HealthPartners, Inc.
(called "HealthPartners")

has issued this
MASTER GROUP CONTRACT
(called "Master Contract")

for
HEALTH MAINTENANCE ORGANIZATION MEDICAL BENEFITS
(called "HMO Benefits")

Master Contract Number: *60738*

Master Contractholder: *Citigroup* (called the "Organization"),

contracts with HealthPartners, to provide HMO Benefits to its eligible persons (called "Employees") and their eligible dependents (called "Dependents") who enroll hereunder in accordance with the terms and conditions of the Master Contract. Consideration for coverage under the Master Contract are the approved applications of the Organization and the Employees and timely payment. Payment in accordance with the "Payment" section constitutes the Organization's acceptance of the terms and conditions of this Contract.

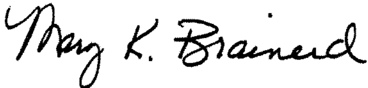
The Master Contract is delivered in the state of Minnesota and governed by its laws.

Master Contract Effective Date: *January 1, 2007*

Master Contract Anniversary Date: *January 1, 2008* (called "Anniversary Date") and annually thereafter.

Master Contract Renewal Dates: the Anniversary Date, following the Master Contract Effective Date, and monthly renewable thereafter (called "Renewal Date"), subject to the terms and conditions of the Master Contract.

Signed for HealthPartners on the date of issue.



Mary K. Brainerd
President

Andrea M. Walsh
Executive Vice President
Marketing, Member Health and Customer Service

HealthPartners
8170 – 33rd Avenue South
P.O. Box 1309
Minneapolis, MN 55440-1309

Prepared by: KAB December 4, 2006

TABLE OF CONTENTS

	Section	Page
1.	Benefits	1
2.	Term	1
3.	Payments	1
4.	Grace Period and Termination	2
5.	Participation and Contribution Requirements	2
6.	Eligibility and Effective Date of Employees	3
	6.1 Disabled Employees	4
7.	Eligibility and Effective Date of an Employee's Dependents	4
8.	Open Enrollment	5
9.	Changes in Benefits	5
10.	Termination of Individual Benefits	5
11.	Termination of the Master Contract	6
12.	Continuation and Conversion Rights	7
13.	Replacement	7
14.	Standard Provisions	8
15.	Rights Shall Not Vest	9
16.	Mutual Indemnification	9
17.	Request for PDF File	9
18.	Protected Health Information	9

1. **Benefits:** HealthPartners provides and underwrites coverage of comprehensive HMO Benefits. A description of coverage for the benefits provided is set forth in the Group Membership Contract (and any attached Amendments) or subsequent Group Membership Contract (and any Amendments) issued periodically. The Group Membership Contract is hereby incorporated and made fully a part of this Master Contract.

2. **Term:** Benefits and payments shall become effective on the Master Contract's Effective Date. They will continue until the Organization's next Anniversary Date and shall be renewed thereafter on each Renewal Date of the Organization. A thirty-one (31) day advance written notice shall be given by HealthPartners or the Organization to change said benefits and/or payments. HealthPartners reserves the right to terminate benefits, as provided in sections 4. and 11.

3. **Payments:** The amount of each payment due, at the time such payment falls due, is the aggregate of the amounts applicable to each enrolled Employee and Dependent of the Organization according to the notice of rates sent to the Organization prior to the issuance of this Contract. The amount so payable is determined according to the benefits for which each Employee and Dependent is enrolled.

   Such payments are due and payable to HealthPartners by the Organization, or its authorized representative, on or before the first day of the month (called "payment due date"), for each month benefits are in force (called "payment period"), for all persons enrolled, at the time such payment falls due. Interest of 1.5% per month (18% per annum), compounded daily, will be charged on any unpaid balances, beginning at the end of the grace period, retroactive to the payment due date, regardless of termination of this Master Contract.

   HealthPartners reserves the right to change the payments on any payment due date. HealthPartners shall give the Organization thirty-one (31) days' advance written notice of any such change. The Organization shall notify each Employee of such change, as necessary.

   HealthPartners may adjust plan rates if, due to a merger, acquisition or sale, the total number of eligible employees changes by more than 20%. Any resulting rate change will be effective on the date of the merger, acquisition or sale.

   The Organization's collection of an Employee's payment contribution is solely for the convenience of the Organization and does not create an agency relationship between the Organization and HealthPartners.

   The Organization shall give HealthPartners written notice, should the Organization change existing benefits which it provides to any or all of its Employees, no less than thirty-one (31) days before the effective date of such change. Upon receipt of such notice, HealthPartners reserves the right to modify the above payments, thirty-one (31) days after the date of said receipt.

   HealthPartners will not extend retroactive coverage, or termination, to Employees or Dependents due to clerical errors by the Organization, for a time period greater than ninety (90) days.

   Benefits for a newly enrolled Employee or Dependent (or additional or increased benefits for an already enrolled Employee or Dependent), who is hired or otherwise becomes eligible for benefits hereunder on or before the fifteenth day of any month, shall be provided on the basis of payment for the full month; benefits for a newly enrolled Employee or Dependent (or additional or increased benefits for an already enrolled Employee or Dependent) who becomes eligible for benefits hereunder after the fifteenth day of any month, shall be provided for the balance of such month without additional payment, unless the new enrollment is 1) due to the addition of a new class of employees, or 2) substantially all employees in an existing class. Under these circumstances, the payment will be pro-rated to reflect the addition of those employees.

4. **Grace Period and Termination:** A grace period of thirty-one (31) days after the payment due date shall be granted for any payment due after the initial payment, provided the Organization has not previously given written notice to HealthPartners that the benefits for all enrolled Employees and Dependents are to be terminated as of the end of the grace period. If the Organization fails to make payment within the grace period, benefits for all enrolled Employees and Dependents shall be terminated, subject to a thirty (30)-day advance written notice of termination by HealthPartners to all Employees of the Organization. The date of termination shall be the end of such grace period, retroactive to the paid-through date, but not more than sixty (60) days prior to the effective date of the notice of termination. The Organization shall be liable to HealthPartners for all payments due and unpaid, including payments for the grace period. If, however, written notice is given by the Organization to HealthPartners during the grace period that the benefits for all enrolled Employees and Dependents are to be terminated before the expiration of the grace period, such benefits shall be terminated as of the date specified by the Organization or the date of receipt of such written notice by HealthPartners, whichever is later, and the Organization shall be liable to HealthPartners for pro-rata payment for the period commencing with the last payment due date and ending with the date of such termination.

