

3M Retiree

**Health Reimbursement
Arrangement (HRA) Plan**

(Effective January 1, 2013)

Summary Plan Description

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Introduction

This booklet is the summary plan description (“SPD” or “Summary”) for the 3M Retiree Health Reimbursement Arrangement Plan (“Plan”). The official terms of the Plan are contained in a plan document for the Plan. If there are any differences or disagreements between this Summary and the plan document, the plan document will control.

To fully understand your benefits, you must read this Summary carefully. It is important that you read the entire Summary. You should keep this Summary for future reference. Share this Summary with your family, particularly your spouse/domestic partner, and make sure they have read it along with yourself and understand it and your responsibilities. One of your responsibilities is to timely provide any required notice or information as described in this Summary and other benefit communications. Another responsibility is to make sure the Enrollment Administrator has your current mailing address and to timely notify 3M of any change in your address. Failure to follow the terms of the Plan or satisfy any Plan requirements can result in delay, reduction, denial or termination of coverage and/or benefits.

You will notice that certain terms and/or phrases are capitalized throughout this Summary. These terms and/or phrases are important and you should remember them. The capitalized terms and phrases are defined in the Summary.

Neither the receipt of this Summary nor its use of the term “you” indicate that you are eligible for benefits under the Plan. Only those individuals who satisfy the eligibility requirements and other criteria contained in the Plan are eligible for benefits.

The information in this Summary may not be relied on as tax advice for any purpose. 3M does not guarantee any specific tax consequences. Ultimately, it is your responsibility to determine whether each benefit to you under this Plan is excludable for tax purposes. For information on how applicable tax law may apply in your personal situation you should consult your own qualified tax advisor.

3M does not endorse or recommend any particular insurance plan, program, provider or agent. Individuals are encouraged to investigate individual insurance plans themselves and make their own informed decision about which individual insurance plan is best for them. The insurance plan that you select is your own individual plan and is not sponsored or maintained by 3M and is not part of any plan or program established or maintained by 3M.

Neither the terms of the Plan nor the benefits provided under the Plan shall be a term of employment of any individual. This Summary and the Plan shall not be deemed an employment contract. Participation in the Plan does not constitute a guarantee of employment.

Customer Service

**Enrollment and
Advocacy Services
Telephone Number**

Aon Hewitt Navigators: **(877) 458-9656** (toll free)

Aon Hewitt Navigators is available to answer question about enrollment or to assist with claims advocacy.

**Enrollment or
Advocacy Questions?**

Monday through Friday: 8 a.m. - 8 p.m. CST

Hours are subject to change without prior notice.

Website

www.aonhewittnavigators.com/3M

**Enrollment
Administrator Address**

Aon Hewitt Navigators
100 Half Day Road
Lincolnshire, IL 60069-3242

**HRA Claims
Administrator
Telephone Number**

Aon Hewitt Your Spending Account: **(877) 458-9656 option 3** (toll free)

Aon Hewitt Your Spending Account is available to answer question about claims.

HRA Questions?

Monday through Friday: 8 a.m. - 8 p.m. EST

Hours are subject to change without prior notice.

Website

<http://resources.hewitt.com/3M>

**Claims Administrator's
Mailing Address**

Claims review requests, and written inquiries may be mailed to the address below:

Aon Hewitt
Your Spending Account
P. O. Box 785040
Orlando, FL 32878-5040

**Eligibility and
Enrollment Questions**

3M FIRST Line Center
100 Half Day Road
Lincolnshire, IL 60069-3242
Tel: (888) 611-5500 (toll free)
Fax: (847) 883-9313
(847) 883-0483 if outside the United States and Canada
Monday through Friday: 8 a.m. - 6 p.m. CST
Central Standard Time (CST)

COBRA and Direct Bill Questions 3M FIRST Line Center
100 Half Day Road
Lincolnshire, IL 60069-3242
Tel: (888) 611-5500 (toll free)
Fax: (847) 883-9313
(847) 883-0483 if outside the United States and Canada

Monday through Friday: 8 a.m. - 6 p.m. CST
Central Standard Time (CST)

General Human Resource Questions North America HR Service Center
(877) 496-3636 (toll free)
(651) 575-5000 (Twin Cities)

Monday through Friday: 7:30 a.m. - 5 p.m. CST
Central Standard Time (CST)

Eligibility

Retiree Eligibility

A retiree who is eligible for the Plan is an “Eligible Retiree.” An Eligible Retiree who becomes covered under the Plan is a “Participant.”

You are eligible to participate in the Plan only if you:

1. Are eligible for Medicare; and
2. Are classified by 3M or a participating 3M affiliate as “retired” from 3M or a participating 3M affiliate under:
 - a. the 3M Pension Plan Portfolio I or II as applicable to employees not subject to a collective bargaining agreement (“retired” with respect to 3M Pension Plan Portfolio I and II means terminating employment after reaching age 55 with five (5) years of pension service or age 65); or
 - b. the 3M Pension Plan as applicable to employees subject to a collective bargaining agreement (“retired” with respect to the 3M Pension Plan as applicable to employees subject to a collective bargaining agreement means terminating employment after reaching age 55 with ten (10) years of pension service or age 65); or
 - c. the 3M Portfolio III Voluntary Investment Plan as applicable to employees not subject to a collective bargaining agreement (“retired” with respect to 3M Portfolio III Voluntary Investment Plan means terminating employment after reaching age 55 with five (5) years of employment service or age 65); or
 - d. the 3M Savings Plan as applicable to employees subject to a collective bargaining agreement hired or rehired on or after January 1, 2009 (“retired” means terminating employment after reaching age 55 with ten (10) years of employment service or age 65), except for such employees who have participated in the 3M Pension Plan in which case the definition of “retired” means terminating employment after reaching age 55 with ten (10) years of pension service or age 65; or
 - e. the 3M Savings Plan as applicable to employees subject to the collective bargaining agreement hired or rehired before January 1, 2009 who were previously employed by Aearo Technologies LLC (“retired” means terminating employment after reaching age 55 with ten (10) years of employment service or age 65); or
 - f. the 3M Pension Plan and were covered under the 3M Basic Medicare Supplement Plan as of December 31, 2010; and
3. Were classified by 3M or a participating 3M affiliate on both payroll and personnel records at the time of retirement as an active regular common-law employee who was a U.S. salaried or non-union production/maintenance/warehouse employee of 3M or a participating 3M affiliate immediately prior to retirement, or were covered by a collective bargaining agreement that provides for your participation in this Plan.

Rule for certain Imation retirees: An individual classified by 3M or a participating 3M affiliate as an Imation retiree who terminated employment with 3M on June 30, 1996 as part of the Imation spin-off and who as of that date was at least age 50 with ten (10) or more years of pension service (as defined under the 3M Pension Plan) or was at least age 60 and who was hired by Imation in connection with the spin-off and terminated employment with Imation after reaching age 55 is eligible to participate in the Plan at the time he or she becomes Medicare eligible.

Rule for certain Norwest retirees: An individual classified by 3M or a participating 3M affiliate as a Norwest retiree who terminated employment with 3M on June 30, 1999 as part of the sale of Eastern

Heights State Bank, an affiliate of 3M, to Norwest and who as of that date was at least age 40 with ten (10) or more years of pension service (as defined under the 3M Pension Plan) and who was hired by Norwest in connection with the sale and terminated employment with Norwest after reaching age 55 is eligible to participate in the Plan at the time he or she becomes Medicare eligible.

Rule for Portfolio III retirees: A retiree who retired under the 3M Portfolio III Voluntary Investment Plan (VIP) is only eligible to participate in the Plan if he or she has unused credits in his or her Retiree Medical Savings Account at the time he or she becomes Medicare eligible.

Rule for employees subject to a collective bargaining agreement who were hired or rehired on or after January 1, 2009: A retiree who, as an employee, was subject to a collective bargaining agreement and was hired or rehired on or after January 1, 2009 is only eligible to participate in the Plan if he or she has unused credits in his or her Retiree Medical Savings Account at the time he or she becomes Medicare eligible.

