MEDICA HEALTH PLANS

EMPLOYEE BENEFIT PLAN

Amended and Restated Effective
January 1, 2012

PLAN NAME: Medica Health Plans Employee Benefit Plan

PLAN SPONSOR: Medica Health Plans

PLAN EFFECTIVE DATE: January 1, 2002

PLAN NUMBER 501

PLAN ADMINISTRATOR Medica Health Plans

PREAMBLE

Medica Health Plans ("Employer"), a Minnesota nonprofit corporation, has established the Medica Health Plans Employee Benefit Plan ("Plan"), a wrap-around welfare benefit plan which may include medical, dental, life, supplemental life, dependent life, accidental death and dismemberment, long-term disability, salary continuation, business travel accident insurance, legal services, vision care, and other benefit components, and may also include a flexible spending account plan (including pre-tax premiums, a health care spending account and dependent care spending account) under which eligible employees of the Employer are permitted to choose among various employee benefits.

Certain components of the Plan constitute an employee welfare benefit plan within the meaning of the Employee Retirement Income Security Act of 1974 ("ERISA"). Certain components of the Plan were formerly maintained as separate plans under ERISA, and were consolidated and restated in the form of this single benefit plan. The Plan is effective as amended and restated January 1, 2012 and is a continuation of the Employer's welfare benefit plans in accordance with the terms and conditions contained herein. This document contains certain definitions and general administrative provisions that govern the Plan. The provisions on the following pages are a part of this Plan. Such provisions alone, including any attachments, schedules, and appendices, constitute the agreement under which payments will be made, and are a part of this Plan as fully as if recited over the signatures hereto affixed.

The Plan Sponsor intends to continue this Plan indefinitely, however, the Plan Sponsor at any time and from time to time may amend, change or terminate the Plan without the consent of any Covered Person or any other persons entitled to receive payment of benefits under the Plan.

IN WITNESS WHEREOF, this Plan has been amended and restated by Medica Health Plans on this XXth day of XXXX 2011, effective as of January 1, 2012.

Signed By: Deb Knutson
Title: Senior Vice President, Human Resources
MEDICA HEALTH PLANS

ARTICLE I - INTRODUCTION

1.1 Purpose of the Plan

The purpose of this Plan is to provide Eligible Employees (as determined under Plan Article III) of the Employer with welfare benefits which may include, but are not limited to, medical care benefits, dental care benefits, life and accidental death and dismemberment benefits, long-term disability benefits, salary continuation benefits, and business travel accident benefits, legal services, vision care and cafeteria plan benefits (including pre-tax premiums, health care spending accounts and dependent care spending accounts). Certain medical care benefits are self-insured and the summary plan description for those benefits is hereby incorporated into this Plan by reference and is set forth in Attachment A. Certain dental benefits are self-insured and the summary plan description for those benefits is hereby incorporated into this Plan by reference and is set forth in Attachment B. Certain life and accidental death and dismemberment benefits are provided through insurance policies and the summary plan description for those benefits is hereby incorporated into this Plan by reference and is set forth in Attachment C. Certain long-term disability benefits are provided through insurance policies and the summary plan description for those benefits is hereby incorporated into this Plan by reference and is set forth in Attachment D. Certain business travel accident benefits are provided through insurance policies and the summary plan description for those benefits is hereby incorporated into this Plan by reference and is set forth in Attachment E. Certain salary continuation benefits are provided through insurance policies and the summary plan description for those benefits is hereby incorporated into this Plan by reference and is set forth in Attachment F. Certain cafeteria plan benefits are described in the Pre-Tax Premium Contribution and Flexible Spending Account Component that is hereby incorporated into this Plan by reference and is set forth in Attachment G. Certain legal services benefits are described in the MetLaw Summary Plan Description Component that is hereby incorporated into this Plan by reference and is set forth in Attachment H. Certain vision care services are described in the Group Vision Care Policy Component that is hereby incorporated into this Plan by reference and is set forth in Attachment I. This Plan, including the components which appear as attachments ("Component Plans"), is a single welfare plan. A Component Plan shall be subject to ERISA only to the extent required by ERISA.

1.2 Interpretation and Law

The Plan is intended to qualify as a group term life insurance plan under Code Section 79, as an accident and health plan under Code Sections 105 and 106 and to comply with ERISA and the regulations and rules promulgated under each. The Plan shall be construed and interpreted in a manner consistent with the requirements of Code Sections 79, 105 and 106, ERISA, and the Pre-Tax Premium Contribution and Flexible Spending Account Component as set forth in Attachment G.

1.3 Effective Date

The Plan, as amended and restated, shall be effective January 1, 2012.

ARTICLE II - DEFINITIONS

The following words and phrases as used herein shall have the following meanings unless a different meaning is plainly required by the context.