   The acceptance by HealthPartners of any late payments by the Organization shall not be construed as a waiver of any provisions in this section.

   Termination of benefits shall not prejudice any claim incurred prior to the date of such termination.

5. **Participation and Contribution Requirements:** The Organization shall contribute at least 50% of lowest cost payments for all Employees in an eligible class.

   In addition, the following provisions apply:

   A. At least 80% of all eligible Employees who have not waived coverage due to coverage under another plan, but no less than 50% of all eligible Employees, must participate under this Master Contract or another group health plan sponsored by the Organization. In addition, at least 15% of all eligible Employees and a minimum of two employees, must participate under this Master Contract or another group health plan sponsored by HealthPartners. Employees who waive coverage must do so in writing to the Organization, and the Company has the right to review such waivers upon request.

   B. All eligible employees within a current eligible class must be offered and allowed to select the HealthPartners coverage.

   C. Employees who waive coverage may receive no more than 50% of the pre-tax single premium in cash or cash equivalent in lieu of medical coverage. Employees who exercise this option must have other group medical coverage.

   D. If the Organization does not contribute toward the cost of coverage for early retirees, the early retiree enrollment may not exceed 20% of the total enrollment in this or any other HealthPartners plan sponsored by the Organization.

   E. If participation under this Master Contract decreases by more than 25% during the twelve months prior to the Renewal Date, or by 35% over the twenty-four months preceding the Master Contract Anniversary Date renewal, coverage under this Contract will be terminated unless, the Organization changes the employee contribution to promote greater participation. Reductions in participation due to mergers, sales of divisions, layoffs, strikes and/or staff reduction will be excluded from this calculation.

   F. If the total number of employees enrolled for coverage is greater than 25, the HealthPartners plan may be offered along side one other carrier/administrator. If the total number of employees enrolled for coverage is greater than 100, the HealthPartners plan may be offered alongside two or more carriers/administrators.

   HealthPartners will periodically review the Organization's participation to determine if the specified participation requirement was met during the preceding calendar year. The Organization agrees to cooperate

with HealthPartners to provide all necessary information relating to participation in accordance with section 14.(e) hereof. In the event the Organization does not meet the participation requirement for any reason, HealthPartners will notify the Organization in writing. The Organization shall then have thirty-one (31) days from the date of notice in which to fulfill the participation requirement. If the participation requirement is not fulfilled within such time period, this Master Contract will be terminated in accordance with section 11. hereof.

6. **Eligibility and Effective Date of Employees:** The Organization's Employees in the following categories, who reside in the service area, are eligible for benefits: *Permanent full-time employees working at least twenty hours (20) per week (Citibank and Citistreet). Regularly working and regularly scheduled employees (Travelers Group), permanent full-time Employees working at least thirty (30)hours per week (Salomon Smith Barney). Retirees for Citibank and Citistreet are covered. Early Retirees at Citibank and Citistreet are covered if age 55 and older with 5 years plus of service prior to retirement*.

   Employees in those categories shall become eligible on: *date of hire* (called "Eligibility Date") subject to section 3. and to the pre-existing condition limitation provision in section IV. "Services Not Covered" of the Group Membership Contract, as specified below.

   An "Employee" is the person who enrolls with the Organization for coverage under this Master Contract.

   If the Employee enrolls with the Organization within the thirty-one (31) day period after the Eligibility Date, benefits shall become effective on the Eligibility Date.

   If the Employee enrolls with the Organization more than thirty-one (31) days after the Eligibility Date and the Employee has maintained continuous coverage (as defined in section II. of the Group Membership Contract), benefits shall become effective on the first of the month following the application date, subject to the pre-existing condition limitation and late entrant provisions.

   When applying the pre-existing condition limitation to employees, as specified in this section, it shall be reduced by the period of time that a member was previously covered under qualifying coverage (as defined in section II. of the Group Membership Contract), provided that the individual has maintained continuous coverage.

   An Employee eligible, but not covered on the Eligibility Date, may also apply for Employee and Dependent benefits on a date later than the Eligibility Date, if one of the following life events occurs, provided the event causes discontinuation of another employer's or other group contractholder's contribution toward the cost, or termination of, another group contract actually covering the Employee for medical benefits. Life events are limited to the following:

   (a) an Employee or Dependent's eligibility during a Special Enrollment Period (as defined in the Group Membership Contract); or
   (b) an Employee's (1) divorce; (2) spouse's layoff from, or loss of, employment; (3) spouse's death.

   The Employee must enroll with the Organization for Employee or Dependent benefits within thirty-one (31) days after the date the life event occurs, and the effective date of benefits shall be the application date.

   No other application made more than thirty-one (31) days after the Eligibility Date shall be accepted, unless made during an annual open enrollment period.

The Organization must submit any enrollment information to HealthPartners as soon as possible following receipt of the information. In any case, HealthPartners will not extend retroactive coverage, or termination, to Employees or Dependents due to clerical errors by the Organization for a time period greater than ninety (90) days.

If an enrolled Employee is not actively-at-work on the date on which benefits would otherwise become effective, benefits shall not become effective until the date of return to active work. The effective date coverage shall not be delayed if the Employee is not actively at work on the effective date of the coverage due to the Employee's health status, medical condition, or disability. "Actively-at-work" means that an Employee is performing in his customary manner all the regular duties of his occupation on a full-time basis, according to the definition of Employee in the first paragraph of this section, at the customary place of employment or business, or at some location to which that employment requires travel. An Employee will be considered actively-at-work for the time period absent from work solely by reason of vacation or holiday, if the Employee was actively-at-work on the last preceding regular work day.

6.1 Disabled Employees: Pursuant to the provisions of Minnesota Statute 62A.148, the Organization and HealthPartners agree not to terminate, suspend or otherwise restrict the participation in, or the receipt of, benefits otherwise payable hereunder, to any enrolled Employee who becomes totally disabled, while employed by the Organization and covered hereunder, while this Master Contract is in force, solely due to absence caused by such total disability. The Organization may require the Employee to pay all or some part of the monthly payment for coverage in this instance. Such payment shall be made to the Organization, by that Employee.