Rule for Aearo Technologies LLC employees subject to a collective bargaining agreement: A retiree who was an Aearo Technologies LLC employee subject to a collective bargaining agreement is only eligible to participate in the Plan if he or she has unused credits in his or her Retiree Medical Savings account at the time he or she becomes Medicare eligible.

Rule for CUNO Incorporated employees subject to a collective bargaining agreement: A retiree who was a CUNO Incorporated employee subject to a collective bargaining agreement is only eligible to participate in the Plan if he or she has unused credits in his or her Retiree Medical Savings account at the time he or she becomes Medicare eligible.

Ineligible Retirees

Regardless if you otherwise satisfy the eligibility rules above, you are not eligible to participate in the Plan if:

- You, as an employee, were subject to a collective bargaining agreement unless and to the extent that the agreement provides for your participation;
- You were classified by 3M or a participating 3M affiliate as a temporary employee;
- You were classified by 3M or a participating 3M affiliate as a leased employee, independent contractor, contingent worker, service worker, consultant, contract worker, agency worker, freelance worker, shared employee or a person other than a common law employee, regardless of you actual legal status;
- Your compensation was not reported on a Form W-2 issued by 3M or a participating 3M affiliate;
- You were or are currently covered by a contract or other written agreement that provides you are not eligible for the Plan or employee benefits; or
- You were employed by an affiliate that was not a participating employer.

In addition, the following classes of retirees are not eligible to participate in the Plan regardless of whether they otherwise satisfy the eligibility rules above: (1) retirees who were covered under the Basic Medicare Supplement Plan and exhausted their \$10,000 Plan maximum prior to December 31, 2010; (2) retirees who were placed on a Pre-Retirement Leave status on or before January 1, 1997, subsequently retired from 3M with less than fifteen (15) years of pension service and whose years of pension service are less than the number of years they have been retired; (3) retirees who retired prior to January 1, 1997 from 3M with less than fifteen (15) years of pension service and whose years of pension service are less than the number of years they have been retired; and (4) retirees who became Medicare-eligible prior to

January 1, 2009 and were not enrolled on December 31, 2008 in a 3M retiree medical plan that covered Medicare-eligible retirees.

Retirees who elect not to enroll in the Plan at the time of their retirement and elect to continue coverage under a 3M active employee medical plan through COBRA shall not be eligible to participate in the Plan and cannot enroll in the Plan at a later date, even after COBRA ends.

An individual who became an employee of 3M or a participating 3M affiliate as a result of an acquisition, merger, consolidation or other similar transaction shall not be eligible to participate in the Plan unless the Plan Administrator declares such individual to be eligible.

3M or a participating 3M affiliate's classification of an individual is conclusive and binding for purposes of determining eligibility to participate in this Plan and shall be made solely in the discretion of 3M or a participating 3M affiliate. No reclassification or determination of a person's status with 3M or a participating 3M affiliate, for any reason, without regard to whether it is initiated by a court, governmental agency or otherwise and without regard to whether or not 3M or a participating 3M affiliate agrees to such reclassification or determination, shall make the person retroactively or prospectively eligible for benefits. However, 3M or a participating 3M affiliate, in its sole discretion, may reclassify a person as benefits eligible on a prospective basis. Any uncertainty regarding an individual's classification will be resolved by excluding the person from eligibility.

Dependent Eligibility

An eligible dependent who becomes covered under the Plan is called a "Covered Dependent."

If you are covered under the Plan as an eligible retiree, your eligible dependents also may be covered. You may be asked to provide evidence substantiating dependent status. Failure to provide such proof to the satisfaction of the Enrollment Administrator will result in termination of coverage. In the event your enrolled dependent becomes ineligible for the Plan, you must notify the Enrollment Administrator within 31 days of the event resulting in ineligibility.

For retirees who are classified as eligible under 2a, 2b or 2f as stated above in Retiree Eligibility, your Medicare-eligible dependent(s) (including your spouse) will be eligible to participate in the Plan if:

1. You are a retiree who is eligible to be covered, or who is covered, under a 3M retiree medical plan; or you were covered under the 3M Basic Medicare Supplement Plan and exhausted your \$10,000 Plan maximum prior to December 31, 2010; and
2. You and your dependent(s) are eligible to participate in the Plan at the time of your retirement; and
3. Your dependent(s) satisfies the applicable eligibility requirements for a "spouse," or "dependent child(ren)" as set forth below.

A dependent is eligible for coverage under this Plan only if they were your eligible dependents **at the time of your retirement**. The only dependent that can be added to your medical coverage after you retire is your biological child, a child legally adopted by you, or a child placed for adoption with you. A spouse who was not eligible at the time of your retirement, such as a spouse who you married subsequent to your retirement, is not eligible to participate in this Plan. Domestic partners and children of domestic partners are not eligible dependents for participation in this Plan.

Your eligible dependents include:

1. Your lawfully married spouse

- For your spouse to be eligible, your spouse must be of the opposite sex, the marriage (including a common law marriage) must be recognized as a legally valid marriage by the state in which you reside and must be your spouse at the time of your retirement.

Note: Upon divorce or legal separation, a spouse ceases to be eligible for coverage regardless of whether the divorce decree or court order requires you to provide coverage to your former spouse.

2. Your eligible dependent child(ren)

A child is eligible only if all of the following are met:

- The child is under age 26; and
- The child is:
 - Your biological child; or
 - A child legally adopted by you or placed with you for adoption; or
 - Your stepchild.

Extending a Child's Eligibility Due to Disability

A dependent child's coverage may continue after reaching age 26 if the Claims Administrator approves coverage and determines that:

- The child continues to satisfy the eligibility requirements listed above for dependent children (except for the age requirement); and
- The child is incapable of sustaining employment; and
- The child has a physical or mental disability.

To be eligible for this continued coverage, you must submit an application to your Claims Administrator before the child's 26th birthday providing evidence of the disability. If the disability status is approved, the Claims Administrator will periodically request that you submit proof that your child continues to satisfy all eligibility/disability requirements. Failure to provide requested information may result in loss of coverage for your dependent.

Qualified Medical Child Support Orders

You may be required under a qualified medical child support order (QMCSO) to cover your child under the Plan. If a medical child support order is issued for your child, he or she will be eligible for coverage if the Enrollment Administrator determines that the order is qualified as a QMCSO. You must notify the Enrollment Administrator as soon as possible if an order is issued for your child. The Plan has procedures for determining whether a medical child support order qualifies as a QMCSO. You and your dependents can obtain, without charge, a copy of such procedures from the Enrollment Administrator.

Ineligible Dependents

Ineligible dependents include but are not limited to the following:

- Parents and grandparents.
- Spouses and children of an eligible child.
- Grandchildren unless they meet the child eligibility requirements listed above.
- Foster Children or children in voluntary/temporary care arrangements with the retiree.
- A child for whom the retiree's parental rights have ended in accordance with state law.

- Domestic partners and children of domestic partners.
- A child for whom you have assumed legal responsibility (guardianship).

In addition, the following classes of dependents are not eligible to participate in the Plan regardless of whether they otherwise satisfy the eligibility rules above: (1) dependents who were covered under the Basic Medicare Supplement Plan and exhausted their \$10,000 Plan maximum prior to December 31, 2010; and (2) dependents who were Medicare-eligible prior to January 1, 2009 and on December 31, 2008 were not enrolled in a 3M retiree medical plan that covered Medicare-eligible retirees.

Covering ineligible individuals under the Plan (such as enrolling an ineligible individual as your dependent or failing to notify the Enrollment Administrator that a dependent has ceased to be eligible) or otherwise making a misrepresentation regarding the basis for Plan coverage to 3M, its Plan, or its administrator(s), is a violation of company policy and is considered fraud under the terms of this Plan. The Plan reserves the right to cancel coverage and deny claim payments retroactively as well as recover any and all benefit payments made on behalf of an ineligible individual. In addition, 3M reserves the right to take disciplinary action, up to and including termination from the Plan of the retiree and all dependents and all other civil and criminal recourse, for such actions.

Dependent Eligibility

An eligible dependent who becomes covered under the Plan is called a “Covered Dependent.”