2.1 Annual Enrollment

means the period, other than a Special Enrollment Period, designated by the Plan Administrator preceding each calendar year during which each eligible Employee not currently enrolled may elect coverage under the Plan, or if currently enrolled, may change the coverage option, to the extent permitted under the terms of the Component Plan. Such Annual Enrollment may be designed as a "negative enrollment."

2.2 Board of Directors

means the Board of Directors of Medica Health Plans as constituted from time to time, or the Personnel and Compensation Committee of the Board of Directors designated by the Board of Directors as having the authority or responsibility to act pursuant to the terms of the Plan and in accordance with federal and state law.

2.3 COBRA

means the Consolidated Omnibus Budget Reconciliation Act of 1985, as now in effect or as hereafter amended, including any regulations and rulings promulgated thereunder and any successor statute of similar import. Reference to any section or subsection of COBRA includes references to any comparable or succeeding provisions of any legislation that amends, supplements, or replaces such section or subsection.

2.4 Code

means the Internal Revenue Code of 1986, as now in effect or as hereafter amended, including any regulations and rulings promulgated thereunder, and any successor statute of similar import. Reference to any section or subsection of the Code includes references to any comparable or succeeding provisions of any legislation that amends, supplements, or replaces such section or subsection.

2.5 Component Plans

means those plans designated or incorporated in the Attachments to this Plan which may include, but are not limited to, the following benefits, as established by the Employer: medical benefits, dental benefits, life and accidental death and dismemberment insurance, long-term disability benefits, salary continuation benefits, business travel accident benefits, legal services, vision care and cafeteria plan benefits (including pretax premiums, health care spending accounts and dependent care spending accounts) under the Pre-Tax Premium Contribution and Flexible Spending Account Component.

2.6 Covered Person

means each eligible Employee or eligible Dependent who is covered under this Plan, including the Component Plans which appear as Attachments A, B, C, D, E, F, G, H and I.

2.7 Dependent

means "dependent" as defined in the applicable Component Plan.

2.8 Effective Date

means January 1, 2002.

2.9 Eligible Employee

means each Employee classified by the Employer as an active, full-time Employee, regularly scheduled to work 20 or more hours per week. An Eligible Employee cannot become a Participant until the first day of the month coinciding with or following the date the Employee satisfies the eligibility requirements specified in Plan Article III.

2.10 Employee

means any person rendering services to the Employer for remuneration that is subject to federal income tax withholding and FICA taxes. Independent contractors, self-employed individuals and any other such person(s) not classified as an employee by the Employer shall not be deemed an Employee for the purpose of this Plan. Leased employees within the meaning of Section 414(n) of the Code, employees covered by a collective bargaining agreement (unless such agreement expressly provides for coverage of the employee under the Plan), temporary employees, seasonal employees and nonresident aliens with no earned income from sources within the United States shall not be Employees for the purpose of this Plan, except as required for purposes of nondiscrimination testing under the Code. All employees who are treated as employed by the Employer under Subsections (b), (c) or (m) of Section 414 of the Code are treated as employed by the Employer for purposes of this Plan. If an employee is reclassified from a non-eligible class of Employee to an eligible class of Employee, the Employee shall become an Eligible Employee as of the later of the date of the reclassification or the date the Employee would otherwise have entered the Plan had the Employee always been in an eligible class and after satisfaction of any other eligibility requirements.

2.11 Employer

means Medica Health Plans, a Minnesota nonprofit corporation, or any successor thereto or any entity now or hereafter affiliated with the Employer which adopts the Plan with

the written consent of the Board of Directors, subject to any conditions or requirements approved by the Board of Directors.

2.12 Enrollment Period

means the Annual Enrollment and Special Enrollment Period.

2.13 ERISA

means the Employee Retirement Income Security Act of 1974, as now in effect or as hereafter amended, including any regulations and rulings promulgated thereunder and any successor statute of similar import. Reference to any section or subsection of ERISA includes references to any comparable or succeeding provisions of any legislation that amends, supplements, or replaces such section or subsection.

2.14 FMLA Leave

means a period of absence from work of up to twelve weeks during a twelve month period that is granted under the FMLA.

2.15 FMLA

means the Family and Medical Leave Act of 1993, as now in effect or as hereafter amended, including any regulations and ruling promulgated thereunder and any successor statute of similar import.

2.16 HIPAA

means the Health Insurance Portability and Accountability Act of 1996, as now in effect or as hereafter amended, including any regulations and rulings promulgated thereunder and any successor statute of similar import.

2.17 Leave of Absence

means the Employee has obtained an approved leave of absence from the Employer as provided for in the Employer's company rules, policies, procedures and/or practices, including FMLA Leave and USERRA Leave. Leave of Absence shall also mean any other unpaid Leave of Absence as administered and approved by the Employer.

2.18 Pre-Tax Premium Contribution and Flexible Spending Account Component

means the Pre-Tax Premium Contribution and Flexible Spending Account Component, together with any and all amendments, supplements and appendices attached thereto, providing Employees the opportunity to choose among certain other benefits as therein described.