For the purpose of this section, the term "total disability" means: (a) the inability of an injured or ill Employee to engage in, or perform the duties of, the Employee's regular occupation or employment within the first two (2) years of such disability and (b) after the first two (2) years of such disability, the inability of the Employee to engage in any paid employment or work for which the Employee may, by education and training, including rehabilitative training, be or reasonably become qualified.

7. Eligibility and Effective Date of an Employee's Dependents: An enrolled Employee with Dependents may enroll a Dependent who is eligible according to the definition of "Eligible Dependents" in the Group Membership Contract and the provisions of this section, provided the Employee enrolls the Dependent with the Organization within thirty-one (31) days of the date the Dependent is eligible for benefits hereunder and the required payment for that Dependent is made. Benefits for the Dependent shall become effective on the eligibility date.

An Employee can apply for Dependent benefits more than thirty-one (31) days after the Dependent is eligible for benefits hereunder if the dependent has maintained continuous coverage (as defined in Section II. of the Group Membership Contract), benefits shall become effective on the first of the month following the application date, subject to the pre-existing condition limitation and late entrant provisions.

When applying the pre-existing condition limitation to Dependents, as specified in this section, it shall be reduced by the period of time that a member was previously covered under qualifying prior coverage, provided that the individual has maintained continuous coverage (as defined in section II. of the Group Membership Contract).

In addition, the following provisions apply when an Employee seeks Dependent benefits:

(a) A Dependent can be added during an open enrollment period. The effective date of benefits shall be the Anniversary Date.
(b) Newborn infants, including a newborn grandchild of a covered grandparent and a newly adopted child, may be covered regardless of when notice is received by us. However, premium is required from the date of eligibility for a newborn infant, before benefits will be paid.
(c) A Dependent can be added at the time of a life event if HealthPartners receives written application reasonably acceptable to HealthPartners within thirty-one (31) days from the date of the life event. The effective date for benefits shall be the date of application.

(d) A Dependent, who is a disabled child, can be added according to the terms and conditions of the "Disabled Dependent" item in the "Eligible Dependents" definition of the Group Membership Contract. The effective date of benefits shall be the date of application.

The Organization must submit any enrollment information to HealthPartners as soon as possible following receipt of the information. In any case, HealthPartners will not extend retroactive coverage, or termination, to Dependents due to clerical errors by the Organization for a time period greater than ninety (90) days.

8. **Open Enrollment:** After the Effective Date of this Master Contract, an open enrollment period of at least fourteen (14) calendar days will be held once each calendar year. During an open enrollment period, any eligible person of the Organization not covered hereunder, may enroll. An Employee may also enroll eligible Dependents, not covered hereunder, during the open enrollment period. The effective date of benefits for newly covered Employees and Dependents will be the Anniversary Date.

9. **Changes in Benefits:** The effective date of any change in benefits requested by HealthPartners or the Organization, shall be the Anniversary Date, subject to our approval of that change, unless the provision pertaining to that change specifically provides otherwise. Any change in benefits required by state or federal law, shall become effective according to law. The effective date of a change in benefits requested by HealthPartners or the Organization, will be delayed for an Employee or Dependent who is confined to a hospital or skilled nursing facility on that date. The delay will end on the date the Employee or Dependent is not so confined.

10. **Termination of Individual Benefits:** If an Employee or Dependent no longer meets the Organization's eligibility requirements, or if the Organization has forwarded enrollment for an Employee or a Dependent to HealthPartners, regardless of whether such Employee meets their eligibility requirements, HealthPartners is required to obtain the Employee's or Dependent's signature before retroactively terminating coverage under this Master Contract. If a required signature is not obtained, the Organization is required to make payment for an Employee or Dependent up to the date of termination. A signature is not required for retroactive termination for any other reason, including, but not limited to, voluntary or involuntary termination of employment or because the enrollee or enrollee's dependent committed fraud or misrepresentation with respect to eligibility or any other material fact.

Coverage for benefits of an Employee and Dependent(s) shall terminate on the earliest of the dates shown below:

A. For Employees:
(a) the date this Master Contract terminates; or
(b) the last day of any payment period for which payment has been made, should the Organization, or the Employee (or former Employee exercising group continuation privileges) fail to make payment when due, subject to section 4.; or
(c) the last day of the month subject to section 3. in which an Employee ceases to be eligible for benefits under this Master Contract, if the Employee does not, within the time limits established by law, elect group continuation privileges as provided under state or federal law; or

(d) the last day of the eligibility period for group continuation privileges provided under state or federal law; or
(e) the date following thirty (30) days' advance notice by HealthPartners, in the event the Employee fails to make the copayments required under the Group Membership Contract. HealthPartners will notify the Employee in writing of that failure. If the Employee then does not make payment or fails to disprove the claim within thirty (30) days of the written notice, benefits terminate; or
(f) the date following thirty (30) days advance notice by HealthPartners, when an Employee no longer lives or works in the service area, provided the termination is made within one year following the date we received written notice from the Employee of the change in status.

B. For Dependents:
(a) the date this Master Contract terminates; or
(b) the date Dependent benefits under this Master Contract are discontinued for all Dependents; or
(c) the last day of the month subject to section 3. on which a person ceases to be eligible to be enrolled as a Dependent, if said Dependent does not, within the time limits established by law, elect group continuation privileges available to the Dependent under state or federal law; or
(d) the last day of the payment period on which the Employee's benefits terminate, as provided under paragraph A. above, if neither the Employee nor the eligible Dependent elects, within the time limits established by law, group continuation privileges available to the Dependent under state or federal law; or
(e) the last day of the eligibility period, for group continuation privileges provided under state or federal law; or
(f) the last day of the payment period for which payment has been made, should the Organization, or the Dependent (or the Employee on the Dependent's behalf) fail to make payment, when due, subject to section 4; or
(g) the date following thirty (30) days' advance notice by HealthPartners when a Dependent no longer lives with the Employee or in the service area, provided the termination is made within one year following the date we received written notice from the Employee of the change in address.

