



# Benefits Booklet

**Mayo Long Term Disability Plan — January 2026**

**COMPONENT OF THE MAYO MEDICAL PLAN**

Offered under the Mayo Clinic Health & Welfare Benefits Plan

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## **INTRODUCTION**

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This benefits booklet for the Mayo Paid Disability Income plan (“Long Term Disability Plan” or “Plan”), commonly referred to as the Mayo Long Term Disability Plan or Mayo LTD Plan, provides information regarding the LTD benefits offered under the Mayo Clinic Health & Welfare Benefits Plan. This benefits booklet describes the Plan, how to submit a claim for benefits, who reviews claims for benefits and other important information about the Plan.

The General Information Booklet for the Mayo Clinic Health & Welfare Benefits Plan (the “General Information Booklet”) provides information such as who is the Plan Administrator, certain ERISA rights you have as a participant in the Plan, and who has the right to amend and terminate the Plan.

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 available under the Mayo LTD Plan. If there are any discrepancies between the Summary Plan Description and the governing plan document, the plan document will control.

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## CONTACT INFORMATION

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Recovery and Claims Services is the Claims Administrator for the Long Term Disability Plan. Recovery and Claims Services processes claims and answers claim questions for the Plan.

For enrollment or eligibility questions, please contact HR Connect. HR Connect is your human resources office for this Plan.

<b>Questions about Claims</b>
<p>Mayo Clinic            Recovery and Claims Services            Rochester, MN 55905            Attn: LTD Claims Administrator            Phone:            (507) 422-0505 (local)            (833) 522-7198 (toll-free)</p>
<b>Questions about Enrollment/Eligibility</b>
<p>HR Connect            200 First Street SW            Rochester, MN 55905              507-266-0440 (local)            1-888-266-0440 (toll free)            M – F, 7 a.m. to 6 p.m CT            (excluding holidays)</p>

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

Spanish (Español): Para obtener asistencia en Español, llame al (888) 266-0440.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (888) 266-0440.

Chinese ( ): (888) 266-0440.

Navajo (Dine): Dineq'ehgo shika at'ohwol ninisingo, kwijjigo holne' (888) 266-0440.

## **LONG TERM DISABILITY BENEFITS**

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Subject to all of the terms and limitations set forth in this Plan, Mayo Clinic sponsors the Plan to provide long term income replacement benefits in the event you are disabled from illness or injury. In general, the Plan applies to disabilities lasting longer than thirteen weeks for eligible Allied Health Staff and to disabilities lasting longer than twenty-six weeks for eligible Consultants/Voting Staff.

You may also be eligible for short term disability benefits. Review your employer's policy to determine your eligibility and the amount of coverage available to you.

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## ELIGIBILITY AND PARTICIPATION

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### **Eligibility for Mayo Clinic and Mayo Clinic Health System Locations**

You are eligible for coverage under the Plan if (1) you are classified as either Allied Health Staff or Consultants/Voting Staff and (2) you are classified by a participating employer for payroll and personnel purposes as an employee who is regularly scheduled to work at least half-time (forty (40) hours or more per pay period) for the employer. You are eligible to participate in the Long Term Disability Plan on the first day of employment provided you are at work on that day. Regularly scheduled means your schedule on file with your employer is .5 FTE or more. A .4 FTE working extra hours does not qualify as regularly scheduled to work .5 FTE.

**Please note:** This Plan has a pre-existing condition limitation that may affect your eligibility.

Your eligibility as Consultant/Voting Staff is determined in accordance with a participating employer's payroll and personnel requirements and procedures. Students, Residents and Research Appointees are excluded from the LTD Plan.

**Please note:** In order to receive long term disability benefits under the Plan as described in this document, your disability must have commenced at a time when you were covered by the Plan. For example, if you were not covered by the Plan prior to January 1, 2026, your disability must have commenced on or after January 1, 2026 in order to be eligible for disability benefits under the Plan as described in this document. Refer to prior versions of the Plan document if your disability commenced prior to January 1, 2026.

### **Actively at Work Requirement**

Actively at work means physically present to work .5 FTE or more at the employee's regular worksite or at an alternative employer worksite at the request of the employer. If you are not actively at work on the day your automatic coverage is scheduled to begin, your coverage will not begin until the first day you begin or return to your employment.

### **Personal, USERRA or Parental Leaves of Absence**

Long term disability income coverage continues in force based on the Annual Benefit Salary in effect at the beginning of your approved personal, USERRA, parental or other employer-approved leave for up to 90 days of authorized leave, measured from the commencement of the leave. Note however, that the Plan does not cover disabilities caused by war or acts of war while in active military service, including USERRA leaves. If your approved personal, USERRA, parental or other employer-approved leave of absence extends beyond 90 days, your long term disability coverage ends on the 90<sup>th</sup> day of your leave. This end of coverage after 90 days of leave does not apply to an employee who is on an approved educational leave and enrolled in a Mayo Clinic School of Health Sciences (MCSHS) one-year NPPA Fellowship program or any MCSHS' nursing specialty program that pays the individual as an employee.

### **Other Benefits While on LTD**

For information on how your other benefits are affected during a period of long term disability, see the summary plan descriptions describing those benefit plans. Your rights to other benefits are subject to the terms of those plans; the Long Term Disability Plan provides no benefits other than disability pay.

### **When Long Term Disability Income Coverage Ends**

Your coverage under the Long Term Disability Plan will end at midnight of the day on which the earliest of the following events occurs:

- The last day of your employment or the day you cease to be an eligible employee under the Plan.
- The day the employer terminates the Plan or its participation in the Plan.
- The effective date of an amendment to the Plan causing you to lose coverage.
- The 90<sup>th</sup> day of an approved personal, USERRA, parental or other employer- approved leave of absence.
- The day before the first day of any leave other than an approved personal, USERRA, parental or other employer-approved leave of absence.
- The date on which you are no longer actively at work unless you are on an approved personal, USERRA, parental or other employer-approved leave of absence but not beyond the period of 89 calendar days.
- The date of your death.

