This document includes the Administrative Services Agreement, Exhibit B of the Administrative Services Agreement and the Excess Loss Insurance Policy.

Please note: Administrative Services Agreement must be signed and returned to us as soon as possible. Can be returned by mail or email:

UnitedHealthcare Level Funded	
P.O. Box 31394	Email: levelfundedbilling@uhc.com
Salt Lake City, UT 84131	

ADMINISTRATIVE SERVICES AGREEMENT

This Administrative Services Agreement ("Agreement") between United Healthcare Services, Inc. ("United in this Agreement) and Westmoor Country Club ("Customer" in this Agreement) is effective April 01, 2022 ("Effective Date"). This Agreement covers the services United is providing to Customer, either directly or in conjunction with one of United's affiliates, for use with Customer's Self-Funded employee benefit plan and apply to claims for Plan benefits that are incurred on or after the Effective Date.

United Healthcare Services, Inc. identifies this arrangement as Contract No.: 1427074.

By signing below, each party agrees to the terms of this Agreement.

United Healthcare Services, Inc.
185 Asylum Street

Hartford, CT 06103-3408

By:___________________________________

Authorized Signature

Print Name: ___________________________

Print Title: ____________________________

Date:________________________________

Westmoor Country Club

400 S MOORLAND RD

BROOKFIELD, WI 53005

By:___________________________________

Authorized Signature

Print Name: ___________________________

Print Title: ____________________________

Date:________________________________

Table of Contents

Section 1 - Definitions.......... 3
Section 2 - Customer's Responsibilities.......... 5
Section 3 - Services Provisions.......... 7
Section 4 - Claims Determinations and Appeals.......... 13
Section 5 - Service Fees.......... 14
Section 6 - Providing Funds For Benefits.......... 16
Section 7 - Term Of The Agreement.......... 19
Section 8 - Termination 20
Section 9 - Records, Information, Audits.......... 21
Section 10 - Taxes and Assessments.......... 23
Section 11 - Indemnification.......... 24
Section 12 - Plan Benefits Litigation.......... 25
Section 13 - Dispute Resolution.......... 26
Section 14 - System Access.......... 27
Section 15 - Miscellaneous.......... 28
EXHIBIT A - STATEMENT OF WORK.......... 30

Section 1 - Definitions

When these terms are capitalized in the Agreement they have the meanings set forth below. The words may be singular or plural.

Bank Account: Benefits Bank Account maintained by United for the payment of Plan benefits, expenses, fees and other Customer financial obligations.

Confidential Information: Information disclosed or made available by a Party in connection with this Agreement, including without limitation the following, regardless of form or the manner in which it is furnished: (a) pricing, discounts, reimbursement terms, payment methodologies and payment processes, compensation arrangements and any similar commercial information and (b) data, information, statistics, trade secrets and any information about business, costs, operations, techniques, know-how or intellectual property. Any material that is derived from or developed from Confidential Information will be deemed Confidential Information for purposes of this Agreement, regardless of the person creating, disclosing or making available such material. Any Confidential Information included in preparations, proposals, scope documents, discussions, findings, summaries, reports and conclusions remain Confidential Information.

Confidential Information does not include: (a) information that is or becomes generally available to the public other than as a result of a disclosure by a receiving Party in violation of this Agreement or other agreement between the Customer and United, (b) information either obtained from a third party or already in a receiving Party's possession before receipt from the other Party, if the receiving Party can demonstrate such information was lawfully obtained and not subject to another obligation of confidentiality, and (c) information independently developed without reference to Confidential Information, if the receiving Party can demonstrate such independence through contemporaneous written records.

Customer IBNR Reserve: A reserve which is calculated in accordance with Section 6.4.

Employee: A current or former employee of Customer or an affiliated employer as described in Section 2.4.

ERISA: Employee Retirement Income Security Act of 1974, as amended from time to time.

IRC: The United States Internal Revenue Code of 1986, as amended from time to time.

IRS: The United States Internal Revenue Service.

Maximum Monthly Claim Liability: Means 1/12th of the annual aggregate deductible under the Stop Loss Policy.

Network: The group of Network Providers United makes available to the Plan who have entered into or are governed by contractual arrangements under which they agree to provide health care services to Participants and accept negotiated fees for these services.

Network Provider: The physician, or medical professional or facility which participates in a Network. A provider is only a Network Provider if they are participating in a Network at the time services are rendered to the Plan Participant.

Overpayments: Payments that exceed the amount payable under the Plan. This term does not include overpayments caused by untimely or inaccurate eligibility information.

Participant: Employee or dependent who is covered by the Plan.

Plan: The ERISA plan to which this Agreement applies, but only with respect to those provisions of the plan relating to the Self-Funded health benefits United is administering, as described in the Summary Plan Description.

Plan Administrator: The current or succeeding person, committee, partnership, or other entity designated the Plan Administrator as defined by ERISA and who is generally responsible for the Plan's operation.

Rebates: All rebates, discounts or other financial incentives (whether access, base, Prescription Drug List (PDL), incentive, market share, volume, or other), and administrative fees which United receives directly or indirectly from a pharmaceutical manufacturer and which are obtained in connection with prescription drug products dispensed to Participants under the Plan's pharmacy benefit or the medical benefit. Rebates do not include any purchasing discounts provided that United obtains the same Rebates for prescription drugs regardless of where the prescription drug is dispensed. Rebates to customers are administered and paid under the medical benefit plan or pharmacy benefit plan as outlined in this Agreement.

Self-Fund or Self-Funded: Means that Customer, on behalf of the Plan, has the sole responsibility to pay, and provide funds, to pay for all Plan benefits. United has no liability or responsibility to provide these funds. This is true even if United's affiliates provide stop loss insurance to Customer.

Stop Loss Policy: Means the excess loss insurance policy issued by a United affiliate to Customer in connection with the Plan.

Stop Loss Policy Period: Means the period specified in the Stop Loss Policy's Schedule of Benefits

Summary Plan Description or SPD: The document(s) ERISA requires Customer to provide to Plan Participants describing the terms and conditions of coverage offered under the Plan.

Surplus: Means, for any Term of the Agreement, the excess, if any, of the cumulative Maximum Monthly Claim Liability payments made by Customer during the Term of the Agreement over the sum of (a) the amount of claims incurred during the Term of the Agreement and paid prior to the Reconciliation Date, less any specific stop loss insurance reimbursements, and (b) the Customer IBNR Reserve.

Systems: Means the systems United owns or makes available to Customer to facilitate the transfer of information in connection with this Agreement.

Tax or Taxes: A charge imposed, assessed or levied by any federal, state, local or other governmental entity.

Term or Term of the Agreement: The period of twelve (12) months commencing on the Effective Date (the "initial Term") and automatically continuing for additional 12-month periods (each a "Renewal Term") until the Agreement is terminated.

Urgent Care Claims: A claim for medical services and supplies which meets ERISA's definition of Urgent Care Claim.

Section 2 - Customer's Responsibilities

Section 2.1 Responsibility for the Plan. United is not the Plan Administrator of the Plan. Any references in this Agreement to United "administering the Plan" are descriptive only and do not confer upon United anything beyond certain agreed upon claim administration duties. Except to the extent this Agreement specifically requires United to have the fiduciary responsibility for a Plan administrative function, Customer accepts total responsibility for the Plan for purposes of this Agreement including its benefit design, the legal sufficiency and distribution of SPDs, and compliance with any laws that apply to Customer or the Plan, whether or not Customer or someone Customer designates is the Plan Administrator. The Customer represents and warrants that the Plan has the authority to pay fees due under this Agreement from Plan assets.

Section 2.2 Plan Consistent with the Agreement. Customer represents that Plan documents, including the Summary Plan Description as described in Exhibit A - Statement of Work, are consistent with this Agreement. Nevertheless, before distributing any communications describing Plan benefits or provisions to Participants or third parties, Customer will provide United with such communications which refer to United or United's services prior to distributing these materials to Employees or third parties. Customer will amend them if United reasonably determines that references to United are not accurate, or any Plan provision is not consistent with this Agreement or the services that United is providing.

Section 2.3 Plan Changes. Customer must provide United with notice of any changes to the Plan and/or Summary Plan Description within a reasonable period of time prior to the effective date of the change to allow United to determine if such change will alter the services United provides under this Agreement. Customer's requested changes must be mutually agreed to in writing prior to implementation of such change.

