



3M Retiree Health Reimbursement Arrangement (HRA) Plan – Medicare Eligible

Summary Plan Description

Effective January 1, 2016

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Introduction

Overview

This is the summary plan description ("SPD" or "Summary") for the 3M Retiree Health Reimbursement Arrangement (HRA) Plan – Medicare Eligible ("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 any dependents covered under this Plan, 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 to participate in the Plan or receive benefits under the Plan. Only those individuals who satisfy the eligibility requirements and other criteria contained in the Plan are eligible to participate in the Plan. Further, participation in the Plan is not a guarantee of benefits under the Plan.

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 coverage and benefits provided under this Plan are excludable for tax purposes. For information on how applicable tax law may apply to your personal situation you should consult your own qualified tax advisor.

3M does not endorse or recommend any particular insurance plan. 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

Overview

Support and Advocacy Services	<p>Aon Retiree Health Exchange (formerly Aon Hewitt Navigators) is available to answer questions or assist with claims advocacy</p> <p>Aon Retiree Health Exchange 475 Bond St. Lincolnshire, IL 60069</p> <p>P.O. Box 1412 Lincolnshire, IL 60069</p> <p>Tel: (877) 458-9656 (toll free) Monday through Friday: 8 a.m. - 8 p.m. CST Hours are subject to change without prior notice</p> <p>www.aonhewittnavigators.com/3M</p>
HRA Claims Administrator	<p>Aon Hewitt Your Spending Account is available to answer questions about claims.</p> <p>Claims review requests, and written inquiries may be mailed to the address below:</p> <p>Aon Hewitt Your Spending Account P.O. Box 785040 Orlando, FL 32878-5040</p> <p>Tel: (888) 611-5500 (toll free) Monday through Friday: 8 a.m. - 8 p.m. EST Hours are subject to change without prior notice.</p> <p>http://resources.hewitt.com/3M</p>

<p>Enrollment Administrator</p>	<p>3M FIRST Line Center is available to answer questions about enrollment and eligibility.</p> <p>3M FIRST Line Center P.O. Box 1459 Lincolnshire, IL 60069-3242</p> <p>Tel: (888) 611-5500 (toll free) Fax: (847) 883-8238 (847) 883-0483 if outside the United States and Canada</p> <p>Monday through Friday: 8 a.m. - 6 p.m. CST</p>
<p>COBRA and Direct Bill Questions</p>	<p>3M FIRST Line Center P.O. Box 1459 Lincolnshire, IL 60069-3242</p> <p>Tel: (888) 611-5500 (toll free) Fax: (847) 883-8238 (847) 883-0483 if outside the United States and Canada</p> <p>Monday through Friday: 8 a.m. - 6 p.m. CST</p>
<p>General Human Resources Questions</p>	<p>North America HR Service Center</p> <p>(877) 496-3636 (toll free) (651) 575-5000 (Twin Cities)</p> <p>Monday through Friday: 7:30 a.m. - 5 p.m. CST</p>

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 satisfy the following requirements (and any applicable rule set out below):

1. You are eligible for Medicare; and
2. You are classified by a Participating Employer (meaning 3M and all 3M affiliates participating in the Plan) as “retired” from a Participating Employer under:
 - a. The 3M Employee Retirement Income Plan if you were not subject to a collective bargaining agreement while employed and were actively participating in, and actively accruing benefits under, the 3M Employee Retirement Income Plan at the time of your retirement (“retired” in this case means terminating employment after reaching age 55 with 5 years of pension service or age 65); or
 - b. The 3M Employee Retirement Income Plan if you were subject to a collective bargaining agreement while employed and were actively participating in, and actively accruing benefits under, the 3M Employee Retirement Income Plan at the time of your retirement (“retired” in this case means terminating employment after reaching age 55 with 10 years of pension service or age 65); or
 - c. The 3M Portfolio III Voluntary Investment Plan if you were not subject to a collective bargaining agreement while employed and were hired or rehired on or after the date the 3M Employee Retirement Income Plan was closed to new participants (“retired” in this case means terminating employment after reaching age 55 with 5 years of employment service with a Participating Employer or age 65); or
 - d. The Savings Plan if you were subject to a collective bargaining agreement while employed and were hired or rehired on or after the 3M Employee Retirement Income Plan close date specified in the applicable collective bargaining agreement (“retired” in this case means terminating employment after reaching age 55 with 10 years of employment service or age 65); or
 - e. The 3M Employee Retirement Income Plan if you were actively participating in, and actively accruing benefits under, the 3M Employee Retirement Income Plan at the time of their retirement and were covered under the 3M Basic Medicare Supplement Plan as of December 31, 2010; and
3. You were classified a Participating Employer at the time of retirement as (i) an active regular employee of a Participating Employer and a common law employee for employment tax purposes, and (ii) an employee hired or rehired before January 1, 2016.

Closed Plan

Employees hired or acquired by a Participating Employer or 3M affiliate on or after January 1, 2016 are not eligible for the Plan upon retirement, even if an employee otherwise satisfies the eligibility requirements for participation in the Plan.

Rule for Rehires on or after January 1, 2016

An employee who was hired or rehired before January 1, 2016 by a Participating Employer but terminated employment and is subsequently rehired by a Participating Employer or 3M affiliate on or after January 1, 2016 is not eligible to participate in the Plan except to the extent provided under the rules for rehires in Appendix C. For information about rehired retirees, please see the section of the Summary titled “Suspending Your Coverage”.

Rule for Portfolio III Retirees

A retiree who either (i) retired under Retirement Portfolio III Voluntary Investment Plan, or (ii) was an employee whose terms of employment were subject to a collective bargaining agreement and was hired or rehired on or after the 3M Employee Retirement Income Plan close date specified in the applicable collective bargaining agreement, and retired under the 3M Savings Plan and had 10 years of employment service with a Participating Employer (referred to as a “Portfolio III Retiree”) is eligible to participate in the Plan only if the retiree satisfies the eligibility requirements above and, at the time the retiree became Medicare eligible, had unused (i) Retiree Medical Savings Account Credits, or (ii) Non-Medicare HRA Credits if the retiree participated in the 3M Retiree Health Reimbursement Arrangement (HRA) Plan – Non-Medicare Eligible. A Portfolio III Retiree who has exhausted all of his or her Retiree Medical Savings Account Credits or, as applicable, Non-Medicare HRA Credits is not eligible to participate in the Plan.

Rule for Purification Union Retirees

A retiree who was a 3M Purification Inc. (formerly known as CUNO) employee subject to a collective bargaining agreement (referred to as a “Purification Union Retiree”) is eligible to participate in the Plan only if the retiree satisfies the eligibility requirements above and, at the time the retiree became Medicare eligible, either had unused (i) Retiree Medical Savings Account Credits, or (ii) Non-Medicare HRA Credits if the retiree participated in the 3M Retiree Health Reimbursement Arrangement (HRA) Plan – Non-Medicare Eligible. A Purification Union Retiree who has exhausted all of his or her Retiree Medical Savings Account Credits or, as applicable, Non-Medicare HRA Credits is not eligible to participate in the Plan.

Rule for certain Imation Retirees

An individual classified by a Participating Employer as an Imation retiree who terminated employment with 3M on June 30, 1996 as part of the Imation spin-off and who as of July 1, 1996 was at least age 50 with 5 or more years of pension service and the sum of employee’s age plus pension service 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 Ferrania Lux S.a.r.l. Retirees

An individual classified by a Participating Employer as a Ferrania Lux S.a.r.l. retiree who terminated employment with 3M on June 30, 1996 as part of the Imation spin-off and who as of July 1, 1996 was at least age 50 with 5 or more years of pension service and the sum of employee’s age plus pension service was at least age 60 and who was hired by Imation in connection with the spin-off and who was subsequently hired by Ferrania Lux S.a.r.l. as part of the sale of Imation’s Photo Color Systems to Ferrania Lux S.a.r.l and terminated employment with Ferrania Lux S.a.r.l after reaching age 55 is eligible to participate in the Plan at the time he or she becomes Medicare eligible.