2.19 Named Fiduciary

means the Plan Sponsor and the Plan Administrator.

2.20 Participant

means any Eligible Employee who participates in the Plan in accordance with Article III, who has commenced participation in the Plan accordingly and whose participation has not terminated under any other applicable provisions of the Plan.

2.21 Plan

means the Medica Health Plans Employee Benefit Plan as described in this document, together with any and all amendments, supplements, attachments, and appendices hereto.

2.22 Plan Administrator

means the Employer, or a person or entity, including a Committee, as appointed by the Employer as the Plan Administrator.

2.23 Plan Sponsor

means the Plan Sponsor as stated on the cover page of this Plan.

2.24 Plan Year

means a period commencing on January 1 and ending on the next December 31.

2.25 Protected Health Information (PHI)

means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a participant; the provision of health care to a participant; or the past, present, or future payment for the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. Protected health information includes information of persons living or deceased.

2.26 Qualified Medical Child Support Order (QMCSO)

means an order which creates or recognizes the existence of a child's right to medical benefits under the Plan and must be in the form of a judgment, decree, or order (including a settlement agreement approved by the court) issued by a court that is deciding the child support issues in a divorce or other family law action. A Qualified Medical Child Support Order must clearly specify:

(a) the name and last known mailing address of an eligible Employee and the name and last known mailing address of each child covered by the order,

(b) a reasonable description of the type of coverage to be provided by the Plan to each child covered by the order, or the manner in which such type of coverage is to be determined,

(c) the period to which the order applies, and

(d) each plan to which such order applies.

A Qualified Medical Child Support Order cannot require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan. The Plan Administrator shall adopt procedures respecting a Qualified Medical Child Support Order in accordance with ERISA Section 609.

2.27 Special Enrollment Period

means, with respect to medical coverage under HIPAA, the periods of enrollment other than Annual Enrollment or other open enrollment periods required under HIPAA or the terms of the Component Plan.

2.28 Uniformed Services

means the Armed Forces, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

2.29 USERRA

means the Uniformed Services Employment and Reemployment Rights Act of 1994, as now in effect or as hereafter amended, including any regulations and rulings promulgated thereunder and any successor statute of similar import.

2.30 USERRA Leave

means leave taken while serving in the Uniformed Services as described in USERRA.

ARTICLE III - PARTICIPATION

3.1 Eligibility

Any Eligible Employee will be eligible to participate in this Plan commencing on the first day of the month coinciding with or following the Employee's date of hire, provided such Eligible Employee continues to be employed with the Employer. The Component Plans incorporated in this Plan may have their own eligibility requirements for participation. The eligibility rules of such Component Plans are in addition to the eligibility rules of this Plan. Notwithstanding any other provision of this Plan to the contrary, an Eligible Employee may become a Participant only after such person has met the eligibility rules of at least one of the Component Plans.

3.2 Determination of Eligibility by Plan Administrator

The determination of an Employee's eligibility to participate in the Plan shall be made by the Plan Administrator, and the Plan Administrator's good faith determination shall be binding and conclusive upon all persons.

3.3 Commencement of Participation

An Eligible Employee shall become a Participant under the Plan in accordance with the rules set forth in Attachments A, B, C, D, E, F, G, H and I, as applicable.

3.4 Elections and Changes in Elections for Benefits

The Plan Administrator may designate an Annual Enrollment Period and the options available for election for the following Plan Year. The election of the options shall be made in the manner and subject to the conditions specified by the Plan Administrator and in accordance with the Pre-Tax Premium Contribution and Flexible Spending Account Component as described in Attachment G . Changes to benefit elections shall also be made in accordance with the Pre-Tax Premium Contribution and Flexible Spending Account Component. Such elections and changes to elections may be designed as "negative enrollments" as determined by the Plan Administrator.

3.5 Participation During Leaves of Absence

(a) Any Participant who is not at work because of an unpaid FMLA Leave, or due to a USERRA Leave lasting more than 31 days, or due to any other approved unpaid personal leave, may, if permitted under the terms of the relevant Component Plan or required by law, at the Participant's option, continue any or all benefits under the Plan that the Participant elected during the period of absence so long as the Participant continue to make any required contributions. During the absence, the Participant may choose to make these contributions by: (i) through payroll contributions provided the Participant is receiving salary continuation pay pursuant to Medica's salary continuation pay policy or paid time off, or some combination thereof; (ii) remitting payment to the

Employer on or before each pay period for which the contributions would have been deducted from the Participant's paycheck if leave had not been taken, provided that any delinquent payments must be made within 30 days of their due date; (iii) through payroll contributions upon return from leave where any required contributions may have been placed in arrears for coverage during an unpaid leave; or (iv) at the Participant's request, prepaying the amounts that will become due during the leave out of one or more of the Participant's paychecks preceding the leave.