United will notify Customer if (i) the change increases United's cost of providing services under this Agreement or (ii) United is reasonably unable to implement or administer the change. If the parties cannot agree to a new fee within (30) thirty days of the notice of the new fee or if United notifies Customer under Section 2.3 that United is unable to reasonably implement or administer the change, then (a) United shall have no obligation to implement or administer the change, and (b) Customer may terminate this Agreement upon (60) sixty days written notice.

Section 2.4 Affiliated Employers. Customer represents that together Customer and any of its affiliates covered under the Plan make up a single "controlled group" as defined by ERISA and/or the IRC. Customer agrees to provide United with a list of Customer affiliates covered under the Plan upon request.

Section 2.5 Information Customer Provides to United. Customer will tell United which of Customer's Employees, their dependents and/or any other persons, or any combination of these, are Participants. This information must be accurate and provided to United in a timely manner. United will accept eligibility data from Customer in the format described in Exhibit A - Statement of Work. Customer will notify United of any change to this information as soon as reasonably possible.

United will be entitled to rely on the most current information in United's possession regarding eligibility of Participants in paying Plan benefits and providing other services under this Agreement and may require proof or confirmation of Participant's eligibility requirements specified by the Plan. United will not be required to make retroactive eligibility changes, process or reprocess claims, but if United agrees to do so, additional fees may apply.

Customer agrees to provide United, in a timely manner with all information that United reasonably requires to provide services under this Agreement. United shall be entitled to rely upon any written or oral communication from Customer, its designated employees, agents or authorized representatives.

Section 2.6 Notices to Participants. Customer will give Participants the information and documents they need to obtain benefits under the Plan within a reasonable period of time before coverage begins. In the event this Agreement is discontinued, Customer will notify all Participants that the services United are providing under this Agreement are discontinued.

Section 2.7 Contact Information. In accordance with Section 15.7 of this Agreement, Customer shall promptly notify United of any change in its legal name, address, telephone number and email address. United shall be entitled to rely on the most current information in United's possession with respect to United's services under this Agreement.

Section 3 - Services Provisions

Section 3.1 Administrative Services. United will provide the administrative services described in Exhibit A - Statement of Work.

Section 3.2 Network Access, Management and Administration. United will provide access to Networks and Network Providers, as well as related administrative services including physician (and other health care professional) relations, clinical profiling, contracting and credentialing, and network analysis and system development. The make-up of the Network can change at any time. Notice will be given in advance or as soon as reasonably possible.

United generally does not employ Network Providers and they are not United's agents or partners, although certain Network Providers are affiliated with United. Network Providers affiliated with United may be included in the top tier where cost sharing for your plan members is lowest or may be the exclusive providers for certain services depending upon your chosen benefit plan design. Otherwise, Network Providers participate in Networks only as independent contractors. Network Providers and the Participants are solely responsible for any health care services rendered to Participants. United is not responsible for the medical outcomes or the quality or competence of any provider or facility rendering services, including Network Pharmacies and services provided through United's affiliates' networks, or the payment for services rendered by the provider or facility.

Value Based Contracting Program.

United's contracts with some Network Providers may include withholds, incentives, and/or additional payments that may be earned conditioned on meeting standards relating to utilization, quality of care, efficiency measures, compliance with United's other policies or initiatives, or other clinical integration or practice transformation standards. Customer shall fund these payments due the Network Providers as soon as United makes the determination the Network Provider is entitled to receive the payment under the Network Provider's contract, either upfront or after the standard has been met. For upfront funding, if United makes the determination that the Network Provider failed to meet a standard, United will return to Customer the applicable amount. United shall provide Customer reports describing the amount of payments made on behalf of Customer's Plan.

Only the initial claims based reimbursement to Network Providers will be subject to the Participant's copayment, coinsurance or deductible requirements. Customer will pay the Network Provider the full amount earned or attributable to its Participants, without a reduction for copayments or deductibles and agree that there will be no impact from these payments on the calculation of the Participant's satisfaction of their annual deductible amount.

Section 3.3 Claim Recovery Services. United will provide recovery services for Overpayments. United will be responsible for any recovery costs incurred by United with respect to such Overpayments. However, with respect to any unrecovered Overpayment, United will be responsible for such Overpayment only to the extent the Overpayment was due to United's gross negligence.

United will also provide services to recover Plan benefits that were paid and are recoverable by the Plan because payment was or should have been made by a third party for the same medical expense (other than in connection with coordination of benefits, Medicare, or other Overpayments). This is referred to as "Third Party Liability Recovery" (or "subrogation"). Customer will not engage any entity except United to provide the services described herein without United's prior approval.

Customer will be charged fees when any Third Party Liability Recovery services described herein are provided by United or through United's subcontractor or affiliate. The fees are deducted from the actual recoveries. Customer will be credited with the net amount of the recovery.

Customer delegates to United the discretion and authority to develop and use standards and procedures for any recovery, including but not limited to, whether or not to seek recovery, what steps to take if United decides to seek recovery, and the circumstances under which a claim may be compromised or settled for less than the full amount of the claim. Customer acknowledges that use of United's standards and procedures may not result in full or partial recovery for any particular case. United will not pursue any recovery if it is not permitted by any applicable law, or if recovery would be impractical. United may initiate litigation to recover payments, but United has no obligation to do so. If United initiates litigation, Customer will cooperate with United in the litigation.

If this Agreement terminates, or, if United's recovery services terminate, United can continue recovery activities for any claims paid when the Agreement was in effect pursuant to the terms of this Section 3.3.

Overpayments. United will attempt to recover Overpayments by employing appropriate outreach to Participants and/or providers to request reimbursement.

Payment Integrity Services. United provides services to help prevent, identify, and resolve irregular claims ("Payment Integrity Services"). United's Payment Integrity Services help guard against potential errors, fraud, waste and abuse by reviewing claims on a pre- or post-adjudicated basis.

United's Payment Integrity Services processes will be based upon United's proprietary and confidential procedures, modes of analysis, and investigations. United will use these procedures and standards in delivering Payment Integrity Services to Customer and to United's other customers. Services include all work to identify recovery and savings opportunities, research, data analysis, investigation, and initiation of all Recovery Processes set forth below. United does not guarantee or warranty any particular level of prevention, detection, or recovery.

Recovery Process – Non-Class Action Recoveries. Customer delegates to United the discretion and authority to develop and use standards and procedures for any recovery opportunity, including but not limited to, whether or not to seek recovery, what steps to take if United decides to seek recovery, whether to initiate litigation or arbitration, the scope of such litigation or arbitration, which legal theories to pursue in such litigation or arbitration, and all decisions relating to such litigation or arbitration, including but not limited to, whether to compromise or settle any litigation or arbitration, and the circumstances under which a claim may be compromised or settled for less than the full amount of the potential recovery. In all instances where United pursues recovery through litigation or arbitration, Customer, on behalf of itself and on behalf of its Plan(s), will be deemed to have granted United an assignment of all ownership, title and legal rights and interests in and to any and all claims that are the subject matter of the litigation or arbitration.

Customer acknowledges that use of United's standards and procedures may not result in full or partial recovery for any particular claim or for any particular customer. United will not pursue any recovery if it is not permitted by any applicable law, or if recovery would be impractical, as determined in United's discretion. While United may initiate litigation or arbitration to facilitate a recovery, United has no obligation to do so. If United initiates litigation or arbitration, Customer will cooperate with United in the litigation or arbitration.

If this Agreement terminates, in whole or in part, United can continue recovery activities for any claims paid when the Agreement was in effect pursuant to the terms of this Section 3.

Recovery Process – Class Action Recoveries. Where a class action purports to affect Customer's (or the Plan(s) it sponsors or administers) right to and interest in any Overpayment, United has the right to determine whether to seek recovery of the Overpayment on the Customer's (or the Plan(s) it sponsors or administers) behalf through litigation, arbitration, or settlement. Customer will cooperate with United in any resulting litigation or arbitration that United may file to pursue the Overpayments.

Section 3.4 Offsetting Process. Overpayment recoveries may occur by offsetting the Overpayment against future payments to the provider made by United. In effectuating Overpayment recoveries through offset, United will follow its established Overpayment recovery rules which include, among other things, prioritizing Overpayment credits based on: (1) the age of the Overpayment for electronic payments and (2) the funding type and the age of the Overpayment for check payments. United may recover the Overpayment by offsetting, in whole or in part, against: (1) future benefits that are payable under the Plan in connection with services provided to any Participants; or (2) future benefits that are payable in connection with services provided to individuals covered under other self-insured or fully-insured plans for which United processes payments (a "Cross Plan Offset"). In addition to permitting United to recover Overpayments on behalf of the Plan from benefits payable under other plans, United will enable other plans (including plans fully insured by United) to recover their Overpayments from benefits payable under the Plan through Cross Plan Offsets. Customer understands and agrees that in doing so, the Plan is participating in a cooperative overpayment recovery effort with other plans for which United acts as the claims administrator. Reallocations pursuant to this process do not impact the decision as to whether or not a benefit is payable under the Plan. Customer represents and warrants that the Plan SPD contains United's approved template language authorizing Cross Plan Offsets.