Rule for certain Kodak Retirees

An individual classified by a Participating Employer as a Kodak retiree who terminated employment with 3M on June 30, 1996 as part of the Imation spin-off and who as of July 1, 1996 was at least age 50 with 5 or more years of pension service and the sum of employee’s age plus pension service was at least age 60 and who was hired by Imation in connection with the spin-off and who was subsequently hired by

Kodak as part of the sale of Imation's imaging business to Kodak and terminated employment with Kodak 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 a Participating Employer 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 10 or more years of pension service 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 3M Health Information Systems, Inc. Retirees

A retiree who retired from 3M Health Information Systems, Inc. ("HIS") is only eligible to participate in the Plan at the time he or she becomes Medicare eligible if he or she was a former 3M employee who transferred employment to HIS on April 1, 2007. However, if such transferred employee subsequently terminates from HIS and is subsequently rehired by HIS, he or she shall not be eligible for the Plan even if he or she otherwise satisfies the eligibility requirements to participant in the Plan.

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 classified or treated by a Participating Employer as:

- Subject to a collective bargaining agreement unless and to the extent that the agreement provides for your participation;
- A temporary employee or a project employee;
- A person who is not a common law employee (including without limitation a leased employee, independent contractor, contingent worker, service worker, consultant, contract worker, agency worker or freelance worker), regardless of your actual legal status or whether you are later determined to be a common law employee;
- A person who retired from a 3M affiliate that was not a Participating Employer at the time of his or her retirement; or
- Covered by a contract or other written agreement that provides you are not eligible for the Plan.

Classes of Ineligible Retirees

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 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 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.

COBRA Enrollees

Retirees who elect not to enroll in the Plan (or, if applicable, the 3M Retiree Health Reimbursement Arrangement (HRA) Plan – Non-Medicare Eligible) 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.

Classification

The classification of an individual by a Participating Employer is conclusive and binding for purposes of determining eligibility to participate in this Plan and shall be made solely in the discretion of the Participating Employer. No reclassification or determination of a person's status with a Participating Employer, 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 Employer agrees to such reclassification or determination, shall make the person retroactively or prospectively eligible for benefits. However, the Participating Employer, 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.

Service Determinations

For purposes of the Plan, "pension service" is determined under the 3M Employee Retirement Income Plan and "employment service" is determined under the 3M Voluntary Investment Plan and, with respect to employees subject to a collective bargaining agreement, the 3M Savings Plan.

Dependent Eligibility

If you are covered under the Plan as an Eligible Retiree, your Eligible Dependents may be covered to the extent provided by the Plan. A dependent who is eligible for the Plan is an "Eligible Dependent." An Eligible Dependent who becomes covered under the Plan is a "Covered Dependent."

Your dependents (including your spouse) are eligible to participate in the Plan only if your dependent satisfies the following requirements (and any applicable rule set out below):

- You:
 - Are a retiree who is eligible to be covered, or who is covered, under a 3M retiree medical plan;
 - Have exhausted your Retiree Medical Savings Account Credits or Non-Medicare HRA Credits; or
 - Were covered under the 3M Basic Medicare Supplement Plan and exhausted your \$10,000 Plan maximum prior to December 31, 2010; and
- You and your dependent is eligible to participate in the Plan at the time of your retirement;
- Your dependent is Medicare eligible; and
- Your dependent satisfies the applicable eligibility requirements for a "spouse," or "dependent children" as set forth below.

Eligible Spouse

A spouse is eligible only if the spouse is your legally married (including a common law marriage) same sex or opposite sex spouse at the time of your retirement. 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. Domestic partners and children of domestic partners are not eligible to participate in the Plan.

Eligible Dependent Children

A child is eligible only if you retired on or before January 1, 2016. If you retire after January 1, 2016, your children are not eligible to participate in the Plan and are not considered an Eligible Dependent for purposes of this Plan, regardless if you have a spouse.

If you retired on or before January 1, 2016, your child is eligible only if the child is: (1) under age 26; and (2) your biological child, a child legally adopted by you or placed with you for adoption, or your step child. Upon divorce or legal separation, your step child ceases to be eligible for coverage regardless of whether the divorce decree or court order requires you to provide coverage to your former step child. If you have an eligible spouse who is not covered under the Plan (for example, your spouse is not Medicare eligible), your dependent children who are Eligible Dependents will not be eligible to be covered under the Plan until your spouse becomes a Covered Dependent under the Plan.

New Dependents

A dependent is eligible for coverage under this Plan only if the dependent was your Eligible Dependent at the time of your retirement. The only dependent that can be added to your 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 is not eligible to participate in the Plan.

Rule for Eligible Dependents of Portfolio III Retirees

An dependent of an Eligible Retiree who either (i) retired under Retirement Portfolio III Voluntary Investment Plan, or (ii) was an employee whose terms of employment were subject to a collective bargaining agreement and was hired or rehired on or after the 3M Employee Retirement Income Plan close date specified in the applicable collective bargaining agreement, and retired under the 3M Savings Plan and had 10 years of employment service with a Participating Employer (referred to as "Portfolio III Retirees") is eligible to participate in the Plan only if the dependent satisfies the eligibility requirements above and, at the time the dependent became Medicare eligible, had unused (i) Retiree Medical Savings Account Credits, or (ii) Non-Medicare HRA Credits if the retiree participated in the 3M Retiree Health Reimbursement Arrangement (HRA) Plan – Non-Medicare Eligible. A dependent of a Portfolio III Retiree who has exhausted all of his or her Retiree Medical Savings Account Credits or, as applicable, Non-Medicare HRA Credits is not eligible to participate in the Plan.

Rule for Eligible Dependents of Purification Union Employees

A dependent of an Eligible Retiree who was a 3M Purification Inc. (formerly known as CUNO) employee subject to a collective bargaining agreement (referred to as a "Purification Union Retiree") is only eligible to participate in the Plan if the dependent satisfies the eligibility requirements above, and at the time the dependent became Medicare eligible, had unused (i) Retiree Medical Savings Account Credits, or (ii) Non-Medicare HRA Credits if the retiree participated in the 3M Retiree Health Reimbursement Arrangement (HRA) Plan – Non-Medicare Eligible. A dependent of a Purification Union Retiree who has exhausted all of his or her Retiree Medical Savings Account Credits or, as applicable, Non-Medicare HRA Credits is not eligible to participate in the Plan.

Extending a Child's Eligibility Due to Disability

The coverage of a child who is a Covered Dependent may continue after reaching age 26 if the Plan Administrator approves coverage and determines that:

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

To be eligible for this extended coverage, you must submit an application to the Plan Administrator before the child's 26th birthday providing evidence of the disability. If the disability status is approved, the Plan Administrator may 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. Only a child who satisfies the definition of an Eligible Dependent can be covered under the Plan pursuant to a QMCSO. A child who does not satisfy the definition of an Eligible Dependent cannot be covered under the Plan regardless of whether a QMCSO provides for such coverage.

Evidence of Eligibility

You may be asked to provide evidence substantiating dependent status of an individual you wish to cover.

Failure to provide such proof to the satisfaction of the Enrollment Administrator will result in denial or 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.

Ineligible Dependents

Ineligible dependents include but are not limited to the following:

- Dependents who are active employees of 3M;
- 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;
- Domestic partners and children of domestic partners;
- 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;
- Dependents who elect to continue coverage under a 3M active employee medical plan through COBRA, even after COBRA ends; and
- Children of an Eligible Retiree who retired after January 1, 2016.

