HEALTHPARTNERS INSURANCE COMPANY

an affiliated company of HealthPartners, Inc.
(called the "Company")

has issued this
GROUP POLICY
(called the "Policy")

for
MAJOR MEDICAL EXPENSE INSURANCE

Policy Number: *0706*

Policyholder: *Minneapolis College Of Art & Design* (called the "Organization"),

contracts with the Company, for the provision of the Benefits described in the Group Certificate(s), to its eligible persons (called "Employees") and their eligible dependents (called "Dependents") who enroll hereunder in accordance with the terms and conditions of the Policy. Consideration for coverage under the Policy are the approved applications of the Organization and the Employees and timely payment of premiums. Payment of premiums in accordance with the "Premiums" section constitutes the Organization's acceptance of the terms and conditions of this Policy.

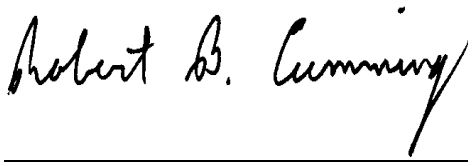
The Policy is delivered in the state of Minnesota and governed by its laws.

Policy Effective Date: *January 1, 2018*

Policy Anniversary Date: *January 1, 2019* (called "Anniversary Date") and annually thereafter.

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

Signed for the Company on the date of issue.



Robert B. Cumming
President

Barbara E. Tretheway
Secretary

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Prepared by: KAB December 4, 2017

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1. **Benefits:** The Company provides and underwrites coverage of benefits described in the Group Certificate(s). The benefits are set forth in the Group Certificate(s), Schedule(s) of Payments and any Amendments attached thereto, or subsequent Group Certificate(s), Schedule(s) of Payments and any Amendments issued periodically. The Schedule of Payments attached to the Group Certificate specifies whether the plan is a Qualified Plan (1, 2 or 3) or Non-Qualified Plan. The Group Certificate(s), Schedule(s) of Payments and any Amendments issued by the Company are hereby incorporated and made fully a part of this Policy.

2. **Term:** Benefits and premiums shall become effective on the Policy'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 the Company or the Organization to change said benefits and/or premiums. The Company reserves the right to terminate benefits, as provided in sections 4. and 11.

3. **Premiums:** The amount of each premium due, at the time such premium falls due, is the aggregate of the amounts applicable to each enrolled Employee and Dependent of the Organization. The amount so payable is determined according to the notice of rates sent to the Organization prior to the issuance of this Policy. Such premiums are due and payable to the Company by the Organization, or its authorized representative, on or before the first day of the month (called "premium due date"), for each month benefits are in force (called "premium period"), for all persons enrolled, at the time such premium 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 your grace period, retroactive to the premium due date, regardless of termination of this Policy.

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

   The Company may adjust payments due if the total number of eligible Employees changes by more than 10%. Any resulting change in payments will be retroactive to the date of the change.

   In addition, the Company may change payments due if the Organization adds or deletes a plan or carrier. Any resulting change in payments will be effective on the date that the plan or carrier was added or deleted.

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

   The Organization shall give the Company 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, the Company reserves the right to modify the above premiums, thirty-one (31) days after the date of said receipt.

   The Company will not extend retroactive coverage to Employees or Dependents due to clerical errors by the Organization, for a time period greater than ninety (90) days. In compliance with state or federal law, the Company will extend retroactive enrollment to Employees or Dependents who are eligible for continuation coverage to 115 days after the date coverage under this Policy terminated due to a qualifying event, and to 160 days if coverage was terminated because of the death of the Employee.

   The Company will only allow retroactive termination of Employees or Dependents due to clerical errors by the Organization if the Employee or Dependent has not paid premium or contribution to the Organization, but in no event for a time period greater than ninety (90) days. It is the responsibility of the Organization to ensure that only those retroactive enrollment changes allowed under this paragraph will be sent to the Company. The Organization is responsible for making payments for any Employee or Dependent coverage that cannot be retroactively terminated under applicable law until the date that termination is permitted.

