Allstate BENEFITS

Thank You for Choosing National General for Your New Group Health Insurance Policy!

Below is the submission checklist in order to install a new group:

The following documents attached that need to be completed are:

- ☐ NGBS Implementation Questionnaire
- ☐ Census Attestation
- ☐ NGBS Self-Funded Program Employer Agreement
- ☐ Business Associate Agreement
- ☐ Administrative Services Agreement
- ☐ Network Agreement
- ☐ Health Care Reform Act
- ☐ Allied ACH Authorization Form

Signatures are required on pages 5, 8, 15, 36, 44, 47, 48, 50, 52, 53 **(If Applicable)**

******In addition to the above/attached documents we must also have:***

- ☐ A **complete census showing all active employees**, even new hires who are in the waiting period. Next to each name please indicate whether they are full time or part time, and if they are waiving or enrolling.
- ☐ Copy of group's most recent **State Quarterly Wage and Tax Report**, including pages that list each employee by name and their earnings. Please be sure to mark the employee's status next to their name (FT Enrolling, FT Waiving, PT, Terminated)
- ☐ Employee waivers if not already sent in with the applications. (only need first page section B completed for a waiver)
- ☐ Final Signed Quote with plan election- **to be signed by employer** (last page of quote)
- ☐ A copy of the most recent prior carrier invoice listing enrolled members (if replacing coverage)

PLEASE TAKE NOTE OF THE FOLLOWING:

***Even if you are not waiving the waiting period we still need an enrollment or a waiver for all full time employees. If you are not waiving the waiting period and a person waives at enrollment they cannot enroll until the group's next year open enrollment- SEE CENSUS ATTESTION FORM FOR FULL GUIDELINE**

Allstate BENEFITS

Employer Self-Funded Implementation Questionnaire
Allstate Benefits
Self-Funded Program

Instructions for completing this agreement:
1) The employer or employer representative must complete the entire Questionnaire with signature.
2) The agent must sign and date this agreement.

Requested effective date:____/____/____ (Must be 1st or 15th*, date subject to underwriting approval)
*Note Meritain POS do not allow the 15th of the month effective dates

SECTION A - Employer Information

1. Company Name: _____
Full legal name of Company

Doing business as (dba):_____

2. Employer address: _____
Street

_____
City County State Zip

Mailing address:_____
(If different) Street City State Zip

3. Phone number: (___)_____ Fax number (___) _____
4. Contact Person and Title: _____
5. Email address: _____
By providing your email address you agree that you may receive your policy and/or certificate of issuance and other correspondence electronically.
6. Owner (s) Name (s): _____
7. Nature of Business/SIC Code: _____
8. Type of ownership/filing status: ☐ Proprietorship ☐Partnership ☐C-Corporation
☐ S-Corporation ☐Government ☐ Other (please specify) _____
9. Federal Tax Identification Number: _____
10. How long has the company been in business? _____
11. Employer Contribution to employees' cost of coverage *(minimum of 50% required)* Medical_____%
12. Waiting/Affiliation period (the length of time future employees must be employed before becoming eligible for coverage):
☐0 days* ☐30 days* ☐ 60 days* ☐ 90 days
*Note: the effective date will be on the first day of the billing cycle following the date the employee satisfied their waiting period and they enrolled for coverage within 31 days of becoming eligible for coverage.
13. Are you waiving the groups waiting/affiliation period for all employees for the group's original effective date?
Note: Groups with 25 or more enrolling employees cannot waive the waiting period
☐ Yes ☐ No

Allstate BENEFITS

SECTION B - Benefit Information

1. Will this plan replace other group coverage? ..... ◯ Yes ◯ No
   a) If Yes, is your current plan a Major Medical Plan..... ◯ Yes ◯ No
   b) If Yes, is your current plan a Fully Insured or Self-Funded Plan... ◯ Fully Insured ◯ Self-Funded
   c) Please provide 12 months of information below and provide a copy of your most recent medical billing statement.

Prior Medical Carrier(s)	Policy Number	Effective Date	Termination Date

2. Will you be or are you offering another group medical plan in addition to this group plan?..... ◯ Yes ◯ No

3. Select one..... ◯ Plan Year Deductible ◯ Calendar Year Deductible

4. Did you employ 20 or more full-time equivalent employees for at least 50% of the previous calendar year?. ..... ◯ Yes ◯ No

5. COBRA enrollment
   a) Do you want to offer COBRA if your current or future group size does not require this..... ◯ Yes ◯ No
   b) Please indicate your COBRA Administrator (If none selected, Allstate Benefits or the TPA will administer):
   ◯ Allstate Benefits ◯ Other _____

6. **Meritain business only**: Are any of your employees selecting Vision or Dental benefits ..... ◯ Yes ◯ No

7. **Meritain POS only** (HSA Option): Will you be offering employees a Health Savings Account?... ◯ Yes ◯ No
   a) If Yes, please indicate your HSA Administrator (if none selected, Allstate Benefits or the TPA will administer):
   ◯ Allstate Benefits ◯ Other _____

SECTION C - Affiliated Companies and Multiple Locations

1. Does your company have other business organizations under common ownership or more than one Federal Tax ID Number? ..... ☐ Yes ☐ No

2. Does your business have more than one physical location..... ☐ Yes ☐ No

If "Yes" to either question, complete the following: Indicate the number of full-time (FT) and part-time (PT) employees' whether enrolling or not (based on the eligible employee requirements **Section D**).

Business Name	Address	Owner (s)	
Nature of Business	Tax ID	(FT)	(PT)
Business Name	Address	Owner (s)	
Nature of Business	Tax ID	(FT)	(PT)
Business Name	Address	Owner (s)	
Nature of Business	Tax ID	(FT)	(PT)

Allstate BENEFITS

SECTION D - Employee Information

All eligible full-time employees, including those in the new employee waiting period, must submit an Enrollment form or Waiver of Coverage form. If additional employees are hired between the date this application is completed and the date coverage is issued, completed Enrollment forms or Waiver of Coverage forms must be submitted within 5 days of the date of hire.

1. Total number of employees (including owners, partners, etc.) working in your business _____
2. How many are full-time employees? _____
3. How many are part-time employees? _____
4. Are any former employees or dependents on or eligible to elect Continuation (COBRA)..... ☐ Yes ☐ No

Name	Start Date	End Date	Type of Continuation	Reason

5. Are any employees currently absent due to illness or injury? Family Medical Leave or receiving Disability benefits?..... ☐ Yes ☐ No
   If Yes, provide employee name(s) and details _____

Eligible Employees

An eligible employee must meet the following requirements: a) performs services on a full-time basis; b) is considered an employee of the Employer for federal employment tax purposes, or are issued an IRS Form 1099 by the Employer, at any of the employer's business establishments (including all affiliated businesses listed in Section C); and c) is at least 18 years old.

The Employer may select the number of hours (between 20 and 40) an employee or 1099 contractor must work each week in order to be considered eligible for coverage. If the employer does not select an eligibility requirement, eligibility will be administered based upon 30 hours per week.

1. Indicate the eligibility requirement between 20 and 40 hours per week _____
2. Complete the census below listing each eligible employee name and indicate whether enrolling or waiving.

	Employee Name:	*E=Enrolling W=Waiving*		Employee Name:	*E=Enrolling W=Waiving*
1			*16*		
2			*17*		
3			*18*		
4			*19*		
5			*20*		
6			*21*		
7			*22*		
8			*23*		
9			*24*		
10			*25*		
11			*26*		
12			*27*		
13			*28*		
14			*29*		
15			*30*		

If additional space is needed, please provide additional information on a separate sheet of paper.

SECTION E - Agreement

The undersigned employer (hereinafter "I" or 'my") will adhere to the contribution rules of Allstate Benefits Self-Funded Program (the "Program") regarding my contribution toward the employee cost of coverage and I acknowledge that stop loss coverage may be terminated if the contribution falls below the minimum contribution requirement. I hereby certify that all employees currently working for me are compensated in a manner that complies with all applicable federal and state requirements. I understand that all eligible employees must enroll in the health plan according to the participation rules of the Program and that coverage may be terminated if the percentage falls below the participation requirements. I understand that (1) The Association Benefits Solutions, LLC ("Allstate Benefits"), in its capacity as Program Administrator, reserves the right to request a state wage and tax statement or other documentation at any time to verify current and future participation and eligibility; (2) the monthly maximum cost is subject to change until all of the following have occurred: a) the stop loss coverage has been approved by the stop-loss carrier approved under the Program; (b) notice of effective date for the stop loss coverage has been confirmed; and (c) the first invoiced amount due for stop-loss premium and other costs attributable to (including the aggregate deductible) the Allstate Benefits Self-Funded Program is paid. I acknowledge I must give notice to the third party administrator within 30 days of any enrolled employee who ceases working the minimum number of hours required to be an eligible employee, as defined on this application, including, but not limited to those on paid or unpaid leave, disability, salary continuation or worker's compensation.

I hereby agree to be bound by all the terms and conditions of the Program. I understand that the benefits I have selected for my self-funded group health plan are reflected on the attached signed proposal which is part of this request for participation in the Program.

As the person acting with the authority of the participating employer, I certify that this information is complete and true to the best of my knowledge and belief. I fully understand that participation in the Program is not effective without the approval of Allstate Benefits. I understand that no agent has the authority to alter or amend any Program agreements, the self-funded health benefit plan I have established, or to adjust any claim for benefits, or to bind Allstate Benefits by making any promise or representation. I understand that any material misstatement and/or omissions may void or result in termination of my participation in the Program.

By signing below, I certify that I have read the entire Implementation Questionnaire, agree to all terms and conditions contained therein and that all information provided is true and accurate.

Signature_____ Title _____

Print Name_____ Date_____

Send your completed application and other required documents to your sales office. Underwriting may request that the employer provide additional documentation (e.g. Payroll Records, business License, etc.) during the underwriting process or at any time while coverage is provided.

SECTION F – Agent Statement

I certify that all of the information contained in the Implementation Questionnaire and any additional documents are correct the best of my knowledge. I have complied with all of the underwriting rules and have fully explained the Program and stop loss coverage to the employer.

Agent Signature:_____ Date:_____

Print Agent Name: _____ Agent#:_____

Agent Address: Agent Phone# _____

SECTION G - Distribution Partner Information

Complete all applicable fields

Office Name: _____ Date: _____

Representative Name:_____ Representative#: _____

Representative Phone#: _____ Representative Fax#: _____

Email Address:_____

The Allstate Benefits Self-Funded Program provides tools for employers owning small to mid-sized businesses to establish a self-funded health benefit plan for their employees. The benefit plan is established by the employer and is not an insurance product. For employers in the Allstate Benefits Self-Funded Program, stop-loss insurance is underwritten by: Integon National Insurance Company in CT, NY and VT; Integon Indemnity Corporation in FL; and National Health Insurance Company in all other states where offered. National Health Insurance Company, Integon National Insurance Company, and Integon Indemnity Corporation are rated “A+” (Superior) by A.M. Best.

Allstate Benefits
Self-Funded Health Program
Initial and Ongoing Enrollment Reporting Requirements

Employer Agreement and Attestation

The Allstate Benefits Self-Funded Health Program (Program) is made available to employers who meet our underwriting criteria. We want to establish a long and successful relationship with you ensuring that our Program meets the needs of you and your employees. In order to pave the path to success you need to understand our underwriting criteria and the need for full disclosure and complete submissions. There are several steps that are necessary to achieve an accurate rate.

Step 1 Employee Enrollment Form Submission

Allstate Benefits relies on Employee Enrollment Forms to develop accurate pricing for the stop loss coverage and overall Program pricing.

- All eligible employees must submit complete and accurate Enrollment Forms if they are enrolling for coverage.
- Any eligible employee who waives coverage should check off the “waive coverage” box on the Enrollment Form.
- If we do not receive an Enrollment Form from any employee eligible for coverage we will assume they are waiving coverage and they will not be eligible to enroll.
- All employees who are currently not eligible for enrollment (such as those in a waiting period), but will be eligible or enrolling within the first 90 days of the program must also submit an Enrollment Form.

This requirement applies to the initial enrollment, acquisition of another business or the addition of a previously ineligible group of employees along with new employees enrolling after the open enrollment period. If your plan allows employees to join outside of the annual open enrollment period if they have a qualifying life event (QLE), that employee must submit evidence of the QLE.

Allstate Benefits reserves the right to not cover under the stop loss policy claims, which means your health plan may be responsible for those claims, for any employee and/or the employee’s dependents if that employee:

- Fails to submit an Enrollment Form; or
- Submits an employee only Enrollment Form and then enrolls dependents in the health insurance plan; or
- Misrepresents or withholds material information on the Enrollment Form; or
- Fails to submit satisfactory evidence of that employee’s eligibility (proof of QLE).

In addition, should your total enrollment vary by more than 10% from the initial enrollment, we reserve the right to revise the stop-loss premiums and other costs attributable to (including the aggregate deductible) for the Program.

Step 2 Census Attestation

I attest that I have disclosed all eligible employees and their dependents (if applicable) currently working for my business(es), including those employees in a waiting, training or affiliation period and any newly hired employees who are not on the most recent quarterly wage and tax report or submitted census, and I have accurately indicated whether such employees are enrolling or waiving coverage.

I agree that I will notify Allstate Benefits within five (5) business days of any eligible employees that are hired prior to the requested effective date of coverage by submitting an Enrollment or waiver form.

I understand that any eligible employees hired prior to the coverage effective date and not disclosed to Allstate Benefits during the initial enrollment process (including those eligible employees in a waiting, training or affiliation period) or who submit an enrollment form within 31 days of the coverage effective date or date coverage is issued (whichever is later), may result in a change in my total premiums and other costs attributable to (including the aggregate deductible) for the Program back to the effective date for the entire group. I also understand that any enrollment forms received for any such employee beyond this 31 day period will NOT be enrolled for coverage until the earlier of: 1. The next annual open enrollment period; or 2. They have a QLE that makes them eligible for coverage.

Additionally, I understand that any eligible employee and/or dependents (if applicable) who waived enrollment during the initial open enrollment process will not be eligible to enroll for coverage until the earlier of: 1. The next annual open enrollment period; or 2. They have a QLE that makes them eligible for coverage.

Step 3 Review and Sign

By signing below, I certify that I have reviewed and understand each of the provisions above and that all information I have provided is true and accurate.

Employer Signature and Title: _____

Print Name: _____

Date: _____

By signing below, I acknowledge that I understand the provisions above and have discussed such provisions with my client.

Agent Signature: _____

Print Name: _____

Date: _____

ALLSTATE BENEFITS SELF-FUNDED PROGRAM
Employer Agreement

This Self-Funded Program Employer Agreement ("Agreement") is effective as of the date of the Employer's signature below.