Classes of Ineligible Dependents

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.

Consequences of Coverage of Ineligible Individuals

The following are a violation of Company policy and are considered fraud under the terms of this Plan:

- 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
- Making a misrepresentation regarding the basis for Plan coverage.

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 Covered Retiree and any Covered Dependents; and
- All other civil and criminal recourse, for such actions.

Enrolling in the Plan

Overview

If you are an Eligible Retiree, you and your Eligible Dependents will be automatically enrolled in the Plan upon becoming Medicare-eligible. Coverage under the Plan begins for you and your Eligible Dependents on the date of your enrollment.

Rules for Spouses Who Are Also Eligible Retirees

If both you and your spouse are Eligible Retirees, you may elect either: (1) each of you will be a Participant in the Plan and each will 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 Covered 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 a child who is an Eligible Dependent and is Medicare eligible, then either Participant may cover a child as a dependent but a child can only be covered as a dependent by one Participant, not both.

Reimbursement Account

Overview

A “Reimbursement Account” will be established for a Participant and his or 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.

Crediting of Accounts

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

The Reimbursement Account is simply a bookkeeping entry, meaning that the Medicare HRA Credits do not represent actual contributions made on behalf of a Participant or Covered Dependent and funds are not deposited into any separate account on behalf of a Participant or Covered Dependent.

Neither a Participant nor any Covered Dependent(s) are able to contribute to the Reimbursement Account. A Covered 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.

Reimbursements

Amounts credited to the Reimbursement Account can only be used for reimbursement of Eligible Expenses incurred by the Participant or Covered Dependent. Any Medicare HRA Credits that are not used during a Plan Year in accordance with the Plan remain available in the next Plan Year.

Eligible Expenses for Reimbursement

Overview

The following expenses incurred by a Participant or Covered Dependent are eligible for reimbursement under the 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;
- 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 Participant or Covered Dependent that resides outside of the United States.

The expense must qualify as an Internal Revenue Code Section 213(d) expense to be eligible for reimbursement under the Plan. An expense that is eligible for reimbursement under the Plan is referred to as an “Eligible Expense”.

Ineligible Expenses

An expense that is not an Eligible Expense is not eligible for reimbursement. Ineligible expenses include but are not limited to the following:

- Any expenses incurred for qualified long term care services;
- Expenses incurred prior to the date that coverage under the Plan becomes effective (but excluding payments for premiums listed above for health care coverage that begins on or after coverage under the Plan becomes effective);
- Expenses incurred in year(s) prior to the date that Medicare HRA Credits are allocated;
- Expenses incurred after the date that coverage under the Plan ends;
- Expenses that have been reimbursed by another plan or for which you plan to seek reimbursement under another health plan; and
- Expenses paid pre-tax.

“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.

Additionally, expenses incurred by individuals who are not a Participant or Covered Dependent are ineligible for reimbursement.

HRA Credits

Overview

Each Plan Year, as a Participant, you will receive an allocation of Medicare HRA Credits to your Reimbursement Account (a “Participant Allocation”). If you have Covered Dependent(s), you will receive one additional allocation of Medicare HRA Credits for all your Covered Dependent(s) to your Reimbursement Account (a “Dependent Allocation”). 3M will make one Dependent Allocation regardless of how many Covered Dependents there are.

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.

If you have a spouse who is not covered under this Plan but have other dependents who are Eligible Dependents, your non-spouse Eligible Dependents will not be covered under the Plan and will not receive Dependent Allocations until your spouse becomes a Covered Dependent under this Plan.

Subject to the applicable rules below, if a Eligible Retiree or Eligible Dependent was covered under the 3M Retiree Health Reimbursement Arrangement (HRA) Plan – Non-Medicare Eligible (referred to as the Non-Medicare HRA Plan) prior to becoming covered under this Plan and had unused Non-Medicare HRA Credits under the Non-Medicare HRA Plan at the time the individual became covered under this Plan, any unused Non-Medicare HRA Credits with respect to that individual will transfer to this Plan and will be credited to the Reimbursement Account upon becoming covered under this Plan. If an Eligible Retiree has more than one Eligible Dependent who was covered under the Non-Medicare HRA Plan, the unused Non-Medicare HRA credits will transfer when the eligible spouse of such Eligible Retiree becomes covered under this Plan or, if the Eligible Retiree does not have an eligible spouse, when the first eligible dependent becomes covered in this Plan. Upon the transfer of the Non-HRA Credits to this Plan, the Reimbursement Account in the Non-Medicare HRA Plan relating to the individual will be reduced to zero.

The amount of Medicare HRA Credits allocated to your Reimbursement Account is described in the Appendices, subject to the rules below. Medicare HRA Credits are pro-rated for the year in which the Reimbursement Account is established.

Rule for Retirees and Dependents with RMCs

A Participant or Covered Dependent who had Retiree Medical Credits will receive a one-time, single allocation of Medicare HRA Credits allocation equal to the individual’s unused (i) Retiree Medical Credits, or (ii) Non-Medicare HRA Credits if the individual was covered under the 3M Retiree Health Reimbursement Arrangement (HRA) Plan – Non-Medicare Eligible. Once the allocation of Medicare HRA Credits is credited to the Reimbursement Account, the individual’s Retiree Medical Credits or, as applicable, Non-Medicare HRA Credits will be reduced to zero and the individual will no longer be eligible to use those credits. The individual will not receive any Participant or Dependent Allocations, as applicable, under this Plan until the one-time, single allocation of Medicare HRA Credits are exhausted.

Once the balance of Medicare HRA Credits is zero, annual allocation of Medicare HRA Credits will commence or, if the individual 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 and their Dependents

A Participant who either (i) retired under Retirement Portfolio III Voluntary Investment Plan, or (ii) was an employee whose terms of employment were subject to a collective bargaining agreement and was hired or rehired on or after the 3M Employee Retirement Income Plan close date specified in the applicable collective bargaining agreement, and retired under the 3M Savings Plan and had 10 years of employment service with a Participating Employer (referred to as a “Portfolio III Retiree”) or a Covered Dependent of a Portfolio III Retiree will receive a one-time, single allocation of Medicare HRA Credits equal to the individual’s unused (i) Retiree Medical Savings Account Credits, or (ii) Non-Medicare HRA Credits if the individual was covered under the 3M Retiree Health Reimbursement Arrangement (HRA) Plan – Non-Medicare Eligible. Once the allocation of Medicare HRA Credits is credited to the Reimbursement Account, the individual’s Retiree Medical Credits or, as applicable, Non-Medicare HRA Credits will be reduced to zero and the individual will no longer be eligible to use those credits. The individual will be able to use the one-time, single allocation of Medicare HRA Credits in accordance with this Plan, but will not be eligible for any annual Participant Allocation or Dependent Allocation, as applicable. Once the initial, single allocation of Medicare HRA Credits has been used and account balance is zero, coverage under the Plan will end for that covered individual.

Rule for Retirees and their Dependents covered under 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 one-time, single allocation of Medicare HRA Credits 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 use the one-time, single allocation Medicare HRA Credits in accordance with this Plan, but will not be eligible for any annual Participant or Dependent Allocations. Once the account balance has been reduced to zero, coverage under the Plan will end for all covered individuals.

