



# Benefits Booklet

**Mayo Dental Plan — Mayo Reimbursement Account  
January 2025**

Offered under the Mayo Clinic Health and Welfare Benefits Plan

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# INTRODUCTION

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This benefits booklet provides information that is applicable to the Mayo Reimbursement Account component of the Mayo Dental Plan (the “MRA” or “Plan”), which is a benefit offered under the Mayo Clinic Health & Welfare Benefits Plan. This benefits booklet describes your MRA benefits, how to submit a claim for benefits, who reviews the claims for benefits and other important information about the MRA. You can enroll in only one component of the Mayo Dental Plan. For example, if you are enrolled in the MRA, you cannot enroll your eligible family members in a different component of the Mayo Dental Plan, such as Delta Dental of MN.

The General Information Booklet for the Mayo Clinic Health & Welfare Benefits Plan (the “General Information Booklet”) provides information about eligibility for coverage under the MRA, how to enroll, opportunities to make mid-year changes, when coverage ends and how you may be able to continue coverage under the MRA if it ends. It also contains information such as who has the right to amend and terminate the MRA.

This benefits booklet, together with the General Information Booklet, constitutes the Summary Plan Description for the MRA as of January 1, 2025 and replaces all prior descriptions of the MRA. It is intended to provide a summary of your benefits available under MRA. If there are any discrepancies between the Summary Plan Description and the governing plan documents, the plan documents will control.

The MRA is a limited purpose health reimbursement arrangement that provides reimbursement of certain dental, orthodontic, and vision expenses for eligible employees of Mayo Clinic and other participating employers.

The MRA is not funded by a trust or individual bank account. Instead, Mayo Clinic allocates annual “credits” to you. All MRA reimbursements are made from the general assets of the employer. Mayo Clinic will allocate annual credits to you, and you can receive reimbursements for amounts paid by you based on your available credits for certain dental, orthodontic, and vision expenses incurred while you and your eligible dependents are covered by the Plan. These credits (including those already allocated) are subject to Mayo Clinic’s generally reserved right to amend and or terminate the Plan. See the General Information Booklet for more information about such amendment rights.

Many of the provisions in the Plan are interrelated. Therefore, please review the entire Summary Plan Description for the Plan so that you understand fully what your benefits and responsibilities are under the Plan.

## CONTACT INFORMATION

Medica ONESource is the Claims Administrator for the MRA and will process claims and answer dental and vision benefit and claim questions for the Plan.

Medica ONESource customer service representatives are available to answer questions regarding the Plan. For enrollment or eligibility questions, please contact Mayo Clinic's HR Connect.

<b>QUESTIONS ABOUT THE MRA</b>
<p>1-866-839-4015            TTY Users: National Relay Center:            711 then ask them to dial Medica ONESource at            1-866-839-4015            Medica.com/SignIn</p> <p>M–F, 7 a.m. to 8 p.m. CT (excluding Thursdays 8 a.m. to 9 a.m. CT and holidays)            Saturday: 9 a.m. to 3 p.m. CT</p>
<b>QUESTIONS ABOUT ENROLLMENT/ELIGIBILITY</b>
<p>HR Connect            200 First Street SW            Rochester, MN 55905</p> <p>507-266-0440 (local)            1-888-266-0440 (toll free)</p> <p>M – F, 7 a.m. to 6 p.m. CT (excluding holidays)</p>
<b>COBRA ADMINISTRATION</b>
<p>WEX            PO Box 2079            Omaha, NE 68108-2079</p> <p>1-866-451-3399</p> <p>M-F, 7 a.m. – 7 p.m. CT (excluding holidays)</p>

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

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

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# ELIGIBILITY AND PARTICIPATION

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## Eligibility for Coverage

You are eligible for coverage under the MRA only if you are an eligible employee as described in the *Who is Eligible* section of the General Information Booklet. Certain family members may also be eligible for coverage. Refer to the *Eligible Family Members* section of the General Information Booklet.

Please refer to the General Information Booklet for additional information regarding your eligibility for coverage under the MRA during a leave of absence.

## When You Can Enroll

Please refer to the *When You Can Enroll* section of the General Information Booklet for information regarding your ability to enroll in the Plan during your initial enrollment period and/or during an open enrollment period. If you are enrolled in the MRA and switch to Delta Dental of MN during Open Enrollment, any MRA account credit balance will be forfeited.

