered
Adult Immunizations	0	not covered
Annual Well-Woman Gynecological Services	0	not covered
Routine Hearing Exams to Age 10	0	not covered

Maximum Benefits

There is a limit on specified preventive services that will result in no cost to you. This means you receive benefit coverage according to the limits based on the calendar year. When you make your appointments, keep in mind that if you received your annual preventive exam in January, you are not eligible for benefit coverage for another preventive exam until the next calendar year.

Important Note: Some preventive care services in the following list of covered items are provided at no charge, but have limits based on age and frequency. There may be coverage under the Plan beyond these limits for additional services or procedures; however, deductibles, copayments, and/or coinsurance may apply.

Covered Preventive Care Services

Age	Preventive Care Service
Birth-10 years	• Expanded newborn screen (blood) • Evoked otoacoustic emissions (EOAE) once at birth • Lead level • Hemoglobin or hematocrit between 6-12 months • Immunizations and tuberculin skin testing • Pediatric vision screening between 0-6 years
11 years and over	• Papanicolaou smear and Human Papillomavirus (HPV) (women) screening annually until age 40 • Human Papillomavirus (HPV) vaccination • Chlamydia, gonorrhea and syphilis screen (women) • Immunizations and tuberculin skin testing
Beginning at 20	• Lipid panel once every 5 years
Beginning at 40	• Mammogram (women) • Papanicolaou smear and Human Papillomavirus (HPV) (women) screening once every 3 years
Beginning at 45	• Glucose screening once every 3 years • Osteoporosis screen one time only (women)
Beginning at 50	• Prostate Specific Antigen (PSA) test (men) • Colorectal Cancer Screen Options (one of the following): • Fecal occult blood test annually (series of three) w/flexible sigmoidoscopy every 5 years • Barium enema and flexible sigmoidoscopy every 5 years • CT colonography every 5 years • Colonoscopy once every 10 years
Between 65-75	• Abdominal aneurysm screen one time only (men)

When your preventive care turns diagnostic:

If, in the course of a screening or test, your doctor diagnoses you with a health condition requiring treatment, the services you receive may no longer be considered "preventive". These services may be considered diagnostic and subject to deductible, coinsurance, and/or copayments.

Ineligible Preventive Care Services

No coverage is provided when you receive preventive services from an out-of-network provider.

Rehabilitative Therapy Services

Service	In-Network Cost to You	Out-of-Network Cost to You Coinsurance after Deductible
Physical therapy	10%	30%, with 20-visit limit per year for physical therapy
Occupational therapy	10%	30%
Speech therapy	10%	30%

Maximum Benefits

The Plan covers a maximum of 20 visits for physical therapy per year for out-of-network services.

Covered Rehabilitative Therapy Services

- Respiratory therapy
- Phase I and Phase II cardiac rehabilitation

Ineligible Rehabilitative Therapy Services

- Vocational rehabilitation, testing, or training (including work hardening)
- Recreational therapy, except when part of inpatient acute rehabilitation, or inpatient mental health or chemical dependency treatment
- Residential and outpatient therapy charges billed by a skilled nursing facility, unless part of the 30 day skilled nursing care facility stay (subacute)
- Phase III and Phase IV cardiac rehabilitation
- Custodial care
- Massage therapy
- Group speech therapy
- Charges for maintenance therapy billed by a skilled nursing facility

Self-Care Resources and Wellness Program

Ask Mayo Clinic (Rochester, Arizona, and Florida)	Toll Free Number 1-888-288-1881 International Number 00 1 507-288-6000
Hours: 24 hours a day	
Mayo Clinic Tobacco Quitline (Rochester, Arizona, and Florida)	Toll Free Number 1-888-288-1881 International Number 00 1 507-288-6000
Hours: 24 hours a day	
Pregnancy Advisory Program (Rochester, Arizona, and Florida)	Toll Free Number 1-888-778-8205
Hours: 24 hours a day	
Mayo Clinic Guide to Self-Care Easy-to-use resource book provided to all employees at orientation	

Important Note: The *Ask Mayo Clinic Nurse Line, Mayo Clinic Tobacco Quitline,* and *Pregnancy Advisory Program* have access to translation services to meet the needs of many non-English speaking persons.

Ask Mayo Clinic

Ask Mayo Clinic is a telephone-based medical resource line to provide health information to help choose appropriate levels of medical care. Those enrolled in the Mayo Medical Plan can call with questions about an illness, injury, or general health topic. All calls are answered by experienced Mayo registered nurses who are specially trained to handle telephone health inquiries. *Ask Mayo Clinic* offers:

- Instruction about preventive health strategies and self-care
- Information to help members decide the appropriate level of care for their situation
- Answers to health questions and concerns
- Instructions for acute and non-acute conditions
- Basic healthcare information
- Follow-up phone call to check health status/symptoms, if appropriate

Mayo Clinic Tobacco Quitline

Mayo Clinic Tobacco Quitline is a telephone-based program designed to help enrolled Plan members discontinue the use of tobacco. *Mayo Clinic Tobacco Quitline* combines the clinical resources of the Mayo Clinic Nicotine Dependence Center, the technical expertise of counselors, and the clinical skills of Mayo registered nurses. *Mayo Clinic Tobacco Quitline* provides the education, support, and motivation needed to live tobacco-free. *Mayo Clinic Tobacco Quitline* offers:

- Comprehensive tobacco use assessment
- Follow-up calls from a counselor for continued support and counseling
- Personalized treatment plans and Educational materials appropriate for the member’s stage of readiness to change
- Different interventions at various stages of behavior change
- Relapse prevention strategies
- Information on local support groups

- Access to Mayo registered nurses 24 hours a day, seven days a week for nicotine withdrawal support

Pregnancy Advisory Program

The Pregnancy Advisory Program is a telephone-based program for enrolled Plan members designed to provide access to an experienced registered nurse. During each trimester of pregnancy and within a month after delivery, this nurse will call with pertinent, helpful information. Mothers-to-be will also receive Educational materials and may call their nurse whenever they have questions.

Mayo Clinic Guide to Self-Care

This resource book, provided to new employees at their benefits orientation and available for purchase at a discount at the Mayo Clinic retail pharmacies, is written by experts at Mayo Clinic. It is an easy-to-use book that helps provide self-care for you and your family members. More than 150 common health conditions are addressed in the Mayo Clinic Guide to Self-Care. Be sure to keep this guide in a convenient location so it is handy when you need information.

Dan Abraham Health Living Center Wellness Program

Mayo Clinic employees have access to the Dan Abraham Healthy Living Center (DAHLC). As a member of the DAHLC you may have an option to participate in wellness programs and certain limited medical services that are available to DAHLC members. If you are enrolled in the Mayo Medical Plan, specified programs and services are covered by the Mayo Medical Plan subject to all plan terms and conditions, including out of pocket medical expenses such as coinsurance, deductibles and co-payments. DAHLC members who are not enrolled in the Mayo Medical Plan must pay a fee for the services. Certain wellness program services are considered preventive screening services, such as a lipid and glucose screening (does not include a full lipid panel). The lipid panel and glucose screening are the only DAHLC services actually paid by the Mayo Medical Plan and are subject to the Preventive Services schedule. If there is a charge for any other service at the DAHLC, you will need to cover it out of pocket or submit your claims to any other insurance or group health plans you have available to you.

Special Services

Service	In-Network Cost to You Coinsurance	Out-of-Network Cost to You Coinsurance after Deductible
Chemotherapy/radiation therapy	10%	30%
Disposable Supplies	10%	30%
Durable Medical Equipment	10%	30%
Non-durable medical supplies	10%	30%
Orthotics	10%	30%
Prosthetics	10%	30%
Tobacco cessation (including in-patient care and over-the-counter medications WITH a prescription)	0%	30%

Important Note: Tobacco Cessation is covered at a Mayo Clinic facility in Rochester and at approved in-network provider in Arizona and Florida.

Important Note: For items not listed as covered or uncovered, Medicare guidelines are used for coverage determination. Charges in excess of $750 or a four-month rental period are reviewed by the Claim Administrator for medical necessity.