11. **Termination of the Master Contract:** Coverage for benefits of all the Organization's and their Employees and Dependents shall continue in force on a guaranteed renewal basis, except as provided below:

(a) the last day of the payment period for which payment has been made, if the Organization is in breach of any of the terms and conditions for coverage of this Master Contract. HealthPartners shall give the Organization written notice of its intent to terminate due to the Organization's breach of any said provisions thirty-one (31) days in advance of the termination date. In the event the Organization makes the changes required by HealthPartners to come into compliance with the specified provisions within the thirty-one (31)-day period following notification of termination, this Master Contract may be continued only upon joint agreement of the Organization and HealthPartners; or
(b) the end of the grace period, as provided in section 4.; or
(c) any payment due date after the first Anniversary Date, specified by the Organization, if the Organization gives HealthPartners written notice at least thirty-one (31) days prior to the date of termination; or
(d) the first renewal date following 120 days notice by HealthPartners to the Organization of our intention to cease doing business in the large employer market; or
(e) withdrawal from the service area.

Termination of the Master Contract shall not prejudice any claims incurred prior to the effective date of termination.

Termination by HealthPartners may be retroactive to the last day of the payment period for which payment has been made, subject to section 3.

12. **Continuation and Conversion Rights:** HealthPartners agrees to provide continuation and conversion coverage, as specified in the Group Membership Contract referenced herein, for an Employee or Dependent who is no longer eligible under the terms of this Master Contract.

13. **Replacement:** This section applies to Employees and Dependents who were covered by a prior carrier on the day prior to the Master Contract's Effective Date. "Prior carrier" means any group medical benefits obtained through the Organization, for which this Master Contract is a replacement.

    Liability of prior carrier.
    The prior carrier remains liable to the extent of its accrued liability and any contractual liability for extension of benefits at the time of replacement.
    "Accrued liability" includes, but is not limited to, responsibility for covered inpatient hospital expenses, subject to applicable deductibles, copayments, and limitations incurred by a covered individual who is confined in a hospital or skilled nursing facility on the date of replacement. The responsibility on the part of the prior carrier continues until the covered individual is discharged from the hospital or contract maximums have been reached, whichever occurs first.

    Liability of HealthPartners as replacement carrier.
    1. Each individual who is eligible under this Master Contract, with respect to provisions regarding eligibility, or nonconfinement in a hospital or skilled nursing facility, is covered by this Contract as of the Effective Date of this Master Contract.
    2. Each individual who is not eligible for coverage in accordance with paragraph 1., is nevertheless covered by this Master Contract in accordance with the following rules, provided that such individual (including an individual who has exercised the option for continuation of coverage pursuant to Minnesota Law) was validly covered under the prior carrier on the date it was discontinued and the individual is otherwise eligible for coverage under this Master Contract.
        a. The minimum level of benefits that shall be provided by this Master Contract, is the lesser of the benefits available under the prior carrier's plan reduced by any benefits payable by the prior carrier, or the benefits available under this Master Contract.
        b. Coverage shall be provided by this Master Contract at least until the earlier of the following dates: the date the individual becomes eligible under the terms of this Master Contract, or the date the individual's coverage would otherwise terminate, for each type of coverage, in accordance with the individual termination of coverage provisions of this Master Contract.
    3. Pre-existing condition limitation. An individual subject to a pre-existing conditions limitation contained in the Group Membership Contract, is nevertheless covered by this Master Contract, if the individual was validly covered by the prior carrier on the date prior to replacement by this Master Contract. The minimum level of benefits under this Master Contract is the lesser of this Master Contract's benefits determined without regard to the pre-existing condition limitation or the benefits provided by the prior carrier.
    4. Deductible or waiting period. In applying any deductible or waiting period, this Master Contract shall give credit for the full or partial satisfaction of the same or similar provisions under the prior carrier. In the case of deductible provisions, the credit shall apply for the same or overlapping benefit periods, to the extent the same expenses are recognized under the terms of this Master Contract and are subject to a similar deductible provision.
    5. Statement of benefits available. In any situation where a determination of the prior carrier's benefits is required by HealthPartners, at our request, the prior carrier shall furnish a statement of the benefits available and other pertinent information sufficient to permit HealthPartners to verify or determine benefits.
    6. Controlling terms. Benefits of the prior carrier shall be determined in accordance with the definitions, conditions and covered expense provisions of the prior carrier rather than those of this Master Contract.

14. Standard Provisions:

(a) Entire Contract; Changes:

This Master Contract, including attached Amendments (if any), the Group Membership Contract(s), including attached Amendments (if any), the application of the Organization, and the individual applications of the Employees constitute the entire contract between the parties. This Master Contract, or any change to this Master Contract, shall be valid only when approved by HealthPartners and the Organization, and such approval is attached hereto or endorsed hereon, or is otherwise acknowledged by the Organization, by making the required payments. No individual who is not an authorized employee of HealthPartners and as such designated by HealthPartners, has authority to change this Master Contract or Group Membership Contract or to waive any of their provisions.

(b) Effective Time:

The effective time for any dates shall be 12:01 A.M., Central Time. For provisions which are based on a calendar year, calendar year means the period commencing at 12:01 A.M., Central Time, on January 1, to 12:00 midnight of the following December 31.

(c) Masculine Pronouns:

Masculine pronouns in the Master Contract apply to both sexes.

(d) Membership Contracts:

A Group Membership Contract will be issued to each Employee, or to the Organization (for delivery to each Employee). The benefits and coverage terms described in the Group Membership Contract are controlled by the provisions of the Master Contract and are subject to any changes in the Master Contract. The Organization must have the Master Contract available for inspection by Employees at all reasonable times. The terms of the Group Membership Contract may be altered by (1) requirements of state or federal law; or (2) the methods outlined in sections 2., 3. and 9. hereof.

(e) Required Information:

The Organization shall furnish all information required by HealthPartners to compute payments due from the Organization, review the Employee participation, and maintain necessary administrative records. The Organization's records which have a bearing on this agreement shall be available for inspection by HealthPartners at any reasonable time.

(f) Misstatement of Age:

If the age of any person enrolled under the Master Contract has been misstated, then: (1) the Organization or HealthPartners (whichever is applicable) agree to adjust payments to correspond to the person's true age; and (2) applicable benefits shall be corrected accordingly (in which case the payments adjustment shall take such a correction into account).

(g) Conformity with State Laws:

Any provision of this Master Contract which, on its Effective Date, is in conflict with the laws of the State of Minnesota, shall be amended to conform to the minimum requirements of such laws.