If you are covered under the Plan as an eligible retiree, your eligible dependents also may be covered. You may be asked to provide evidence substantiating dependent status. Failure to provide such proof to the satisfaction of the Enrollment Administrator will result in termination of coverage. In the event your enrolled dependent becomes ineligible for the Plan, you must notify the Enrollment Administrator within 31 days of the event resulting in ineligibility.

For retirees who are classified as eligible under 2c, 2d or 2e as stated above in Retiree Eligibility, your Medicare-eligible dependent(s) (including your spouse or domestic partner) will be eligible to participate in the Plan if:

1. You are a retiree who is eligible to be covered, or who is covered, under a 3M retiree medical plan; or you have exhausted your Retiree Medical Savings Account balance; and
2. You and your dependent(s) are eligible to participate in the Plan at the time of your retirement and
3. Your dependent(s) satisfies the applicable eligibility requirements for a “spouse,” “domestic partner” or “dependent child(ren)” as set forth below.

Dependents are eligible for coverage under this Plan only if they were your eligible dependents **at the time of your retirement**. The only dependent that can be added to your medical coverage after you retire is your biological child, a child legally adopted by you, or a child placed for adoption with you. A spouse or domestic partner who was not eligible at the time of your retirement, such as a spouse who you married subsequent to your retirement, is not eligible to participate in this Plan.

Rule for dependents of Portfolio III retirees: A dependent of an eligible retiree who retired under the 3M Portfolio III Voluntary Investment Plan (VIP) is only eligible to participate in the Plan if he or she has unused credits in his or her Retiree Medical Savings Account at the time he or she becomes Medicare eligible.

Rule for dependents of employees subject to a collective bargaining agreement and were hired or rehired on or after January 1, 2009: A dependent of an eligible retiree who, as an employee, was subject to a collective bargaining agreement and was hired or retired on or after January 1, 2009 is only

eligible to participate in the Plan if he or she has unused credits in his or her Retiree Medical Savings Account at the time he or she becomes Medicare eligible.

Rule for dependents of Aeero Technologies LLC employees subject to a collective bargaining agreement: A dependent of a retiree who was an Aeero Technologies LLC employee subject to a collective bargaining agreement is only eligible to participate in the Plan if he or she has unused credits in his or her Retiree Medical Savings account at the time he or she becomes Medicare eligible.

Rule for dependents of CUNO Incorporated employees subject to a collective bargaining agreement: A dependent of a retiree who was a CUNO Incorporated employee subject to a collective bargaining agreement is only eligible to participate in the Plan if he or she has unused credits in his or her Retiree Medical Savings account at the time he or she becomes Medicare eligible.

Your eligible dependents include:

1. Your lawfully married spouse

- For your spouse to be eligible your spouse must be of the opposite sex and the marriage (including a common law marriage) must be recognized as a legally valid marriage by the state in which you reside.

Note: Upon divorce or legal separation, a spouse ceases to be eligible for coverage regardless of whether the divorce decree or court order requires you to provide coverage to your former spouse.

2. Your eligible domestic partner

Note: Domestic Partner Benefits are not available to retirees in Puerto Rico.

- An individual is eligible as your domestic partner only if one of the following applies:
 - You and your domestic partner are members of the same sex and (1) you are legally married in a state that permits the marriage between members of the same sex, (2) you have entered into a legal, state-sanctioned marriage alternative arrangement between members of the same sex (such as a civil union), or (3) you have registered as domestic partners in a state, county or municipality which has a domestic partner registration process; **OR**
 - You and your domestic partner (1) are members of the same sex, (2) have resided together for at least 12 consecutive months immediately preceding the signing of the required Affidavit and intend to continue to reside together, (3) are not related by blood closer than would bar marriage in your state of residence, are not legally married to anyone, and are the sole partners of each other, (4) are both 18 years of age or older, and are mentally competent to consent to contract, (5) are in a committed relationship of mutual support and are jointly responsible for your common welfare, and (6) reside in a state whose laws do not permit marriage between members of the same sex; **OR**
 - If marriage is available to you and your domestic partner in the state in which you reside, you and your domestic partner must take advantage of that option to be certified as domestic partners. If you move to a state that permits same-sex marriages or the state in which you reside changes from one that does not permit such marriages to one that does, you and your domestic partner must marry within one year of its availability in order to remain certified as domestic partners.

- For your domestic partner to be eligible for coverage, you must submit a domestic partner affidavit and certify your domestic partner's tax status when you add them to coverage and during annual enrollment.

Note: If (1) you terminate your domestic partner relationship, or (2) your domestic partner ceases to satisfy the criteria above for an eligible domestic partner, you must complete a life event or call the Enrollment Administrator.

3. Your eligible dependent child(ren)

A child is eligible only if all of the following are met:

- The child is under the age 26; and
- The child is:
 - Your biological child; or
 - A child legally adopted by you or placed with you for adoption; or
 - Your stepchild; or
 - A child of your domestic partner.
- The value of coverage provided to a child of your domestic partner who is not your qualified tax dependent shall be imputed as income to you and subject to federal income tax. The value of coverage provided to all non-qualified tax dependent children may also be subject to state income taxes. You should consult with your tax advisor for guidance on how the tax laws apply to your situation.
- When adding a domestic partner's child you will be required to certify online as to the tax dependent status of your child. This will also be required during annual enrollment each year. You may also call the Enrollment Administrator to complete the enrollment. If the tax dependent status changes for a child covered under the Plan, you must notify 3M immediately by contacting the Enrollment Administrator.

Extending a Child's Eligibility Due to Disability

A dependent child's coverage may continue after reaching age 26 if the Claims Administrator approves coverage and determines that:

- The child continues to satisfy the eligibility requirements listed above for dependent children (except for the age requirement); and
- The child is incapable of sustaining employment; and
- You provide over half of the child's support during the year, and
- The child has a physical or mental disability.

If you have a child for whom you have assumed legal responsibility, the child must also have the same principal place of residence as you and must be a member of your household.

To be eligible for this continued coverage, you must submit an application to your Claims Administrator before the child's 26th birthday providing evidence of the disability. If the disability status is approved, the Claims Administrator will periodically request that you submit proof that your child continues to satisfy all eligibility/disability requirements. Failure to provide requested information may result in loss of coverage for your dependent.

Qualified Medical Child Support Orders

You may be required under a qualified medical child support order (QMCSO) to cover your child under the Plan. If a medical child support order is issued for your child, he or she will be eligible for coverage if the Enrollment Administrator determines that the order is qualified as a QMCSO. You must notify the Enrollment Administrator as soon as possible if an order is issued for your child. The Plan has procedures for determining whether a medical child support order qualifies as a QMCSO. You and your dependents can obtain, without charge, a copy of such procedures from the Enrollment Administrator.

Ineligible Dependents

Ineligible dependents include but are not limited to the following:

- Parents and grandparents.
- Spouses, domestic partners and children of an eligible child.
- Grandchildren unless they meet the child eligibility requirements listed above.
- Foster Children or children in voluntary/temporary care arrangements with the retiree.
- A child for whom you have assumed legal responsibility (guardianship).
- A child for whom the retiree's parental rights have ended in accordance with state law.

Covering ineligible individuals under the Plan (such as enrolling an ineligible individual as your dependent or failing to notify the Enrollment Administrator that a dependent has ceased to be eligible) or otherwise making a misrepresentation regarding the basis for Plan coverage to 3M, its Plan, or its administrator(s), is a violation of company policy and is considered fraud under the terms of this Plan. The Plan reserves the right to cancel coverage and deny claim payments retroactively as well as recover any and all benefit payments made on behalf of an ineligible individual. In addition, 3M reserves the right to take disciplinary action, up to and including termination from the Plan of the retiree and all dependents and all other civil and criminal recourse, for such actions.

Enrolling in the Plan

If you are eligible, you and your eligible dependents will be automatically enrolled in the Plan upon becoming Medicare-eligible.

Rules For Spouses Who Are Also Eligible Retirees: In the case where both you and your spouse are Eligible Retirees, you may elect either (1) each of you will be a Participant in the Plan and have your own Reimbursement Account, or (2) one of you will be a Participant in the Plan and cover the other as a Covered Dependent, in which case the dependent rules will apply. However, you both cannot cover each other as a Covered Dependent. This means that if your spouse elects to be a Participant, he or she cannot be covered under the Plan as your dependent. Likewise, if you elect to cover your spouse as your Covered Dependent, he or she cannot elect to participate in the Plan as a Participant. If you both elect to be a Participant in the Plan, and you have an eligible child(ren) who is Medicare eligible, then each Participant may cover a child as a dependent but a child can only be covered as a dependent by one Participant, not both.

