



Benefits Booklet

**Mayo Dental Plan — Retiree Mayo Reimbursement Account
and Dental Assistance Plan — January 2026**

Offered under the Mayo Clinic Health and Welfare Benefits Plan

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INTRODUCTION

This benefits booklet provides information that is applicable to the Retiree Mayo Reimbursement Account (MRA) and Dental Assistance Plan (DAP) component of the Mayo Dental Plan, which is a benefit offered under the Mayo Clinic Health & Welfare Benefits Plan. MRA and DAP (collectively, the “Plan”) are available to certain retirees who retired on or before December 31, 2010.

This benefits booklet describes the MRA and DAP benefits, how to submit a claim for benefits, who reviews the claims for benefits and other important information about the MRA and DAP. The General Information Booklet for the Mayo Clinic Health & Welfare Benefits Plan (the “General Information Booklet”) provides information about how to enroll and how you may be able to continue coverage under the MRA and DAP if it ends. It also contains information such as who has the right to amend and terminate the MRA and DAP.

This benefits booklet, together with the General Information Booklet, constitutes the Summary Plan Description for the Plan as of January 1, 2026 and replaces all prior descriptions of the Plan. It is intended to provide a summary of your benefits under the Plan. If there are any discrepancies between the Summary Plan Description and the governing plan documents, the plan documents will control.

The Plan is a retiree-only limited purpose health reimbursement arrangement that provide reimbursements of certain dental, orthodontic, and vision expenses for eligible retirees of Mayo Clinic and other participating employers.

The Plan is not funded by a trust or individual bank account. Instead, Mayo Clinic allocates annual “credits” to you. All Plan 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 (MRA only) 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.

If you are eligible for the Plan, you are also eligible for the orthodontia component of the Mayo Dental Plan, which is also described in this document.

CONTACT INFORMATION

Medica ONESource is the Claims Administrator for the Plan 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.

QUESTIONS ABOUT THE PLAN
<p>1-866-839-4015 TTY Users: National Relay Center: 711 then ask them to dial Medica ONESource at 1-866-839-4015 www.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>
QUESTIONS ABOUT ENROLLMENT/ELIGIBILITY
<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>
COBRA ADMINISTRATION
<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.

ELIGIBILITY AND PARTICIPATION

Who is Eligible

To qualify for retiree coverage under the MRA or DAP, you (and any eligible family member) must have been (1) enrolled in a component of the Mayo Dental Plan when you retired; (2) retired on or before December 31, 2010; and (3) have met the following age and continuous service requirements. If you satisfy these rules and if you retired before the age of 65 (Medicare eligibility) the only component of the Plan that will be available to you will be the MRA until age 65 and then you will convert to DAP at the age of 65. If you retired at age 65 or older, the only component of the Plan that will be available to you will be the DAP. If you are enrolled in the MRA at retirement, any MRA credits you have at retirement will transfer to your MRA or DAP if you are eligible for and enroll in retiree coverage. Coverage under any component of the Plan is not available to any individual or their spouse or other family members if the employee retires after December 31, 2010. Please note retiree MRA and DAP coverage is not offered by every participating employer in the Mayo Dental Plan. See the *Participating Employers for MRA/DAP* section of this document for more information.

Age at Retirement	Continuous Years of Benefit-Eligible Service
62 and over	10 continuous years
60 and 61	15 continuous years
55 through 59	20 continuous years
Under age 55	30 continuous years

Continuous Service has the meaning ascribed to it under the Mayo Pension Plan.

Eligible Family Members

Your family members may be eligible for coverage under the Plan. Refer to the *Eligible Family Members* section of the General Information Booklet.

When You Can Enroll

Eligible retirees will be given an open enrollment period to enroll for coverage in the Plan option (e.g., MRA if retired before age 65; DAP if retired on or after age 65) available to them at the location from where they retired, provided retirement occurred on or before December 31, 2010. If you do not elect retiree coverage at that time, you will not be eligible for any coverage under any component of the Plan. Following retirement, retirees also have an annual open enrollment until age 65. Enrollment rights as described in this *Eligibility and Participation* section apply to retiree dental and vision plan coverage, subject to the limitation of Plan options as noted above.

If you marry or remarry during retirement, you may enroll your spouse and any newly eligible family members for coverage in the Plan if you notify HR Connect within 31 days of the date of marriage or eligible family member eligibility. The effective date of coverage is the date of marriage or, if applicable, the date of eligible family member eligibility.

Open Enrollment

Prior to the start of a coverage year, the Plan has an open enrollment period. The terms of the open enrollment period, including duration of the election period, shall be determined by the Plan Administrator and communicated prior to the start of the open enrollment period. The open enrollment effective date of coverage is January 1.

Mid-Year Coverage Changes

As a HIPAA excepted benefit, there are no HIPAA special enrollment rights under the Plan. However, the Plan will allow mid-year coverage changes as outlined below.

