STOP LOSS APPLICATION; POLICY; *and* ADMINISTRATIVE SERVICES AGREEMENT

by and between ______________________________ (hereinafter called the "Plan Sponsor")
and Alliant Health Plans, Inc. (hereinafter called the "Company")

EFFECTIVE DATE: ___________________________

The Plan Sponsor (also referred to herein as the "Applicant"), hereby applies to the Company for a stop loss insurance policy providing the insurance coverage described in the Policy in connection with its self-funded health benefit plan.

It is understood and agreed, as conditions precedent to the approval of this Stop Loss Application (this "Application"), that:

All documentation requested by the Company must be submitted before any approval of this Application.

Issuance of the Stop Loss Policy (the "Policy") relies on information provided by the Applicant and any person acting on behalf of the Applicant. Accordingly, should subsequent information become known that, if known before issuance of the Policy, would have affected the rates, deductibles, terms, or conditions for coverage, the Company will have the right to revise the rates, deductibles, terms, or conditions as of the Effective Date of issuance, by providing written notice to the Plan Sponsor.

The Policy, if issued, may be void if, whether before or after a claim or loss, any material fact or circumstance was concealed or misrepresented on behalf of the Applicant or if the Applicant or its agent committed fraud in connection with this Application.

Receipt of monetary consideration and its deposit in connection with this Application shall not constitute an acceptance of liability. If the Company denies this Application, its sole obligation shall be to refund such monetary sum to the Applicant.

If a Policy is issued and rescinded, all benefits paid will be deducted from the sum of all monetary considerations paid by the Plan Sponsor. If the result is positive, the Company will refund such an amount to the Applicant. If the result is negative, such an amount will be paid by the Applicant to the Company.

The initial monetary consideration will be paid on or before the Effective Date, and subsequent financial obligations are due no later than the first day of each calendar month during the period that the Administrative Service Agreement between the parties is in effect.

Applicant acknowledges that the Policy, which is the subject of this Application, is a reimbursement contract. Therefore, the Applicant must first pay claims before submitting them for reimbursement.

Oral Statements not expressly incorporated herein are not part of this Application, the Policy, or the Administrative Services Agreement. No person, other than the President or Executive Officer of the Company has authority to accept and approve this Application, or otherwise alter any Policy or Administrative Services Agreement provision or waive any of the Company's rights or requirements. All changes must be in writing and attached to this Application, the Policy, or the Administrative Services Agreement (as applicable).

NEITHER THIS APPLICATION NOR THE TERMS OF THIS APPLICATION MAY BE ALTERED.

In making this Application, the Applicant represents that Applicant has read the entire Application and certifies that the underwriting information presented to the Company, whether provided by the Applicant or any person acting on behalf of or at the direction of the Applicant, voluntarily or in response to the Company's request, is complete and accurate. Such underwriting information, if any, is considered to be part of this Application.

Any Policy issued based on this Application, together with any of its Schedule of Insurance, amendments, or riders, shall control the stop loss insurance coverage and terms and conditions of such insurance. In the event of a conflict between the Application and the terms of the Policy, the Policy shall prevail.

Signature of Authorized Officer:	Printed Name of Authorized Officer:	Date Signed:

Acceptance

Accepted on behalf of the Company, this________________day of________________20____

By:

Title:

Administrative Services Agreement

Whereas the Plan Sponsor has expressed its intention to provide benefits for certain classes of individuals (referred to herein as "Members") in accordance with a self-funded employee welfare benefit plan (referred to herein as the "Plan"); and

Whereas, except as expressly provided herein, the Plan Sponsor will retain all liabilities under the Plan, and the Company will provide the agreed-upon services to the Plan without assuming any such liability; and

Whereas the Plan is an employee benefit plan that is not subject to the Employee Retirement Income Security Act of 1974 ("ERISA") either as (i) a governmental plan (as defined under Section 3(32) of ERISA) or (ii) a church plan (as defined under Section 3(33) of ERISA) that has not elected to be subject to ERISA under Section 410(d) of the Internal Revenue Code (such a governmental plan or church plan is referred to herein as a “Non-ERISA Plan”), and the Plan Sponsor, who is the Plan Administrator, hereby retains the Company to provide services for the Plan in accordance with the following terms and conditions.

Now, therefore, in consideration of the payments to the Company as provided herein, and subject to the terms and conditions contained herein, it is hereby agreed as follows:

Section 1. Definitions

As used in this Administrative Services Agreement (the “Agreement”), its appendices and attachments, unless otherwise expressly provided:

A. "Anniversary Date" means 12 months from the Effective Date shown on the 1st page of the Stop Loss Application and the same date each subsequent year.

B. "Agreement Month" means a calendar month.

C. "Agreement Year" means 12 consecutive months that begin on the Effective Date and each subsequent Anniversary Date.

D. "Claim Payment Recovery" is a recovery of a claim payment or a portion thereof that (based on applicable Plan terms and provisions) is identifiable to a specific Member and is recoverable because that payment:

   (1) is in excess of the benefit amount otherwise payable;

   (2) should not have been paid;

   (3) did not take into account other forms of insurance or coverage, which paid or should have paid before the Plan; or

   (4) is paid to the wrong payee(s).

   Claim Payment Recovery shall not include the services described in the "Subrogation and Right of Recovery" provision in the "Other Financial Provisions" Section.

E. "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, and federal regulations thereunder.

F. "Effective Date" means the Effective Date shown on the 1st page of the Stop Loss Application.

G. "Health Information" means any information, including "Protected Health Information" defined by HIPAA, related to the past, present or future physical or mental health condition of a Member or the provision of health care to a Member or the past, present or future payment for the provision of health care to a Member that identifies or could reasonably be used to identify a Member.

H. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Health Information Technology for Economic and Clinical Health (HITECH) Act and federal regulations implementing those laws.

I. "Member" means any employee, or covered dependent, if any, as defined by the Plan, including those whose coverage under the Plan is being continued under the Plan's COBRA health continuation provision (or similar state law provisions), if applicable.

J. "Party" means the Plan Sponsor or the Company and, when used collectively, is "Parties."

K. "Plan" means the group health plan established by the Plan Sponsor and the benefits described in the Summary Plan Description ("SPD"), which constitute benefits available under the Plan and are referred to collectively in this Agreement as "the Plan."

L "Plan Administrator" shall have a similar meaning to that ascribed to the term "administrator" under ERISA. The Plan Administrator is a role typically performed by a named person or committee attached to the Plan Sponsor. It is not the same as a plan administrator (lower case); typically, a TPA (third-party administrator) or insurance carrier performing administrative duties on behalf of the Plan Sponsor. The Company is not the Plan Administrator of the Plan, and any references in this Agreement to the Company "administering the Plan" are descriptive only and do not confer upon the Company anything beyond certain agreed upon administration duties.

Section 2. Services

A. Non-ERISA Plan. Plan Sponsor acknowledges and understands that, although the Plan is a Non-ERISA Plan, the Company's intent is to provide administrative services to the Plan consistent with the principals under ERISA and similar to those provided to plans that are subject to ERISA, including, but not limited to, the rules and requirements relating to:

(1) Plan fiduciaries and fiduciary duties;

(2) Plan assets and prohibited transactions; and

(3) Claims procedures.

B. Services under this Agreement. The Company will provide the services listed in the "Services to be Provided by the Company" attachment. In addition, although the Plan is a Non-ERISA Plan, the Company will process claims following the time frames and other rules outlined in federal law and regulations applicable to group health plans subject to ERISA. The Company:

(1) agrees to process and pay claims on behalf of the Plan Sponsor in accordance with the Plan's terms. Any exceptions requested by the Plan Sponsor will be the sole financial responsibility of the Plan Sponsor and will not be eligible for stop-loss reimbursement.

(2) is hereby authorized to use its best judgment in administering the Plan's benefits following specific Plan provisions set forth by the Plan Sponsor, standard administrative practices, and applicable law.

(3) is authorized to order, request, and make investigations of any claims of any type in which, in its best judgment, such investigation is required for processing the claim.

(4) is authorized and empowered to pay claims, reject and refuse payment of claims, or compromise and settle disputed claims subject to the directions of the Plan Sponsor.

(5) will pay all claims it has determined to properly qualify under the terms of the Plan, without additional consent from the Plan Sponsor.

Section 3. Banking Arrangements

Establishment and Maintenance of Bank Account. Concerning the Plan's claims and Plan Sponsor's obligations under this Agreement, the Company shall establish and maintain a bank account to administer claims payments and stop-loss coverage reimbursement of the Plan. The Plan Sponsor shall make monthly payments as outlined in the Plan Sponsor's Payment Obligations Attachment to the Company, as well as any other financial obligations under this Agreement, and the Company will deposit these funds in this account less administrative fees, broker fees, and additional fees or taxes as necessary. Payment of claims and reimbursement of stop-loss insurance will be handled through this bank account, and a reconciliation of the account will be provided to the Plan Sponsor at a minimum on an annual basis. This account shall be owned and operated by the Company. The Plan has no ownership rights or access to this banking arrangement other than to fund claims, stop-loss premiums, and health benefit plan administration. The Company may receive earnings and interest on funds held in this bank account and any such earnings or interest shall be part of Company's compensation. Plan Sponsor acknowledges and understands that fees otherwise charged by the Company under this Agreement would be greater if Company did not retain such earnings and interest on these funds.

Section 4. Payments to the Company

A. Fees. The Plan Sponsor shall pay the Company the fees described in more detail in the Plan Sponsor's Payment Obligations Attachment and at the fee rates as communicated to the Plan Sponsor by the Company in writing from time to time, which shall form part of this Agreement. In addition to the fees specified in the Plan Sponsor's Payment Obligations Attachment, the Plan Sponsor must also pay the Company any additional fee that is authorized by a provision elsewhere in this Agreement or is otherwise agreed to by the Parties.

