CONFIDENTIAL

MEDICA INSURANCE COMPANY
MEDICA GROUP PRIME SOLUTION
MASTER GROUP CONTRACT
INDIVIDUALLY BILLED

Employer Group Sponsor Name: _____

Group #: _____

Effective Date: _____

Contract #: _____

ARTICLE 1
INTRODUCTION

This Master Group Contract ("Contract") provides group health insurance coverage through Medica Prime Solution (Medicare cost). This Contract is governed by Medicare and other applicable federal law, and to the extent state law applies, the laws of the State of Minnesota. This Contract is entered into by and between Medica Insurance Company ("Medica") and the employer named above ("Sponsor"), an employer under Minnesota law and other applicable law. This Contract includes a Schedule A, titled "Premium & Purchased Benefits," attached hereto and incorporated herein by this reference, and the Evidence of coverage, incorporated herein by this reference, and any amendments. The terms and conditions of the Benefits provided under this Contract are explained more fully in the Evidence of Coverage for the Plan provided under this Contract. Schedule A will be read consistently with the Evidence of Coverage to the extent feasible. If there is a conflict between the terms and conditions of Schedule A and the Evidence of Coverage, the Evidence of Coverage will govern. This Contract is delivered in the state of Minnesota. This Contract is subject to annual review by the federal government. Availability of coverage in future years is not guaranteed.

The capitalized and other terms used in this Contract have the same meanings given those terms defined in Schedule A and the Evidence of Coverage, unless otherwise specifically defined in this Contract.

If this Contract is purchased by Employer to provide benefits under an employee welfare benefit plan governed by the Employee Retirement Income Security Act, 29 U.S.C. 1001, et seq. ("ERISA"), this Contract is governed by ERISA and, to the extent state law applies, the laws of the State of Minnesota, to the extent not preempted by applicable federal law.

If this Contract is not governed by ERISA, it is governed by the laws of the State of Minnesota. If this Contract is governed by ERISA, any legal action between the parties to this Contract arising out of or relating to this Contract will be brought in the federal district court for the district of Minnesota. If this Contract is not governed by ERISA, any legal action between the parties of

this Contract arising out of or relating to this Contract will be brought in state court in Hennepin County, Minnesota.

In consideration of payment of the monthly premiums ("Medica Premium") paid by Members and payment of any applicable Deductible(s), Copayments, and Coinsurance by or for Members, Medica will provide coverage for the Benefits set forth and defined in Schedule A and the Evidence of Coverage, and any amendments thereto, subject to all terms and conditions, including limitations and exclusions, in this Contract. "Member" is an individual properly enrolled for coverage under the Evidence of Coverage.

This Contract replaces and supersedes any previous agreements between Sponsor and Medica relating to Benefits under this Contract.

Medica will not be deemed or construed to be an employer for any purpose with respect to the administration or provision of Benefits under the Sponsor's welfare benefit plan. Medica will not be responsible for fulfilling any duties or obligations of Sponsor, including but not limited to any regulatory filings required of Sponsor, plan administrators, or plan sponsors.

[Sponsor is responsible for notifying eligible persons of all contractual changes relating to premiums and enrollment information, if applicable. Should Medica and Sponsor agree that Medica will be responsible for these notifications, administrative costs associated with the printing and mailing of these materials may be prorated to the Sponsor.]

[Medica is responsible for notifying eligible persons of all contractual changes relating to Medica Premiums and enrollment information, if applicable.]

ARTICLE 2
TERM OF CONTRACT

Section 2.1 Term and Renewal. The initial term of this Contract is effective from [_____, ___] ("Effective Date") to [_____, ___] ("Expiration Date"), and may be renewed in accordance with the following paragraph. All coverage under this Contract begins at 12:01 a.m. Central Time.

This Contract may be renewed for an additional term of one year at the end of the initial term and at the end of each Contract renewal term. At least 30 days before the end of the initial term or each Contract renewal term, Medica will notify Sponsor of any modifications to this Contract, including Medica Premiums and Benefits for the next one-year term of this Contract ("Renewal Terms"). If Sponsor accepts the Renewal Terms or if Sponsor and Medica agree on different Renewal Terms, this Contract is renewed for the additional Contract term, unless Medica or Sponsor terminates this Contract pursuant to Section 2.2.

Section 2.2 Termination of This Contract.