Effective Date of Coverage

Coverage under the Plan for an Eligible Retiree and Eligible Dependent(s) begins on the date you become Medicare-eligible.

Note: Retirees who elect to continue coverage under a 3M active employee medical plan through COBRA will be ineligible for the 3M Retiree Health Reimbursement Arrangement, even after COBRA ends.

Tax Considerations for Domestic Partners and Domestic Partner's Child(ren)

Eligible Domestic Partner/Domestic Partner Child(ren)

Retirees must understand the federal and state tax implications of enrolling an eligible domestic partner and a domestic partner's child(ren) for employer provided health care coverage who is not a qualified tax dependent.

If your eligible domestic partner/domestic partner's child(ren) meets the definition of tax dependent under the Internal Revenue Code:

- The value of the coverage provided by 3M will be tax-free to you.

If your eligible domestic partner/domestic partner's child(ren) **does not meet** the definition of tax dependent under the Internal Revenue Code:

- The value of the coverage provided by 3M will be treated as taxable income to you and is subject to applicable taxes. However, the value of coverage provided to you and your eligible dependents remains tax-free. For an estimate of the imputed income for domestic partner/domestic child(ren) coverage, call the Enrollment Administrator.

Annual Recertification of Your Domestic Partner and Domestic Partner Child(ren) Tax Status

You will be asked to recertify "tax status" during annual enrollment for any domestic partner or domestic partner's child(ren). Otherwise, your domestic partner's and your domestic partner's child(ren) coverage will default to non-qualified dependent tax status.

Reimbursement Account

A “Reimbursement Account” will be established for a Participant and his/her Covered Dependent(s), if any, at the time the Eligible Retiree becomes a Participant in the Plan. If an Eligible Retiree has an eligible dependent who becomes covered under the Plan prior to the Eligible Retiree becoming covered, the Reimbursement Account will be established at the time the eligible dependent becomes covered under the Plan. A Participant and his or her Covered Dependent(s), if any, will share one Reimbursement Account.

Each Plan Year you are eligible, 3M credits the Reimbursement Account with a specified amount of “HRA Credits” that can be used for reimbursement of Eligible Medical Expenses. During the Plan Year, the Reimbursement Account will be debited for any amount of any reimbursement of Eligible Medical Expenses for any Participant or Covered Dependent up to the number of HRA Credits in the account.

A Participant and any Covered Dependent(s) are not able to contribute to the Reimbursement Account. A dependent may, however, be required to pay the “applicable premium” for continuation of Plan coverage under COBRA. See “General Notice of COBRA Continuation Coverage” section for more information regarding COBRA continuation coverage.

The Reimbursement Account is a notional arrangement, meaning that the HRA Credits do not represent actual contributions made on your behalf and funds are not deposited as the HRA Credits are earned.

Eligible Medical Expenses

”Eligible Medical Expense” is a medical care expense listed below incurred by you or your Covered Dependent(s). The following medical expenses are eligible for reimbursement under this Plan (provided all other terms and conditions of the Plan have been satisfied):

- Premiums for Medicare Part B, a Medigap Plan, a Medicare Advantage Plan, a Medicare Prescription Drug Plan, a dental insurance plan and a vision insurance plan; and
- Co-payments, co-insurance or deductibles under Medicare Part B, a Medigap Plan, a Medicare Advantage Plan, a dental insurance plan or a vision insurance plan; except amounts relating to expenses incurred for prescription drugs are not eligible for reimbursement; and
- Premiums, co-payments, co-insurance or deductibles for a medical insurance plan, a dental insurance plan, a vision insurance plan or a prescription drug plan purchased outside of the United States for a retiree and/or dependent(s) that resides outside of the United States.

All expenses that are not within the scope of “Eligible Expenses” listed above are excluded. “Incurred” means the date the service or treatment is provided, not when the expense arising from the service or treatment is paid. Thus, an expense that has been paid but not incurred (e.g. pre-payment to a physician) will not be reimbursed until the services or treatment giving rise to the expense has been provided.

In no event will the following expenses be eligible for reimbursement:

1. Any expenses that is not a Code Section 213(d) expense;
2. Any expenses incurred for qualified long term care services;
3. Expenses incurred prior to the date that coverage under the Plan becomes effective (not including payments for premiums listed above for health care coverage that begins on or after coverage under the Plan becomes effective);
4. Expenses incurred in year(s) prior to the date that HRA Credits are allocated;
5. Expenses incurred after the date that coverage under the Plan ends; and
6. Expenses that have been reimbursed by another plan or for which you plan to seek reimbursement under another health plan.

HRA Credits

Each Plan Year, as a Participant, you will receive an allocation of HRA Credits to your Reimbursement Account (a “Participant Allocation”). If you have Covered Dependent(s), you will receive one additional allocation of HRA Credits for all your Covered Dependent(s) to your Reimbursement Account (a “Dependent Allocation”). You will only receive one Dependent Allocation regardless of how many Covered Dependents you have.

If an eligible dependent becomes covered under the Plan prior to you becoming covered under the Plan, your Covered Dependent will receive a Dependent Allocation but you will not receive a Participant Allocation until you become a Participant. If you cease to be a Participant in the Plan for any reason, both Participant and Dependent Allocations (if any) shall end, subject to any COBRA rights that may exist. Dependent Allocations will end upon the last Covered Dependent ceasing to be covered under the Plan, subject to any COBRA rights that may exist.

The amount of HRA Credits allocated to your Reimbursement Account is described in Appendix A or Appendix B. HRA Credits are pro-rated for the year in which the Reimbursement Account is established.

Rule For Portfolio II Retirees: A Participant who retired prior to January 1, 2013 under the 3M Portfolio II Pension Plan will receive a one-time HRA allocation equal to the unused credits in his or her Retiree Medical Credits account at the time he or she enrolls in the 3M HRA. The Participant will not receive any Participant or Dependent Allocations until the one-time HRA allocation is spent down. Once the account balance is spent down, annual HRA allocations will commence or, if the Participant had elected the annuity option for Retiree Medical Credits, the account will be credited with an amount of credits equal to that annuity amount ongoing unless the amount in Appendix B is a larger amount.

Rule For Portfolio III retirees: A Participant who retired under the 3M Portfolio III Voluntary Investment Plan (VIP) and has unused credits in a Retiree Medical Savings Account, or a Covered Dependent with unused credits in a Retiree Medical Savings Account, may roll over those unused credits in that account into this Plan upon becoming Medicare eligible provided such individual satisfies all other eligibility requirements for participation in this Plan. A Participant who rolls over any Retiree Medical Savings Account credits into this Plan will be able to spend down those credits in accordance with this Plan, but will not be eligible for any additional Participant or Dependent Allocations. Once the account balance has been spent down, coverage under the Plan will end.

Rule for employees subject to a collective bargaining agreement who were hired or rehired on or after January 1, 2009: A Participant who retired and has unused credits in a Retiree Medical Savings Account, or a Covered Dependent with unused credits in a Retiree Medical Savings Account, may roll over those unused credits in that account into this Plan upon becoming Medicare eligible provided such individual satisfies all other eligibility requirements for participation in this Plan. A Participant who rolls over any Retiree Medical Savings Account credits into this Plan will be able to spend down those credits in accordance with this Plan, but will not be eligible for any additional Participant or Dependent Allocations. Once the account balance has been spent down, coverage under the Plan will end.

Rule for employees subject to a collective bargaining agreement who were hired or rehired before January 1, 2009 and were previously employed by Aeero Technologies LLC: A Participant who retired and has unused credits in a Retiree Medical Savings Account, or a Covered Dependent with unused credits in a Retiree Medical Savings Account, may roll over those unused credits in that account into this Plan upon becoming Medicare eligible provided such individual satisfies all other eligibility

requirements for participation in this Plan. A Participant who rolls over any Retiree Medical Savings Account credits into this Plan will be able to spend down those credits in accordance with this Plan, but will not be eligible for any additional Participant or Dependent Allocations. Once the account balance has been spent down, coverage under the Plan will end.