Rule for Short Service Retirees and their Dependents

A Participant who had less than 15 years of 3M pension service at retirement and retired or elected pre-retirement leave before January 1, 1997 (referred to as a “Short Service Retiree”) and the Covered Dependents of a Short Service Retiree will only receive a Participant and Dependent Allocation 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 pension service. This means that Short Service Retirees and their Covered Dependents are subject to a maximum number of Participant and Dependent Allocations. For example, a Short Service Retiree with only 13 years of pension service at retirement in 1997 would be ineligible for an allocation in 2010 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 Non-Union Retirees and their Dependents

Medicare HRA Credits for Participants and their Covered Dependents who retired from 3M Purification Inc. (formerly known as CUNO), or were a 3M Purification Inc. employee who retired from a Participating Employer, on or after December 1, 2008 are based on pension service beginning December 1, 2008.

Rule for 3M Purification Union Retirees and their Dependents

A Participant who was an employee of 3M Purification Inc. (formerly known as CUNO) subject to a collective bargaining agreement (referred to as a "Purification Union Retiree) or a Covered Dependent of a Purification Union Retiree will receive a one-time, single allocation of Medicare HRA Credits equal to the individual's unused (i) Retiree Medical Savings Account Credits, or (ii) Non-Medicare HRA Credits if the retiree participated in the 3M Retiree Health Reimbursement Arrangement (HRA) Plan – Non-Medicare Eligible. Once the allocation of Medicare HRA Credits are credited to the Reimbursement Account, the individual's Retiree Medical Savings Account Credits or, as applicable, Non-Medicare HRA Credits will be reduced to zero and the individual will no longer be eligible to use those credits. The individual will be able to use the one-time, single allocation of Medicare HRA Credits in accordance with this Plan, but will not be eligible for any annual Participant or Dependent Allocation as applicable. Once the initial, single allocation of Medicare HRA Credits has been used and account balance is zero, coverage under the Plan will end for that covered individual.

Rule for Surviving Spouses and Dependents

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 use any Medicare HRA Credits in the Reimbursement Account, but will not receive any future allocations, subject to any COBRA rights that may exist. Once the Medicare HRA Credits balance reaches zero, coverage will end for the Covered Dependents.

Credits

The Plan Administrator reserves the right to change retroactively or prospectively how the Medicare HRA Credits have been calculated and credited to a Reimbursement Account. This right includes reducing or eliminating any Medicare HRA Credits that have been credited to a Reimbursement Account. Individuals do not have a vested right to Medicare HRA Credits. The Plan Administrator's calculation of Medicare HRA credits is final and conclusive.

Medicare HRA Credits are notional arrangements, meaning that the Medicare HRA Credits do not represent actual contributions made on your behalf and funds are not deposited into any separate account on your or your dependent's behalf. 3M reserves the right to reduce or eliminate Medicare HRA Credits, both prior to or after an individual becomes covered under the Plan. Individuals do not have a vested right to Medicare HRA Credits. An employee who did not become covered under this Plan at the time of the employee's retirement, forfeit any Medicare HRA Credits that the employee or eligible dependents may have otherwise been eligible to receive. An employee or eligible dependent may have requested or received a projection of Medicare HRA Credits prior to the employee's actual retirement, but there is no guarantee that the individual will actually be eligible or receive such Medicare HRA Credits and receiving such projection does not entitle an individual to Medicare HRA Credits generally or the amount of Medicare HRA Credits specified in the projection. 3M reserves the right to determine and change the value of Medicare HRA Credits.

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.

Exhaustion of Administrative Remedies

You must exhaust the entire claims procedure prior to bringing a civil action to recover benefits, enforce or clarify your rights under the Plan.

Deadline to Commence a Lawsuit

If you file your claim within the required time, you 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 the earlier of:

- Two years after you knew or reasonably should have known of the facts behind your claim; or
- Ninety days after the claims procedure is complete.

Coordination of Benefits

Overview

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

Suspending Your Coverage

Overview

Your coverage in this Plan will be suspended if you are a Participant who is rehired by 3M or an affiliate as an employee. Your Reimbursement Account will be suspended on the date that you return to active employment and you will not be considered a Participant in this Plan during active employment. When your coverage is suspended, neither you nor your Covered Dependents will be entitled to reimbursement of any claims under the Plan.

When the circumstance described above ends, a Participant may request that the Account be actively resumed by contacting the Enrollment Administrator. However, expenses incurred during the period that the Account is suspended will be ineligible for reimbursement, even after the Account is no longer suspended and even if such expenses are otherwise Eligible Expenses.

When Coverage Ends

Overview

Coverage for you will end upon any of the following:

- You cease to be eligible for the Plan;
- There are no remaining amounts credited to the Reimbursement Account and the balance in the account is zero and there will not be any future Medicare HRA Credit allocations;
- 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 or suspend coverage;
- Your death;
- You attempt to obtain benefits fraudulently for yourself or others (such as enrolling an ineligible dependent); or
- You fail to follow the Plan's procedures or 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;
- 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 or suspend coverage;
- Your covered dependent's death;
- Your covered dependent attempts to obtain benefits fraudulently for himself/herself or others; or
- Your covered dependent fails to follow the Plan's procedures or violates the terms of the Plan as determined by the Plan Administrator.

If your dependents cease to satisfy the eligibility requirements, contact the Enrollment Administrator. In most events, coverage ends on the last day of the month that the dependent no longer meets the dependent eligibility requirements.

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

No future Medicare HRA Credits will be allocated to the Reimbursement Account for Covered Dependents 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.

If coverage ends for you or your Covered Dependents a temporary extension may be available through COBRA. See the "Continuing Your Coverage" section for more information. At the end of a COBRA period, your Covered Dependents will not be eligible for any future Dependent Allocations of Medicare HRA Credits, however, in limited circumstances, your Covered Dependents may be eligible to continue to

participate in the Plan and use remaining Medicare HRA Credits in the Reimbursement Account until the date your Covered Dependents would otherwise lose coverage under the terms of the Plan.

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.

Rule for Surviving Spouses

If you die and have a surviving spouse who is a Covered Dependent, your surviving spouse may be eligible for a subsidized COBRA rate. If your surviving spouse elects continuing coverage under COBRA, 3M will pay the COBRA premiums for your surviving spouse's coverage for the remainder of the year in which you die and the following year. After this period of subsidized COBRA coverage, your spouse may be eligible to continue COBRA coverage for the remainder of the COBRA period at full COBRA rates.

Continuing Your Coverage

General Notice of COBRA Continuation Coverage

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), created the right to continue health 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. This “Continuing Your Coverage” section:

- Contains important information about your right to COBRA continuation coverage;
- Explains when COBRA coverage may become available; and
- Describes what you need to do to protect your right to receive COBRA coverage.

For additional information about your rights and obligations under the Plan and under federal law, contact the Enrollment Administrator.

COBRA Eligibility – COBRA Qualified Beneficiaries

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 “qualified beneficiary.” You, your spouse and your dependent children could become qualified beneficiaries if you are covered under the Plan on the day before the qualifying event and that coverage is lost because of a qualifying event. As discussed below, there is one circumstance in which you could be a qualified beneficiary as well. Qualified beneficiaries also include any children born to you or placed for adoption with you during the COBRA continuation period.

The Plan offers COBRA continuation coverage to qualified beneficiaries only after 3M is notified that a qualifying event has occurred. Qualified beneficiaries who elect COBRA continuation coverage must pay for it on an after-tax basis.

COBRA Qualified Beneficiaries

Your spouse becomes a COBRA qualified beneficiary if you are covered under the Plan and he or she loses coverage under the Plan because of any of the following qualifying events:

- You die; or
- You become divorced or legally separated from your spouse.

Also, if you eliminate coverage for your spouse in anticipation of a divorce or legal separation, your 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 your ex-spouse to notify 3M of the divorce or legal separation even if coverage had been eliminated earlier. Your ex-spouse should follow the procedures outlined under the “Notification of Qualifying Events” topic under this section for providing such notice.