Covered Special Services

- Wigs and artificial hair pieces, if worn for hair loss resulting from alopecia areata or oncology chemotherapy (maximum benefit of one purchase per year with a maximum payment of $350)
- Replacement or repair (cost of parts only) of durable medical equipment, prosthetics or orthotics are covered due to normal wear and tear if they have outlived their useful life, or to accommodate bodily growth or atrophy

Disposable Supplies

- Dressings (wound care)
- Alcohol, peroxide, butadiene, phisohex, iodine
- Adhesive liquid and adhesive remover
- Splints
- Braces
- Ostomy and colostomy supplies
- Slings
- Needles and syringes (needles and syringes used as diabetic supplies must be purchased at an in-network pharmacy)

Durable Medical Equipment

For items not listed, Medicare guidelines are used for coverage determination

- Home renal dialysis equipment and supplies
- Equipment necessary to treat respiratory failure
- For insulin-treated diabetics, insulin pumps and blood glucose monitoring devices (blood glucose monitoring devices must be purchased at an in-network pharmacy and are limited to one per year)
- Inhalation devices including CPAP
- Apnea monitoring devices
- Oxygen and equipment for a supplemental oxygen delivery system
- Wheelchair or a hospital bed with no features over and above the medical necessity
- Bronchial drainage systems that employ a chest percussion vest and vest compressor
- Urinal
- Osteogenesis stimulator
- Jobst (compression) sleeves and gloves
- Therapeutic mattress

Prosthetics

- Removable, non-dental prosthetic devices that are durable and custom made for you, but do not require surgical connection to nerves, muscles, or other tissue
- Orthopedic appliances that are durable and custom made for you

Safety Equipment

- Restraints
- Transfer belts
- Transfer boards
- Bed rails
- Toileting equipment

Ineligible Special Services

- Replacement or repair of durable medical equipment, prosthetics, or orthotics which are stolen, lost, damaged, or destroyed by misuse, abuse, or carelessness
- Charges for labor to repair durable medical equipment, prosthetics, or orthotics
- Charges incurred for the rental or purchase of any type of air conditioner, air purifier, or similar device or appliance
- Ordinary over-the-counter items, except related to wound care
- Batteries, except for implantable devices
- Orthopedic shoes or similar device which is not custom made

- Splints, braces, or mouth guards used for non-medical purposes (i.e., support worn primarily during participation in sports or similar physical activities)
- Charges for equipment, models, or devices having features over and above that which meets the medical necessity
- Motor vehicles, lifts for wheelchairs, or stair lifts
- Room humidifiers and dehumidifiers
- Food blenders
- Exercise equipment
- Orthopedic mattresses
- Home or automobile modification
- Environmental change
- Pools, whirlpools, and similar items, even if recommended, ordered, or prescribed by a health care provider

Transplant Services

Service	in-network Cost to You	Out-of-Network Cost to You
Transplant services	See *Inpatient* and *Outpatient Hospital Services* subsections of this *Schedule of Benefits* section for cost to you.	

Prior Authorization: Prior authorization is required for all transplant services received outside the continental United States. Each time prior authorization is required but not obtained in connection with a covered service, the charges related to the service will not be covered. The cost to you will be 100% of the charges. For information on how to obtain prior authorization, see the *Accelerated Claim Procedure* subsection of the *Claim Payment and Appeal Procedures* section.

Covered Transplant Services

Those directly related to the transplantation of:

- Human bone marrow
- Cornea
- Kidney
- Liver
- Heart/lung
- Heart
- Lung
- Pancreas
- Eligible medical charges incurred by the recipient

- Eligible medical charges incurred by the donor (only if the charges are not covered under the donor's health care coverage)
- When the donor is also participating in the Plan, eligible medical charges incurred by the donor are covered by the recipient's health plan; the recipient's health plan shall be considered primary.
- Securing an organ from a cadaver or tissue bank, including the surgeon's fee for removal of the organ and the hospital fee for storage and transportation of the organ
- Testing to determine transplant feasibility and donor compatibility

Ineligible Transplant Services

- Charges associated with the purchase of any organ
- Transportation of a living donor
- Travel expenses including lodging

EXCLUSIONS

Notwithstanding any provision in the Plan to the contrary, the Plan will not provide benefits for the following services, medical procedures, or supplies regardless of medical necessity or recommendation by a health care provider. The participant is responsible for 100% of the charges associated with the listed exclusions. These charges are not covered services and, therefore, will not count toward the annual out-of-pocket maximum or deductible. In addition to the exclusions listed below, the *Schedule of Benefits* section contains exclusions in addition to those shown below.

- Charges for any service or supply (including tests and physical examinations) not needed for the medical care of a diagnosed illness or injury (except charges incurred for services and supplies in connection with routine circumcision of a newborn child). To be needed a service or supply must:
  - Be ordered by a physician
  - Be commonly and customarily recognized throughout the medical profession as appropriate in the treatment or diagnosis of the illness or injury
  - Be neither educational nor experimental in nature (investigational procedures are considered experimental)
  - Not be furnished mainly for the purpose of medical or other research
  - Have such government approval as required
- Services or supplies that are not medically necessary, except if specifically listed in the Schedule of Benefits section as covered services
- Charges incurred for custodial care
- Charges in connection with cosmetic non-functional surgery performed by a physician unless due to a functional correction of a congenital defect to a child under the age of 16
- Charges in excess of allowed amounts
- Eye examination (refraction) charges to determine the need for (or change of) eyeglasses or lenses of any type
- Examinations to determine the need for a hearing aid device as well as purchase, fitting, or adjustment of a hearing aid device (unless it is a surgically implanted device)
- Eyeglasses, lenses, contact lenses, sunglasses (including any colored or tinted lenses), safety glasses, or frames
- Eye surgery (such as radial keratotomy) when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness), or astigmatism (blurring)
- Vision therapy or eye exercises
- Repair of lenses or frames
- Contact lens fitting
- Surgical correction of refractive error and refractive keratoplasty including radial keratotomy (RK), automated lamella keratoplasty (ALK), Lasik surgery, or any similar procedure
- Payment for medical expenses that a covered person is entitled to under Medicare, if Medicare is the primary payer under applicable federal law
- Services for self-treatment or the treatment of immediate family members, other than self-prescribed non-controlled substances
- Charges incurred for education, training, bed and board while you or your covered family member is confined in an institution that is primarily a school or other institution for training, a place of rest, a place for the aged, or a nursing home

- Charges incurred while you or an eligible family member is confined in a hospital operated by the United States of America or an agency thereof, unless payment is legally required
- Charges incurred in connection with any disease or accident for which benefits are payable in accordance with the provisions of any Workers' Compensation or similar law
- Services and supplies for treatment of military service related injury, when the covered person is legally entitled to other coverage
- Charges provided and/or billed by a chiropractor
- Health club memberships and all services provided by a health club facility
- Charges for personal growth/development, holistic medicine, or other programs with an objective to provide complete personal fulfillment
- Homeopathy
- Herbal therapy
- Chelation therapy (except in the treatment of heavy metal poisoning)
- Coma stimulation programs
- Charges related to or in connection with adoption
- Duplicate services or supplies
- Outpatient nutritional supplements including:
  - Home meals
  - Food
  - Food supplements
  - Diets, naturopathic or homeopathic services/substances
  - Other nutritional supplies
  - Over-the-counter electrolyte supplements
- Food for the treatment of obesity or weight control
- Financial or legal counseling services
- Housekeeping or meal services in your home
- Services that do not meet the Plans standards of licensure and certification
- Autopsies and related charges
- Treatment, equipment, drugs, and/or devices that do not meet generally accepted standards of practice in the medical community
- Educational materials and supplies, except inpatient
- Applied Behavioral Analytic or similar therapies and/or interventions for autism spectrum disorders
- Massage Therapy
- Acupuncture unless performed at a Mayo Facility
- Transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery
- Sports medicine fitness training or aerobic exercise program

UTILIZATION MANAGEMENT

This section describes utilization management programs under the Plan and your responsibilities under these programs. Utilization management programs assist you to ensure maximum benefit coverage while optimizing clinical outcomes across a continuum of care.

The utilization management programs are designed to assist the Plan in:

- Evaluating your health care services for medical necessity and appropriateness
- Coordinating care needs
- Identifying benefit limitations
- Identifying high-risk participants for proactive case management

The Plan uses the methods described in this *Utilization Management* section to coordinate and review care and determine whether services are covered under the Plan.

Medical Care Decisions

Your medical care is between you and your health care provider. The ultimate decision on your medical care must be made by you and your health care provider. The Plan has authority only to determine whether provided services are covered under the Plan.

Definitions Used In Utilization Review

Discharge Planning

Discharge planning assists you with the transition to an appropriate level of care following acute inpatient and/or outpatient health care services. If you are not able to return home, the Plan may coordinate or assist in the coordination of your care to identify the most appropriate alternative setting and services.

Case Management

Case management is collaborative, systematic, and ongoing management of eligible participants with complex diagnoses, catastrophic Injuries or illnesses, chronic health problems, and/or poor histories of self-management or compliance. Case management involves coordination of your health care needs and a treatment plan across the health care continuum.