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 premium 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 premium, 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 premium 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 premium due date shall be granted for any premium due after the initial premium payment, provided the Organization has not previously given written notice to the Company 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 premium 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 the Company 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 the Company for all premiums due and unpaid, including premiums for the period that coverage is in effect. If, however, written notice is given by the Organization to the Company 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 the Company, whichever is later, and the Organization shall be liable to the Company for pro-rata premium payment for the period commencing with the last premium due date and ending with the date of such termination. The acceptance by the Company 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 75% 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 Policy or another group health plan sponsored by the Company and the Organization. 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. 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.

The Company 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 the Company 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, the Company 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 Policy will be terminated in accordance with section 11. hereof.

6. Eligibility and Effective Date of Employees: The Organization's Employees in the following categories are eligible for benefits: *Regular employees scheduled to work at least 1,000 hours per year are eligible to participate; employees designated as casual, temporary, or adjunct faculty are not eligible to participate, but if they complete an average of 30 hours per week during a measurement period they can earn eligibility for the following one year period. Terminating employees and their spouses/dependents may be eligible for COBRA continuation coverage, which can generally continue for up to 18 months. Retirees (and their spouses) who are 62 or over at the time of their retirement from MCAD may continue their medical coverage under COBRA until the later of the expiration of the 18-month period or the end of the month in which they reach age 65. In no case can COBRA be taken for more than a total of 36 months..*

Employees in those categories shall become eligible on: *the first day of the month following the date of hire* (called "Eligibility Date") subject to section 3.

An "Employee" is the person who enrolls with the Organization for coverage under this Group Policy.

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 Certificate), benefits shall become effective on the first of the month following the application date.

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:

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. 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 a special enrollment period or annual open enrollment period, as described in section VI. "Effective Date and Eligibility" of the Group Certificate.

The Organization must submit any enrollment information to the Company as soon as possible following receipt of the information. In any case, the Company will not extend retroactive coverage to Employees or Dependents due to clerical errors by the Organization, for a time period greater than ninety (90) days. In compliance with state or federal law, the Company will extend retroactive enrollment to Employees or Dependents who are eligible for continuation coverage to 115 days after the date coverage under this Policy terminated due to a qualifying event, and to 160 days if coverage was terminated because of the death of the Employee.

The Company will only allow retroactive termination of Employees or Dependents due to clerical errors by the Organization if the Employee or Dependent has not paid premium or contribution to the Organization, but in no event for a time period greater than ninety (90) days. It is the responsibility of the Organization to ensure that only those retroactive enrollment changes allowed under this paragraph will be sent to the Company. The Organization is responsible for making payments for any Employee or Dependent coverage that cannot be retroactively terminated under applicable law until the date that termination is permitted.

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 of coverage shall not be delayed if the Employee is not actively at work on the effective date of 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 the Company 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 Policy 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 premium for coverage in this instance. Such premium 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 Certificate 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 premium 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 date the Dependent is eligible for benefits hereunder if the Dependent has maintained continuous coverage (as defined in Section II of the Group Certificate), and benefits shall become effective on the first of the month following the application date.

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) A Dependent can be added during a special enrollment period, as described in section VI. "Effective Date and Eligibility" of the Group Certificate.
(c) 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 the Company. However, premium payments are required from the date of eligibility for a newborn infant; therefore, benefits may be reduced by the amount of past due premium.
(d) A Dependent can be added at the time of a life event, if the Company receives written application reasonably acceptable to the Company within thirty-one (31) days from the date of the life event. The effective date for benefits shall be the date of application.
(e) A Disabled Dependent can be added according to the terms and conditions of the "Disabled Dependent" definition under "Eligible Dependents" in the Group Certificate. The effective date of benefits shall be the date the Company receives and accepts written application and the appropriate premium payment.