Your dependent children become COBRA qualified beneficiaries if you are covered under the Plan and they lose coverage under the Plan because of any of the following qualifying events:

- You die;
- You become divorced or legally separated; or
- The child loses eligibility for coverage as a “dependent child” under the Plan.

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 Qualifying Events

You or your qualified beneficiaries **must notify 3M** of certain qualifying events. These events include your death; your divorce or legal separation and your dependent child’s loss of eligibility for coverage because he or she is no longer a dependent child. The Plan offers COBRA continuation coverage to qualified beneficiaries only after 3M is notified that a qualifying event has occurred. To notify 3M, call the Enrollment Administrator within 60 days after the later of the:

- Date the qualifying event occurs; or
- Date your spouse or your dependent loses (or would lose) coverage on account of the qualifying event.

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. When you call, you are asked to furnish:

- Your name;
- The names of all qualified beneficiaries affected by the event;
- The qualifying event that has occurred (you may be required to submit additional evidence of the qualifying event);
- The date of the qualifying event; and
- Your address and the addresses of any qualified beneficiaries who do not live with you.

If you are not a 3M retiree, notify 3M of the qualifying event in writing by completing a Qualified Beneficiary Notice Form (contact the Enrollment Administrator to request a form).

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 furnish:

- Your name;
- The names of all qualified beneficiaries affected by the event;
- The qualifying event that has occurred (you may be required to submit additional evidence of the qualifying event);
- The date of the qualifying event; and
- Your address and the addresses of any qualified 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 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.

Electing COBRA Coverage

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Retirees may elect COBRA continuation coverage on behalf of his or her spouse, and parents may elect COBRA continuation coverage on behalf of his or her child(ren). It is critical that you (or anyone who may become a qualified beneficiary) maintain a current address with the Enrollment Administrator to ensure that you receive a COBRA enrollment notice following a qualifying event.

You (and any qualified beneficiary) 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 begins on the date coverage under the Plan would otherwise end.

How 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 postmarked no later than the last day of the 60-day election period or no later than the date on the election form.

How Long COBRA Continuation Coverage Lasts

COBRA continuation coverage is a temporary continuation of coverage. It lasts for up to a total of 36 months when the qualifying event is:

- Death of the retiree;
- Your divorce or legal separation; or
- Your dependent child losing his or her eligibility as a dependent child.

Cost of Continuation Coverage

COBRA participants must pay monthly premiums for coverage. Each qualified beneficiary will be required to pay the entire cost of COBRA continuation coverage plus 2% for administrative costs. Dependents making separate elections are charged the same rate as a single employee. 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.

Paying for COBRA Continuation Coverage

Qualified beneficiaries 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 COBRA continuation coverage is elected, no payment has to be sent at the time of the enrollment election. However, the first payment for COBRA continuation coverage must be made no later than 45 days after the date of election. (This is the date the enrollment election is postmarked, if mailed.)

If the first payment for COBRA continuation coverage is not made in full within 45 days after the COBRA election date, all COBRA continuation rights under the Plan are lost. Qualified beneficiaries are responsible for making sure that the first payment's amount is correct. Call the Enrollment Administrator to confirm the correct payment amount.

At the time of election, qualified beneficiaries will be told where to send the first payment.

Ongoing Payments for COBRA Continuation Coverage

Ongoing monthly payments are due on the first of each month, but there is a 30-day grace period (for example, June payment is due June 1, but is accepted if postmarked by June 30).

COBRA continuation coverage is 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 ongoing payments are not made before the end of the grace period, all rights to COBRA continuation coverage under the Plan are lost. If COBRA continuation coverage is cancelled for nonpayment, coverage will not be reinstated, and you will have no further rights to COBRA continuation coverage.

When COBRA Coverage Ends

COBRA coverage ends before the maximum continuation period if one of the following occurs:

- Any required premium is not paid in full on time;
- A qualified beneficiary becomes covered under another health plan not offered by 3M;
- After electing COBRA continuation coverage, a qualified beneficiary becomes entitled to Medicare (Part A, Part B, or both); or
- 3M stops providing health benefits to any employee.

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).

Notify the Enrollment Administrator immediately if a qualified beneficiary becomes covered under another group health plan or enrolls in Medicare.

Keep Your Plan Informed of Address Changes

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

Employee Retirement Income Security Act (ERISA) Statement of Rights

About Your ERISA 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), as amended. ERISA provides that all Plan participants will be entitled to the information as described in this section.

Receive Information About Your Plan and Benefits

ERISA provides that all Plan Participants will be entitled to:

- 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 (EBSA) at:

Public Disclosure Room
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W., Room N 15
Washington, D.C. 20210

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description (SPD). The Plan 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

ERISA provides that all Plan Participants will be entitled to:

- 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 SPD and the documents governing the Plan on the rules governing your continuation coverage rights.
- Receive 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.

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 a 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.
- If you file suit against the Plan, 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 the Plan, 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, contact the nearest office of the Employee Benefits Security Administration (EBSA), 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 EBSA at (866) 444-3272;
- Logging on to the Internet at dol.gov/ebsa; or
- Contacting the EBSA field office nearest you.

Important Plan Information

Plan Administrator

The Plan Administrator shall have the discretionary power and authority to:

- Control and manage the operation of the Plan;
- Prescribe applicable Plan procedures;
- Make all decisions and determinations with respect to the Plan; and
- 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. This includes 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 has:

- The authority to make benefit determination under the Plan;
- Direct payments with respect to the Plan, and
- 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 has:

- The authority to make enrollment determinations under the Plan; and
- Other responsibilities and authority as delegated by the Plan Administrator.

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;
- Amount of credits in a Reimbursement Account; and
- 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. In addition, 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. Failure to repay an overpayment and cooperate with the Plan Administrator in collecting an overpayment may result in loss of coverage under the Plan.

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, assign, sell, transfer, 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.

Except as may be required by law, your benefits under the Plan are not subject to the claims of your creditors.

A participant may not assign and/or transfer to anyone his or her right to file a lawsuit against the Plan, the Plan Sponsor, any Participating Employer, the Plan Administrator, any Plan fiduciary, any party-in-interest with respect to the Plan, or anyone else with respect to the Plan.

Misconduct

The Plan Administrator reserves the right to terminate coverage under the Plan for an individual and that individual's dependents if it determines that an individual:

- 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
- Engaged in behavior determined by the Plan Administrator to be detrimental or adverse to the Plan.

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 have the right to require any person claiming eligibility to participate in, or benefits under, the Plan to:

- Furnish any information or documentation it determines necessary,
- Certify or sign an affidavit attesting to certain facts, and
- 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 described in this summary is a notional arrangement. The arrangement is simply a bookkeeping device that allows 3M and you to keep track of Medicare HRA Credits credited to your account and reimbursements made to you under the Plan. You do not have an interest in the Medicare 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. Medicare 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 Plan. As noted above, although benefits may be paid through the VEBA, the Medicare 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 Employers. 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 Rewards during normal business hours upon reasonable notice. There may be a charge for copying.

Privacy of Protected Health Information

The Plan has been amended to permit the Plan to share your and your dependents' protected health information with 3M and third parties (including the Claims Administrator) for certain purposes, such as operation of the Plan and payment of claims pursuant to the HIPAA Privacy Rules. For more information, review the Plan's Notice of Privacy Practices. You have a right to request a copy of this notice.

Participating Employers

In addition to 3M, Participating Employers include any 3M affiliate that adopts this Plan if such adoption is approved by 3M and reflected on the list of Participating Employers. The list of Participating Employers may be amended from time to time.