## Coverage for Family Members after Your Death

If you had not met the required years of Continuous Service coverage for retiree coverage as provided under the Mayo Dental Plan, and if your spouse, and eligible family members were enrolled in the Plan at the time of your death, MRA coverage for your eligible family members will continue until they no longer meet the definition of eligible family member. Coverage for your spouse will continue until he/she is gainfully employed, remarried, or age 65. Coverage will not be available for any eligible family member not enrolled at the time of your death. 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 HR Connect for enrollment details.

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# WHEN DOES COVERAGE END

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## Employee Coverage Ends

Refer to the *When Employee Coverage Ends* section of the General Information Booklet.

## Eligible Family Member Coverage Ends

Refer to *When Eligible Family Member Coverage Ends* section of the General Information Booklet.

## Account Credit Balances When Employee Plan Coverage Ends

In the event that you lose coverage as described above, any and all MRA account credit balance is forfeited at the time of the loss of coverage, unless (1) you and your eligible family members have and elect COBRA continuation rights and are entitled to continue the Plan coverage, or (2) your employment is terminated but you return to work at the employer within 30 days.

Please refer to the *Continuation of Health Care Coverage under COBRA* section of the General Information Booklet for more information.

## Effect of Return to Employment

Special rules apply when you return to work after previously working for the participating employer. Your participation in the Plan will depend on the length of time between when your employment terminated and when you return to work for the Employer.

**Thirty 30 Days or Less.** If you return to work within 30 days of the date you terminated employment, your coverage and prior account credit balance will be reinstated automatically; however, you will not receive an additional contribution for that Plan year. Covered expenses you incurred during the period you were terminated will not be reimbursed from your account.

**After 30 Days.** If you return to work more than 30 days from the date you terminated employment, you will be treated as a newly hired employee, and the initial enrollment rules will apply. Refer to the *Enrollment* section for more information. Your prior balance will not be reinstated unless you elected COBRA. Please refer to the *Continuation of Health Care Coverage under COBRA* section of the General Information Booklet for more information.

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# MAYO REIMBURSEMENT ACCOUNT

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The total annual employer credit contribution to your account is \$1,150. You can use your MRA account credit balance to obtain reimbursement for eligible dental and vision expenses incurred by you or your eligible family members while you are covered by the MRA. At no time will you be reimbursed for expenses that exceed your account credit balance. In addition, if you incur expenses after you have exhausted your account credit balance or incur expenses that exceed your account credits in a calendar year, you are not allowed to use future credit to cover such expenses.

**NOTE:** The credit contribution is pro-rated for new employees and/or newly benefits eligible employees. For example, a new employee on January 1, 2025 will receive the total \$1,150. That amount will decrease by one-twelfth of the annual credit each month or approximately \$95.83 each month thereafter for new hires or an employee that becomes benefit eligible mid-year. For example, an eligible employee hired on July 1<sup>st</sup>, will receive a \$575 MRA credit for the remainder of the calendar year.

## Choice of Providers

The Plan will reimburse covered expenses for services of any legally qualified dental or vision care provider of your choice, and the dental or vision care provider/patient relationship will be maintained.

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# CONTRIBUTIONS AND MAXIMUM ACCOUNT BALANCES

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## Annual Credits

On the first day of your enrollment and each January 1 thereafter, you will receive the specified credit to your Plan account. However, because you are allowed to carry over any credits in your account from the previous year and because the credits are subject to a maximum equal to \$5,000, the annual credits contributed will be reduced as necessary to prevent your balance from exceeding the specified credit maximum. The examples below show how this works.

If your spouse is also an eligible employee who has also elected coverage under this MRA option, you will each receive separate annual or pro-rated credit contributions and separate credit maximums of \$5,000. Note that no separate credit contributions are made for both you and your spouse when your spouse is an eligible employee who has not elected the MRA option, but is instead covered under the MRA in a dependent spouse capacity – in such case, you share your credit contribution with all of your covered dependents.

## Maximum Account Balance

Because you are allowed to carry over credits left in your account from the previous year and because the credits are subject to a maximum, contributions will be reduced to prevent your total credits from exceeding the specified maximum of \$5,000.

The examples below show how this works.

**Example #1:** You participate in MRA. On December 31 your credit balance is \$3,000. Your \$3,000 credit balance will be carried forward for use in the next year. On January 1 you will receive the full credit contribution of \$1,150 because the full contribution will not cause your credit balance to exceed the credit maximum of \$5,000.