In United’s application of Overpayment recovery through offset, timing differences may arise in the processing of claims payments, disbursement of provider checks, and the recovery of Overpayments. As a result, the Plan may in some instances receive the benefit of an Overpayment recovery before United actually receives the funds from the provider. Conversely, United may receive the funds before the Plan receives the credit for the Overpayment. It is hereby understood that the Parties may retain any interest that accrues as a result of these timing differences. Details associated with Overpayment recoveries made on behalf of the Plan through offset will be identified in the monthly reconciliation report provided to the Customer’s Plan. The monthly reconciliation report will contain information relating only to Customer’s Plan and will not contain information relating to other plans for which United acts as the claims administrator.

Section 3.5 Medical Benefit Drug Rebate Payments. From time to time, United or a subcontractor may negotiate with drug manufacturers regarding the payment of medical benefit Rebates on applicable prescription drug products dispensed to Participants under the Plan's medical benefit. United will retain 100% of such medical benefit Rebates as part of United's compensation.

Customer agrees that during the term of this Agreement, neither Customer nor the Plan will negotiate or arrange or contract in any way for medical benefit Rebates on or the purchase of prescription drug products from any manufacturer under the Plan's medical benefit. If Customer or the Plan does, United may, without limiting United's right to other remedies, immediately terminate Customer's and Plan's entitlement to medical benefit Rebates (including forfeiture of any medical benefit Rebates earned but not paid). In addition, Customer agrees to reasonably cooperate with United in order to obtain medical benefit Rebates.

Section 3.6 Pharmacy Benefit Services.

Definitions Specific to Pharmacy Benefit Services:

> **Average Wholesale Price (AWP):** The average wholesale price, as reflected on the Medi-Span Prescription Pricing Guide (with supplements) (“Medi-Span”), of a Prescription Drug based on the eleven (11) digit NDC of the Drug on the date dispensed. United will rely on Medi-Span as updated by United no less frequently than every seven days to determine AWP for purposes of establishing the pricing provided to Customer under this Agreement.

United will not establish AWP, and United will have no liability to Customer arising from use of Medi-Span.

Brand Drug: A single-source or multi-source Prescription Drug product as designated by the Medi-Span Prescription Pricing Guide (with supplements) or other available data resources that identify as a Brand product.

Dispensing Fee: The contracted rate of compensation paid to a Network Pharmacy for the processing and filling of a prescription claim.

Prescription Drug List (PDL): The list of Prescription Drugs as developed by United and approved and adopted by Customer for use with the Plan.

Mail Order Pharmacy: A facility that is duly licensed to operate as a pharmacy at its location and to dispense Prescription Drugs via postal or commercial courier delivery to individuals, including Participants. Mail Order Pharmacy includes pharmacies that are affiliates of United.

Network Pharmacy: A retail pharmacy, Mail Order Pharmacy, Specialty Pharmacy or other facility that is duly licensed to operate as a pharmacy at its location and to dispense Prescription Drugs to Participants and has entered into a Network Pharmacy agreement. An affiliate of United, in its capacity as a Mail Order Pharmacy or Specialty Pharmacy is a Network Pharmacy of the Customer.

Prescription Drug: An FDA approved drug required to be dispensed or administered only by prescription from a licensed health care professional in accordance with laws.

Rebate: Any discount, price concession or other remuneration United receives from a drug manufacturer under a rebate agreement that is contingent upon and related directly to Participant use of a Prescription Drug under the Plan's pharmacy benefit or the medical benefit during the Term. Rebate does not include any, discount, price concession, manufacturer administration fees or other direct or indirect remuneration United receives from a drug manufacturer for direct purchase of a Prescription Drug.

Single-Source Generic: A Generic Drug that has only one generic manufacturer.

Specialty Drugs: Prescription Drugs available at United's Specialty Pharmacy, including: (a) biotechnology drugs; (b) orphan drugs used to treat rare diseases; (c) typically high-cost drugs; (d) drugs administered by oral or injectable routes, including infusions in any outpatient setting; (e) drugs requiring on-going frequent patient management or monitoring; and (f) drugs that require specialized coordination, handling and distribution services for appropriate medication administration

Specialty Pharmacy: A facility that is duly licensed to operate as a pharmacy to dispense Specialty Drugs. Specialty Pharmacy includes pharmacies that are affiliates of United.

Pharmacy Network. United or its affiliate will provide the Pharmacy Benefit Services described in this Section.United will make Network Pharmacies available to Customer Participants, through United's affiliate. United will determine which pharmacies are Network Pharmacies. Network Pharmacies can change at any time. United will make a reasonable effort to provide Customer with advance notice if any material changes occur to the network. Upon request, United will provide Customer information on the reimbursement rate to United's affiliated Network Pharmacies.

Mail Order Pharmacy Services. United will provide through its affiliate, mail order pharmacy services for Customer's Participants. Customer's pricing terms for mail order pharmacy services are based on the actual package dispensed and at least a 46-day supply. Prescriptions filled through the mail order pharmacy that are less than a 46-day supply will be processed at retail pricing and will be counted with retail utilization.

Prescription Drug List (PDL) Customer has adopted one or more of United's PDLs for use with Customer's benefit plans. Customer agrees not to copy, distribute, sell, or otherwise provide the PDL to another party without United's prior written approval, except to Participants as described below. On termination of this Agreement or if Customer terminates the Pharmacy Benefit Services portion of this Agreement, Customer will stop all use of the PDL.

While Customer is the ultimate decision-maker on selecting the design of Customer's PDL(s), Customer has requested that United supply and assist, Customer with, certain PDL development and management functions including but not limited to drug tiering decisions. United's intent is to provide Customer with the same PDL and management strategies that United develops and employs in the management of United's fully insured business.

United makes the final classification of an FDA-approved prescription drug product to a certain tier of the PDL by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the prescription drug product, as well as whether supply limits or notification requirements should apply. Economic factors may include, but are not limited to, the prescription drug product's acquisition cost including, but not limited to, available Rebates, and assessments on the cost effectiveness of the prescription drug product.

United may periodically change the placement of a prescription drug product among the tiers and/or recommend specific Prescription Drug product exclusions from coverage. These changes generally will occur three times per year, but no more than six times per calendar year. These changes may occur without prior notice to Customer however United will provide notice to Customer of material changes to the PDL, United's drug tier classification procedures, coverage exclusions, and clinical programs. Current drug placement and related information may be obtained from the member website, or by calling customer service.

Claims Processing. United will process the claims received from a Network Pharmacy in accordance with the Summary Plan Description, as well as the pricing and other terms of the Network Pharmacy’s participation agreement. On mail order and retail and specialty pharmacy services, United will retain the difference between what United reimburses the Network Pharmacy and Customer payment for a prescription drug product or service.

United maintains systems for processing pharmacy claims and may receive access fees as compensation for services United provides to Network Pharmacies.

Section 3.7 - Pharmacy Benefit Rebates

Allocation and Payment of Rebates. United will negotiate with drug manufacturers for the payment of Rebates to United. United will retain 100% of the Rebates paid to United and any related interest. The amount of Rebates retained depends on many factors, including whether Customer has an incentive benefit design, arrangements with drug manufacturers, the volume of prescription drug claims and the structure of the PDL.

If a government action or a major change in pharmaceutical industry practices that eliminates or materially reduces manufacturer Rebate programs, shall constitute a change in the Agreement as described in the Service Fees Section such that United has the right to increase the service fees for the Pharmacy Benefits Management services. Termination of pharmacy benefit services shall constitute a change in the Agreement as described in the Service Fees Section such that United has the right to increase Customer's services fees under this Agreement.

Payments to Pharmacies. In connection with prescription drug claims, there may be a timing difference between when United withdraws funds from Customer's claims account and when United issues payments to pharmacies and other payees. United may retain interest earned on these amounts during this time. Interest is expected to be paid at overnight deposit rates by United's banking institution.