General Plan Information

Plan Name:	3M Retiree Health Reimbursement Arrangement (HRA) Plan—Medicare Eligible, 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 Director, Total Rewards Program Management, (or his or her successor), is the Plan Administrator. Total Rewards 3M Company 3M Center St. Paul, MN 55144-1000 (877) 496-3636 (toll free) (651) 575-5000 (Twin Cities)
Enrollment Administrator:	3M FIRST Line Center P.O. Box 1459 Lincolnshire, IL 60069-3242
Claims Administrator:	Aon Hewitt Your Spending Account P.O. Box 785040 Orlando, FL 32878-5040 (888) 611-5500 (toll free)
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.
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Appendix A – Portfolio I

Description of Eligible Class

The following class of Participants and their Covered Dependents are eligible for Medicare HRA Credits pursuant to the rules in this Appendix A:

- Participants who either (i) retired under 3M Retirement Portfolio I, or (ii) were employees who terms of employment were subject to a collective bargaining agreement that provided for participation in this Plan and the 3M Employee Retirement Income Plan, and were hired or rehired by a Participating Employer before January 1, 2001.

Calculation of Credits

The 2015 Medicare HRA Credits allocation are noted in the charts below based on your 3M pension service, retirement eligibility and retirement date. The amount of Medicare HRA Credits grows at a notional rate of 3% per year. Effective January 1, 2016 for Participants who retired on or after January 2, 2016 and their Covered Dependents, the 3% adjustment to the annual credit allocation was reduced to 1.5%.

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+	\$1,910	\$1,910
14	\$1,791	\$1,791
13	\$1,672	\$1,672
12	\$1,552	\$1,552
11	\$1,433	\$1,433
10	\$1,313	\$1,313
9	\$1,195	\$1,195
8	\$1,075	\$1,075
7	\$955	\$955
6	\$836	\$836
5 or less	\$717	\$717

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+	\$1,910	\$1,433
14	\$1,791	\$1,344
13	\$1,672	\$1,252
12	\$1,552	\$1,164
11	\$1,433	\$1,075
10	\$1,313	\$986
9	\$1,195	\$896
8	\$1,075	\$805
7	\$955	\$717
6	\$836	\$627
5 or less	\$717	\$538

Appendix B – Portfolio II

Description of Eligible Class

The following class of Participants and their Covered Dependents are eligible for Medicare HRA Credits pursuant to the rules in this Appendix B:

- Participants who either (i) retired under the 3M Retirement Portfolio II (including individuals who elected Transitional Retirement or Bridge to Retirement status), or (ii) were employees whose terms of employment were subject to a collective bargaining agreement that provided for participation in this Plan and the 3M Employee Retirement Income Plan, and were hired or rehired by a Participating Employer on or after January 1, 2001 and before the 3M Employee Retirement Income Plan closed date specified in the applicable collective bargaining agreement.

Calculation of Credits

The 2015 Medicare HRA Credits allocation are noted in the charts below based on your 3M pension service, retirement eligibility and retirement date. The amount of Medicare HRA Credits grows at a notional rate of 3% per year. Effective January 1, 2016 for Participants who retired on or after January 2, 2016 and their Covered Dependents, the 3% adjustment to the annual credit allocation was reduced to 1.5%.

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+	\$1,910	\$1,910
14	\$1,791	\$1,791
13	\$1,672	\$1,672
12	\$1,552	\$1,552
11	\$1,433	\$1,433
10	\$1,313	\$1,313
9	\$1,195	\$1,195
8	\$1,075	\$1,075
7	\$955	\$955
6	\$836	\$836
5 or less	\$717	\$717

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+	\$1,195	\$1,195
14	\$1,121	\$1,121
13	\$1,045	\$1,045
12	\$970	\$970
11	\$896	\$896
10	\$822	\$822
9	\$746	\$746
8	\$672	\$672
7	\$596	\$596
6	\$523	\$523
5 or less	\$448	\$448

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+	\$1,195	\$896
14	\$1,121	\$839
13	\$1,045	\$784
12	\$970	\$727
11	\$896	\$672
10	\$822	\$615
9	\$746	\$559
8	\$672	\$504
7	\$596	\$448
6	\$523	\$391
5 or less	\$448	\$335

Appendix C – Retiree Medical Savings Account Credits

Description of Eligible Class

The following class of retirees is eligible for an allocation of Retiree Medical Savings Account (RMSA) Credits described in this Appendix C:

- Eligible Retirees who retired on or after January 1, 2013 and either (i) retired under the 3M Retirement Portfolio I, or (ii) were employees whose terms of employment was subject to a collective bargaining agreement that provided for participation in this Plan and the 3M Employee Retirement Income Plan, and were hired or rehired by a Participating Employer before January 1, 2001. This class of Eligible Retirees is hereinafter referred to as “Portfolio I Retirees”.
- Eligible Retirees who retired on or after January 1, 2013 and either (i) retired under the 3M Retirement Portfolio II, or (ii) were employees whose terms of employment was a subject to a collective bargaining agreement that provided for participation in this Plan and the 3M Employee Retirement Income Plan, and were hired or rehired by a Participating Employer on or after January 1, 2001 and before the 3M Employee Retirement Income Plan closed date specified in the applicable collective bargaining agreement. This class of Eligible Retirees is hereinafter referred to as “Portfolio II Retirees”.
- Eligible Retirees who were hired prior to January 1, 2016 and either (i) retired under the 3M Retirement Portfolio III Voluntary Investment Plan, or (ii) were employees whose terms of employment were subject to a collective bargaining agreement and were hired or rehired on or after the date the 3M Employee Retirement Income Plan was closed to new participants, and retired under the 3M Savings Plan and had 10 years of employment service with a Participating Employer. This class of Eligible Retirees is hereinafter referred to as “Portfolio III Retirees”.

Calculation of Retiree Medical Savings Account Credits (RMSAs)

An Eligible Retiree described in the above class and the retiree’s Eligible Dependent are eligible to receive an allocation of Retiree Medical Savings Account Credits based on the rules set forth below:

Eligible Retirees who were employed by a Participating Employer on January 1, 2009

The Retiree Medical Savings Account Credits for Eligible Retirees who were employed by a Participating Employer on January 1, 2009 (but excluding any Portfolio III Retiree who was hired by a Participating Employer or affiliate on January 1, 2009) is calculated as follows:

- If the Eligible Retiree was age 40 or older on January 1, 2009, the Eligible Retiree will receive an opening balance of Retiree Medical Savings Account Credits equal to 1,200 credits for each year of eligible 3M pension service earned after attaining age 40 and prior to January 1, 2009.
- The Eligible Retiree also will receive an annual allocation of Retiree Medical Saving Account Credits for each year of eligible post-age 40 pension service after January 1, 2009 and prior to retirement. The credit allocation for a given year is credited annually on January 1 of the following year. The credit amount on January 1, 2009 was 1,200. From 2009 to 2015 the annual credit grew at a notional rate of 3% per year. By

way of example, the credit amount in 2009 was 1,200 and was increased to 1,236 (2010), 1,273 (2011), 1,311 (2012), 1,350 (2013), 1,391 (2014), and 1,433 (2015). Effective January 1, 2016, for Eligible Retirees who retired on or after January 2, 2016, the 3% adjustment to the annual credit allocation was reduced to 1.5%. The credit allocation made in 2016 (representing the 2015 increase) was 1,476.