### **Rescission of Coverage**

According to the U.S. Department of labor regulations for disability claims filed on or after April 1, 2018, long term disability coverage under this plan may be rescinded under certain circumstances. Specifically, coverage may be retroactively cancelled or terminated if you act fraudulently or make material misrepresentations of material fact (whether intentional or not). It is your responsibility to provide accurate information and to make accurate and truthful statements including information and statements in response to the Claims Administrator's questions. In addition, it is your responsibility to update previously provided information and statements. Failure to do so may result in your coverage being cancelled and such cancellation may be retroactive.

A determination by the plan that a rescission is warranted will be considered an adverse benefit determination for purposes of review and appeal. An individual whose coverage is being rescinded will be provided a required notice as described in the regulatory guidance. Such notice shall be considered an adverse benefit determination. At the conclusion of the required notice period, coverage shall be terminated retroactively to the date identified in the notification. Benefits that were paid under the plan after the retroactive date of termination will be treated as erroneously paid long term disability benefits according to the provision "erroneous payments" under coverage section of this plan.

### **Cost of Coverage**

Your employer pays the full cost of the Long Term Disability Plan coverage. Any benefits you receive from the Plan are taxable at the time you receive them.

### **Claimant's Responsibilities**

You have an obligation to cooperate with the Plan. You are responsible for providing the Claims Administrator with your current contact information such as address, phone number and/or email address. Any notices required or permitted to be given to you hereunder shall be deemed given if directed to the address most recently provided by you and mailed by first class United States mail. The Claims Administrator has no obligation or duty to locate you. If you fail to keep the Claims Administrator informed of any changes in your address, the Plan may temporarily suspend the long term disability benefits until you provide the Claims Administrator with your current contact information. The burden of proof rests upon the employee to prove their disabling condition by submitting objective medical evidence/records that support the claimed medical condition. Long term disability benefits will not be approved or paid based solely on subjective symptoms.

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## PLAN BENEFITS

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Benefits under the Plan are different for eligible employees classified as Allied Health Staff and those classified as Consultants/Voting Staff.<sup>1</sup> The first part of this section on Plan Benefits provides separate information for each of these two groups. The remainder of the section applies to both Allied Health Staff and Consultants/Voting Staff.

### Allied Health Staff Benefits

- **Elimination Period.** The Long Term Disability Plan pays benefits for qualifying disabilities that extend beyond 13 calendar weeks.
- **Amount of Benefit.** For the purpose of determining the amount of long term disability income benefits available to eligible employees who are classified as Allied Health Staff, the Plan uses your Annual Benefit Salary as defined in the Glossary. The Monthly Benefit you are eligible to receive is **65%** of your Annual Benefit Salary at the time your disability commences, converted to a Monthly Benefit, which is paid every two weeks. This benefit is taxable income to you and is paid to you through your employer's payroll system.
- **Partial-month Disabilities.** If you are disabled for a portion of a month, the benefit you receive from the Long Term Disability Plan will be based on the number of working days you are absent because of the disability.
- **Partial Disability Benefits.** If you qualify for partial disability (discussed below), your benefit will be reduced by 80% of the income you earn through your partial disability/work. Partial Disability employment status is available for up to 52 weeks.

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<sup>1</sup> A small number of Allied Health Staff employees are classified as "special status" on payroll and personnel records and receive benefits at the Consultant/Voting Staff levels. These employees are individually notified of this special status.

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## Consultants/Voting Staff Benefits

- **Elimination Period.** The Long Term Disability Plan pays benefits for qualifying disabilities that extend beyond twenty six calendar weeks.
- **Amount of Benefit.** For the purpose of determining the amount of long term disability income benefits available to eligible employees who are classified as Consultants/Voting Staff, the Plan uses your Annual Benefit Salary as defined in the Glossary. The Monthly Benefit you are eligible to receive is based on 84% of your Annual Benefit Salary at the time your disability commences, converted to a Monthly Benefit which is paid every two weeks. This benefit is taxable income to you and is paid to you through your employer's payroll system. There is an annual cost of living adjustment for total disabilities that extend beyond one calendar year. The amount of the Monthly Benefit increases by 2% on April 1 of each subsequent calendar year of disability, if you were disabled under the Plan and receiving long term disability benefits on the preceding October. In no event, however, will the Monthly Benefit exceed 1/12 of your pre-disability Annual Benefit Salary. The annual cost of living increase is discretionary and may be amended at any time.
- **Partial-month Disabilities.** If you are disabled for a portion of a month, the benefit you receive from the Long Term Disability Plan will be based on the number of working days you are absent because of the disability.
- **Partial Disability.** If you are partially disabled and earning at least 20% of your pre disability Annual Benefit Salary, converted to a monthly amount, but less than your pre disability salary, your benefit will be based on 84% of your wage loss. Your wage loss is the difference between your pre disability salary and your current gross earnings based on your employment, converted to monthly amounts, at Mayo Clinic or another employer. If you are earning less than 20% of your pre-disability Annual Benefit Salary, converted to a monthly amount, you are not considered partially disabled and your benefit will be based on Total Disability and any other Plan provisions including the reductions outlined in the next section. If you are earning equal to or more than your pre disability Annual Benefit Salary, your LTD benefits will be terminated.
- **Partial Disability Example.** Assume a \$240,000 pre-disability Annual Benefit Salary and current annual earnings of \$120,000. Your annual wage loss is \$120,000 (\$240,000-\$120,000) and monthly wage loss is \$10,000. Your annual partial disability benefit is \$100,800 (84% of \$120,000). This annual benefit is pro-rated for 26 pay periods per year.
- **Partial Disability Example with other Reductions.** Assume a \$240,000 pre- disability Annual Benefit Salary and current annual earnings of \$120,000, as well as \$2,000 monthly Social Security Disability Benefits (SSDI). SSDI is pro-rated over 26 pay periods, so a \$2,000 monthly award results in a \$923.07 per pay period reduction ( $\$2,000 \times 12 = \$24,000$  annual SSDI award, then divided by 26 to arrive at a per pay period reduction of \$923.07). Your annual wage loss is \$120,000 (\$240,000-\$120,000). Your annual partial disability benefit is \$76,800 (84% of \$120,000), less \$24,000 in annual SSDI benefits).