The Organization must submit any enrollment information to the Company as soon as possible following receipt of the information. In any case, the Company will not extend retroactive coverage to Dependents due to clerical errors by the Organization, for a time period greater than ninety (90) days. In compliance with state or federal law, the Company will extend retroactive enrollment to Employees or Dependents who are eligible for continuation coverage to 115 days after the date coverage under this Policy terminated due to a qualifying event, and to 160 days if coverage was terminated because of the death of the Employee.

The Company will only allow retroactive termination of Employees or Dependents due to clerical errors by the Organization if the Employee or Dependent has not paid premium or contribution to the Organization, but in no event for a time period greater than ninety (90) days. It is the responsibility of the Organization to ensure that only those retroactive enrollment changes allowed under this paragraph will be sent to the Company. The Organization is responsible for making payments for any Employee or Dependent coverage that cannot be retroactively terminated under applicable law until the date that termination is permitted.

8. Open Enrollment: After the Effective Date of this Policy, 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 regardless of health status. 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 the Company or the Organization shall be the Anniversary Date, subject to the Company's 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 the Company 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 group health plan sponsor's eligibility requirements, or if the group health plan sponsor has forwarded enrollment for an Employee or a Dependent to the Company, regardless of whether such Employee or Dependent meets their eligibility requirements, the Company is required to obtain the Employee's or Dependent's signature before we may retroactively terminate coverage under this Policy. If a required signature is not obtained, the group health plan sponsor is required to pay the premiums 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 Policy terminates; or
   (b) the last day of the premium period for which premium payment has been made, should the Organization, or the Employee (or former Employee exercising group continuation privileges) fail to pay premium 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 Policy, 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 open enrollment date, if the Employee elects to terminate benefits under this Policy, provided the Employee gives written notice to the Company, at least thirty (30) days prior to such date.
   (f) if the Employee knowingly gives false information on his/her application or otherwise misrepresents or omits a fact, and if that false information or omission is material to our acceptance, coverage for the Employee will automatically terminate upon thirty (30) days' notice, provided discovery of the false information is made within two (2) years of the date of enrollment.

   To the extent that a termination would be considered a rescission under federal law under item (c), the group health plan sponsor is required to give the Employee 30 days advance notice of termination.

B. For Dependents:
   (a) the date this Policy terminates; or
   (b) the date Dependent benefits under this Policy are discontinued for all Dependents; or
   (c) the last day of the month subject to section 3. in 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 month in 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 premium period for which premium payment has been made, should the Organization, or the Dependent (or the Employee on the Dependent's behalf) fail to pay premium, when due, subject to section 4.; or
   (g) the last day of the premium period if an Employee elects to terminate Dependent coverage.

   To the extent that a termination would be considered a rescission under federal law under item (c), the group health plan sponsor is required to give the Employee 30 days advance notice of termination.

11. Termination of the Policy: Coverage for benefits of all the Organization's and their Employees and Dependents shall terminate on the earliest of the dates described below:

(a) the last day of the premium period for which premium payment has been made, if the Organization is in breach of any of the terms and conditions for coverage of this Policy. The Company 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 the Company to come into compliance with the specified provisions within the thirty-one (31)-day period following notification of termination, this Policy may be continued only upon joint agreement of the Organization and the Company; or
(b) the end of the grace period, as provided in section 4.; or
(c) any premium due date after the first Anniversary Date, as specified by the Organization, if the Organization gives the Company 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 the Company to the Organization of the Company's intention to cease doing business in the large employer market.

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

Termination by the Company may be retroactive to the last day of the premium period for which premium has been made, subject to section 4.

We make a good faith effort to notify all Employees of the termination at least 30 days before the effective termination date, unless we have reasonable evidence to indicate that it will be replaced by a substantially similar policy, plan or contract. In no event shall this provision extend coverage more than 120 days beyond the date coverage would otherwise cancel, based on the terms shown above.