B. Medical Claims. The Plan Sponsor shall pay to the Company: (i) an amount equal to the amount of the Plan Sponsor's maximum monthly and run-out claim liabilities for self-funded medical claims under the Plan as described in more detail in the Plan Sponsor's Payment Obligations Attachment (to be included as claims or claim money are costs and expenses of investigation of claims); and (ii) the Plan Sponsor's portion of provider incentive payments, if any, as determined by the Company, under fee arrangements negotiated by the Company with health care providers.

C. Drug Claims. Some drug claims are processed by a third-party Pharmacy Benefits Manager (PBM), while the Company processes claims for drugs covered under the Plan. The Plan Sponsor shall pay the Company an amount equal to the amount of the Plan Sponsor's maximum monthly and run-out liabilities for self-funded drug claims under the Plan. Such provision of money for drug claims is included in the Plan Sponsor's payments described in the Plan Sponsor's Payment Obligations Attachment. The drug claims are considered to include (i) charges for drugs, plus (ii) dispensing fees for prescriptions filled for Members by participating and mail-order pharmacies, and (iii) sales tax where required by law.

   Charges for drugs provided to Members may be based on the average wholesale price of a prescription drug as calculated by the PBM using a variety of factors, including but not limited to the First DataBank National Drug Data File or another nationally recognized pricing source. The PBM's method of calculating the average wholesale price of a prescription drug may change from time to time, as the PBM shall determine. The Company shall have no duty to notify the Plan Sponsor of any such change.

D. Deposit. The Company reserves the right to require the Plan Sponsor to pay a deposit amount (the "Deposit") which shall be payable within 15 business days of demand. The Company shall hold the deposit for the duration of this Agreement. The deposit shall not exceed the amount projected by the Company to be sufficient to cover the Plan Sponsor's payment obligations (as outlined in the Plan Sponsor's Payment Obligations Attachment) for one month. The Company reserves the right to increase the amount of the deposit during the term of this Agreement. The Company shall not pay, and the Plan Sponsor shall not be entitled to receive any interest payments on the deposit. The deposit shall not be applied toward any obligation of the Plan Sponsor to the Company during the term of this Agreement but before termination. Any deposit monies remaining after the expiration of 90 days after the termination of this Agreement shall be returned to the Plan Sponsor, less any outstanding amounts owed by the Plan Sponsor to the Company.

Section 5. Pharmacy Benefit Management Services

A. Services to be provided by the PBM

   Where Pharmacy Benefit Management Services apply to the Plan Sponsor, the Company shall arrange for services to be provided by a pharmacy benefit manager (PBM) to support the pharmacy expense benefit provided under the Plan Sponsor's Plan, as follows:

   (1) The PBM shall perform pharmacy services for Members through its network of participating pharmacies.

   (2) The PBM shall adjudicate claims for pharmacy expenses covered under the Plan submitted by participating pharmacies using the PBM's electronic online claim adjudication system. The PBM's claim adjudication system will include all Plan information regarding deductibles, copayments, coinsurance, Member out-of-pocket maximums, benefit maximums, and any other features of the Plan to be used in processing claims. Participating pharmacies may collect from Members at the point of sale the amount specified in the Plan. The PBM shall reimburse participating pharmacies for such claims according to the terms of the PBM's Agreement with the participating pharmacy.

   (3) The PBM reserves the right to revise the drug formulary at any time and without prior notice.

B. Services to be provided by Company

The Company shall provide the following support for the pharmacy expense benefit provided under the Plan Sponsor's Plan:

(1) Based on the information it receives from the Plan Sponsor, timely notify PBM of the identity of each Member eligible for pharmacy expense benefits under the Plan, the date the Member becomes eligible, and the date the Member's eligibility ends.

(2) Reimburse PBM for the total amount of all payments due according to the Drug Claims provision in this Agreement's Section 4, "Payments to the Company," for drugs provided to Members during the preceding billing period, including dispensing fees the PBM charged for prescriptions filled for Members by participating and mail-order pharmacies during the prior billing period.

(3) The Plan Sponsor acknowledges that the PBM's mail service pharmacy may, from time to time, engage in therapeutic interchanges.

(4) The PBM's mail service pharmacy may dispense drugs to Members even if the prescription is not accompanied by the correct copayment, coinsurance, or deductible amount. If the Company is charged for any uncollectible copayment, coinsurance, or deductible amount, the Plan Sponsor shall be liable to the Company for such amount if reasonable collection efforts by the PBM fail.

C. Limitations

The Company does not direct or exercise any control over the professional judgment exercised by any pharmacist in dispensing prescriptions or providing pharmaceutical-related services at a PBM participating pharmacy. Participating pharmacies are independent, not employees or agents of the Company, and the Company shall not have any liability to Plan Sponsor or any Member for any loss or damage related to or in any way growing out of any act or omission of any PBM participating pharmacy or its agent or employee.

Section 6. Plan Sponsor Responsibilities

A. Status of Plan. Plan Sponsor represents and warrants that the Plan is a Non-ERISA Plan at all times during the term of this Agreement; provided that, if Plan Sponsor takes any action to subject the Plan to ERISA or otherwise discovers that the Plan is not a Non-ERISA Plan, Plan Sponsor will notify the Company in writing prior to taking such action (or within three business days of such discovery, if applicable) and the Parties will enter into good faith negotiations to amend the terms of this Agreement, including any attachments or schedules thereto, as necessary or appropriate in light of the Plan becoming subject to ERISA.

B. Responsibility for the Plan. Plan Sponsor accepts total responsibility for the Plan for purposes of this Agreement, including its benefit design, the legal sufficiency and distribution of Plan documents, and compliance with any laws that apply to Plan Sponsor or the Plan, whether or not Plan Sponsor or someone Plan Sponsor designates is the Plan Administrator. Plan Sponsor represents and warrants ongoing compliance with applicable notice and distribution requirements under applicable laws, including timely distribution of the summary of benefits and coverage (“SBC”), and any other documents required under applicable law. Plan Sponsor will notify the Company within 30 days of discovery of any failure to comply with such requirements. The Plan Sponsor represents and warrants that the Plan has the authority to pay fees due under this Agreement from Plan assets.

C. Payments to Company. The Plan Sponsor shall make all payments under this Agreement as provided in this Agreement and the Plan Sponsor's Payment Obligations Attachment.

D. Enrollment and Determination of Eligibility.

(1) The Plan Sponsor shall:

(1) handle all routine inquiries from Members, including inquiries from Members seeking information concerning enrollment in the Plan and information concerning particular aspects of the Plan;

(2) handle all enrollment activity; and

(3) notify Members of their right to apply for benefits and make available the necessary enrollment, claim, and any other necessary forms supplied by the Company.

(2) In determining any person's right to benefits under the Plan, the Company shall rely on eligibility information consistent with the description in the Plan and information provided by the Plan Sponsor. It is mutually understood that the adequate performance of this Agreement by the Company will require that it be advised on a timely basis by the Plan Sponsor of the identity of persons covered under the Plan and the effective date or the termination date of their coverage.

To determine fees under this Agreement, a Member shall be considered to be:

(1) enrolled on the date of enrollment if the enrollment date is the first date of the month;

(2) enrolled on the first day of the first month following the month in which the Member is eligible to receive benefits under the Plan where the enrollment is after the first of the month; and

(3) terminated on the last day of the last month in which the Member is eligible to receive benefits under the Plan.

Retroactive adjustments for Member enrollment or termination may be allowed for periods not exceeding sixty (60) days. Plan Sponsor shall remain liable to Company for any claims paid on the Plan's behalf for services rendered to a Member after the date on which Plan Sponsor seeks to terminate said Member but before Company's notification of such retroactive termination.

E. Plan Benefits. The Plan Sponsor shall retain the responsibility for all Plan benefit claims and all expenses incident to the Plan. The Plan Sponsor has partially fulfilled such responsibility by its payments made according to this Agreement's Section 4 and the Plan Sponsor's Payment Obligations Attachment. The Plan Sponsor shall also be responsible for:

(1) any state premium or similar tax, or any other tax, including assessments from the Affordable Care Act (“ACA”), including any penalties and interest payable with respect thereto, assessed against the Company based on or measured by the amount of Plan benefits administered by the Company according to this Agreement; and

(2) subject to Section 7 of this Agreement, any amounts that the Company may become liable for which arise from any legal action or proceeding related to the recovery of benefits under the Plan or the administration of the Plan; and

(3) reviewing any claims/benefits payment reports for any readily apparent errors, including but not limited to those related to eligibility, furnished by the Company to the Plan Sponsor and informing the Company of any errors contained therein within thirty (30) days of the Plan Sponsor's receipt of said claim report(s). Failure to notify the Company shall constitute a waiver on the Plan Sponsor's part of any claim against the Company for failure to accurately pay the claim at issue. Any claims errors shall not be an excuse for failing to make payments that are due to the Company; and

(4) reimbursing the Company for any Plan benefits paid by the Company to Members who were not eligible for Plan benefits and with respect to whom the Plan Sponsor does not timely notify Company of such Member's lack of eligibility; and

(5) reimbursing any health care service provider with whom Company has entered into a provider agreement that has provided covered services to a Member if Company is unable to or otherwise does not reimburse such provider as a result of Plan Sponsor's failure to fulfill its obligations under this Agreement, including but not limited to providing sufficient funds as required under this Agreement. Plan Sponsor further acknowledges that it is responsible and is a guarantor of payment for covered benefits under the Plan. In addition, the Plan Sponsor recognizes that, through provider Agreements negotiated by Company, Plan Sponsor, as the party responsible for payment, has certain obligations not inconsistent with the terms of this Agreement, even though it is not a party to such provider agreements. As such, any Agreement provider may bring a cause of action or assert a lien against Plan Sponsor for payment of any unpaid claims for covered services rendered by such provider to a Member.

