



Summary Plan Description

Retiree Health Reimbursement Arrangement — January 2026

Offered under the Mayo Clinic Health & Welfare Benefits Plan

HOW TO USE THIS DOCUMENT

The Table of Contents provides an overview of the detailed information for the Health Reimbursement Arrangement (HRA).

You will also find a glossary of terms used in the HRA document.

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

INTRODUCTION

Mayo Clinic (Plan Sponsor) sponsors the Mayo Clinic Retiree Health Reimbursement Arrangement (HRA), also referred to in this document as the Plan, for the benefit of its retirees and the retirees of its affiliates participating in the Plan. The Plan Sponsor and participating affiliates are collectively referred to herein as the Employer. The purpose of the Plan is to reimburse eligible retirees for certain medical expenses which are not otherwise reimbursed. Reimbursements for eligible medical expenses paid by the Plan generally are excludable from the participant's taxable income.

The Plan is intended to qualify as a self-insured medical reimbursement plan for purposes of Sections 105 and 106 of the Internal Revenue Code, as amended (Code), as well as a health reimbursement arrangement as defined in IRS Notice 2002-45. This HRA is a group health plan for the purposes of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Employee Retirement Security Act of 1974 (ERISA) and shall be administered in a manner consistent with HIPAA and ERISA. This HRA covers only retirees, and not active employees, of Plan Sponsor and participating affiliates. Therefore, it is not subject to part A of title XXVII of the Public Health Service Act (PHS Act) relating to group health plans and health insurance issuers in the group and individual markets, as amended by the Patient Protection and Affordable Care Act, Public Law 111-148, enacted on March 23, 2010; and the Health Care and Education Reconciliation Act, Public Law 111-152, enacted on March 30, 2010.

This document serves as both the Plan Document and the Summary Plan Description (SPD). This SPD describes the basic features of the HRA and how it operates. It is very important to review this document carefully to confirm a complete understanding of the benefits available, as well as responsibilities, under the HRA.

The HRA is a retiree-only general purpose HRA and is "self-insured," which means benefits are paid from the Employer's general assets. There is no trust or other fund from which benefits are paid. Plan Sponsor will allocate annual benefit credits to you and you can receive reimbursements for amounts paid by you based on your available benefit credits while you and your spouse are covered by the HRA. The benefit credits (including those already allocated) are subject to Mayo's generally reserved right to amend and or terminate the Plan at any time for any reason in its sole discretion.

Note that terms used in this SPD are defined the first time they are used or are defined in *Plan Administrative Information* at the end of this booklet. Please note that you, your and my when used in this SPD refer to you, the retiree.

CONTACT INFORMATION

Via Benefits is the Claims Submission Agent for initial claims under the Plan and will be referred to as the Claims Submission Agent throughout this SPD.

For eligibility questions, please contact Mayo Clinic's HR Connect.

CLAIMS SUBMISSION AGENT
Via Benefits PO Box 981156 El Paso, TX 79998-1156
QUESTIONS ON PLANS, PREMIUMS AND ENROLLMENT
Via Benefits Medicare-eligible retirees 855-873-0105 or my.viabenefits.com/mayo M-F, 7a.m. – 6p.m. CT
QUESTIONS ABOUT ELIGIBILITY
Mayo Clinic HR Connect 200 First Street SW Rochester, MN 55905 507-266-0440 (local) 888-266-0440 (toll free) M-F, 7 a.m. - 6 p.m. CT (excluding holidays)
COBRA ADMINISTRATION
WEX Health, Inc WEX Health PO Box 2079 Omaha, NE 68108-2079 866-451-3399 M-F, 6 a.m. – 9 p.m. CT (excluding holidays) cobradmin@wexhealth.com

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

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ELIGIBILITY AND PARTICIPATION

Who is Eligible

Retired employees of the Employer are eligible to participate in the Plan if they meet all requirements to be an eligible retiree as defined below and retired (or re-retired) on or after January 1, 2015. Eligible retirees who become covered under the Plan are called participants. Note that certain self-employed persons (such as sole proprietors, partners and 2% shareholders of an "S" corporation) may not participate in the Plan. In addition, you are not eligible to participate in the Plan unless you are classified by the Employer as a former employee who satisfies the eligibility requirements, even if you are later determined by a court or governmental agency to be or to have been a former common law employee of the Employer.

Eligible retiree means an employee who retires or re-retired from the Employer on or after January 1, 2015 with a continuous service date (CSD) before January 1, 2002 and that meet the following age and years of continuous years of service:

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

Retirees that meet the CSD and age/years of service will be eligible for this Plan if retired from Rochester, Arizona, Florida, Mayo Clinic Ambulance sites, Decorah or Lake City. See Employers Participating in Health Reimbursement Arrangement section. Retirees that transferred between sites during employment, see eligibility requirements below.

HRA Eligibility for Transfers between Mayo Clinic Affiliated Sites

- 1) Employees that did not have rights to subsidized retiree medical as of December 31, 2012 will not receive such rights by transferring to a subsidy Mayo site on or after January 1, 2013.
- 2) Employees that have rights to subsidized retiree medical 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, Mayo Clinic Ambulance, Decorah and Lake City. All other Mayo sites/employers are "non-subsidy sites." To be eligible for subsidized retiree medical, 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:

Before January 1, 2013:

Such employee will be entitled to the subsidized retiree medical coverage in place at the subsidy site at the time of retirement.