Sponsor may terminate this Contract after at least [60] days prior written notice to Medica. This Contract is guaranteed renewable and will not be terminated by Medica except for the reasons

as stated below and effective as stated below. Terminations for the reasons stated below require at least [60] days written notice from Medica, unless otherwise specified:

(a) Upon notice to an authorized representative of the Sponsor when any Member does not pay the required Medica Premium when due, provided, however, that this Contract can be reinstated when Member coverage is reinstated pursuant to Section 4.2;

(b) On the date specified by Medica because Sponsor provided Medica with false information material to the execution of this Contract or to the provision of Benefits under this Contract. Medica has the right to rescind this Contract back to the Effective Date, subject to applicable law:

(c) [On the date specified by Medica due to Sponsor's violation of the participation or contribution rules as determined by Medica;]

(d) Automatically on the date Sponsor ceases to do business pursuant to 11 U.S.C. Chapter 7;

(e) On the date specified by Medica, after at least [90] days prior written notice to Sponsor, that this Contract is terminated because Medica will no longer issue this particular type of group health benefits plan within the applicable Sponsor market;

(f) On the date specified by Medica, after at least [180] days prior written notice to the Sponsor and, if required, to the applicable state authority, that this Contract will be terminated because Medica will no longer renew or issue any group health benefits plan within the applicable Sponsor market;

(g) On the date specified by Medica when there is no longer any Member who resides in Medica's approved service area;

(h) On the date specified by Medica upon termination of Medica's contract with the Centers for Medicare and Medicaid Services ("CMS");

(i) [If this Contract is made available to Sponsor only through one or more bona fide associations, on the date specified by Medica after Sponsor's membership in the association ceases;]

(j) [On the date specified by Medica, when the employer fails to contribute at least 50% toward the cost of each eligible person's coverage;]

(k) [At the conclusion of the term of the Contract, when fewer than 75% of the Employer's eligible persons [who have not waived coverage] continue to participate under this Plan;] and

(l) Any other reasons or grounds permitted by the licensing laws and regulations governing Medica, provided not inconsistent with applicable Federal law.

Notwithstanding the above, Medica may modify the Medica Premium rate(s) and/or the coverage at renewal. Nonrenewal of coverage as a result of failure of Medica and the Sponsor to reach agreement with respect to modifications in the Medica Premium rate(s) or coverage will not be considered a failure of Medica to provide coverage on a guaranteed renewable basis.

Failure of any Member to pay required Medica Premiums on a timely basis to Medica will result in termination of coverage to the Member.

Section 2.3 Notice of Termination.

Medica will notify:

(a) Sponsor in writing if Medica terminates this Contract for any reason;

(b) Sponsor and Member in writing if Medica terminates a Member's coverage under the Contract due to nonpayment of Medica Premium by such Member.

Sponsor will provide timely written notification to Members of such termination in all circumstances for which Medica does not provide written notification to Members.

Section 2.4 Effect of Termination. In the event of termination of this Contract:

(a) All Benefits under this Contract will end at 12:00 midnight Central Time on the effective date of termination;

(b) Medica will not be responsible for any Claims for health services received by Members after the effective date of the termination, unless otherwise specified in the Evidence of Coverage;

(c) Individual Members will be and will remain liable to Medica for the payment of any and all Medica Premiums that are unpaid at the time of termination; and

(d) Upon termination of the Contract, Members will automatically revert to traditional Medicare Part A and Part B coverage.

ARTICLE 3
ENROLLMENT AND ELIGIBILITY

Section 3.1 Eligibility and Enrollment. Sponsor has sole discretion to determine whether a person is eligible to enroll for Benefits, subject to applicable laws, the terms of this Contract, and the following eligibility requirements:

Eligibility Requirements – to be eligible to enroll, an individual must:

(a) be [either (i)] a Medicare eligible retiree of the Sponsor [or (ii) a Medicare eligible spouse [or Domestic Partner (as defined below)] or a Medicare eligible dependent of a retiree of the Sponsor]; and

(b) be enrolled in Medicare Parts A and B or enrolled in Medicare Part B only (Failure by a Member to enroll in both Medicare Parts A and B, resulting in Member coverage through Medicare Part B only, will result in substantial gaps in coverage.); and

(c) continue to pay his or her Medicare Part B premium; and

(d) reside permanently within the Medica Group Prime Solution service area; and

(e) not have End Stage Renal Disease (ESRD) unless the individual is enrolled in a Medica commercial plan at the time of enrollment for Medica Group Prime Solution, subject to Section 3.3 below; and

(f) agree to abide by all of the Medica Group Prime Solution rules[.] [; and

(g) meet the eligibility criteria established by the Sponsor: [e.g. union retiree [or spouse [or Domestic Partner] of a union retiree]].