Mid-Year Coverage Change Due to Loss of Other Health Coverage

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

- a. The eligible retiree or eligible family member satisfies all of the following criteria:
 - Was covered under another group health plan or other health insurance coverage (this prior coverage does not include continuation coverage required under federal and state law) at the time the eligible retiree or eligible family member was previously eligible to enroll under the Plan.
 - Declined Mayo coverage for the reason described above.
 - Presents to the Plan Administrator, or its designee, evidence of loss of prior coverage due to loss of eligibility for that coverage, or evidence of the termination of employer contributions toward that coverage.
 - Loss of eligibility is not due to the eligible retiree's or eligible family member's failure to pay premiums on a timely basis or termination for cause but is due to:
 - Cessation of dependent status
 - Death
 - Divorce
 - Employer contributions toward the coverage terminate
 - Incurring a claim that would meet or exceed a lifetime limit on all benefits (note that benefits paid under one Mayo medical plan option count as benefits paid under all other options for purposes of determining whether the lifetime maximum is reached)
 - Legal separation
 - Loss of HMO or similar coverage because you change your residence or work place and as a result coverage is no longer available
 - Reduction in the number of hours of employment
 - Termination of employment
 - The Plan is changed so that you, your spouse or eligible family member are no longer eligible
 - Notifies the Plan Administrator, or its designee, in writing within 31 days of the date of the loss of coverage or the date the employer's contribution toward that coverage terminates.
- b. The eligible retiree or eligible family member satisfies all of the following criteria:
 - Was covered under benefits available under COBRA
 - Declined coverage for that reason

- Presents to the Plan Administrator, or its designee, evidence that the eligible retiree family member has exhausted such COBRA coverage and has not lost such coverage due to the failure of the eligible retiree or dependent to pay premiums on a timely basis or termination of coverage for cause. COBRA would therefore be deemed to be exhausted if it ended for any of these reasons:
 - another employer or responsible entity fails to remit premiums for the coverage as a whole (but not if you or a eligible family member lose coverage for your or your eligible family member's non-payment)
 - loss of HMO or similar coverage because of change in residence or work place that makes coverage available
 - incurring a claim that would meet or exceed a lifetime limit on all benefits
 - Notifies the Plan Administrator, or its designee, in writing within 31 days of the date of the loss of coverage.
- c. The eligible retiree or eligible family member satisfies all of the following criteria:
- Effective April 1, 2009, an eligible retiree or eligible family member with coverage under a state Medicaid plan or Children's Health Insurance Program (CHIP) loses such eligibility.
 - Loss of eligibility is not due to the eligible retiree's or eligible family member's failure to pay premiums on a timely basis or termination for cause.
 - Notifies the Plan Administrator or its designee, in writing within 60 days of the date of the loss of coverage.

Who Can Enroll After Mid-Year Coverage Change Events That Are Loss of Other Coverage?

If your eligible family member loses coverage as explained above, and that eligible family member is eligible for coverage under the Plan, you can add that eligible family member. You will not be able to add your family member to the Plan if you are not enrolled in the Plan.

Who Can Enroll After Mid-Year Coverage Change Events That Are Addition of Family Member?

The addition of a new family member triggers special enrollment rights for an eligible retiree and the spouse. Even if the retiree does not participate in the Mayo Dental Plan at the time of the event, the employee could add Plan coverage. For example, upon the birth of an eligible retiree's child, the eligible retiree (assuming he/she did not previously enroll), his/her spouse and his/her newborn may all enroll because of the child's birth.

Mid-Year Coverage Change Enrollment Due to Addition of Eligible Family Member

The following events for an eligible retiree trigger special enrollment rights:

- Birth, adoption, or placement for adoption of an eligible retiree's child
- Marriage

Rules and Procedures for Mid-Year Coverage Changes

Time Period for Mid-Year Coverage Changes

The eligible retiree must request a mid-year coverage change in the Plan within 31 days of the marriage or birth, adoption or placement for adoption of his/her child.

Effective Date of Mid-Year Coverage Change

Enrollment in the Plan under this mid-year coverage provision will be the date of the event.

Can I Cancel My MRA/DAP Coverage?

Because your MRA/DAP is funded solely with employer contributions and you make no pre-tax contributions, you are not limited by the same rules that limit your ability to change or cancel other health plan elections which are paid for on a pre-tax basis. You can cancel your own or your eligible family member's MRA/DAP coverage at any time. However, if you do so, you will lose your right to renew or re-establish any MRA/DAP coverage for you or your eligible family members at any time and for any reason. You should contact HR Connect before canceling your coverage.

When Does My Coverage Become Effective?

Refer to the *When Coverage Becomes Effective* section of the General Information Booklet.

Coverage for Family Members after Your Death

If your spouse and eligible family members were enrolled in the Plan at the time of your death, MRA/DAP 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 reaches 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 are not eligible and do not participate in annual open enrollment.