Utilization Management Criteria

You will receive benefits under the Plan for covered services that are determined to be medically necessary. The fact that an individual health care provider has prescribed, ordered, recommended, or approved a health care service, or informed you of its availability do not in itself make it medically necessary. The Plan will make the final determination of whether any service meets the Plan's standard for medically necessary care.

The Plan relies, in part, upon Mayo Clinic Health Solutions, the Claims Administrator, in order to determine whether the service meets the Plan's standard of medically necessary care. Mayo Clinic Health Solutions may rely upon Benefit Interpretations in certain claims. The Benefit Interpretations are available upon a written request if relevant to a benefit determination.

Prior Authorization

Certain covered services require prior authorization under the Plan. If you do not obtain authorization from the Plan before receiving those services, coverage for the services will be reduced or denied. The *Accelerated Claim Procedure* subsection described in the *Claim Payment and Appeal Procedures* section explains how to obtain prior approval from the Plan and how to appeal if approval is denied.

The covered services that require prior authorization under the Plan are listed in the *Schedule of Benefits* and include:

- Certain prescription drugs listed in the *Pharmacy and Prescription Drugs* subsection
- All transplant services received outside the continental United States
- Skilled nursing facility
- Out-of-network inpatient admissions

Limitations

Prior authorization does not guarantee that proposed health care services are covered under the Plan. Coverage for authorized services is subject to the definitions, conditions, limitations, and exclusions of the Plan. Services provided after prior authorization is received may be subject to further review by the Plan to ensure the services are medically necessary. Benefits will be denied if you are not eligible for coverage under the Plan on the date services are incurred, if services received are not medically necessary, or if the Plan has terminated.

Obtaining Prior Authorization

See the *Accelerated Claim Procedure* subsection in the *Claim Payment and Appeal Procedures* section for information on how to obtain prior authorization and how to file an appeal if authorization is denied.

Penalty for Not Obtaining Prior Authorization

Each time prior authorization is required but not obtained in connection with a covered service, the charges related to the service will not be covered. Your responsibility will be 100% of the charges. Any such claims do not apply to the deductible or annual out-of-pocket maximum.

Questions Regarding Utilization Management Procedures

If you have any questions regarding these procedures, you or your health care provider should contact the Claim Administrator's Customer Service at the phone number listed in the *Contact Information* section of this Plan.

COORDINATION OF BENEFITS

Coordination of Group Coverage

If you or eligible family members are covered by another group or government sponsored medical plan or by no-fault automobile insurance that provides medical coverage, you may get payment from those plans as well as the Plan.

The benefits paid from the Plan will coordinate to pay up to 100% of the allowed amounts. A plan without a coordinating provision similar to the plan the person is enrolled in always pays first. Provided both plans have a coordination of benefits feature, payment will be made as follows:

a) The plan covering the person as an employee or retiree (if not eligible for Medicare) pays benefits first; the plan covering the person as an eligible family member pays second.

b) If a child is covered under both parents' plans, the plan directly covering the parent whose birthday comes first during the calendar year is the primary plan. If the parents have the same birthday, the plan covering the parent longer pays benefits first. However, if the parents are divorced, the Plan pays in this order:

    1. If the terms of a court decree have established one parent as financially responsible for the child's health care expenses, the plan of the parent with that responsibility is primary.
    2. The plan of the parent with custody of the child pays next.
    3. The plan of the stepparent married to the parent with custody of the child pays next.
    4. The plan of the parent without custody of the child pays last.

When a determination cannot be made, the plan that has covered the individual longer is primary. Coverage under any workers' compensation act or similar law is primary. Coverage under any no-fault act for auto insurance or similar law is primary.

This coordination of benefits provision does not apply to the outpatient prescription drug benefit. Also, these rules do not apply to coordination with Medicare for retirees and their eligible family members. For those rules, see the sections on *Medical Coverage in Retirement* or *Attaining Medicare Eligibility*.

There is no coordination of benefits between any components of the Mayo Medical Plan.

Benefits after Age 65 or Medicare Eligibility Date

The Medicare rules in this section do not apply to coordination with Medicare for retirees and their eligible family members. For those rules, see the sections on *Medical Coverage in Retirement* or *Attaining Medicare Eligibility*.

For purposes of this section, the following terms have the definitions given below:

- Age 65 means the age attained at 12:01 a.m. on the first day of the month in which you or your eligible family member reaches age 65.
- ESRD means end-stage renal disease, defined as the stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplantation to maintain life.

- Medicare Primary Recipient means:
    a. A participant or covered person who is eligible for Part A of Medicare because of age and who is no longer employed by Mayo (e.g., a person on COBRA).
    b. A participant or covered person who is eligible for primary Medicare benefits because of ESRD after 30 months of eligibility for Medicare benefits because of ESRD.
    c. A participant or covered person not in current employment who is eligible for Part A of Medicare because of disability.
- Medicare Secondary Recipient means:
    a. A participant or covered person age 65 or over who is eligible for Part A of Medicare because of age, who is not entitled (and could not upon filing an application become entitled) to Medicare on the basis of ESRD, and who has coverage under the Plan due to current employment status.
    b. A spouse age 65 or over who has coverage under the Plan due to your current employment status.
    c. A spouse age 65 or over who has retired from their employment will continue to be secondary under the plan until you are no longer employed.
    d. A participant or covered person who is eligible for secondary Medicare benefits because of ESRD during the first 30 months of eligibility for Medicare benefits because of ESRD.
    e. A participant or covered person in current employment who is eligible for Part A of Medicare because of disability.

As a Medicare Primary Recipient, Medicare pays its full benefits first, then the Plan pays its benefits, if any.

As a Medicare Secondary Recipient, the Plan will pay benefits first; however, if the services are not covered under the Plan, or if you or a covered person have exhausted the applicable benefit limitations provided under the Plan, Medicare will make primary payments for Medicare covered services and supplies.

Workers' Compensation

Coverage under the Plan is not in lieu of Workers' Compensation and does not affect any aspect of coverage under Workers' Compensation.

Subrogation and Reimbursement

There may be situations in which a covered person has a legal right to recover the costs of health care or medical expenses as a result of injury or illness caused by, or the responsibility of, a third party. For example:

- If you are injured in a store, the owner may be responsible for the health care or other expenses of that injury. If you are in a motor vehicle accident, another driver may be responsible.
- If you become sick or injured in the course and scope of employment, your employer or a Workers' Compensation insurer may be responsible for health care or other expenses from the illness or injury.

- If someone else is legally responsible or agrees to compensate a covered person for Injuries or illness, the Plan has the right to recover any and all benefits it has paid in connection with the injury or illness.

By enrolling and accepting coverage in the Plan, the covered person agrees to the following:

a. The entire amount collected by the covered person from any source will be considered to be a first recovery of benefits paid under the Plan regardless of the terms of any award, agreement, regulation, statute, etc., to the contrary. The fact that only a part of the payment or even none of the payment is allocated to medical, dental, or disability expenses does not affect the Plan's rights to recover all benefits paid in connection with the covered person's injury or illness. The Plan shall have a lien and a security in all such claims.

b. Until the Plan has been reimbursed for the full amount of all benefits paid under the Plan, the covered person or the covered person's attorney or other representative shall hold the payment from any source in constructive trust for the Plan. The term "any source" shall include, but is not limited to, any recoveries, settlements, judgments, or other amounts the covered person, heirs, guardians, executors, attorneys, or other representatives receive or are awarded, or become entitled to from any plan, entity, insurer (first party or third party), and/or insurance policy (including no-fault automobile insurance), an uninsured or underinsured motorists plan, a homeowner's plan, renter's plan, or liability plan.

c. The Plan will be reimbursed 100% from any and all recovery before payment of any other existing claims including any claim made by the covered person for general damages.

d. The Plan may collect the proceeds of any recovery, payment, settlement, or judgment recovered by the covered person or the covered person's legal representative regardless of whether the covered person has been fully compensated or "made whole."

e. The covered person has an obligation to cooperate completely with the Plan. The covered person or legal guardian must complete and sign all documents that may be required by the Plan and take any other action necessary to secure the Plan rights. The covered person also has an obligation to notify the Plan in writing immediately any time the Plan may have a reimbursement right and to identify any and all parties who may be liable.

f. If the covered person fails to immediately repay amounts owed to the Plan, the Plan may withhold future payments or benefits to satisfy the covered person's obligation.

g. If the covered person voluntarily accepts a lump sum, other settlement, or award from any source without the Plan's consent which may or may not cause the Plan to lose its reimbursement rights, the Plan will have no obligation to pay any past, present, or future benefits or expenses relating to the injury or illness caused by, attributable to, or otherwise the responsibility of the other party. Past payments may be recovered from the medical provider.