(h) The Organization agrees to include the following information in the employer's plan documents and make such information available to Employees and Dependents as may be required by law: name of employer plan, address of employer plan, plan year, plan fiscal year ending date, eligible classes, waiting periods (if any), employer name and Internal Revenue Service identification number, plan identification number, employer contribution levels and the name and address of the person or entity that should receive notices from enrolled Employees and Dependents under item (c) in subsection 3. "Election of Continuation Coverage" of the "Continuation of Group Coverage or Conversion to Non-Group Coverage" section of the Group Membership Contract. In addition, the Organization agrees to provide, if required, a general notice of pre-existing condition exclusion to Employees and Dependents. Such notice must be provided as part of any written application materials distributed by the plan for enrollment or on the earliest date reasonably possible following a request for enrollment.

(i) Final discretionary authority to construe the terms of the plan and coverage of a claim under the Group Membership Contract is with HealthPartners. This is not intended to abrogate any common law principles on contract construction.

(j) Notice of Change to Self-Insured Coverage:

If the Organization is terminating the coverage under this Master Contract and replacing it with a self-insured plan, the Organization must notify HealthPartners of such change by the tenth of the month prior to the effective date of the change. If the Organization fails to give HealthPartners such notice, HealthPartners may bill the Organization for any claims incorrectly processed due to late notice.

15. **Rights Shall Not Vest:** No provision or benefits provided hereunder, shall vest in any Employee rights which would prevent modification or change of such provision or benefits, mutually agreed to by the parties to this Master Contract.

16. **Mutual Indemnification:** HealthPartners shall indemnify and hold harmless the Organization, its affiliates, officers, directors, employees and agents, from any and all medical and/or dental malpractice claims brought as a result of health and/or dental care provided, or neglected to be provided, under this Master Contract by HealthPartners and by health and/or dental care providers employed by HealthPartners.

    In the event that HealthPartners contracts with a vendor to provide ancillary services not involving the delivery of health care, and such vendor limits, by contract, its liability for damages to the fair and reasonable cost of the services provided or otherwise limits its liability, that limit shall apply to the Organization with respect to any and all claims by the Organization against the vendor or HealthPartners premised on the alleged acts or omissions of the vendor, their affiliates, officers, directors, employees and agents.

    The Organization shall indemnify and hold harmless HealthPartners, its affiliates, officers, directors, employees and agents, from any and all claims premised on the alleged acts or omissions of the Organization.

17. **Request for PDF File:** In response to a specific request, HealthPartners will furnish to the Organization, or an agent of the Organization, an electronic version of the Group Membership Contract or other document in a PDF or comparable format solely for the convenience of the Organization or its agent. The Organization agrees that the sole permissive use is a display of the PDF file on an internal intranet site or individual computer for the exclusive use of Organization or its agent, in a complete and unaltered format. The Organization must display the file in the manner designated by HealthPartners (including any and all disclaimers and introductory text accompanying the Group Membership Contract or other document) and cease using the PDF file immediately upon request by HealthPartners. The Organization agrees to indemnify and hold harmless HealthPartners and its related organizations for any negligent or intentional acts by Organization or its employees, officer or agents which result in damage to HealthPartners or its related organizations in regards to the provision and use of the electronic version of the Group Membership Contract or other document, to include, but not limited to: improper distribution of the PDF file, alteration of the PDF file after delivery by HealthPartners or inaccurate or incomplete information resulting from improper posting and/or maintenance of the PDF file after delivery by HealthPartners. This provision shall be in effect indefinitely throughout the use and possession of the PDF file by Organization or its agent.

18. **Protected Health Information:** In the event that protected health information is requested by the Organization, HealthPartners may only disclose such information as permitted by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and regulations promulgated thereunder and as amended for purposes including certain plan administrative functions, such as: claims review, subrogation, the quality assurance, auditing, monitoring and management of carve out plans. Information may be disclosed to the Organization only upon receipt of a certification from the Organization that this plan document has been amended to include the following provisions and that the Organization agrees to:

    a. Not use or further disclose information except as listed above or as required or permitted by law;
    b. Ensure that any agents or subcontractors agree to the same restrictions and conditions that apply to the Organization and that such agents and subcontractors agree to implement reasonable and appropriate security measures to protect electronic protected health information;
    c. Not use or disclose any information for employment–related actions or decisions;
    d. Not use or disclose any information in connection with any other employee benefit plan of the Organization;
    e. Report to HealthPartners any security incident related to electronic protected health information it becomes aware of and any disclosure of the information that is inconsistent with the uses or disclosures described above;
    f. Make information available to fulfill employee rights to access protected health information;
    g. Make information available for amendment or to incorporate applicable amendments;
    h. Make information available in order to provide an accounting of disclosures;

i. Make internal practices, books and records relating to the use and disclosure of information received from HealthPartners available to Department of Health and Human Services to determine compliance with HIPAA;

j. Return or destroy all protected health information received from HealthPartners, if feasible, when use or disclosure is no longer required. If return or destruction is not possible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;

k. Ensure only certain classes of employee designated by the Organization are permitted access to protected health information for plan administration functions;

l. Implement an effective mechanism for handling noncompliance by the employees designated access to protected health information;

m. Implement administrative, physical and technical safeguards that reasonably and appropriately protect confidentiality, integrity and availability of the electronic protected health information that is created, received, maintained or transmitted on behalf of the group health plan; and

n. Ensure adequate separation between the group health plan and the Organization is supported by reasonable and appropriate security measures.

Amendment to HealthPartners Primary Clinic Group Membership Contract

Keep this Amendment with your Group Membership Contract

Master Contractholder: Citigroup

Group Number: 60738

Effective Date: The later of January 1, 2007 and your effective date for coverage under the Master Group Contract.