Customer Compliance. Customer agrees that during the term of this Agreement, neither Customer nor the Plan will negotiate or arrange or contract in any way for Rebates on or the purchase of Prescription Drug products from any manufacturer with respect to the pharmacy benefits. If Customer or the Plan does, United may, without limiting United's right to other remedies, immediately terminate Customer's and Plan's entitlement to Rebates (including forfeiture of any Rebates earned but not paid) and/or terminate the pharmacy benefit services. Termination of pharmacy benefit services shall constitute a change in the Agreement as described in the Service Fees Section such that United has the right to increase the services fees for medical management services under this Agreement.

In addition, Customer agrees to reasonably cooperate with United in order to obtain Rebates. Customer will encourage Customer's Participants to use a Network Pharmacy. Customer will also encourage Customer's Participants to electronically access the PDL on www.myuhc.com, and encourage Participants to share the PDL with their physicians or refer their physicians to the PDL on United's website.

Section 4 - Claims Determinations and Appeals

Section 4.1 ERISA Claim Procedures. Customer appoints United a named, ERISA fiduciary under the Plan with respect to (i) performing initial benefit determinations and payment, (ii) performing the fair and impartial review of first level internal appeals, and (iii) performing the fair and impartial review of second level internal appeals. As such, Customer delegates to United the discretionary authority to (i) construe and interpret the terms of the Plan, (ii) determine the validity of charges submitted to United under the Plan, and (iii) make final, binding determinations concerning the availability of Plan benefits under the Plan's internal appeal process, all in compliance with applicable law and regulation.

If it is determined that a benefit is payable, United will issue a check for, or otherwise electronically credit, the benefit payment to the appropriate payee.

If United denies a Plan benefit claim, in whole or in part, United will notify the claimant of the adverse benefit determination and the claimant shall have the appeal rights set forth in the Summary Plan Description, and/or those which are required under applicable law. If after the exhaustion of the two levels of internal appeal United determines that the Plan benefit is still not payable, United will notify the claimant of that the adverse benefit determination has been upheld. This notification will be designed to comply with ERISA's applicable requirements for adverse benefit determination notices. This determination will be final and binding on the claimant, and all other interested parties except as otherwise provided under the external review program described in below Section 4.2.

Appeals of Urgent Care Claims. Notwithstanding the foregoing, with respect to Urgent Care Claims, United will conduct one review of a denied Urgent Care Claim and issue a final determination as soon as possible, in accordance with applicable law.

Section 4.2 External Review Program. United will notify claimants of the option to request an external review of adverse benefit determinations following the required internal appeal process. United will, in accordance with applicable law: (i) provide claimant with the necessary procedures to obtain the review, (ii) coordinate submission of the claimant's case to an independent review organization, and (iii) notify the claimant of the final external review decision.

Section 4.3 Catastrophic Events. During such time as a government agency declares a state of emergency or otherwise invokes emergency procedures with respect to Participants who may be affected by severe weather or other catastrophic events (a "Catastrophic Event Timeframe"), Customer directs United to implement certain changes in its claim procedures for affected Participants, including, for example: (a) exemption from the application of prior authorization requirements and/or penalties; (b) waiver of out-of-network restrictions (e.g., out-of-network providers paid at the Network Provider level) , (c) extension of time frames for timely claims filing and/or appeals; (d) early replacement of lost or damaged durable medical equipment, and (e) other protocols reasonably required to provide Participants with access to health plan and pharmacy benefits, as applicable. Such protocols are applicable to Participants whose place of residency falls within impacted areas of the Catastrophic Event, and for dates of service that fall within the Catastrophic Event Timeframe.

Section 5 - Service Fees

Section 5.1 Service Fees. Customer will pay fees to United as compensation for services provided by United. In addition to the fees specified in Exhibit B of this Agreement are effective for the Term of the Agreement shown in the Exhibit. In addition to the service fees specified in Exhibit B, Customer must also pay United any additional fee that is authorized by a provision elsewhere in this Agreement or is otherwise agreed to by the parties.

Section 5.2 Changes in Service Fees. United can change the service fees on each Term Period anniversary ("Renewal Term"). United will provide Customer with thirty (30) days prior written notice of the revised service fees for subsequent Renewal Terms. Any such service fee change will become effective on the later of the first day of the new Renewal Term or thirty (30) days after United provides Customer with written notice of the new fees. United will provide Customer with a new Exhibit B that will replace the existing Exhibit B for the new Renewal Term.

United also can change the services fees (i) any time there are changes made to this Agreement or the Plan, which affect the fees, (ii) when there are changes in laws or regulations which affect or are related to the services United is providing, or will be required to provide, under this Agreement, including the Taxes and fees noted in Section 11.3 or (iii) if the number of Employees covered by the Plan or any Plan option changes by ten percent (10%) or more. Any new service fee required by such change will be effective as of the date the changes occur, even if that date is retroactive.

If Customer does not agree to any change in service fees, Customer may terminate this Agreement upon thirty (30) days written notice after Customer receives written notice of the new fees. Customer must still pay any amounts due for the periods during which the Agreement is in effect.

Section 5.3 Due Dates, Payments, and Penalties. For the Standard Medical Service Fees described in Exhibit B, United will provide Customer with an invoice in advance of the first of each month, as long as the premium for the prior month has been received by United. Invoices are generated on: (a) the 10th of each month for direct billing, or (b) the 20th of each month for electronic fund transfers, or (c) the date premium is received by United for the prior month if the previous dates are in the past. If authorized by Customer pursuant to this Agreement or by subsequent authorization, certain fees will be paid through a withdrawal from the Bank Account.

Late Payment: If amounts owed under this section are not paid within thirty (30) days after their Due Date ("Grace Period"), United may charge Customer interest on these amounts at the interest rate that United charges to its self-funded customers. Customer agrees to reimburse United for any costs that United incurs to collect these amounts. United's decision to provide Customer with a Grace Period will be based on United's assessment of Customer's financial condition, as of the Effective Date, and Customer's compliance with material financial obligations. If United determines, based on reasonable information and belief, that Customer's financial condition has deteriorated, or Customer continues to fail to comply with the material financial obligations specified in this Agreement, United may remove the Grace Period upon notice to Customer and reserves the right to either charge interest on payments not received after the Due Date or terminate the Agreement if payments are not received by the Due Date.

Section 5.4 Deferred Service Fees. Customer shall pay United the following Deferred Service Fees:

If both this Agreement and the Stop Loss Policy are in effect at the end of the third calendar month following the close of the Term of the Agreement, Customer shall pay United a Deferred Service Fee equal to one third of the Surplus for the Term of the Agreement. No Deferred Service Fee is due if there is no Surplus for the Term of the Agreement.

If this Agreement or the Stop Loss Policy terminates before the end of the third calendar month following the close of the Term of the Agreement, Customer shall pay United a Deferred Service Fee, calculated as of the Reconciliation Date, equal to the difference between the account balance held in Customer's claim account and the Customer IBNR for the Term of the Agreement.

Section 5.5 Stop Loss Premium. For purposes of convenience, Customer authorizes United to withdraw the amount of any premium due under the Stop Loss Policy from the amounts Customer sends United under Sections 6 or 7 of this agreement.

Section 6 - Providing Funds For Benefits

Section 6.1 Providing Funds for Benefits. The Plan is Self-Funded. Customer is solely responsible for providing funds for payment for all Plan benefits payable to Participants, Network Providers, or non-Network Providers.

Section 6.2 Banking Arrangement. United will establish and maintain a Bank Account on behalf of United's self-funded customers for the sole purpose of payment of Plan benefits, Plan expenses (such as state surcharges or assessments) and when authorized by Customer, service fees. United does not charge Customer banking charges for this account and no interest shall accrue on the funds held in the bank account. The funds held by United on Customer's behalf are Customer's until withdrawn to reimburse United for Plan benefits, expenses and fees.

United will bill Customer for the Maximum Monthly Claim Liability to fund the account for the payment of Plan benefits. Customer's monthly billing will also include any service fees due pursuant to Section 5 and any stop loss premium due the Stop Loss carrier with respect to the Stop Loss Policy. Amounts owed are due and payable on the Due Date shown on the bill. When United receives Customer's payments United will be responsible to apply and transfer the funds to the bank account for Plan benefits and to the stop loss carrier.

Section 6.3 Issuing and Providing Funds for Checks and Non-Draft Payments. The checks United writes and issues to pay Plan benefits under this Agreement will be written on one or more common accounts that are maintained for United's customers. When the checks for Plan benefits are presented to the bank, the bank will notify United and United will direct the bank to accept or reject the checks.