## Reduction of Benefits for Other Income

The benefit from the Long Term Disability Plan will be reduced by the amount of (1) any other income and/or (2) a benefit for loss of income for which you, your family or a third party on your behalf is paid or is eligible to receive as a result of the period of total disability for which you claim benefits under the Plan (“other income”) with the exception of Critical Illness, Accident and Hospital Indemnity benefits offered by Mayo Clinic. These reduction in benefits rules for other income apply to all disability payments to both Allied Health Staff and Consultants/Voting Staff, except as provided for in the Partial Disability section for Consultants/Voting Staff. Periodically you will be required to provide appropriate financial records, such as Federal income tax returns including schedules and other attachments necessary to substantiate your income.

Such other income includes, without limitation, any of the following:

- **Employment Income.** Any income you receive or are entitled to receive for any employment that you perform while eligible for disability benefits will reduce your disability benefits, regardless of the source or characterization of the income and including, but not limited to, any type of wage, bonus, commission, incentive pay, stock option and/or deferred compensation. All such income must be promptly reported to Recovery and Claims Services. **Note** that special rules apply to the reduction in benefits relating to income received by Allied Health Staff if eligible for partial disability benefits.
- **Severance or Separation Payments.** Any payments you receive upon separation from service from an employer as severance pay, separation pay or pursuant to an employment agreement.
- **Social Security Benefits.** Social Security benefits because of your total disability (including the primary benefit applicable to you, and one half the Social Security benefit applicable to your spouse and children).
- **Benefit under a Workers’ Compensation Law or Similar Law.** Additionally, note that receipt of workers’ compensation benefits excludes you from eligibility to benefit under this Plan.
- **Employer Disability Benefits.** Benefits under another total disability plan provided by a participating employer or any other employer, regardless of whether the premiums or cost of coverage are paid by the employer or by you.
- **No Fault Automobile Plan Benefits.**
- **Government Benefits.** Benefits from any federal, state, county or municipal Government disability, disability retirement and/or loss of time plans or laws.
- **Benefits under any Other Individual or Group Long Term Disability Policy.**
- **Benefits under compulsory benefit laws or law or any other act or law of like intent (for example Veterans Administration disability benefits)**
- **Social Security Retirement Benefits.** Social Security retirement benefits that commence after you become disabled.
- **Pension Benefits.** Defined benefit pension benefits received from an employer other than Mayo Clinic that commence after you become disabled.
- **Settlement or Judgment of a Lawsuit.** Any portion of a settlement or judgment of a lawsuit related to your disability and/or its cause, regardless of whether the settlement or judgment is characterized as reimbursement for loss of earnings, medical expenses, disability, pain and suffering or some other loss.

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## **Special Rules for Social Security Benefits and other Federal, State, County or Municipal Benefits**

If you become disabled, you must contact the Social Security Administration (and any other federal, state, county or municipal source of disability benefits) as soon as possible to apply for disability benefits. When you know the amount of your Social Security benefit or when your claim is denied, you must notify Recovery and Claims Services.

Generally, until you know the amount of your Social Security benefit, no Social Security reduction will be made from your Plan benefit. However, it is important you make a reasonable attempt to obtain Social Security (or other federal, state, county or municipal) benefits, including, if necessary, any step in the appeal process. The Claim Administrator will reduce your benefit under this Plan by the estimated amount of any Social Security disability benefits as well as any federal, state, county or municipal programs you would be eligible for if you are unwilling to take the necessary steps to obtain (including applying for and pursuing available appeals) Social Security or other federal, state, county or municipal benefits.

After you notify Recovery and Claims Services of the final benefit from the Social Security Administration or any other sources, your long term disability benefits from the Plan will be recalculated. As further described in the next section, if there is an overpayment of the long term disability benefits from the Plan, you will be responsible for paying back the amounts of overpayment. Your failure to repay the amounts of overpayment constitutes misconduct and is grounds for termination of your eligibility for benefits under this Plan.

### **Erroneous Payments**

If the Plan makes a payment to an individual whose long term disability coverage is rescinded by the Plan, the Plan shall be entitled to recover such erroneous payments from the recipient.

### **How the Plan Reduces Benefits Because of Other Income**

All sources of other income described above (including, but not limited to, Social Security and/or other governmental disability benefits) are offset against disability benefits under this Plan. If you receive a retroactive payment of other income, any other type of lump sum payment and/or any other type of other income that will be paid to you on a periodic basis, you must report the other income immediately to Recovery and Claims Services.

You will likely owe some or all of a lump sum or retroactive payment for disability benefits you have already received under this Plan. If you fail to repay Mayo Clinic from the lump sum or retroactive payment, your disability benefits under this Plan will be reduced to zero until the offset is fully satisfied.

If you receive other income (including, but not limited to, Social Security) going forward, your payments under this Plan will be reduced by those other income payments on a going-forward basis.

If, at the end of your eligibility for disability benefits under this Plan, you have been overpaid long term disability benefits under this Plan because of other income you have received, you will be responsible for paying back the amounts of overpayment.

Failure to report other income to Recovery and Claims Services is a basis to terminate eligibility for benefits under this Plan.

**Disability Benefits Example – Allied Health Staff**

Assumptions:

- a. Annual Benefit Salary: \$84,000.  $\$84,000/12 = \$7,000$  monthly.
- b. You are eligible for partial disability benefits and earn \$1,500 per month. This is the only “other income” benefit you are receiving.

Under these assumptions, your Monthly Benefit from the Plan would be calculated as follows:

<b>Payment Example</b>	
Monthly Annual Benefit Salary	\$7,000
Rate of Reimbursement	65%
Monthly Taxable Benefit	\$4,550
Offset for 80% of Monthly Partial Disability Benefits	– \$1,200
Monthly Taxable Benefit after Reduction	\$,3350

**Disability Benefits Example – Consultants/Voting Staff**

Assumptions:

- a. Annual Benefit Salary: \$150,000.  $\$150,000/12 = \$12,500$  monthly.
- b. Your Social Security disability benefits plus one-half of the benefit your spouse is eligible to receive if you are disabled is equal to \$900. This is the only “other income” benefit you are receiving.