F. COBRA. If COBRA (including any state-based continuation of coverage law) applies to the Plan Sponsor, the Plan Sponsor is solely responsible for performing the duties required by COBRA, including distribution of any required COBRA notices. The Plan Sponsor agrees to indemnify the Company for any losses directly related to the Plan’s failure to establish or follow reasonable COBRA notice procedures. The experience from any COBRA coverage shall be charged to the Plan.

G. Delays. The Company shall not be responsible for any delay in the performance of its duties under this Agreement or non-performance hereunder if such delay or non-performance is caused or contributed to in whole or in part by the failure of the Plan Sponsor to promptly furnish any required or requested information.

H. IRS and Other Regulatory Filings. The Plan Sponsor shall be solely responsible for submitting all required IRS forms and

other regulatory filings. The Company, however, shall provide the Plan Sponsor with information in its possession reasonably necessary for the Plan Sponsor to submit said forms upon request of the Plan Sponsor.

(1) If Plan Sponsor is required to satisfy applicable reporting requirements under the ACA using Forms 1094-B and 1095-B, the Company will assist Plan Sponsor with preparing and distributing Forms 1095-B to current and former Members. However, Plan Sponsor remains solely responsible for preparation of any Form 1094-B and for filing Forms 1094-B and 1095-B with the IRS. The Company will not prepare, file, or distribute Forms 1094-C and 1095-C on behalf of Plan Sponsor. The Company shall provide the Plan Sponsor with applicable information in its possession reasonably necessary for the Plan Sponsor to submit 1095 Forms upon request of the Plan Sponsor. In the event the Company fails to provide the Plan Sponsor with the requisite information before the filing deadline, Plan Sponsor is not relieved of its responsibility to timely submit said 1095 Forms. Instead, Plan Sponsor should submit the 1095 Forms and indicate that it has not yet received all pertinent information. The Company's failure to provide the Plan Sponsor with the information necessary to submit the 1095 Forms shall not be a material breach of this Agreement, and the Plan Sponsor's sole remedy for such failure shall be the termination of this Agreement.

(2) Plan Sponsor shall be solely responsible for calculation and payment of any Patient-Centered Outcomes Research Institute fees (“PCOR fees”) imposed on Plan Sponsor under Section 4376 of the Internal Revenue Code. The Company, however, shall provide the Plan Sponsor with information in its possession reasonably necessary for Plan Sponsor to calculate the PCOR fees, including information necessary for Plan Sponsor to determine the average number of lives covered under the Plan during the applicable plan year being reported.

I. Furnishing of Information. The Plan Sponsor will furnish the Company with correct and complete information required by the Company to provide the services contemplated under this Agreement, including, but not limited to, eligibility information, the identity of agents and brokers, information to verify contribution and participation requirements concerning insurance Policies issued by the Company, and a copy of the Plan and any amendments thereto. The information will be furnished at times, and in the manner, the Company may request. The Company will assume that all such information is complete and accurate and will be under no duty to question the accuracy of such information. The Company, at its discretion, may charge reasonable additional fees to the extent other services are requested or required because the information is not furnished, incomplete or inaccurate, or not furnished at the time or in the manner requested. The Company shall be entitled to rely upon any written or oral communication from the Plan Sponsor, its designated employees, agents, or authorized representatives.

J. Plan Changes. The Plan Sponsor must provide the Company with advance written notice of any changes to the Plan or SPD within a reasonable period of time prior to the effective date of the change to allow the Company to determine if such change will alter the services the Company provides under this Agreement. The Plan Sponsor's requested changes must be mutually agreed to in writing prior to implementation of such change. The Company will notify the Plan Sponsor if (i) the change increases the Company's cost of providing services under this Agreement or (ii) the Company is reasonably unable to implement or administer the change. If the Parties cannot reasonably agree to a new fee within thirty (30) days of the notice of the new fee, or if the Company notifies the Plan Sponsor that the Company is unable to reasonably implement or administer the change, the Company shall have no obligation to implement or administer the change.

K. Compliance with Appendices. The Plan Sponsor shall comply with the Attachments that form part of this Agreement.

L. Plan Sponsor's Affiliates and Subsidiaries. With advance notice to and the approval of the Company, the Plan Sponsor may include the employees and dependents of a subsidiary or affiliated companies under this Agreement. The Plan Sponsor will be liable for the payment of all amounts due to the Company and the adequate funding with regard to Members of any subsidiary and affiliated companies covered under this Agreement. The Plan Sponsor represents that together the Plan Sponsor and any of its affiliated companies covered under the Plan make up a single "controlled group" as defined by Section 414 of the Internal Revenue Code of 1986, as amended.

M. Disclosures to Members. The Plan Sponsor will distribute SPDs and the Summary of Benefits and Coverage to all Members as required by law. In addition, the Plan Sponsor will make all disclosures to Members under its Plan as required by applicable law, including (as applicable) the Health Insurance Portability and Accountability Act, the Newborns' and Mothers' Health Protections Act, the Women's Health and Cancer Rights Act, the ACA and COBRA.

N. Third-Party Legal Proceedings. The Company will have complete authority and discretion to determine all matters related solely to claims appeals. Plan Sponsor shall be responsible for the defense of any legal action brought by a third party related to the Plan. Nothing herein shall require the Plan Sponsor to defend the Company in any action in which the

Company is a named party. Nothing herein shall require the Company to defend the Plan Sponsor. The Company and the Plan Sponsor shall cooperate in defense of any legal proceeding. Each Party will furnish the other and its legal counsel with all pertinent information regarding the proceeding.

O. Special Payments. To the extent that the federal or state government, through Medicare, Medicaid, the Veterans Administration, or any other agency or entity asserts a reimbursement right against the Plan Sponsor or the Company, according to that agency's or entity's rights under applicable law (for example, Medicare Secondary Payor rules), with respect to claims processed by the Company under this Agreement, the Plan Sponsor shall be responsible for reimbursing any such amounts determined to be owed (which amounts may be reimbursed on the Plan Sponsor's behalf by the Company from the bank account established pursuant to Section 3). Any such reimbursements requested of the Company during this Agreement before its termination shall be processed by the Company in the same manner as any other claim, and the Company shall be responsible for asserting any applicable defenses to such request. Any such reimbursements requested of the Company after the termination of this Agreement shall be forwarded to the Plan Sponsor for resolution. The Company will work with the Plan Sponsor to determine whether and to what extent such request must be honored, and the Plan Sponsor shall promptly make any necessary payment. This provision shall survive the termination of this Agreement.

Section 7. Indemnification and Limitation of Liability

A. Plan Sponsor's Indemnification. The Plan Sponsor will indemnify, protect and hold the Company harmless against any and all losses, liabilities, penalties, fines, costs, damages, and expenses the Company incurs, including reasonable attorneys' fees and costs, which arise out of:

(1) The Plan Sponsor or its vendors', subcontractors' or authorized agents' negligence or willful misconduct in the performance of the Plan Sponsor's or its vendors', subcontractors, or authorized agents' (i) obligations under this Agreement, or (ii) performance under any other agreements entered into by the Company with those third parties on the Plan Sponsors' behalf.

(2) The Plan Sponsor's material breach of (i) this Agreement, or (ii) any other agreements entered into by the Company with third parties on the Plan Sponsor's behalf;

(3) A breach by a third party of any other agreements the Company enters into with such third party on Plan Sponsor's behalf; and

(4) Third party claims brought against the Company as the claims administrator (e.g. a claim raised by the federal government based on the federal Medicare Secondary Payor laws).

If the parties are unable to mutually resolve the matter, or are unable to resolve it through mediation, the indemnification obligations set forth in this Section are enforceable against Plan Sponsor only as determined by a court or other tribunal having jurisdiction of the matter.

B. The Company's Indemnification. The Company will indemnify and protect Plan Sponsor and hold Plan Sponsor harmless against any and all losses, liabilities, penalties, fines, costs, damages, and expenses, that Plan Sponsor incurs, including reasonable attorneys' fees and costs, which arise out of:

(1) the Company or its vendors', subcontractors' or authorized agents' gross negligence or willful misconduct in the performance of the Company or its vendors', subcontractors' or authorized agents' obligations under this Agreement; and

(2) the Company's material breach of this Agreement.

If the parties are unable to mutually resolve the matter, or are unable to resolve it through mediation, the indemnification obligations set forth in this Section are enforceable against the Company only as determined by a court or other tribunal having jurisdiction of the matter. Plan Sponsor will remain responsible for payment of benefits and the Company's indemnification will not extend to indemnification of Plan Sponsor or the Plan against any claims, liabilities, damages, judgments, or expenses that constitute payment of Plan benefits.

C. Exclusion from Indemnification. The Company shall not be responsible for Plan Sponsor's lost profits, exemplary, special, punitive, or consequential damages or be liable to the Plan Sponsor for the same.

D. Plan Benefits Litigation.

(1) If a demand is asserted, or litigation or administrative proceedings are begun, by a Member or healthcare provider against the Company to recover Plan benefits related to the Company's duties under this Agreement ("Plan Benefits

Litigation"), the Company will select and retain defense counsel to represent its interest. If Plan Benefits Litigation is begun against the Plan Sponsor and/or the Plan, the Plan Sponsor will select and retain counsel to represent its interest. If Plan Benefits Litigation is begun against the Plan and the Company jointly, and provided no conflict of interest arises between the Parties, the Parties may agree to joint defense counsel. If the Parties do not agree to joint defense counsel, then each Party will select and retain separate defense counsel to represent their own interests.

(2) All reasonable legal fees and costs the Company incurs in any Plan Benefits Litigation will be paid by the Plan Sponsor if the Company gives the Plan Sponsor reasonable advance notice of the Company's intent to charge the Plan Sponsor for such fees and costs, and the Company consults with the Plan Sponsor in a manner consistent with the Company's obligations under applicable law on the Company's litigation strategy.

(3) Both Parties will cooperate fully with each other in the defense of Plan Benefits Litigation.

(4) In all events, the Plan Sponsor is responsible for the full amount of any Plan benefits paid as a result of Plan Benefits Litigation.