The Plan subrogation and reimbursement right also applies to the covered person's coverage under workers' compensation plans, disability, lost time coverage, other substitute coverage, any other right of recovery, or any claim payment received from any source. The Plan reserves the right to recover Expenses Incurred on behalf of the covered person even if the recovery is made by a family member if that recovery is based on the covered person's injuries or illness. At all times the Plan represents itself in subrogation, reimbursement, and intervention interests. Therefore, the Plan claim is not subject to reduction for attorney fees, costs, or expenses, or withholding from the Plan's recovery under the "common fund" doctrine or otherwise.

CLAIM PAYMENT AND APPEAL PROCEDURES

This section describes the two claim procedures used by this Plan:

- Accelerated Claim Procedure
- Standard Claim Procedure

The accelerated claim procedure applies only if the benefit requires prior authorization. A service requires prior authorization if the benefit will be reduced or denied if you do not obtain authorization from the Plan before receiving the service. Services requiring prior authorization are noted in the Schedule of Benefits section within the description of benefits that are provided under each option of this Plan. A listing is also located in the section called *Utilization Management*.

The standard claim procedure applies to all other claims. If a benefit requires prior authorization and you receive the service or supply before obtaining authorization, the standard claim procedure will apply.

Important Notes

- Unless specifically noted, oral inquiries about coverage and benefits are not considered claims or appeals. In addition, a request for a pre-determination is not a claim for benefits and you do not have appeal rights.
- All time periods described in this section are in calendar days, not business days.
- An authorized representative can file claims and appeals on your behalf. For the standard claim procedure, you must complete an authorized representative form, which is available by calling the Claim Administrator. For the accelerated claim procedure, your health care provider or physician will be recognized as your authorized representative unless you direct otherwise.
- If you do not file a claim or follow the claim procedure, you are giving up important legal rights.
- Except as specifically noted, the claim procedure for prescription drug benefits is the same as for other medical benefits in the Plan. For prescription drug benefits, the pharmacist is considered the health care provider, and the prescription drug is considered the service or supply.
- The addresses for Claim Administrators and Committees responsible for deciding claims in the Plan are given in a chart at the end of this section.
- This section does not apply to requests for distributions from your HSA. Fidelity Investments will provide you with information about such requests.
- This section does not apply to disputes related solely to paying for coverage pre-tax under the Pre-Tax Premium Rules and/or denials of requests to make changes to pre-tax elections during the year. If you have such a dispute, explain your concern in writing to the Employee Service Center. You will receive a written response.

Pre-Determination

You may wish to file a pre-determination before receiving a service or supply to determine if it will be paid by the Plan. A request for a pre-determination is not a claim for benefits and you do not have appeal rights or rights to pursue a lawsuit against the Plan under ERISA. Pre-determinations are offered as a courtesy and involve medical services or benefits that do not require prior approval under the Plan. To request a pre-determination, send the following information in writing to the Claim Administrator:

- Name of the plan

- Name, address, and date of birth of person to receive the service or supply
- Complete description of the service or supply, including diagnosis, prognosis, and cost (this information should be obtained from the health care provider)
- Statement that you are requesting a determination in advance whether the service or supply will be covered by the Plan

Once health care services have been rendered for services in the pre-determination process, the claim will be processed as a post-service claim.

The Claim Administrator has 30 days to decide your pre-determination request and notify you if the services or benefits will be covered in whole or in part.

You may be notified that an extension of up to 15 days is needed to decide your pre-determination request due to reasons beyond the control of the Claim Administrator. If the extension is required because you need to provide additional information in order for your predetermination request to be decided, you will be given at least 45 days to provide that information. The time it takes you to provide the information will not count against the time the Claim Administrator has to make its decision.

Standard Claim Process

All claims in the Plan except those related to benefits requiring prior authorization are handled under this standard claim procedure.

Time for Filing a Claim

Your initial claim must be received by the Claim Administrator no later than 12 months from the date the service or supply is received.

Filing a Claim

Generally, your health care provider or pharmacist will electronically submit your initial claim directly to the Claim Administrator, and payment will be made directly to them. You are responsible for paying any coinsurance directly to the provider either at the time of your visit or when your provider sends you a bill for the amounts.

In some instances you may need to pay your provider or pharmacist in full and then submit a claim for reimbursement to the Claim Administrator at the address indicated in the chart at the end of this section. Claims for reimbursement, if approved, will be paid to you, not the provider. Your claim for reimbursement must be submitted on a universal billing and/or CMS 1500 form (obtained from your provider) and must contain the following information:

- Name of the plan
- Name, address, and date of birth of person to receive the service or supply
- Date of service
- Name,credentials and National Provider Identifier (NPI) of the health care provider
- Place of service
- Specific diagnosis code (current International Classification of Disease, Clinical Modification (ICD, CM) format)
- Specific service code for which payment is requested (current Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) format)
- Amount of billed charges

Special Rules for Filing Initial Prescription Drug Claims

Presenting a prescription to the pharmacist is not considered a claim for benefits. If you present a prescription to the pharmacist and are told that the drug is not covered, or you disagree with the amount you are charged, you can either (1) pay for the prescription and file a claim for reimbursement or (2) file a claim for benefits before having the prescription filled. In either case, the procedure for filing a claim for reimbursement described above must be followed.

No prescription drug benefits are available through a pharmacy that is not in the Mayo Clinic Health Solutions or Catamaran network of providers except in the case of an emergency. If you obtain a prescription drug outside the network in an emergency, you must file a claim for reimbursement.

Claim Decision

The Claim Administrator has 30 days to decide your claim and notify you if your claim is denied in whole or in part. If your claim is denied, the notice will contain the information required by federal regulations.

You may be notified that an extension of up to 15 days is needed to decide your claim due to reasons beyond the control of the Claim Administrator. If the extension is required because you need to provide additional information in order for your claim to be decided, you will be given at least 45 days to provide

that information. The time it takes you to provide the information will not count against the time the Claim Administrator has to make its decision.

Appeal Procedure for Standard Claims

Filing First Level Appeal (Standard Claim Process)

You must file an appeal within 180 days after the date you received notice your claim is denied.

Your written appeal must be submitted to the Claim Administrator and include the following information:

- Name of plan
- Name, address, and date of birth of patient
- Information regarding the denial of benefits such as the Explanation of Benefits you received, claim number listed on the Explanation of Benefits, or copy of denial letter
- A statement that you are appealing the denial of benefits
- The reason(s) you disagree with the denial of your claims
- Any information, documents, or arguments you want considered in the first appeal

Appeal Decision

The Claim Administrator has 30 days to make a decision and notify you. If your appeal is denied, the notice will contain the information required by federal regulations.

Filing Second Level Appeal (Standard Claim Process)

You must file an appeal within 60 days after the date you received notice that your first level appeal was denied.

Your written appeal must be submitted to the Plan Review Committee and include:

- Name, address, and date of birth of patient
- A copy of the previous denial letter
- A statement that you are appealing the denial of benefits
- The reason(s) you disagree with the denial of your claims
- Any information, documents, or arguments that you want considered in the second appeal

Appeal Decision

The Plan Review Committee will decide your second level appeal no later than 30 days from the date the second appeal request was received.

Special Rule for Claims Related to a Course of Treatment

If you are notified that a benefit you were granted for a specified period of time or number of treatments will be reduced from what was previously granted, that notice is considered a claim denial and will be provided to you sufficiently in advance of the benefit reduction to allow you to file first and second level appeals.

Accelerated Claim Procedure

This accelerated claim procedure applies if you are: (1) seeking approval for a benefit that requires prior authorization and (2) you have not already received the service or supply.

A benefit requires prior authorization if the benefit will be reduced or denied if you do not obtain authorization from the Plan before receiving the service. If the benefit requires prior authorization but you receive the service or supply before obtaining that authorization, your benefit claim will be handled under the standard claim procedure.

Prior authorization is required for some services in the Plan. Please review the list of services requiring prior authorization in the *Utilization Management* section for your particular plan option.

Timeframe for Filing an Initial Accelerated Claim

The timeframes for the accelerated claim procedure are shown on the *Timeframe for Accelerated Claim Procedure* chart.

Filing an Initial Accelerated Claim

You or your treating physician can file your accelerated claim by contacting Mayo Clinic Health Solutions and providing the following information:

- Name of the plan
- Name, address, and date of birth of the patient
- Proposed date(s) of service
- Name and credentials of the health care provider
- Order or request to the health care provider for the requested service
- Proposed place of service
- Specific diagnosis
- Specific proposed service code for which approval or payment is requested (current Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) format)
- Clinical information for Plan to make determination that service satisfies Plan medical necessity requirements

If a claim is filed incorrectly, you will be notified within five days, or if the claim is urgent (as defined below), within 24 hours.