(b) Any Participant who is absent from work for any paid leave of absence, including salary continuation, may continue any and all benefits elected under this Plan, as permitted under the terms of the relevant Component Plan or as required by law, in accordance with Attachment G, and Employee contributions for those benefits that the Participant chooses to continue while on the leave of absence will continue to be deducted from the Participant's paychecks during the absence. Participants approved for long-term disability benefits may continue only those benefits that are required under COBRA or any applicable state continuation law.

(c) Any Participant returning from an FMLA Leave, USERRA Leave, or other approved unpaid personal leave shall, as permitted under the terms of the relevant Component Plan or as required by law, be reinstated in equivalent benefits to the benefits they received prior to the FMLA Leave or USERRA Leave, adjusted for any changes in benefits that affected the workforce as a whole.

3.6 Contribution Basis

The coverage for which a Covered Person is eligible may be contributory, as determined by the Plan Administrator and communicated during the Annual Enrollment period.

Contributions to this Plan shall be made by a Participant on an after-tax basis with regard to dependent life insurance, long-term disability insurance, and legal services, and on a pre-tax basis for all other benefits pursuant to a salary redirection agreement in entered into accordance with the terms of the Pre-Tax Premium Contribution and Flexible Spending Account Component described in Attachment G (or any successor plan).

3.7 Effective Dates and Conditions

In order to participate in a particular Component Plan and receive benefits under this Plan, an Employee must meet any additional participation requirements as set forth in Attachments A, B, C, D, E, F, G, H and I as applicable. An Employee must elect any such benefits on forms provided by the Plan Administrator unless the benefit is automatically provided. Such coverage shall be effective as of the date or dates set forth in Attachments A, B, C, D, E, F, G, H and I, as applicable.

3.8 Termination Coverage

Coverage under this Plan of any Employee or Dependent will terminate in accordance with the rules and procedures set forth in Attachments A, B, C, D, E, F, G, H and I , as applicable.

3.9 Continuation/Conversion

Notwithstanding Plan Section 3.8, opportunities to continue and/or convert coverage under this Plan, including Component Plans which appear as attachments, shall be provided in accordance with applicable state and federal law, including COBRA and USERRA.

3.10 Incorporation of Plans and Policies

The eligibility provisions, benefit provisions and such other provisions of the Component Plans, as may be modified from time to time hereafter, and as are consistent with the terms and conditions of this Plan, shall be incorporated herein by reference and shall be of the same force and effect under this Plan as if they were set forth herein. Furthermore, if any provisions in the Component Plans shall at any time hereafter conflict with the provisions of this Plan, such provisions of the Component Plan shall no longer be deemed a part of this Plan.

3.11 QMCSO

The Plan Administrator shall adopt procedures respecting QMCSOs in accordance with ERISA Section 609. Such procedures shall comply with ERISA Section 609 and shall be administered in a nondiscriminatory manner by the Plan Administrator.

ARTICLE IV - BENEFITS

4.1 Generally

Subject to the requirements of the Pre-Tax Premium Contribution and Flexible Spending Account Component (as described in Attachment G) regarding benefit elections, each Participant may elect to purchase any of the benefits set forth in the Component Plans described in Attachments A, B, C, D, E, F, G, H and I, for which he or she is eligible. The Component Plans may be the subject of separate plan documents, trust agreements, or contracts, the terms of which are incorporated in the Attachments to this Plan.

4.2 Benefit Election

During the Enrollment Period, a Participant may elect to either receive any or all of the benefits described in the Component Plans (with the exception of supplemental life

insurance and dependent life insurance), in accordance with the Pre-Tax Premium Contribution and Flexible Spending Account Component (as described in Attachment G). The price of each option shall be determined annually by the Plan Administrator. Each Eligible Employee and each Participant shall be notified of the price of each option prior to the Enrollment Period for the Plan Year. Again, such Enrollment Period may be designed as a "negative election" at the Plan Administrator's discretion.

ARTICLE V - CLAIMS

5.1 Claims Procedure

(a) The claims procedure to be followed by Covered Persons to obtain payment of benefits under this Plan shall be in accordance with the rules and procedures set forth in Attachments A, B, C, D, E, F, G, H and I, as applicable.

(b) The claims procedure set forth in this Article V of the Plan shall apply with respect to each Component Plan which appears as an attachment only to the extent that the claims procedure of the Component Plan does not otherwise apply to the claim being made.

5.2 Procedures for Claims Not Otherwise Covered

(a) Any person claiming a benefit, or requesting an interpretation or ruling under the Plan, or requesting information under the Plan with respect to a claim to which the claims procedure of a Component Plan does not apply shall present a request in writing to the Plan Administrator.