Rule for individuals previously covered by The 3M Basic Medicare Supplement Plan: A Participant or Covered Dependent who was covered under the 3M Basic Medicare Supplement Plan (“Supplement Plan”) as of December 31, 2010 will have an opening balance equal to the Supplement Plan’s lifetime reimbursement limit (generally \$10,000) minus the sum of all benefits previously paid on that individual’s behalf under the Supplement Plan as of July 31, 2010. The individual will be able to spend down these credits in accordance with this Plan, but will not be eligible for any additional Participant or Dependent Allocations. Once the account balance has been spent down, coverage under the Plan will end for that individual.

Rule for short service retirees: Participants who had less than 15 years of 3M pension service at Retirement and retired or took pre-retirement leave before January 1, 1997 (“Short Service Retirees”) and their Covered Dependent(s), will only receive Participant and Dependent Allocation of HRA Credits if the Participant subsequently retired from 3M with less than fifteen (15) years of pension and the number of years they have been retired does not exceed their years of 3M pension service. This means that Short Service Retirees are subject to a maximum number of Participant and Dependent Allocations. For example, a Short Service Retiree with only 13 years of 3M pension service at retirement in 1997 would be ineligible for an allocation in 2012 whereas a Short Service Retiree with only 13 years of pension service at retirement in 2001 would be eligible for an allocation through 2013.

Rule for 3M Purification Inc. non union retirees: HRA Credits for Participants who retired from 3M Purification Inc. (formerly known as CUNO), or were a 3M Purification Inc. employee who retired from a participating affiliate, on or after December 1, 2008 are based on 3M pension service beginning December 1, 2008.

Rule for 3M Purification Inc. employees subject to a collective bargaining agreement: A Participant who retired and has unused credits in a Retiree Medical Savings Account, or a Covered Dependent with unused credits in a Retiree Medical Savings Account, may roll over those unused credits in that account into this Plan upon becoming Medicare eligible provided such individual satisfies all other eligibility requirements for participation in this Plan. A Participant who rolls over any Retiree Medical Savings Account credits into this Plan will be able to spend down those credits in accordance with this Plan, but will not be eligible for any additional Participant or Dependent Allocations. Once the account balance has been spent down, coverage under the Plan will end. HRA Credits for Participants who retired from 3M Purification Inc. (formerly known as CUNO), or were a 3M Purification Inc. employee who retired from a participating affiliate, on or after January 1, 2012 are based on 3M pension service beginning January 1, 2012.

Rule for surviving spouses/dependent(s): Upon the death of a Participant, Participant and Dependent Allocations shall cease, except that any remaining Covered Dependents will be eligible for one annual Dependent Allocation for the year following the Participant’s death. Covered Dependents may continue to spend down any HRA Credits, but will not receive any future allocations, subject to any COBRA rights that may exist. Once the HRA Credits are completely spent down, coverage will end for the Covered Dependents.

Claims Procedures

Reimbursement from Reimbursement Account

Claims can be submitted online or you can obtain a reimbursement form from the Claims Administrator. You must complete the reimbursement form and submit it to the Claims Administrator with a copy of a cancelled check or bank statement (i.e. proof of payment), a copy of your insurance premium bill or an EOB (explanation of benefits) or, if no EOB is provided, a written statement or receipt from the service provider. The written statement from the service provider must contain the following: a) the name of the patient, b) the date service or treatment was provided, c) a description of the service of treatment; and d) the amount incurred.

Your claim is deemed filed when it is received by the Claims Administrator. If your claim for reimbursement is approved, you will be provided reimbursement as soon as reasonably possible following the determination.

The maximum reimbursement amount that you can receive is equal to your Reimbursement Account balance at the time the request for reimbursement is processed.

Denied Reimbursement from Reimbursement Account

If you are denied a benefit under the Plan, you should proceed in accordance with the following claims review procedures:

Step 1: *Notice is received from Claims Administrator.* If your claim is denied, you will receive written notice from the Claims Administrator that your claim is denied as soon as reasonably possible but no later than 30 days after receipt of the claim. For reasons beyond the control of the Claims Administrator, the Claims Administrator may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the notice of the extension to obtain that information. The time period during which the Claims Administrator must make a decision will be suspended until you provide the information or the end of the 45-day period, whichever comes first.

Step 2: *Review your notice carefully.* Once you have received your notice from the Claims Administrator, review it carefully. The notice will contain:

- The reason(s) for the denial and the Plan provisions on which the denial is based;
- A description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- A description of the Plan's appeal procedures and the time limits applicable to such procedures; and
- A right to request all documentation relevant to your claim.

Step 3: *If you disagree with the decision, file an Appeal.* A claimant has a right to appeal an adverse benefit determination under these claims procedures. These appeal procedures provide a claimant with a reasonable opportunity for a full and fair review of an adverse benefit determination. A claimant must exhaust these appeal procedures before commencing any legal action in state or federal court. The Plan Administrator will follow these procedures when deciding an appeal:

1. A claimant must file an appeal within 180 days following receipt of a notice of an adverse benefit determination within which to appeal the determination;
2. A claimant will have the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
3. The individual who reviews and decides the appeal will be a different individual than the individuals who made the initial benefit decision and will not be a subordinate of that individual;
4. The Plan Administrator will give no deference to the initial benefit decision;
5. The Plan Administrator will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit decision;
6. The Plan Administrator will provide the claimant, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim, any internal rule, guideline, protocol or similar criterion relied upon in making the initial benefit decision; and applying the terms of the Plan to the claimant's benefit.

A claimant must file an appeal within 180 days following receipt of the notice of an adverse determination. A claimant's failure to comply with this important deadline may cause the claimant to forfeit any right to any further review under these claims procedures or in a court of law. An appeal is filed when a claimant (or authorized representative) submits a written request for review to the Plan Administrator. A claimant is responsible for submitting proof that the claim for benefits is covered and payable under the Plan.

Step 4: *Notice of Denial is received from Plan Administrator.* The Plan Administrator will provide the claimant with written notice of the appeal decision. The notification will include the reason for the adverse benefit determination, reference to the relevant plan provision(s) and other information as required by ERISA. The Plan Administrator will decide the appeal within a reasonable period, but no later than 60 days after receipt of the written request for review. If the claimant does not receive a written response to the appeal within 60 days the claimant may assume that the appeal has been denied. The decision by the Plan Administrator on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. These claims procedures must be exhausted before any legal action is commenced.

Important Information

Other important information regarding your appeals:

If you file your claim within the required time, complete the entire claims procedure, and your appeal is denied, you may sue over your claim (unless you have executed a release of your claim). You must, however, commence that suit within 30 days after you knew or reasonably should have known of the facts behind your claim or, if earlier, within 6 months after the claims procedure is complete.

Coordination of Benefits

Only medical care expenses that have not been or will not be reimbursed by any other source may be Eligible Medical Expenses (to the extent all other conditions for Eligible Medical Expenses have been satisfied). As such, the Plan does not coordinate benefits with any other group or individual health coverage except as provided herein.

When Coverage Ends

Coverage for you will end upon any of the following:

- Your retiree status ends;
- The Plan is terminated or amended such that you are no longer eligible for coverage;
- You no longer meet the eligibility requirements;
- You elect to end coverage;
- Your death;
- You attempt to obtain benefits fraudulently for yourself or others (such as enrolling an ineligible dependent) or otherwise violate the terms of the Plan as determined by the Plan Administrator;

Coverage for your covered dependents will end upon any of the following:

- Your coverage ends;
- Your portion of the required premium, contribution or other required payment is not paid timely;
- The Plan is terminated or amended such that your covered dependent is no longer eligible for coverage;
- Your covered dependent no longer meets the eligibility requirements;
- Your covered dependent elects to end coverage;
- Your covered dependent's death;
- Your covered dependent attempts to obtain benefits fraudulently for himself/herself or others or otherwise violate the terms of the Plan as determined by the Plan Administrator.