This document contains important information about the establishment and operation of the Allstate Benefits Self-Funded Program ("the Program"), a package of services established by The Association Benefits Solution, LLC marketed as Allstate Benefits Self-Funded Program ("Allstate Benefits" or "AB") that combines several elements to enable _____("Employer") to establish a self-funded plan and provide health care benefits to its employees. These services and products include:

- A self-funded employer health benefit plan that Employer establishes for its employees ("Plan");
- Stop Loss insurance purchased from a stop loss insurance company: National Health Insurance Company, Integon National Insurance Company, or Integon Indemnity Corporation (the "Stop Loss Insurance Company"); and
- Third party administrators (the "Administrator(s)") that provide administrative services with regard to the Plan established by Employer. Such Administrators include Allied Benefit Systems, LLC ("Allied"), Key Benefit Administrators, Inc. ("KBA"), and Meritain Health, Inc. ("Meritain").
- Access to national networks of health care providers that provide discounts to enrolled employees and their dependents for treatment or services covered under the Plan.

This Agreement explains the responsibilities of the various parties associated with the Program, including Employer's responsibilities as an employer sponsoring a group health plan. Please note that the Program has been carefully designed as one integrated program with each of its elements working in concert with the others. Therefore, by executing the agreement, Employer accepts all of the particular elements of the Program as they are currently offered and will not be able to make changes to any one of those elements and remain in the integrated Program without the prior written consent of AB.

Section 1: Overview

The Program will operate as follows:

Employer agrees to adopt a group health plan for the benefit of its eligible employees and, if applicable, their eligible dependents (the "Plan"). For convenience, AB will make available a form of a group health plan for adoption by Employer which establishes the Plan. The Plan is separate and distinct from any other plan maintained by any other AB employer member. The costs of the Plan Benefits may be paid by Employer or by a combination of Employer and the employees pursuant to the Program's minimum employer contribution guidelines. The Plan is described more fully in Section 2.

Employer will purchase a stop loss contract from the Stop Loss Insurance Company. The Stop Loss Policy will reimburse Employer for claims paid under the Plan if they exceed a predetermined level. The Stop Loss Policy and the Stop Loss Insurance Company are described more fully in Section 4.

Employer shall enter into a contract with the Administrator, if required, pursuant to which the Administrator will provide administrative services with respect to the Employer's Plan. The Administrators will also process all claims for benefits under the Plan pursuant to the Summary Plan Description ("SPD"). The Administrator will remit claim payments out of the funds provided by the Employer or from reimbursements received from the Stop Loss Policy issued by the Stop Loss Insurance Company. The services to be provided by the Administrator and Stop Loss Insurance Company are described more fully in Section 6.

RESPONSIBILITIES

Employer agrees to comply with all reasonable requirements of AB for the efficient and lawful operation and administration of the Plan, including the terms of any agreements with any service providers to the Plan, including the Administrators and Stop Loss Insurance Company. Employer's responsibilities under the various agreements are summarized on Schedule A. Among other things, Employer agrees, upon reasonable request to provide, on a timely basis, all notices, communications and other materials respecting the Plan to employees and dependents; and to provide, on a timely basis, all requested information concerning the Plan, including enrollment and eligibility information.

Section 2: The Plan

Employer will receive the applicable SPD, which sets forth the benefits that will be provided to Plan participants under Employer's Plan. Any changes or amendments to the Plan are subject to the approval of AB and the Stop Loss Insurance Company. The Plan is a self-funded employee health plan, and although the Stop Loss Policy will reimburse Employer for claims that exceed a certain amount, the Employer remains obligated to pay benefits under the Plan (including the obligation to fund the payment of claims), subject to Employer's right to terminate the Plan on a prospective basis.

AB will assist Employer in determining which of its employees (and their dependents) are eligible to enroll in coverage under the Plan, based on eligibility requirements established by Employer.

Section 3: Funding

Employer shall fund claims incurred under the Plan pursuant to Schedule C.

As of the end of the policy year, allowing for the run-out period set forth in the Stop Loss Policy for all claims to be reported ("Run-out Period"), if the claims are below the Aggregate Attachment Point, Employer shall receive either 50% or 100% of the difference between the Aggregate Attachment Point and the claims paid, subject to the terminal liability reserve charge described in Section 6. The applicable percentage due to Employer shall be based on the option selected by Employer in the signed quote. Any refund due to Employer will be provided after the end of the Run-out Period and may be provided via a check or credit toward a subsequent reissue.

Section 4: The Stop Loss Policy

By completing this Agreement and any additional required application materials, Employer is applying for stop loss coverage under the Stop Loss Policy. If Employer is approved for coverage under the Stop Loss Policy, the Stop Loss Policy will be issued to Employer. The purpose of the Stop Loss Policy is to protect the Employer from health claim costs incurred under the Plan that exceed a predetermined level (the "Attachment Point"). The Stop Loss Insurance Company will reimburse Employer for those excess claims under the Stop Loss

Policy; however, the Stop Loss Policy has an “accommodation” option that allows you to avoid having to pay claims before being reimbursed and instead requires the Stop Loss Insurance Company to advance funds to Employer in the amount of excess claims so that those claims can be paid. This policy covers excess claims under the Plan. Individual Plan participants are not covered by the Stop Loss Policy.

Section 5: Monthly Contributions

AB will inform Employer of the amount of contributions for health care costs and associated expenses it will be expected to make during the applicable plan year; see Schedule B. The amount of contributions will be determined based on Employer’s maximum liability for expected claims (at the attachment point), administrative expenses and the premium for the Stop Loss Policy. AB will also inform Employer of the amount of the administrative expenses under the Program.

Employer will then be required to make monthly contributions to pay these costs, expenses and fees. Employer will receive a monthly statement that sets forth the monthly contribution and the date forwhich such contribution is due. **Failure to remit in full the monthly contribution will result in the termination of the Stop Loss Policy, a refusal by the Administrators and other service providers to provide the administrative services necessary to operate the Plan, and the denial of health claims submitted by your employees who are Plan participants.**

Section 6: Health Claims & Administrative Services

Under the terms of the administrative services agreement, if required, the applicable Administrator will provide claims administration services for the Plan. Such services will include receiving claims and authorizing payment of those claims to the extent they are consistent with the terms of the Plan. Claims will be paid first from the Employer Claim Account. In the event claims exceed the Attachment Point of the Stop Loss Policy, the Stop Loss Policy will provide funds for used to pay those claims in accordance with the Employer’s Stop Loss Policy. The Administrator is not acting as an insurance company with respect to the Plan and shall never pay claims from its own funds.

The applicable Administrator will make the first determination as to whether a claim is covered by the Plan and provide any additional services as outlined in the administrative services agreement between the Administrator and Employer, if required.

Employer will enter into an administrative services agreement with applicable Administrator, if required. Pursuant to such agreement, if Employer fails to perform the duties specified in the agreement, it could excuse the Administrators from their obligation to provide services to the Plan and may result in the inability of Employer’s employees (and their dependents) to receive benefits under the Plan.

AB will also provide or arrange for the provision of certain administrative services in connection with the Plan. If services other than those provided by the Administrators are necessary for the administration of the Plan, AB shall enter into a contract with the appropriate service provider at AB’s sole discretion. Such service provider shall be considered a subcontractor of AB. See Schedule D for administrative services provided by AB with regard to the Plan.

Terminal liability coverage continuing stop loss protection through the 24th month following the end of the of the plan year and/or policy period will be provided, subject to the Early Termination

provision of Section 8 below. If claims are less than the Aggregate Attachment Point at the end of the run-out period, a terminal liability reserve charge will be taken and retained by AB from the Employer Claim Account in an amount no greater than 3% of the Annual Aggregate Attachment Point, prior to calculation of the applicable refund from the Employer Claim Account.

Section 7: Compensation

Employer shall pay the administrative fees, stop loss premium, and funds for claims payment as specified in Schedule B, which amounts may be subject due to any change in census, or other changes in accordance with Program guidelines. Schedule B may be changed with advance written notice. If Employer does not respond to such a notice, Employer thereby authorizes the amendments to Schedule B set forth by the notice.

If the Stop Loss Insurance Company elects to reissue the Employer a Stop Loss Policy, the Stop Loss Policy premiums due by Employer may be adjusted accordingly.

There is no guaranteed renewal for the Stop Loss Policy and this Agreement. If the Stop Loss Insurance Company elects to reissue the Stop Loss Policy, Employer will receive a written notice of the reissued rates for the Stop Loss Policy and all associated administrative expenses with that reissue within prior to the end of the contract year. The reissued rates will be binding upon the effective date of the reissue.

Section 8: Term and Termination

Upon Employer's execution, this Agreement will constitute a binding agreement for an initial one-year period (or such other period specified in any quote that you have accepted) and, in the event you re-enroll in subsequent years thereafter, for the period of the reissued Stop Loss Policy(ies).

This agreement will terminate when:

A. The Employer's Stop Loss Policy terminates;
B. The Employer's administrative services agreement with the applicable Administrator terminates, if required;
C. The Employer's Plan terminates;
D. Both AB and Employer agree to terminate the Agreement; or
E. Either party is in material breach of this Agreement, other than by non-payment or late payment by the Employer of fees owed, and does not correct the breach within 30 days after being notified in writing by the other party; or
F. Any state or other jurisdiction penalizes a party for administering the Plan under the terms of this Agreement and in connection with such penalty, such state or other jurisdiction requires termination of this Agreement.

Employer understands that Employer's termination of the Plan and/or Stop Loss Policy prior to the end of the plan year and/or policy period ("Early Termination") has severe financial implications. In the event the Employer invokes an Early Termination, Employer will be liable for any claims incurred prior to the termination date up to the full specific or aggregate attachment point under the Stop Loss Policy, and the full cost of all claims incurred under the Plan after the termination date. Terminal liability coverage is not provided in cases of Early Termination. Any advances provided under the Stop Loss Policy that have not otherwise been reimbursed to the Stop Loss Insurance Company must be repaid to the Stop Loss Insurance Company by Employer. In addition, Early Termination will result in Employer's forfeiture of any excess funds remaining in Employer Claim Account, for purposes of administration costs associated with claims processing

after the termination date.

Section 9: Indemnification

Each party shall and does hereby indemnify and hold harmless the other party and its affiliates and each of their officers, directors, employees, agents, subcontractors, and representatives, from and against any and all claims and demands of every kind and nature asserted by a third party, whether groundless or otherwise, including, but not limited to, any and all actions, causes of action, suits, judgments, controversies, losses, damages, costs, liens, charges, court costs, reasonable attorney's fees, payments, penalties, liabilities and expenses, occasioned by, resulting from, arising out of, related to, or in connection with any grossly negligent or willful act or omission of the indemnifying party, its employees, officers, directors, agents or representatives, or any of them, in performance of this agreement, including, but not limited to, failure of the indemnifying party to comply with applicable local, state, or federal law, or the terms of this Agreement.

Each party shall notify the other party of any claim, demand, suit or threat of suit for which it intends to seek indemnification under this section promptly upon receipt of notice of any such claim, demand, suit or threat of suit. Neither party will settle an indemnified claim without the consent of the indemnified party, which consent shall not be unreasonably withheld or delayed. The provisions of this Section shall survive termination of this Agreement.

Section 10: Limitation of Liability

THE PARTIES AGREES THAT NEITHER PARTY SHALL BE LIABLE TO THE OTHER PARTY OR ANY OTHER PERSON FOR ANY LOST PROFITS OR SPECIAL, INCIDENTAL OR CONSEQUENTIAL DAMAGES.

The provisions of this Section shall survive termination of this Agreement.

Section 11: Employer Representations and Agreement

Employer hereby represents and agrees that:

A. Employer wishes to purchase the bundle of services, known as the Allstate Benefits Self-Funded Program, described in this Agreement to administer the Plan. Employer understands that each of the services described herein is a required component of the Program, and any decision by Employer to use any service other than those described herein will result in the Plan being ineligible to receive any of the services described herein.

B. If so elected in the quote signed by Employer, Employer hereby establishes a wellness program administered by The Vitality Group, LLC. Employer acknowledges that any charges incurred for health screenings coordinated through the wellness program shall be claims incurred under the Plan and payable as such. Employer further authorizes AB to access and utilize the data collected through the wellness program, including but not limited to, participation metrics and outcomes and health screening results.

C. By its participating in the Program, Employer will also purchase Stop Loss insurance coverage from the Stop Loss Insurance Company pursuant to the terms of the Stop Loss Policy.

D. Employer has read this Agreement and agrees to be bound by its terms.

In the event Employer's Administrator is Meritain, Employer has received and read a copy of the Employer Agreement and understand that Employer's compliance with its terms is a prerequisite to the provision of services to the

Plan and to Employer'semployees (and their families).

E. As a fiduciary of the Plan, Employer is aware that funds are being provided to the Fund Account Holder (if applicable), the applicable Administrator, and the Stop Loss Insurance Company, and Employer hereby approves such funds.

F. Employer acknowledges that AB, and any subcontractors that provide Employer services pursuant to this Agreement, are not fiduciaries of the Plan pursuant to ERISA.

G. A duly authorized representative has signed this Agreement on behalf of the Employer named below.

Section 12: Adoption of Agreements

By the signature below of Employer, or its duly authorized representative, Employer hereby:

Adopts the _____ Employee Health Plan, including the Plan Document and Summary Plan Description and any subsequent amendments or modifications, for the benefit of its eligible employees and their eligible dependents (if applicable).

Adopts the Employer Agreement (if applicable) that provides direction for the payment of benefits under the Plan.

Adopts the Section 125 Plan Adoption Agreement as set forth on Schedule E and the Section 125 Premium Only Plan, including the Plan Document and Summary Plan Description and any subsequent amendments or modifications, unless Employer has otherwise established a Section 125 Plan.

By: _____ For:

(Signature)

_____

(Name)

_____

(Title)

_____

(Date)

SCHEDULE A
Employer Responsibilities

The following responsibilities shall apply to Employer upon its participation in the Allstate Benefits Self-Funded Program:

A) Employer will be responsible for providing all payroll/eligibility information to AB or its designee in a pre-approved format, which will include its employees' completion of an enrollment form (including newly hired employees that are still in the Waiting Period).

B) Employer will provide complete and accurate payroll/eligibility information on all eligible employees (including eligible employees in a waiting period and those waiving enrollment), including, but not limited, to the following:

- Employee Names
- List of employees enrolling in the Plan or waiving enrollment in the Plan
- Completed employee enrollment forms

C) Employer will provide complete and accurate information on existing COBRA participants, including but not limited to:

- Name
- Social Security Number and Birth Date
- Eligible Dependents (with SSN, birth date and address) Types of Coverages Elected
- Last Known Address of any COBRA Participant
- Date and Type of Qualifying Event of any COBRA Participant Paid Through Date

D) Employer will provide AB or its designee in the pre-approved format with timely, accurate and complete information regarding:

- New Hires (requires completion of an employee enrollment form),
- Change Requests or COBRA Qualifying Events
- Terminations

E) Employer will remit the required health care costs and associated fees as billed via either check or Electronic Funds Transfer (EFT) by the first of each month for which they are due provided that we have received a bill by the 23rd of the month prior to the due date.