**Example #2:** You participate in MRA. On December 31 your credit balance is \$4,200. Your \$4,200 credit balance will be carried forward for use in the next year. On January 1 you will receive a credit of an additional \$800. The \$1,150 annual credit you would otherwise receive must be reduced to \$800 to keep your credit balance from exceeding the maximum of \$5,000.

## Orthodontia Credits

The Mayo Dental Plan has a separate component that provides a one-time orthodontia benefit. You and each of your eligible family members will receive a one-time only \$1,500 credit contribution for orthodontia to an orthodontia account at certain participating employers. Benefits are paid from the employers general assets. Once used, this benefit will not be available under any other Mayo benefit plan, including Delta Dental of MN. This contribution is a life-time maximum benefit under the Mayo Dental Plan. This means:

- If you terminate and then return to employment with Mayo, you will not receive another \$1,500 contribution
- If you (or your eligible family members) previously exhausted the \$1,500 contribution, you will not receive an additional contribution
- If your spouse is also an eligible employee, your joint eligible family members will receive coverage under two \$1,500 contributions.



The orthodontia credits will be used first to pay qualifying orthodontia expenses under the Mayo Dental Plan. See “Orthodontia Services” for additional information, including information on coinsurance for these services.

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# SCHEDULE OF BENEFITS

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The following section describes services that are reimbursable under the Plan (referred to as “covered services”). Benefits for covered services are subject to the definitions, exclusions, conditions, and limitations of the Plan.

## Dental Services

**Important Note:** Not all dental services are covered under the Plan. Dental services not listed under the covered items may be covered under Mayo Medical Plan if you are enrolled in a component of that medical plan. Please refer to your Mayo Medical Plan Summary Plan Description to determine eligible expense under that plan.

**Important Note:** In administering the Plan, Medica ONESource and/or Mayo Clinic may, in its sole discretion, consult various Internal Revenue Service publications, rulings, notices, and other authorities to determine if an expense is eligible. Mayo Clinic reserves the right to deny payment for any service it considers ineligible.

### Covered Dental Services

You may be reimbursed from your MRA for any covered services that qualify as medical care for dental and vision services as defined by section 213(d) of the Internal Revenue Code, except those listed as exclusions in the following section.

Examples of reimbursable dental expenses:

- Athletic mouthguard
- Accident related treatment
- Amalgams
- Composites
- Dentures
- Initial orthodontic exam and consult
- Local anesthesia required for dental services
- Oral surgery and surgical procedures
- Osseo prosthesis, abutments, titanium screw, or fixture/implants
- Orthodontic records (x-ray, study casts, and photographs)
  - Initial
  - Progress
- Periodontal scaling and root planning
- Periodontal surgery
- Replacement retainers
- Routine dental x-rays
- Routine preventative dental treatment
- Single crowns
- Surgical root canal
- Teeth extractions, including simple adult and child teeth extractions
- Treatment of teeth, jaws, or mouth as a result of injury or illness

**Ineligible Dental Services**

- Claims received after March 31 filing deadline
- Coinsurance, copayment, or deductible for dental services covered under any medical plan
- Craniofacial anomalies including cleft lip or cleft palate
- Dental diagnosis and treatment in conjunction with a medical illness including x-rays, consultation, and treatment (i.e., oral cancer or jaw injury)
- Dental hygiene products
- Dental treatment that is determined to be unnecessary or not customary
- Desensitizing medicament
- Discounts given by the dental provider
- Fluoride gel carrier
- Hospital charges including emergency room care
- Labial veneers
- Orthodontic treatment regardless of medical diagnosis (other than initial consult and exam, orthodontic records and replacement retainers). See *Orthodontic Services* subsection of the *Schedule of Benefits*
- Prescription and nonprescription drugs ordered from dental services
- Snoring nose piece
- Membership fees and/or discount programs for services
- Treatment or services for cosmetic purposes including, but not limited to, tooth bleaching and facings on molar crowns or pontics

**Vision Services****Covered Vision Services**

- Eye refractions
- Eyeglass and contact lens supplies (lens cleaner, contact solution, repair kits)
- Over-the-counter eye drops
- Refractive Surgery (LASIK, Photorefractive keratectomy [PRK])
- Routine eye exams
- New prescription lenses including frames, lens, and contact lens
- Surgical eye loupes
- RxSight Light Adjustable Lens™ — an option for intraocular lens placed during cataract surgery