A person who does not satisfy the above requirements is not eligible to enroll for coverage under this Contract. If there is a conflict between the Evidence of Coverage and the eligibility requirements in this Section of the Contract, this Section of the Contract governs.

["Domestic Partner" is defined as an adult who Sponsor determines:
(a) is in a committed and mutually exclusive relationship with the retiree [or active employee] and is jointly responsible for the retiree's [or active employee's] welfare and financial obligations; and
(b) resides with the retiree [or active employee] in the same principle residence and intends to do so permanently; and
(c) is at least 18 years of age and unmarried; and
(d) is not a blood relative of the retiree [or active employee] [; and
(e) is of the same gender as the retiree [or active employee]].]

Medica will rely upon Sponsor's determination for participation in the Plan under this Contract regarding a person's eligibility to enroll for Benefits. Sponsor will be responsible for maintaining information verifying its continuing eligibility and the continuing eligibility of eligible Members under this Contract. This information will be provided to Medica as reasonably requested by Medica. [Sponsor will also maintain written documentation of a waiver of coverage by an eligible person and provide this documentation to Medica upon reasonable request.]

Sponsor will provide the following eligibility information [to Medica on a [monthly] [annual] basis:] [when requested by Medica:] [full legal name of eligible person or Member,] [social security number,] [identification number,] [proposed effective date for coverage to begin,] [proposed termination date and reason for termination,] [date of birth,] [address,] and [phone number].

Section 3.2 Initial[/Open][/Off-Cycle] Enrollment. As determined by Sponsor, enrollment may be limited to initial [and open] enrollment periods [and off-cycle enrollment due to qualifying event], as follows:
(a) "Initial Enrollment Period" is the [30-90]-day period starting with the date the person is first eligible to enroll for coverage under this Contract. An eligible person must apply within this period for coverage to begin the first day of the month following Medica's receipt of the application and acceptance of enrollment by CMS. An eligible person who does not enroll during the Initial Enrollment Period may enroll for coverage during the next [Open Enrollment Period] [or] [Off-Cycle Enrollment Due to Qualifying Event (Special Election Period)].
(b) ["Open Enrollment Period" is a minimum [14-30]-day period set by the Sponsor and Medica each year during which eligible persons may enroll for coverage.]
[(c) "Off-Cycle Enrollment Due to Qualifying Event (Special Election Period)" is allowed if the eligible person was enrolled for health coverage under a spouse's [or Domestic Partner's] health benefits plan and such coverage ends due to one of the following qualifying event[s]:
    [(i) spouse's [or Domestic Partner's] voluntary or involuntary termination or layoff from employment;
    [(ii) death or permanent disability of the spouse [or Domestic Partner];] or
    [(iii) divorce].

Section 3.3 Eligibility and Enrollment for ESRD. A Sponsor group-type health benefit plan must provide primary coverage with respect to Medicare for an individual with end stage renal disease (ESRD) during the coordination period. Medicare is the secondary payer during the coordination period. The coordination period is the first thirty (30) months after the individual becomes eligible for Medicare based on ESRD. These ESRD coverage rules apply regardless of the number of participants who are covered under the Sponsor group health plan and without regard to the active or inactive status of the individual. ESRD coverage rules may vary in

instances where an individual has dual entitlement to Medicare (a combination of age or disability, and ESRD).

Section 3.4 Effective Date of Enrollment. Applications must be signed, dated and received by Medica by the last business day of the month in order to be effective the first day of the following month. However, the enrollment is not effective until Medica considers the application complete and it is accepted by CMS. Coverage begins at 12:01 a.m. on the Member's effective date. Applications may be submitted up to three months immediately prior to the person's entitlement to Medicare Part B. No retroactive enrollments will be allowed except as permitted by CMS.

Section 3.5 Effective Date of Request for Disenrollment. The disenrollment will be effective the last day of the month in which notification is received by Medica, unless a later date is requested. The requested disenrollment date cannot be effective more than three months after Medica's receipt of the request. The disenrollment request will come from the Sponsor in writing. Additional disenrollment provisions are specified in the Evidence of Coverage. No retroactive disenrollment will be allowed except as permitted by CMS.