Your Group Membership Contract is amended as follows:

In Section II. "DEFINITIONS OF TERMS USED" in the definition of "Eligible Dependents":

1. **Part 2. "Child" is replaced as follows:**

2. Child. This is an enrollee's (a) unmarried natural or legally adopted child (effective from the date placed for adoption); (b) unmarried grandchild; (c) unmarried child for whom the enrollee or the enrollee's spouse is the legal guardian; (d) unmarried step-child of the enrollee (that is, the child of the enrollee's spouse); or (e) a child covered under a valid qualified medical child support order (as the term is defined under Section 609 of the Employee Retirement Income Security Act (ERISA) and its implementing regulations) which is enforceable against an enrollee. In each case the child must be either under 19 years of age, a full-time student, or a disabled dependent, as described below. An unmarried child who is a full-time student is an eligible dependent until attainment of age 25. Eligibility continues until the end of the calendar year in which the dependent attains age 19 or the full-time student attains age 25. In order to qualify as a dependent under clause (b) or (d) above, the child must be dependent on the enrollee for a majority of his or her financial support.

(A description of the procedures governing qualified medical child support order determination can be obtained, without charge, from us.)

2. **Part 5. "Domestic Partner" is added as follows:**

5. Domestic Partner. This is an enrollee's spousal equivalent, provided the enrollee and the domestic partner:
(a) share the same regular and permanent residence; and
(b) are jointly responsible for basic living expenses; and
(c) are not married to anyone and have been each other's sole domestic partner for at least twelve months; and
(d) are each 19 years of age or older; and
(e) are each mentally competent to consent to a contract; and
(f) have completed the form required by the group health plan sponsor for coverage of a domestic partner and have agreed to any conditions specified in that form.

After terminating a partnership, there will be a twelve-month waiting period to cover the same partner again or a new partner. An enrollee may also enroll the eligible dependent child(ren) of his or her domestic partner for coverage under this contract, so long as the child meets the definition of unmarried step-child of the enrollee (that is the unmarried child of the enrollee's domestic partner) and the domestic partner remains eligible. Domestic partners and their eligible dependent children are eligible for continuation and conversion coverage under this Contract.

HealthPartners Primary Clinic
Schedule of Payments

Master Contractholder:	Citigroup
Group Number:	60738
Effective Date:	The later of January 1, 2007 and your effective date of coverage under the Master Group Contract.

See the Membership Contract for additional information about covered services and limitations.

The amount that we pay for covered services is listed below. The member is responsible for the specified dollar amount and/or percentage of charges that we do not pay.

HealthPartners Benefits are underwritten by HealthPartners.

These definitions apply to the Schedule of Payments. They also apply to the Contract.

Charge:

For covered services delivered by participating network providers, or network referral providers, is the provider's discounted charge for a given medical/surgical service, procedure or item.

For covered services delivered by non-network providers, is the provider's charge for a given medical/surgical service procedure or item, according to the usual and customary charge allowed amount.

The Usual and Customary Charge is the maximum amount allowed we consider in the calculation of payment of charges incurred for certain covered services. It is consistent with the charge of other providers of a given service or item in the same community.

A charge is incurred for covered ambulatory medical and surgical services, on the date the service or item is provided. A charge is incurred for covered inpatient services, on the date of admission to a hospital. To be covered, a charge must be incurred on or after the member's effective date and on or before the termination date.

Combined Day Limit:

Your total benefit is combined for inpatient hospitalization, skilled nursing facility care services and inpatient mental and chemical health services, and limited to 365 days per period of confinement.

Copayment/Coinsurance:

The specified dollar amount, or percentage, of charges incurred for covered services, which we do not pay, but which a member must pay, each time a member receives certain medical services, procedures or items. Our payment for those covered services or items begins after the copayment or coinsurance is satisfied. Covered services or items requiring a copayment or coinsurance are specified in this Contract.

For services provided by a network provider:
An amount which is listed as a flat dollar copayment is determined by a formula set forth in law which is based on the network provider's retail (undiscounted) charges for that service. However, if the network provider's discounted charge for a service or item is less than the flat dollar copayment, you will pay the network provider's discounted charge. An amount which is listed as a percentage of charges or coinsurance is based on the network provider's discounted charges, calculated at the time the claim is processed, which may include an agreed upon fee schedule rate for case rate or withhold arrangements.

For services provided by a non-network provider:
Any copayment or coinsurance is applied to the lesser of the provider's charges or the usual and customary charge for a service.

A copayment or coinsurance is due at the time a service is provided, or when billed by the provider. The copayment or coinsurance applicable for a scheduled visit with a HealthPartners network provider will be collected for each visit, late cancellation and failed appointment.

Preferred Drug List: This is a current list, which may be revised from time to time, of preferred prescription drugs, medications, equipment and supplies covered by us as indicated in the Schedule of Payments which are covered at the highest benefit level. We have written guidelines and procedures for granting an exception to the preferred drug list that is available to you upon request. These guidelines and procedures include exceptions to the preferred drug list for anti-psychotic prescription drugs prescribed to treat emotional disturbances or mental illness and your right to receive certain non-preferred prescription drugs for diagnosed mental illness or emotional disturbance when our preferred drug list changes or you change health plans. The preferred drug list is available by calling Member Services, or on our web site at www.healthpartners.com.

Non-Preferred Drug: This is a prescription drug which is not on the preferred drug list, is medically necessary and is not investigative or otherwise excluded under this Contract.

Out-of-Pocket Expenses: You pay the specified copayments/coinsurance and deductibles applicable for particular services, subject to the out-of-pocket limit described below. These amounts are in addition to the monthly enrollment payments.

Out-of-Pocket Limit: You pay the copayments/coinsurance and deductibles for covered services, to the individual or family out-of-pocket limit. Thereafter we cover 100% of charges incurred for all other covered services, for the rest of the calendar year. You pay amounts greater than the out-of-pocket limit if any benefit maximums are exceeded.

You are responsible to keep track of the out-of-pocket expenses. Contact our member services department for assistance in determining the amount paid by the enrollee for specific eligible services received. Claims for reimbursement under the out-of-pocket limit provisions are subject to the same time limits and provisions described under the "Claims Provisions" section of the contract.

Specialty Drug List: This is a current list, which may be revised from time to time, of prescription drugs, medications, equipment and supplies, which are typically bio-pharmaceuticals. The purpose of a specialty drug list is to facilitate enhanced monitoring of complex therapies used to treat specific conditions. Specialty drugs are covered by us as indicated below. The specialty drug list is available by calling Member Services, or on our web site at www.healthpartners.com.