On or after January 1, 2013:

Such employee will not be entitled to subsidized retiree medical coverage.

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

Before January 1, 2013:

Such employees are not entitled to subsidized retiree medical coverage.

On or after January 1, 2013:

Such employees are entitled to the subsidized retiree medical coverage 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 the subsidized retiree medical coverage at the site at which they retired from.

On or after January 1, 2013:

Such employees are entitled to the subsidized retiree medical coverage 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 and for any reason in its sole discretion. You do not have vested benefits in the Mayo Medical Plan or this Plan, including balances in any HRA, which may be amended or terminated at any time and any balances would be forfeited.

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 (or former employee) retroactively or prospectively eligible for benefits. Any uncertainty regarding an employee's (or former employee's) classification will be resolved by excluding that person from eligibility. For question regarding eligibility to participate in the Plan, please call HR Connect at 888-266-0440.

Can my dependent participate in the Plan

Your dependent who meets all requirements to be an eligible dependent may also become a participant in the Plan. Your dependent generally includes your spouse at the time of your retirement.

When do I become a Participant in the Plan

An eligible retiree or an eligible dependent actually becomes a participant in the Plan on the later of the effective date of the Plan as provided in *Plan Administrative Information* or the date that such individual has satisfied all of the following requirements:

- Is retired;
- Has become eligible for Medicare;
- Has obtained an individual health insurance policy through Willis Towers Watson or any of its affiliates or, if permitted by the Plan Sponsor as reflected below, he or she has provided satisfactory evidence to the Plan Administrator that such person has other coverage permissible to the Plan Administrator
 - Has health coverage under TRICARE or VA; or

- Has health coverage under a plan provided by Mayo Clinic through his or her spouse;
or
 - Resides outside the United States; and
- Has completed any enrollment forms (which may be electronic) or procedures required by the Plan Administrator.

WHEN DOES COVERAGE END

When do I cease participation in the Plan

If you are an eligible retiree, you will cease being a participant in the Plan on the earlier of:

- The date you cease to be an eligible retiree for any reason;
- The date you are rehired by the Employer;
- The date you cease to be eligible for Medicare;
- Your date of death;
- The effective date of any amendment terminating your eligibility under the Plan; or
- The date the Plan is terminated.

If you are an eligible dependent, you will cease being a participant in the Plan on the earlier of:

- The date you cease to be an eligible dependent for any reason;
- The date the retired employee of the Employer is rehired by the Employer;
- The date you cease to be eligible for Medicare;
- the date you divorce the eligible retiree;
- Your date of death;
- The effective date of any amendment terminating your eligibility under the Plan; or
- The date the Plan is terminated.

You may not obtain reimbursement of any eligible medical expenses incurred after the date your eligibility ceases. You have 180 days after your eligibility ceases, however, to request reimbursement of eligible medical expenses you incurred before your eligibility ceased. Notwithstanding anything in this section to the contrary, the Outbreak Period will be disregarded in determining the deadline for filing a claim, in accordance with applicable legal guidance.

In addition, you and/or your eligible dependent may be eligible to continue coverage under the Plan beyond the date that their coverage would otherwise end if coverage is lost for certain reasons. Their continuation of coverage rights and responsibilities are described below in the Continuation of Health Care Coverage under CORBA section.

What happens if I do not use all of the benefit credits allocated to my HRA Account during the Plan Year

If you do not use all of the amounts credited to your HRA Account during a Plan Year, those amounts will be carried over to subsequent Plan Years. These credits can be used to reimburse participants for eligible medical expenses incurred during subsequent Plan Years.

What happens if I die

The Plan Sponsor has elected the combined account structure, such that if the eligible retiree dies with no eligible dependent participating in the Plan, his or her HRA Account is immediately forfeited upon death, but the deceased eligible retiree's estate or representatives may submit claims for eligible medical expenses incurred by the eligible retiree and his or her eligible dependents before his or her death. Claims must be submitted within 180 days of his or her death. Notwithstanding anything in this section to the contrary, the Outbreak Period will be disregarded in determining the deadline for filing a claim, in accordance with applicable legal guidance.

Similarly, if the eligible retiree dies with a dependent who is a participant in the Plan, his or her HRA Account shall continue and the eligible dependent who is a participant can continue to submit eligible medical expenses for reimbursement. In the event that an eligible dependent, who is also a participant in the Plan, dies, but is survived by the eligible retiree participant, the HRA Account shall continue, but no further benefit credits shall be made to the HRA Account on behalf of the deceased eligible dependent participant.

How long will the Plan remain in effect

The Plan Sponsor has the right to modify or terminate the Plan at any time for any reason based on its sole discretion, including the right to change the classes of persons eligible for participation, the amount credited to HRA Accounts or to reduce or eliminate any amounts currently credited to a participant's HRA Account.

Any affiliate participating in the Plan other than the Plan Sponsor - may terminate its participation in the Plan at any time upon 60 days written notice to the Plan Sponsor and Plan Administrator.