Generally, coverage for a Covered Dependent that ceases to be eligible ends on the last day of the month that the dependent no longer meets the dependent eligibility requirements. Retirees and dependents should notify the Enrollment Administrator when an Eligible or Covered Dependent ceases to be eligible.

No future HRA Credits will be allocated to your account once coverage ends. You are able to submit claims for reimbursement for Eligible Medical Expenses until the account balance has been spent down.

No future HRA Credits will be allocated to the Reimbursement Account for Covered Dependent(s) once coverage ends for the last Covered Dependent. As described below, in some circumstances, your Covered Dependents may be entitled under COBRA to continue coverage that would otherwise end.

In addition, as described elsewhere in the Summary, benefits may not be payable or may be reduced, terminated or suspended under certain circumstances even if you are otherwise covered under the Plan.

If coverage ends for you or your dependents a temporary extension may be available in certain circumstances. See the "Continuing Your Coverage" section for more information.

Continuing Your Coverage

General Notice of COBRA Continuation Coverage

COBRA continuation coverage is a temporary extension of coverage under a 3M group health plan (“Plan”) after you or your family loses coverage in certain circumstances. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). If you have questions about your COBRA continuation rights, please contact the Enrollment Administrator.

COBRA continuation coverage is available under the Plan. COBRA continuation coverage can become available to you and your family members when you and your family members would otherwise lose health coverage under the Plan due to certain events. This section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

COBRA Eligibility

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” After a qualifying event (and any required notice of that event is properly provided), COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” Generally, in an employee health plan, only your spouse and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. As discussed below, there is one circumstance in which you could be a qualified beneficiary as well. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are the spouse of a retiree, you will become a qualified beneficiary if you lose coverage under the Plan because any of the following qualifying events occur:

- Your spouse dies.
- You become divorced or legally separated from your spouse. (Also, if an employee eliminates coverage for his or her spouse in anticipation of a divorce or legal separation, the ex-spouse may still be entitled to COBRA continuation coverage even though he or she lost coverage before the divorce or legal separation. It is therefore important for the ex-spouse to notify 3M of the divorce or legal separation even if coverage had been eliminated earlier. The ex-spouse will need to follow the procedures outlined below for providing such notice.)

Your dependent children (including children participating under a Qualified Medical Child Support Order) will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events occur:

- Parent- retiree dies;
- Parents become divorced or legally separated.
- Child stops being eligible for coverage under the Plan as a dependent child.

Under COBRA, if you are a retiree, you can only become a qualified beneficiary in the very unlikely event that 3M files for a proceeding in bankruptcy under Title 11 of the United States Code. If a proceeding in bankruptcy were filed, and if you and/or any family members lose coverage within one year before or after, and as a result of, the bankruptcy filing, you, your spouse and your dependents will become qualified beneficiaries.

Notification of COBRA Continuation Coverage Election

You Must Give Notice of Some Qualifying Events

You must notify 3M of certain qualifying events. These events include the divorce or legal separation of the retiree and spouse, and a dependent child's losing eligibility for coverage. A COBRA election will be available only if you, your spouse or your dependent notify 3M of the qualifying event within 60 days after the later of (1) the date of the qualifying event and (2) the date on which your spouse or your dependent loses (or would lose) coverage under the terms of the plan as a result of the qualifying event. The next paragraphs explain the procedure to provide this notice.

Retirees and qualified beneficiaries should notify 3M of the qualifying event by calling the Enrollment Administrator. You must notify the Enrollment Administrator of the qualifying event by the 60 day deadline described above. The 60-day period is extended to the next business day if the last day of the 60-day election period falls on a Saturday, Sunday, or legal holiday. On the call you will be asked to furnish your name, the names of all qualifying beneficiaries affected by the event, the qualifying event that has occurred, the date of the qualifying event, and your address and the addresses of any qualifying beneficiaries who do not live with you. You may be required to submit evidence of the qualifying event.

If you are not a 3M retiree, you should notify 3M of the qualifying event in writing by completing a Qualified Beneficiary Notice Form. To request a Qualified Beneficiary Notice Form, call the Enrollment Administrator.

If mailed, the Qualified Beneficiary Notice Form must be postmarked no later than the deadlines described above. If faxed, the Qualified Beneficiary Notice Form must be sent by the deadlines described above. To complete the Qualified Beneficiary Notice Form, you will have to furnish your name, the names of all qualifying beneficiaries affected by the event, the qualifying event that has occurred, the date of the qualifying event, and your address and the addresses of any qualifying beneficiaries who do not live with you. If you are notifying 3M of a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation. You may be required to submit other or additional evidence of the qualifying event.

You must provide notice in a timely manner. If you, your spouse or your dependent fails to provide notice in the manner outlined above during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage.

Election of COBRA Coverage

Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Retirees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. You (and any qualified beneficiary) will have 60 days after the date of the COBRA election notice (or, if later, 60 days after the date coverage is lost) to decide whether to elect COBRA under the Plan. For each qualified beneficiary who timely elects COBRA continuation coverage, COBRA continuation coverage will begin on the date coverage under the Plan would otherwise end.

Procedures to Elect COBRA Continuation Coverage

After proper and timely notice of a qualifying event, you will be sent a COBRA Enrollment Notice. To elect COBRA continuation coverage, you, your spouse or your dependents must complete the enrollment election by calling the Enrollment Administrator within 60 days from the date of the COBRA Enrollment

Notice (or, if later, the date coverage is lost) according to the directions on the form. If you (on behalf of your spouse or dependents) or your spouse and dependent children do not elect continuation coverage within this period, your spouse and/or dependents will not receive continuation coverage. If mailed, your enrollment election must be post-marked no later than the last day of the 60-day election period or no later than the date on the election form.

Special Considerations in Deciding Whether to Elect COBRA

If your spouse or your dependents experience a qualifying event, in considering whether to elect COBRA continuation coverage, they should take into account that a failure to continue group health coverage under the Plan will affect their future rights under federal law. First, they can lose the right to avoid having pre-existing condition exclusions applied to them by other group health plans if they have more than a 63-day gap in health coverage, and election of COBRA continuation coverage may help them not have such a gap. Second, they will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if they do not elect and remain covered under COBRA continuation coverage for the maximum time available to them. Finally, they should take into account that they have special enrollment rights under federal law. They have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by their employer) within 30 days after their group health coverage ends because of a qualifying event. They will also have the same special enrollment right at the end of COBRA continuation coverage if they remain covered under COBRA continuation coverage for the maximum time available to them.

Length of COBRA Continuation Coverage

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the retiree, your divorce or legal separation, or a dependent child losing eligibility, COBRA continuation coverage lasts for up to 36 months.

Cost of Continuation Coverage

Each qualified beneficiary will be required to pay the entire cost of COBRA continuation coverage plus a 2% administrative fee. The amount of COBRA premiums can be increased from time to time during your period of COBRA coverage to the extent permitted by federal law.

In the case of a death, the surviving spouse and dependents may be eligible for COBRA coverage under the medical plan at a subsidized rate for a limited period of time, after which you will be charged full COBRA rates for coverage. For more information, you should call the Enrollment Administrator.

Payment for COBRA Continuation Coverage

Your spouse and/or dependents will not be considered to have made any COBRA payment if their check is returned due to insufficient funds or otherwise.

First payment for COBRA continuation coverage

If your spouse and/or dependents elect COBRA continuation coverage, no payment has to be sent at the time of the enrollment election. However, the first payment for COBRA continuation coverage must be made not later than 45 days after the date of their election. (This is the date the enrollment election is post-marked, if mailed.) If they do not make their first payment for COBRA continuation coverage in full within 45 days after the date of their election, they will lose all COBRA continuation coverage rights under the Plan. They are responsible for making sure that the amount of the first payment is correct. To confirm the correct amount of their first payment, you can call the Enrollment Administrator.

At the time of their election they will be told where to send their first payment.

Periodic payments for COBRA continuation coverage

After your spouse and/or dependents make their first payment for COBRA continuation coverage, they will be required to make payments for each subsequent month of coverage. Under the Plan, these periodic payments for COBRA continuation coverage are due on the first of each month. If mailed, COBRA payment must be postmarked on or before the first of the month to be timely. If they make a periodic payment on or before the first day of the month to which it applies, their coverage under the Plan will continue for that month without any break. The Plan may not send periodic notices of payments due each month. Periodic payments for COBRA continuation coverage should be sent to the same address as the first payment.