12. Continuation Rights: The Company agrees to provide continuation coverage, as specified in the Group Certificate referenced herein, for an Employee or Dependent who is no longer eligible under the terms of this Policy.

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

1. Each individual who is eligible under this Policy, with respect to provisions regarding eligibility, or nonconfinement in a hospital or skilled nursing facility, is covered by this Policy as of the Effective Date of this Policy.
2. Each individual who is not eligible for coverage in accordance with paragraph 1., is nevertheless covered by this Policy 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 Policy.
    a. The minimum level of benefits that shall be provided by this Policy, 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 Policy.
    b. Coverage shall be provided by this Policy at least until the earlier of the following dates: the date the individual becomes eligible under the terms of this Policy, 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 Policy.
3. Deductible or waiting period. In applying any deductible or waiting period, this Policy 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 Policy and are subject to a similar deductible provision.
4. Statement of benefits available. In any situation where a determination of the prior carrier's benefits is required by the Company, at the Company's request, the prior carrier shall furnish a statement of the benefits available and other pertinent information sufficient to permit the Company to verify or determine benefits.
5. 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 Policy.

14. Standard Provisions:

(a) Entire Policy; Changes:
This Policy, including attached Amendments (if any), the Group Certificates 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 Policy, or any change to this Policy, shall be valid only when approved by the Company and the Organization, and such approval is attached hereto or endorsed hereon, or is otherwise acknowledged by the Organization, by making the required premium payments. No individual who is not an authorized employee of the Company and as such designated by the Company, has authority to change this Policy or the Group Certificate 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 Policy apply to both sexes.

(d) Group Certificates:
A Group Certificate will be issued to each Employee, or to the Organization (for delivery to each Employee). The benefits and coverage terms described in the Group Certificates are controlled by the provisions of the Policy and are subject to any changes in the Policy. The Organization must have the Policy available for inspection by Employees at all reasonable times. The terms of the Group Certificate 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 the Company to compute premiums 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 the Company at any reasonable time.

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

(g) Conformity with State Laws:
Any provision of this Policy 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 and 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" section of the Group Certificate.

(i) Final discretionary authority to construe the terms of the plan and coverage of a claim under the Group Certificate is with the Company. 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 Group Policy and replacing it with a self-insured plan, the Organization must notify the Company of such change by the tenth of the month prior to the effective date of the change. If the Organization fails to give the Company such notice, the Company may bill the Organization for any claims incorrectly processed due to late notice.

(k) Medicare Secondary Payer Mandatory Reporting Requirements issued by the Centers for Medicare and Medicaid Services: The Organization shall furnish all information required by the Centers for Medicare and Medicaid Services.

(l) Summaries of Benefits and Coverage (SBC):
The Organization shall furnish to participants or employees the SBC for each benefit plan provided by the Company for which such participants or employees are eligible no later than the first date on which the participant or employee is eligible to enroll in coverage for participant or any beneficiaries. The Organization must notify the Company at least 30 days prior to the effective date of coverage of any change to the plan benefits currently reflected in the distributed SBC. No change in benefits may occur after the effective date of coverage without 60 days prior notification to participants and beneficiaries.

(m) New insureds:
For classes of Employees covered under this policy, the Organization may add newly eligible Employees and their Dependents in accordance with sections 6., 7., and 8. of this policy and section VI. of the Group Certificate.

(n) **IMPORTANT CONSUMER INFORMATION**

1. You have the right to a grace period of 31 days for each enrollment payment due, when falling due after the first enrollment payment, during which period the contract shall continue in force.
2. Insureds on Medicare have the right to voluntarily disenroll from HealthPartners Insurance Company and the right not to be requested or encouraged to disenroll, except in circumstances specified in federal law.
3. Insureds on Medicare have the right to a clear description of nursing home and home care benefits covered by HealthPartners Insurance Company.
4. Certain services or medical supplies are not covered. Read this Certificate for a detailed explanation of all exclusions.
5. You may continue coverage or convert to an individual contract under certain circumstances. Read this Certificate for a description of your continuation rights.
6. Your coverage may be cancelled by you or us only under certain conditions. Read this Certificate for the reasons for cancellation of coverage.

