MAYO CLINIC

Benefits Booklet

Headspace Emotional Support Plan — January 2024

Employees Residing in Florida and Georgia
Department of Medicine, Rochester

COMPONENT OF THE MAYO MEDICAL PLAN

Offered under the Mayo Clinic Health & Welfare Benefits Plan

INTRODUCTION

This benefits booklet for the Headspace Emotional Support Plan provides information that is applicable to the on-demand mental health support benefits offered under the Mayo Clinic Health & Welfare Benefits Plan for employees physically residing in Florida and Georgia or employees working for the Department of Medicine in Rochester, effective as of January 1, 2024 (the "Plan" or "Headspace").

The General Information Booklet for the Mayo Clinic Health & Welfare Benefits Plan (the "General Information Booklet") provides information such as who has the right to amend and terminate the Plan. This benefits booklet, together with the General Information Booklet, constitute the Summary Plan Description for the Plan as of January 1, 2024. It is intended to provide a summary of your benefits available under the Plan. If there are any discrepancies between the Summary Plan Description and the governing documents, the plan documents will control.

Although the Plan is a group health plan subject to ERISA, it is intended to be an "excepted benefit," which does not provide "significant benefits in the nature of medical care or treatment" as defined under relevant agency guidance and regulations.

Mayo Clinic sponsors Headspace to provide additional mental health resources to help meet the needs of its staff and eligible family members. The Plan is offered through Headspace, and services are provided through the Headspace Emotional Support app, which is in addition to existing mental health services available through other Mayo Clinic-sponsored benefits, such as the Mayo Clinic Employee Assistance Program and the Mayo Medical Plan.

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PARTICIPATION

Who is Eligible

If you are classified by a participating employer for payroll and personnel purposes as an employee physically residing in Georgia or Florida, or are an employee working for the Department of Medicine in Rochester.

In addition, an eligible employee's spouse and child (or children) age 13 and older are eligible for Headspace. 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.

How to Enroll

As an employee of a participating employer physically residing in Georgia or Florida, or as an employee working for the Department of Medicine in Rochester, you are automatically eligible for services provided through Headspace, following enrollment in the Headspace Emotional Support app and compliance with the app's terms of service.

PLAN BENEFITS

How Headspace Works

Each Headspace enrollee will receive access to non-clinical, emotional support coaching services provided by behavioral health coaches. There is no cost to eligible employees and family members to use Headspace. This benefit is paid for by Mayo Clinic, and is separate and distinct from mental health services you may seek under the Mayo Medical Plan, or other health coverage.

Your Right to Confidentiality

All interactions between you and Headspace on the app are strictly confidential and will not be noted in any official company record, clinical record, or in your personnel file. Information from Headspace may be released only with your written permission, in response to state or federal statute/regulation, or from a court or other legal order. The law may require the release of specific information when the life or safety of a person is seriously threatened.

How to Obtain Covered Services

If you are eligible for Headspace, you will receive an email allowing you to enroll and use the Headspace app.

You and your eligible family members may contact Headspace through the chat feature of the Headspace app, or you may contact Headspace Care Member Support at caresupport@headpsace.com or 855-446-4374.

Covered Services

The Headspace app features live texting with coaches and live video chats with licensed therapists and psychiatrists. It is designed to deliver virtual mental health care at the right level of support, at the right time.

Covered Counseling Services

Examples of personal problems Headspace can help with are:

- Marital and relationship problems
- Parenting and child concerns
- Drug or alcohol use and/or dependence
- Interpersonal conflicts at work or home
- Work/life balance
- Emotional problems such as depression, anxiety, or stress-related issues
- Occupational problems
- Life event issues such as leaving school, entering college, starting a new career, marriage, divorce, retirement
- Bereavement

This is not intended to be an all-inclusive list. Please contact Headspace if you have an issue with which you need assistance.

Exclusions

Headspace does not cover and does not pay claims submitted by any health care provider from whom you are also seeking mental health care. Note that the Headspace benefit is separate and distinct from any

health care received which is covered under the Mayo Medical Plan or other health coverage in which you may be enrolled.

CLAIMS ADMINISTRATION

You (or your authorized representative) may make a claim for benefits under the Plan by providing notice of your claim to the Claims Administrator. The Claims Administrator has the authority to review certain claims and, in connection with this review, to interpret the plan and decide claims-related questions. Because the Plan is a group health plan (as defined under ERISA), special rules apply to claims filed and appealed under the Plan, as described further in this document.

Claims must be submitted in writing. Your claim is not considered submitted until you provide all information that is necessary for determination of your claim.

Notification of Initial Determination

After you make your claim for benefits, you will be notified of the benefit determination within 30 days after receipt of the claim by the Claims Administrator. The Claims Administrator may extend this period for up to 15 days, if necessary. If extra time is needed to process your claim, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. If additional information is needed because necessary information is missing from the request, the notice will specify what information is needed. You must provide the specified information to the Claims Administrator within 45 days after receiving the notice. The determination period will be suspended on the date the Claims Administrator sends a notice of missing information and the determination period will resume on the date you respond to the notice.

Content of Initial Notification

If any part of your claim is denied, you will be notified in writing or electronically. This notice will tell you the reason for the denial, including the provisions of the Plan on which the denial is based. It also will describe any additional information that may be needed to change the decision denying your claim and explain why such information is necessary. Also, the notice will describe the procedures for appealing the decision, including the time limits for doing so, and include a statement of your right to bring a civil action for benefits following an adverse determination on appeal.

In addition, the notification also will explain any rule, guideline, protocol or similar criterion relied upon in making the adverse determination, or include a statement that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge upon request (collectively, the “Rule and Guideline Summary”). 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 of Determination

If you receive an adverse benefit determination, you have 180 days to appeal the decision. Your appeal must be in writing and state that a formal appeal is being requested and include all pertinent information regarding the claim in question. You should describe the reasons why you think the decision on your claim was incorrect.

Appeals should be directed to the Claims Administrator with which you filed your initial claim. You or your authorized representative will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information related to your claim.

If you do not file an appeal within the time permitted, your claim will be deemed abandoned and you may not reassert it under these procedures or in a court or any other venue. If you fail to raise issues or present evidence on appeal, you may not be able to raise those issues present that evidence in any later proceeding or judicial review of your claim.

Content of Appeal Notification

If your appeal is denied, you will be notified in writing or electronically within 60 days. The denial will tell you the reason for the denial, including the provisions of the Plan on which the denial is based. It also will inform you of your right to receive reasonable access to, and copies of, any documents, records and other information related to your appeal. In addition, the notice will tell you about your right to bring a civil action for benefits. Finally, the notice will contain the Rule and Guideline Summary and Medical Necessity/ Experimental Treatment Summary described above.

Legal Action

You may not bring a civil action for benefits unless you have exhausted your administrative review rights under the internal claims procedures for the Plan. No civil action may be brought more than one year after the date on which your claim is denied on final appeal.

COBRA CONTINUATION COVERAGE

Except for termination of employment based on gross misconduct, if Headspace would have ended based on a COBRA qualifying event, you and your eligible family members will automatically continue to be covered under COBRA at no charge for 36 months. You do not need to elect coverage. COBRA qualifying events include termination of employment, death of the employee, divorce or legal separation, and losing status as an eligible family member.

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