E. Survival. The terms of this Section shall survive the termination of this Agreement.

Section 8. Authority to Control and Manage the Plan

A. Agency Relationship. The Company, in performing its duties under this Agreement, is acting only as an agent of the Plan Sponsor, and the rights and responsibilities of the Parties shall be determined in accordance with the law of agency except as otherwise herein provided.

B. Company's Control and Authority.

(1) The Company and the Plan Sponsor agree that while this Agreement is in effect, the Company and its delegates shall have exclusive authority to provide the Plan with the services listed in the attachments and that during such time the Plan Sponsor shall not undertake on its own nor shall it authorize or allow any other person or entity to provide any of those services without the prior written consent of the Company.

(2) The Company and the Plan Sponsor agree that the Company shall have no liability under this or any other agreement between the said Parties for any payment of benefits or other activity that violates the provisions of subsection 8.B.1 above.

C. Plan Sponsor's Control and Authority. The Plan Sponsor acknowledges that, except as expressly provided in this Agreement, it and the Plan Administrator have the exclusive authority to control and manage the Plan. The Plan Sponsor expressly agrees that the Company is not the Plan Administrator. The Plan Sponsor expressly agrees that the Company is not the named fiduciary or a fiduciary of the Plan and that neither the Plan Sponsor nor the Plan Administrator will designate the Company as the named fiduciary or a fiduciary of the Plan. Nothing in this Agreement shall be deemed to confer upon the Company any power, discretion, authority, or control over the Plan or Plan assets, or responsibility for the terms or validity of the Plan, or to alter, modify, or waive any terms or conditions of the Plan, or to waive any breach of any such terms of conditions, or to bind the Plan Sponsor, except as described in Section 2, hereof.

D. Plan Documents. The Plan Sponsor acknowledges that the Plan Administrator is responsible for providing Members with an SPD and making sure other materials and information are available to Members. To the extent that the Plan Sponsor uses documents, including but not limited to the SPD, or other materials or information provided to the Plan Sponsor by the Company to satisfy the Plan Administrator's obligations, the Plan Sponsor acknowledges that it adopts such documents and other material and information as to its own as if they were drafted and made available to Members by the Plan Sponsor and under the authority of the Plan Administrator. The fact that the Company has prepared or assisted in drafting any document, including but not limited to the SPD, or provided any other materials or information to the Plan Sponsor, shall not be construed as the exercise of any discretion, authority, or control by the Company concerning the Plan, and shall not be construed as establishing any fiduciary, agency, trust, or other similar relationship whatsoever between the Company and the Plan Sponsor or between the Company and any Member.

E. Relationship to Members. Nothing herein will be deemed to impose any obligation to any Member under the Plan upon the Company. Members shall not have any rights hereunder and shall not have any right to bring an action based on this Agreement.

Section 10. Company's Use and Disclosure of Records

A. Confidentiality. The Company shall maintain the confidentiality of Members' Health Information in accordance with the

provisions of the HIPAA Privacy Attachment and the Business Associate Agreement between the Company and the Plan.

B. Ownership of Records. Subject to subsection A above, the original files and other records in possession of the Company, regardless of how such records are kept, will be maintained in accordance with the Company's corporate record retention policy. Copies of such files and records may be made available to the Plan Sponsor upon request and to the extent needed.

Section 11. Collection of and Liability for Claim Payments Recoveries Not Including Subrogation and Right of Recovery

A. Payment Recoveries. The Company shall take appropriate steps as it would for its own business under similar circumstances to collect Claim Payment Recoveries. The Company shall not be required to initiate court proceedings to recover a Claim Payment Recovery but is expressly authorized to take all actions to pursue recovery, including retaining counsel, settling and compromising claims, and delegating recovery to a third-party vendor to assist it in its collection efforts. For any Claim Payment Recoveries initially identified by the Company, the Company first attempts to pursue recovery itself. If the Company cannot recover Claim Payment Recoveries, it may retain a third-party vendor(s) to assist with the recovery. In such instances, the amount to be credited as the returned claim money will be net of any fees charged by such vendor or counsel. The Company's decision to retain a third-party vendor(s) to assist with recovery may be based upon the amount of the Claim Payment Recoveries or other factors as determined by the Company. The Company currently retains third-party vendors to assist with recovery for Claim Payment Recoveries that are in excess of specified minimum amounts. That threshold may change from time to time, at the Company's sole discretion. Don't hesitate to contact your Company account executive for further information on the Company's current practices.

B. Hospital Bill Audits. The Company shall perform hospital bill audits. Such audits are limited to inpatient, outpatient, emergency, and provider claims that the Company has identified as meeting its auditing guidelines.

C. Claims in Process. Upon termination of this Agreement for any reason other than the Company's breach, the Company shall continue to be authorized to provide recovery and auditing services with respect to all claims in process on the termination date. Claims are considered in the process if the Company or its third-party vendor has evaluated, screened, audited, or processed them, including all claims inventoried in Company's claim payment database.

D. Responsibility. The Company will not be responsible for Claim Payment Recoveries caused directly or indirectly by the Plan Sponsor, its agents, employees, or providers. The Company retains the sole right to determine whether to seek repayment from the payee.

E. Credits. For any refund of an overpayment of Plan monies received from a third party on behalf of a specific Member's account, the Company shall provide a credit as returned claim money. The Company shall have the right to retain any returned overpayments received more than 15 months following the termination of this Agreement.

Section 12. Term and Termination

A. Agreement Term. This Agreement shall be effective on the "Effective Date" shown on the 1st page of the Stop Loss Application and shall continue in force for one year (the “Initial Term”) unless earlier terminated under this Section. This Agreement shall expire at the end of the Initial Term, subject to the right of the Parties to renew the Agreement as set forth herein, in which case, the Agreement shall remain in force until the expiration of the period for which the Agreement was renewed (the "Renewal Term"), unless earlier terminated under this Section.

B. Agreement Renewal. The Company shall submit to the Plan Sponsor, not later than 30 days before the expiration of the Initial Term and any Renewal Term, the Company's proposed terms, and conditions for the renewal of the Agreement (the "Renewal Proposal").

C. Termination Upon Notice. This Agreement may be terminated:

(1) By the Company upon amendment of the Plan in a manner deemed unsatisfactory by the Company, and on notice to the Plan Sponsor, such termination to be effective on the effective date of such amendment.

(2) By the Company upon amendment of the Stop Loss Policy between the Company and the Plan Sponsor, which, in the Company's sole determination, makes such Stop Loss Policy's terms no longer compatible with specific unique terms and requirements of this Agreement, and on notice to the Plan Sponsor, such termination to be effective on the effective date of such amendment.

D. Immediate Termination. This Agreement shall terminate immediately and without notice:

(1) at the option of the Company upon termination of the Stop Loss Policy, if any, between the Company and the Plan Sponsor;

(2) upon failure of the Plan Sponsor to comply with any material term or condition of this Agreement, such as but not limited to, failure to make the payments as specified in the Section of this Agreement entitled "Payments to the Company."

E. Suspension of Company's Performance. Instead of treating this Agreement as being immediately terminated upon the Plan Sponsor's failure to comply with any material or condition of the Agreement as described above, the Company has the right to treat the Agreement as being continued and to immediately suspend the Company's performance of its duties under the Agreement including, but not limited to, the Company's claims processing duties. In exercising such rights, the Company will notify the Plan Sponsor of the Plan Sponsor's failure and request the Plan Sponsor to cure such failure. The Plan Sponsor must completely cure its failure within the Company's then prescribed time frame ("performance suspension period" and "cure period"), not to exceed ten days. The Company is not required to resume its duties' performance until after the Plan Sponsor's failure is completely cured. This Agreement shall terminate immediately and without notice after the expiration of the performance suspension period if the Plan Sponsor fails to completely cure its failure by the end of the applicable cure period.

F. Termination by Law. Suppose any state or other jurisdiction enacts a law that prohibits or effectively prevents the continuance of this Agreement, or the existing law is interpreted to so prohibit or effectively prevent the continuation of this Agreement. In that case, the Agreement shall terminate automatically as to such time or jurisdiction on the effective date of such law or interpretation.

G. Effect of Termination.

(1) If, on the date this Agreement terminates, the Plan Sponsor has not made all payments then due under this Agreement; the Company will have the right to immediately stop providing the services contemplated under this Agreement, including but not limited to processing claims, on the effective date of such termination. In this case, information regarding all outstanding claims which are unpaid (regardless of when the claim was incurred and when the Company received the claim) or received after such date may be returned by the Company to the Plan Sponsor. In addition, the Plan Sponsor will notify each Member covered under the Plan of such termination.

(2) Upon termination of this Agreement, or the termination of individual employee or dependent coverages, it is the Plan Sponsor's responsibility to take reasonable steps to prevent further use of the I.D. cards by any employee or dependent post-termination. The Plan Sponsor will be responsible for reimbursing the Company for any claims incurred by the Company for any employee or dependent who is no longer covered by the Plan and who uses an I.D. card before the date the Plan Sponsor notifies the Company of such termination.

(3) Except for termination for the Plan Sponsor's failure to meet its payment obligations (as outlined in the Plan Sponsor's Payment Obligations Attachment) or for the Plan Sponsor's breach of this Agreement, the Company will continue to adjudicate and make payments for claims that are incurred before the termination of this Agreement and are submitted for payment consideration within the 48 months immediately following the termination date of this Agreement.

(4) The Company shall not be responsible for processing or payment of any claims (a) incurred before, and not submitted to the Company within 48 months after, the termination of this Agreement, and (b) claims incurred after the termination of this Agreement.