Under these assumptions, your Monthly Benefit from the Plan would be calculated as follows:

<b>Payment Example</b>	
Monthly Annual Benefit Salary	\$12,500
Rate of Reimbursement	84%
Monthly Taxable Benefit	\$10,500
Offset for Social Security Benefits Received	– \$900.00
Monthly Taxable Benefit after Reduction	\$9,600

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## QUALIFYING DISABILITIES

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The Plan has different definitions of qualifying disabilities, depending on whether eligible employees are classified as Allied Health Staff or as Consultants/Voting Staff. Benefits are payable for your period of disability only if the period of disability began while you were covered under the Plan.

### **Allied Health Staff Qualifying Disabilities**

Eligible employees who are classified as Allied Health Staff are eligible for long term disability benefits if they have a total disability, as defined in this section below.

#### **Total Disability—Allied Health Staff**

Total disability for eligible Allied Health Staff, for the first two years and 13 weeks of a disability, means that the Claim Administrator determines that you are completely unable to perform the duties of your regular occupation and you are not engaged in some other occupation (except as provided by the partial disability benefit rules of this Plan) due to illness or injury, and you are under the regular care of a physician. Your regular occupation refers to any occupation with duties similar to the occupation you were in when you became disabled.

After the initial two-year and 13 calendar week period, your total disability ends unless the Claim Administrator determines that you are completely unable to engage in any gainful occupation for which you are fitted by education, training or experience due to illness or injury (except as provided by the partial disability benefit provisions of this Plan), and you are under the regular care of a physician.

### **Consultants/Voting Staff Qualifying Disabilities**

Eligible employees who are classified as Consultants/Voting Staff are eligible for long term disability benefits if they have a total disability or partial disability, as defined below.

#### **Total Disability—Consultants/Voting Staff**

Total disability for eligible Consultants/Voting Staff means the Claim Administrator determines that you are completely unable to perform the material and substantial duties of your regular occupation due to illness or injury, and you are under the regular care of a physician. Your regular occupation refers to any occupation with duties similar to the occupation you were in when you became disabled.

#### **Partial Disability—Consultants/Voting Staff**

Partial disability for eligible Consultants/Voting Staff means that the Claim Administrator determines that all of the following conditions are met:

- You are not able to perform the duties of your regular occupation due to illness or injury on a full-time basis. Your regular occupation refers to any occupation with duties similar to the occupation you were in when you became disabled.
- You are working for wage or profit:
  - at your regular occupation, but you are not able to perform your duties on a full-time basis;
  - or
  - at another occupation.

- Your partial disability earnings are at least 20% but not equal to or more than your pre-disability earnings. Your pre-disability earnings are the amount of your Annual Benefit Salary before your period of total disability began.
- You are under the regular care of a physician.

# PAYMENTS FOR TOTAL AND PARTIAL DISABILITIES

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## **Elimination Period**

The elimination period is counted from the first day you are totally (or, for Consultants/Voting Staff, partially) and continuously disabled from an onset of a non-occupational illness or injury, as supported by objective medical evidence. In addition, any time lost from work in the preceding 13 weeks (for Allied Health Staff) or 26 weeks (for Consultants/Voting Staff) which is as a result of this same illness will be counted toward the elimination period.

## **Benefits for Total Disability**

If you have a total disability, your Monthly Benefit will begin on the first day after the elimination period and will continue until you are no longer eligible for benefits under the Plan. If you are disabled for a portion of a month, the benefits you receive from the Long Term Disability Plan will be based on the number of working days you are absent because of the disability.

While eligible, you will receive disability benefits through biweekly payroll payments.

## **Partial Disability Benefits (Allied Health Staff Only)**

If you are an Allied Health Staff employee attempting to return to work at Mayo Clinic (or with another participating employer in the Plan) while you are disabled, you may be able to continue your long term disability benefits from the Plan for a limited period of time of 52 calendar weeks from the date you are released to return to work (under Partial Disability provision of this Plan). **Note** that only employment with Mayo Clinic or another participating employer in the Plan qualifies you for this program.

Once you are qualified for return to work and your total disability ends, you may be eligible for partial long term disability benefits if you are released to return to work with restrictions and are not able to work your previous FTE due to the disabling condition. In total, your partial disability benefits may not last beyond a 52-week period. While you are on an approved partial disability status, you will receive your long term disability benefits reduced by 80% of any pay you earn during your partial disability status.

## **Benefits for Partial Disability (Consultants/Voting Staff Only)**

If you have a partial disability (available to Consultants/Voting Staff only), your Monthly Benefit will begin on the first day after the elimination period (if you are not then receiving benefits for total disability) and will continue until you are no longer eligible for benefits. If you are disabled for a portion of a month, the benefit you receive from the Long Term Disability Plan will be based on the number of working days you are absent because of the disability. The elimination period does not apply to a partial disability that starts while you are receiving benefits under this Plan for total disability. While eligible, you will receive disability benefits through biweekly payroll payments.

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## **DISABILITIES NOT COVERED AND LIMITATIONS AND EXCLUSIONS ON PLAN BENEFITS**

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Disabilities will not be covered by the Long Term Disability Plan if they are caused by, or contributed to by:

- Intentionally self-inflicted bodily injury or attempted suicide.
- Pre-existing Condition (any medical condition for which an employee had expenses or received treatment, consultation, care, diagnostic services, or had taken prescription drugs or medicines) for which the employee has treated for within three months prior to becoming covered by the Plan. The pre-existing condition exclusion expires after the employee has worked their full FTE performing all essential job functions for 120 days. This exclusion does not apply to pregnancy related conditions.
- The commission or attempt to commit a felony or you were engaged in an illegal act or occupation.
- An illness or injury that occurs while on active duty in the military service if such illness or injury is caused by or arises out of such military service, including but not limited to war or acts of war (whether declared or not declared). Note that if you are on military leave, including USERRA leave, coverage ends after 90 days and no illness or injury is covered after that date. Disabilities that commence before you become covered or after you are no longer covered under the Plan.
- Occupationally related illness or injury.