SCHEDULE B
Fee Disclosure

Monthly Contribution:

The applicable monthly cost, including claims funding, administrative expenses and stop loss policy premium that is set forth in the quote signed by Employer, and defined below. The Monthly Contributionis subject to change due to changes in census, or other changes as allowed under Program guidelines.

- **Employer Claim Account:** The portion of the Monthly Contribution used for the payment of claims and, if applicable, any case management or health management fees, claim discount percent-of-savings, and/or claim re-pricing fees incurred under the Plan.

- **Administrative Expenses:** The portion of the Monthly Contribution attributable to administrative expenses, including, but not limited to, fees due to the applicable Administrator, marketing fees, or any other fees due for administrative services provided with regard to the Program. If the optional Teladoc benefit and/or wellness program is included in the Plan (based on Employer's election at the time of purchase), the Administrative Expense charge includes the amounts included in the quote/bill for payment of the access fee to Teladoc and/or the wellness program vendor, the administration fee to the Administrator (if applicable) and the coordination and marketing fee to AB. Wellness program fees may also include funding of participation incentive costs.

- **Stop Loss Insurance Policy Premium:** The portion of the Monthly Contribution attributable to the premium due with respect to the Stop Loss Policy.

SCHEDULE C
Funding

I. **Meritain**. In the event Employer's Administrator is **Meritain**, then the following shall apply:

A. Employer hereby adopts an Employer Agreement ("Employer Agreement") appointing Actuarial Management Resources to handle the funds of its Plan and take certain actions on its behalf. Employer acknowledges having had an opportunity to read and consider theEmployer Agreement and understands that its terms are binding on Employer.

B. By adopting the Employer Agreement, Employer is appointing and directing the Fund Account Holder to hold the assets on its behalf. The Fund Account Holder will only take action pursuant to standing directions as stated in this Agreement and the Employer Agreement. As part of those instructions, Employer hereby directs the Fund Account Holder to hold the funds and pay them out pursuant to such directions; and in carrying outthese directions, the Fund Account Holder may act directly or may act through agents, including AB. These directions are binding on the Fund Account Holder.

C. The monthly amounts deposited as described in Section 5 will be held in a segregated portionof the Fund. Those funds will not be used to pay the claims of any other self-funded employee health plans that participate in the Fund, and will remain Employer's general assets. There will be a bank account (the "Bank Account") to hold such amounts.

D. AB or its agent will send Employer a monthly statement of the expected health care costs and all fees associated with the Plan, and Employer will be required to deposit employer and employee contributions into a bank account (the "Funding Account") by the date for which they are due. This will allow the Funding Account Holder to identify the specific amounts that need to be paid to the AB, the Administrators and the Stop Loss Insurance Company without requiring Employer to make multiple monthly payments. The Funding Account Holder will promptly transfer the remainder of the funds to the Bank Account or the Stop Loss Insurance Company, as applicable. Monthly payments are described more fully in Section 5.

II. **Allied.** In the event Employer's Administrator is **Allied**, then the following shall apply:

A. Employer shall provide funds for the payment of claims incurred under the Plan pursuantto the Employer's administrative services agreement with Allied. Such funds are provided from and remain the Employer's general assets.

B. Allied will provide Employer a monthly statement, which includes the funds used to payhealthcare costs, Stop Loss Policy premium, and administrative expenses with regard to the Program.

III. **KBA.** In the event Employer's Administrator is **KBA**, then the following shall apply:

A. Employer shall provide funds for the payment of claims incurred under the Plan pursuantto the Employer's administrative services agreement with KBA. Such

funds are provided from and remain the Employer's general assets.

B. KBA will provide Employer a monthly statement, which includes the funds used to pay healthcare costs, Stop Loss Policy premium, and administrative expenses with regard to the Program.

SCHEDULE D
Administrative Services Provided By AB

I. **Meritain**. In the event Employer's Administrator is **Meritain**, then AB will provide Employer the following administrative services, which such services may be provided by AB's designee/subcontractor or Meritain:

A. Preparation, for review and approval by Employer, drafts of the Plan document, Summary Plan Description ("SPD") and the Summary of Benefits and Coverage ("SBC") consistent with the plan benefit designs available to Employer as a participant in the Program.

B. Receipt of, on behalf of Employer, claims data and documentation from participants and providers.

C. Processing of claims submitted by Participants and Providers according to the SPD.

D. Processing, issuance and distribution of checks to participants, providers or others as may be applicable.

E. To the extent maintained by AB or its designee, provision to Employer, upon request, of information ERISA requires, within the time frame required by ERISA, to enable Employer to file the Annual Report (IRS Form 5500) for the Plan.

F. Establishment of network arrangements with health care providers that agree to provide services covered under the Plan to participants at a negotiated rate ("Network Services Arrangements").
    a. AB and/or its designee shall have the sole discretion as to which Network Services Arrangement (both primary and passive or ancillary) will be available for access by Plan.
    b. Providers participating in the network may change at any time without notice to Employer. AB or its designee will update the provider information to reflect changes as soon as reasonably possible. Network providers are not employees, agents, or partners of AB or its designee. Network providers participate in the Provider Network only as independent contractors.
    c. Network providers and Plan participants are solely responsible for any healthcare services rendered to the Plan participants. Neither AB nor its designee makes anyrepresentations regarding the value or cost effectiveness of any provider network adopted by Employer.
    d. Employer acknowledges that each provider network is solely responsible for: its own provider credentialing, contracting with providers, recruiting, licensing, accreditation, maintaining adequate staffing, practice and professional standards, and all other activities pertinent to the responsibilities accorded provider networks. Access to a selected provider network is at all times conditioned upon Employer's compliance with applicable network rules, including without limitation, the timely funding of claims at the network provider's contracted rate.

G. Provide to Internal Revenue Service an annual report of tax reportable payments made to medical care providers.

H. Provide Plan participants with a toll-free telephone number for servicing.

I. Advise the Employer as to all matters actually known to AB or its designee involving threatened or actual legal actions involving the Plan and/or Employer.

J. If it is subsequently determined that any payment has been made to or on behalf of an ineligible Plan participant, or that any payment made was incorrect as to amount, AB, or its designee, will promptly correct underpayments and use reasonable efforts to recover overpayments.

K. Prepare and send explanation of benefits forms to Plan participants as required by ERISA, which will provide an explanation of the adjudication of the claim or reason(s) for the denial of benefits.

L. Provide reasonable assistance to Employer in pursuing rights of recovery arising from coordination of benefits, bill negotiation, discount programs, cost management, subrogation,and fraud detection.

M. AB and/or its designee shall be solely responsible for the provision of all health management and utilization management services as they relate to the Plan. Without limiting the foregoing, this includes all stages of health management, including utilization management and case management, and may include disease management as determined appropriate by AB. AB shall investigate those claims referred by Employer or the Administrator thatrequire a clinical determination. AB, or its designee, will provide professionals with appropriate credentials to make such determinations. AB and/or its designee shall issue a determination to the Participant and/or providers in the manner and within the time frame set by applicable law, provide the appropriate notice of any additional appeal rights, and handle all appeal levels related to such determinations.
    a. Employer understands that the performance of such duties involves the exercise of discretion on AB's, or its designee's, part in the determination and evaluation of facts and evidence presented in support of any claim or appeal. Employer hereby delegates to AB, or its designee, discretionary authority to determine entitlement to benefits (which includes the discretion to decide an initial claim for benefits and the first level of appeal) under the applicable Plan documents for each claim received, including discretionary authority to determine and evaluate facts and evidence, and discretionary authority to construe the terms of the Plan.
    b. If denial is upheld in the second level of appeal, AB, or its designee, will determine if the appeal is eligible for external review by an independent External Review Organization ("ERO"). If the appeal is eligible for review by an ERO, then AB, or its agent, will inform the participant of such right to appeal to the ERO.

N. AB or its designee shall provide pharmacy benefit management services with regard to the Plan. Any and all reimbursements, rebates or other monies received by AB in connection therewith shall be the property of AB.

II. **Allied**. In the event Employer's Administrator is **Allied**, then AB shall provide Employer the following administrative services with regard to the Plan:

A. Establishment of certain network arrangements with health care providers that agree

to provide services covered under the Plan to participants at a negotiated rate ("Network Services Arrangements").

1. AB and/or its designee shall have the sole discretion as to which Network Services Arrangement (both primary and passive or ancillary) will be available for access by Plan.
2. AB shall pay the network access fee required under any such Network Services Arrangement.
3. Providers participating in the network may change at any time without notice to Employer. AB will provide Employer with continuing access to provider information to assist covered persons in locating network providers. AB or its designee will update the provider information to reflect changes as soon as reasonably possible. Network providers are not employees, agents, or partners of AB or its designee. Network providers participate in the Provider Network only as independent contractors.
4. Network providers and Plan participants are solely responsible for any healthcare services rendered to the Plan participants. Neither AB, nor its designee, make any representations regarding the value or cost effectiveness of any provider network adopted by Employer.
5. Employer acknowledges that each provider network is solely responsible for: its own provider credentialing, contracting with providers, recruiting, licensing, accreditation, maintaining adequate staffing, practice and professional standards, and all other activities pertinent to the responsibilities accorded provider networks. Access to a selected provider network is at all times conditioned upon Employer's compliance with applicable network rules, including without limitation, the timely funding of claims at the network provider's contracted rate.
6. If Employer has elected to utilize the Aetna Signature Administrators ® program as its Network Services Arrangement, Employer agrees to comply with all terms of the Network Services Agreement by and between AB and Aetna Life Insurance Company, as may be amended from time to time.

B. AB or its designee shall provide out of network pricing and negotiation services, which may include but is not limited to the negotiations with providers to obtain discounts on claims that meet the appropriate criteria as determined by the Plan. Employer agrees to immediately fund the payment of any claim which has been negotiated through these services when necessary to secure the discount. Employer understands and agrees that: (a) any such negotiated claim which is not funded in a timely manner may lose the negotiated discount, (b) Employer may be responsible for the applicable fee associated with such negotiation services if the discount is lost, and (c) AB will not be responsible for the loss of such a negotiated discount.

C. AB and/or its health management vendor (for purposes of this section, hereinafter referred to as "Designee") shall be solely responsible for the provision of all health management and utilization management services as they relate to the Plan. Without limiting the foregoing, this includes all stages of health management, including utilization management and case management, and may include disease management as determined appropriate by AB. AB shall investigate those claims referred by Employer or the Administrator that require a clinical determination. AB, or its Designee, will provide professionals with appropriate credentials to make such determinations. AB and/or its Designee shall issue a determination to the Participant and/or providers in the manner and within the time frame set by applicable law,

provide the appropriate notice of any additional appeal rights, and administer all appeal levels related to such determinations.

1. If denial is upheld in the second level of appeal, AB, or its designee, will determine if the appeal is eligible for external review by an Independent Review Organization ("IRO"). If the appeal is eligible for review by an IRO, then AB, or its agent, will inform the participant of such right to appeal to the IRO.

D. AB, or its designee, shall provide pharmacy benefit management services with regard to the Plan. Any and all reimbursements, rebates or other monies received by AB in connection therewith shall be the property of AB.

E. AB will assist Employer and/or Administrator in the creation of the Summary of Benefits and Coverage ("SBC") for the Plan in accordance with 26 CFR § 54.9815-2715 and 29 CFR §2590.715-2715 and subsequent related federal guidance. Employer will remain responsible for the distribution of the SBC in accordance with federal law.

III. **KBA**. In the event Employer's Administrator is **KBA**, then AB shall provide Employer the following administrative services with regard to the Plan:

A. AB requires and shall provide oversight to Administrator with respect to Administrator's provision of all health management and utilization management services as they relate to the Plan. Without limiting the foregoing, this includes all stages of health management, including utilization management case management, and disease management as determined appropriate by Administrator.

B. AB will provide oversight to Administrator in connection with its provision of pharmacy benefit management services with regard to the Plan. Any and all reimbursements, rebates or other monies received by AB in connection therewith shall be the property of AB.

C. AB will assist Employer and/or Administrator in the creation of the Summary of Benefits and Coverage ("SBC") for the Plan in accordance with 26 CFR § 54.9815-2715 and 29 CFR §2590.715-2715 and subsequent related federal guidance. Employer will remain responsible for the distribution of the SBC in accordance with federal law.

SCHEDULE E
Section 125 Plan Adoption Agreement

A. Do you currently offer a Section 125 Plan to your eligible employees?

☐ Yes ☐ No

B. If you selected "Yes" to Item A. above:

1. Is Allied the Administrator of your Section 125 Plan?

☐ Yes ☐ No

2. Do you want Allied to continue to administer your Section 125 Plan, or replace your current Section 125 Plan Administrator (if you do not currently use Allied for this purpose)?

☐ Yes ☐ No

C. If you selected "No" to Item A. above, please complete the following:

1. Name of Employer: _____
2. Employer Address: _____
3. Employer Identification Number: _____
4. Name of Plan: _____ Section 125 Premium Only Plan
5. Other participating Employers and the effective dates of their participation [identify all 80% or more owned affiliates of the named employer]:

EMPLOYER	DATE

6. Effective Date: _____
7. Plan Year: The 12 month period ending _____
8. The Benefit Options that are to be offered on a pre-tax basis through the Plan and the name of the Benefit Plan under which each Benefit Option is provided are all Qualified Insurance Premiums (*select all that apply*):

☒ A. Medical coverage

☒ 1. Name of Plan:
- ☒ a. Employee Only
- ☒ b. Employee Plus Spouse
- ☒ c. Employee Plus One or More Children
- ☒ d. Employee Plus Family
- ☐ e. Other:

☐ No Coverage

2.

☐ B. Dental coverage

☐ 1. Name of Plan: _____
- ☐ a. Employee Only
- ☐ b. Employee Plus Spouse
- ☐ c. Employee Plus One or More Children
- ☐ d. Employee Plus Family
- ☐ e. Other:

☐ 2. No coverage

☐ C. Vision coverage

☐ 1. Name of Plan: _____
- ☐ a. Employee Only
- ☐ b. Employee Plus Spouse
- ☐ c. Employee Plus One or More Children
- ☐ d. Employee Plus Family
- ☐ e. Other:

☐ 2. No coverage

☐ D. Other Qualified Insurance coverage

☐ 1. Name of Plan: _____
- ☐ a. Employee Only
- ☐ b. Employee Plus Spouse
- ☐ c. Employee Plus One or More Children
- ☐ d. Employee Plus Family
- ☐ e. Other:

☐ 2. No coverage

9. For new hires who fail to complete and return the applicable enrollment form (and for individuals who fail to complete and return an election form during the initial Plan Year enrollment), the following Benefit Options will be treated as having been automatically elected: _____

SCHEDULE F
BUSINESS ASSOCIATE ADDENDUM

THIS BUSINESS ASSOCIATE ADDENDUM ("Addendum") supplements and is made a part of the Allstate Benefits Self-Funded Program Employer Agreement ("Agreement") between _____ **(**Employer Name**)**, plan sponsor of the (Employer Name**)** Employee Health Plan ("Covered Entity") and The Association Benefits Solution, LLC marketed as Allstate Benefits Self-Funded Program ("Allstate Benefits" or "AB") or any of its affiliates (hereafter "Business Associate") (individually, "Party" and collectively, the "Parties").