ARTICLE 4
PREMIUMS

Section 4.1 Monthly Medica Premiums.
The monthly Medica Premiums for this Contract are specified in Schedule A. Invoices are generated and sent to Members on or about the [15th] of the month for the month following. Medica Premiums must be submitted by Member to Medica by the [1st] day of each calendar month.

1. Member will be responsible for payment to Medica of the monthly Medica Premium.

[2. If the Medicare Prescription Drug Benefit Program ("Part D Benefits") are included in Schedule A, the following CMS restrictions apply.

(a) Sponsor may not vary the monthly Member contribution for the Part D Benefits Premium for individuals within a given class of Members.

(b) Sponsor may under Part D regulations subsidize different amounts for different classes of Members in a plan provided such classes are reasonable and based on objective business criteria, such as years of service, date of retirement, business location, job category and nature of compensation (e.g., salaried v. hourly). Different classes cannot be based on eligibility for the Low Income Subsidy, as defined below.

(c) Sponsor will determine the amount of the monthly Member contribution for the Part D Benefits Premium and Sponsor may subsidize different amounts for different classes of Members in Sponsor group Part D Benefits provided such classes are reasonable and based on objective business criteria, such as years of service, date of retirement, business location, job category, and nature of compensation (e.g., salaried vs. hourly). Different classes may not be based on eligibility for the Low Income Subsidy, as defined below. Sponsor may not vary the monthly Member contribution for the Part D Benefits Premium for individuals within a given class of Members.

(d) Sponsor may not charge a Member more for prescription drug coverage provided under the Evidence of Coverage than the monthly Member contribution for the Part D Benefits Premium attributable to basic prescription drug coverage and 100% of the monthly Member contribution attributable to his or her non-Medicare Part D Benefits. Sponsor must pass through any direct subsidy payments received from CMS to reduce the amount that Member pays (or in those instances where a Member who is the subscriber in Plan pays premiums on behalf of a Medicare eligible spouse or dependent, the amount the subscriber pays).

(e) For all Members eligible for the Low Income Subsidy program, as defined below, the low income premium subsidy amount will first be used to reduce the monthly Member contribution for the Part D Benefits Premium with any remaining portion of the subsidy amount then applied toward the monthly Sponsor contribution for the Part D Benefits Premium. (The "Low Income Subsidy" program is a Medicare Prescription Drug Benefit Program that provides assistance in the form of a subsidy for prescription drug costs to eligible individuals whose income and resources are limited.)

(f) If the low income premium subsidy amount for which a Member is eligible is less than the monthly Member contribution for the Part D Benefits, then Sponsor should communicate to the Member the financial consequences for enrolling in a Sponsor sponsored group prescription drug benefit as compared to enrolling in another Medicare Prescription Drug Benefit Program with a monthly premium equal to or below the low income premium subsidy amount. Sponsor should also communicate to the Member any adverse consequences to enrollment in Sponsor's Medicare Plan if Member chooses to disenroll from the Sponsoring group's Part D Benefits.]

Member must continue to pay Medicare Part B premiums, and Medicare Part A premiums (if required).

How to pay Medica Premiums:

Member will pay Medica Premiums to Medica at the billing address stated in the Acceptance of Contract provision, set forth at the end of this Contract, and the Evidence of Coverage. In exchange for Medica Premiums paid, Medica will arrange for the provision of Benefits. In doing so, Medica may enter into agreements with Providers of health care, one or more insurers, and such other individuals and entities as may be necessary to enable Medica to fulfill its obligations under this Contract.

Section 4.2 Grace Period and Reinstatement.

Member has a grace period of [10] calendar days after the due date stated in Section 4.1 to pay the Medica Premium. Failure to pay such premium, in whole or in part, within the grace period will result in Medica pursuing its collection process against the Member.

If Member fails to pay the Medica Premium, the Member's coverage under the Contract will be terminated and the Contract may be terminated in accordance with Section 2.2. Member's coverage under the Contract (and this Contract if terminated) will be reinstated if Member pays all Medica Premium owed within 60 days of the Medica Premium due date, unless the Member has applied for reinstatement on two or more prior occasions.

In the event Member's coverage under the Contract is not reinstated pursuant to this Section, Medica will not be responsible for any Claims for health services received by Members 30 days after the notice date of such termination.

Section 4.3 Medica Premium Calculation. The Medica Premium owed by Members will be calculated by Medica in accordance with Medica's community rating system. Member coverage for Benefits may be terminated only at the end of the calendar month in which Medica is notified and a full Medica Premium rate for that month will apply.