You will also not be eligible for disability benefits and/or disability benefits will immediately terminate if any of the following exclusions apply:

- You are confined in a penal institution or other house of correction as a result of conviction for a criminal or other public offense.
- You are not under the regular care of physician and/or you are not following a recommended course of medical and/or vocational treatment for the disabling condition (including pain management and/or work hardening programs).
- You do not provide the necessary claim information, records or documents including your medical records.
- You do not provide requested authorizations necessary for claim adjudication.
- You refuse to cooperate with the Claims Administrator's request that you have a medical examination by a physician selected by the Claims Administrator or a vocational examination with the examiner selected by the Claims Administrator.
- You fail to satisfy the definition of active participation for your condition as specified in Glossary. You do not participate in or follow any recommendations with respect to vocational rehabilitation.

- You commit fraud or misconduct with respect to the benefits sought or received under the Plan or you intentionally misrepresent the facts of your situation. **Please note** that your failure to repay the amounts of overpayment constitutes misconduct as described in *Subsection Special Rules for Social Security Benefits and other Federal, State, County or Municipal Benefits*.
- You fail to report other income to Recovery and Claims Services.
- You make a written request for benefits to be terminated.
- You commit fraud or misconduct in your employment relationship with your participating employer regardless of whether the fraud or misconduct occurs at work and regardless of whether it occurs before or after the commencement of the period of disability and regardless of when it is discovered.
- In the case of fraud or misconduct, and in amplification of the repayment obligation discussed below, the Claim Administrator reserves the right to recoup disability benefits that would not have been paid had the fraud or misconduct been known to the Claim Administrator, to the full extent permitted by applicable law.
- The Plan terminates and provides that benefits end.
- You were receiving Partial LTD benefits but you begin to earn or are capable of earning an amount equal to or more than your pre disability income as determined by the Plan and Claims Administrator.
- Please note that if you terminate employment with Mayo Clinic and wish to begin receiving your Mayo Pension Plan benefit, your coverage under the Long Term Disability Plan will end, which means any payments made under the Long Term Disability Plan will cease as of your termination date.

**Repayment Obligation:** In the event a participant receiving benefits under the Plan provides false information to the Plan, fails to provide requested information, otherwise makes any false statement or misrepresentation and/or otherwise engages in any act or omission involving fraud or dishonesty with respect to Mayo Clinic, a Mayo Clinic affiliate, or any plan sponsored by Mayo Clinic or a Mayo Clinic affiliate, such participant shall be obligated to and agrees to repay Mayo Clinic for the gross amount of any and all Plan payments made to him or her, regardless of the amount thereof, in addition to and without prejudice to any other remedies available to Mayo Clinic or any Mayo Clinic affiliate, at law or in equity.

## WHEN LONG TERM DISABILITY BENEFITS END

If you become disabled on or before age 60, benefits under the Long Term Disability Plan are payable, as long as you continue to be eligible for Plan benefits, up to age 65 (the maximum benefit duration). If, however, you become disabled at or after age 60, a **combination of both short term and long term disability benefits** will continue, as long as you continue to be eligible for Plan benefits, according to the following schedule:

Age at Disablement	Maximum Benefit Duration (STD/LTD Combined)
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69-74	12 months
75 & over	6 months

If you become disabled, benefits will be paid for your period of total disability or partial disability (Consultants/Voting Staff only) or the maximum benefit duration, whichever period is shorter.

### Recurrent Disability

If your total disability benefits end based on the terms of this Plan and you are no longer employed by Mayo or a participating employer, you have no additional coverage under the Plan. If your total disability benefits end and you return to work at a your participating employer as an eligible employee, but then become disabled again, that disability will be considered a continuation of the first, but only if you satisfy all of the following:

- The periods of disability are caused by the same disability.
- The periods of disability are separated by an interval during which you have performed all the important duties of a job less than the length of the elimination period applicable to you. This is considered the “Monitoring Period.”
- There is no Monitoring Period if you have exhausted the Partial Disability benefit (Allied Health Staff) provision.

### Special Rules for Combined Total and Partial Disabilities (Consultants/Voting Staff Only)

Periods of disability of Consultants/Voting Staff that include times when you are totally disabled as well as times when you are partially disabled, including any part of the elimination period, are one period of disability unless:

- The period meets the conditions for separate periods of disability described above.
- The disability is not treated as continuous under the waiting period in the schedule of benefits.

Benefits for one such period of disability are not payable for more than the maximum benefit duration.

The benefits are payable for your period of partial disability only if the period of disability began while you were covered under the Plan.

## **SITUATIONS AFFECTING PLAN BENEFITS**

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### **Continuing Proof of Disability**

Your claim will be periodically reviewed to verify that you continue to satisfy all Plan requirements and remain eligible for disability benefits. LTD approval is not permanent and may be discontinued at any time based on Plan rules.

From time to time during your disability, your employer may request that you have a medical examination by physicians they select. The purpose of the examination is to provide further evidence of your disability and to consider treatment recommendations. You are also required to follow a recommended course of treatment for the disabling condition.

### **Disabilities Due to Mental, Psychoneurotic or Personality Disorders, Alcoholism or Drug Addiction**

To receive long term disability benefits for disabilities resulting from mental, psychoneurotic or personality disorders, alcoholism or drug addiction, you must satisfy the definition of active participation as specified in the Glossary.

### **Mental Health Claims**

Mental Illness is a psychiatric or psychological condition classified in the Diagnostic and Statistical Manual of Mental Health Disorders (DSM), published by the American Psychiatric Association, most current as of the start of a disability. If the DSM is discontinued or replaced, these disorders will be those classified in the diagnostic manual then used by the American Psychiatric Association as of the start of a disability.