WHEREAS, Covered Entity and Business Associate are parties to the Agreement pursuant to which Business Associate provides certain services to Covered Entity. In connection with Business Associate's services, Business Associate creates or receives Protected Health Information ("PHI") and/or Electronic Protected Health Information ("EPHI") (defined below) from or on behalf of Covered Entity, which information is subject to protection under the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d et seq.), and its implementing privacy and security regulations ("HIPAA"). The purpose of this Addendum is to satisfy certain standards and requirements ofHIPAA; and

WHEREAS, Covered Entity is obligated under Title II, Subtitle F ("Administrative Simplification") of HIPAA and regulations promulgated to ensure that Business Associate uses, discloses and protects PHI and EPHI consistent with the requirements of the Privacy, Security, and Omnibus Rules (defined below) and as outlined in this Addendum; and

WHEREAS, Business Associate acknowledges that with the enactment of the American Recovery and Reinvestment Act of 2009, Title XIII, Subtitle D (Pub. L. No 111-5 (2009)) ("HITECH"), certain provisions of HIPAA were amended in a way that directly impacts and regulates the Business Associate's responsibilities, obligations, and activities under the Privacy and Security Rules; and

WHEREAS, Business Associate acknowledges that it must comply with all HITECH provisions relatedto the activities of Business Associate including, but not limited to, HITECH Sections 13401, 13402, 13404, and 13405 and any regulations promulgated thereunder, including the Final Rule at 78 Federal Register 17, Part II (2013) (hereafter the "Omnibus Rule").

NOW THEREFORE, the Parties agree as follows:

1. Definitions

Breach shall have the same meaning as specified in 45 CFR § 164.402, as may be amended.

Effective Date is the date on which the underlying Agreement goes into effect.

Electronic Protected Health Information ("EPHI") shall have the same meaning as specified in 45 CFR § 160.103, as may be amended, limited to all such information relating to the Covered Entity's customers, applicants or claimants that Business Associate may receive, review, create, transmit, observe, or otherwise have an opportunity to use or disclose while performing its obligations under this Addendum or the underlying Agreement.

Protected Health Information ("PHI") shall have the same meaning as specified in 45 CFR § 160.103, as may be amended, limited to all such information, regardless of its form, relating to the Covered Entity's customers, applicants or claimants that Business Associate may receive, review, create, transmit, observe, or otherwise have an opportunity to use or disclose while performing its obligations under this Addendum or the underlying Agreement. PHI includes EPHI as defined above.

Privacy Rule shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164, subparts A and E and any subsequent amendments including, but not limited to, the Omnibus Rule.

Secretary shall mean the Secretary of Health and Human Services (HHS) or any HHS officer, employee, or agent to whom the Secretary delegates authority.

Security Incident shall have the same meaning as specified in 45 CFR § 164.304, as may be amended.

Security Rule shall mean the Security Standards and Implementation Specifications at 45 CFR Parts160 and 164, subparts A and C and any subsequent amendments including, but not limited to, the Omnibus Rule.

Subcontractor shall have the same meaning as specified in 45 CFR § 160.103, as may be amended, limited to a Subcontractor to whom Business Associate delegates a function, activity, or service that is necessary for Business Associate to meet its obligations for or on behalf of Covered Entity under the terms of this Addendum or the underlying Agreement.

2. Obligations and Activities of Business Associate

   a. Confidentiality of PHI. Business Associate agrees to not use or disclose PHI other than as permitted or required by this Addendum or as required by law. Business Associate shall not at any time access any PHI for any purpose other than those specifically authorized by Covered Entity or required by law.

   b. Permitted Uses and Disclosures. Except as otherwise provided in this Addendum, Business Associate shall use and disclose PHI solely for meeting its obligations and performing any functions, activities and/or services for or on behalf of Covered Entity under the terms of this Addendum, the Agreement, or as allowed or required by law. In addition, Business Associate may: use or disclose PHI in the following instances:

      1. Use PHI as necessary for the proper management and administration of Business Associate.

      2. Disclose PHI as necessary for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate, provided that:
      (1) the disclosure is required by law; or (2) Business Associate obtains reasonable assurances from the third-party who receives the disclosed PHI that the confidentiality of the PHI will be maintained, that PHI will be further disclosed only as required by law or for the purpose for which it was disclosed, and that third-party will notify Business Associate of any breaches of confidentiality of PHI.

   c. Disclosure to Subcontractor. Business Associate may allow a Subcontractor to create,

receive,maintain or transmit PHI on behalf of Business Associate if Business Associate obtains satisfactory assurances by a written agreement or contract that conforms with 45 CFR §§ 164.502(e)(1)(ii), 164.504, 164.308(b)(2), and 164.314(a) acknowledging that the Subcontractor will comply with all applicable provisions of the Privacy, Security, and Omnibus Rules.

d. Prohibited Uses and Disclosures. Business Associate shall not use or disclose PHI in any manner that would constitute a violation of the Privacy Rule if used or disclosed by Covered Entity, except as permitted by sections 2(b)(1) and (2) above and section (2)(e) below. Additionally, Business Associate must comply with all applicable provisions of 45 CFR § 164.502(a)(5).

e. Aggregation of Data. Business Associate may aggregate the PHI received or obtained from Covered Entity with other PHI in its possession provided that the purpose of such aggregation is to provide Covered Entity with data analyses related to Covered Entity's "health care operations" (45 CFR § 164.501) as that term is defined in the Privacy Rule.

f. Appropriate Safeguards.

1. Business Associate shall use reasonable and appropriate safeguards to maintain the privacy and security of PHI and to prevent unauthorized use, disclosure, damage, or destruction of PHI.

2. Business Associate shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI in compliance with the Security Rule and any subsequent amendments, including any applicable provision of the Omnibus Rule.

3. Such efforts shall also include the adoption and enforcement of policies and procedures to reasonably and appropriately implement the requirements of the Privacy, Security, and Omnibus Rules.

4. Business Associate shall encrypt Covered Entity's EPHI prior to saving it on portable media and while in transit. In other circumstances, Business Associate shall encrypt Covered Entity's EPHI whenever reasonably practicable.

g. Reporting Improper Use or Disclosure. Business Associate shall report to Covered Entity, any unauthorized use, disclosure, damage, destruction, or Breach of PHI by Business Associate or its Subcontractors, or any other Security Incident of which it becomes aware, and to establish procedures for mitigating, to the greatest extent possible, any harmful effect that is created by any improper use, disclosure, damage, destruction, Security Incident, or Breach of PHI. Business Associate shall assist in Covered Entity's notification of the occurrence to all necessary parties as required by law, regulation, or as determined necessary by Covered Entity. To the extent that the Security Incident, Breach, or other unauthorized use, disclosure, damage, or destruction of PHI occurs while the PHI is in the possession of the Business Associate or its Subcontractor, Business Associate will be responsible for all costs incurredin resolving the Security Incident, Breach, or other unauthorized use, disclosure, damage, or destruction of PHI.

h. Access to PHI.

1. To enable Covered Entity to fulfill its obligations under the Privacy Rule, Business Associate shall, at the request and direction of Covered Entity, make PHI maintained by Business Associate or its Subcontractors available to Covered Entity or a designated individual for inspection and copying within ten (10) days of receipt of such a request from Covered Entity.

   If Business Associate maintains PHI electronically and an individual requests from Covered Entity or Business Associate an electronic copy, Business Associate shall provide Covered Entity access to the requested PHI in an electronic form and format as requested by individual if that form and format is readily producible. Otherwise, Business Associate shall provide the PHI in an agreed upon electronic readable form and format.

2. In the event an individual requests that his or her PHI be sent directly to a designated individual, Business Associate will, upon Covered Entity's direction, send the PHI directly to the designated individual if the request meets all the requirements of Section 164.524(c)(3)(ii).

i. Amendment of PHI. To enable Covered Entity to fulfill its obligations under the Privacy Rule, Business Associate shall, within ten (10) days of a request from Covered Entity, make PHI maintained by Business Associate or its Subcontractors available for amendment and, as directed by Covered Entity, shall incorporate any amendment or related statements into the information held by Business Associate and its Subcontractors. If any individual directly requests that Business Associate or its Subcontractor amend PHI, Business Associate and its Subcontractors shall notify Covered Entity within ten (10) days of such request.

j. Accounting of Disclosures. Business Associate and its Subcontractors shall, within ten (10) days of a request from Covered Entity, make available the information necessary for Covered Entity to provide an individual with an accounting of the disclosures of his or her PHI as required under the Privacy Rule. At a minimum, such information shall include: 1. the date of the disclosure; 2. the name and address of the entity or person receiving the PHI; 3. a brief description of the PHI disclosed; and 4. a brief description of the reason for the disclosure or a copy of the written request for the disclosure. Such information must be maintained by Business Associate and its Subcontractors for a period of six (6) years from the date of each disclosure for which accounting is required under 45 CFR § 164.528(a)(1). If any individual directly requests that Business Associate or its Subcontractors provide an accounting of disclosures of PHI, Business Associate or its Subcontractors shall notify Covered Entity within ten (10) days of such request.

k. Covered Entity's Obligations. To the extent that Business Associate is required under the Arrangement to carry out obligations of Covered Entity imposed by the Privacy Rule, Business Associate will comply with all applicable provisions of the Privacy, Security, and Omnibus Rules in performing such obligations.

l. Minimum Necessary. Business Associate agrees that it will not request or disclose more than the minimum amount of PHI necessary to accomplish the purpose of the request, use, or disclosure or request.

m. Right to Audit, Inspection, and Enforcement. Business Associate agrees to make its internal practices, processes, books, and records relating to the use or disclosure of PHI available to Covered Entity, Covered Entity's parent and the Secretary or the Secretary's designee for purposes of determining Covered Entity's compliance with the Privacy Rule, Security Rule and applicable provisions of the Omnibus Rule.

Covered Entity shall be entitled, upon reasonable prior written notice to Business Associate,to conduct an on-site audit of Business Associate's internal practices, processes, books, and records to verify Business Associate's compliance with the terms of this Addendum.

Employee Training and Awareness. Business Associate shall provide appropriate training regarding the requirements of this Addendum to any employee (or other workforce member) accessing, using or disclosing PHI and shall develop and implement a system of sanctions for any employee (or other workforce member) or Subcontractor who violates the requirements imposed by this Addendum.

n. Restriction Requests; Confidential Communications. Business Associate shall comply with any restriction request and any confidential communication request of which Covered Entity makes Business Associate aware pursuant to section 3.c, below.

o. Notice of Privacy Practices. Business Associate shall use and disclose PHI in compliance with the terms of Covered Entity's updated privacy practices notice, as provided to Business Associate pursuant to section 3.a, below.

p. Transactions Rule Compliance. If Business Associate conducts a Standard Transaction (as that term is defined in 45 CFR § 162.103) for or on behalf of Covered Entity, Business Associate will comply, and will require any of its Subcontractors to comply, with each applicable requirement of 45 CFR Part 162.

3. Obligations of Covered Entity

a. Notice of Privacy Practices. Covered Entity agrees to inform Business Associate of its current privacy practices and any future changes to those practices by providing Business Associate with updated copies of its notice of privacy practices.

b. Revocation of Authorization by Individual. Covered Entity agrees to inform Business Associate of any change to or revocation of an individual's authorization to use or disclose PHI to the extent that such changes may affect Business Associate's use or disclosure of PHI.

c. Restrictions on Use and Disclosure. Covered Entity agrees to notify Business Associate of any restrictions to the use or disclosure of PHI agreed to by Covered Entity in accordance withthe Privacy, Security, and Omnibus Rules to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

d. Permissible Requests. Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy, Security, or Omnibus Rulesif done by Covered Entity.

4. Term and Termination

a. Term. This Addendum shall be effective from the Effective Date until all PHI provided by

or created for Covered Entity is destroyed or returned to Covered Entity or, if it is infeasible to return or destroy PHI, protections are extended to such PHI in accordance with the terms of this Agreement.

b. Material Breach. A breach by Business Associate of any material provision of this Addendum or the Privacy, Security, or Omnibus Rules, as determined by Covered Entity, shall constitute a material breach of this Addendum and shall provide grounds for the immediate termination of this Addendum and the Agreement.

c. Business Associate's Reasonable Steps to Cure Breach. If Covered Entity knows of a pattern of activity or practice of Business Associate that constitutes a material breach or violation of Business Associate's obligations under this Addendum or the Privacy, Security or Omnibus Rules, Covered Entity may provide Business Associate with an opportunity to cure the breach or violation. If Business Associate fails to cure the breach or violation to the satisfaction of Covered Entity within the time period specified by Covered Entity, Covered Entity shall have the right to terminate the Addendum and the underlying Agreement.

d. Reasonable Steps to Cure Breach. If Business Associate knows of a pattern of activity or practice by Subcontractor that constitutes a material breach or violation of Subcontractor's obligations toBusiness Associate, or the Privacy, Security, or Omnibus Rules, Business Associate may provideSubcontractor with an opportunity to cure the breach or violation. If Subcontractor fails to cure the breach or violation to the satisfaction of Business Associate and/or Covered Entity within the time period specified by Business Associate or Covered Entity, Business Associate shall terminate the relationship with the Subcontractor and retrieve all PHI from the Subcontractor. In the event termination or cure is not feasible, Business Associate shall report Subcontractor's breach or violation to the Secretary.

e. Remedies. Notwithstanding any rights or remedies set forth in this Addendum or providedby law, Covered Entity retains all rights to seek injunctive relief to prevent or stop the unauthorized use or disclosure of PHI by Business Associate or its Subcontractors or any third party who has received PHI from Business Associate.

f. Effect of Termination.

    1. Upon termination of the Agreement (including termination due to material breachof this Addendum pursuant to section 5.a, above), Business Associate shall return or destroy all PHI in its possession or the possession of its Subcontractors. Business Associate agrees that it will not retain any copies of PHI it returns or destroysin any form or medium except as required by law.
    2. If it is infeasible to return or destroy any or all PHI, Business Associate and its Subcontractors shall continue to extend the protections of this Addendum to such information and limit further use and disclosure of such PHI to those purposes that make the return or destruction of such PHI infeasible.