- Portfolio I Retirees also will receive an additional 1,000 credits a year for each year of eligible 3M pension service after age 40, beginning in 2009 or the date the employee attained age 40, if later, and ending in the earlier of 2013 or retirement. The total of these additional credits will not exceed 5,000 and this additional credit will not apply to any Eligible Dependent. These additional credits are not adjusted from year to year as noted above for the annual allocation of credits.
- The years of eligible post-age 40 pension service used to calculate all Retiree Medical Savings Account Credits (including any opening balance credits and annual allocations of credits) is capped at 25 years. No years of pension service beyond 25 years is taken into account, regardless of whether the Eligible Retiree has additional years of pension service.
- If the Eligible Retiree had an Eligible Dependent at retirement, the Eligible Dependent received an allocation of Retiree Medical Savings Account Credits. The allocation of Retiree Medical Savings Account Credits was calculated in a manner similar to the Eligible Retiree; except that if the Eligible Retiree was (i) a Portfolio I Retiree who was not eligible to retire under the 3M Employee Retirement Income Plan as of January 1, 2009 or (ii) a Portfolio II Retiree, the credit amount used to calculate the opening balance and the starting credit amount used to calculate the annual allocation is 600 instead of 1,200.
- Beginning in 2009, the balance of Retiree Medical Savings Account Credits received an interest credit of 4% at the end of each year until the Eligible Retiree retires. Effective January 1, 2016, for Eligible Retirees who retired on or after January 2, 2016, interest credits will no longer be applied.

Eligible Retirees who were employed by a Participating Employer after January 1, 2009

The Retiree Medical Savings Account Credits for Eligible Retirees who were employed by a Participating Employer on or after January 1, 2009 (including any Portfolio III Retiree who was hired by a Participating Employer on January 1, 2009) is calculated as follows:

- The Eligible Retiree will receive an annual allocation of Retiree Medical Saving Account Credits for each year of eligible pension service earned after attaining age 40, beginning at the later of (i) the Eligible Retiree's hire date, (ii) the date the employer of the Eligible Retiree became a Participating Employer, or (iii) the date the Eligible Retiree attained age 40, and ending at the Eligible Retiree's retirement or 25 years. The credit allocation for a given year is applied annually on January 1 of the following year. The starting credit amount on January 1, 2009 was 1,200. From 2009 to 2015 the annual credit grew at a notional rate of 3% per year. By way of example, the credit amount in 2009 was 1,200 and was increased to 1,236 (2010), 1,273 (2011), 1,311 (2012), 1,350 (2013), 1,391 (2014), and 1433 (2015). Effective January 1, 2016, for Eligible Retirees who retired on or after January 2, 2016, the 3% adjustment to the annual credit allocation was reduced to 1.5%. The credit allocation made in 2016 (representing the 2015 increase) was 1,476.
- The years of eligible post-age 40 pension service used to calculate all Retiree Medical Savings Account Credits is capped at 25 years. No years of pension service beyond 25 years is taken into account, regardless of whether the Eligible Retiree has additional years of pension service.
- If the Eligible Retiree had an Eligible Dependent at retirement, the Eligible Dependent received an allocation of Retiree Medical Savings Account Credits. The allocation of Retiree Medical Savings Account Credits was calculated in a manner similar to the Eligible Retiree except the credit amount used to calculate the starting credit amount used to calculate the annual allocation is 600 instead of 1,200.

- Beginning in 2009, the balance of Retiree Medical Savings Account Credits received an interest credit of 4% at the end of each year until the Eligible Retiree retires. Effective January 1, 2016, for Eligible Retirees who retired on or after January 2, 2016, interest credits interest credits will no longer be applied.
- For Portfolio III Retirees, eligible 3M employment service with a Participating Employer is used instead of eligible 3M pension service for purposes of calculating Retiree Medical Savings Account Credits.

Rehires

An employee who would have been eligible for Retiree Medical Savings Account Credits upon retirement but who terminated employment (including a transfer to a 3M affiliate that is not a Participating Employer) prior to retirement forfeits all Retiree Medical Savings Account Credits upon termination.

If the employee is rehired by a Participating Employer before January 1, 2016, the forfeited credits will be restored and the employee will be eligible for future Retiree Medical Savings Account Credits in accordance with this Appendix C; provided however that if the employee does not become an Eligible Retiree then all Retiree Medical Savings Account Credits (both restored and future credits) will be forfeited.

If the employee is rehired by a Participating Employer on or after January 1, 2016, the forfeited credits will be restored but the employee will not be eligible for any future Retiree Medical Savings Account Credits; provided however that if the employee does not become an Eligible Retiree than all restored Retiree Medical Savings Account Credits will be forfeited.

General Rules

The following rules apply generally to the calculation of Retiree Medical Credits for all classes of Eligible Retirees:

- Credit amounts were prorated for the year in which an employee first became eligible for Retiree Medical Savings Account Credits. Participants receive a prorated credit allocation for the year in which they retire.
- An eligible employee who does not retire and become a Participant in this Plan forfeits all his or her credits, and the employee's eligible dependents, if any, also forfeits their credits.
- Except as provided above for certain rehired employees, Retiree Medical Savings Account Credits are not available for employees hired or rehired on or after January 1, 2016.
- With respect to Eligible Retirees who retire on or after January 2, 2016, Retiree Medical Savings Account Credits will only be provided to an Eligible Dependent who is an eligible spouse. The dependent child of an Eligible Retiree who retires on or after January 2, 2016 will not be eligible for any Retiree Medical Savings Account Credits, including any credits that relate to service prior to 2016 that may have been available for a dependent child.
- Except as provided above for certain rehired employees, Eligible Retirees and Eligible Dependent do not earn additional Retiree Medical Savings Account Credits following the Eligible Retiree's retirement. Retiree Medical Savings Account Credits are calculated at the time of the Eligible Retiree's retirement, and no additional Retiree Medical Credits can be earned following retirement or by future service.
- Retiree Medical Savings Account Credits are provided at the time of an Eligible Retiree's retirement. An Eligible Retiree or an Eligible Dependent cannot access Retiree Medical Savings Account Credits prior to the Eligible Retiree's actual retirement.

Retiree Medical Savings Account Credits

3M creates a notional account for an eligible employees employed by a Participating Employer when the eligible employee attains age 40 that allows the employee to project Retiree Medical Savings Account Credits that may be available to an eligible employee and eligible dependent upon retirement under the current Plan design. While allocations of Retiree Medical Savings Account Credits are reflected in the notional account, this is simply a bookkeeping device. This means that Retiree Medical Savings Account Credits do not represent actual contributions made on behalf of an employee or employee's dependents and funds are not deposited into any separate account on behalf of an employee or employee's dependents.

3M reserves the right to reduce or eliminate Retiree Medical Savings Account Credits, both prior to or after an individual becomes covered under the Plan. Individuals do not have a vested right to Retiree Medical Savings Account Credits. An employee who did not become covered under this Plan at the time of the employee's retirement, forfeit any Retiree Medical Savings Account Credits that the employee or eligible dependents may have otherwise been eligible to receive. An employee or the employee's dependent may have requested or received a projection of Retiree Medical Savings Account Credits prior to the employee's actual retirement, but there is no guarantee that the individual will actually be eligible or receive such Retiree Medical Savings Account Credits and receiving such projection does not entitle an individual to Retiree Medical Savings Account Credits generally or the amount of Retiree Medical Savings Account Credits specified in the projection. 3M reserves the right to determine and change the value of Retiree Medical Savings Account Credits.

Appendix D – Retiree Medical Credits

Description of Eligible Class

The following class of retirees was eligible for an allocation of Retiree Medical Credits pursuant to the rules in this Appendix B:

- Eligible Retirees who retired prior to January 1, 2013 and either (i) retired under the 3M Retirement Portfolio II, or (ii) were employees whose terms of employment were subject to a collective bargaining agreement that provided for participation in this Plan and the 3M Employee Retirement Income Plan, and were hired or rehired by a Participating Employer on or after January 1, 2001 and before the 3M Employee Retirement Income Plan closed date specified in the applicable collective bargaining agreement.