CLAIMS FOR BENEFITS

How do I receive reimbursement under the Plan

You must complete a reimbursement form and mail to the Claims Submission Agent as provided in *Plan Administrative Information*, along with a copy of your insurance premium bill, an explanation of benefits (EOB), or, if no EOB is provided, a written statement from the service provider or you can file a claim on the website and set up direct deposit. The written statement from the service provider must contain the following: (a) the name of the patient, (b) the date service or treatment was provided, (c) a description of the service or treatment, (d) the amount incurred (e) the name of the person, organization or other provider to whom the health care expense was or is to be paid, (f) a statement that the participant has not been and will not be reimbursed for the health care expense by insurance or otherwise, and has not been allowed a deduction in a prior year (and will not claim a tax deduction) for such health care expense under Code Section 213 and (g) a written bill from an independent third party stating that health care expense has been incurred and the amount of such expense and, at the discretion of the Claims Submission Agent, a receipt showing payment has been made. The Claims Submission Agent may require the participant to furnish a bill, receipt, cancelled check or other written evidence or certification of payment or of obligation to pay health care expenses. You can obtain a reimbursement form from the Third Party Administrator identified in *Plan Administrative Information*. Your claim is deemed filed when it is received by the Claims Submission Agent. (Do not mail your form to the Third Party Administrator as this may result in a delay in processing.)

If your claim for reimbursement is approved, you will be provided reimbursement as soon as reasonably possible following the determination. Claims are paid in the order in which they are received by the Claims Submission Agent. The Plan Administrator may establish such other rules as it deems desirable regarding the frequency of reimbursement of expenses, the minimum dollar amount that may be requested for reimbursement and the maximum amount available for reimbursement during any single month.

Expenses eligible for coverage under any medical, HMO, dental or vision care plans in which the participant or his or her dependent are enrolled must be submitted first to all appropriate claims administrators for such plans before submitting the expenses to the provider for reimbursement under the Plan. A participant who is entitled to payment or reimbursement under a health care reimbursement account in a cafeteria plan under Code Section 125 must receive his or her maximum annual reimbursement under the health care reimbursement account in the cafeteria plan before they are entitled to any reimbursement under this Plan.

What happens if my claim for benefits is denied

If your claim for reimbursement is wholly or partially denied, you will be notified in writing within 30 days after the Claims Submission Agent receives your claim. If the Claims Submission Agent determines that an extension of this time period is necessary due to matters beyond the control of the Plan, the Claims Submission Agent will notify you within the initial 30-day period that an extension of up to an additional 15 days will be required. If the extension is necessary because you failed to provide sufficient information to allow the claim to be decided, you will be notified and you will have at least 45 days to provide the additional information. The notice of denial will contain:

- The reason(s) for the denial;
- Specific reference to pertinent Plan provisions on which the denial is based;
- A description of any additional material or information necessary for the claimant to perfect the claim, why the information is necessary, and your time limit for submitting the information;

A description of the Plan's appeal procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) to appeal any adverse benefit determination on review;

- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits;
- A copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and a copy of such rule will be provided to claimant free of charge upon request; and
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the notification also will contain either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request (collectively, the "Medical Necessity/Experimental Treatment Summary").

Appeal

If your request for reimbursement under the HRA is denied in whole or in part and you do not agree with the decision, upon receipt of the denial, you can request an informal or formal review (i.e., an appeal) of your claim. It is important to note that, upon denial of a claim, you have 180 calendar days of receipt of the notification of adverse benefit determination to appeal the claim. Notwithstanding anything in this section to the contrary, the Outbreak Period will be disregarded in determining the deadline for filing a written appeal, in accordance with applicable legal guidance.

To request an informal review, contact Via Benefits HRA at 855-873-0105. If you are not satisfied with the informal review, you can request Via Benefits HRA Administration to send you a Level I Appeal Initiation Form. You should submit all information identified in the notice of denial as necessary to perfect your claim and any additional information that you believe would support your claim. Note that if you do not submit a Level I Appeal within 180 calendar days of receiving the notification of your initial adverse benefit determination, you will lose the right to appeal, and your claim under the Plan will be permanently waived and abandoned (but see note above regarding disregard of the Outbreak Period when determining the deadline for filing this appeal). Once you have completed the form, you can mail your Level I Appeal Initiation Form to:

Via Benefits HRA
Health Reimbursement Account
PO Box 981156
El Paso, TX 79998-1156

Via Benefits HRA has 30 days to make a decision and notify you. If your appeal is denied, the notice will contain:

- The reason(s) for the denial;
- Specific reference to pertinent Plan provisions on which the denial is based;
- A description of the Plan's appeal procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following any final internal adverse benefit determination;

- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits;
- A copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and a copy of such rule will be provided to claimant free of charge upon request; and
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the Medical Necessity/Experimental Treatment Summary.

Authority

Mayo Clinic is the Plan Administrator and has delegated the authority to decide benefits claims and appeals as described in these claims procedures. Via Benefits HRA 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. Via Benefits HRA decision on appeal is conclusive and binding on all parties.

Time Limit for Commencing Legal Action

If Via Benefits HRA denied your appeal, you may sue over your claim (unless you have executed a release on your claim). You must, however, commence the suit within one year from the date your final appeal under the Plan's claims procedures was denied.

Exhaustion of Administrative Remedies

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

Are my Benefits Taxable

The Plan is intended to meet certain requirements of existing federal tax laws, under which the benefits you receive under the Plan generally are not taxable to you. However, the Employer cannot guarantee the tax treatment to any given participant, as individual circumstances may produce different results. If there is any doubt, you should consult your own tax advisor.