5. Miscellaneous

a. Relationship of Parties. None of the provisions of this Addendum are intended to create or shall be deemed to create any relationship between the Parties other than that of independent parties contracting with each other solely for the purposes of effecting the

provisions of this Addendum and any Agreement between the Parties.

b. Ownership of PHI. The PHI and any related information created for or received from Covered Entity is, and will remain, the property of Covered Entity. Business Associate agrees that it acquires no ownership rights to, or title in, the PHI or any related information.

c. No Third Party Beneficiaries. Nothing express or implied in this Addendum is intended to confer,nor shall anything herein confer, upon any person or entity other than Covered Entity, Business Associate and their respective successors and assigns, any rights, remedies,obligations or liabilities whatsoever.

d. Successors and Assigns. This Addendum shall be binding on the Parties and their successors, but neither Party may assign the Addendum without the prior written consent of the other, which consent shall not be unreasonably withheld.

e. Waiver. No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation,or shall prohibit enforcement of any obligation, on any occasion.

f. Severability. In the event that any provision of this Addendum is held by a court of competent jurisdiction to be invalid or unenforceable, the remainder of the provisions of this Addendum shallremain in full force and effect.

g. Modification to Comply with Law. The Parties acknowledge that state and federal laws relating to the security and privacy of PHI are rapidly evolving and that modification of this Addendum may be required to provide for procedures to ensure compliance with such developments. The Parties specifically agree to take such action as is necessary to implement the standards and requirements of the Privacy, Security, and Omnibus Rules. Upon request of either party, the other party agrees to promptly enter into negotiations concerning the terms of a modification to this Addendum embodying written assurances consistent with the standards and requirements of the Privacy, Security, and Omnibus Rules. Covered Entity may terminate this Addendum upon thirty (30) days written notice in the event: 1) Business Associate does not promptly enter into negotiations to modify this Addendum when requested by Covered Entity under this section; or 2) Business Associate does not enter into a modification of this Addendum providing assurances regarding the safeguarding of PHI that Covered Entity, in its sole discretion, deems sufficient to satisfy the standards and the requirements of the Privacy, Security, and Omnibus Rules.

h. Amendment. This Addendum may be amended or modified only in a writing signed by the Parties.

i. Notice. Any notice to the other Party pursuant to this Addendum shall be deemed providedif sent in accordance with those provisions set forth in Section 12 of the Agreement.

j. Interpretation. This Addendum shall be interpreted as broadly as necessary to implement and comply with the Privacy, Security, and Omnibus Rules. The Parties agree that any ambiguity in this Addendum shall be resolved in favor of a meaning that complies with and is consistent with the Privacy, Security, and Omnibus Rules.

ADMINISTRATIVE SERVICES AGREEMENT
GROUP NO. XXXXX

This Agreement is made and entered into as of this ___ day of _____, 20___ ("Effective Date") by and between (Group Name) (hereinafter referred to as "Employer") and Allied Benefit Systems, LLC. (hereinafter referred to as "TPA"). The purpose of this Agreement is to detail the responsibilities and obligations of the parties with respect to the Employer's program of providing medical and/or other benefits for employees and their dependents (hereinafter referred to as "Benefit Plan").

Therefore, for and in consideration of the mutual covenants contained herein and for other valuable consideration, it is agreed as follows:

1. RESPONSIBILITIES OF THE EMPLOYER

a. Furnish the TPA with a written detailed description of the Benefit Plan.
b. Determine the claims administration procedures and practices to be followed, which are not self-evident from the Benefit Plan.
c. Determine the eligibility of an employee or dependent to receive benefits. The Employer shall supply the TPA in writing or by electronic medium with all information regarding the eligibility of employees and dependents.
d. Remit all fees and insurance premiums when due. Failure to do so may result in a loss of coverage and cessation of administrative services and will relieve the TPA of any further responsibility under this Agreement. Payments received after the due date may be subject to a $50.00 late fee.
e. Perform and comply with the obligations set forth in the HIPAA Business Associate Addendum, attached as Exhibit A to this Agreement and incorporated hereto by reference.
f. Provide the TPA with the social security numbers and Medical Health Insurance Claim Numbers ("HICNs") (if applicable) for all Benefit Plan participants (employees and dependents) upon request in order for the TPA to supply such information to the Centers for Medicare and Medicaid Services in compliance with the Medicare, Medicaid and SCHIP Extension Act.
g. The Employer shall furnish the TPA with the following information for each employee and dependent for which COBRA coverage will be offered by the Employer:
    i. name
    ii. address
    iii. social security number
    iv. date of birth
    v. type of qualifying event
    vi. date of qualifying event
    vii. premium rate
    viii. available coverage
    ix. any other appropriate information requested by the TPA.

Such information will be forwarded to the TPA within thirty (30) days of the date of the qualifying event.
h. Furnish the TPA with sufficient information regarding claims incurred before the effective date of the claims administration of the Benefit Plan by the TPA to allow it to determine the liability of the Benefit Plan for related claims incurred thereafter.
i. Promptly inform the TPA of the addition or deletion of persons covered by the Benefit Plan with the agreement that the Benefit Plan shall remain liable for benefit claims which are pre-certified, or which have been paid, as being covered until such time as the TPA is notified of the change in eligibility of any person covered under the Benefit Plan.
j. Acknowledge its fiduciary responsibility per the Employee Retirement Income Security Act of 1974.
k. Reconcile monthly billings and notify TPA of any discrepancies within 60 days of the billing date. Notwithstanding the foregoing, Employer must nonetheless pay all bills timely.

2. RESPONSIBILITIES OF TPA

a. Provide Benefit Plan documents for the Employer's review.
b. Arrange for the production and distribution of summary plan descriptions, ID cards, summaries of benefits and coverage and other agreed upon Benefit Plan-related documents for Benefit Plan participants.
c. Follow the claims administration procedures and practices provided for under the Benefit Plan, and consult with the Employer on any changes.
d. Provide suitable facilities, personnel, procedures, forms and instructions and other services reasonably necessary for the processing of claims under the Benefit Plan.
e. Determine, in accordance with the Benefit Plan and claims processing procedures and practices, the qualification of claims submitted, making as required, such investigations as may be reasonably necessary as determined by the TPA.
f. Forward payment with Employer funds as provided for in Section 5 of amounts due with respect to claims that qualify under the Benefit Plan as provided above.
g. Submit to the Employer a reconciliation, which includes a monthly accounting of payments made in sufficient detail to provide for the audit and control of funds used.
h. Submit to the Employer a monthly accounting of benefit payments for all lines of coverage and payments to individuals.
i. Submit to each employee and dependent specified by the Employer a COBRA package containing the necessary election forms and premium rates established by the Employer. Such information will be forwarded to any individual specified by the Employer within fourteen (14) days of the date the TPA receives the Employer's request. If COBRA coverage is elected, the TPA shall forward to the individual(s) payment coupons indicating the monthly premium payments for continued coverage. Such coupons will be forwarded within fourteen (14) days of the date the signed and completed election form is received by

the TPA.
j. If requested, assist the Employer in the preparation and filing of Form 5500 for the Benefit Plan.
k. If the Employer has elected to utilize the Aetna Signature Administrators® program as its network, and in the event the TPA becomes aware that the Employer has (a) filed an application for, or consented to the appointment of a receiver, trustee, or liquidator of all or a substantial portion of the Employer's assets; (b) filed a voluntary petition in bankruptcy or admission in writing of its inability to pay its debts as they become due; or (c) filed a petition or an answer seeking reorganization or arrangement with creditors to take advantage of any insolvency law; or (d) refused to fund any covered claims of participating providers, then, if the Employer is not current on its payment, the TPA will require Employer to immediately notify all members of the Benefit Plan and all health care providers whose claims are pended as a result of the delinquency of funding. Such notification shall be in writing and a copy forwarded to the TPA and Aetna Life Insurance Company.
l. Comply with the requirements imposed on the Claims Processor by the Medicare, Medicaid and SCHIP Extension Act, including the transmission of the social security numbers and HICNs of Employer's Benefit Plan participants to the Centers for Medicare and Medicaid Services as applicable.
m. Using information provided by the Employer, maintain eligibility files of employees and dependents to obtain benefits under the Benefit Plan.
n. Provide appropriate billings for all services and insurance coverages, request additional funding when the Benefit Plan does not meet or exceed the cumulative claim fund contribution and remit collected funds to the appropriate party.
o. TPA, at its sole cost and expense, shall procure and maintain policies of general liability and professional liability insurance.
p. Provide standard eligibility and claim reports.
q. Maintain records related to the Benefit Plan and the TPA's services provided hereunder for a period of ten years.

3. ADMINISTRATION FEE

TPA shall collect from Employer the agreed-upon administration fee, which shall include the fee to which TPA is entitled for its performance of the services outlined in this Agreement. TPA shall remit the remaining portions of the administration fee to Employer's contracted vendors, as directed by Employer. Separately, with respect to any subrogation matter of which TPA is involved, Employer shall pay TPA a fee in the amount of 25% of any monetary recovery.

4. BENEFIT PLAN ACCOUNT

Employer shall provide funds to be used to make Benefit Plan payments to, or on behalf of, plan participants as funds are needed to cover such payments. Upon the request of TPA, Employer or the Benefit Plan will transfer to TPA those funds which are necessary to provide for the payment of approved claims and other approved expenses of the Benefit Plan. All funds transferred to TPA will be used solely and exclusively for the purpose of paying approved claims or for the payment of other approved expenses of the Benefit Plan. TPA shall not be liable for provider/facility charges claimed as a result of purported lost discounts, or for any other expenses incurred as a result of purported lost discounts, unless such charges or expenses are a result of TPA's sole negligence or willful misconduct.

5. AUDIT

Upon reasonable prior written notice, the Employer and/or its designated auditor may conduct an on-site audit to examine any records of TPA relating to the performance of its responsibilities under this Agreement, including processing of eligibility, claims, claims payments, and the issuing of checks for payment of claims. The audit must be reasonable in scope as mutually determined by the Employer and TPA. In addition, TPA must consent to the choice of auditor, such consent shall not be unreasonably withheld. Audits performed on a contingency fee basis will not be allowed by the TPA. Employer shall pay all expenses and fees associated with the auditor, and shall also pay a fee to TPA for TPA's time and costs associated with the audit. The amount of this fee to TPA shall be agreed to in writing between the parties in advance of the audit.

6. LIABILITY AND INDEMNITY

a. TPA does not insure nor underwrite the liability of Employer under the Benefit Plan. Employer acknowledges and agrees that: (a) Employer is the fiduciary under the Benefit Plan, pursuant to the Employee Retirement Income Security Act of 1974 ; (b) the services provided by TPA to the Benefit Plan shall be performed within the framework established by the Employer; (c) the Employer retains the ultimate responsibility for claims made under the Benefit Plan, COBRA compliance, the purchase of stop-loss, the filing of Form 5500 and all expenses incident to the Benefit Plan; (d) the Employer retains the exclusive discretionary authority and control to manage and otherwise administer the Benefit Plan and the disposition of its assets, , and (e) with the exception of payments made by Employer to TPA in satisfaction of any administrative fees, TPA will act as a mere custodian, financial intermediary, or commercial conduit with respect to any funds provided by Employer to TPA pursuant to this Agreement, and TPA shall not be considered an initial transferee of those funds, as those terms are applied to Section 550 of Title 11 of the United States Code. Except to the extent TPA is otherwise indemnified by a third party, Employer agrees to indemnify the TPA and hold the TPA harmless against claims for insurance premiums, taxes, penalties, employee benefits and any and all losses, damages,

expenses, costs or liabilities, including reasonable attorneys' fees and court costs, arising out of claims brought against the TPA 1) to recover benefits under the Benefit Plan, 2) to recover damages for failure to pay such benefits, including any purported lost discounts, or 3) in connection with any other action or claim relating to the Benefit Plan, including, without limitation, any action for recovery of amounts paid to the TPA for the Benefit Plan (with the exception of payments in satisfaction of administrative fees), whether under Sections 544, 547, and 548 of Title 11 of the United States Code or otherwise, unless such losses, damages, expenses, costs or liabilities are incurred solely as a result of the negligence or willful misconduct of TPA.

b. Except to the extent TPA is otherwise indemnified by a third party, Employer agrees to indemnify TPA and hold TPA harmless for penalties levied by the federal government against TPA for failure to provide all social security numbers and HICNs (when applicable) of Employer's Benefit Plan participants to the Centers for Medicare and Medicaid Services, pursuant to the Medicare, Medicaid and SCHIP Extension Act. This section will not apply when such failure is based on the negligence of TPA. TPA agrees to send a letter to Employer on a quarterly basis regarding the necessary social security numbers.

c. During the continuance of this Agreement, the TPA agrees to indemnify the Employer and hold the Employer harmless against any and all loss, damage, and expense with respect to this Benefit Plan resulting from or arising out of the dishonest, fraudulent, negligent or criminal acts of TPA's employees, acting alone or in collusion with others. TPA shall maintain blanket bond coverage for employee dishonesty.

d. Any regulatory or governmental assessment, tax, fee or penalty assessed or imposed on the TPA (except to the extent such a penalty is assessed or imposed as a result of the TPA's negligence or willful misconduct), as a result of the existence of the Benefit Plan or the TPA's administration of the Benefit Plan, will be the responsibility of the Employer.

e. TPA shall not be liable to Employer for any claim which is asserted by Employer more than one (1) year after Employer is or should have been reasonably aware of such claim, and will in no event be liable to Employer for any claim which is asserted by Employer more than twenty-four (24) months after the event resulting in damage or loss.

f. The provisions contained within this Section 6 shall survive termination of this Agreement.

7. ASSESSMENTS, TAXES, PENALTIES AND GOVERNMENTAL FEES

Subject to Section 6, entitled "Liability and Indemnity," all assessments will be paid in accordance with and will be the responsibility of the applicable party set forth or otherwise prescribed in the regulation or other applicable law governing the applicable assessment. To the extent the regulation or other applicable law does not identify the responsible party, the following guidelines shall be used to determine the party responsible for the payment of such assessment:

a. Assessments directly related to the payment for medical care will be processed and paid in the same manner as claims paid in accordance with the terms of the Benefit Plan. As such, these assessments are not the responsibility of the TPA.

b. Residency taxes and/or fees will be billed to and paid by the Employer as a separate line item on its monthly bills. As such, these taxes and/or fees are not the responsibility of the TPA.

c. TPA license fees that are charged as a result of doing business, as well as TPA's corporate taxes, will be the responsibility of TPA.

d. Except to the extent otherwise agreed upon between TPA and a third party, nothing in this section shall preclude TPA from passing through to the Employer any applicable assessment, tax, penalty or fee for which the responsible party cannot be determined based on the foregoing.

8. SEVERABILITY

Should any part of this Agreement be declared invalid, any remaining portion shall remain in full force and effect as if this Agreement had been executed with the invalid portion eliminated.

9. TERMINATION AND REVISION

This Agreement shall commence as of the Effective Date and shall continue in full force and effect for one (1) year, and thereafter shall automatically renew for additional terms of one (1) year unless terminated in accordance with the remainder of this Section and/or other provisions of this Agreement.