The non-draft payments, if any, United issues to pay Plan benefits under this Agreement will be paid from one or more common accounts that are part of the network of accounts maintained at the bank for United's customers. United will direct the bank to withdraw funds from the amounts Customer maintains with United to fund the non-draft payments.

At any time, Customer's cumulative year to date Maximum Monthly Claim Liability payments may be greater than the sum of the Plan's actual year to date claim payments. In such event, Customer agrees that any such excess funds will be held by United for Customer and used to fund the Plan's claim payments during subsequent months of the Term of the Agreement.

At any time, Customer's cumulative year to date Maximum Monthly Claim Liability payments may be less than the sum of the Plan's actual year to date claims payments. In such event, Customer hereby requests that United advance payments as provided in the Stop Loss Policy (without any interest charge) to fund Plan claim liabilities to the extent of such shortfall. Customer authorizes United to thereafter apply any reimbursement under the aggregate coverage of the Stop Loss Policy to reimburse United for the amount advanced. If no reimbursement is available under the Stop Loss Policy's aggregate coverage, Customer authorizes United to withdraw the amount advanced by United from the then available balance of Customer's Maximum Monthly Claim Liability payments held by United in the Claim Account.

The total claim payments under the Plan on behalf of any one Participant in an Term of the Agreement may exceed the Stop Loss Policy's individual stop loss limit. In that event, Customer requests United to make an advance using United's own funds (without any interest charge) to pay any additional Plan claims incurred by that Participant during the balance of the Term of the Agreement. Customer authorizes United to thereafter apply any reimbursement due under the individual stop loss coverage of the Stop Loss Policy to reimburse United for the amount it has advanced.

Section 6.4 Reconciliation. If both this Agreement and the Stop Loss Policy are in effect at the end of the third calendar month following the close of the Term of the Agreement, United shall conduct a reconciliation after the third calendar month following the close of each Term

of the Agreement (the "Reconciliation Date") and also calculate a reserve (the "Customer IBNR Reserve") for claims incurred during the Term of the Agreement but not paid prior to the Reconciliation Date. United will reconcile the amount of the cumulative Maximum Monthly Claim Liability payments paid to United for the Term of the Agreement over (i) the amount of claims incurred during the Term of the Agreement and paid before the Reconciliation Date, less any specific stop loss insurance reimbursements, and (ii) the Customer IBNR Reserve.

The Customer IBNR Reserve shall be calculated according to the following formula: (5% of the Maximum Monthly Claim Liability amount for the 10th month of the Term of the Agreement) + (10% of the Maximum Monthly Claim Liability amount for the 11th month of the Term of the Agreement) + (25% of the Maximum Monthly Claim Liability for the 12th month of the Term of the Agreement).

The Customer IBNR Reserve or the remaining funds United is holding on Customer's behalf, whichever is less, shall be held by United on Customer's behalf in Customer's claim account for a period of up to sixty (60) months from the first day of the Term of the Agreement, and shall be used to reimburse claims which were incurred during the Term of the Agreement but which were paid after the Reconciliation Date. Any funds remaining in Customer's claim account on the last day of the 60 month period shall be returned to Customer.

If the cumulative Maximum Monthly Claim Liability payments made during the Term of the Agreement exceeds the sum of (a) the actual claims paid less any specific stop loss insurance reimbursements during the Term of the Agreement (b) claims paid less any specific stop loss insurance reimbursements after the Term of the Agreement but prior to the Reconciliation Date, and (c) the Customer IBNR Reserve, a Surplus shall exist. To the extent that there is a Surplus Customer shall be liable for a Deferred Service Fee, as determined pursuant to Section 5.4 of this Agreement. If no Surplus exists, United shall not be entitled to any Deferred Service Fee.

United will provide a final reconciliation report to Customer after the Reconciliation Date. The results of any prior Term of the Agreement reconciliations do not impact reconciliations of subsequent Term of the Agreements.

Section 6.5. Reconciliation In the Event of Early Termination. If this Agreement or the Stop Loss Policy terminates during the Term of the Agreement or before the end of the third calendar month following the close of the Term of the Agreement, United shall conduct a reconciliation after the twenty fourth calendar month following the close of that Term of the Agreement (the "Reconciliation Date") and also calculate a reserve (the "Customer IBNR Reserve") for claims incurred during the Term of the Agreement but not paid prior to the Reconciliation Date. United will reconcile the amount of the cumulative Maximum Monthly Claim Liability payments paid to United for the Term of the Agreement over (i) the amount of claims incurred during the Term of the Agreement and paid before the Reconciliation Date, less any specific stop loss insurance reimbursements, and (ii) the Customer IBNR Reserve. The Customer IBNR Reserve shall be equal to 100% of claim payments made during the three months prior to the Reconciliation Date, and in no event shall the Customer IBNR Reserve be less than $0. Any amount in excess of the Customer IBNR shall be payable to United as a Deferred Service Fee in accordance with the applicable provision in Section 5.4.

The Customer IBNR Reserve or the remaining funds United is holding on Customer's behalf, whichever is less, shall be held by United on Customer's behalf in Customer's claim account for a period of up to sixty (60) months from the first day of the Term of the Agreement, and shall be used to reimburse claims which were incurred during the Term of the Agreement but which were paid after the Reconciliation Date. Any funds remaining in Customer's claim account on the last day of the 60 month period shall be returned to Customer.

United will provide a final reconciliation report to Customer after the Reconciliation Date. The results of any prior Term of the Agreement reconciliations do not impact reconciliations of subsequent Term of the Agreements.

Section 6.6 Underfunding. If Company does not provide the amounts equal to Customer's Maximum Monthly Claim Liability for the month or to cover any withdrawals: (1) Customer must correct the deficiency within one business day and provide prompt notice to United. (2) If United learns of the funding deficiency, United will notify Customer so Customer can correct the deficiency. (3) United may stop issuing checks and non-draft payments and suspend any of United's other services under this Agreement for the period of time Customer does not provide the required funding. (4) If Customer does not provide the required funding, United may terminate this Agreement effective as of the last business day of the calendar month for which Customer made the required funding. The notice provisions contained in Termination Events, Section 8.1, do not apply to this breach.

If this Agreement terminates because Customer has not provided the required funding or service fees, Customer may apply for reinstatement. Reinstatement of this Agreement is in United's sole discretion. United may limit the amount of times that reinstatement is available to Customer.

Customer will authorize United to initiate Automated Clearing House (ACH) transfers from Customer's corporate funding bank account to United's bank account for payment of Plan benefits.

Section 6.7 Outstanding Checks. United will send a search letter to the payee on all checks that have not been cashed within six (6) months.

Section 7 - Term Of The Agreement

Section 7.1 Services Begin. United will begin providing Customer claim processing services under this Agreement on the Effective Date. These services apply only to claims for Plan benefits that are incurred on or after the Effective Date.

This Agreement will apply for an initial Term of the Agreement commencing on the Effective Date and will automatically continue for additional Term of the Agreements, unless and until this Agreement is terminated.

Section 7.2 Services End. United's services under this Agreement stop on the date this Agreement terminates, regardless of the date that claims are incurred. However, United may agree to continue providing certain services beyond the termination date, as provided in Exhibit A - Statement of Work.

Section 8 - Termination

Section 8.1 Termination Events. This Agreement will terminate under the following circumstances:

1. The Plan terminates.
2. Both parties agree in writing to terminate the Agreement.
3. After the initial Term of the Agreement, either party gives the other party at least ten (10) days prior written notice.
4. United gives Customer notice of termination because Customer did not pay the fees or other amounts Customer owed United or Customer's stop loss carrier when due under the terms of this Agreement or any agreement with the stop loss carrier.
5. United gives Customer notice under the terms of this Agreement that the Minimum Participation or Minimum Contribution requirements set forth in Exhibit B are no longer met.
6. As of the last business day of the calendar month for which Customer made the required funding if Customer fails to provide the required funds for payment of benefits under the terms of this Agreement.
7. Either party is in material breach of this Agreement, other than by non-payment or late payment of fees owed by Customer or the funding of Plan benefits, and does not correct the breach within thirty (30) days after being notified in writing by the other party.
8. United may terminate this Agreement in the event of a filing by or against the Customer of a petition for relief under the Federal Bankruptcy Code.
9. Any state or other jurisdiction prohibits a party from administering the Plan under the terms of this Agreement, or imposes a penalty on the Plan or United and such penalty is based on the administrative services specified in this Agreement. In this situation, the party may immediately discontinue the Agreement's application in such state or jurisdiction. Notice must be given to the other party when reasonably practical. The Agreement will continue to apply in all other states or jurisdictions.
10. On the date United gives Customer notice that this Agreement is to be terminated because Customer, its agent, an Employee or Participant made a misrepresentation, concealment or omission of a fact, or a mistake of fact (whether or not a mutual mistake), any of which materially affected the terms and conditions of this Agreement or the underwriting, premium, rating or terms and conditions of the excess loss insurance policy issued by United's affiliate or United's subsidiary to Customer in connection with the Plan.
11. On the date United gives Customer notice of termination because the excess loss insurance policy issued by United's affiliate or United's subsidiary to Customer in connection with the Plan has been terminated, or Customer has received notice of termination of the excess loss insurance policy.
12. As otherwise specified in this Agreement.