Grace periods for periodic payments

Although periodic payments are due on the first of each month, they will be given a grace period of 30 days after the first day of the month to make each periodic payment. Their COBRA continuation coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. If mailed, COBRA payment must be postmarked on or before the end of the grace period.

If they fail to make a periodic payment before the end of the grace period for that month, they will lose all rights to COBRA continuation coverage under the Plan. If COBRA continuation coverage is cancelled for nonpayment, coverage will not be reinstated and they will have no further rights to COBRA continuation coverage.

Termination of COBRA Continuation Coverage Before the End of the Maximum Coverage Period

COBRA continuation coverage will automatically terminate before the end of the maximum period if (1) any required premium is not paid in full on time, (2) after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan (but only after any preexisting condition exclusions of that other plan for a pre-existing condition of the qualified beneficiary have been exhausted), (3) after electing COBRA continuation coverage, a qualified beneficiary becomes entitled to Medicare (Part A, Part B or both), or (4) the employer ceases to provide any group health plan for its employees. COBRA continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA continuation coverage (such as fraud).

If your spouse and/or dependents become covered under another group health plan or they enroll in Medicare, they must notify the Enrollment Administrator immediately. You, your spouse or your dependent should contact the Enrollment Administrator.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Enrollment Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you or a family member send to the Enrollment Administrator.

Employee Retirement Income Security Act (ERISA) Statement of Rights

As a participant in the Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants will be entitled to:

- **Receive Information About Your Plan and Benefits**
 - Examine without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts, and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
 - Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.
 - Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

- **Continue Group Health Plan Coverage**
 - Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your continuation coverage rights.
 - Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health Plan if you have creditable coverage from another Plan. You should be provided a certificate of creditable coverage, free of charge, from your group health Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect continuation coverage, when your continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for up to 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating certain rights for the Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court after exhausting the Plan's appeal procedure. In addition, if you should disagree with the Plan's decision or lack thereof concerning the qualified status of domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that the fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds that your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue Northwest, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Important Plan Information

Plan Administrator

The Plan Administrator shall have the discretionary power and authority to (1) control and manage the operation of the Plan, (2) prescribe applicable Plan procedures, (3) make all decisions and determinations with respect to the Plan, and (4) interpret and apply the terms of the Plan. This discretionary power and authority includes, without limitation, determining all factual and legal questions, interpreting any ambiguous or unclear terms in the Plan and the underlying documents, deciding eligibility for coverage and eligibility for benefits and establishing rules to carry out administration of the Plan. All determinations, interpretations, rules and decisions of the Plan Administrator will be made, in its sole discretion, and will be final, conclusive and binding as to all parties. In any legal action, all explicit and all implicit determinations by the Plan Administrator shall be afforded the maximum deference permitted by law. The Plan Administrator may delegate all or a portion of its powers, authority, responsibilities, discretion and rights under the Plan to an individual, entity or committee. Any delegation may, if specifically stated, allow further delegation by the individual, entity or committee to whom the delegation has been made. The Plan Administrator reserves the right to correct any errors, defects, inconsistencies and omissions that may occur in the administration of the Plan as the Plan Administrator, in its discretion, determines appropriate, including reducing or eliminating benefits under the Plan, and such correction shall be final and binding all persons. Subject to any delegation of authority, the Plan Administrator shall be the named fiduciary for the purposes of ERISA.

Claims Administrator

The Plan Administrator has contracted with the Claims Administrator to assist in the handling of benefit determinations under the Plan and to provide assistance in the administration of the Plan. The Claims Administrator will have the authority to make benefit determination under the Plan and direct payments with respect to the Plan, and will have such other responsibility and authority as delegated by the Plan Administrator.

Enrollment Administrator

The Plan Administrator has contracted with the Enrollment Administrator to assist with enrollment of individuals in the Plan and to make enrollment determinations. The Enrollment Administrator will have the authority to make enrollment determinations under the Plan, and will have other responsibilities and authority as delegated by the Plan Administration.

Benefit Determinations

The Plan Administrator delegates its full and final discretionary power and authority with respect to benefit determinations to the Claims Administrator. This power and authority includes, without limitation, determining all factual and legal questions, interpreting any ambiguous or unclear terms in the Plan and the underlying documents, determining the amount of benefits, if any, to which an individual is entitled to under the Plan, deciding the manner and terms of payment, prescribing forms to be used and procedures to be followed in applying for benefits and appealing any adverse benefit decision under the Plan, and deciding all claims for benefits, adverse benefit determinations and appeals. The Claims Administrator has discretionary authority to grant or deny benefits under the Plan. Benefits under the Plan shall only be paid if the Claims Administrator decides, in its discretion, that an individual is entitled to them. With respect to benefit determinations, all determinations, interpretations, rules and decisions of the Claims Administrator shall be final, conclusive and binding as to all parties. This delegation of authority shall not, however, apply to determinations pertaining to eligibility to participate in the Plan, which shall remain with the Plan Administrator. With respect to its delegated authority, the Claims Administrator is a named fiduciary under the Plan.

Amendment or Termination

3M reserves the right to amend and terminate the Plan in whole or in part, at any time and in any respect and for any reason and either prospectively or retroactively or both. 3M's right to amend or terminate the Plan includes, without limitation, changes in the eligibility requirements, cost-sharing and funding arrangements, benefits provided and termination of all or a portion of the coverage provided under the Plan. No oral statements or representations can amend the Plan. 3M makes no promise to continue the Plan or the benefits offered under the Plan in the future, and individuals have no vested right to the Plan or the benefits offered under the Plan.

Benefit Adjustments

The Plan Administrator, in its discretion, may restrict enrollment and/or adjust an individual's benefits to enable the Plan to comply with requirements imposed by the law or required to comply with nondiscrimination provisions of an applicable law, including without limitation ERISA or the Internal Revenue Code. In addition, all benefits payable under the Plan are subject to set-off for any debts owed by an individual to the Plan or 3M to the extent permitted by law as well as for any reimbursement rights the Plan has against the individual or a third party.

Recovery of Overpayment

If a benefit payment to you or on your behalf exceeds for any reason the benefit amount you are entitled to receive in accordance with the terms of the Plan, the Plan Administrator has the right to require the return of the overpayment on request, and upon request you must immediately refund the overpayment as well as help the Plan Administrator obtain the refund of the overpayment from another person or entity. This includes any overpayment resulting from retroactive awards received from any source, fraud or any error made in processing your claim. The Plan Administrator also has the right, at its option, to recover the overpayment by reducing or offsetting against any future benefit payments. Such rights do not affect any other right of recovery the Plan Administrator may have with respect to such overpayment and the Plan Administrator reserves the right to obtain the overpayment by any other method permitted by the law. The Plan Administrator will determine in its sole discretion the method by which the repayment of the overpayment shall be made.

Assignment Prohibited

Except as permitted by this Summary or the Plan Administrator, no individual shall have any transmissible interest in any benefit under the Plan or any power to anticipate, alienate, dispose of, pledge or encumber the same, nor shall 3M recognize an assignment thereof, either in whole or in part, nor shall any benefit be subject to attachment, garnishment, execution following judgment or other legal process.

Misconduct

If the Plan Administrator determines that an individual has engaged in fraud or made misrepresentations with respect to the Plan, engaged in illegal behavior in connection with the Plan, failed to provide requested information or sign any required documentation, failed to cooperate with 3M or the Plan, or otherwise engaged in behavior determined by the Plan Administrator to be detrimental or adverse to the Plan, the Plan Administrator reserves the right to terminate coverage under the Plan for the individual and that individual's dependents. In the case of fraud or an intentional misrepresentation of a material fact, the Plan Administrator reserves the right to rescind coverage and deny claim payments retroactively as well as recover any and all benefit payments already made. 3M also reserves the right to take disciplinary action and all other civil and criminal recourse for such actions.