An “urgent” claim is a claim for a benefit that requires prior authorization and a delay in treatment could either (1) seriously jeopardizes your life, health, or ability to regain maximum function or (2) in the opinion of a physician with knowledge of your medical condition, cause you severe pain. If you or your authorized representative or physician believe that your claim is urgent, notify Mayo Clinic Health Solutions and provide the information you want considered regarding your claim.

Claim Decision

You will be notified of the decision, and if your claim is denied, the notice will contain the information required by federal regulations.

Filing a First Level Appeal and Decision

If you disagree with a claim decision, you must make a first level appeal to the Claim Administrator. The timeframes for the accelerated claim procedure are shown on the *Timeframe for Accelerated Claim Procedure* chart.

Your first level appeal must include:

- Name of plan
- Name, address, and date of birth of patient
- Information regarding the denial of benefits, such as the Explanation of Benefits you received, the claim number listed on the Explanation of Benefits, or a copy of denial letter
- Statement that you are appealing the denial of benefits
- Reason you disagree with the denial of your claims
- Any information or documents you want considered in the appeal

Appeal Decision

You will be notified of the decision. If your appeal is denied, the notice will contain the information required by federal regulations.

Filing a Second Level Appeal and Decision

If you disagree with the decision of your first level appeal, you must make a second level appeal to the Plan Review Committee. The timeframes for the accelerated claim procedure are shown on the *Timeframe for Accelerated Claim Procedure* chart.

Your second level appeal must include:

- The reason you disagree with the denial of your claim.
- Any information, documents, or arguments that you want considered in the second appeal

Appeal Decision

You will be notified of the decision. If your appeal is denied, the notice will contain the information required by federal regulations.

Timeframe for Accelerated Claim Procedure

Accelerated Claim Procedure Timeframe						
Type of Claim	**Initial Decision**	**Extension of Initial Decision**	**Filing First Level Appeal**	**First Level Appeal Decision**	**Filing Second Level Appeal**	**Second Level Appeal Decision**
Non-urgent	30 days after receipt of claim**	15 additional days	No later than 180 days after receipt of initial claim decision	15 days after receipt of appeal	No later than 60 days of first level decision	15 days after receipt of second level appeal
Urgent	72 hours**	None	No later than 180 days after receipt of initial claim decision	36 hours after first level appeal	No later than 60 days of first level decision	36 hours after second level appeal

**Insufficient Information Timeframe

Non-Urgent Claims — If the information received with an initial claim is insufficient, you will be given 45 days to provide the requested information. The 45-day period will not count toward the time for the Claim Administrator to make a decision.

Urgent Claims — If the information received with an initial claim is insufficient, you will be notified within 24 hours after the claim is received. The decision will be made 48 hours after (1) the additional information is requested or, if earlier, (2) you provide the requested information.

Special Rule for Claims Related to Course of Treatment

If you are notified that a benefit you were granted for a specified period of time or number of treatments will be reduced from what was previously granted, the notice is considered a claim denial and will be provided to you sufficiently in advance of the benefit reduction to allow you to file first and second level appeals. If you were granted treatment for a specified time or number of treatments, and you request an extension of that course of treatment within 24 hours before the treatment ends, you will be notified within 24 hours whether the extension is approved or denied. If you request the extension less than 24 hours before the treatment ends, your request will be processed as shown on the chart above depending on whether the claim is urgent or non-urgent.

General Rules Applicable to All Claim Procedures

Authority

Mayo Clinic is the Plan Administrator and has delegated the authority to decide benefit claims and appeals as described in these claim procedures. The Plan Review Committee (or Mayo Clinic Health Solutions for the accelerated process) has the discretion, authority, and responsibility to make final decisions on all factual and legal questions under the Plan, to interpret and construe the Plan and any ambiguous or unclear terms, and to determine whether a participant is eligible for benefits and the amount of the benefits. The Claim Administrator and/or applicable committee may rely on any applicable statute of limitations as a basis to deny a claim. The Plan Review Committee's decisions are conclusive and binding on all parties.

Time Limit for Commencing Legal Action

If you file your initial claim within the required time, and the Claim Administrator and Plan Review Committee deny your claim and appeal, you may sue over your claim (unless you have executed a release on your claim). You must, however, commence suit within three years from the time your initial claim was submitted.

Exhaustion of Administrative Remedies

Before commencing legal action to recover benefits or to enforce or clarify rights, you must exhaust the claim and review procedures for this Plan.

Claim Administration and Committee Contacts for Appeal Process

Plan	Claim Administrator
Mayo Medical Plan	Mayo Clinic Health Solutions PO Box 211698 Eagan, MN 55121

First Level Appeal	Second Level Appeal
Mayo Clinic Health Solutions 4001 41 Street NW Rochester, MN 55901-8901	Plan Review Committee Mayo Clinic Health Solutions 4001 41 Street NW Rochester, MN 55901-8901

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 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.

Employee contributions for the Plan are determined by the Plan Administrator and announced during the annual open enrollment. Your contribution amount varies by plan option, work schedules for full time (60 or more hours per pay period) or part-time (40-59 hours per pay period) employment, and whether or not you choose a single or family coverage level. The Plan Administrator reserves the discretion and right to change the amounts of employee contributions during the Plan year.

The portion of the cost of coverage for which you are responsible may be paid on a pre-tax basis through the Pre-Tax Premium Rules, subject to the special rules for coverage for same-sex domestic partners and their children.

A same-sex domestic partner's cost of coverage will be paid by you on an after-tax basis unless the same-sex domestic partner is an eligible employee or your tax dependent under Section 152(a) (9) of the Internal Revenue Code. A detailed guideline regarding taxation of benefits for same-sex domestic partners is available from the Plan Administrator. You are encouraged to obtain guidance from your tax advisor prior to enrolling your non- tax dependent same-sex domestic partner and/or the same-sex domestic partner's children.

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 Plans

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

Effective April 14, 2003, the Plan was subject to new federal privacy requirements. As a participant you will receive a Notice of Privacy describing your rights under these regulations. The privacy requirements are contained in a separate document entitled “HIPAA Provisions to Mayo Clinic Group Health Plans,” which is a component of the Plan document. The privacy provisions permit Mayo as Plan Sponsor to obtain your protected health information for certain limited purposes, such as operation of the Plan. However, these provisions require Mayo to agree to various safeguards to protect your health information from impermissible uses and disclosures. You may obtain a copy of the privacy provisions by contacting the Plan Administrator.

No Guarantee of Employment

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

Non-Discrimination Policy

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

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

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, Claim Administrator, and any other provider of services to the Plan.

Erroneous Payments

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

Section Titles

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

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. The bill has a provision that requires health plans to provide coverage for certain mastectomy related procedures. As a participant of the Mayo 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 and deductibles (where applicable) as other covered surgical procedures. For more information on copayments and deductibles for surgical procedures, see the *Schedule of Benefits*.

PLAN ADMINISTRATION

Powers and Duties of the Plan Administrator

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

- The discretion to determine all factual and legal questions relating to the eligibility of individuals to participate, or for you to remain a participant in the Plan and to receive benefits under the Plan. With respect to claims for benefits, the Plan Administrator has delegated authority and discretion as stated in “Claim Administration and Committee Contacts for Appeal Process.”.
- To require any person to furnish such reasonable information as the Plan Administrator may request for the proper administration of the Plan as a condition of eligibility for you or eligible family members to participate under the Plan and to receive any benefits under the Plan.
- By action to delegate to other persons authority to carry out any duty or power which, under the terms of the Plan or applicable law, would otherwise be a responsibility of the Plan Administrator, including but not limited to appointment of and delegation of duties to the Salary and Benefit Committee.
- To maintain or delegate to others the duty of maintaining necessary records for the administration of the Plan.
- To interpret the provisions of the Plan, make and publish such rules and procedures for regulation of the Plan, and prescribe such forms as the Plan Administrator will deem necessary.

Records

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

Release of Medical Information

The Plan Administrator and Claim Administrator are entitled to use and disclose information reasonably necessary to administer the Plan (including the uses and disclosures permitted by 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 the necessary authorization directing any health care provider to release to the Plan Administrator and Claim Administrator, upon request, such information, records, or copies of records relating to attendance, examination, or treatment rendered to you, if necessary to determine whether to pay the claim. If you fail to sign the necessary authorization, the Plan has no obligation to pay claims.