Section 4.4 Retroactive Medica Premium Adjustments. In accordance with applicable law, retroactive adjustments may be made for any additions of Members not reflected in Medica's records at the time Medica Premiums were calculated by Medica. With respect to terminations of Member's coverage, no retroactive credit will be granted for any month in which a Member received Benefits. No retroactive Medica Premium refund will be granted for termination of Member's coverage unless permitted by CMS.

Notwithstanding the preceding paragraph, Member will pay Medica Premium for any month during which a Member received Benefits.

Section 4.5 Medica Premium Reconciliation and Collection. Medica will complete a billing reconciliation for Medica Premium payments received.

If there is a credit after Medica completes the billing reconciliation process, a letter will be sent to the Member within 30 calendar days from the receipt date of the payment. A refund will be issued or the credit will be applied to the next billing, according to the Member's instruction to Medica.

If partial payment was received and there is a debit after the billing reconciliation process has been completed, a letter will be sent to the Member within 30 calendar days from the receipt date of the payment, requesting additional payment or appropriate documentation from the Member.

If the entire Medica Premium amount is past due, a letter will be sent to the Member and Medica will initiate its collection process against the Member.

Section 4.6 Medica Premium Changes. Medica may change Medica Premiums after [30-90] days prior written notice to Sponsor and Member [on:

[(a)] [the first anniversary of the effective date of this Contract;]
[(b)] [any monthly due date after the first anniversary of this Contract;] [or]
[(c)] [any date the provisions of this Contract are amended]].

[Section 4.7 Fees. Medica may charge Member :

(a) a late payment charge [in the form of a finance charge of [__%] per annum] [in the amount permitted under law] for any Medica Premiums not received by the due date; [and

(b) a service charge for any non-sufficient-fund check received in payment of Medica Premiums.]

ARTICLE 5
INDEMNIFICATION

Medica will hold harmless and indemnify Sponsor against any and all claims, liabilities, damages or judgments asserted against, imposed upon or incurred by Sponsor, including reasonable attorney fees and costs, that arise out of Medica's grossly negligent acts or omissions in the discharge of its responsibilities to a Member.

Sponsor will hold harmless and indemnify Medica against any and all claims, liabilities, damages or judgments asserted against, imposed upon or incurred by Medica, including reasonable attorney fees and costs, that arise out of Sponsor's or Sponsor's employees', agents', and representatives' grossly negligent acts or omissions in the discharge of its or their responsibilities under this Contract.

Sponsor and Medica will promptly notify the other of any potential or actual claim for which the other party may be responsible under this Article 5.

ARTICLE 6
ADMINISTRATIVE SERVICES

The services necessary to administer this Contract and the Benefits provided under it will be provided in accordance with Medica's or its designee's standard administrative procedures. If Sponsor requests such administrative services be provided in a manner other than in accordance with these standard administrative procedures, including requests for non-standard reports, and if Medica agrees to provide such non-standard administrative services, Sponsor will pay for such services or reports at Medica's or its designee's then-current charges for such services or reports.

ARTICLE 7
CLERICAL ERROR

A Member will not be deprived of coverage under the Contract because of a clerical error. Furthermore, a Member will not be eligible for coverage beyond the scheduled termination date because of a failure to record the termination.

ARTICLE 8
ERISA / CONTRACT INTERPRETATION

If all or a portion of this Contract is entered into by Sponsor to provide Benefits under an employee welfare benefit plan governed by ERISA, Medica will not be named as and will not be the plan administrator or the named fiduciary of the employee welfare benefit plan, as those terms are used in ERISA.

Regardless of whether all or a portion of this Contract is subject to ERISA, the parties agree that Medica has sole, final, and exclusive discretion without approval of Sponsor to:

(a) interpret and construe the Benefits under the Contract and the Evidence of Coverage;

(b) interpret and construe the other terms, conditions, limitations and exclusions set out in the Contract and the Evidence of Coverage;
(c) change, interpret, modify, withdraw or add Benefits; and
(d) make factual determinations related to the Contract, Evidence of Coverage and the Benefits.

For purposes of overall cost savings or efficiency, Medica may, in its sole discretion, provide services that would otherwise not be Benefits. The fact that Medica does so in any particular case will not in any way be deemed to require it to do so in other similar cases.

Medica may, from time to time, delegate discretionary authority to other persons or entities providing services under this Contract.