Section 14. Compensation to Agents or Brokers

An agent or broker's compensation paid by Company is a stop-loss policy commission, not a service fee. The Plan Sponsor acknowledges that Company may pay reasonable compensation to the agent or broker of record. Unless explicitly stated, all agents and brokers are hereby declared to be an agent(s) of the Plan Sponsor and not the Company. An agent or broker is not a trustee of the Plan, a Plan Administrator, a named fiduciary of the Plan, or a fiduciary who is expressly authorized in writing to manage, acquire, or dispose of the assets of the Plan on a discretionary basis. The Plan Sponsor shall notify the Company, in writing, if the Plan Sponsor changes its agent or broker. Changes shall be effective on the first day of the month following thirty (30) days after receipt of the notice of a change.

Section 15. Other Financial Provisions

A. Savings Initiatives.

(1) In its sole discretion, the Company may undertake initiatives in addition to the services described in this Agreement to save additional money for the Plan. Examples of such initiatives might include, but are not limited to, subrogation and right of recovery, provider bill/fee negotiation and discounts on claims from providers outside the Company's primary network of providers, and COB identification and recovery when performed by a third-party vendor.

(2) The Company may retain third-party vendors to pursue savings under this provision.

(3) Company may also arrange for third parties to provide care management services to:

(i) contain the cost of specified health care services/items overall concerning all plans insured or administered by Alliant Health Plans, Inc., or

(ii) improve adherence to evidence-based guidelines designed to promote patient safety and efficient patient care.

B. Subrogation and Right of Recovery. For purposes of subrogation and right of recovery, the Company will have the sole right to make claims under the Subrogation and Right of Recovery Provision contained in the Plan. In its sole discretion, the Company may litigate, negotiate, settle, compromise, release or waive any such claim. The Plan Sponsor hereby assigns to the Company all of its rights to make, litigate, negotiate, settle, compromise, release or waive any such claim. Claims subject to this subrogation and right of recovery section include, but are not limited to, recovery of medical expenses incurred by a Member as the result of injuries or illness caused by a third party, recovery of medical expenses incurred by a Member due to work-related injury or sickness, and recovery of medical expenses through class action lawsuits.

The Plan Sponsor will notify the Company immediately of any work-related accident suffered by a Member for which recovery may be available under any Workers' Compensation law or similar law. The Plan Sponsor also agrees to advise the Company of any potential subrogation rights or other contractual rights of recovery known to the Plan Sponsor. Legal expenses will not be used when calculating the aggregate stop-loss benefits, if any, according to the Stop Loss Policy issued by the Company to the Plan Sponsor.

C. Compensation and Financial Arrangements with Third Parties. The Plan Sponsor acknowledges that the fees charged to the Plan Sponsor under this Agreement are calculated on the basis that the Company may receive compensation from third parties with which the Company has agreements or other arrangements. For example, the Company maintains agreements with providers such as, but not limited to, hospitals, physician groups, individual physicians, labs, and clinics; and with vendors that assist the Company with certain services, such as, but not limited to, pharmacy benefit management, disease management, claims negotiation and claims audit vendors. Some of the Company's agreements with providers and vendors provide compensation to the Company through discounts, rebates, allowances, rate differentials, commissions, administrative fees, distribution or marketing fees, incentives, adjustments, settlements, minimum guaranteed payments, or other financial arrangements.

Such compensation is for the sole benefit of the Company. The Company may retain such compensation, regardless of the form or manner in which it is received, to defray expenses of the Company and provide for a profit.

Section 16. Resolution of Disputes

Any dispute between the Parties arising from or relating to the performance or interpretation of this Agreement ("Controversy") shall be resolved exclusively pursuant to the following mandatory dispute resolution procedures:

A. The Parties agree to mediate the Controversy in accordance with the American Health Lawyers Association Alternative Dispute Resolution Service Rules of Procedure for Mediation ("Mediation"). The mediation shall be conducted in a city and state as determined by the mediator. Each Party shall assume its own costs and attorneys' fees. In addition, the Parties shall equally bear the mediator's compensation and expenses and any administrative fees or costs associated with the mediation proceeding.

B. If the Controversy has not been resolved by mediation, the Controversy shall be settled exclusively by binding arbitration. The arbitration shall be conducted in the same location as noted in Section 16.A. above, in accordance with the American Health Lawyers Association Alternative Dispute Resolution Service Rules of Procedure for Arbitration. The arbitration shall be binding on the Parties to the Agreement and on any respective affiliates which joined in the arbitration. The arbitrator's decision shall be final, conclusive, and binding, and no action at law or in equity may be instituted by either Party other than to enforce the arbitrator's award. Judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof. Each Party shall assume its own costs and attorneys' fees. The Parties shall equally

bear the arbitrator's compensation and expenses and any administrative fees or costs associated with the arbitration proceeding.

C. The terms of this Section shall survive the termination of this Agreement.

Section 17. General

A. The Company may use its affiliates or subcontractors to perform the Company's services under this Agreement. The Company will be responsible for those services to the same extent that the Company would have been had it performed those services without the use of an affiliate or subcontractor.

B. Company's relationship with the Plan Sponsor will be that of an independent contractor, and nothing in this Agreement will be construed as creating the relationship of employer and employee between the Plan Sponsor and officers, employees, or agents of Company. Company's power or authority will extend no further than is expressly stated in this Agreement, and no power or authority will be implied from the granting or denial of powers specifically mentioned herein.

C. Nothing in this Agreement is considered to be waived by any Party, unless the Party claiming the waiver submits the waiver in writing to the other Party and the other Party approves of the waiver in writing. No breach of the Agreement is considered to be waived unless the nonbreaching Party waives it in writing. A waiver of one provision does not constitute a waiver of any other. A failure of either Party to enforce at any time any of the provisions of this Agreement, or to exercise any option which is provided in this Agreement, will in no way be construed to be a waiver of such provision of this Agreement.

D. Suppose during the operation of the Plan, any tax, surcharge, or other government-imposed levees (other than statutory state or federal income taxes), or any other assessment or premium charge, will be assessed against the Plan or Company, and Company is required to pay such tax or charge. In that case, Company will report the payment to the Plan Sponsor, and the Plan Sponsor will reimburse Company for the same.

E. Any modification or amendment of this Agreement must be in writing and duly executed by the Parties hereto. The Plan Sponsor may assume that any officer of Company and Company may assume that any officer of the Plan Sponsor is authorized to execute any such modification or amendment.

F. In performing its obligations under this Agreement, the Company acts only as an agent of the Plan Sponsor. For any applicable federal or state law, the Plan Sponsor will be deemed the Plan Administrator of this Plan unless the Plan Sponsor, by its action of its Board of Directors, designates an individual or committee to act as Plan Administrator. In no instance is Company deemed to be, or act as, the Plan Sponsor.

G. Neither Party shall be bound by any notice, directive, or request unless and until such notice is received in writing at its office addressed to the attention of the:

Chief Executive Officer/President,
Alliant Health Plans, Inc.
201 W. Waugh Street, Dalton, GA 30720

Or for the Plan Sponsor, as shown below.

H. This Agreement will be construed and enforced according to the laws of the State of Missouri, except to the extent preempted by any applicable federal law covering employer group health plans. It is the intention and Agreement of the Plan Sponsor and Company that nothing in this Agreement conflicts with any state or federal law or governmental regulation thereunder. If it is determined through interpretation that there is a conflict, this Agreement will be amended by incorporating such law or regulation to avoid such conflict.

I. This Agreement or any right or duty hereunder is not assignable, in whole or part, by either Party without the prior written consent of the other Party. Any purported assignment in violation of this paragraph shall be null and void.

J. Nothing in this Agreement shall confer upon any person other than the Parties and their respective successors or assigns, any rights, remedies, obligations, or liabilities whatsoever.

K. The invalidity or unenforceability of any provision of this Agreement will not affect the validity or enforceability of any other provision. However, it is intended that a court of competent jurisdiction construe any invalid or unenforceable

provision of this Agreement by limiting or reducing it so as to be valid or enforceable to the extent compatible with applicable law.

L. The rights and obligations of the Parties as set forth in this Agreement shall survive the termination of this Agreement as set forth herein and to the extent necessary to effectuate the intent of the parties as expressed herein. This Section shall not obligate the Company to pay any claims (regardless of the dates incurred), or perform claims administrative functions, after the termination of this Agreement, for any reason whatsoever, unless otherwise agreed upon by the Parties.

M. This Agreement, with its attachments, constitutes the entire agreement between the Parties governing the subject matter of this Agreement. This Agreement replaces any prior written or oral communications or agreements between the Parties relating to the subject matter of this Agreement. The headings and titles within this Agreement are for convenience only and are not part of the Agreement.

[Signature Page to Follow]

IN WITNESS WHEREOF, the Parties hereto have caused this Agreement to be executed by their respective officers duly authorized to do so.

Dated: ____

Company: ____	Alliant Health Plans, Inc. ______________________________
By: ____ (Printed Name)	____ (Printed Name)
____ (Signature of Authorized Representative)	____ (Signature of Authorized Representative)
____ (Official Title)	____ (Official Title)

____

Address for Plan Sponsor

SERVICES TO BE PROVIDED BY THE COMPANY

The following services will be provided with the administration of the Plan Sponsor's Plan:

Claims Adjudication and Management

- Claim payment utilizing proprietary claims system
- Claims audit and review services
- Claims scrubbing software to help ensure proper coding of claims
- Stop-loss accounting and claims filing
- Provider network access

Clinical Services

- Prior Authorization Management
- Case Management
- Transplant Management
- Utilization Review
- Specialized care programs
- Pharmacy step therapy and prior authorization review
- Pharmacy formulary optimization review and analysis
- Pharmacy utilization programs

Online Services

- Explanation of Benefits (EOB) – current, pending, and history
- Accumulator information
- Order ID cards / temporary I.D. cards
- Pharmacy locator and low-cost Rx search tool
- PPO provider directories
- Resource library

Reporting

- Access to on-demand reporting packages
- Annual claims and expense projections

Administrative Services

- Toll-free number for employees
- Coordination of SPD with Plan Sponsor
- Company ID cards and enrollment forms
- IRS 1099 reports for providers of health care
- Guidance in plan arrangement, funding & reserving
- Grievance and Appeals Administration
- Subrogation services
- Dedicated Account Manager
- Routine scheduled on-site meetings (Annually)
- Ongoing consultation with Plan Sponsor to review program performance and objectives
- Attendance at Benefit Fairs and other related noteworthy events as requested

PLAN SPONSOR'S PAYMENT OBLIGATIONS ATTACHMENT (LEVEL FUNDING)

Plan Sponsor shall make the following payments to the Company:

1. Monthly Fees.

A. Stop Loss Policy Premium, Administration, Taxes, and Other Fees. No later than one day prior to the first day of each Agreement Month, Plan Sponsor shall pay Company all obligations under the Stop Loss Policy, Plan Sponsor-Specific Administration Attachment, Administrative Services Agreement, and other taxes and fees, as billed by the Company, for Members covered under the Plan during that Agreement Month at the rate outlined below.