The Mayo LTD plan recognizes the potential severity of mental health diagnoses and provides a comprehensive LTD benefit aligned with industry standards. When a medical condition affects the ability to work on a regular basis getting appropriate medical care from a health care provider specializing in the condition is important. In serious mental health conditions, that expert is usually a psychiatrist who can guide diagnosis and treatment including hospitalization, outpatient programs, medication, behavioral/psychotherapy, group therapy, and ongoing specialized testing, and follow up.

Physician means a legally qualified physician. If any part of a period of total disability is caused, to any extent, by a mental condition, “physician” shall mean a legally qualified physician who is:

- Specialized in psychiatry; or
- Trained or experienced to evaluate and treat a mental condition.
- A provider deemed qualified by the Claims Administrator

For the purpose of this Mental Health Claims section, Mental Illness does not include the following mental disorders outlined in the Diagnostic and Statistical Manual of Mental Disorders:

- 1) Intellectual Disability;
- 2) Pervasive Developmental Disorders;
- 3) Motor Skills Disorder;

- 4) Substance-Related Disorders;
- 5) Delirium, Dementia, and Amnesic and Other Cognitive Disorders. This Mental Health Claims Section will not be applied to dementia if it is a result of:
  - stroke;
  - trauma;
  - viral infection;
  - Alzheimer's disease; or
  - other conditions not listed which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment.
- 6) Narcolepsy and Sleep Disorders related to a General Medical Condition;
- 7) Primary personality disorders (e.g., antisocial personality disorder and borderline personality disorder).

**Note** that LTD benefits for the above disorders will be administered in accordance with the main provisions of this Plan.

## **HOW TO RECEIVE BENEFITS AND CLAIM FILING DEADLINE**

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If your disability is expected to continue beyond 13 weeks (for Allied Health Staff) or 26 weeks (for Consultants/Voting Staff), notify the Claims Administrator as soon as possible. You or your authorized representative must submit a written application on a long term disability claim form along with medical documentation to the Claims Administrator in order for your claim to be considered. A benefit determination will not be made on an incomplete claim or when an employee provides written notice stating the claim is being withdrawn. See *Claims and Appeal Procedures* for more information.

### **Time Limit to File the Initial Claim**

You must file your written claim for long term disability benefits with the Claims Administrator, Recovery and Claim Services, no later than one year (365 days) from the date that you satisfied the Elimination Period. Any claim received after this date is not covered and/or compensable under this Plan.

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## **SUBROGATION AND REIMBURSEMENT**

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There may be situations in which you have a legal right to recover damages or losses including loss of income 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 your illness or injury. If you become sick or injured in the course of your job, your employer or workers' compensation insurer may be responsible for your loss of income or other expenses from the illness or injury. If someone else or an entity is legally responsible or agrees to compensate you for your injury or illness, the Plan has the right to recover any and all benefits it has paid in connection with the accident, illness or injury. Of course, this applies only if you receive any form of payment from any source through an award, judgment, damages, settlement or compromise as a result of the accident, illness or injury caused by, attributable to or otherwise the responsibility of a third party or entity.

By enrolling and accepting coverage in any of the Mayo Clinic disability plans, you agree to the following:

- The entire amount collected by you or your family members will be considered to be a first recovery of benefits paid under this Plan regardless of the terms of any award, agreement, regulation, statute, etc., to the contrary. The fact that only a part of the payment, settlement or recovery is allocated to loss of income or disability expenses does not affect the Plan's rights to recover all the benefits paid in connection with your injury. The Plan shall have a lien and a security in all such claims.
- The Plan will be reimbursed 100% from any and all recovery before any payment of any existing claims including any claim made by you or your covered family members for general damages.
- The Plan may collect the proceeds of any settlement or judgment recovered by you or your covered family members or your legal representative regardless of whether you have been fully compensated or made whole.
- You have an obligation to cooperate completely with the Plan. You must sign all documents that may be required and take any other action necessary to secure these Plan rights. You also have an obligation to notify the Plan in writing immediately any time the Plan may have rights against another person or entity.
- 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.
- If you voluntarily accept a lump sum or other settlement from any source without the Plan's consent and this causes the Plan to lose its subrogation or reimbursement rights, the Plan will have no obligation to pay any past, present or future benefits or expenses relating to the injury or illness caused by, attributable to in any degree or otherwise the responsibility of another person, party or entity.
- You may not assign any rights or causes of action you have or may have without the express written consent of the Plan.

Subrogation and reimbursement also applies to coverage under workers' compensation plans, disability and lost time coverage, other substitute coverage, any other right of recovery or any claim payment received from any motor vehicle insurance including no-fault or med-pay insurance, underinsured and uninsured insurance and liability insurance. In addition, it applies in the event you fail to obtain any mandated insurance coverage. The Plan reserves the right to recover expenses incurred on your behalf even if a family member makes the recovery if that recovery is based on your injuries. At all times, the Plan represents itself in subrogation and intervention interests. Therefore, no reduction for attorney fees, costs or expenses will be withheld from the Plan's recovery. The common fund doctrine will not govern the allocation of attorney's fees incurred by you or your dependents.

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## CLAIMS AND APPEALS PROCEDURES

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Claims under the Mayo Long Term Disability Plan are handled according to the claims procedure outlined in this section.

Unless specifically noted, time periods are in calendar days, not business days, and oral inquiries about coverage and benefits are not considered claims.

### **Authorized Representative**

For the purpose of this Plan's claims and appeal procedures, an Authorized Representative may act on your behalf with respect to any aspect of a claim or appeal.

In order to determine whether an individual has been authorized to act on your behalf, an "Authorized Representative" form must be received by the Plan in order for a person to be recognized as your Authorized Representative for both claims and appeals. Such forms are available by calling or writing the Claims Administrator's office at:

Mayo Clinic  
Recovery and Claims Services  
200 First Street SW  
Rochester, MN 55905  
Attn: LTD Claims Administrator  
833-522-7198

Once an Authorized Representative is recognized, the Plan will direct all information, notification, etc. regarding the claim to the Authorized Representative, unless you provide specific written direction otherwise.