What happens if I receive an overpayment under the Plan or a reimbursement is made in error from my HRA Account

If it is later determined that you or your eligible dependent received an overpayment or a payment was made in error (e.g., you were reimbursed from your HRA Account for an expense that is later paid by another medical plan), you or your eligible dependent will be required to refund the overpayment or erroneous reimbursement to the Employer.

If you do not refund the overpayment or erroneous payment, the Employer reserves the right to offset future reimbursements equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from any amounts due to you from the Employer. If all other attempts to recoup the overpayment/erroneous payment are unsuccessful, the Plan Administrator may treat the overpayment as a bad debt, which may have tax implications for you or your failure to repay the amounts of overpayment could constitute misconduct and could be grounds for termination of your eligibility for benefits under this Plan.

How does the Plan interact with other medical plans

Only medical care expenses that have not been or will not be reimbursed by any other source may be eligible medical expenses (to the extent all other conditions for eligible medical expenses have been satisfied). You must first submit any claims for medical expenses to the other plan or plans before submitting the expenses to this Plan for reimbursement. This requirement includes health care flexible spending accounts (FSA).

CONTINUATION OF HEALTH CARE COVERAGE UNDER COBRA

What is continuation coverage and how does it work

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

Introduction

If you are eligible to elect COBRA continuation coverage under the HRA, you will be able to elect this coverage separately from any other coverage you have. If you are eligible for and elect COBRA under the HRA, you will have continued access to the balance in your account (if any) at the time you would otherwise lose coverage (less any reimbursements). You will however be required to pay 102% of the cost of coverage to maintain HRA coverage under COBRA. Read this section for additional information about your COBRA rights.

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 and your spouse could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

For purposes of this SPD, the following terms shall have the meanings set forth below:

COBRA Continuation Coverage means the continuation of the Plan benefits being provided to a qualified beneficiary immediately prior to a qualifying event.

Election Period means a period of at least 60 days’ duration that begins no later than the date on which the qualified beneficiary’s coverage under the Plan would otherwise terminate by reason of a qualifying event and that ends 60 days after the later of: (1) the date such coverage would otherwise end, or (2) the date the qualified beneficiary receives notice of his or her right to continued coverage under the Plan. Notwithstanding anything in this section to the contrary, the Outbreak Period will be disregarded in determining the deadline for electing COBRA continuation coverage, in accordance with applicable legal guidance.

Qualified Benefits means the HRA benefit under this Plan.

Qualified Beneficiary means the participant’s spouse (or former spouse).

Qualifying Event means any of the following events which would result in the loss of coverage of a qualified beneficiary:

1. The divorce or legal separation of a participant and his or her spouse or

2. Mayo Clinic files a proceeding in bankruptcy.

Similarly Situated Beneficiary means, in the case of a qualified beneficiary who has a qualifying event, an individual who has the same coverage options under the Plan that the qualified beneficiary would have had if the qualifying event had not occurred; provided that determinations of similar status shall be made by the Plan Administrator in accordance with and taking into account the factors permitted under Code Section 4980B and the regulations issued thereunder to the extent such law or regulations apply.

Notification of COBRA Continuation Coverage Election

Note that the eligible dependent is required to notify the Plan Administrator in writing of a divorce or legal separation within 60 days of the event or they will lose the right to continue coverage under the Plan. The Employer must notify the Plan Administrator within 30 days of the qualifying event. Within fourteen days of its receipt of any notice required, the Plan Administrator shall notify the qualified beneficiary of his or her right to COBRA Continuation Coverage under the Plan. Any notification to a spouse or former spouse of a participant by the Plan Administrator shall also be treated as notification to all other qualified beneficiaries residing with said spouse at the time such notification is made. Notice from the Plan Administrator shall be deemed complete upon placement of the notice of election period in the United States mail, provide there is sufficient postage for first class mailing and said notice is addressed to the qualified beneficiary's last known primary residence (any address other than the qualified beneficiary's last known primary residence shall only be known to the Plan Administrator if the qualified beneficiary specifically notifies the Plan Administrator of the change in address).

Your written notice must include the following:

- The name of this Plan
- The type of qualifying event (e.g., divorce)
- The date of the event
- Your name and the name of your spouse.

Verbal notice, including 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 your eligible family member fails to provide notice to the COBRA Administrator during this 60-day period, your spouse or dependent children who lose coverage will not be offered the option to elect continuation coverage. Notwithstanding anything in this section to the contrary, the Outbreak Period will be disregarded in determining the deadline for electing COBRA continuation coverage, in accordance with applicable legal guidance.

Who May Elect COBRA Continuation Coverage

Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. 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 (but see the note regarding the Outbreak Period above). For each qualified beneficiary who elects COBRA continuation coverage, COBRA 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 or your spouse does 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. Notwithstanding anything in this section to the contrary, the Outbreak Period will be disregarded in determining the deadline for electing COBRA continuation coverage, in accordance with applicable legal guidance.

Special Considerations in Deciding Whether to Elect COBRA

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

You may 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 may 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 divorce COBRA continuation coverage lasts for up to 36 months.

There are two 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, you 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 sixty-first 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
- 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

on page 4. 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 name and address of your spouse.

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.