Guaranteed Issue: Coverage under this policy is offered on a guaranteed issue basis in accordance with the Affordable Care Act.

(o) Reinstatement: If any renewal premium is not paid within the time granted the policyholder for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy. If the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the policyholder in writing of its disapproval of such application.

(p) Legal Actions: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

15. Sole Carrier: The benefits provided under this Policy by the Company to the Employees of the Organization shall be the sole benefits offered to such Employees by the Organization.

16. 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 Policy.

17. **Request for PDF File:** In response to a specific request, the Company will furnish to the Organization, or an agent of the Organization, an electronic version of the Group Certificate 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 the Company (including any and all disclaimers and introductory text accompanying the Group Certificate or other document) and cease using the PDF file immediately upon request by the Company. The Organization agrees to indemnify and hold harmless the Company and its related organizations for any negligent or intentional acts by the Organization or its employees, officer or agents which result in damage to the Company or its related organizations in regards to the provision and use of the electronic version of the Group Certificate or other document, to include, but not limited to: improper distribution of the PDF file, alteration of the PDF file after delivery by the Company, or inaccurate or incomplete information resulting from improper posting and/or maintenance of the PDF file after delivery by the Company. 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, the Company 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, 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 the Company any security incident related to electronic protected health information it becomes aware of and any use or 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 the Company available to Department of Health and Human Services to determine compliance with HIPAA;
    j. Return or destroy all protected health information received from the Company, 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 employees 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 the 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.

HealthPartners Insurance Company
8170 33rd Avenue South, Minneapolis, MN 55440
952-883-5000

NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN INSOLVENCY UNDER THE MINNESOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION LAW

If the insurer that issued your life, annuity, or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer.

In addition, residents of Minnesota who purchase life insurance, annuities, or health insurance from insurance companies authorized to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

Minnesota Life and Health Insurance Guaranty Association
4760 White Bear Parkway, Suite 101
White Bear Lake, MN 55110
651-407-3149

The maximum amount the guaranty association will pay for all policies issued on one life by the same insurer is limited to $500,000. Subject to this $500,000 limit, the guaranty association will pay up to $500,000 in life insurance death benefits, $130,000 in net cash surrender and net cash withdrawal values for life insurance, $500,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values, $250,000 in annuity net cash surrender and net cash withdrawal values, $410,000 in present value of annuity benefits for annuities which are part of a structured settlement or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant's lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be $500,000 in present value. Unallocated annuity contracts issued to retirement plans, other than defined benefit plans, established under section 401, 403(b), or 457 of the Internal Revenue Code of 1986, as amended through December 31, 1992, are covered up to $250,000 in net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the association shall not be responsible for more than $10,000,000 in claims from all Minnesota residents covered by the plan. If total claims exceed $10,000,000, the $10,000,000 shall be prorated among all claimants. These are the maximum claim amounts. Coverage by the guaranty association is also subject to other substantial limitations and exclusions and requires continued residency in Minnesota. If your claim exceeds the guaranty association's limits, you may still recover a part or all of that amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The guaranty association assesses insurers licensed to sell life and health insurance in Minnesota after the insolvency occurs. Claims are paid from this assessment.

THE COVERAGE PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY OR POLICY, YOU SHOULD NOT RELY ON COVERAGE BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF LIFE, ANNUITY, OR HEALTH INSURANCE POLICIES OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES FINANCIALLY INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL LIFE, ANNUITY, AND HEALTH INSURANCE POLICIES ARE REQUIRED TO PROVIDE THIS NOTICE.