Unless otherwise provided, this Agreement may be terminated effective upon (a) the first day of any month following thirty (30) days written notice of termination by either party to the other, (b) failure of Employer to pay its monthly administration fee, if such fee is not received by TPA within 31 days following the applicable due date or (c) failure of Employer to pay its first monthly administration fee upon re-issue, if such fee is not received by TPA within 40 days following the applicable due date. Upon termination of this Agreement, TPA will provide services in accordance with the terms of the Benefit Plan, and/or Employer's stop-loss policy, during the Employer's applicable run-out period, and all claim files shall remain in TPA's possession until the completion of all such services. If requested by the Employer in writing, the TPA will provide a computer - generated Paid Claims Analysis Report and Eligibility Listing for the period of this Agreement. No other services will be provided by the TPA after the termination of this Agreement unless agreed to in writing by both

parties.

10. INDEPENDENT CONTRACTOR

It is understood and agreed that the TPA is engaged to perform services under this Agreement as an independent contractor and not as an employee, agent, partner or joint venturer of the Employer, its broker or consultant or any other vendor.

11. NO CONTINUING WAIVER

Failure of either party to enforce at any time any of the provisions of this Agreement shall in no way be construed to be a waiver of such provision or in any way offset the validity of this Agreement or any part thereof or the right of such party to thereafter enforce each and every provision of this Agreement. No waiver of any breach of this Agreement shall be held to be a waiver of any other or subsequent breach.

12. THIRD PARTY RIGHTS

Nothing contained in this Agreement, expressed or implied, is intended to confer, or shall confer, upon any individual participant in or beneficiary under the Benefit Plan any rights or remedies under or by reason of this Agreement.

13. NONSOLICITATION

During the term of this Agreement and for a period of twenty-four (24) months following termination of this Agreement, for any reason, with or without cause, neither party shall solicit or induce (or attempt to solicit or induce) any employee or independent contractor of the other party to leave or terminate his/her employment and/or independent contractor relationship. This provision shall survive termination of this Agreement.

14. SUCCESSORS AND ASSIGNS

This Agreement shall be binding upon, and shall inure to the benefit of the parties hereto and their respective successors and assigns.

15. HEADINGS, GENDER AND NUMBER

Paragraph numbers and headings have been inserted solely for convenience and reference and shall not be construed to affect or limit the meanings, construction or effect of this Agreement. Use of the masculine gender shall include the feminine gender and vice versa. Use of the word "party" shall mean and include any trust, corporation, partnership, or other entity. The singular number shall include the plural number and vice versa.

16. APPLICABLE LAW

This Agreement and the rights and obligations of the parties hereunder shall be construed in accordance with and governed by the laws of the State of Wisconsin.

17. AMENDMENTS AND MODIFICATIONS

Unless stated otherwise in this Agreement, this Agreement may only be revised by a written agreement signed by both parties.

18. ENTIRE AGREEMENT

This Agreement represents the entire agreement between the parties and no other representations, oral or otherwise, are binding.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed and delivered on the day and year first above written.

FOR THE EMPLOYER:

BY:_____

TITLE:_____

DATE:_____

FOR THE TPA:

BY: 

TITLE: Vice President of Administration

ALLIED BENEFIT SYSTEMS, LLC
200 West Adams
Suite 500
Chicago, IL 60606

EXHIBIT A
HIPAA BUSINESS ASSOCIATE ADDENDUM

This HIPAA Business Associate Addendum ("Addendum") supplements and is made a part of the Administrative Services Agreement ("Agreement") between (Group Name)_____ , plan sponsor of the (Group Name Employee Benefit Plan)_____ _ ("Covered Entity") and Allied Benefit Systems, LLC ("Business Associate").

Covered Entity and Business Associate are parties to the Agreement pursuant to which Business Associate provides certain services to Covered Entity. In connection with Business Associate's services, Business Associate creates, receives, maintains and/or transmits Protected Health Information ("PHI") on behalf of Covered Entity. To that end, the purpose of this Addendum is to comply with the requirements of (i) the implementing regulations at 45 C.F.R Parts 160, 162, and 164 for the Administrative Simplification provisions of Title II, Subtitle F of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") (*i.e.,* the HIPAA Privacy, Security, Breach Notification, and Enforcement Rules ("the Implementing Regulations"), (ii) the requirements of the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 (the "HITECH Act") that are applicable to business associates, and (iii) the requirements of the final modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules as issued on January 25, 2013 and effective March 26, 2013 (75 Fed. Reg. 5566 (Jan. 25, 2013)) ("the Final Regulations"). The Implementing Regulations, the HITECH Act, and the Final Regulations are collectively referred to in this Addendum as "the HIPAA Requirements."

Covered Entity and Business Associate agree to incorporate into this Addendum any regulations issued by the U.S. Department of Health and Human Services ("HHS") with respect to the HIPAA Requirements that relate to the obligations of business associates to be reflected in a business associate agreement. Business Associate recognizes and agrees that it is obligated by law to meet the provisions of the HIPAA Requirements directly applicable to Business Associate, and that it has direct liability for any violations of such HIPAA Requirements.

In the event of an inconsistency between the provisions of this Addendum and a mandatory term of the HIPAA Requirements (as these terms may be expressly amended from time to time by HHS or as a result of interpretations by HHS, a court, or another regulatory agency with authority over the parties), the interpretation of HHS, such court or regulatory agency shall prevail.

Where provisions of this Addendum are different from those mandated by the HIPAA Requirements, but are nonetheless permitted by the HIPAA Requirements, the provisions of this Addendum shall control.

In light of the foregoing and the requirements of HIPAA, Business Associate and Covered Entity agree to be bound by the following terms and conditions:

1. **Definitions.**

(a) General. Terms used, but not otherwise defined, in this Addendum shall have the same meaning as those terms are defined in the HIPAA Requirements.

(b) Specific.

i. Breach. "Breach" shall mean, as defined in 45 C.F.R. § 164.402, the acquisition, access, use or disclosure of Unsecured Protected Health Information in a manner not permitted by the HIPAA Requirements that compromises the security or privacy of that Protected Health Information.

ii. Business Associate Subcontractor. "Business Associate Subcontractor" shall mean, as defined in 45 C.F.R. § 160.103, any entity (including an agent) that creates, receives, maintains or transmits Protected Health Information on behalf of Business Associate.

iii. Electronic Protected Health Information. "Electronic Protected Health Information" ("EPHI") shall have the same meaning set forth in 45 C.F.R. § 160.103, as amended from time to time, and generally means Protected Health Information that is transmitted or maintained in any electronic media.

iv. Individual. "Individual" shall have the same meaning as the term "individual" in 45 CFR 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR 164.502(g).

v. Privacy Rule. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR part 160 and part 164, subparts A and E.

vi. Protected Health Information. "Protected Health Information" or "PHI" shall have the same meaning as the term "protected health information" in 45 CFR §160.103, limited to the information created, received, maintained, or transmitted by Business Associate from or on behalf of Covered Entity pursuant to this Addendum.

vii. Required By Law. "Required by Law" shall have the same meaning as the term "required by law" in 45 CFR 164.501.

viii. Security Incidents. The term "Security Incidents" has the meaning set forth in 45 C.F.R. § 164.304, as amended from time to

time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

ix. Security Rule. "Security Rule" shall mean the Standards for Security of Individually Identifiable Health Information created, transmitted, maintained or received in an electronic media (45 C.F.R. Parts 160, 162 and 164.)

x. Secretary. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.

xi. Unsecured Protected Health Information. "Unsecured Protected Health Information" shall mean, as defined in 45 C.F.R. §164.402, Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by HHS.

2. **Flow-Down of Obligations to Business Associate Subcontractors**. Business Associate agrees that as required by the HIPAA Requirements, Business Associate will enter into a written agreement with all Business Associate Subcontractors that: (i) requires them to comply with the Privacy and Security Rule provisions of this Addendum in the same manner as required of Business Associate, and (ii) notifies such Business Associate Subcontractors that they will incur liability under the HIPAA Requirements for non-compliance with such provisions. Accordingly, Business Associate shall ensure that all Business Associate Subcontractors agree in writing to the same privacy and security restrictions, conditions and requirements that apply to Business Associate with respect to PHI.

3. **Obligations and Activities of Business Associate under HIPAA Privacy Rules.**

(a) Use and Disclosure. Business Associate agrees to not use or disclose PHI other than as permitted or required by this Addendum or as Required by Law. When performing the functions and activities specified in the Agreement and this Addendum (including when requesting PHI from another covered entity or business associate), Business Associate agrees to use, disclose, or request only the minimum necessary PHI to accomplish the intended purpose of the use, disclosure, or request.

(b) Appropriate Safeguards. Business Associate shall establish, implement and maintain appropriate safeguards, and comply with the Security Standards (Subpart C of 45 C.F.R. Part 164) with respect to electronic PHI, as necessary to prevent any use or disclosure of PHI other than as provided for by this Addendum. Without limiting the generality of the foregoing, Business Associate agrees to protect the integrity and confidentiality of any PHI it electronically exchanges with Covered Entity.

(c) Mitigation. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Addendum.

(d) Reporting. Business Associate shall report to Covered Entity any use or disclosure of PHI that is not provided in this Addendum of which Business Associate becomes aware, including reporting Breaches of Unsecured PHI as required by 45 C.F.R. § 164.410 and this Addendum.

(e) Access to Designated Record Sets. To the extent that Business Associate possesses or maintains PHI in a Designated Record Set, Business Associate agrees to provide access, at the request of Covered Entity, and in the time and manner reasonably requested by Covered Entity, to PHI in a Designated Record Set, to Covered Entity or, as directed by Covered Entity, to those individuals who are the subject of the PHI (or their designees) in order to meet the requirements under 45 CFR 164.524. Business Associate shall make such information available in an electronic format where directed by Covered Entity.

(f) Amendments to Designated Record Sets. To the extent that Business Associate possesses or maintains PHI in a Designated Record Set, Business Associate agrees to make any amendment(s) to PHI in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 CFR 164.526 at the request of Covered Entity or an Individual, and in the time and manner reasonably requested by Covered Entity.

(g) Access to Books and Records. Business Associate agrees to make internal practices, books, and records, including policies and procedures and PHI, relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of, Covered Entity available to the Covered Entity, or to the Secretary, in a time and manner reasonably requested by the Covered Entity or designated by the Secretary, for purposes of the Secretary determining Covered Entity's and/or Business Associate's compliance with the HIPAA Requirements.

(h) Accountings. Business Associate agrees to document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR 164.528.

(i) Requests for Accountings. Business Associate agrees to provide to Covered Entity or an Individual, in the time and manner reasonably requested by Covered Entity, information collected in accordance with Section 3.h. of this Agreement, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR 164.528.

4. Obligations and Activities of Business Associate under HIPAA Security Rules.

(a) Business Associate shall use appropriate administrative, technical, and physical safeguards ("Safeguards"), that reasonably and appropriately

protect the integrity, confidentiality, and availability of, and to prevent non-permitted or violating use or disclosure of, EPHI created, transmitted, maintained, or received in connection with the services provided under the Agreement.
(b) Business Associate shall document and keep these Safeguards current. These Safeguards shall extend to transmission, processing, and storage of EPHI. Transmission of EPHI shall include transportation of storage media, such as magnetic tape, disks or compact disk media, from one location to another. Upon Covered Entity's request, Business Associate shall provide Covered Entity access to, and copies of, documentation regarding such Safeguards.
(c) Business Associate shall comply with and implement the requirements of the HIPAA Security Rule (45 C.F.R. Parts 160, 162, and 164) by:

i. Implementing administrative, physical, and technical safeguards required by the Security Rule that reasonably protect the confidentiality, integrity, and availability of EPHI that it creates, receives, maintains, or transmits on behalf of Covered Entity.
ii. Ensuring that any Business Associate Subcontractors to whom it provides such information agree to implement reasonable and appropriate safeguards to protect such information;
iii. Reporting and tracking all Security Incidents as described below:
iv. Business Associate shall report to Covered Entity any Security Incident that results in (i) unauthorized access, use, disclosure, modification, or destruction of Covered Entity's EPHI of which Business Associate becomes aware, or (ii) interference with Business Associate's system operations in Business Associate's information systems, of which Business Associate becomes aware;
v. Business Associate shall report to Covered Entity within twenty-one (21) days after Business Associate learns of such Security Incident. For any other Security Incident, Business Associate shall aggregate the data and provide such reports on a quarterly basis, or more frequently upon Covered Entity's request.
vi. Making Business Associate's policies and procedures and documentation required by the Security Rule related to these safeguards available to the Secretary for purposes of determining Covered Entity's and/or Business Associate's compliance with the Security Rule.

(d) Business Associate agrees to take all reasonable steps to mitigate, to the extent practicable, any harmful effect that is known to Business Associate resulting from any unauthorized access, use, disclosure modification or destruction of EPHI.

5. <u>Notice and Reporting Obligations of Business Associate.</u>
(a) Business Associate shall notify Covered Entity within twenty-one (21) days after discovery by Business Associate, any unauthorized access, use, disclosure, modification, or destruction of PHI (including any successful Security Incident) that is not permitted by this Addendum, by applicable law, or permitted in writing by Covered Entity.
(b) Business Associate shall, as required by law, notify Covered Entity of the discovery of any Breach of Unsecured Protected Health Information. Notice must be made without any unreasonable delay and no later than twenty-one (21) days after discovery of the Breach by Business Associate.
(c) As provided for in 45 C.F.R. Sec. 164.402, Business Associate recognizes and agrees that any acquisition, access, use or disclosure of Unsecured PHI in a manner not permitted under the HIPAA Privacy Rule (Subpart E of 45 C.F.R. Part 164) is presumed to be a Breach. As such, Business Associate shall assist Covered Entity in performing a risk assessment to examine whether there is a low probability that the Unsecured PHI has been compromised to determine whether a Breach has in fact occurred.

Business Associate shall cooperate with Covered Entity in furtherance of Covered Entity's Breach notification obligations under the HIPAA Requirements by:

- Identifying each individual (if known) whose Unsecured PHI has been or is reasonably believed to have been accessed, acquired, or disclosed.
- Identifying the nature of the Breach, including the date of the Breach and date of the discovery.
- Identifying the nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification.
- Identifying the unauthorized person who used the PHI or to whom the disclosure was made.
- Determining whether the PHI was actually acquired or viewed.
- Identifying what corrective or investigational action Business Associate took or will take to prevent further non-permitted accesses, uses, or disclosures.
- Determining the extent to which the risk to the PHI has been or will be mitigated by Business Associate.
- Determining whether the incident falls under any of the Breach notification exceptions.