**Ineligible Vision Services**

- Add-ons to existing prescription lenses
- Claims received after March 31 filing deadline
- Eyewear clip-ons
- Non-prescription lenses (for example, reading glasses and sunglasses)
- Prescription and nonprescription drugs ordered from vision services

- Membership fees and/or discount programs for services
- Vision treatment that is determined to be unnecessary or not customary
- Warranties

## Orthodontia Services

**Important Note:** You and your eligible family members will be reimbursed from the applicable individual account for eligible orthodontic expenses you incur while a participant, but only up to the available amount of your individual account balance (\$1,500 lifetime maximum per participant). In no event will you be reimbursed for expenses that exceed your individual balance. See *Coordination of Benefits* section for details regarding other insurance.

### Covered Orthodontia Services

You may be reimbursed from your orthodontic account or from the orthodontic accounts of your eligible dependents (depending on which individual has the services), for 100% of any expense incurred for orthodontic services that qualifies as orthodontic care as defined by section 213(d) of the Internal Revenue Code, except those listed as ineligible expenses in the following section.

The following are examples of reimbursable orthodontic expenses:

- Orthodontic appliances including:
  - Banding
  - Braces (date appliance was placed)
  - Invisalign
  - Habit correct appliance
  - Initial orthodontic retainers
  - Removable appliance treatment
- Orthodontic exam and consult
- Post-treatment records

### Ineligible Orthodontia Services

- An active appliance which was installed before you or your eligible family member was covered under the Plan
- Treatment or procedures performed while you or your eligible family member was not eligible.
- On-line or internet orthodontic services

The above lists of ineligible expenses are not intended to be comprehensive. For questions about whether an expense is reimbursable, contact Medica ONESource.

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## EXCLUSIONS

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Notwithstanding any provision in the Plan to the contrary, the Plan will not provide benefits for the following, dental, hearing, orthodontic or vision procedures, or supplies, regardless of dental/vision/medical necessity or recommendation by a health care provider. You will not receive reimbursement from your Plan account for the following exclusions:

- Cochlear or baha implants (may be covered under your medical plan)
- Claims received after March 31 filing deadline
- Expenses covered under any group or individual insurance policy, or any other plan or program (private or governmental, subject to any applicable Medicare Secondary Payer Rules)
- Expenses due to an accident related to employment or disease covered under Workers' Compensation or similar law
- Expenses incurred before you or your eligible family member became participants
- Expenses incurred during any year you or your eligible family members are enrolled in another component of the Mayo Dental Plan
- Expenses incurred at a time when you have exhausted your account credit balance or expenses incurred that exceed your account credit balance. You may not use future account credits to cover claims incurred in the prior calendar year
- Expenses that exceed your balance at the time submitted
- Hearing aid batteries
- Hearing aids (device)
- Hearing aid fitting
- Repair or rebuild of existing hearing aid device
- Treatment by other than a legally licensed dentist, optometrist or physician, except services by a licensed hygienist under the dentist's supervision

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# COORDINATION OF BENEFITS

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## Coordination of Group or Individual Coverage

If you or eligible family members are covered by any group, individual or government sponsored dental and/or vision plan or by no-fault automobile insurance that provides dental and/or vision coverage, you must get payment from those plans first and your MRA coverage is considered secondary coverage. You may submit a claim for reimbursement under the MRA after your primary coverage has processed and paid your claims.

If you or your dental/vision provider submits a claim to your other dental or vision plan and that plan denies your claim, based on the existence of other coverage that may be primary, or, based on a coordination of benefits provision with that other plan, then, the following coordination of benefit rules shall apply to cover up to 100% of your claim. A plan without a coordination of benefits provision always pays first.

(a) The plan covering the person as an employee or retiree pays benefits first.

(b) If a child is covered under both parents' plans, the plan covering the parent whose birthday comes first during the calendar year is the primary plan. If the birth dates of the parents are the same, the plan that has covered the parent for the longer period of time is the primary plan and pays first. If the parents are divorced, the plans pay in this order:

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

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.

There is no coordination of benefits between any components of the Mayo Dental Plan other than the Delta Dental plan option which is primary to this Plan if the individual is covered by both .