Right to Information

The Plan Administrator and Claim Administrator shall have the right to require any person claiming eligibility to participate in, or benefits under, the Plan to (a) furnish any information or documentation it determines necessary, (b) certify or sign an affidavit attesting to certain facts, and (c) undertake a medical examination or an autopsy in the case of death. These rights are in addition to, not in lieu of, any rights of the Plan Administrator and Claims Administrator set forth in the Summary.

Funding

The Reimbursement Account is a notional arrangement. The arrangement is simply a bookkeeping device that allows 3M and you to keep track of HRA Credits allocated to your account and reimbursements made to you under the Plan. You do not have an interest in the HRA Credits. You have no property rights in the Reimbursement Account. The Reimbursement Account is not funded, nor does it bear interest or accrue earnings of any kind. HRA Credits cannot be paid out to an individual or used for any other purpose than described in the Plan.

3M has established a separate trust fund, called a Voluntary Employees' Beneficiary Association (VEBA), to pay for benefits provided through the 3M Health Reimbursement Arrangement Plan. As noted above, although benefits may be paid through the VEBA, the HRA Credits are not held in trust. To the extent that any self-funded benefits are not funded through a VEBA or other trust, 3M will pay such benefits directly from its general assets.

Plan Expenses

3M may pay the expenses of administering the Plan; however, if 3M does not pay for an expense, then the expense shall be paid out of Plan assets.

Governing Law

The Plan shall be construed in accordance with the applicable provisions of ERISA and the Internal Revenue Code and, to the extent not preempted by federal law, in accordance with the laws of the State of Minnesota. Any litigation commenced or arising in connection with the Plan shall be commenced and venued exclusively in the United States District Court for the District of Minnesota.

Unclaimed Property

Any benefit payments that are unclaimed (for example, uncashed benefit checks) by the close of the Plan Year following the Plan Year in which the expense was incurred shall be forfeited.

Satisfaction of Claims

Any payment to or for the benefit of any individual, legal representative or person chosen in accordance with the provisions of the Plan shall, to the extent of the payment, be in full satisfaction of all claims against the Plan and 3M, either of which may require the payee to execute a receipted release as a condition precedent to the payment.

Collective Bargaining Agreement

The Plan covers both eligible union and non-union retirees. The part of the Plan that covers eligible union retirees is maintained pursuant to one or more collective bargaining agreements with unions representing employees of 3M and participating affiliates. A copy of the applicable collective bargaining agreement as well as a complete list of employers sponsoring the Plan and unions whose members may be eligible to participate in the Plan as retirees may be obtained by a participant or beneficiary upon written request to the Plan Administrator, or may be examined at the Total Compensation Resource Center during normal business hours upon reasonable notice. There may be a charge for copying.

Privacy of Protected Health Information

Effective April 14, 2003, the Plan became subject to federal privacy requirements established by the Health Insurance Portability & Accountability Act of 1996 (“HIPAA Privacy Rules”), which require the Plan to protect the privacy of information about your health and that of your dependents. The Plan is permitted under the HIPAA Privacy Rules to share your and your dependents’ protected health information with 3M Company and third parties (including the Claims Administrator) for certain purposes, such as operation of the Plan and payment of claims. For more information, you should review the Plan’s Notice of Privacy Practices. You have a right to request a copy of this notice.

Plan Name: 3M Retiree Health Reimbursement Arrangement Plan, a component of the 3M Retiree Welfare Benefit Plan.

Type of Plan: The Plan is a welfare benefit plan providing retiree health care benefits.

Plan Year: The plan year is the calendar year beginning each January 1 and ending each December 31.

Plan Number: 522

Employer/Plan Sponsor: 3M Company
3M Center
224-2W-15
St. Paul, MN 55144
(877) 496-3636 (toll free)
(651) 575-5000 (Twin Cities)

Participating Employers: You may obtain a complete listing of participating companies and subsidiaries by contacting the Plan Administrator.

Plan Sponsor's Employer Identification Number: 41-0417775

Plan Administrator: 3M's Vice President, Global Compensation and Benefits or his or her successor, is the Plan Administrator.

Global Compensation and Benefits
3M Company
3M Center
St. Paul, MN 55144-1000
(877) 496-3636 (toll free)
(651) 575-5000 (Twin Cities)

Enrollment Administrator: Aon Hewitt Navigators
100 Half Day Road
Lincolnshire, IL 60069-3242
(877) 458-9656 (toll free)

Claims Administrator: Aon Hewitt
Your Spending Account
P.O. Box 785040
Orlando, FL 32878-5040
(877) 458-9656 (toll free) option 3

Trustee:

Bank of New York Mellon
135 Santilli Highway
Everett, MA 02149
(617) 722-7000

Agent for Services of Legal Process:

3M Company
3M Center
Secretary
224-2W-15
St. Paul, MN 55144

Service of legal process may also be made on the Plan Administrator and the Trustee.

APPENDIX A

HRA CREDITS FOR PORTFOLIO I OR A COLLECTIVE BARGAINING UNIT EMPLOYEE HIRED, REHIRED BY 3M U.S. BEFORE JAN. 1, 2001

The 2013 HRA Credits allocation are noted in the charts below based on your 3M pension service, retirement eligibility and retirement date.

This chart applies if you retired from 3M before Jan. 1, 2009 or were eligible to retire from 3M as of Jan.1, 2009.		
Years of 3M Pension Service at Retirement	Participant Allocation	One Dependent Allocation for all Covered Dependent(s)
15+	\$1,800	\$1,800
14	\$1,688	\$1,688
13	\$1,576	\$1,576
12	\$1,463	\$1,463
11	\$1,350	\$1,350
10	\$1,238	\$1,238
9	\$1,126	\$1,126
8	\$1,014	\$1,014
7	\$900	\$900
6	\$788	\$788
5 or less	\$676	\$676

This chart applies if you were not eligible to retire from 3M as of Jan. 1, 2009.		
Years of 3M Pension Service at Retirement	Participant Allocation	One Dependent Allocation for all Covered Dependent(s)
15+	\$1,800	\$1,350
14	\$1,688	\$1,267
13	\$1,576	\$1,181
12	\$1,463	\$1,097
11	\$1,350	\$1,014
10	\$1,238	\$929
9	\$1,126	\$845
8	\$1,014	\$759
7	\$900	\$676
6	\$788	\$591
5 or less	\$676	\$507

APPENDIX B

HRA CREDITS FOR PORTFOLIO II (including those who retired from Transitional Retirement or Bridge to Retirement status) OR A COLLECTIVE BARGAINING UNIT EMPLOYEE HIRED, REHIRED BY 3M U.S. ON OR AFTER Jan. 1, 2001 and prior to January 1, 2009

The 2013 HRA Credits allocation are noted in the charts below based on your 3M pension service, retirement eligibility and retirement date.

This chart applies if you retired from 3M before Jan. 1, 2009.		
Years of 3M Pension Service at Retirement	Participant Allocation	One Dependent Allocation for all Covered Dependent(s)
15+	\$1,800	\$1,800
14	\$1,688	\$1,688
13	\$1,576	\$1,576
12	\$1,463	\$1,463
11	\$1,350	\$1,350
10	\$1,238	\$1,238
9	\$1,126	\$1,126
8	\$1,014	\$1,014
7	\$900	\$900
6	\$788	\$788
5 or less	\$676	\$676

This chart applies if you were eligible to retire from 3M as of Jan. 1, 2009.		
Years of 3M Pension Service at Retirement	Participant Allocation	One Dependent Allocation for all Covered Dependent(s)
15+	\$1,126	\$1,126
14	\$1,056	\$1,056
13	\$985	\$985
12	\$915	\$915
11	\$845	\$845
10	\$775	\$775
9	\$703	\$703
8	\$633	\$633
7	\$562	\$562
6	\$493	\$493
5 or less	\$422	\$422

This chart applies if you were not eligible to retire from 3M as of Jan. 1, 2009.

Years of 3M Pension Service at Retirement	Participant Allocation	One Dependent Allocation for all Covered Dependent(s)
15+	\$1,126	\$845
14	\$1,056	\$791
13	\$985	\$739
12	\$915	\$685
11	\$845	\$633
10	\$775	\$580
9	\$703	\$527
8	\$633	\$475
7	\$562	\$422
6	\$493	\$369
5 or less	\$422	\$316