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 or terminate the Plan, or any benefit option described in any document for the Mayo Medical Plan, including this document at any time, for any reason, and in any respect. Mayo Clinic's right to amend or terminate the Plan or benefit options includes, but is not limited to, changes in eligibility requirements, employee and employer contributions, benefits provided, and termination of all or a portion of any coverage provided under the Plan. If the Plan or any benefit option is amended or terminated, you will be subject to all the changes effective as a result of such amendment or termination, and your rights will be reduced, terminated, altered, or increased accordingly as of the effective date of the amendment or termination. You do not have ongoing rights to any plan or program benefit other than payment of covered expenses you incurred prior to the Plan amendment or termination. You do not have rights to vested benefits in the Mayo Medical Plan. The rights with respect to amendment and termination of the Plan have been delegated to the Salary and Benefits Committee.

The Salary and Benefits Committee 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 termination, benefits will be paid only for covered services 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 the employee Retirement Income Security Act of 1974 (ERISA). The Pre-Tax Premium Rules are not subject to ERISA. ERISA provides that all Plan Participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine without charge at the Plan Administrator's office and 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 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 eligible family members if there is a loss of coverage under the Plan as a result of a qualifying event. You or your eligible family members may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Prudent 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 employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you, 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 Administrator. After you exhaust the Plan's claim procedures, if your appeal is denied in whole or in part, you may file suit in a state or federal court. If Plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court

will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay 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, 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 components of the Mayo Medical Plan.

Plan Sponsor, Plan Administrator	Mayo Clinic 200 First Street SW Rochester, MN 55905 (507) 266-0440
Plan Sponsor EIN	41-6011702
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
Plan Year	January 1 - December 31
Collectively Bargained Groups	The Plans are maintained in part pursuant to one or more collective bargaining agreements. A copy of any such agreement may be obtained by you upon written request to the Plan Administrator and is available for examination.
Type of Plan	Group Health Plan
Plan Number	502
Type of Administration	Contract Administration
Source of Contributions	This Plan is funded with employer contributions from its general assets and employee contributions.
Claim Administrators ***Please Note:*** The Claim Administrators perform claim processing services pursuant to a written contract; they do not insure benefits under Mayo Medical Plan.	Mayo Clinic Health Solutions PO Box 211698 Eagan, MN 55121 1-800-635-6671 (toll free) 507-266-5580 (local)
Components of Mayo Medical Plan Document	Mayo Universal Mayo Choice Mayo Horizon Mayo Medicare Supplement Mayo Regional Standard Mayo Regional Value Privacy Rules

Employers Participating in Mayo Medical Plan

Employers Participating in Mayo Medical Plan	Medical Plan Benefit Options Available A Medicare supplement benefit option is available at all Employers for Medicare eligible disabled Employees and eligible retirees. (Exception: Mayo Clinic Health System-Cannon Falls)
Mayo Clinic Health System-Austin and Albert Lea (Albert Lea employees only)	Mayo Regional Standard (including Medicare Supplement) Mayo Regional Value
Mayo Clinic Health System-Cannon Falls	Mayo Regional Standard Mayo Regional Value
Mayo Clinic Health System-Decorah Clinic Physicians	Mayo Regional Standard (including Medicare Supplement) Mayo Regional Value
Mayo Clinic Health System-Fairmont	Mayo Regional Standard (including Medicare Supplement) Mayo Regional Value
Franklin Heating Station	Mayo Choice Mayo Universal Mayo Horizon Mayo Medicare Supplement
Gold Cross Ambulance Services	Mayo Regional Standard (including Medicare Supplement) Mayo Regional Value
Mayo Clinic Health System-Lake City Medical Center	Mayo Regional Standard (including Medicare Supplement) Mayo Regional Value
Mayo Clinic	Mayo Choice Mayo Universal Mayo Horizon Mayo Medicare Supplement
Mayo Clinic Arizona	Mayo Choice Mayo Universal Mayo Horizon Mayo Medicare Supplement
Mayo Clinic Florida	Mayo Choice Mayo Universal Mayo Horizon Mayo Medicare Supplement
Mayo Clinic Jacksonville	Mayo Choice Mayo Universal Mayo Horizon Mayo Medicare Supplement
Mayo Foundation for Medical Education and Research	Mayo Choice Mayo Universal Mayo Horizon Mayo Medicare Supplement

Employers Participating in Mayo Medical Plan	Medical Plan Benefit Options Available A Medicare supplement benefit option is available at all Employers for Medicare eligible disabled Employees and eligible retirees. (Exception: Mayo Clinic Health System-Cannon Falls)
Mayo Clinic Hospital - Rochester	Mayo Choice Mayo Universal Mayo Horizon Mayo Medicare Supplement
Mayo Medical Laboratories New England	Mayo Choice Mayo Universal Mayo Horizon Mayo Medicare Supplement
Mayo Clinic Health System-Owatonna (Faribault employees only)	Mayo Regional Standard (including Medicare Supplement) Mayo Regional Value
Mayo Clinic Health System-Red Cedar, Inc.	Mayo Regional Standard (including Medicare Supplement) Mayo Regional Value
Mayo Clinic Health Systems-New Prague	Mayo Regional Standard (including Medicare Supplement) Mayo Regional Value
Mayo Clinic Health System-Waycross	Mayo Choice Mayo Horizon Mayo Medicare Supplement
Rochester Airport Company	Mayo Choice Mayo Universal Mayo Horizon Mayo Medicare Supplement
Charterhouse	Mayo Choice Mayo Universal Mayo Horizon Mayo Medicare Supplement
Mayo Clinic Health Solutions	Mayo Choice Mayo Universal Mayo Horizon Mayo Medicare Supplement
Mayo Collaborative Services	Mayo Choice Mayo Universal Mayo Horizon Mayo Medicare Supplement

GLOSSARY

Allowed amount
The maximum dollar amount eligible for payment of a procedure or service as determined by the Mayo Medical Plan. This includes billed charges, contracted amounts, or usual, customary and reasonable rates, depending on the physician's relationship with Mayo Medical Plan and/or the services provided.

Ambulance
A specially designed or equipped vehicle used only for transporting the critically ill or injured to a health care facility. The ambulance service must meet state and local requirements for providing transportation of the sick or injured and must be operated by qualified personnel who are trained in the application of basic life support.

Annual Out-of-Pocket Maximum
Unless specifically excluded, the total deductible and coinsurance amounts for certain covered services that are your responsibility during a coverage year. The following amounts are not considered or taken into account: charges that are not covered services under Mayo Medical Plan (e.g.; Charges which exceed the Mayo Clinic Health Solutions fee schedule for out-of-network services and amounts paid by you as a result of your failure to comply with prior authorization requirements); charges for out-of-network services in excess of usual, customary and reasonable rates; charges in excess of Mayo Medical Plan benefit maximums or; charges exceeding allowed amount for non-formulary prescription drugs; and charges that are not covered services under Mayo Medical Plan (e.g.; the difference in price between the generic drug and the brand name drug if a brand name drug is dispensed when a generic drug is available).

When the annual out-of-pocket maximum is met, Mayo Medical Plan will pay 100 percent of the allowed amount for certain eligible covered services incurred during the remainder of the coverage year. The Plan will pay 100 percent of the allowed amount for formulary prescription drugs after the annual out-of-pocket maximum. The annual out-of-pocket maximum renews each January 1.

Appeal
A request for your health insurer or plan to review a decision or a grievance again

Balance Billing
When a provider bills you for the difference between the provider's charge and the *allowed amount.* For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. An in-network provider may ***not*** bill you for covered services.

Cardiac Rehabilitation Phase I
A medically supervised multidisciplinary program covered under the inpatient hospital benefit.

Cardiac Rehabilitation Phase II
Outpatient rehabilitation and risk factor modification program usually beginning upon dismissal from the hospital. It is physician directed and closely supervised by paramedical personnel. The program components Include carefully prescribed exercise, education, counseling, and risk factor modification.

Cardiac Rehabilitation Phase III
Applies to patients who no longer need medical supervision while exercising.

Cardiac Rehabilitation Phase IV
A maintenance program consisting of efforts to modify risk factors with a routine program of physical activity.

Charges
The actual billed cost of services rendered.

Child or Children
Biological children, stepchildren, adopted children, and children legally placed with you for adoption who are under the age of 26.

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

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

Coinsurance
Your share of what you must pay for certain covered health care services after applicable deductibles have been paid and until the annual out-of-pocket maximum has been reached. Coinsurance is based on the initial charge after applicable contractual adjustments are made at in-network providers. Covered services subject to coinsurance and the amounts are listed in the *Schedule of Benefits*

section. Coinsurance is a percentage of the allowed amount. The coinsurance may differ based on whether the provider is in-network or out-of-network. In some instances, you will be responsible at the time and place of service to pay any coinsurance directly to the health care provider. In other instances, you will be billed by the health care provider. These arrangements are between you and the health care provider.