Cost of COBRA Continuation Coverage

Each qualified beneficiary may be required to pay the entire cost of COBRA continuation coverage (including Employer contributions) plus a two percent administrative fee. The amount of your COBRA premiums can be increased from time to time during your period of COBRA continuation coverage.

Payment for 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 not 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 the first payment for COBRA continuation coverage in full not later than 45 days after the date of your election, you will lose all COBRA continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the COBRA Administrator to confirm the 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 on page 4. Notwithstanding anything in this section to the contrary, the Outbreak Period will be disregarded in determining the deadline for making your first payment for COBRA continuation coverage, in accordance with applicable legal guidance.

Periodic Payments for COBRA Continuation Coverage

After you make the 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 to be timely. If you make a periodic payment on or before the first day of the month to which it applies, your coverage under the Plan will continue for that month without any break. The Plan will not send periodic notices of payments due each month. Periodic payments for COBRA continuation coverage should be sent to the same address as the first payment. Notwithstanding anything in this section to the contrary, the Outbreak Period will be disregarded in determining the deadline for making your periodic payments for COBRA continuation coverage, in accordance with applicable legal guidance.

Grace Periods 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).
- 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 or recovers from a 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 or your spouse 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 COBRA 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 COBRA Administrator.

What is alternative coverage

The Plan Sponsor may make available to a qualified beneficiary coverage in lieu of the continued coverage described above. The Plan Sponsor will provide more information on any alternative coverage that may be available under the Plan upon the occurrence of a qualifying event.

If the qualified beneficiary chooses the continuation coverage above, they waive the right to the alternative coverage. If the qualified beneficiary chooses the alternative coverage, they waive the right to continuation coverage as described above.

Who do I contact if I have questions about the Plan

If you have any questions about the Plan, you should contact the Third Party Administrator or the Plan Administrator. Contact information for the Third Party Administrator and the Plan Administrator is provided in *Plan Administrative Information*.

HEALTH REIMBURSEMENT ARRANGEMENT

How does the Plan work

One HRA Account will be established for you and your spouse. Benefit credits for you and your spouse will be credited to that HRA Account.

Benefit credits will be credited to HRA Accounts for eligible retirees and spouses by the Employer in the amount of: \$1,764 per person for eligible retirees and spouses who are Medicare eligible not to exceed \$3,528.

Benefit credits will be credited to the HRA Accounts on January 1 of each year or as soon as administratively possible upon qualification for the HRA. The initial benefit credit will be prorated based on the month when the qualification requirement has been met (annual allocation divided by 12). For example, if a retiree becomes Medicare eligible in October, they would have a benefit credit in the amount of \$441 ($(\$1,764/12) \times 3$).

Benefit credits will be reduced by the amount of any premium payments or eligible medical expenses for which the participant is reimbursed under the Plan. At any time, the participant may receive reimbursement for eligible medical expenses up to the amount in his or her HRA Account. Note that participants are legally prohibited from making any contributions to their HRA Accounts.

An HRA Account is merely a bookkeeping account on the Employer's records; it is not funded and does not bear interest or accrue earnings of any kind. Each HRA Account established pursuant to the Plan shall be a hypothetical account which merely reflects a bookkeeping concept and does not represent assets that are actually set aside for the exclusive purpose of providing benefits to the participant under the terms of the Plan or that are protected from the reach of the Employer's creditors. In no event may any benefits under the Plan be funded with participant contributions. All benefits under the Plan are paid entirely from the Employer's general assets.

What happens to my HRA Account if I am re-hired or my spouse is hired

If you, as the retiree and are rehired by the Employer, your entire HRA Account is frozen and your, and your eligible dependent's, participation in the Plan is suspended. Credit balances cannot be used by the retiree or dependent for any purpose. No additional benefit credits will be allocated to the HRA account while you are working at the Employer.

If your spouse is hired by Mayo Clinic, your spouse is no longer an active participant in the Plan. Credit balances cannot be used for such dependent for any purpose. No additional benefit credits will be credited to the account for the dependent.

When the retired employee, referenced above, stops working at the Employer, participation in the Plan will resume for the retiree and eligible dependent provided that each individual is otherwise eligible (e.g., the eligible dependent is not actively employed by Employer), and the Plan remains in effect. Any such reinstated coverage will be subject to all Plan terms and limitations as of the date of the reinstatement. The applicable suspended credit balance will be restored to your HRA Account pursuant to Plan terms and additional benefit credits will resume pursuant to Plan terms. There are no retroactive benefit credits under the Plan and if your suspended account is reinstated mid-year, your benefit credit will be prorated based on the number of months eligible in the year after which you re-retired.

What is an eligible medical expense

An eligible medical expense is an expense incurred by you or your spouse for medical care, as that term is defined in Code Section 213(d) (generally, expenses related to the diagnosis, care, mitigation, treatment or prevention of disease). Some common examples of eligible medical expenses include:

- Dental expenses;
- Dermatology;
- Physical therapy;
- Contact lenses or glasses used to correct a vision impairment;
- Chiropractor treatments;
- Hearing aids;
- Wheelchairs; and
- Premiums for medical, prescription drug, dental, vision or long-term care insurance.
- Prescription drug out-of-pocket expenses

Some examples of common items that are not eligible medical expenses include:

- Baby-sitting and child care;
- Long-term care services;
- Cosmetic surgery or similar procedures (unless the surgery is necessary to correct a deformity arising from a congenital abnormality, accident or disfiguring disease);
- Funeral and burial expenses;
- Household and domestic help;
- Massage therapy (unless prescribed by physician to treat a specific injury or trauma);
- Custodial care;
- Health club or fitness program dues; and
- Cosmetics, toiletries, toothpaste, etc.