Section 9 - Records, Information, Audits

Section 9.1 Records. United will keep records relating to the services United provides under this Agreement for as long as United is required to do so by law.

Section 9.2 Access to Information. If Customer needs information in United's possession for purposes other than an audit, but in order to administer the Plan, United will provide Customer access to that information, if it is legally permissible, the information relates to United's services under this Agreement, and Customer gives United reasonable advance notice and an explanation of the need for such information.

Customer represents that it has reasonable procedures in place for handling PHI, as required by law. Customer will only use or disclose PHI to administer the Plan, to perform under this Agreement, or as otherwise permitted under this Agreement.

Section 9.3 Audits. During the term of the Agreement, and at any time within forty eight (48) months following its termination, Customer or a mutually agreeable entity may audit United once each calendar year to determine whether United is fulfilling the terms of this Agreement. Prior to the commencement of this audit, United must receive a signed, mutually agreeable confidentiality agreement.

Customer must advise United in writing of its intent to audit. The place, time, type, duration, and frequency of all audits must be reasonable and agreed to by United. All audits will be limited to information relating to the calendar year in which the audit is conducted, and/or the immediately preceding calendar year. With respect to United's transaction processing services, the audit scope and methodology will be consistent with generally acceptable auditing standards, including a statistically valid random sample or other acceptable audit technique as approved by United ("Scope").

Customer will pay any expenses that Customer incurs in connection with the audit. In addition, Customer will be charged a reasonable per claim charge and a $1,000 charge per day for audits outside of the following parameters: (1) more than one audit per calendar year; (2) any on-site audit visit that is not completed within five (5) business days; (3) sample sizes exceeding the Scope specified above; or (4) any audit initiated after this Agreement has terminated. The additional fees cover the additional resources, facility fees, and other incremental costs associated with an audit that exceeds the Scope.

In addition to Customer's expenses and any applicable fees, Customer will also pay any extraordinary expenses United incurs in connection with the audit. For any audit initiated after this Agreement is terminated, Customer will pay all expenses incurred by United.

Customer will provide United with a copy of any audit reports within thirty (30) days after Customer receives the audit report(s) from the auditor.

Section 9.4 Use of Confidential Information. Neither Party may disclose the other's Confidential Information to any person or entity other than to the receiving Party's employees and Business Associates needing access to such information to administer the Plan, to perform under this Agreement, or as otherwise permitted under this Agreement.

Notwithstanding the foregoing, (i) United may disclose Customer Confidential Information to its affiliates and subcontractors as needed for those entities to provide services under this Agreement, (ii) Customer will not be prohibited from providing provider-specific cost or quality of care information or data, through a consumer engagement tool or any other means, to referring providers, the Plan Sponsor, Participants, or individuals eligible to become Participants of the Plan, to the extent required by Law, (iii) Customer may only use United’s Confidential Information for Plan administration purposes and (iv) before United’s Confidential Information can be disclosed, United may require a mutually agreed upon confidentiality agreement consistent with Law.

Neither party may sell, license or grant any other rights to the other Party's Confidential Information.

If a Party is requested or required to disclose Confidential Information by subpoena, legal process or applicable law, including public records acts, such Party shall (to the extent permitted by law), provide the other Party with immediate written notice of that request or requirement. Such Party shall reasonably cooperate in any efforts by the other Party to seek an appropriate protective order or other remedy or otherwise challenge or narrow the scope of that disclosure request or requirement. If a protective order or other remedy is not obtained, such Party shall furnish only that portion of the Confidential Information that is legally required.

If Customer requests that United provide information about the Plan that is in United's possession after the Agreement terminates and any applicable run out period has expired, then United may, in its discretion, provide such information subject to a fee.

Section 9.5 PHI. The parties' obligations with respect to the use and disclosure of PHI are outlined in the Business Associate Agreement attached to this Agreement as Exhibit C.

Section 10 - Taxes and Assessments

Section 10.1 Payment of Taxes and Expenses. In the event that any Taxes are assessed against United as a claim administrator in connection with United's services under this Agreement, including all topics identified in Section 10.3 Customer will reimburse United through the balance Customer maintains with United for Customer's proportionate share of such Taxes (but not Taxes on United's net income). United has the authority and discretion to reasonably determine whether any such Tax should be paid or disputed. Customer will also reimburse United for a proportionate share of any cost or expense reasonably incurred by United in disputing such Tax, including costs and reasonable attorneys' fees and any interest, fines, or penalties relating to such Tax, unless caused by United's unreasonable delay or unreasonable determination to dispute such Tax.

Section 10.2 Tax Reporting. In the event that the reimbursement of any benefits to Participants in connection with this Agreement is subject to Plan or employer based tax reporting requirements, Customer agrees to comply with these requirements.

Section 10.3 State and Federal Surcharges, Fees and Assessments. The Plan will remain responsible for state or Federal surcharges, assessments, or similar Taxes imposed by governmental entities or agencies on the Plan, or United, including but not limited to those imposed pursuant to the Patient Protection and Affordable Care Act, of 2010 ("PPACA"), as amended from time to time. This includes the funding, remittance and determination of the amount due for PPACA required Taxes and fees.

Section 11 - Indemnification

Section 11.1 Indemnification of United. Customer shall indemnify United for any and all losses, liabilities, penalties, fines, costs, damages, judgements and expenses, United incurs, including reasonable attorneys' fees and costs, to the extent arising out of one or more of the following: (i) Customer’s breach of this Agreement; (ii) Customer’s design and operation of the Plan and claims brought against United as the claims administrator; and (iii) a breach by a third party of any agreements United enters into with third parties on Customer’s request.

Section 11.2 Indemnification of Customer.

United shall indemnify Customer for any and all claims, losses, liabilities, penalties, fines, costs, damages, judgments and expenses, Customer incurs, including reasonable attorneys' fees and costs, to the extent arising out of one or both of the following: (i) United’s breach of this Agreement; and (ii) a breach by a third party of any agreements United enters into with third parties to perform services under this Agreement.

Customer remains responsible for payment of all benefits and United does not indemnify Customer or the Plan for any claims, losses, liabilities, penalties, fines, costs, damages, judgments, or expenses that constitute payment of Plan benefits.

Section 12 - Plan Benefits Litigation

Section 12.1 Litigation Against United. United will select and retain defense counsel to represent United's and the Plan's interest if a demand is asserted, or litigation or administrative proceedings are begun by a Participant or health care provider against United, or against the Plan and United jointly, to recover Plan benefits, related to United's duties under this Agreement ("Plan Benefits Litigation"). United will select and retain defense counsel to represent its interest.

Section 12.2 Litigation Against Customer. If Plan Benefits Litigation is begun against Customer and/or the Plan, Customer will select and retain counsel to represent its interest.

Section 12.3 Litigation Against United and Customer. If Plan Benefits Litigation is begun against both Customer and United jointly, and provided no conflict of interest arises between the parties, the parties may agree to joint defense counsel. If the parties do not agree to joint defense counsel, then each party will select and retain separate defense counsel to represent their own interests.

Section 12.4 Litigation Fees and Costs. All reasonable legal fees and costs United incurs will be paid by Customer (except as provided in Section 12.2) if United gives Customer reasonable advance notice of United's intent to charge Customer for such fees and costs, and United consults with Customer in a manner consistent with United's fiduciary obligations under ERISA on United's litigation strategy.

Section 12.5 Litigation Cooperation. Both parties will cooperate fully with each other in the defense of Plan Benefits Litigation.

Section 12.6 Payment of Plan Benefits. In all events, Customer is responsible for the full amount of any Plan benefits paid as a result of such litigation.

Section 12.7 Survival. This provision shall survive the termination of this Agreement.