If your spouse is eligible for coverage as an employee under the Plan, contact HR Connect for enrollment details.

WHEN DOES COVERAGE END

Retiree Coverage Ends

Refer to *When Retiree 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 Retiree Plan Coverage Ends

In the event that you lose coverage as described above, any and all MRA/DAP account credit balance is forfeited at the time of the loss of coverage unless you are eligible and elect COBRA continuation coverage as described in the *Continuation of Health Care Coverage under COBRA* section of the General Information Booklet.

MAYO REIMBURSEMENT ACCOUNT (MRA)

The total annual employer credit contribution to your MRA 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.

DENTAL ASSISTANCE PLAN (DAP)

If you are covered by the MRA, upon turning age 65, you become ineligible for MRA coverage and your dental and vision coverage will be changed automatically to the DAP component of the Mayo Dental Plan effective on the first of the month in which you reach age 65. The credit balance of your MRA account will be transferred to the DAP. No further credit contributions will be made to your DAP account after that transfer until your account balance at the end of the year falls below the maximum account balance for the DAP plan that applies to you.

The total annual employer credit contribution to your DAP account is \$475. You can use your DAP account credit balance to obtain reimbursement for eligible dental expenses incurred by you or your eligible family members while you are covered by DAP. At no time will you be reimbursed for expenses that exceed your account credit balance.

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.

CONTRIBUTIONS AND MAXIMUM ACCOUNT BALANCES

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 as noted below, 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/retiree who is covered under MRA or DAP, you will each receive separate annual or pro-rated credit contributions and separate credit maximums.

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 maximums.

Maximum Account Balances	
MRA	\$5,000
DAP	\$1,900

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 DAP. On December 31 your credit balance is \$1,700. Your \$1,700 credit balance will be carried forward for use in the next year. On January 1 you will receive a credit of an additional \$200. The \$475 annual credit you would otherwise receive must be reduced to \$200 to keep your credit balance from exceeding the maximum of \$1,900.

Orthodontia Credits

The Mayo Dental Plan has a separate component that provides a one-time orthodontia benefit, this amount is limited to any unused amount from the Mayo Dental Plan. You and each of your eligible family members will receive a one-time only \$1,500 credit contribution for orthodontia to an orthodontia account. 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 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/retiree under the Mayo Dental Plan with respect to the orthodontia credit, your joint eligible family members will receive only one \$1,500 contribution, not two

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.

SCHEDULE OF BENEFITS

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
- Treatment or services for cosmetic purposes including, but not limited to, tooth bleaching and facings on molar crowns or pontics
- Membership fees and/or discount programs for services

Vision Services (Retiree MRA Only)**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
- Vision treatment that is determined to be unnecessary or not customary
- Warranties
- Membership fees and/or discount programs for services

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

EXCLUSIONS

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 healthcare 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 incurred before you or your eligible family member became participants
- Expenses due to an accident related to employment or disease covered under Workers' Compensation or similar law
- Expenses incurred on a date that either 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 prior calendar years
- 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

COORDINATION OF BENEFITS

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/DAP coverage is considered secondary coverage. You may submit a claim for reimbursement under the MRA/DAP 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 a 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:
 1. If the terms of a court decree have established one parent as financially responsible for the child's healthcare expenses, the plan of that parent is primary.
 2. The plan of the parent with custody of the child pays next.
 3. The plan of the stepparent married to the parent with custody of the child pays next.
 4. The plan of the parent without custody of the child pays last.

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.

SUBROGATION AND REIMBURSEMENT

There may be situations in which you or your eligible family members have a legal right to recover healthcare 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 the health care or other expenses of that injury. If you are in a motor vehicle accident, another driver may be responsible.
- If you become sick or injured in the course and scope of employment, your employer or a Workers' Compensation insurer may be responsible for health care or other expenses from the illness or injury.
- If someone else is legally responsible or agrees to compensate a covered person for Injuries or illness, the Plan has the right to recover any and all benefits it has paid in connection with the injury or illness.

By enrolling and accepting coverage in the Plan, 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

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 claims procedure, you must complete an authorized representative form, which is available by calling the Claims Administrator. For the accelerated claims procedure, your healthcare 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 claims 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 at in the General Information Booklet.

STANDARD CLAIM PROCEDURE

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

Filing an Initial Claim

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/DAP paper claim form. You are responsible for paying the dental or health care provider for covered services under the MRA/DAP 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 Claims 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

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 Claims 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.

PARTICIPATING EMPLOYERS

Employers Participating in Retiree MRA and DAP components of Mayo Dental Plan
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Charterhouse, Inc.

Franklin Heating Station LLC

Mayo Clinic

Mayo Clinic Arizona

Mayo Clinic Florida (a non-profit corporation)
--

Mayo Clinic Hospital-Rochester

Mayo Collaborative Services, LLC

Mayo Foundation for Medical Education and Research
--

Rochester Airport Company

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