B. Broker Fee. No later than one day prior to the first day of each Agreement Month, Plan Sponsor shall pay Company a Monthly Broker Fee, as billed by the Company, for Members covered under the Plan during that Agreement Month at the rate outlined below.

C. Run out claim payment services. Upon termination of the Agreement, no additional fees will be charged for run-out payment services through the 60th month following the Effective Date or Anniversary Date (as applicable) of the final Agreement Year. If an extension of that period is requested from the Plan Sponsor, payment for such services will be negotiated in good faith between the parties. Plan Sponsor acknowledges, understands, and agrees that the Company will have no obligation or liability with respect to any claims incurred following termination of the Agreement, or with respect to any claims that are not properly submitted before the end of the applicable run-out period (even if such claims are incurred during the term of the Agreement).

2. Amounts to be Held by Company and Required to Fund Plan Sponsor's Plan Liabilities Not Covered under the Stop Loss Policy and Other Expenses.

A. **Amounts Required to Fund Plan Sponsor's Maximum Monthly Claim Liability.**
Before the first day of each Agreement Month, Plan Sponsor shall pay an amount equal to the Plan Sponsor's maximum monthly claim liability for such month (as determined according to the Stop Loss Policy).

i. At any time, Plan Sponsor's cumulative Agreement Year-to-date maximum monthly claim liability payments may exceed the Plan's cumulative Agreement Year-to-date claim payments. Plan Sponsor agrees that any excess claims funds will be held by the Company for the Plan Sponsor and used to fund the Plan's claim payments during subsequent Agreement Months. Based on the Stop Loss Policy terms for payment of incurred claims, following the appropriate calendar month after the Anniversary Date of the Policy Year, the Company shall return the Plan Sponsor any excess claims funds concerning that Policy Year except for such portion of the surplus as due to the Company for any late fees or payments owed.

ii. At any time, Plan Sponsor's cumulative Agreement Year-to-date maximum monthly claim liability payments may be less than the Plan's cumulative Agreement Year-to-date claim payments. In such an event, the Plan Sponsor requests that Company advance payments as provided in the Stop Loss Policy *(without any interest charge)* to fund the Plan claim liabilities to the extent of such shortfall. Plan Sponsor authorizes the Company to apply any reimbursement under the aggregate coverage of the Stop Loss Policy to reimburse the Company for the amount advanced.

a. Suppose no reimbursement is available under the Stop Loss Policy's aggregate coverage. In that case, the Plan Sponsor authorizes the Company to withdraw the amount advanced by the Company from the then available balance of the Plan Sponsor's maximum monthly claim liability payments held by the Company for Plan Sponsor.

B. ______(initial) **If the Agreement is terminated prior to the end of the Initial Term or Renewal Term (as applicable), additional amounts may be required to fund Plan run-out of claims liability based on the terms of the Stop Loss Policy in place.** The Company may require the Plan Sponsor to pay an additional projected amount upon notification of the termination if the Company has agreed to contract to handle run-out claims payment services.

C. Amounts Required to Fund Plan Sponsor's Liability for Ex-Gratia Payments. Suppose, at the Plan Sponsor's request, the Company makes payment of expenses that Company determines is not covered under the Plan. In that case, Plan Sponsor shall immediately pay Company an amount equal to such payment. While held by the Company, the payment amounts identified in B and C of this Section 2 may be credited with interest at the Company's then-current short-term interest rates. Plan Sponsor agrees that the Company shall retain all such income earned concerning such amounts held by the Company.

EXCESS CLAIMS FUND DISTRIBUTION. A surplus occurs if actual medical costs total less than expected throughout the Agreement Year. The final surplus is determined as part of year-end accounting. The Company will reconcile the Plan's claims fund approximately 180 days (roughly the 18th month) after the Agreement Year closes. The Company sends the Plan 80% of the surplus and retains 20%. The Company keeps this 20% for an additional 6-month period in the event that new covered claims are received after the termination period. After this 24th month, any remaining surplus is returned to the Plan Sponsor.

Attach a copy of the Final Funding Quote

HIPAA PRIVACY ATTACHMENT

ALLIANT HEALTH PLANS, INC.

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you and your employees may be used and disclosed and how you can get access to this information. Please review it carefully.

Alliant Health Plans, Inc. provides insurance services that require compiling personal and sometimes sensitive information. Alliant Health Plans, Inc. takes seriously a commitment to protecting the confidentiality and security of information collected about individuals. We respect the confidentiality of your health information and will protect your information in a responsible and professional matter. We are required by law to maintain the privacy of your health information, to send you this notice, abide by the terms of the notice currently in effect, and notify you if there is a breach in the privacy or security of your health information.

This notice explains how we use information about you and when we can share that information with others. It also informs you about your rights with respect to your health information and how you can exercise these rights.

If you have questions about this notice or how we use or share information, please contact the HIPAA Official of Alliant Health Plans, Inc, at 1-877-668-1015. Business hours are Monday through Friday from 9:00 a.m. to 5:00 p.m. or our Regulatory Compliance Department at Alliant Health Plans, Inc., 201 W. Waugh Street, Dalton, GA 30720.

Suppose you believe your privacy rights have been violated. In that case, you may file a complaint with us by contacting our Regulatory Compliance Department at Alliant Health Plans, Inc., 201 W. Waugh Street, Dalton, GA 30720.

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint.

Any additional questions regarding this Policy may be addressed to us at:

Privacy Policy
Alliant Health Plans, Inc.,
201 W. Waugh Street, Dalton, GA 30720

YOUR RIGHTS

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Ask us to restrict how we use or disclose your information for treatment, payment, or health care operations
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated.

YOUR CHOICES

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information.

OUR USES AND DISCLOSURES

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions
- To assist in fundraising activities within our health care operations.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This Section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, by home or office phone) or to send mail to a different address.
- We will consider all reasonable requests and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years before the date you ask, whom we shared it with, and why.
- We will include all the disclosures except treatment, payment, health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you request another within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will ensure the person has this authority and can act for you before taking action.

File a complaint if you feel your rights are violated

- You can complain if you think we have violated your rights by contacting us using the information on page 1. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. Talk to us if you have a clear preference for how we share your information in the situations described below. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation.

If you cannot tell us your preference, for example, if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information.

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

- We can use your health information and share it with professionals treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.

Example: We use your health information to develop better services for you.

Pay for your health services

- We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental Plan to coordinate payment for your dental work.

Administer your Plan

- We may disclose your health information to your health plan sponsor for plan administration.

Example: Your Company contracts with us to provide a health plan, and we provide your Company with specific statistics to explain the premiums we charge.

How else can we use or share your health information?

- We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. However, we must meet many conditions in the law before sharing your information for these purposes.
- For more information, see www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety.

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we comply with federal privacy law.
- We may report information to state agencies that regulate us, such as the Georgia Department of Insurance.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- When an individual dies, we can share health information with a coroner, medical examiner, or funeral director.

Address workers' compensation, law enforcement, and other government requests. We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- Special government functions include military, national security, and presidential protective services.

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order or reply to a subpoena.

Assist in fundraising activities

We can use or share health information for purposes of fundraising activities within these guidelines:

- The information used or disclosed must be limited to your demographic information and the health care dates.
- If we are not preparing the fundraising within our organization, the information can only be disclosed to a business associate or an institutionally related foundation.
- Any fundraising materials must include a description of how you can opt-out of future fundraising communications.
- Your PHI will not be used for fundraising activities unless you provide authorization for the fundraising activity.
- Upon authorization of your use of PHI in a fundraising activity, we will provide instructions on how you may opt-out of future fundraising communications or revoke the authorization relating to these activities.
- We will maintain a log of all individuals who have revoked fundraising authorizations or opted out of receiving future communications.
- We must make reasonable efforts to ensure that you do not receive further fundraising materials if you have revoked your authorization or exercised your opt-out rights.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will promptly inform you if a breach may have compromised your information's privacy or security.
- We must follow the duties and privacy practices described in this notice and give you a copy.
- We will not use or share your information other than as described here unless you tell us, in writing, that we may. If you tell us we can, you may change your mind anytime. Let us know in writing if you change your mind. Once you authorize us to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information.

For more information, see www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request on our website, and we will mail a copy to you.

This notice is effective: March 2021

STOP LOSS INSURANCE POLICY

Alliant Health Plans, Inc.
201 W. Waugh Street
Dalton, Georgia 30722

(A Georgia Insurance Corporation herein called Alliant)

This Policy will be construed under the law of the jurisdiction in which it is delivered.

In consideration of premium payments by the Insured in the amounts and at times provided, Alliant agrees with the Insured to provide insurance following the Policy terms.

For the purpose of effective dates and termination dates under this Policy, all days begin and end at midnight. This Policy is non-participating.

In Witness Whereof, Alliant Health Plans, Inc. has signed this Policy in Dalton, Georgia.

Mark Mixer, President, and CEO, Alliant Health Plans, Inc.