(b) The Plan Administrator shall give notice to a Covered Person within 90 days of the Covered Person's written claim for benefits under Section 5.2(a) of the Covered Person's eligibility or noneligibility for benefits under the Plan. If the Plan Administrator determines that a Covered Person is not eligible for benefits or full benefits, the notice shall set forth (a) the specific reasons for such denial, (b) a specific reference to the provision of the Plan on which the denial is based, (c) a description of any additional information or material necessary for the claimant to perfect the claim, and a description of why it is needed, and (d) an explanation of the Plan's claims review procedure and other appropriate information as to the steps to be taken if the Covered Person wishes to have the claim reviewed. If the Plan Administrator determines that there are special circumstances requiring additional time to make a decision, the Plan Administrator shall give notice to the Covered Person of the special circumstances and the date by which a decision is expected to be made, and may extend the time for up to an additional 90-day period.

(c) If a Covered Person is determined by the Plan Administrator under Section 5.2(b) above to be ineligible for benefits, or if the Covered Person believes that the Covered Person is entitled to greater or different benefits, the Covered Person shall have the opportunity to have the claim reviewed by filing a petition for review within 60 days after

the Covered Person has been given the notice issued by the Plan Administrator. A petition shall state the specific reasons the Covered Person believes that the Covered Person is entitled to benefits or greater or different benefits. Within 60 days after the petition has been filed, the Plan Administrator shall afford the Covered Person an opportunity to present the Covered Person's position to the Plan Administrator as the case may be, in writing, and the Covered Person shall have the right to review pertinent documents. The Plan Administrator, as the case may be, shall give notice to the Covered Person of its decision in writing within said 60-day period, stating specifically the basis of the decision written in a manner calculated to be understood by the Covered Person and the specific provisions of the Plan on which the decision is based. If, because of special circumstances, the 60-day period is not sufficient, the decision may be deferred for up to another 60-day period at the election of the Plan Administrator or the Trustee, as the case may be, but notice of this deferral shall be given to the Covered Person.

(d) Anyone making a claim for benefits under the Plan must exhaust the administrative reviews and appeals available under the Plan before bringing a lawsuit in state or federal court for relief with respect to a claim for benefits.

(e) In the event benefits are provided through an insurance contract, the insurance company will be the appropriate named fiduciary and shall have full and final discretionary authority to interpret and apply all terms and provisions of the insurance policy through which benefits are provided.

5.3 Recovery of Payments

Unless a Component Plan specifically provides otherwise, the Plan shall have the right to deduct from any benefits properly payable under this Plan the amount of any payment that has been made:

(a) in error; or

(b) pursuant to a misstatement contained in a proof of loss; or

(c) pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences; or

(d) with respect to an ineligible person; or

(e) in anticipation of obtaining a recovery in subrogation; or

(f) pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational injury or disease to the extent that such benefits are recovered. This provision (f) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

Such deduction may be made against any claim for benefits under this Plan by a Covered Person if such payment is made with respect to such covered Employee or any person covered or asserting coverage as a Dependent of such covered Employee. Any such reduction in benefit shall be subject to the review and appeal processes set forth in this Plan, and in Attachments A, B, C, D, E, F, G, H, and I, as applicable.

ARTICLE VI - PLAN ADMINISTRATION

6.1 Plan Administrator

The Plan Administrator shall supervise the administration of the Plan. It shall be a principal duty of the Plan Administrator to ensure that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discriminating among them. Subject to and in accordance with any applicable requirements of law, the Plan Administrator shall have the full discretionary power to administer the Plan in all of its detail. For this purpose, the Plan Administrator's powers and duties include, but shall not be limited to, the following authority in addition to all other powers provided by this Plan:

(a) interpret the terms and provisions of the Plan, its good faith interpretation thereof to be final and conclusive on all persons claiming benefits under the Plan;

(b) make and enforce such rules and regulations it deems necessary or proper for the efficient administration of the Plan including the establishment of any claims procedures that may be required by the provisions of any applicable law;

(c) perform all acts necessary to meet the reporting and disclosure obligations imposed by ERISA Sections 101 through 111, if any, and Code Section 6039D;

(d) delegate, in writing, specific responsibilities for the operation and administration of the Plan to any Employees or agents it deems advisable;

(e) appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in the administration of the Plan;

(f) maintain records and accounts pertaining to the Plan;

(g) receive, review and keep on file the annual reports of the Plan, if any;

(h) determine eligibility under the Plan; such good faith determination to be binding and conclusive on all persons; and

(i) correct any defect, supply any omission, or reconcile any inconsistencies in the manner and to the extent the Employer considers proper to carry the Plan into effect.

6.2 Records and Reports of the Plan Administrator

The Plan Administrator shall keep such written records as it shall deem necessary or proper, which records shall be open to inspection by the Employer. The Plan Administrator shall prepare and submit to the Employer an annual report which shall include such information as the Plan Administrator deems necessary or advisable.