Section 13 - Dispute Resolution

In the event of any dispute, claim, or controversy of any kind or nature between the parties arising out of this Agreement or the Services (“Dispute”), a party may provide written notification of the Dispute to the other party. After such notice, a representative from each party shall meet in person or telephonically and make a good faith effort to resolve the Dispute. If the Dispute is not resolved within thirty (30) days after the parties first meet to discuss it, and either party wishes to pursue the Dispute further, that party will refer the Dispute to binding arbitration.

Any Dispute that has not been resolved pursuant to the above may be submitted to binding arbitration. Either party may initiate arbitration by filing a claim with the American Arbitration Association (“AAA”) in accordance with the then-current Commercial Arbitration Rules of the AAA (“Arbitration Rules”). The arbitration will be conducted in accordance with the Arbitration Rules. In no event may the arbitration be initiated more than one year after the date a party first gave written notification of the Dispute to the other party. The parties will treat the Dispute, the existence of the arbitration and the outcome of the arbitration as confidential. Each party hereby waives any right to a class action arbitration.

Any arbitration proceeding will be conducted at a mutually agreeable location. Any arbitrator may construe or interpret but must not vary or ignore the terms of this Agreement and will be bound by controlling law. No arbitrator has the authority to award punitive, exemplary, indirect or special damages.

Nothing in this Section 13 will be interpreted to limit, waive or nullify any other rights under this Agreement.

Section 14 - System Access

Section 14.1 Access. United grants Customer the nonexclusive, nontransferable right to access and use the functionalities contained within the Systems, under the terms specified in this Agreement. Customer agrees that all rights, title, and interest in the Systems and all rights in patents, copyrights, trademarks, and trade secrets encompassed in the Systems will remain United's. To obtain access to the Systems, Customer will obtain, and be responsible for maintaining, at no expense to United, the hardware, software, and Internet browser requirements United provides to Customer, including any amendments thereto. Customer will be responsible for obtaining an Internet Service Provider or other access to the Internet. Customer will not (i) access Systems or use, copy, reproduce, modify, or excerpt any Systems documentation provided by United in order to access or utilize Systems, for purposes other than as expressly permitted under this Agreement or (ii) share, transfer or lease Customer's right to access and use Systems, to any other person or entity which is not a party to this Agreement. Customer may designate any third party, with prior approval from United, to access Systems on Customer's behalf, provided the third party agrees to these terms and conditions of Systems access and Customer assumes joint responsibility for such access.

Section 14.2 Security Procedures. Customer will use commercially reasonable physical and software-based measures to protect the passwords and user IDs provided by United for access to and use of any web site provided in connection with the services. Customer shall use commercially reasonable anti-virus software, intrusion detection and prevention system, secure file transfer and connectivity protocols to protect any email and confidential communications provided to United, and maintain appropriate logs and monitoring of system activity, Customer shall notify United within a reasonable timeframe of any (a) unauthorized access or damage, including damage caused by computer viruses resulting from direct access connection, and (b) misuse and/or unauthorized disclosure of passwords and user IDs provided by United which impact the System.

Section 14.3 Termination. United reserves the right to terminate Customer's System access (i) on the date Customer fails to accept the hardware, software and browser requirements provided by United, including any amendments thereto or (ii) immediately on the date United reasonably determines that Customer has (i) breached, or allowed a breach of, any applicable provision of this Section or (ii) materially breached or allowed a material breach of, any other applicable provision of this Agreement. Customer's System Access will also terminate upon termination of this Agreement, provided however that if run-out is provided in accordance with Exhibit A - Statement of Work, Customer may continue to access applicable functionalities within the Systems during the run-out period. Upon any of the termination events described in this Agreement, Customer agrees to cease all use of Systems, and United will deactivate Customer's identification numbers, passwords, and access to the System.

Section 15 - Miscellaneous

Section 15.1 Subcontractors. United can use its affiliates or subcontractors to perform United's services under this Agreement. United will be responsible for those services to the same extent that United would have been had United performed those services without the use of an affiliate or subcontractor.

Section 15.2 Assignment. Except as provided in this paragraph, neither party can assign this Agreement or any rights or obligations under this Agreement to anyone without the other party's written consent. That consent will not be unreasonably withheld. Nevertheless, United can assign this Agreement, including all of United's rights and obligations to United's affiliates, to an entity controlling, controlled by, or under common control with United, or a purchaser of all or substantially all of United's assets, subject to notice to Customer of the assignment.

Section 15.3 Governing Law. This Agreement is governed by ERISA and, if applicable, the laws of the State of New York. This provision shall survive the termination of this Agreement.

Section 15.4 Entire Agreement. This Agreement, with its exhibits, constitutes the entire agreement between the parties governing the subject matter of this Agreement. This Agreement replaces any prior written or oral communications or agreements between the parties relating to the subject matter of this Agreement. The headings and titles within this Agreement are for convenience only and are not part of the Agreement.

Section 15.5 Amendment. Except as may otherwise be specified in this Agreement, the Agreement may be amended only by both parties agreeing to the amendment in writing, executed by a duly authorized person of each party.

Section 15.6 Waiver/Estoppel. Nothing in this Agreement is considered to be waived by any party, unless the party claiming the waiver receives the waiver in writing. No breach of the Agreement is considered to be waived unless the non-breaching party waives it in writing. A waiver of one provision does not constitute a waiver of any other. A failure of either party to enforce at any time any of the provisions of this Agreement, or to exercise any option which is provided in this Agreement, will in no way be construed to be a waiver of such provision of this Agreement.

Section 15.7 Notices. Any notices, demands, or other communications required under this Agreement will be in writing and may be provided via electronic means or by United States Postal Service by certified or registered mail, return receipt requested, postage prepaid, or delivered by a service that provides written receipt of delivery.

Section 15.8 Use of Name. The parties agree not to use each other's name, logo, service marks, trademarks or other identifying information without the written permission of the other, except that Customer grants United permission to use Customer's name, logo, service marks, trademarks or other identifying information to the extent necessary for United to carry out United's obligations under this Agreement (e.g. on SPDs and ID cards).

Section 15.9 Compliance with Laws and Regulations. The parties agree to comply with all applicable federal, state and other laws and regulations with respect to this Agreement.

Section 15.10 No Third Party Beneficiaries. Nothing in this Agreement shall confer upon any person other than the parties and their respective successors or assigns, any rights, remedies, obligations, or liabilities whatsoever.

Section 15.11 Severability. The invalidity or unenforceability of any provision of this Agreement will not affect the validity or enforceability of any other provision. However, it is intended that a court of competent jurisdiction construe any invalid or unenforceable provision of this Agreement by limiting or reducing it so as to be valid or enforceable to the extent compatible with applicable law.

Section 15.12 Acceptance. Following the Effective Date and after Customer has provided three (3) months' worth of funds for the processing of claims and/or the payment of administrative fees, this Agreement is deemed executed by the parties.

EXHIBIT A - STATEMENT OF WORK

The following are the administrative services United has agreed to provide to Customer. Customer may request that United provides services in addition to those set forth in this Agreement. If United agrees to provide them, those services will be governed by the terms of this Agreement and any amendments to this Agreement. Customer will pay an additional fee, determined by United, for these additional services.

The services described in this exhibit will be made available to Customer's eligible Participants consistent with the Summary Plan Description under which the Participant is covered.

A. ACCOUNT MANAGEMENT SERVICES

Service	Comments
Implementation and maintenance of account.	
Enrollment meetings and support for locations that meet United's criteria.	Minimum six weeks notice of meeting.
Standard initial enrollment kit.	
Initial enrollment kits are available to the Customer for distribution to Customer's employees on the employer portal.	
Summary Plan Description (SPD) Assistance. United shall provide Customer with a copy for distribution to Customer's participants.	

B. ELIGIBILITY MANAGEMENT SERVICES

Service	Comments
Standard ID Card production and issuance.	

C. UNDERWRITING AND FINANCIAL SERVICES

Service	Comments
Overall program accounting	Customer will receive a Fund Reconciliation report annually. United reserves the right from time to time change the content, format and/or style of our reports.
Annual government filings of 1099 reports to the IRS regarding payments made to physicians and other health care professionals	
Provide required data necessary to enable Customer to file Form 5500.	

Executive Summary Report	This report is issued at least once annually. United reserves the right from time to time change the content, format and/or style of United's reports.
Escheat Services	

D. CLAIMS ADMINISTRATION SERVICES

Service	Comments
Claims for Plan benefits must be submitted in a form that is satisfactory to United in order for United to determine whether a benefit is payable under the Plan's provisions. Customer delegates to United the discretion and authority to use United's claim procedures and standards for Plan benefit claim determination.	
Implementation of Customer's benefit plans.	
Claims accumulator load from one prior carrier using United's standard process.	To populate claim accumulators and deductibles. Additional charges will apply for more than one prior carrier load.
Standard claims processing including: • Re-pricing and payment of claims. • Auto and manual adjudication using proprietary software. • Claim edit/review and cost containment program • Pending and subsequent claim review.	