ARTICLE 9
DATA OWNERSHIP, USE AND NON-DISCLOSURE

To the extent not inconsistent with applicable law, information and data acquired, developed, generated, or maintained by Medica in the course of performing under this Contract will be Medica's sole property. Except as this Contract or applicable law requires otherwise, Medica will have no obligation to release such information or data to Sponsor. Medica may, in its sole discretion, release such information or data to Sponsor, but only to the extent permitted by law and subject to any restrictions determined by Medica. Sponsor acknowledges that the benefits and pricing of this Plan are designed exclusively to meet the needs of Sponsor's retirees and should not be presumed to be transferrable to other plan sponsors or employers. Sponsor agrees not to disclose the terms and conditions of this Contract, including without limitation the pricing terms, other than for the purposes of fulfilling the objectives of this Contract.

ARTICLE 10
AMENDMENTS AND ALTERATIONS

Section 10.1 Standard Amendments. Except as provided in Section 10.2, amendments to this Contract are effective [30-90] days after Medica sends Sponsor a written amendment. Unless regulatory authorities direct otherwise, or unless otherwise set forth in this Contract, Sponsor's signature will be required. No Medica agent or broker has authority to change this Contract or to waive any of its provisions.

Section 10.2 Regulatory Amendment. Medica may amend this Contract to comply with requirements of state and federal law ("Regulatory Amendment") and will issue to Sponsor such Regulatory Amendment and give Sponsor notice of its effective date. The Regulatory Amendment will not require Sponsor's consent and, unless regulatory authorities direct otherwise, Sponsor's signature will not be required. Any provision of this Contract that conflicts with the terms of applicable federal or state laws, regulations, or CMS policies or requirements is deemed amended to conform to the minimum requirements of such laws, regulations, or CMS policies or requirements.

ARTICLE 11
ASSIGNMENT

Neither party will have the right to assign any of its rights and responsibilities under the Contract to any person, corporation or entity without the prior written consent of the other party; provided, however, that Medica may, without the prior written consent of the Sponsor, assign this Contract to any entity that controls Medica, is controlled by Medica, or is under common control with Medica. In the event of assignment, the Contract will be binding upon and inure to the benefit of each party's successors and assigns. Any purported assignment of Sponsor's rights or obligations in violation of this Article is null and void.

ARTICLE 12
DISPUTE RESOLUTION

In the event that any dispute, claim or controversy of any kind or nature relating to this Contract arises between the parties, the parties agree to meet and make a good faith effort to resolve the dispute. The party requesting the meeting will provide the other, in advance of the meeting, with written notice of the claimed dispute. Upon receipt of the written notice, representatives for each party will meet promptly to attempt to resolve the dispute. If a mutually agreeable resolution is not reached within 30 days following receipt of the written notice, either party may pursue legal action in accordance with the terms of this Contract. The parties may mutually agree to waive the informal dispute resolution process set forth herein. Any such waiver must be in writing and executed by both parties.

ARTICLE 13
TIME LIMIT ON CERTAIN DEFENSES

No statement made by Sponsor, except a fraudulent statement, will be used to void this Contract after it has been in force for a period of 2 years.

ARTICLE 14
RELATIONSHIPS OF PARTIES

The relationship between Sponsor and any Member is that of Sponsor and Member as defined in this Contract.

The relationship between Medica and Sponsor is a **solely** contractual relationship between independent contractors. Sponsor is not an agent or representative of Medica, and Sponsor will not be liable for any acts or omissions of Medica, its agents or employees, or any other person or organization with which Medica has made, or hereafter will make, arrangements for the performance of services under this Contract. Medica is not an agent or representative of Sponsor, and Medica will not be liable for any acts or omissions of Sponsor, its agents or employees or providers, or any other person or organization with which Sponsor has made, or hereafter will make, arrangements for the performance of services under this Contract.

The relationship between Medica and Network Providers is a **solely** contractual relationship between independent contractors. The relationship between a Medica Network Provider and

any Member is that of provider and patient, and the Network Provider is solely responsible for the services provided to any Member.

ARTICLE 15
SPONSOR RECORDS

Sponsor will be responsible for obtaining any required consents from Members which allow Medica to receive a Member's Protected Health Information, as defined below. Medica may at any reasonable time inspect all documents furnished to Sponsor by an individual in connection with the Benefits, Sponsor's payroll records, and any other records pertinent to the Benefits under this Contract.