For more information about what items are and are not eligible medical expenses, consult IRS Publication 502, Medical and Dental Expenses, under the headings What Medical Expenses Are Includible and What Expenses Are Not Includible. (Be careful in relying on this Publication, however, as it is specifically designed to address what medical expenses are deductible on Form 1040, Schedule A, not what is reimbursable under a health reimbursement account.) If you need more information regarding whether an expense is an eligible medical expense under the Plan, contact the Third Party Administrator as provided in *Plan Administrative Information*.

Only eligible medical expenses incurred while you are a participant in the Plan may be reimbursed from your HRA Account. Similarly, only eligible medical expenses incurred while your spouse is a participant in the Plan may be reimbursed from his or her HRA Account. Eligible medical expenses are “incurred” when the medical care is provided, not when you or your eligible dependent are billed, charged or pay for the expense. Thus, an expense that has been paid but not incurred (e.g., pre-payment to a physician) will not be reimbursed until the services or treatment giving rise to the expense has been provided.

The following expenses may not be reimbursed from an HRA Account:

- Expenses incurred for qualified long term care services;
- Expenses incurred *prior to the date* that you became a participant in the HRA;
- Expenses incurred *after the date* that you cease to be a participant in the HRA;

- Expenses that have been reimbursed by another plan or for which you plan to seek reimbursement under another health plan;
- Any other expenses specifically identified as excluded; and
- Expenses incurred for any dependent other than your spouse (with the exception of plan premiums).

PLAN ADMINISTRATION

The Plan Administrator shall be responsible for the performance of all reporting and disclosure obligations under ERISA, and all other obligations required to be performed by the Plan Administrator under ERISA or the Code, except such obligations and responsibilities as may be delegated under the Plan to such person or entity as the Plan Administrator designates. The Plan Administrator shall be the designated agent for service of legal process with respect to the Plan.

Duties of the Plan Administrator

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

- The Plan Administrator shall have the sole discretion and authority to control and manage the operation and administration of the Plan.
- The Plan Administrator shall have complete discretion to interpret the provisions of the Plan, make findings of fact, correct errors, supply omission, and determine the benefits payable under this Plan. All decisions and interpretations of the Plan Administrator made in good faith pursuant to the Plan shall be final, conclusive and binding on all persons, subject only to the claims procedure, and may not be overturned unless found by a court to be arbitrary and capricious.
- The Plan Administrator shall have all other powers necessary or desirable to administer the Plan, including, but not limited to, the following:
 - To prescribe procedures to be followed by participants in making elections under the Plan and in filing claims under the Plan;
 - To prepare and distribute information explaining the Plan to participants;
 - To receive from participants and dependents such information as shall be necessary for the proper administration of the Plan;
 - To keep records of election, claims, and disbursements for claims under the Plan, and any other information required by ERISA or the Code;
 - To appoint individuals or committees to assist in the administration of the Plan and to engage any other agents as it deems advisable;
 - To accept, modify or reject participant elections under the Plan;
 - To promulgate election forms and claims forms to be used by participants, which may be electronic in nature;
 - To determine and enforce any limits on benefit elections hereunder; and
 - To correct errors and make equitable adjustments for mistakes made in the administration of the Plan, specifically, and without limitation, to recover erroneous overpayments made by the Plan to a participant or dependent, in whatever manner the Plan Administrator deems appropriate, including suspension or recoupment of, or offsets against, future payments due that participant or dependent.

Allocation and Delegation of Duties

The Plan Administrator shall have the authority to allocate, from time to time, by instrument in writing filed in its records, all or any part of its responsibilities under the Plan to one or more of its employees, officers or members as may be deemed advisable, and in the same manner to revoke such allocation of responsibilities. In the exercise of such allocated responsibilities, any action of the employee, officer, or member to whom responsibilities are allocated shall have the same force and effect for all purposes hereunder as if such action had been taken by the Plan Administrator. The Plan Administrator shall not be liable for any acts or omissions of such employee, officer, or member. The employee, officer, or

member to whom responsibilities have been allocated shall periodically report to the Plan Administrator concerning the discharge of the allocated responsibilities.

The Plan Administrator shall have the authority to delegate, from time to time, by written instrument filed in its records, all of any part of its responsibilities under the Plan to such person or persons as it may deem advisable (and may authorize such person to delegate such responsibilities to such other person or persons as the Plan Administrator shall authorize) and in the same manner to revoke any such delegation of responsibility. Any action of the delegate in the exercise of such delegated responsibilities shall have the same force and effect for all purposes hereunder as if such action had been taken by the Plan Administrator. The Plan Administrator shall not be liable for any acts or omissions of any such delegate. The delegate shall periodically report to the Plan Administrator concerning the discharge of the delegated responsibilities.