### **Determination of Benefits – In General**

The Plan shall ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

In addition, during an initial disability claim or pending appeal, you are entitled to receive, at no additional charge, new or additional evidence considered, relied upon or generated by the Claims Administrator. Such evidence or rationale must be provided as soon as possible and sufficiently in advance of the date on which any appeal denial notice is required to be provided.

## Initial Claim and Decision

If you believe you are eligible to receive long term disability benefits from the Plan, you must file a written claim with the Claims Administrator (see address below). Your initial claim must be submitted by written application which may be obtained from the Claims Administrator, and you must provide medical support from a physician for your claim. The burden of proof rests upon the employee to prove their disabling condition by submitting objective medical evidence/records that support the claimed medical conditions. The written application to be completed is entitled "Claimant Statement for Long Term Disability Benefits" and is available from the Claims Administrator. A benefit determination will not be made on a request for benefits unless it is a formal Claim submitted on the Mayo Clinic Long-Term Disability Claim Application Form. Additional information may be requested by the Claims Administrator.

Claims must be filed no later than one year (365 days) from the date that the Claims Administrator determines that you satisfied the applicable Elimination Period under this Plan.

The Claims Administrator may require a medical examination or additional information regarding the claim. If a medical examination is required, the Claims Administrator will notify you of the date and time of the examination and the physician's name and address.

The Claims Administrator has 45 days to decide your claim and to notify you if your claim is denied in whole or in part. Under special circumstances, the Claims Administrator may take up to an additional 30 days to review the claim if it determines that such an extension is necessary due to matters beyond its control. If an extension of time is required, you will be notified before the end of the initial 45-day period of the circumstances requiring the extension, and the date by which the Claims Administrator expects to render a decision. If, prior to the end of the first 30-day extension period, the Claims Administrator determines that an additional extension is necessary due to matters beyond its control, the Claims Administrator may take up to an additional 30 days to review the claim. If an additional extension of time is required, you will be notified before the end of the initial 30-day extension period of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. If the Claims Administrator extends its period for reviewing a claim due to special circumstances, the notice of extension you receive will include an explanation of the standards on which entitlement to benefits is based, the unresolved issues that prevent a decision on the claim and any additional information needed to resolve these issues. You have at least 45 days to provide the specified information.

## Adverse Benefit Determination

You or your authorized representative will be provided notice of such Adverse Benefit Determination<sup>1</sup>, which will be written in a manner calculated to be understood by you and provided in a culturally and linguistically appropriate manner, as required under ERISA. Further, if your claim is denied, in whole or in part, you will receive a Notice of an Adverse Determination in written form in accordance with the timeframes noted immediately above. The notice will include the following:

- The specific reason(s) for the denial;
- Reference to the specific Plan provision(s) on which the determination is based;
- Description of any additional material or information necessary to process the claim and an explanation of why such information is necessary;

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<sup>1</sup> Adverse Benefit Determination is defined under ERISA to include any denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a disability benefit that has a retroactive effect. This means that a retroactive cancellation of disability coverage will be treated as a "denied" disability claim, and therefore subject to the new claims procedures described above. Rescissions of disability coverage for failure to pay premiums or required contributions are excluded from the scope of "Adverse Benefit Determination."

- Description of the Plan's review procedures and time limits for appeal of the Adverse Benefit Determination, including a statement of your right to bring civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on review;
- An explanation as to why the Plan disagreed with the health care professionals and/or vocational experts who treated you or advised the Plan;
- An explanation as to why the Plan disagreed with the disability determination of the SSA;
- If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and
- 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 your claim for benefits.

### Appeals Process

Federal Regulations require appeal procedures for Adverse Benefit Determinations under which you receive a full and fair review of your claim and Adverse Benefit Determination. The following will apply to your appeal of an Adverse Benefit Determination:

- **Right to Review Claim File:** The claimant will have the right to review his or her claim file. The claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined in accordance with ERISA claims regulations.
- **Submission and Consideration of Comment:** The claimant will have the right to present "evidence and testimony" as that phrase is clarified through regulatory guidance. The claimant will have the opportunity to submit documents, written comments, or other information in support of the appeal. The review of the Adverse Benefit Determination will take into account all information, whether or not presented or available for the initial determination. No deference will be given to the prior determination.
- **Disclosure of New or Additional Evidence or Rationale:** Claimant will be provided, as soon as possible, any new or additional evidence or rationale considered relied upon, or generated by or at the direction of the Plan during the pendency of the appeal in connection with the claim. The claimant will then be given a reasonable opportunity to respond to the evidence or rationale before a decision is announced. This information will be provided free of charge upon request.
- **Decision:** The review will be made by a person different from the person who made the prior determination and such person will not be a subordinate of the prior decision maker.

- **Consultation with Independent Medical or Vocational Expert:** In the case of a claim denied on the grounds of a medical or vocational judgment, a healthcare provider or vocational expert with appropriate training and experience will be consulted. The healthcare provider or vocational expert who is consulted on appeal will not be the individual who was consulted, if any, during the prior determination or a subordinate of that individual. You will be provided with the name and qualifications of the expert(s) that was consulted in the process of the Adverse Benefit Determination. This information will be provided free of charge upon request.

If you disagree with the denial of your claim, you may appeal that decision. Your appeal must be in writing to the Appeals Administrator (see address below). The appeal must state the reason you disagree with the denial of your claim and must be filed within 180 days after you received the notice denying your claim (which is assumed to be three days after the date of such denial letter). If you fail to file an appeal within this timeframe, your claim will be deemed permanently waived and abandoned. You should submit all documents and written arguments you want considered at the review. The Appeals Administrator will not request any records on your behalf.

The Appeals Administrator has 45 days to make a decision on your appeal and to notify you if the denial of your claim is upheld. Under special circumstances, the Appeals Administrator may take up to an additional 45 days to review the appeal if it determines that such an extension is necessary due to matters beyond its control. If an extension of time is required, you will be notified before the end of the initial 45-day period of the circumstances requiring the extension and the date by which the Appeals Administrator expects to render a decision.