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

Confinement

A continuous stay in the hospital(s) or extended care facility(ties) or combination thereof due to an Illness or Injury diagnosed by a physician, which lasts at least one day and one night.

Complications of Pregnancy

Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Continued Care

Certain specified hours of service per day provided by a Registered Nurse, Licensed Practical Nurse, or Home Health care aide during a period of skilled care needed in order to maintain your illness at home.

Continuous Service

Period of unbroken service from hire date to termination date with the employer or an affiliated company by an employee who is classified as a regular employee and is scheduled to work at least half-time (.5 FTE).

Copayment

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

Cost Sharing Amounts

The dollar amount you are responsible for paying when covered services are received from a health care provider. Cost sharing amounts include coinsurance, copayment, and deductible amounts. Applicable cost sharing amounts are identified in the *Schedule of Benefits* section. Health care providers may bill you directly or request payment of cost sharing amounts at the time covered services are provided.

Covered Person

An eligible employee and his eligible family members whose enrollment form has been accepted, whose coverage is in force, in whose name the membership card is issued, and whose coverage has not terminated. This includes a former employee or eligible family member that is otherwise entitled to coverage and properly enrolled under any of the Plan options. May also be referred to as you/your.

Covered Service

Health care services provided by a health care provider and as described in the Mayo Medical Plan *Schedule of Benefits* section for which Mayo Medical Plan benefits will be provided, unless limited or excluded in any ***Exclusions*** section. A covered service is incurred on the date the health care service is received.

Coverage Year

The coverage year is the time period, not to exceed twelve (12) months, from the effective date of the Plan to the anniversary date. All subsequent coverage years shall begin on the anniversary date and consist of a period of not more than twelve (12) months. The Plan's coverage year is January 1 through December 31.

Creditable Coverage

Defined by HIPAA and generally means coverage without a lapse of more than 63 days. Creditable coverage is health care coverage provided under:

- A health benefit plan (without regard to whether it was issued to a small employer and Including blanket accident and sickness insurance)
- Part A or Part B of Medicare
- Medical assistance under Minnesota Statutes, Chapter 256B
- General assistance
- A state high-risk pool
- A self-insured health plan

- The Civilian Health and Medical Program of the Uniformed Services (TRICARE FLNLA) or other coverage provided under United State Code, title 10, chapter 55
- A health care network cooperative or by a health provider cooperative under state law
- A medical care program of the Indian Health Service or of a tribunal organization
- The Federal Employees Health Benefits Plan or other coverage provided under United States Code, title 5, chapter 89
- A health benefits plan under section 5(e) of the Peace Corps Act, United States Code, title 22, section 2504(e)
- A plan similar to any of the above plans provided in this state or another state, or as required by state law

Custodial Care

A type of care designed to assist an individual to meet the activities of daily living. The care is of a nature that does not require the continuing attention of trained medical or paramedical personnel. Custodial care is not skilled care. These services can be provided by persons without professional skills or training. Custodial care includes assistance in walking, getting in and out of bed, bathing, dressing, preparation of meals (Including special diets), supervision of medication that can be self-administered, and care that does not require the continuing attention of licensed medical personnel. Custodial care also includes rest cures and home care provided by Eligible Family Members.

Deductible

The aggregate amount for certain covered services that are your responsibility each coverage year before Mayo Medical Plan will begin to pay for covered services (with the exception of preventive services). Prior authorization penalties and charges in excess of allowed amounts, including charges in excess of usual, customary and reasonable rates for out-of-network services, do not count toward the deductible.

Disposable Supplies

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

Durable Medical Equipment (DME)

Standard model medical equipment and/or supplies which are medically necessary, prescribed by a health care provider for a specific therapeutic purpose in treating an illness or injury, and designed to be used repeatedly, generally over extended periods of time.

EBSA

Employee Benefits Security Administration (EBSA) formerly known as Pension and Welfare Benefits Administration.

Educational

The primary purpose of a service or supply is to provide the eligible employee with any of the following: training in the activities of daily living, instruction in scholastic skills such as reading and writing, preparation for an occupation, or treatment for learning disabilities.

Eligible Employee

The employee eligible for coverage under the Plan; may include a former employee who is otherwise entitled to coverage and properly enrolled under any of the Plan options.

Eligible Family Member

Your eligible family member who qualifies for membership under this Plan in accordance with the requirements specified below:

- A spouse
- A same-sex domestic partner
- A child (or Children) as defined by the Plan
- A child who is physically or mentally incapable of self-support at age 26 and beyond may continue coverage under the Plan. Effective January 1, 2014, new hires and newly benefit-eligible employees will require proof of disability as defined by Social Security Disability Insurance (SSDI) for children who are age 26 or older. The employee must provide proof that the child has been declared disabled and is receiving SSDI prior to age 26. Adult dependents over the age of 26, currently on the plan, will have until December 31, 2015 to apply and receive a SSSDI Designation. Coverage will end if your own coverage ends or if the child marries or is no longer incapacitated.
- A child or children of a same-sex domestic partner who are wholly dependent on the eligible employee for financial support may be eligible as well.

Emergency Medical Condition

Any condition requiring immediate care to preserve life, prevent serious impairment to bodily functions, organs or parts, or to prevent placing your physical or mental health in serious jeopardy.

An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation

Ambulance services for an emergency medical condition.

Emergency Room Care

Emergency services you get in an emergency room.

Emergency Services

Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Employee

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

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

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

Employer

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

ERISA

Employee Retirement Income Security Act of 1974, as amended from time to time.

Excluded Services

Health care services that your health insurance or plan doesn't pay for or cover.

Expenses Incurred

An expense is incurred when the service or the supply for which it is incurred is provided.

Experimental or Investigative

Health care services that are not widely accepted as effective by entities such as the Centers for Medicare & Medicaid Services, the American Medical Association, the National Institutes of Health, and American Health Care Professionals; or have not been scientifically proven to be effective.

Extended Care Facility

A health care facility offering skilled nursing care, rehabilitation, and convalescent services for patients no longer needing hospital care.

FMLA

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

Gainfully Employed

Earnings subject to FICA received by an individual who is considered gainfully employed in a benefit eligible position.

Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. The services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance

A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Health Care Provider

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

Advanced Practice Registered Nurse - Including a Clinical Nurse Specialist, Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife, and Nurse Practitioner.

Ambulatory Surgical Facility - a facility with an organized staff of physicians that:

- has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis.
- provides treatment by or under the direct supervision of a physician or other health care provider.
- does not provide inpatient accommodations.
- is not, other than incidentally, a facility used as an office or clinic for the private practice of a physician or dentist.

Chiropractor - a Doctor of Chiropractic (DC).

Dentist – a Doctor of Dental Surgery (DDS), Oral Pathologist, Oral Surgeon, or Doctor of Dental Medicine (DMD).

Home Health Agency - an agency that provides home health care and is Medicare certified and licensed **or** approved under state or local law.

Hospice - a Medicare certified organization or agency that primarily provides services for pain relief, symptoms management, and supportive services to terminally ill persons and their families.

Hospital - a licensed institution operated pursuant to law that is engaged in providing inpatient and outpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of sick and injured persons by or under the direct supervision of physicians or other health care providers.

Licensed Practical Nurse (LPN)

Licensed Registered Dietitian

Occupational Therapist

Ophthalmologist-Doctor of Ophthalmology

Optometrist –Doctor of Optometry

Physical Therapist

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

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

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

Psychologist

Radiation Therapist

Registered Nurse (RN)

Respiratory Therapist

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

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

Speech Therapist

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

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

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

Home Health Care
Health care services a person receives at home. Skilled care for the treatment of homebound illness or injury requiring only intermittent care.

Hospice Services
Services to provide comfort and support for person in the last stages of a terminal illness and their families.

Hospitalization
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care
Care in a hospital that usually doesn't require an overnight stay.

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

Including or Includes
Including, but not limited to.

Injury
A non-occupational accidental bodily injury caused directly and exclusively by external, violent, and purely accidental means. The term "injury" does not include injury with respect to which benefits are payable under any workers' compensation, occupational disease, or similar law.

In-Network
Mayo facilities, the Mayo Clinic Health Solutions network, Blue Cross and Blue Shield of Arizona for staff working in Arizona, and PHCS Exclusive Network/NHBC are all in-network health care providers.

For the prescription drug benefit, in-network shall mean Mayo Pharmacies and the Catamaran Network.

In-Network Coinsurance
The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network coinsurance usually costs you less than out-of-network coinsurance.

In-Network Copayment
A fixed amount (for example, $25) you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

Inpatient
A person who occupies a hospital bed, crib, or bassinet while under observation, care, diagnosis, or treatment for at least 24 hours.