Alliant Health Plans, Inc.
201 W. Waugh Street
Dalton, Georgia 30722

Section 1. Declarations

STOP LOSS INSURANCE POLICY FOR:

INSURED:

See "Plan Sponsor" listed in Stop Loss Application

POLICY EFFECTIVE DATE:

See "Effective Date" listed in Stop Loss Application

DATE OF ISSUE:

See Stop Loss Application

Attach a copy of the Final Quote

Section 2. Insuring Agreement

Alliant will reimburse the Insured for Eligible Claim Expenses during a Policy Year that are in excess of the applicable Aggregate Stop Loss Amount. Such payments are hereafter called Stop Loss payments.

In no event will Stop Loss payments in any Policy Year for Eligible Claim Expenses in excess of the Aggregate Stop Loss Amount exceed the Maximum Annual Aggregate Stop Loss Payment Amount shown in the Schedule of Insurance.

Section 3. Definitions

1. "Aggregate Accommodation" means an advance of the Aggregate Benefit during the Policy Year.
2. "Aggregate Benefit" means the amount that Alliant agrees to pay the Insured after the end of the Policy Year for Eligible Claim Expenses as set forth in Section 1. Declarations and pursuant to the terms, conditions, and limitations of this Policy.
3. "Aggregate Stop Loss Amount" is the total dollar amount of Eligible Claim Expenses that must be paid by the Insured for all Members during the Policy Year before Aggregate Stop Loss benefits are payable. It is determined at the end of the Policy Year and is based on: (a) the sum of each month's number of eligible employees reported to Alliant, multiplied by (b) the Aggregate Stop Loss Factor(s).
4. "Aggregate Stop Loss Factor(s)" are based on (a) expected claims, multiplied by the Aggregate Stop Loss Percentage, divided by (b) the expected number of employees at the beginning of the Policy Year, divided by (c) the number of months in the Policy Year.
5. "Aggregate Stop Loss Percentage" means the percentage amount (e.g., 10%) above expected paid claims (e.g., 110%).
6. "Contract" means the Administrative Services Agreement between the Insured and Alliant.
7. "Covered Benefits" are the benefits for Members covered by the Plan as indicated on the Schedule of Insurance.
8. "Eligible Claim Expenses" are expenses for Covered Benefits paid by the Insured according to the Plan and are not excluded under the terms of this Policy. Payment for Eligible Claim Expenses is considered to be paid as of the date Alliant issues the payment instrument.
9. "Employee" means a U.S.-based employee of the Insured who works at least 20 hours per week and for whom the Insured is deducting any required U.S. FICA taxes.
10. "Experimental and Investigational" means a drug, device, procedure, or treatment Alliant determines is not accepted as standard medical treatment of a condition or illness.
11. "Medically Necessary" means a health care service or supply that is:
    - (a) appropriate and consistent with the diagnosis and the omission of which could adversely affect or fail to improve the patient's condition;
    - (b) compatible with the standards of acceptable medical practice in the United States;
    - (c) not provided solely for a Member's convenience or the convenience of the doctor, health care provider or hospital;
    - (d) not primarily custodial care; and
    - (e) provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms.

    The Company reserves the right to determine whether a health care service or supply is Medically Necessary. The fact that a physician has prescribed, ordered, recommended or approved a service or supply does not, in itself, make it Medically Necessary.
12. "Member" has the same meaning as provided under the Contract.
13. "Plan" means the self-funded group health plan sponsored by the Insured for which Alliant is providing administrative services pursuant to the Contract.
14. "Policy Anniversary Date" means 12 months from the Effective Date of this Policy and the same date each subsequent year.

15. “Policy Month” means any month during a Policy Year.

16. “Policy Year” means the period beginning on the Effective Date and ending at 11:59 PM Eastern Standard Time (EST) on the day immediately preceding the date that is 12 months following the Effective Date, and each subsequent 12 month period, during which this Policy is in effect.

Section 4. Exclusions

The following are <u>not included</u> as Eligible Claim Expenses:

1. Expenses paid on the direction of the Member that Alliant determines are not payable under the Contract following Alliant's then-current standard claim practices established for the health and welfare benefit plan administered by Alliant. This includes expenses for services or supplies that are not Medically Necessary or expenses for drugs, treatment, services, or supplies that are considered Experimental or Investigational.

2. If the Member has valid and collectible insurance, reinsurance or indemnity, or any reimbursement agreements covering a loss also covered by this Policy, the covered benefits afforded by this Policy shall be in excess of and shall not contribute with such other insurance, reinsurance, or indemnity.

3. Expenses incurred by an individual who is not a Member under the Plan.

4. Expenses paid for an Employee and their dependents who did not enroll following the terms of the Plan, until they are enrolled following the terms of the Plan.

5. Expenses for services, treatment or supplies for treatment of illness or injury which is caused by or attributed to by war or any act of war, participation in a riot, civil disobedience or insurrection. "War" means declared or undeclared war, whether civil or international, or any substantial armed conflict between organized forces of a military nature.

6. Expenses incurred before the Effective Date of this Policy, unless otherwise specified in the Summary Plan Description.

7. Expenses paid for a Member following termination of coverage under the Contract concerning a class of employees and their dependents that includes the Member. A class of employee may mean a specific location, division, salaried, hourly, retiree, or other employee designation that requires a distinct and separate structure in Alliant's claim system.

8. Expenses paid for Members who are disabled on or before the Effective Date; provided that expenses will not be excluded from Eligible Claim Expenses on or after the date that the disabled Member:
    (a) if an Employee, they return to active, full-time employment for at least one (1) full working day; or
    (b) if a dependent or COBRA qualified beneficiary, they can perform the normal functions of a person of like sex and age.

9. Benefits paid for expenses incurred for treatment of an illness or injury for which a Member is entitled to benefits under any Workers' Compensation law, occupational disease law, or any other legislation of similar purpose.

10. Expenses paid for benefits not listed in the Plan or the Summary Plan Description.

11. Expenses for taxes, fees, and surcharges that may be imposed on the Plan by any government body.

12. Benefits paid for retired Employees and their dependents, unless explicitly provided for in Section 1. Declarations.

13. Benefits paid for individuals who are classified by the Insured as independent contractors, unless explicitly provided for in Section 1. Declarations, even if such individuals are later deemed misclassified.

14. Expenses for any other benefits the Insured and Alliant mutually agree on will not be subject to the Stop Loss insurance.

Section 5. Conditions

Premiums

The first Policy Year's monthly Premium Rate is shown in Section 1. Declarations.

Premium Calculation: An estimated premium will be calculated, which will be payable monthly or on any other basis mutually agreed upon by the Insured and Alliant. The estimated premium will be based on the Premium Rates shown in Section 1, Declarations, and the estimated number of employees. A final funding quote is attached in Section 1. Declarations.

Premium Payments: Alliant will issue a Stop Loss premium invoice for the payment of the estimated premium. Within 180 days following the end of each Policy Year, Alliant will prepare and submit to the Insured a financial accounting as to the total premium for that Policy Year. The total actual premium will be the sum of the products, for each month of that Policy Year, of:

(a) the Premium Rate(s), times
(b) the number of employees.

Right to Recalculate: Alliant reserves the right to make adjustments in the Premium Rate or the estimated premium on the first day of any Policy Month, as of the date any of the following events occur:

(a) any change of 10% +/- in the number of employees;
(b) any change in the coverage or types or amounts of benefits offered under the Plan which will change the expected cost of coverage;
(c) any change in this Policy;
(d) any addition or deletion of a unit, division, subsidiary, affiliated, or an associated company from this Policy; and
(e) any other change in factors bearing on the risk assumed (including but not limited to: age, sex, geographic changes, occupations, etc.), which Alliant determines to change the nature of the risk by more than 10%.

Failure to adjust the Premium Rate or the estimated premium during a Policy Year will not preclude adjusting during any subsequent Policy Year.

Suppose the total actual premium (determined by the financial accounting) is less than the amount of estimated premiums paid. In that case, the difference will be paid to the Insured when the accounting is submitted. However, if the total actual premium exceeds the amount paid, the difference will be paid to Alliant within 31 days of the date the accounting is furnished to the Insured.

Minimum Premium: The Minimum Premium, as stated in Section 1. Declarations, must be paid prior to the termination date if this Policy is terminated prior to the end of the Policy Year. The Minimum Premium requirement only applies if this Policy is terminated prior to the end of the Policy Year. Reimbursements under this Policy may be limited and coverage under this Policy may be rescinded entirely if the Minimum Premium is not paid. If this Policy terminates prior to the end of the Policy Year and the Minimum Premium has not been paid within 30 days following the termination date, the Company may (at its option): (1) offset the shortfall in the actual premiums paid against any claims submitted for reimbursement; (2) rescind this Policy; or (3) seek the required Minimum Premium through any legal remedy. If payment of the Minimum Premium in full is not made within this thirty-day period, Alliant will be entitled to assess monthly a late payment fee equal to 7% per annum of the outstanding balance, plus any reasonable expenses including, but not limited to, collection agency fees, bank fees, and legal fees.

Aggregate Stop Loss Factor

Alliant reserves the right to make adjustments in the Aggregate Stop Loss Factor as of the date of any change in the Plan or as of the date of any other change in factors bearing on the risk assumed, including but not limited to:

(a) a 10%+/- change in the census estimate used to calculate the Aggregate Stop Loss Factor;
(b) any change in the coverage or types or amounts of benefits offered under the Plan which will change the expected cost for coverage;
(c) any change in this Policy;
(d) any addition or deletion of a unit, division, subsidiary, affiliated, or an associated company from this Policy; and
(e) any other change in factors bearing on the risk assumed (i.e., age, sex, geographic changes, occupations, etc.) which are expected to change the nature of the risk by more than 10%.

Failure to adjust the Aggregate Stop Loss Factor during a Policy Year will not preclude adjusting during any subsequent Policy Year.

Modification of Policy

Changes in this Policy may be made by written mutual Agreement between Alliant and the Insured.