Although it is not anticipated that Sponsor will receive Protected Health Information, to the extent required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Sponsor agrees that it has amended its documents to reflect the restrictions on use and disclosure of protected health information ("PHI") as required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and that the Sponsor agrees to the required use and disclosure restrictions provided by HIPAA as follows:

1. The Sponsor will not use or further disclose such PHI other than as permitted or required by this Contract or as required by law (as defined in the HIPAA privacy standards).
2. The Sponsor will ensure that any agents, including a subcontractor, to whom the Sponsor or any party acting on behalf of the Sponsor provides PHI, agree to the same restrictions and conditions that apply to the Sponsor with respect to such PHI.
3. The Sponsor will not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Sponsor, except under an authorization which meets the requirements of the HIPAA privacy standards.
4. The Sponsor will report to Medica any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Sponsor becomes aware.
5. The Sponsor will make available PHI in accordance with a covered person's right of access under the HIPAA privacy standards.
6. The Sponsor will make available PHI for amendment and incorporate any amendments to PHI in accordance with the HIPAA privacy standards.
7. The Sponsor will make available the information required to provide an accounting of certain disclosures of PHI in accordance with the HIPAA privacy standards.
8. The Sponsor and any of its agents, including a subcontractor, will make its internal practices, books and records relating to the use and disclosure of PHI available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Sponsor with the HIPAA privacy standards.
9. If feasible, the Sponsor and any of its agents, including a subcontractor, will return or destroy all PHI received from any party when the PHI is no longer needed for the purpose for which it was disclosed. If such return or destruction is not feasible, the Sponsor will impose all necessary protections to maintain the security of the PHI.
10. The Sponsor will ensure that PHI is only accessible to employees on an "as need to know basis."

11. Sponsor will provide access to a copy of this Contract to Medica upon request by Medica or CMS.

ARTICLE 16
MEMBER RECORDS

By accepting Benefits under this Contract, each Member authorizes and directs any person or institution that has provided services to the Member to furnish Medica or any of Medica's designees at any reasonable time, upon its request, any and all information and records or copies of records relating to the Benefits provided to the Member. In accordance with applicable law, Medica and any of Medica's designees will have the right to release any and all records concerning health care services: (i) as necessary to implement and administer the terms of this Contract; or (ii) for appropriate medical review or quality assessment. Such Member information and records will be considered confidential medical records by Medica and its designees.

ARTICLE 17
NOTICE

Except as provided in Article 2 and required by applicable law, notice will be given by Medica to Sponsor at the addresses set forth in the Sponsor's application.

All notices to Medica will be sent to the corporate office address as set forth below in the Acceptance of Signature provision. All notices to Sponsor will be sent to the person(s) and address(es) as set forth below in the Acceptance of Signature provision. All notices will be deemed delivered:

(a) if delivered in person, on the date delivered in person;
(b) if delivered by a courier, on the date stated by the courier;
(c) if delivered by an express mail service, on the date stated by the mail service vendor; or
(d) if delivered by United States mail, 3 business days after date of mailing.

A party can change its address for receiving notices by providing the other party a written notice of the change.

ARTICLE 18
COMMON LAW

No language contained in the Contract constitutes a waiver of Medica's rights under common law.

ACCEPTANCE OF CONTRACT

This Contract is deemed accepted by Sponsor upon the earlier of Medica's receipt of its first payment of the Medica Premium or upon Sponsor's execution of this Contract by its duly authorized representative. This Contract is deemed accepted by Medica upon Medica's deposit

of the first payment of the Medica Premium. Such acceptance renders all terms and provisions herein binding on Medica and Sponsor.

[Signature page follows.]

IN WITNESS WHEREOF, authorized representatives of the Parties to this Contract have executed this Contract on the date set forth below to take effect on the Effective Date stated in the Contract.

MEDICA INSURANCE COMPANY	**SPONSOR**
Corporate Office Address: [401 Carlson Parkway Minnetonka, MN 55305-5387] [(952) 992-2362] [1-800-575-2330]	Sponsor Address: Telephone:
Billing Address: [P.O. Box 64847 St. Paul, MN 55164-0847]	
Mailing Address: [P.O. Box 9310 Mail Route CP320 Minneapolis, MN 55440]	
By: _____ [Name]	By: _____ Sponsor Name
Title: _____	Title: _____
Date: _____	Date: _____

Annual Plan Summary
Premium & Purchased Benefits for [Group Name]
Master Group Number [xxxxxx] [Group][Individual] Billing