Institutional Health Care Provider
Health care provider Including an ambulatory surgical facility, home health agency, hospice, hospital, skilled nursing facility, or urgent care facility.

Intermittent Care
A medically predictable need for skilled care at least once every sixty (60) days.

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

Mayo Clinic Health System

A family of clinics, hospitals and health care facilities serving over 70 communities in Iowa, Georgia, Wisconsin and Minnesota.

Mayo Facility
An institutional health care provider that is owned and operated by Mayo Clinic or has an affiliation with Mayo Clinic.

Mayo Medical Plan
The Mayo Medical Plan for the provision of health care benefits to you, as amended from time to time.

Mayo Pharmacy
Mayo Clinic Pharmacy mail service and Mayo Clinic Pharmacies.

Medically Necessary/Medical Necessity
Health care services appropriate, in terms of type, frequency, level, setting, and duration, to your diagnosis or condition, and diagnostic testing and preventive services that are not otherwise excluded under Mayo Medical Plan. Medically necessary care must:

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

Medicare
Title XVIII of the Social Security Act, as amended from time to time.

Membership Card
A Mayo Medical Plan identification card issued in your name identifying your membership number and the Mayo Medical Plan option selected.

Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provider health care services

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

Orthotics
A custom made brace or external device made for a weak, diseased, or injured body part. An orthotic can increase, decrease, eliminate motion, or support the weak, diseased, or injured body part.

Out-of-Network
Health care providers that are not in-network.

Out-of-Network Co-insurance
The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do ***not*** contract with your health insurance or plan. Out-of-network coinsurance usually costs your more than in-network co-insurance

Outpatient
A person who visits a clinic or health care facility and receives health care without being admitted as an overnight patient.

Part-Time Care
Care that is required less than eight (8) hours a day or forty (40) hours a week.

Plan
The Mayo Medical Plan for the provision of health care benefits, as amended from time to time.

Plan Administrator
The Plan Administrator is Mayo Clinic and it retains ultimate authority for the Plan including final appeal determinations. The Plan Administrator is also the named fiduciary for purposes of ERISA.

Plan Participant
An eligible employee and his/her eligible family members whose enrollment form has been accepted, whose coverage is in force, in whose name the membership card is issued, and whose coverage has not terminated. This includes a former employee or eligible family member that is otherwise entitled to coverage and properly enrolled under any of the Plan options. May be referred to as you/your.

Plan Sponsor
Mayo Clinic is the plan sponsor.

Pre-determination

Advance information from the Plan as to whether or not a service will be covered. Obtaining a pre-determination is described in the *Claim Payment and Appeal Procedure* section. A predetermination is not a claim for benefits

Prescription Drug

Medications and drugs that bear the legend, "Federal law prohibits dispensing without a prescription." This term Includes medicines and drugs that contain a legend drug that requires compounding by a pharmacist to the order of a physician or other authorized health care provider and are approved by the U.S. Food and Drug Administration (FDA). Insulin and diabetic supplies (e.g., syringes, lancets, and testing strips) are generally covered as prescription drugs as well. Prescription drugs Include:

- **Brand Name Drug -** a patent protected prescription drug.
- **Generic Drug** - a prescription drug whose patent has expired and is usually manufactured by several pharmaceutical companies. FDA A-rated generic drugs (which are the only type of generic drugs covered under the Mayo Medical Plan) contain the same active ingredient as the brand name drug, are manufactured under the same FDA standards, and are considered equivalent in all respects to the brand name drug.
- **Mayo Clinic Formulary (Formulary) -** an approved, continually updated list of medications and dosage recommendations supplemented with drug monographs or references, policies, and criteria for use. The Mayo Pharmaceutical Formulary Committee develops the Mayo Clinic Formulary which is based on drug safety, effectiveness, and cost.

Preventive Care

Health care services rendered solely for the purpose of health maintenance and not for the treatment of an illness or injury.

Primary Care

Basic or general health care as opposed to specialist or sub-specialist care. Primary care providers often oversee the total care of patients, referring the patient to other professionals as appropriate. Physicians whose practices are predominantly primary care include general or family practitioners, internists, and pediatricians. Primary care also may be provided by nurse practitioners, physicians' assistants, or other midlevel practitioners.

Primary Care Location

The physical setting for the Physician, Nurse Practitioner, or Physician Assistant practicing at a primary care area.

Primary Care Provider (PCP)

A Physician, Nurse Practitioner, or Physician Assistant practicing at a primary care location.

Prior Authorization

Authorization from the Plan that is required for specific covered services before they are received. If authorization is not obtained before such services are received, coverage will be reduced or denied. For a list of services that require prior authorization, see the *Utilization Management* section. For a description of how to obtain prior authorization and how to appeal if authorization is not given, see the *Claim Payment and Appeal Procedure* section.

Professional Health Care Provider

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

Prosthetic

A fixed or removable device that replaces all or part of an extremity or body part Including such device as an artificial limb, intra-ocular lens, or breast prosthesis.

Provider Directory

A list of in-network health care providers for Mayo Medical Plan. The ***Mayo Medical Plan Provider Directory*** is continually updated. For information regarding specific health care providers or to request an additional copy of the ***Mayo Medical Plan Provider Directory***, call Mayo Clinic Health Solutions Customer Service. This provider list does not include PHCS Exclusive Network and Blue Cross and Blue Shield of Arizona.

Qualified Medical Child Support Order (QMCSO)

A judgment, decree, or order that:

- is issued by a court of competent jurisdiction pursuant to a state domestic relations law or community property law
- creates or recognizes the right of an alternative recipient to receive benefits under his or her parent's employer's group health plan
- Includes certain information relating to the participant and alternate recipient

QMCSO as determined by the Plan Administrator under procedures established by the Plan Administrator. Upon request to the Plan Administrator, you may obtain a copy of the procedures governing QMCSO determinations at no charge.

Rescission or Rescind

A cancellation of coverage or discontinuance of coverage under the Plan that has retroactive effect. Such action is prohibited under Health Care Reform unless attributable to (a) a failure to timely pay the cost of coverage, or (b) fraud or intentional misrepresentation of material fact, as those circumstances are described under Health Care Reform and regulatory guidance.

Regularly Scheduled

The schedule on file with your Employer is your regular schedule. If it is .5 FTE or more you qualify to enroll in certain benefit plans with your Employer. A schedule of .4 FTE working additional hours does not qualify as regularly scheduled.

Respite Care

Care provided while you are receiving covered services for hospice care, for the purpose of giving your uncompensated primary caregivers relief when necessary at your home.

Same-sex Domestic Partner

A same-sex domestic partner qualifies for membership under this Plan in accordance with each of the five requirements specified below:

- Is in a committed relationship with an eligible employee
- Is not related to the eligible employee
- Resides in a state that does not permit same-sex marriage
- Is the same-sex as the eligible employee
- The eligible employee has completed and submitted the Certificate of Domestic Partnership that has been approved by the Plan Administrator.

There is one exception to the residency rule related to same-sex domestic partners through December 31, 2014 based on the states that currently permit same-sex marriage.

Same-sex domestic partners who (1) reside in a state that permits same-sex marriage and (2) who were actually enrolled in the Plan as of August 1, 2013 based on a Certificate of Domestic Partnership, remain eligible as a same-sex domestic partner through December 31, 2014 subject to all other Plan terms and limitations. After this date, same-sex domestic partners residing in a State that permits same-sex marriage must be legally married and meet the definition of a Spouse to maintain eligibility under the Plan. If additional States amend their laws and permit same-sex marriages, same-sex domestic partners enrolled at that time will have the later of 180 days from the laws effective date or until December 31, 2014 to enter a legal marriage in order to maintain the domestic partners eligibility.

A Certificate of Domestic Partnership must be completed and approved by the Plan Administrator before coverage begins for same-sex domestic partners.

Skilled Care

Nursing or rehabilitative services requiring the skills of technical or professional medical personnel to develop, provide, and evaluate care and assess your changing condition.

Skilled Nursing Facility

A nursing facility with the staff and equipment to provide skilled nursing care and/or skilled rehabilitation services and other related health services.

Spouse

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

Summary Plan Description (SPD)

A written summary of benefits under an employee welfare benefit plan as required under section 102 of ERISA.

Urgent Care

A condition requiring medical care to treat an unforeseen illness or injury to prevent serious deterioration of health, and which cannot be reasonably delayed until the next available appointment.

Usual, Customary, and Reasonable

Reimbursement for provider services based on prevailing rates in the community.

Utilization Review (UR)

A cost-control mechanism for reviewing the appropriateness and quality of care provided to patients. UR may be before (prospective), at the same time (concurrent), or after (retroactive) the services are rendered.

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