6.3 Named Fiduciaries

The Employer and Plan Administrator shall be the "Named Fiduciaries" of the Plan for the purposes of ERISA Section 402(a)(l), and shall have only those duties, responsibilities and obligations (referred to collectively as "fiduciary duties") as specifically are given them under the Plan or as otherwise are imposed by applicable law.

6.4 Employer Duties

All responsibilities not specifically delegated to another Named Fiduciary in this Plan document remain with the Employer. The Employer shall have sole authority to appoint, terminate, remove and replace the Plan Administrator and any other Named Fiduciaries.

6.5 Examination of Records

The Plan Administrator shall make available to each Participant such of the Participant's records under the Plan as pertain to him, for examination at reasonable times during normal business hours.

6.6 Reliance on Tables, etc.

In administering the Plan, the Plan Administrator shall be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by, or in accordance with the instructions of, accountants, counsel or other experts employed or engaged by the Plan Administrator. All actions taken in a good faith reliance on advice from such advisors are conclusive and binding upon all persons.

6.7 Indemnification of Plan Administrator

As permitted by law, and as limited by any written agreement between the Employer and the Plan Administrator, the Employer agrees to indemnify and to defend any Employee, individual, officer, or director serving as the Plan Administrator or as a member of a committee designated as Plan Administrator (including any Employee or former Employee, individual, officer or director who formerly served as Plan Administrator or as a member of such committee) against all liabilities, claims, loss, damages, costs and expenses (including attorneys' fees and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

6.8 Availability of Documents

A copy of the Plan and any and all future amendments and such records and data as are required under ERISA shall be available to any Participant, Employee or an employee organization that represents Employees of the Employer at reasonable times during normal business hours at the business office of the Plan Administrator or the business office of the Employer.

6.9 Legal Process

The Plan Administrator shall be the agent for service of legal process unless it designates another person to be such agent.

6.10 Administrative Expenses

All expenses not paid by the Plan, including a Component Plan, that are incurred prior to termination of the Plan and that arise in connection with the administration of the Plan, including, but not limited to, administrative expenses, and compensation and other expenses and charges of any actuary, accountant, counsel, specialist or other person who shall be employed by the Plan Administrator in connection with the administration, shall be paid by the Employer.

6.11 Delegation

The Plan Administrator may authorize one or more of its members or any agent to make any payment on its behalf, or to execute or deliver any instrument on its behalf.

6.12 Coordination with Component Plans

Article VI of this Plan shall apply with respect to each Component Plan which appears as an attachment, but only to the extent that the Component Plan does not otherwise specifically address an issue described in Article V in a manner that is consistent with applicable state and federal law.

However, any references to Plan Administrator shall be construed in accordance with the definition and description of duties contained in this Article VI.

ARTICLE VII - INSURANCE

7.1 Insurance Generally

To the extent that insurance is procured, the Participant's right to such benefits shall be limited to the amounts payable by such insurance and the receipt thereof shall be subject

to satisfaction of all of the terms, covenants, conditions, rules and regulations of the insurer. The Employer shall not have any independent obligation or duty to provide benefits to Covered Persons to the extent that such benefits are to be provided by insurance. The Plan Administrator shall have the right from time to time to change the coverages or carriers of any one or more insurance policies.

7.2 Provisions Relating to Insurers

No insurer shall be required or permitted to issue an insurance policy or contract that is inconsistent with the purposes of this Plan, nor be bound to take any action not in accordance with the terms of any policy or contract in connection with this Plan.

7.3 Conflicting Provisions

If any provision of any insurance policy or contract conflicts with any provision of this Plan, the provision of the insurance policy or contract shall prevail.

ARTICLE VIII - PROVISION OF PROTECTED HEALTH INFORMATION TO PLAN SPONSOR AND TO NON-HEALTH COMPONENTS OF THE PLAN

8.1 Hybrid Entity

The Plan has elected to be treated as a hybrid entity within the meaning of regulation 45CFR 164.504(a) and hereby designates the following components of the Plan as the "covered entity" for purposes of HIPAA:

(a) the medical component of the Plan as described in Attachment A;

(b) the dental component of the Plan as described in Attachment B; and

(c) the portion of the Medica Health Plans Flexible Spending Accounts Plan as described in Attachment G to the extent that it provides amounts for medical care as defined under HIPAA.

The "covered entity" portion of the Plan shall be referred to in this Article VIII as the Health Plan. All other components of the Plan shall not be part of the Health Plan for purposes of this Article VIII. The Health Plan consists of fully insured and self-insured components. Certain provisions of this Article VIII, as indicated herein, will apply only to the self-insured portion of the Health Plan.

8.2 Permitted Disclosure of Enrollment/Disenrollment Information

The Health Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose to the Plan Sponsor information on whether the individual is participating in the Health Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Health Plan.