Calculation of Retiree Medical Credits (RMCs)

An Eligible Retiree described in the above class and the retiree's Eligible Dependent were eligible to receive an allocation of Retiree Medical Credits based on the rules set forth below:

Eligible Retirees who elected Retirement Portfolio II during the choice window in 2001

The Retiree Medical Credits for Eligible Retirees who elected 3M Retirement Portfolio II during the choice window in 2001 and their Eligible Dependents were calculated as follows:

- If the Eligible Retiree was age 40 or older on January 1, 2002, the Eligible Retiree received an opening balance of Retiree Medical Credits equal to 1,000 credits for each year of eligible pension service earned after attaining age 40 and prior to January 1, 2002.
- The Eligible Retiree also received 3,000 Retiree Medical Credits for each year of eligible post-age 40 pension service after January 1, 2002 and prior to retirement.
- The years of eligible post-age 40 pension service used to calculate Retiree Medical Credits is capped at 22 years. No years of pension service beyond 22 years is taken into account, regardless of whether the Eligible Retiree has additional years of pension service.
- If the Eligible Retiree was married to spouse who was an Eligible Dependent at retirement, the spouse received an allocation of Retiree Medical Credits equal to those provided to the Eligible Retiree.

Eligible Retirees who were hired on or after January 1, 2001

Retiree Medical Credits for Eligible Retirees who were hired on or after January 1, 2001 and their Eligible Dependents were calculated as follows:

- An Eligible Retiree received 3,000 Retiree Medical Credits for each year of eligible pension service after attaining age 40 and prior to retirement.
- The years of eligible post-age 40 pension service used to calculate Retiree Medical Credits is capped at 22 years. No years of pension service beyond 22 years is taken into account, regardless of whether the Eligible Retiree has additional years of pension service.

- If an Eligible Retiree was married to a spouse who was an Eligible Dependent at retirement, the spouse received an allocation of Retiree Medical Credits equal to those provided to the Eligible Retiree.

Eligible Retirees who elected Transitional Retirement status

Retiree Medical Credits for Eligible Retirees who elected Transitional Retirement status under a 3M severance plan and their Eligible Dependents was calculated as follows:

- An Eligible Retiree who was participating in the 3M Retirement Portfolio I received 1,000 Retiree Medical Credits for each year of eligible pension serviced earned after attaining age 40, and prior to January 1, 2002, and 3,000 Retiree Medical Credits for each year of eligible post-age 40 pension service after January 1, 2002 (including up to 5 years while on Transitional Retirement status) and ending at retirement.
- An Eligible Retiree who was participating in the 3M Retirement Portfolio II received 3,000 Retiree Medical Credits for each year of eligible post-age 40 pension service after January 1, 2001 (including up to 5 years while on Transitional Retirement status) and ending at retirement.
- The years of eligible post-age 40 pension service used to calculate Retiree Medical Credits is capped at 22 years. No years of pension service beyond 22 years is taken into account, regardless of whether the Eligible Retiree has additional years of pension service.
- If an Eligible Retiree was married to a spouse who was an Eligible Dependent at retirement, the spouse received an allocation of Retiree Medical Credits equal to those provided to the Eligible Retiree.

Eligible Retirees who elected Bridge to Retirement status

Retiree Medical Credits for Eligible Retirees who elected Bridge to Retirement status under a 3M severance plan and their Eligible Dependents was calculated as follows:

- An Eligible Retiree who was participating in the 3M Retirement Portfolio I received 1,000 Retiree Medical Credits for each year of eligible pension serviced earned after attaining age 40, and prior to January 1, 2002, and 3,000 Retiree Medical Credits for each year of eligible post-age 40 pension service after January 1, 2002 (including up to 2 years while on Bridge to Retirement status) and ending at retirement.
- An Eligible Retiree who was participating in the 3M Retirement Portfolio II received 3,000 Retiree Medical Credits for each year of eligible post-age 40 pension service after January 1, 2001 (including up to 2 years while on Bridge to Retirement status) and ending at retirement.
- The years of eligible post-age 40 pension service used to calculate Retiree Medical Credits is capped at 22 years. No years of pension service beyond 22 years is taken into account, regardless of whether the Eligible Retiree has additional years of pension service.
- If an Eligible Retiree was married to a spouse who was an Eligible Dependent at retirement, the spouse received an allocation of Retiree Medical Credits equal to those provided to the Eligible Retiree.

Rehired Retirees

An Eligible Retiree who was allocated Retiree Medical Credits under the rules of this Appendix B and who returned to employment with a Participating Employer prior to January 1, 2009 and subsequently retired prior to January 1, 2013, received Retiree Medical Credits for the period of eligible pension service following the retiree's re-hire date and prior to the retiree's retirement, subject to the 22 year cap.

General Rules

The following rules apply generally to the calculation of Retiree Medical Credits:

- In all cases, the maximum number of Retiree Medical Credits that an Eligible Retiree or Eligible Dependent can receive is 66,000 credits.
- Except as provided above for certain rehired retirees, Eligible Retirees and Eligible Dependent do not earn additional Retiree Medical Credits following the Eligible Retiree's retirement. Retiree Medical Credits are calculated at the time of the Eligible Retiree's retirement, and no additional Retiree Medical Credits can be earned following retirement or by future service.
- Only an eligible spouse can be an Eligible Dependent for purposes of eligibility for Retiree Medical Credits. Dependent children, even if otherwise eligible, are not eligible to receive an allocation of Retiree Medical Credits.
- Retiree Medical Credits are allocated at the time of an Eligible Retiree's retirement. An Eligible Retiree or an Eligible Dependent cannot access Retiree Medical Credits prior to the Eligible Retiree's actual retirement.

Annuity Option

Upon retirement, Eligible Retirees and Eligible Dependents whose Retiree Medical Credits were determined under this Appendix B had an option to select an annuity option for their Retiree Medical Credits in the form of an monthly allocation. The form of distribution for an Eligible Dependent, if any, was identical to the form chosen by the Eligible Retiree. The annuity option increases 5% annually prior to Medicare attainment and is adjusted downward 60% at Medicare attainment and increased 5% annually thereafter. Credit allocations under the annuity option were determined using a 6% discount factor and the 1983 Group Annuity Mortality Table on a unisex basis. Retiree Medical Credits balances were increased annually as of each December 31 in an amount equal to the average rate of return on 30 year U.S. Treasury Bonds for the preceding November. Upon becoming covered under this Plan, the annuity credit allocation is converted into an annual amount of HRA Credits and the annual amount is increased by 5% annually prior to Medicare attainment and is adjusted downward 60% at Medicare attainment and increased 5% annually thereafter.

Retiree Medical Credits

3M created a notional account for an eligible employee employed by a Participating Employer when the eligible employee attained age 40 that allowed the employee to project Retiree Medical Credits that may be available to the employee and the employee's eligible dependent upon retirement under the current Plan design. While allocations of Retiree Medical Credits are reflected in the notional account, this is simply a bookkeeping device. This means that Retiree Medical Credits do not represent actual contributions made on behalf of an employee or employee's dependents and funds are not deposited into any separate account on behalf an employee or employee's dependents.

3M reserves the right to reduce or eliminate Retiree Medical Credits, both prior to or after an individual becomes covered under the Plan. Individuals do not have a vested right to Retiree Medical Credits. An employee who did not become covered under this Plan at the time of the employee's retirement forfeited any Retiree Medical Credits that the employee or eligible dependents may have otherwise been eligible to receive. An employee or the employee's dependent may have requested or received a projection of Retiree Medical Credits prior to the employee's actual retirement, but there is no guarantee that the individual will actually be eligible to receive such Retiree Medical Credits and receiving such projection does not entitle an individual to Retiree Medical Credits generally or the amount of Retiree Medical Credits specified in the projection. 3M reserves the right to determine and change the value of Retiree Medical Credits.