The Plan Administrator may employ such legal counsel, accountants, consultants, actuaries, and other agents as it shall deem advisable. The compensation of such legal counsel, accountants, consultants, actuaries and other agents and any other expenses incurred by the Plan Administrator in the administration or management of the Plan or in furtherance of its duties hereunder shall be paid by the Plan by reduction of participant HRA Accounts to the extents not paid by the Employer.

Indemnification

The Employer, jointly and severally, shall indemnify and save the Plan Administrator, and any employees to whom the Plan Administrator has allocated or delegated its responsibilities in accordance with the provisions hereof, harmless from and against all claims, losses, damages, expense, and liability arising from their responsibilities in connection with the administration and management of the Plan which is not otherwise paid or reimbursed by insurance, unless the same shall result from their own willful misconduct.

GENERAL PROVISIONS

Adoption by Affiliates

Any affiliate, with the consent of the Plan Sponsor and under such terms and conditions as the Plan Sponsor may prescribe, may become an Employer hereunder. By its adoption of the Plan and participation therein, each Employer agrees to be bound by the terms of the Plan, as amended from time to time. Any Employer other than the Plan Sponsor shall have the right at any time and under such terms and conditions as the Plan Sponsor may prescribe (including terms and conditions with respect to the satisfaction of any contingent liability by the company to the Plan) to withdraw from the Plan on sixty days' written notice to the Plan Sponsor and the Plan Administrator.

Alienation of Benefits

No benefit under this Plan may be voluntarily or involuntarily assigned or alienated and any attempt to do so shall be void and unenforceable.

Amendment and Termination

The Plan Sponsor reserves the right to amend, modify, or terminate this Plan at any time and for any reason in its sole discretion, including but not limited to the right to modify persons eligible for participation, benefits paid by the Plan, and the amount of benefit credits to be credited, and the right to reduce or eliminate existing HRA Accounts. Notwithstanding anything to the contrary contained in this section or elsewhere in the Plan, the Plan Administrator shall have the authority to approve all technical, administrative, regulatory and compliance amendments to the Plan, and any other amendments that will not increase the cost of the Plan to the Employer, as the Plan Administrator shall deem necessary or appropriate.

Applicable Law and Venue

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

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

Employer Liability

Benefits under the Plan are paid by the Employers out of their general assets. Specifically, and notwithstanding anything herein to the contrary, the Employer who employs the participant as of the date of the participant's qualifying retirement shall be solely responsible for the payment of benefits to such participant and his or her family members under this Plan. The Employer shall have no liability with respect to the payment of any benefits hereunder to any participant last employed by any other employer prior to eligibility under the Plan or his or her family members.

Facility of Payment

If the Plan Administrator deems any person incapable of receiving benefits to which they are entitled by reason of minority, illness, infirmity, or other incapacity, it may direct that payment be made directly for the benefit of such person or to any person selected by the Plan Administrator to disburse it, whose receipt shall be complete acquittance therefor. Such payment shall, to the extent thereof, discharge all liability of the Plan Administrator, Plan Sponsor and the Employer.

Lost Distributees

Any benefit payable hereunder shall be deemed forfeited if, after reasonable efforts, the Plan Administrator is unable to locate the participant to whom payment is due.

QMCSO

In the event the Plan Administrator receives a medical child support order (within the meaning of ERISA Section 609(a)(2)(B)), the Plan Administrator shall notify the affected participant and any alternate recipient identified in the order of the receipt of the order and the Plan's procedures for determining whether such an order is qualified medical child support order (within the meaning of ERISA Section 609(a)(2)(A)). Within a reasonable period, the Plan Administrator shall determine whether the order is qualified medical child support order and shall notify the participant and alternate recipient of such determination.

Section Titles

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

Severability

If any provision of this Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provision, and this Plan shall be construed and enforced as if such provision had not been included.

Status of Benefits

Neither the Employer nor the Plan Administrator makes any commitment or guarantee that any amounts paid to or for the benefit of a participant under this Plan will be excludable from the participant's gross income for federal, state, or local income tax purposes. It shall be the obligation of each participant to determine whether each payment under this Plan is excludable from the participant's gross income for federal, state and local income tax purposes and to notify the Plan Administrator or Employer if the participant has any reason to believe that such payment is not so excludable. Any participant, by accepting a benefit under this Plan, agrees to be liable for any tax that may be imposed with respect to those benefits, plus any interest as may be imposed.

Mothers' and Newborns' Health Protection Act (NMHPA)

The Plan may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of the above periods. Notwithstanding any provision of this Plan to the contrary, this Plan shall be operated and maintained in a manner consistent with NMHPA.

ERISA STATEMENT OF RIGHTS

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

Receive Information about Your Plan and Benefits

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, 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.
2. Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description. The Plan Administrator may apply a reasonable charge for the copies.
3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Plan Coverage

Continue Plan coverage for your eligible family members if there is a loss of coverage under the Plan as a result of a qualifying event. However, 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 COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for 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 the participants and beneficiaries. No one, including your former employer, your former union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit from the Plan, or from exercising your rights under ERISA.

Enforcement of Your Rights

If your claim for a welfare benefit is denied 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 a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may

file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance 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 Ave., N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration. Live assistance is available Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern Time by calling 1-866-4-USA-DOL (1-866-487-2365) or TTY 1-877-889-5627.

PLAN ADMINISTRATIVE INFORMATION

The following information applies to the Plan.