## Workers' Compensation

Coverage under the Plan does not apply to any work related injury or illness covered by any workers' compensation program or insurance or any similar state or federal law.

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## SUBROGATION AND REIMBURSEMENT

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There may be situations in which you or your eligible family members have a legal right to recover health care or dental/vision expenses as a result of an 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 health care or other expenses for 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 you for injuries or an illness suffered by you, 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, you and eligible family members agree to the following:

- a) The entire amount collected by you 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 part of the payment or even none of the payment is allocated to dental or vision expenses do not affect the Plan's rights to recover all the benefits paid in connection with your 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 benefits paid under the Plan, you, your eligible family member, or your/their 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, recoveries, settlements, judgments, or other amounts that you or your eligible family members, heirs, guardians, executors, attorneys, or other representatives receive, are awarded, or become entitled to from any plan, person, entity, insurer (first party or third party), and/or insurance policy (including no-fault automobile insurance, an uninsured or underinsured motorists plan, 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 existing claims including any claim made by you for general damages.
- d) The Plan may collect the proceeds of any recovery, payment, settlement, or judgment recovered by you or your legal representative regardless of whether you have been fully compensated or "made whole."
- e) You have an obligation to cooperate completely with the Plan. You must complete and sign all documents that may be required by the Plan and take any action necessary to secure the Plan rights. You also have an obligation to notify the Plan immediately in writing any time the Plan may have a reimbursement right and identify any and all parties who may be liable.
- f) If you fail to immediately repay amounts owed to the Plan under this rule, the Plan may withhold future payments from the Plan to satisfy your obligation.
- g) If you voluntarily accept a lump sum or other settlement from any source without the Plan's consent which may or may not cause the Plan to lose its subrogation 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 dental/vision provider.

The Plan's subrogation and reimbursement right also applies to your 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 your behalf (even if the recovery is made by a family member) if the recovery is based on your 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, and will be paid by the Plan or withheld from the Plan's recovery under the "common fund" doctrine or otherwise.



# CLAIMS PAYMENT AND APPEAL PROCEDURES

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The standard claims procedure applies to all claims.

## **Important Notes**

Unless specifically noted, oral inquiries about coverage and benefits are not considered claims or appeals.

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 claims 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 claims procedures, you are giving up important legal rights.

Except as specifically noted, the claim procedure for prescription drug benefits is the same as for other dental/vision 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 Claims Administrator deciding claims and appeals under the Plan are given in a chart in the General Information Booklet.

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## STANDARD CLAIMS PROCEDURES

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All claims in the Plan except those related to benefits requiring prior authorization are handled under these standard claims procedures.

### Filing an Initial Claim

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#### Time for Filing a Claim

Your initial claim must be received by the Claims Administrator no later than March 31 following the year in which you received the service or supply.

#### Filing a Claim

Your dental or vision care provider may submit your initial claim directly to the Claims Administrator. Your claims may be submitted by using the online portal, mobile app or the MRA paper claim form. You are responsible for paying the dental or health care provider for covered services under the MRA either at the time of the visit or when you are billed for the covered services.

A claim for services or supplies should include the following information:

- Date(s) of service
- Name and address of provider
- Specific ADA Procedure codes and description of treatment
- Itemized charges
- Proof of payment may be submitted if a member has already paid for the service

If you exhaust your current year contribution, you are not able to submit any additional claims that were incurred that year against the next year's contribution.

#### Claim Decision

If approved, the reimbursement will be paid to you (not to your provider) after you or your eligible family member has incurred the expenses and as long as you have an available balance in your account. You will be reimbursed by means of a check or direct deposit.

The Claim Administrator has 30 days to decide your claim and notify you if the claim is denied in whole or in part.

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”).

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 Claims 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 Claims Administrator has to make its decision.

### **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 an appeal.

## **APPEALS PROCEDURES FOR STANDARD CLAIMS**

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### **Time for Filing Appeal**

You must file an appeal within 180 days after the date you received notice your claim is denied. *If an appeal is not filed within this 180-day period, you lose the right to appeal.*

### **Filing Appeal**

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
- Supporting documentation

### **Appeal Decision**

The Claims Administrator has 30 days to make a decision and notify you. If your appeal is denied, the notice will contain 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.

If your claim is approved on appeal, you will receive notice that the decision has been reversed and your claim has been approved.

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