6. **<u>Permitted Uses and Disclosures by Business Associate.</u>**
(a) <u>Agreement</u>. Business Associate agrees to create, receive, use, disclose, maintain or transmit PHI only in a manner that is consistent with this Addendum or the HIPAA Requirements, and only in connection with providing the services identified in the Agreement. To that end, Business Associate may not use or disclose PHI in a manner that would violate the requirements of the Privacy Rule if done by Covered Entity, subject to subsections 6(b) and (c), or the minimum necessary policies and procedures of Covered Entity. Business Associate further agrees that to

the extent it is carrying out one or more of the Covered Entity's obligations under the Privacy Rule (Subpart E of 45 C.F.R. Part 164), it shall comply with the requirements of the Privacy Rule that apply to the Covered Entity in the performance of such obligations.

(b) Use for Administration of Business Associate. As permitted by the HIPAA requirements, Business Associate may use PHI received by the Business Associate in its capacity as a Business Associate to the Covered Entity for 1) the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate, or 2) data aggregation services relating to health care operations of the Covered Entity.

(c) Disclosure for Administration of Business Associate. As permitted by the HIPAA Requirements, Business Associate may disclose PHI received by the Business Associate in its capacity as a Business Associate to the Covered Entity for the proper management and administration of the Business Associate, provided that disclosures are Required by Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required by Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

7. **Obligations of Covered Entity.**

(a) Notice of Privacy Practices. Covered Entity shall provide Business Associate with the notice of privacy practices that Covered Entity produces in accordance with 45 CFR 164.520, as well as any changes to such notice.

(b) Notification of Changes Regarding Individual Permission. Covered Entity shall provide Business Associate with any changes in, or revocation of, permission by Individual to use or disclose PHI, if such changes affect Business Associate's permitted or required uses and disclosures.

(c) Notification of Restrictions to Use or Disclosure of PHI. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR 164.522.

(d) Obligations of Covered Entity with respect to a Breach of Unsecured PHI. Covered entity shall:

- Investigate any unauthorized access, use, or disclosure of Unsecured PHI.
- Perform a risk assessment to determine if there is a low probability that the PHI has been compromised
- Determine whether the incident falls under any of the HITECH Breach notification exceptions.
- Notify each Covered Entity plan member impacted by a Breach by first class mail (or by other methods applicable under law) without any unreasonable delay and no later than 60 days after discovery of the Breach. The notification will comply with the HIPAA Requirements.
- Maintain a log and submit to HHS an annual report of Breaches of Unsecured PHI that impact fewer than 500 individuals under the time frames required by the HIPAA Requirements.
- Notify HHS in the event the Breach of Unsecured PHI impacts 500 or more individuals under the time frames required by the HIPAA Requirements.
- Notify media when required by the HIPAA Requirements.

8. **Permissible Requests by Covered Entity.**

Except as set forth in Section 6 of this Addendum, Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

9. **Term and Termination.**

(a) Term. This Addendum shall be effective as of effective date of the Administrative Services Agreement and shall terminate when all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions in this Section.

(b) Termination for Cause. Upon either party's knowledge of a material breach by the other party, including the breaching party engaging in a pattern of activity or practice that constitutes a material breach or violation of the breaching party's obligations under this Addendum, the non-breaching party shall either:

i. Provide an opportunity for the breaching party to cure the breach or end the violation. If the breaching party does not cure the breach or end the violation within the time specified by the non-breaching party, the non-breaching party shall terminate the Agreement and this Addendum;

ii. Immediately terminate the Agreement and this Addendum if the breaching party has breached a material term of this Addendum and cure is not possible; or

iii. If neither termination nor cure are feasible, the breaching party shall report the violation to the Secretary.

(c) Effect of Termination.

i. Except as provided in paragraph ii. of this Section 9.c., upon termination of the services provided to Covered Entity under the Agreement, for any reason, Business Associate shall return or destroy all PHI received from Covered Entity, or created, maintained, or received by Business Associate on behalf of Covered Entity. This provision shall apply to PHI that is in the possession of Business Associate Subcontractors. Business Associate shall retain no copies of the PHI.

ii. In the event that Business Associate

determines that returning or destroying the PHI is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon mutual agreement of the parties that return or destruction of PHI is infeasible, Business Associate shall extend the protections of this Addendum and the HIPAA Requirements to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

10. **Miscellaneous.**

(a) Regulatory References. A reference in this Addendum to a section in the Privacy Rule or Security Rule means the section as in effect or as amended.

(b) Amendment. The parties agree to take such action as is necessary to amend this Addendum from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy Rule, the Security Rule and HIPAA.

(c) Survival. Business Associate's and Covered Entity's obligation to protect the privacy and security of the PHI they created, received, maintained, or transmitted in connection with services to be provided under the Agreement and this Addendum will be continuous and survive termination, cancellation, expiration, or other conclusion of this Addendum or the Agreement.

(d) Information Systems. If Business Associate is provided access to any Covered Entity information system or network containing any EPHI, Business Associate agrees to comply with all Covered Entity policies for access to and use of information from the information systems or network

(e) Interpretation. Any ambiguity in this Addendum shall be resolved to permit Covered Entity to comply with the applicable provisions of the Privacy Rule and Security Rule.

(f) No Third Party Beneficiaries. Nothing in this Agreement shall be construed as creating any rights or benefits to any third parties.

(g) Miscellaneous. The Addendum constitutes the entire agreement between the parties with respect to the subject matter contained herein, and no other representations, oral or otherwise, are binding.

Business Associate Agreement

THIS BUSINESS ASSOCIATE AGREEMENT ("Agreement") is entered into by and between

_____ (hereinafter "Covered Entity") and _____
EMPLOYER GROUP NAME AGENT/AGENCY NAME
(hereafter "Business Associate") (individually, "Party" and collectively, the "Parties"). This Agreement is effective on the date it is signed by both Parties ("Effective Date").

Business Associate agrees not to engage in any practice harmful to the best interests of Covered Entity. Business Associate further agrees that any such practice can serve as the basis for the immediate termination of this Agreement.

Services provided by Business Associate may be subject to state and federal privacy laws and regulations, including but not limited to the Gramm-Leach-Bliley Act ("GLBA"), Health Insurance Portability and Accountability Act ("HIPAA"), Health Information Technology for Economic and Clinical Health ("HITECH"), and their implementing regulations, as amended from time to time, any and all applicable state privacy and security statutes and any relevant regulations enacted or promulgated in conjunction with applicable state and federal privacy and security laws.

For purposes of the following, capitalized terms not otherwise defined shall have those meanings ascribed by HIPAA/HITECH. In the capacity as a Business Associate to Covered Entity, Business Associate agrees:

1. not to use or to disclose Protected Health Information ("PHI") other than as permitted or required by this Agreement or as required by law;
2. to use appropriate safeguards to prevent use or disclosure of PHI other than as provided for by this Agreement;
3. to only request or disclose the minimum amount of PHI necessary to accomplish the purpose of the use or disclosure;
4. to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI that Business Associate creates, receives, maintains or transmits on behalf of Covered Entity as required under HIPAA/HITECH;
5. to report to Covered Entity, within 24 hours of discovery, any use or disclosure or disclosure of the PHI by Business Associate or Business Associate's Agents, including Subcontractors, that is not provided for by this Agreement and of which Business Associate becomes aware;
6. to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use, disclosure or Breach of PHI by Business Associate in violation of the requirements of this Agreement;
7. to the extent that the unauthorized use or disclosure occurs while the PHI is in the possession of Business Associate and/or its Agents, including Subcontractors, or representatives, Business Associate will be responsible for: (1) immediately reporting any such unauthorized use of disclosure to Covered Entity; (2) assisting Covered Entity in the notification of the occurrence to all necessary parties as required by law, regulation or as determined necessary by Covered Entity; and (3) for all costs incurred in resolving the incident;
8. to provide access, at the request of Covered Entity, and in the time and manner it specifies in writing with reasonable advance notice, to PHI in a Designated Record Set, to Covered Entity or, as directed by Covered Entity, to individuals who are the subject of the PHI (or their designees);
9. to make any amendment(s) to PHI in a Designated Record Set that Covered Entity directs in response to a request of Covered Entity or an Individual, and in the time and manner as Covered Entity may specify in writing with reasonable advance notice;
10. to make available to Covered Entity, or to the Secretary of the Department of Health and Human Services (the "Secretary"), Business Associate's internal practices, books, and records, including policies and procedures and PHI, relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of Covered Entity (the "Materials"). The Materials shall be provided by Business Associate in the time and manner specified by Covered Entity in writing with reasonable advance notice to Business Associate or designated by the Secretary;
11. to document disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with HIPAA/HITECH;
12. to provide to Covered Entity or an Individual designated by Covered Entity, in the time and manner as Covered Entity may specify in writing with reasonable advance notice, information Business Associate has collected in order to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with HIPAA/HITECH;

13. to ensure that any Agent, including a Subcontractor, to whom Business Associate provides PHI either received from, or created or received by Business Associate on behalf of Covered Entity, agrees in writing to the same restrictions and conditions that apply to Business Associate under this Agreement and HIPAA/HITECH with respect to such information;
14. to provide appropriate training regarding the requirement of this subsection to any employee or Subcontractor accessing, using or disclosing PHI and shall implement a system of sanction for any employee, Agent or Subcontractor who violates this agreement;
15. at termination of this Agreement, to return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity or to extend the protections of this Agreement to the information and to limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI; and
16. to comply at all times with all applicable HIPAA/HITECH laws and regulations, as may be amended that are not otherwise addressed herein.

Miscellaneous

A. Indemnification. Business Associate shall indemnify and hold harmless Covered Entity from and against any and all losses, expenses, damages, or injuries that Covered Entity may sustain as a result of, or arising out of, a breach of this Agreement by Business Associate or its employees, agents, or subcontractors including, but not limited to, any unauthorized use, disclosure, damage, or destruction of PHI, or any negligent acts or omissions or intentional misconduct of Business Associate or its employees, agents, or subcontractors.

B. Relationship of Parties. None of the provisions of this Agreement are intended to create or shall be deemed to create any relationship between the Parties other than that of independent parties contracting with each other solely for the purposes of effecting the provisions of this Agreement and any Arrangement between the Parties.

C. Ownership of PHI. The PHI and any related information created for or received from Covered Entity is, and will remain, the property of Covered Entity. Business Associate agrees that it acquires no ownership rights to, or title in, the PHI or any related information.

D. No Third Party Beneficiaries. Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person or entity other than Covered Entity, Business Associate and their respective successors and assigns, any rights, remedies, obligations or liabilities whatsoever.

E. Successors and Assigns. This Agreement shall be binding on the Parties and their successors, but neither Party may assign the Agreement without the prior written consent of the other, which consent shall not be unreasonably withheld.

F. Waiver. No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any occasion.

G. Severability. In the event that any provision of this Agreement is held by a court of competent jurisdiction to be invalid or unenforceable, the remainder of the provisions of this Agreement shall remain in full force and effect.

H. Amendment. This Agreement may be amended or modified only in a writing signed by the Parties.

I. Notice. Any notice to the other Party pursuant to this Agreement shall be deemed provided if sent by first class United States mail, postage prepaid.

J. Interpretation. This Agreement shall be interpreted as broadly as necessary to implement and comply with the Privacy, Security, and Omnibus Rules. The Parties agree that any ambiguity in this Agreement shall be resolved in favor of a meaning that complies with and is consistent with the Privacy, Security, and Omnibus Rules.

Covered Entity	Business Associate
Signed by: _____	Signed by: _____
Name: _____	Name: _____
Title: _____	Title: _____
Date: _____	Date: _____

SCHEDULE C
EXHIBIT 1 – NETWORK SERVICE AGREEMENT

This Network Service Agreement ("NSA") is between Cigna Health and Life Insurance Company (“Cigna”) and the undersigned employer sponsoring the Plan (“Plan Sponsor”).

WHEREAS, Cigna directly and through affiliates has established a national panel of physicians, hospitals and other health care practitioners and entities (“Participating Providers”) to provide or arrange for the provision of certain health care services and supplies (“Covered Services”) at rates of reimbursement specified in agreements with the Participating Providers (the “Provider Agreements”); and

WHEREAS, Plan Sponsor has established a self-insured health care benefit plan (“Plan”) that provides for the reimbursement of Covered Services in accordance with the terms and conditions of the Plan; and

WHEREAS, Cigna and National General Management Corp., on behalf of itself and The Association Benefits Solution, LLC (collectively, “Company”) have entered into an administrative services agreement (“ASA”) for the shared administration of Participating Provider; and

WHEREAS, through a program marketed as Allstate Benefits Self-Funded Program, Company provides a healthcare solution under which Company markets, provides risk management, and arranges for the administration of health care benefit plans (“Program”); and

WHEREAS, under the ASA, Company will offer the Program to the Plan; and

WHEREAS, Plan Sponsor desires to make the Participating Providers available to those of its employees and their dependents who are covered under the Plan (“Members”) for the provision of Covered Services.

NOW, THEREFORE, in consideration of the foregoing premises and the mutual promises and covenants contained herein, Cigna and Plan Sponsor hereby agree as follows:

I. CIGNA DUTIES

Cigna shall make the Participating Providers available for the provision of Covered Services to Members at the reimbursement rates determined by Cigna in accordance with its applicable Participating Provider Agreements for Cigna’s Medical Network (“Participating Provider Rates”). Cigna shall be responsible for the credentialing and re-credentialing, if any, of Participating Providers in accordance with its credentialing standards. Cigna reserves the right to remove any Participating Provider from its panel of Participating Providers. Cigna or its designee shall make available to Members its list of Participating Providers. Participating Providers will be required by Cigna to accept as payment in full for all Covered Services rendered to Members the charges reflected in the applicable Provider Agreements with respect to network products. Cigna's standard Provider Agreements shall require that Participating Providers look solely to Plan Sponsor for reimbursement of charges for Covered Services provided to Members except for (i) coinsurance, co-payments and deductibles identified in the Plan which are the responsibility of Members; and (ii) any payment obligations associated with Network Performance Fees that have been paid by Plan Sponsor which are the responsibility of Cigna.