Individual Calendar Year Out-of-Pocket Limit	$3,000
Family Calendar Year Out-of-Pocket Limit	$5,000

COVERED SERVICES

	Benefits
A. ACUPUNCTURE	100% of the charges incurred, subject to a member copayment of $15 per office visit.
B. AMBULANCE AND MEDICAL TRANSPORTATION	100% of the charges incurred.

COVERED SERVICES	Benefits
C. BEHAVIORAL HEALTH	
Mental Health Services	
a. Outpatient Services, including family therapy	100% of the charges incurred, subject to a member copayment of $15 per visit. For family therapy, only one member copayment will be charged, regardless of the number of members primarily involved in the therapy.
Group Therapy	100% of the charges incurred, subject to a member copayment of $7.50 per visit.
b. Inpatient Services, including Day Treatment Services	See Inpatient Hospital Services Benefit. Limited to 365 day maximum per period of confinement, subject to the combined day limit. Any calendar day in which you receive any Day Treatment Services counts as a half day toward the combined day limit, for the same period of confinement.
Chemical Health Services	
a. Outpatient Services	100% of the charges incurred, subject to a member copayment of $15 per visit. For family therapy, only one member copayment will be charged, regardless of the number of members primarily involved in the therapy. We cover the overnight stay at a contracted organization for members actively involved in an affiliated licensed chemical dependency day treatment program for treatment of alcohol or drug abuse.
b. Inpatient Services, including Day Treatment Services	See Inpatient Hospital Services Benefit. Limited to 365 day maximum per period of confinement, subject to the combined day limit. Any calendar day in which you receive any Day Treatment Services counts as a half day toward the combined day limit, for the same period of confinement.
Hospital or Residential Treatment Facility Care for Emotionally Handicapped Children	See Inpatient Hospital Services Benefit Limited to 365 day maximum per period of confinement subject to the combined day limit.
D. CHIROPRACTIC SERVICES	100% of the charges incurred, subject to a member copayment of $15 per office visit.

COVERED SERVICES	Benefits
E. DENTAL SERVICES	
Accidental Dental Services	
a. Accidental Dental Services Within the Network	80% of the charges incurred.
b. Emergency Accidental Dental Services Outside the Network	Subject to a deductible of $50 per calendar year, and a maximum benefit of $300 per calendar year, 80% of the charges incurred. *For all accidental dental services, treatment and/or restoration must be initiated within six months of the date of the injury. Coverage is limited to the initial treatment (or course of treatment) and/or initial restoration. Only services provided within twenty-four months from the date treatment or restoration was initiated are covered.*
Medical Referral Dental Services	
a. Medically Necessary Outpatient Dental Services	100% of the charges incurred, subject to a member copayment of $15 per office visit.
b. Medically Necessary Hospitalization and Anesthesia for Dental Care	See Inpatient Hospital Services Benefit. Limited to 365 day maximum per period of confinement, subject to the combined day limit.
c. Medical Complications of Dental Care	100% of the charges incurred, subject to a member copayment of $15 per office visit.
Oral Surgery	100% of the charges incurred, subject to a member copayment of $15 per office visit.
Orthognathic Surgery Benefit	75% of the charges incurred.
Treatment of Cleft Lip and Cleft Palate of a Dependent Child	100% of the charges incurred, subject to a member copayment of $15 per office visit.
Treatment of Temporomandibular Disorder (TMD) and Craniomandibular Disorder (CMD)	100% of the charges incurred, subject to a member copayment of $15 per office visit.
F. DIAGNOSTIC IMAGING SERVICES *We cover services provided in a clinic or outpatient hospital facility (to see the benefit level for inpatient hospital or skilled nursing facility services, see benefits under Inpatient Hospital and Skilled Nursing Facility Services)*	
a. Outpatient Magnetic Resonance Imaging (MRI) and computing Tomography (CT)	80% of the charges incurred.
b. All other outpatient diagnostic imaging services	100% of the charges incurred.

COVERED SERVICES	Benefits
G. DURABLE MEDICAL EQUIPMENT, INCLUDING ORTHOTICS AND PROSTHETICS	100% of the charges incurred. *Wigs for hair loss resulting from alopecia areata are subject to a $350 maximum payment per calendar year. No more than a 93-day supply of diabetic supplies are covered and dispensed at a time.*
H. EMERGENCY AND URGENTLY NEEDED CARE SERVICES	
Emergency and Urgently Needed Care Within the Network	
Emergency and Urgently Needed care at network clinics	100% of the charges incurred, subject to a member copayment of $15 per office visit.
Emergency care in a hospital emergency room, including professional services of a physician	100% of the charges incurred, subject to a member copayment of $55 per visit. *Emergency room copayment is waived if admitted for the same condition within 24 hours.*
Emergency and Urgently Needed Care Outside the Network	
Professional services of a physician, urgent care treatment, emergency room treatment and inpatient hospital services	80% of the first $2,500 and 100% thereafter of the charges incurred per calendar year.
I. HEALTH EDUCATION	
Provider office visit/session in connection with preventive services	100% of the charges incurred.
Provider office visit/session in connection with the management of a chronic health problem (such as diabetes)	100% of the charges incurred, subject to a member copayment of $15 per office visit.
J. HOME HEALTH SERVICES	
Physical therapy, occupational therapy, speech therapy, respiratory therapy and home health aide services	100% of the charges incurred, subject to a member copayment of $15 per visit. *If more than one home health visit occurs in a day, a separate copayment applies to each. For example, if a nurse and a physical therapist visit a member in the same day, a separate copayment will be charged for each visit.*
TPN/IV therapy, skilled nursing services, postnatal services and phototherapy	100% of the charges incurred.
Routine prenatal services and child health services	100% of the charges incurred.
Maximum visits	120 visits per calendar year.