If your appeal is denied, in whole or in part, the Appeals Administrator will notify you in writing, in a culturally and linguistically appropriate manner, as required under ERISA. The notice will include the following:

- The specific reason(s) for the denial;
- Reference to the specific Plan provision(s) on which the determination is based;
- 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 statement about your right to bring a civil action under Section 502(a) of ERISA and any applicable contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires;
- An explanation as to why the Plan disagreed with the health care professionals and/or vocational experts who treated you or advised the Plan;
- An explanation as to why the Plan disagreed with the disability determination of the SSA;
- If the decision is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgement applying the terms of this Plan to your medical circumstances or a statement that such explanation will be provided free of charge upon request; and
- Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.

**Additional Information and Extensions of Time Periods**

If the extension of time to decide a claim or an appeal is necessary because you need to submit additional information, you will be given up to 45 days to provide that information, and the time it takes you to provide that information will not count against the time the Claims Administrator or the Appeals Administrator has to make its decision. Inquiries about the extensions of time periods can be made to the Claims Administrator and Appeals Administrator at the address below.

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## CLAIMS ADMINISTRATION CONTACTS

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**Claims Administrator**

Mayo Clinic  
Recovery and Claims Services  
200 First Street SW  
Rochester, MN 55905  
Attn: LTD Claims Administrator

**Appeals Administrator**

Mayo Clinic  
Plan Review Committee  
200 First Street SW  
Rochester, MN 55905

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## GLOSSARY

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### Active Participation

Active participation means:

- You are being treated by a physician trained in assessment and management of your health conditions;
- You are regularly and actively complying with treatment recommendations and participating in all aspects of your treatment program – medication, therapy, testing, and follow up; as documented in your medical record

### Annual Benefit Salary (i.e., base salary)

Annual Benefit Salary means your base salary at the time your Disability commenced. Your Annual Benefit Salary and your base salary do not include any supplements to your base salary including (but not limited to) bonuses, commissions, overtime pay, shift pay, pay for additional shifts, reimbursements, gross up pay, imputed income, or any other extra compensation. Your base salary is determined by using the base salary on the employer's payroll system (e.g., the Oracle payroll system). The Claims Administrator strictly relies on the employer's system data to determine your base salary.

The Claims Administrator also has the sole discretion to interpret your Annual Benefit Salary as your base salary for the purposes of benefit administration.

### Authorized Representative

An individual or organization that is selected by you to represent your interests in all aspects of your claim and/or appeal process.

### Claim

A request for a Plan benefit or benefits made by you in accordance with the Plan's reasonable procedures for filing benefit claims. A formal written request to the Mayo LTD Plan Administrator asking for a payment of LTD benefits constitutes a Claim under this Plan. The Claim is completed by submitting the Mayo Clinic Long-Term Disability Claim Application Form along with supporting medical records/documentation. A request for benefits submitted on the Mayo Clinic Long-Term Disability Claim Application Form will be considered a Claim.

### Disability

Disability means that as a result of illness or injury, your provider deems that you are completely unable to perform the duties of your regular occupation and you are under the regular care of a physician, as supported by objective medical evidence. Disability includes the period of time of the Elimination Period.

### Elimination Period

The period of time between the beginning of a person's disability and the start of long term disability benefits. The elimination period differs for Allied Staff (13 weeks) and Consultants/Voting Staff (26 weeks).

### Illness

A non-occupational sickness or disease (including pregnancy) that commenced while you are covered under the Plan.

**Injury**

A non-occupational accidental bodily injury caused directly and exclusively by external, violent and purely accidental means. The term injury excludes self-inflicted injury, an injury with respect to which benefits are payable under any workers' compensation, occupational disease or similar law or, an illegal occupation or during the commission or attempted commission of an assault or any felony.

**Long Term Disability**

A significant period of disability lasting longer than 13 weeks (Allied Health Staff) or 26 weeks (Consultants/Voting Staff or Allied Health Staff – Special Status category).

**Maximum Benefit Duration**

The maximum period a person who is disabled under the terms of the Plan can receive benefits.

**Mayo Clinic Health System Locations**

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

**Medical Director**

The Medical Director of Recovery and Claims Services, or his or her designee.

**Monthly Benefit**

The amount of Annual Benefit Salary converted to a "per pay period" amount (26 times per year).

**Objective Medical Evidence**

Factual, measurable data derived from medical tests, examinations, and imaging studies that support the disabling symptoms and limitations.

**Onset of a Non-Occupational Illness or Injury**

Means the first appearance of the signs or symptoms of an illness or injury.

**Partial Disability**

- For Consultants/Voting Staff only, an illness or injury that prevents you from performing the material and substantial duties of your occupation on a full-time basis such that your partial disability earnings are at least 20% but not equal to or more than 100% of your pre-disability earnings.
- For Allied Health Staff, an illness or injury that allows you to work with restrictions but prevents you from working your previous FTE, or you need intermittent time off work due to the disability condition. In total, your partial disability benefits may not last beyond a 52-week period.

**Physician**

Means a legally qualified physician. If any part of a period of total disability is caused, to any extent, by a mental condition, "physician" shall mean a legally qualified physician who is:

- Specialized in psychiatry; or
- Trained or experienced to evaluate and treat a mental condition
- A provider deemed qualified by the Claims Administrator

**Regular Care**

Means that you:

- Personally visit a physician as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition(s); and
- Are receiving the most appropriate treatment and care which conform to generally accepted medical standards, for your disabling condition(s) by a physician whose specialty or experience is the most appropriate for your disabling condition(s), according to generally accepted medical standards.

**Short Term Disability**

A period of disability lasting usually not longer than 13 weeks (Allied Health Staff) or 26 weeks (Consultants/Voting Staff or Allied Health Staff – Special Status category).

**Subjective Symptom**

A symptom apparent to the individual afflicted but not observable to others.

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