Name of Plan:	Mayo Clinic Retiree Health Reimbursement Arrangement
Effective Date:	January 1, 2015
Name, address, and telephone number of the Plan Sponsor and Plan Administrator: The Plan Administrator has the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD issued in connection with the Plan. The Plan Administrator may delegate one or more of its responsibilities to one or more individuals or committees.	Mayo Clinic 200 First Street SW Rochester, MN 55905 (507) 266-0440
Named Fiduciary:	Salary and Benefits Committee Mayo Clinic 200 First Street SW Rochester, MN 55905
Agent for Service of Legal Process:	Mayo Clinic c/o William A. Brown, Assistant Treasurer 200 First Street SW Rochester, MN 55905 (507) 266-0440 <i>The Plan Administrator may also be served with process</i>
Plan Sponsor's federal tax identification number:	41-6011702
Plan Number:	524
Plan Year:	January 1 – December 31
Type of Plan:	Retiree-only general purpose health reimbursement arrangement
Third Party Administrator:	Via Benefits by Willis Towers Watson Health Reimbursement Account 10975 South Sterling View Drive South Jordan, UT 84095-4074
Sources of Contributions:	The Plan is funded with Employer contributions from its general assets.
Claims Submission Agent for Initial Claims: All reimbursement forms, and supporting documentation, must be provided to the Claims Submission Agent. Forms should not be mailed to the Third Party Administrator.	Via Benefits Health Reimbursement Account P.O. Box 981156 El Paso, TX 79998-1156
Level I Appeals Administrator:	Via Benefits HRA Health Reimbursement Account PO Box 981156 El Paso, TX 79998-1156
Components of Retiree Health Reimbursement Arrangement Account Document	Retiree Health Reimbursement Arrangement Privacy Rules

Employers Participating in the HRA

Charterhouse
Franklin Heating Station
Mayo Clinic Ambulance Service
Mayo Clinic
Mayo Clinic Arizona
Mayo Clinic Florida (a non-profit corporation)
Mayo Clinic Health System-Decorah Clinic Physicians
Mayo Clinic Health System-Lake City Medical Center
Mayo Clinic Hospital-Rochester
Mayo Clinic Jacksonville (a non-profit corporation)
Mayo Collaborative Services, LLC
Mayo Foundation for Medical Education and Research
Rochester Airport Company

GLOSSARY

Appeal

A request for the Plan to review an adverse claim decision.

Affiliate

Any entity which, with the Plan Sponsor, is a member of a controlled group of corporations, a group of trades or businesses under common control, an affiliated service group, or a group of corporations otherwise required to be aggregated, as provided in Code Sections 414(b), (c), (m) and (o), respectively.

Benefit Credit

The amount credited to a participant's HRA Account for the provision of benefits under the Plan.

Claims Submission Agent

The Claims Submission Agent's responsibilities typically consist of initially determining the validity of claims and administering benefit payments under the Plan.

COBRA

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

Code

The Internal Revenue Code of 1986, as amended from time to time.

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).

Dependent

The spouse of an eligible retiree who is a dependent of the eligible retiree within the meaning of Code Section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof.

Eligible Family Member

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

- A spouse

Employer

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

ERISA

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

Expenses Incurred

When the service or the supply is provided.

Health Care Expense

An expense incurred by a participant or by an eligible dependent, for medical care as defined in Code Section 213(d) and the rules, regulations and Internal Revenue Service interpretations thereunder, including premiums for health care insurance coverage and premiums for long-term care insurance coverage. Health Care Expenses shall not include expenses reimbursed or reimbursable under any private, employer-provided, or public health care reimbursement or insurance arrangement or any amount claimed as a deduction on the federal income tax return of the participant or the participant's dependent. In addition, and notwithstanding anything herein to the contrary, Health Care Expenses are incurred when the medical care is provided, not when the participant is formally billed, charged for, or pays the expense.

Health Reimbursement Arrangement (HRA) Account

The hypothetical account established for a participant to hold his or her benefit credits.

HIPAA

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

Medicare

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

Outbreak Period

The period from March 1, 2020 through the date that is 60 days after the announced end of the national emergency related to the COVID-19 pandemic, or through such other date announced by the federal agencies.

Participant

An eligible retiree and dependent whose enrollment form has been accepted, coverage is in force, and whose coverage has not terminated. This includes a former employee or dependent who is otherwise entitled to coverage and properly enrolled under the Plan. May be referred to as you/your.

Plan

The Mayo Clinic Retiree Health Reimbursement Arrangement, that may be amended from time to time.

Plan Administrator

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

Plan Sponsor

Mayo Clinic is the Plan Sponsor.

Plan Year

The period from the effective date through the next following December 31. Thereafter, Plan Year means the 12 month period commencing on each January 1.

Protected Health Information (PHI)

Protected health information as described in 45 C.F.R. § 164.103, and generally includes individually identifiable health information held by or on behalf of the Plan.

Provider

Any entity with which the Plan Sponsor or Plan Administrator has entered into a contract for the purpose of processing claims under the Plan or otherwise administering benefits under the Plan.

Spouse

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

Willis Towers Watson

The Claims Submission Agent for the Plan retained by the Plan Administrator and Plan Sponsor. The actual responsibilities of Willis Towers Watson are described in a contract between the Plan Administrator, Plan Sponsor, and Willis Towers Watson.

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