Effective Date:	[1/1/2010]		Total Premium:	[$xxx]
Renewal Date:	[1/1/2011]			
Contract Type:	[Calendar][non-Calendar]		Low Income Subsidy:	[$xxx]
Product:	Group [Prime][Advantage][Select] Solution		Group Domicile State:	[MINNESOTA]
Group Number:	[XXXXX]		[RDS:]	[yes]

Benefit Summary

Deductable		Maximum Out of Pocket	
Medical	[$xxx]	Medical	[$xxx]
Pharmacy	[$xxx]	Pharmacy	[$xxx]
		[Combined Medical & Pharmacy]	[Yes][No] [$xxx]

Medical Benefits		Pharmacy Benefits	
Preventive Services (mammogram, colorectal screen, pap smear, prostate screen) Flu Shot	[100% covered] [$xx copay] [xx% coinsurance]		
Office Visit	[$xx copay] [xx% coinsurance]	Formulary	[Open][Closed] [Commercial]
Specialty Visit	[$xx copay] [xx% coinsurance]	Tier 1 Generic	[$xx copay] [xx% coinsurance]
PT OT ST	[$xxxx]	Tier 2 [Formulary][Preferred] Brand	[$xx copay] [xx% coinsurance]
Lab Visit (routine-no copay; due to a condition-office visit copay may apply)	[$xx copay] [xx% coinsurance]	[Tier 3 [[non-][Formulary][Non-Preferred] Brand]	[[$xx copay] [xx% coinsurance]]
Immunizations, tetanus & allergy shots (no copay for shot; office visit copay may apply)	[$xx copay] [xx% coinsurance]	[Tier 4 Specialty]	[[$xx copay] [xx% coinsurance]]
Emergency Room	[$xx copay] [xx% coinsurance]	Retail Monthly Drug Supply	31 Days
Ambulance	[$xx copay] [xx% coinsurance]	Choice 90/93 Maximum Drug Supply	[90][93] days [Other]
Urgent Care (in-network)	[$xx copay] [xx% coinsurance]	Mail Order Maximum Drug Supply	[90][93] days
Urgent Care (out of-network)	[$xx copay] [xx% coinsurance]	[Employer Wrap Drugs]	[Yes][No]
Durable Medical Equipment & Prosthetics	[$xx copay] [xx% coinsurance]	[Gap Coverage (y-fills coverage gap)]	[Yes][No]

Scalp Prosthesis due to Alopecia Areata (Medica will pay up to $350 annually)	[$xx copay] [xx% coinsurance]	[Part D]Diabetic Supplies	[Yes][No] [Part D] [$xx copay] [xx% coinsurance]
Outpatient Services	[$xx copay] [xx% coinsurance]	Self Administered EPO	[$xx copay] [xx% coinsurance]
Inpatient Hospital Services	[$xx copay] [xx% coinsurance]	Blood Clotting Factors	[$xx copay] [xx% coinsurance]
Outpatient Services	[$xx copay] [xx% coinsurance]	Growth Hormone	[$xx copay] [xx% coinsurance] [Part D pharmacy copays apply]
Eyewear after Cataract	[$xx copay] [xx% coinsurance]		
Skilled Nursing Facility	[$xx][xx%] per days [x-xxx][; [$xx][xx%] per days [x-xxx]]	Part B Drugs	[$xx copay] [xx% coinsurance]
Skilled HHC (office visit copay may apply)	[$xx copay] [xx% coinsurance]	Part B Diabetic Supplies (includes training)	[$xx copay] [xx% coinsurance]
Medicare Accidental Dental and other dental related services, not due to medical condition	[$xx copay] [xx% coinsurance]	Part B Other: (Nutritional therapy, PKU, Dialysis and Training etc)	[$xx copay] [xx% coinsurance]
[Optional Supplemental Eyewear Allowance]	[up to [$xx] per [x] year[s]]		
[Optional Hearing Aid Allowance]	[up to $xxx per [x] year[s]]		
[Preventative Dental]	[Not covered]		

Customer Initial: _____ Medica Initial: _____ Date: _____

Quote Number: [[group name_[[01012010]_510]]

The above rate and benefits are not valid until initialed by both parties and dated. The rate will expire on the renewal date.

The Benefits set forth in this Schedule A are explained more fully in the Evidence of Coverage. This Schedule A is to be read consistently with the Evidence of Coverage to the extent feasible. If there is a conflict between the terms and conditions of this Schedule A and the Evidence of Coverage, the Evidence of Coverage will govern.