Optional Policy Renewal

The Policy will renew on the Policy Anniversary Date, upon the Plan Sponsors' acceptance of the renewal terms, unless it has otherwise terminated or is subject to termination following the termination provisions of this Policy. Changes to the Schedule of Insurance for each Policy Year after the first shall be indicated in a written notice sent to the Insured and shall be effective on the date stated in such notice.

Stop Loss Payments

Alliant will make payment not later than 180 days after the end of each Policy Year to or on behalf of the Insured of the Stop Loss payment due under the terms of this Policy, less any Aggregate Accommodation payments previously paid. The amount of any premiums due but unpaid may be deducted from the Stop Loss payment otherwise payable to the Insured. This right will not prevent the termination of this Policy for non-payment of premium under the termination provisions of this Policy.

Alliant agrees to make an Aggregate Accommodation payment to the Insured at any time during the Policy Year when the Eligible Claims Expenses paid from the first day of the Policy Year, in the aggregate, exceeds (i) the estimated Aggregate Stop Loss Amount per month accumulated since the first day of the Policy Year, less (ii) any Aggregate Accommodation payments previously paid and not repaid. If, at the end of any Policy Month, the sum of Aggregate Accommodation payments paid to the Insured during the Policy Year exceeds (i) the Eligible Claims Expenses paid from the first day of the Policy Year, less (ii) the estimated Aggregate Stop Loss Amount per month accumulated since the first day of the Policy Year, this amount shall be repaid to Alliant within 30 days after Alliant requests such repayment.

If the Policy terminates before the end of the Policy Year, the Insured must immediately repay to Alliant all Aggregate Accommodation payments made to the Insured, less any amount the Insured has already repaid, within 30 days from the date the Policy terminates.

Alliant’s sole liability hereunder is to the Insured, subject to the terms, conditions and limitations of this Policy. Nothing in this Policy shall be construed to permit a Member to have a direct right of action against Alliant.

Subrogation/Right of Recovery

The Plan must include a provision for subrogation/reimbursement in its Summary Plan Description, and the Plan must pursue enforcement of this provision. Should the Plan fail to pursue any claims or action against a responsible party, then Plan Sponsor agrees that Alliant shall be subrogated to or assigned Plan Sponsor's reimbursement rights and shall assume the Plan's rights to pursue any claims against all parties. The Plan will be responsible for any reasonable expenses incurred in pursuing such claims, including the fees and costs charged by any contracted subrogation vendor or attorney and any additional legal costs. Alliant has the right to seek all claims covered under this Policy and paid by the Plan and to pursue recovery, in the name of the Plan, of the entire claim, including both the portion of the Plan benefits for which the Plan has been paid under this Policy and the amount of the claim consisting of benefits paid by the Plan but not payable under this Policy.

The Plan must notify Alliant within 30 days of receiving information that may give rise to the Alliant's subrogation rights. Further, the Plan shall cooperate with Alliant and do all necessary things for Alliant to pursue any action to recover against a responsible party. The Plan may not take any action or neglect any activity that will prejudice or impair the rights of Alliant to pursue recovery from any other responsible party. The Plan may not, without consent of Alliant, settle or give release for any claim to any other party if doing so would impair or prevent Alliant from exercising its rights of recovery.

Alliant is entitled to recover in full any amount paid by Alliant under this Policy and any expenses of collection incurred by Alliant before the Plan shares in any amount so recovered. Alliant will reduce its recovery amount by a pro-rata share to reflect the Net Recovery obtained by the Plan. “Net Recovery” is the gross amount recovered by the Plan, less such factors as

costs incurred by the Plan in getting the recovery, comparative fault issues involving the Plan member, or factors affecting the Plan member's inability to fully recover for their injuries. If Alliant recovers an amount greater than its reimbursement, the excess, reduced by the costs to obtain the recovery, will be returned to the Plan. Suppose the Plan recovers any such payment from a responsible party. In that case, the recovered amount cannot be used to satisfy any retention requirement or Aggregate Stop Loss specifications noted on the final funding quote, until Alliant's recovery rights are satisfied.

If the Plan receives a recovery before Alliant reimburses any covered expenses under the Policy, the Plan must deduct the amount of such recovery from any reimbursement request. For example, suppose the Plan receives a recovery after Alliant has made payment to the Plan for some or all a particular claim. In that case, the Plan must reimburse Alliant to the full extent of the payment by the Alliant, less a pro-rata reduction to reflect the Net Recovery obtained by the Plan. The Plan's obligation to reimburse Alliant remains, whether this Policy is still in force on the recovery date. Such reimbursement to Alliant must occur within 30 days of any recovery by the Plan or Plan Sponsor. The Plan shall account to Alliant for amounts recovered. These rights and obligations imposed on the Plan and Alliant under this Section shall survive termination of the Policy.

Stop Loss Overpayments

If Alliant determines that the Insured has been overpaid due to a claim credit resulting from a coordination of benefit change, a subrogation recovery, audit, or billing or payment error, the Insured will promptly refund such overpayment to Alliant. If this Policy terminates, any reimbursements made for claims paid by the Insured after the termination date will immediately be refunded to Alliant. If the Insured fails to refund any overpayments to Alliant promptly, Alliant reserves the right to obtain such overpayments from future payments due under this Policy.

Termination of Policy

Alliant may terminate this Policy on any Policy Anniversary Date by providing at least 30 days prior written notice to the Insured. The Insured may terminate this Policy on any premium due date by providing at least 30 days prior written notice to Alliant and paying the Minimum Premium for the Policy Year. The Policy may also be terminated on any date mutually agreed to in writing by Alliant and the Insured.

Suppose the Insured does not comply with any terms and conditions of the Policy, including but not limited to providing required reports or other information reasonably requested by Alliant. In that case, Alliant also reserves the right to terminate the Policy effective on the date of such failure.

This Policy shall also terminate automatically upon the occurrence of any of the following:

(a) If the Insured fails to pay any monthly premium in full within 31 days from the due date shown on the invoice, this Policy will terminate as of the due date shown on the invoice.
(b) If the Contract terminates, this Policy will terminate on the same date, and at the same time, the Contract terminates.
(c) Suppose the Insured fails to meet the underwriting requirements of Alliant, including but not limited to maintaining the minimum number of 2 Employees. In that case, the Policy will terminate as of the first day of the first month following the date the underwriting requirement was not met.
(d) If the Insured fails to pay claims under the Plan or make available funds to pay claims as required by the Plan, the Policy will terminate on the first day that the Insured failed to fund benefits under the Plan.

Reports

The Insured shall furnish Alliant with all information necessary to carry out the Policy's provisions.

Inspection and Audit

Alliant shall be permitted to inspect the Insured's records pertaining to the Contract and this Policy at any reasonable time during the period that this Policy is in effect and within three years after termination of this Policy, to the extent that they relate to the premium basis or Eligible Claim Expenses under this Policy.

Fraud

This entire Policy will be void if, whether before or after a claim or loss, the Insured has concealed or misrepresented any material fact or circumstance concerning this Policy or the subject of this Policy, including any claim under this Policy, or in any case of fraud by the Insured relating to this Policy.

Taxes

The Insured shall be responsible for any state premium taxes incurred with respect to funds paid to or by the Insured under the Plan. Taxes incurred with respect to premiums paid for this Policy will be the responsibility of Alliant.

Incontestability

The validity of this Policy shall not be contested, except for non-payment of premium, after it has been in force for two years from the Policy Effective Date.

Liability and Indemnification

Alliant has neither the right nor the obligation under this Policy to directly pay any Member or provider of covered services for any benefit the Insured has agreed to provide through the terms of the Plan(s). Alliant's sole liability under this Policy is to the Insured, subject to the terms, conditions, and limitations of this Policy.

Assignment

Assignment of interest under this Policy shall not bind Alliant without its written consent.

Notice of Actions

The Insured agrees to give Alliant prompt notice of any event or development which might result in an action at law or equity related to this Policy and to forward promptly to Alliant copies of any pleadings and reports of investigation that Alliant requests. A copy of any document filed by or against the Insured in any court concerning such litigation under the Plan must immediately be furnished to Alliant.

The Insured shall pay all attorneys' fees, expenses of experts and investigations, and any damages (including exemplary or punitive damages) payable by Alliant in connection with any litigation in which Alliant shall, without Alliant's fault, become involved through or on account of this Policy or the Plan.

Suppose any time limitation in this Policy is less than that permitted by the state law in which the Application was taken. In that case, the limitation is hereby extended to be consistent with the minimum period allowed by the law.

PLAN SPONSOR-SPECIFIC ADMINISTRATION ATTACHMENT

The Plan Sponsor's eligibility, participation, and contributions requirements are as follows:

1. Number of Hours Required to be Eligible for Coverage __________

2. Total Number of Eligible Employees __________

3. Total Number of Enrolled Employees __________

4. Classes of Eligible Employees

- All employees meeting the eligible hourly requirement __________
- Non-traditional employees to be eligible (mark all that apply):

  Owner ☐

  Independent Contractors Union ☐

  Other (Please Specify: __________________________) ☐

5. Contribution (Employer's %)

- Employee __________
- Dependent __________

6. Waiting Period for New Employees (please check **one**)

☐ Date of Hire (DOH)
☐ First of month after DOH
☐ 30 days after DOH
☐ 60 Days after DOH
☐ 90 Days after DOH

New eligible enrollees will become effective on (check one):

☐ First day of the month following completion of waiting period (not available if electing a 90-day waiting period)
☐ First day following completion of waiting period (required for 90-day waiting period)

The "standard" effective date is the first of the month following completion of the waiting period.

7. Type of Non-ERISA Plan (please check **one**)

☐ Governmental Plan (as defined under Section 3(32) of ERISA)
☐ Non-Electing Church Plan (as defined under Section 3(33) of ERISA)

8. Need to Add COBRA Administration by Alliant?

☐ Yes, $1.00 Per Employee Per Month
☐ No