II. PLAN SPONSOR’S DUTIES

Plan Sponsor shall fund all Covered Services and shall ensure that Company processes and pays Participating Providers for all such Covered Services in accordance with the terms of the Participating Provider Agreements with the exception of any amounts paid or payable by Cigna on Plan Sponsor’s behalf in association with a Network Performance Fee. In the event of a conflict between this NSA and any Participating Provider Agreement, the Participating Provider Agreement shall prevail. Plan Sponsor shall ensure, through its agreement with Company that Participating Providers are reimbursed for Covered Services in accordance with the terms of the applicable Participating Provider Agreement less deductibles, copayments, coinsurance and any reductions in benefits due to a Member’s non-compliance

with the terms of the Plan. Plan Sponsor acknowledges and agrees that, in some instances, payment to Participating Providers in accordance with Participating Provider Agreements may result in payment of amounts in excess of billed charges. Notwithstanding the foregoing, the Participating Provider Rates shall not apply to Covered Services provided to Members by Participating Providers unless the Plan provides an incentive (through benefit differentials or otherwise) for Members to use Participating Providers rather than other health care providers and the ID cards provided to Members conspicuously identify Cigna. Plan Sponsor may seek reimbursement from Participating Providers for claim payments made with respect to individuals whose eligibility as a Member ceased prior to the provision of the services/supplies for which the payment was made within sixty (60) days following the date the Participating Provider submitted the claim to Cigna for payment. Plan Sponsor shall, through its agreement with Company, provide for the payment of all fees due to Cigna under the ASA in accordance with the terms of the ASA. Plan Sponsor shall, directly or through its agreement with Company, provide Cigna with information, including paid claim data, reasonably requested by Cigna in association with the ASA or this NSA. Plan Sponsor acknowledges that access to health services under this NSA creates an obligation between Plan Sponsor and the Participating Provider and between Plan Sponsor and Cigna, and if Plan Sponsor fails to perform its obligations, the Participating Provider and/or Cigna, as applicable, will have a direct cause of action against Plan Sponsor.

III. EFFECTIVE DATE & TERMINATION

This NSA shall, be effective the earlier of:

(i) the date this NSA is signed by Plan Sponsor, or
(ii) the date the Plan and/or its Members first access Cigna's Medical Network.

In no event shall this NSA take effect unless there is then in effect an agreement between Plan Sponsor and Company for administration of the Plan by Company.

This NSA shall automatically terminate upon:

(i) termination of the Plan,
(ii) termination of Plan Sponsor's agreement with Company for the administration of the Plan,
(iii) termination of the ASA, or
(iv) termination of Plan Sponsor's access to Cigna's Medical Network.

If this NSA is terminated, Cigna will, in accordance with the ASA, provide twelve (12) months of run-out services on claims incurred prior to the termination effective date.

IV. RESPONSIBILITY FOR COVERED SERVICES

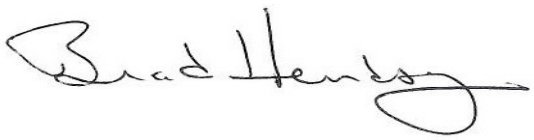
Plan Sponsor acknowledges and agrees that, with the exception of any obligations to be paid by Cigna in association with Network Performance Fees that have been paid by Plan Sponsor, Cigna and its affiliates shall not, under any circumstances, be financially responsible to Plan Sponsor, the Plan, a Member, a Participating Provider or any other party for the payment of any Covered Services under the Plan. It is understood and agreed that, with the exception of any obligations to be paid by Cigna in association with Network Performance Fees that have been paid by Plan Sponsor, the payment of all Covered Services is the responsibility of Plan Sponsor. This provision shall survive the termination of this NSA.

V. GENERAL

Any use of the name, logo, trademark, or service mark of Cigna or any Cigna Affiliate by Plan Sponsor without Cigna's prior written approval is prohibited. Any controversies or claims between Cigna and Plan Sponsor arising out of or in any way directly or indirectly connected with this NSA shall be resolved by binding arbitration. Such arbitration shall be administered by the American Arbitration Association in accordance with its Commercial Arbitration Rules ("AAA Rules"). The arbitral proceeding will be held in Bloomfield, Connecticut and shall be before a single arbitrator jointly agreed to by the parties. If the parties are unable to agree upon an arbitrator, the arbitrator shall be chosen in accordance with the AAA

Rules. Discovery shall be limited to mutual exchange of documents relevant to the dispute, controversy or claim; depositions shall not be permitted unless agreed to by both Parties. Each party will assume its own costs related to the arbitration, which includes any costs, fees (including attorneys' fees), and expenses of any kind. The arbitration shall be subject to the laws of the State of Delaware, without regard to its conflict of law provisions. The arbitrator may grant any remedy or relief deemed just and equitable with the exception of punitive or exemplary damages. Judgment upon the award rendered by the arbitrator may be entered in any court of competent jurisdiction. Arbitration is the exclusive remedy for the resolution of disputes under this NSA. The decision of the arbitrator will be final, conclusive and binding, and no action at law or in equity may be instituted by either party other than to enforce the award of the arbitrator. The existence and results of any arbitration will be treated as confidential by both parties. The relationship of the parties under this NSA is that of independent contractors. This NSA is made solely and specifically among and for the benefit of the parties hereto, and their respective successors and assigns, and no other person shall have any rights, interest or claims hereunder or be entitled to any benefits under or on account of this NSA as a third party beneficiary or otherwise, including, but not limited to, Members and Participating Providers. This NSA as well as any subsequent amendments represent the entire agreement between the parties hereto and supersede any and all previous written or oral agreements or understandings regarding the subject matter of this NSA. Neither party may assign or transfer any duty or interest in this NSA without the written consent of the other party,and any attempted transfer or assignment without such consent shall be void, except Cigna may assignor transfer any duty or interest in this NSA to an Affiliate without the consent of Plan Sponsor. This NSA may be amended upon the mutual written consent of the parties, except Cigna shall have the right to unilaterally amend this NSA as follows: (1) upon ninety (90) days written notice to Plan Sponsor to administer any changes in law, provided, Plan Sponsor has the right to terminate this NSA within the ninety (90) day period; (2) upon one hundred and eighty (180) days prior written notice to Plan Sponsor, provided, Plan Sponsor has the right to terminate this NSA within the one hundred and eighty (180) day period; or (3) to the extent amendment is required by law.

CIGNA HEALTH AND LIFE INSURANCE COMPANY



Brad Hendsey
Vice President, Payer Solutions

PLAN SPONSOR
Sign below and return to Cigna care of:

Company's name and address for collection of this NSA:

_____

Plan Sponsor Name: _____

By: Signature: _____

Printed Name: _____

Title: _____

Dated: _____

NEW YORK STATE DEPARTMENT OF HEALTH
Division of Health Care Financing

Third Party Administrator (TPA) or Administrative Services Only (ASO) Status Change

HEALTH CARE REFORM ACT – PUBLIC GOODS POOL

This form must be completed if an electing payor is adding or changing their TPA/ASO.

Effective Date:_____

PAYOR INFORMATION:

Payor Name: _____ Payor FEIN: _____

Contact Person: _____ Phone #: _____

Type of Status Change (check appropriate box):

☐ **Additional TPA/ASO** (complete Section II only)

☐ **Changing TPA/ASO** (complete Sections I, II & III)

I. PREVIOUS TPA/ASO INFORMATION:

TPA/ASO Name: _____ TPA/ASO FEIN: _____

II. NEW or ADDITIONAL TPA/ASO INFORMATION:

TPA/ASO Name: _____ TPA/ASO FEIN: _____

Address: 200 West Adams, Suite 500

Chicago, IL 60606

TPA/ASO Contact Person: Teresa Bates TPA/ASO Phone #: 888-292-0272

III. CHECK ONE OF THE FOLLOWING:

☐ Previous TPA/ASO will continue to process claims and file reports for all dates of service prior to the change for a period of one year following the end of the year in which the change in TPA occurred or until all such claims have been adjudicated, at which time a final monthly report with a copy of this form indicating same will be filed.

☐ All self-insured claims that previous TPA/ASO was responsible for have been adjudicated effective_____.

☐ New TPA/ASO is assuming responsibility for all pending claims and HCRA reporting requirements.

Signature of Payor: _____ **Date:** _____

Please mail completed form to:
Mr. Jerome Alaimo, Pool Administrator
Office of Pool Administration
Excellus BlueCross BlueShield, Central New York Region
P.O. Box 4757
Syracuse, New York 13221-4757

HEALTH CARE REFORM ACT – PUBLIC GOODS POOL

Effective Date: _____

FEDERAL EMPLOYER IDENTIFICATION # (FEIN): _____

PAYOR NAME: _____

D/B/As (IF APPLICABLE): _____

ADDRESS: _____

_____

CONTACT PERSON: _____

PHONE #: _____

E-MAIL ADDRESS: _____

If the above referenced entity is a payor that utilizes a third-party administrator (TPA)/administrative services only (ASO) for claims processing, please provide the following information:

TPA/ASO NAME: _____

TPA/ASO FEIN: _____

By signature below, the above entity elects to make all public goods surcharge payments directly to the Office of Pool Administration for all its coverages for which it assumes risk for the payment of medical claims and agrees to:

1. remit to the Department's Office of Pool Administration required surcharge payments for all applicable services on a monthly basis on or before the 30th day following the calendar month for which monies have been paid to designated providers of service;

2. provide the Department's Office of Pool Administration monthly certified reports on or before the 30th day following the calendar month for which monies have been paid which separately report patient service expenditures for services provided by designated provider type(s) (i.e., hospital inpatient, hospital outpatient, diagnostic & treatment center, laboratory[1], or ambulatory surgery center) by product line;

3. provide the Department with certification of data and access to allowance expenditure data upon request for audit verification purposes; and

[1]For services provided on or after October 1, 2000, freestanding clinical laboratories with Article 5 Title V permits are exempt from HCRA surcharges.

4. the jurisdiction of the state to maintain an action in the courts of the State of New York to enforce any provision of section 2807-j of the Public Health Law (see note below).

5. the Department's website posting of the above entity's FEIN in accordance with Public Health Law Section 2807-j(5)(a)(iii)(D).

By signature below, the above entity also agrees to make public goods covered lives payments directly to the Department's Office of Pool Administration in instances where it provides inpatient coverage as a corporation organized and operating in accordance with Article 43 of the Insurance Law, an organization operating in accordance with Article 44 of the Public Health Law, a self-insured fund, or an HMO or insurer licensed outside New York State and authorized to write accident and health insurance and whose policy provides inpatient coverage on an expense incurred basis. In such instances the above entity agrees to:

1. remit to the Department's Office of Pool Administration within 30 days after the end of each month one-twelfth of both the individual and family unit annual assessment amounts for each of the individuals and family units residing in the state which were included on the payor's membership rolls for all or a portion of the prior month and for which the payor covered general hospital inpatient care, including retroactive additions and deletions;

2. provide the Department with data certification and access to individual and family unit data, upon request, for audit verification purposes; and

3. the jurisdiction of the state to maintain an action in the courts of the State of New York to enforce any provision of section 2807-t of the Public Health Law (see note below).

By signature below, the Chief Financial Officer or other duly authorized individual of the above entity certifies that the data submitted on all applicable attachments have been carefully prepared in accordance with instructions provided, and to the best of his/her knowledge, the information presented is accurate and correct.

Signature_____**Title**_____
Chief Financial Officer or Duly Authorized Individual

Date_____

Note: Payors making an election are only agreeing to the jurisdiction of NYS courts for purposes of enforcing payments required under 2807-j and 2807-t. This does not, in any way, preclude a payor from litigating other issues in Federal court such as ERISA based challenges, etc.

Payor Election Application

COVERAGE INFORMATION (See Attached For Further Explanation)

PAYOR NAME:_____ FEDERAL ID#:_____

TPA/ASO NAME:_____TPA/ASO FEDERAL ID#:_____

MARK AN "X" IN EACH COLUMN TO INDICATE TYPE OF COVERAGE BY PAYOR TYPE

	TYPE OF PAYOR:	IDENTIFICATION OF TYPE OF COVERAGE:									
		INDEMNITY COVERAGE	HMO NON-MEDICAID OR NON-NYS MEDICAID COVERAGE	SELF-INSURED COVERAGE	NEW YORK STATE HMO/PHSP MEDICAID COVERAGE	NEW YORK STATE GOVT PROGRAM W/INPATIENT COMPONENT & NYS LOCAL GOVT CORRECTIONS	NEW YORK STATE WORKERS COMPENSATION LAW COVERAGE	NEW YORK STATE MOTOR VEHICLE REPARATIONS ACT COVERAGE	NEW YORK STATE VOLUNTEER AMBULANCE WORKER'S BENEFIT LAW COVERAGE	NEW YORK STATE VOLUNTEER FIREFIGHTERS' BENEFIT LAW COVERAGE	OTHER COVERAGE
1	Corporations Organized & Operating in accordance with Article 43 of the NYS Insurance Law										
2	Corporations that are Commercial Insurers licensed in New York State										
3	Corporations Organized & Operating in accordance with Article 44 of the NYS Public Health Law, not incorporated as Commercial Insurers or under Article 43 of the NYS Insurance Law										
4	Self-Insured Fund with No Third Party Administrator/Administrative Svcs Only Organization for Claims Processing										
5	Self-Insured Fund with a Third Party Administrator/Administrative Svcs Only Organization for Claims Processing			X							
6	New York State Governmental Agency/ New York State Local Government										
7	Other (please explain below): Includes: State/Local Governments outside New York for Medical Assistance Programs; insurers licensed outside New York State, authorized to write OTHER than Accident and Health										
8	HMOs and insurers licensed outside New York State, authorized to write Accident and Health										

Explanation of "Other" Payor Identification

HEALTH CARE REFORM ACT – PUBLIC GOODS POOL

◯ **New Request** ◯ **Revision to Existing Account**

Payor/Third Party Administrator/Administrative Services Only Organization/Provider Name:

_____

Federal Employer Identification # (FEIN):_____

Operating Certificate # (FOR PROVIDERS ONLY): _____

Report(s) being filed electronically (check ALL that apply):

X Public Goods Pool

☐ 1% Statewide Assessment **(for hospitals only)**

By signature below, the Chief Financial Officer or other duly authorized individual of the above named entity authorizes the Office of Pool Administration to assign a secure electronic filing user ID and password to the entity. This information will be mailed directly to the attention of the signer and must remain secured. It is the responsibility of the above named entity to ensure that this information is released only to those individuals requiring knowledge thereof.

Signature _____

Name (Please Print) _____

Title _____

Phone Number _____

Address _____

_____

City _____ **State** _____ **Zip Code** _____

E-mail Address _____

Date _____

Note: All fields on this form are required to be accurately completed in order for your request to be processed.

Please mail completed form to:
Mr. Jerome Alaimo, Pool Administrator
Office of Pool Administration
Excellus BlueCross BlueShield, Central New York Region
P.O. Box 4757
Syracuse, New York 13221-4757

Allied ACH Authorization

Corporate Banking ACH Debit Authorization Release for Invoice Payment
Please send form to the billing department: 312-906-9778 or ACHForms@alliedbenefit.com

☐ **Invoice Payments** ***Please Note, payments will automatically be debited on your monthly billing due date.*

Group Name:	Group Number:	
Address:		
City:	State:	Zip:

Corporate Bank Name:									
Corporate Routing Number:									
Corporate Account Number:									
Account Type:	☐ Checking			☐ Savings					

Does the above account have an ACH Debit Filter?	☐ Yes (See below)	☐ No
If yes, please instruct your bank to add the following company ID: • to allow **Invoice Payments** to go through: 363086057R		

I hereby authorize Allied Benefit Systems, Inc. to initiate ACH transfer entries for the above depository.

Signature: _____ Date: _____

Print: _____ Title: _____