8.3 Permitted Uses and Disclosure of Summary Health Information

The Health Plan may disclose Summary Health Information to the Plan Sponsor, provided the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under the Health Plan; or (b) modifying, amending, or terminating the Health Plan.

"Summary Health Information" means: information that (a) summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a Plan Sponsor had provided health benefits under the Health Plan; and (b) from which the information described at 45 CFR § 164.514(b)(2)(i) has been deleted, except that the geographic information described in 45 CFR § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit zip code.

8.4 Permitted and Required Uses and Disclosure of PHI for Administrative Purposes

Unless otherwise prohibited by law, and subject to the conditions of disclosure described in Section 8.5 and obtaining written certification pursuant to Section 8.7, the self-insured components of the Health Plan may disclose PHI to the Plan Sponsor, provided the Plan Sponsor uses or discloses such PHI only for Plan administration functions as described in HIPAA.

Notwithstanding the provisions of this Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR § 164.504(f).

8.5 Conditions of Disclosure for Plan Administration Purposes

The Plan Sponsor agrees that with respect to any PHI (other than enrollment/ disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the self-insured components of the Health Plan, the Plan Sponsor shall:

(a) Not use or further disclose the PHI other than as permitted or required by the Health Plan or as required by law.

(b) Ensure that any agent, including a subcontractor, to whom it provides PHI received from the Health Plan or from another party acting on behalf of the Health Plan,

agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI.

(c) Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

(d) Report to the Health Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.

(e) Make available PHI to comply with HIPAA's right to access in accordance with 45 CFR § 164.524.

(f) Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR § 164.526.

(g) Make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528.

(h) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Health Plan, or another party acting on behalf of the Health Plan, available to the Secretary of Health and Human Services for purposes of determining compliance by the Health Plan with HIPAA's privacy requirements.

(i) If feasible, return or destroy all PHI received from the Health Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

(j) Ensure adequate separation between the Health Plan, the other components of the Plan, and the Plan Sponsor (i.e., the "firewall"), as required in 45 CFR § 504(f)(2)(iii).

8.6 Adequate Separation Between Health Plan and Plan Sponsor

Only the following persons under control of the Plan Sponsor may be given access to the PHI that is disclosed according to the terms of the Health Plan: Director of Human Resources, Senior Benefits Analyst, and Manager – HR Operations. These specified employees (or classes of employees) shall only have access to and use PHI to the extent necessary to perform the plan administration functions that the Plan Sponsor performs for the Health Plan. In the event that any of these specified employees do not comply with the provisions of this Section, the Plan Sponsor will impose sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions may be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate. Sanctions, when imposed, will be commensurate with the severity of the violation.

8.7 Certification of Plan Sponsor

The Health Plan shall disclose PHI to the Plan Sponsor only upon the receipt of a certification by the Plan Sponsor that the Health Plan has been amended to incorporate the provisions of 45 CFR §164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth in Section 8.5 of this Article.

ARTICLE IX - AMENDMENT AND TERMINATION

9.1 Approval of Board of Directors

While the Employer intends to continue the Plan for an indefinite period of time, the Employer reserves the right at any time to amend or terminate the Plan, in whole or in part, by written instrument without prior notice. Any amendment to modify, amend, or terminate the Plan shall be effected by the decision of the Personnel and Compensation Committee of the Board of Directors through its normal decision-making procedures. A summary of Plan changes describing any material changes or modifications to the Plan will be distributed to all Participants. Written notice of any termination of the Plan, and the effective date of such termination, shall be provided to Participants.

9.2 Effect of Changes

All changes to this Plan shall become effective as of a date established by the Personnel and Compensation Committee of the Board of Directors.

ARTICLE X - GENERAL PROVISIONS

10.1 Written Notice

Any written notice required under this Plan shall be deemed received by a Covered Person if sent by regular mail, postage prepaid, to the last address of such Covered Person on the records of the Plan Administrator.

10.2 Information to be Furnished

Participants shall provide the Employer and Plan Administrator with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administering the Plan.

10.3 Limitation of Rights

Neither the establishment of the Plan nor any amendment thereof, or the payment of any benefits, shall be construed as giving to any Participant, Employee or other person any legal or equitable right against the Employer, any officer, agent or other Employee of the

Employer, Plan Administrator or member of the Plan Administrator, except as expressly provided herein or as provided by applicable federal law.

10.4 Nonguarantee of Employment

Neither the establishment and maintenance of this Plan, nor any modification thereof, nor the creation of any account, nor the payment of any benefits shall be construed as giving to any Employee or other person, any legal right or equitable right against the Employer, any officer or Employee of the Employer, or against the Plan Administrator, except as herein provided. Under no circumstances shall the terms of employment of any Participant or Employee be modified or in any way affected by this Plan.

10.5 No Vested Interest

Except for the right to receive any benefit payable under the Plan, no person has any right, title, or interest in or to the assets of the Employer because of the Plan.