COVERED SERVICES	Benefits
K. HOME HOSPICE SERVICES	
Part-time care	100% of the charges incurred.
Continuous care	100% of the charges incurred.
Limit of 30 days of continuous care and respite care combined.	
Respite care	100% of the charges incurred.
Respite care is limited to 5 days per episode, and 30 days of continuous care and respite care combined.	
Medically necessary medications for pain and symptom management	100% of the charges incurred.
Semi-electric hospital beds and other durable medical equipment	100% of the charges incurred.
Emergency and non-emergency care	100% of the charges incurred.
L. HOSPITAL AND SKILLED NURSING FACILITY SERVICES	
Medical or Surgical Hospital Services	
a. Inpatient Hospital Services	100% of the charges incurred, subject to a member copayment of $500 per admission. Limited to 365 day maximum per period of confinement, subject to the combined day limit. *Each member's admission or confinement, including that of a newborn child, is separate and distinct from the admission or confinement of any other member.*
b. Outpatient Hospital, Ambulatory Care or Surgical Facility Services *(to see the benefit level for diagnostic imaging services, laboratory services and physical therapy, see benefits under Diagnostic Imaging Services, Laboratory Services and Physical Therapy)*	100% of the charges incurred, subject to a member copayment of $15 per visit.
Skilled Nursing Facility Care	See Inpatient Hospital Services Benefit. Limited to 120 day maximum per period of confinement, subject to the combined day limit.
M. INFERTILITY SERVICES	80% of the charges incurred.
Maximum Benefit:	$5,000 per calendar year. *Drugs for the treatment of infertility are not subject to this maximum.* *Artificial insemination and/or super-ovulatory drugs for members diagnosed with infertility are limited to six cycles per confirmed pregnancy.*

COVERED SERVICES	Benefits
N. LABORATORY SERVICES *We cover services provided in a clinic or outpatient hospital facility (to see the benefit level for inpatient hospital or skilled nursing facility services, see benefits under Inpatient Hospital and Skilled Nursing Facility Services)*	100% of the charges incurred.
O. MASTECTOMY RECONSTRUCTION BENEFIT	Coverage level is same as corresponding HealthPartners benefit, depending on type of service provided, such as Office Visits for Illness or Injury, or Inpatient or Outpatient Hospital Services.
P. OFFICE VISITS FOR ILLNESS OR INJURY	100% of the charges incurred, subject to a member copayment of $15 per office visit.
Q. OUT OF AREA CARE	
Authorized Care Outside the Service Area	80% of the charges incurred.
R. PHYSICAL THERAPY, OCCUPATIONAL THERAPY AND SPEECH THERAPY *We cover services provided in a clinic. We also cover physical therapy provided in an outpatient hospital facility. (to see the benefit level for inpatient hospital or skilled nursing facility services, see benefits under Inpatient Hospital and Skilled Nursing Facility Services)*	
Rehabilitative Care	100% of the charges incurred, subject to a member copayment of $15 per visit.
Habilitative Care	100% of the charges incurred, subject to a member copayment of $15 per visit.
S. PRESCRIPTION DRUG SERVICES	
Drugs and medications must be obtained at a Network Pharmacy	
Outpatient drugs	100% of the charges incurred, subject to a member copayment of $10 for generic preferred drugs and $20 for brand name preferred drugs. Non-preferred drugs are covered at 100% of the charges incurred, subject to a copayment of $40. *Drugs for the treatment of sexual dysfunction are limited to six doses per month.*
Specialty Drugs which are self-administered	See Specialty Drugs benefit under HealthPartners benefits below *Specialty Drugs must be obtained from a designated vendor.*
Tobacco cessation products, as determined by HealthPartners. Must be prescribed by a licensed provider and filled at a network pharmacy. Limited to a 180-day supply per calendar year. No more than a 31-day supply will be covered and dispensed at a time.	See Outpatient drugs benefit.

COVERED SERVICES

	Benefits
Mail Order Drugs	You may also get outpatient prescription drugs which can be self-administered through HealthPartners mail order service. Outpatient drugs ordered through this service are covered at the benefit percent shown in Outpatient Drugs above, subject to two copayments for each 93-day supply, or portion thereof, or for three manufacturer's pre-packaged dispensing units, if applicable. For your convenience, you may also order insulin and tobacco cessation products through the mail order service without a discounted benefit. Specialty Drugs are not available through the mail order service. For information on how to obtain drugs through HealthPartners mail order service, refer to your enrollment material.
Injections administered in a physician's office:	
Allergy injections	100% of the charges incurred.
Immunizations	100% of the charges incurred.
All other injections	100% of the charges incurred.
Injectable and implantable birth control drugs/devices (Implantable drugs/devices are limited to one every five years.)	80% of the charges incurred.
Special dietary treatment for Phenylketonuria (PKU)	80% of the charges incurred.
Drugs for treatment of infertility	80% of the charges incurred. *Super-ovulatory drugs for members diagnosed with infertility are limited to six cycles per confirmed pregnancy.*

COVERED SERVICES | Benefits

Specialty Drugs which are self-administered — See HealthPartners Outpatient Drugs benefit.

Drugs for the treatment of growth deficiency — 80% of the charges incurred.

Specialty Drugs must be obtained from a designated vendor.

Unless otherwise specified in this section, you may receive up to a 31-day supply per prescription. No more than a 93-day supply will be covered and dispensed at a time. No more than a 31-day supply of Specialty Drugs will be covered and dispensed at a time. We have written guidelines and procedures for granting an exception to the preferred drug list that are available to you upon request. If there is a generic equivalent, brand name drugs are only covered up to the charge that would apply to the generic drug, minus any required copayment. The member copayment for a drug will not exceed the cost of the drug. If a member copayment is required, you must pay one member copayment for each 31-day supply, or portion thereof, or for each manufacturer's pre-packaged dispensing unit, if applicable, except as follows:

For insulin, a copayment will apply per vial or box of insulin cartridges.

For contraceptive barrier devices, a copayment will apply per device.

For Mail Order Drugs, see benefit above.

T. PREVENTIVE SERVICES

Service	Benefits
Routine health exams and periodic health assessments	100% of the charges incurred.
Child health supervision services	100% of the charges incurred.
Routine prenatal services	100% of the charges incurred.
Routine postnatal services	100% of the charges incurred.
Routine screening procedures for cancer	100% of the charges incurred.
Routine eye and hearing exams	100% of the charges incurred.
Professional voluntary family planning services	100% of the charges incurred.
Adult immunization	100% of the charges incurred.

U. SPECIFIED NON-NETWORK SERVICES

Coverage level is same as corresponding network benefit, depending on type of Service provided, such as Office Visits for Illness or Injury. See "Specified Non-Network Services" in section III. "Description of Covered Services" of the Group Membership Contract for a description of covered services.

V. TRANSPLANT SERVICES

See Inpatient Hospital Services Benefit. Limited to 365 day maximum per period of confinement, subject to the combined day limit.