10.6 Clerical Error/Delay

Clerical errors made on the records of the Plan Administrator and delays in making entries on such records shall not invalidate coverage or cause coverage to be in force or to continue in force. Rather, the effective dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to Covered Persons have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

10.7 Applicable Law

This Plan shall be construed, administered and enforced according to the federal laws governing employee benefit plans, including ERISA, and to the extent not inconsistent therewith, in accordance with the laws of the State of Minnesota and the state insurance laws and regulations of any other state applicable to any insurance policy issued hereunder. Any provision of this Plan in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

10.8 Waiver

The failure of the Plan Administrator to strictly enforce any provision of this Plan shall not be construed as a waiver of the provision. Rather, the Plan Administrator shall have the right to strictly enforce each and every provision of this Plan at any time regardless of the prior conduct of the Plan Administrator and regardless of the similarity of the circumstances or the number of prior occurrences.

10.9 Severability

If any provision of the Plan shall be held invalid or illegal for any reason, any invalidity or illegality shall not affect the remaining parts of the Plan, but the Plan shall be construed and enforced as if the invalid or illegal provision had never been inserted. The Employer shall have the privilege and opportunity to correct and remedy those questions of invalidity or illegality by amendment as provided in the Plan.

10.10 Nonalienation of Benefits

Except as specifically provided in the applicable Component Plan and to the extent permitted by law, the rights or interests of any Participant or the Participant's beneficiary to any benefits hereunder shall not be subject to attachment or garnishment or other legal process by any creditor of any such Participant or beneficiary, nor shall any such Participant or beneficiary have any right to alienate, anticipate, commute, pledge, encumber or assign any of the benefits which he may expect to receive, contingently or otherwise, under this Plan, and any attempt to anticipate, alienate, commute, pledge, encumber, or assign any right to benefits hereunder shall be void.

10.11 Workers' Compensation

This Plan is not instead of and does not affect any requirement for coverage by Workers' Compensation insurance.

10.12 Gender and Number

Whenever used in this Plan, a masculine pronoun or adjective shall be deemed to include the masculine, feminine and neuter gender, and a singular word shall be deemed to include the singular and the plural, unless the context clearly indicates otherwise.

10.13 Headings

The headings used in this Plan are for the purpose of convenience of reference only. Covered Persons are advised not to rely on any provisions because of the heading. In all cases, the full text of this Plan will control.

10.14 Disability or Death

If the Plan Administrator shall find that any Employee or covered Dependent to who or for whom any amount is payable under this Plan, is unable to care for his or her affairs because of illness or accident, or is a minor, or has died, then any payment due to such person or such person's estate (unless a prior claim therefore has been made by a duly appointed legal representative) may, if the Plan Administrator so elects, be paid to such person's spouse, a child, a relative, an institution maintaining or having custody of such person, or any other person deemed by the Plan Administrator to be a proper recipient on behalf of such person otherwise entitled to payment. Any such payment shall be a

complete discharge of the liability of the Employer, the Plan Administrator, the Plan, and any of the Component Plans.

10.15 Legal Actions

In any action or proceeding involving the Plan assets or any property constituting part or all thereof, or the administration thereof, no Employee, former Employee, Dependent, Covered Person, or any other person having or claiming to have an interest in this Plan shall be necessary parties and no such person shall be entitled to any notice or process, except to the extent required by applicable law. Any final judgment which is not appealed or appealable that may be entered in any such action or proceeding shall be binding and conclusive on the parties hereto and upon all persons having or claiming to have any interest in this Plan.

10.16 Plan Funding

The Plan is funded by Participant and Employer contributions, in accordance with the Pre-Tax Premium Contribution and Flexible Spending Account Component as described in Attachment G. The Employer shall make contributions, including Employee salary redirections prescribed by their Pre-Tax Premium Contribution and Flexible Spending Account Component pre-tax elections and any other contributions required of Participants and remitted to the Employer, to the Plan Sponsor in such amounts and at such times as shall be required to provide benefits as described in this Plan. The determinations of the Plan Sponsor with respect to the amounts and times of payment shall be binding upon each Employer. Plan Administrator shall use funds contributed by Employees solely to pay benefits. Employer shall pay plan service providers out of Employer's general assets and the Plan shall not reimburse Employer for such administrative expenses.

ATTACHMENT A

Medical Plan Document

ATTACHMENT B

Dental Plan Summary Plan Description

ATTACHMENT C

Group Life Insurance Policy

ATTACHMENT D

Long-Term Disability Policy

ATTACHMENT E

Business Travel Accident

ATTACHMENT F

Salary Continuation Policy

ATTACHMENT G

Medica Employee Flexible Benefits Plan

ATTACHMENT H

MetLaw Summary Plan Description

ATTACHMENT I

Group Vision Care Policy

ATTACHMENT J - LIST OF PARTICIPATING EMPLOYERS

Medica Health Plans