Service	Comments
Standard claim forms (when applicable).	
Medical claim review of specific health care claims to promote coding accuracy, benefit interpretation, and apply reimbursement policy.	
Standard coordination of benefits for all claims with automated investigation once every 12 months.	
Processing of run-out claims (meaning claims incurred prior to the termination date) for forty eight (48) months following termination.	If the Agreement terminates because Customer fails to pay United fees due, fails to provide the funding for the payment of benefits, or United terminates for any other material breach, run-out will not apply. The fees associated with providing run-out claims processing are included in United's monthly administrative fees as described in

	Exhibit B. No additional fee will apply to run-out claims processing, provided, however, if the Agreement is terminated prior to the end of the initial Term for any reason, there will be an additional fee, determined by United, for the remaining months of the run-out claims processing term. Termination of Run-out Processing Run-out claims processing will terminate if Customer fails to provide the required funds for payment of benefits under the terms of this Agreement. Such termination shall apply to all claims regardless of dates of service.
United will retain **claim fiduciary responsibility** as described in Section 4.	

E. MEMBER SERVICES

Service	Comments
Toll-free access to customer service using a dedicated number	

F. NETWORK SERVICES

Service	Comments
Network access, management and administrative activities	Standard on all network plans.
Maximum Non-Network Reimbursement Program (MNRP) for non-emergency non-network claims.	
Extended Non-Network Reimbursement Program (ENRP). Offers a reimbursement policy on specialty services provided by a non-Network Provider in a facility, including emergency services provided by a non-Network physician or facility.	
Shared Savings Program Application of the Shared Savings Program provides additional savings on select non-Network facility and physician claims not eligible for standard network discounts. Program provides access to discounted charges made available to United from health care providers who contract or will negotiate with, a third party to provide such discounted charges.	The services under this program provide access to provider discounts only and do not include credentialing of providers or other Network services. United is not responsible for the medical outcomes or the quality or competence of any provider or facility rendering services under the Shared Savings Program. Either party can terminate the Shared Savings Program at any time for any reason with written notice.

G. CARE MANAGEMENT AND OUTREACH SERVICES

Service	Comments
Medical policy functions, as guided by a medical director.	Standard on all managed plans.

H. MANAGED PHARMACY SERVICES

Service	Comments
Integrated Pharmacy Services including: • **Claims processing** • **Eligibility management** • **Benefits management** • **Retail Pharmacy Network Management.** • **Retail Point-of-Sale Discount** • **Mail Order Services** • **Customer Care Center Services** - Toll-free access to customer care voice response unit (for location of network pharmacies), and a pharmacist • **Specialty Pharmacy** • **Support staff and account management**	Member retail discount at point-of-sale based on PDL.
Additional programs such as dispense as written (DAW) interventions, retail flags and edits, maximum allowable cost pricing (retail), and generic and mail order programs.	

I. SUBROGATION AND PAYMENT INTEGRITY SERVICES

Service	Comments
Application of subrogation services.	
Abuse and Fraud Management Recovery Program.	The fee includes all work to identify recovery opportunities, research, conduct data analysis, investigate, negotiate settlements without the use of outside counsel, and draft legal documents. If outside counsel is retained for a group of payers seeking the recovery, a proportionate amount of the outside legal fees, equal to the payer's exposure in the case to the total

Service	Comments
	exposure in the case, will be deducted from the gross recovery amount, after the fee has been deducted.
Hospital Bill Audit Program	

EXHIBIT B - SERVICE FEES

This exhibit lists the service fees Customer must pay United for its services during the term of the Agreement. These fees apply for the period from April 01, 2022 through March 31, 2023. Customer acknowledges that the amounts paid for administrative services are reasonable.

Administrative Service Fees - Standard Medical Service Fees

The Standard Medical Fees listed below are based upon the following Minimum Participation and Minimum Contribution requirements:

Minimum Participation Requirement: A minimum of 50 percent participation of all eligible persons is required. Notwithstanding, at least 5 employees or the state mandated minimum, whichever is higher, must enroll.

The Standard Medical Service Fees are the sum of the following:

Employee only	$43.76 per month
Employee + Spouse	$76.08 per month
Employee + Children	$62.20 per month
Family	$96.79 per month

Administrative Service Fees - Optional and Non-Standard Fees

Service Description	Fee
Third Party Liability Recovery (Subrogation) Services	Fee equal to twenty five percent (25%) of the gross recovery amount
Consolidated Appropriations Act, 2021 ("CAA") Support Services. United will support Customer's compliance with the requirements of the CAA, including the No Surprises Act ("NSA"), by the respective enforcement date as follows: • NSA medical billing and the independent dispute resolution ("IDR"): ▪ United will determine if a claim is subject to the NSA billing protections. ▪ If United and a provider are unable to come to an agreement within the prescribed negotiation period for a claim subject to the NSA billing protections, United will manage, direct, and make	United will not charge separate service fees outside of base rates for the CAA Support Services.

decisions and submissions to support the IDR for Customer. ▪ All qualifying payment amounts under the NSA will be calculated based on an insurance market across all self-insured group health plans administered by United. ▪ United will not be using third party provider networks for services covered by the NSA. ▪ The fees for programs in which the parties share in the savings achieved off a provider's billed charge will continue to apply to all services covered under NSA. ▪ Customer shall fund all settlement amounts and payments required as a result of any IDR process decision through the Bank Account. • Revised medical Plan ID cards. • Provider directory enhancements. • Continuity of care and external appeals support for surprise medical bills. • Support related to Mental Health Parity Non-Quantified Treatment Limitations audits initiated by the U.S. Department of Labor, U.S. Department of Health and Human Services or the U.S. Department of Treasury. • Provide language to support Customer's anti-gag clause attestation requirement.	

EXHIBIT C - BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement (BAA) is incorporated into and made to the Administrative Services Agreement (Agreement) between United Healthcare Services, Inc. on behalf of itself and its Affiliates (Business Associate) and Westmoor Country Club ("Covered Entity") and is effective on April 01, 2022 (Effective Date).

The Parties hereby agree as follows:

1. **DEFINITIONS**

a) Unless otherwise specified in this BAA, all capitalized terms used in this BAA not otherwise defined have the meanings established for purposes of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations as amended from time to time (collectively, "HIPAA")

b) "Privacy Rule" means the federal privacy regulations as amended from time to time issued pursuant to HIPAA, and codified at 45 CFR Parts 160 and 164 (Subparts A & E).

c) "PHI" means Protected Health Information, as defined in 45 C.F.R. 160.103, and is limited to the Protected Health Information received from, or received or created on behalf of, Covered Entity by Business Associate pursuant to the performance of the Services.

d) "Security Rule" means the federal security regulations, as amended from time to time, issued pursuant to HIPAA, and codified at 45 CFR Parts 160 and 164 (Subparts A & C).

e) "Services" means, to the extent and only to the extent they involve the receipt, creation, maintenance, transmission, use or disclosure of PHI, the services provided by Business Associate to Covered Entity as set forth in the Agreement, including those set forth in this BAA in Section 4, as amended by written agreement of the parties from time to time.

2. **RESPONSIBILITIES OF BUSINESS ASSOCIATE**

With regard to its use and/or disclosure of Protected Health Information ("PHI"), Business Associate agrees to:

a) not use and/or disclose PHI except as necessary to provide the Services, as permitted or required by this BAA and/or the Agreement, and in compliance with each applicable requirement of 45 C.F.R. 164.504(e) or as otherwise Required by Law; except that, to the extent Business Associate is to carry out Covered Entity's obligations under the Privacy Rule, Business Associate will comply with the requirements of the Privacy Rule that apply to Covered Entity in the performance of those obligations.

b) implement and use appropriate administrative, physical and technical safeguards and comply with applicable Security Rule requirements with respect to Electronic Protected Health Information, to prevent use or disclosure of PHI other than as provided for by this BAA and/or the Agreement.

c) without unreasonable delay, report to Covered Entity: (i) any use or disclosure of PHI not provided for by this BAA and/or the Agreement, of which it becomes aware, in accordance with 45 C.F.R. 164.504(e)(2)(ii)(C); and/or (ii) any Security Incident of which Business Associate becomes aware in accordance with 45 C.F.R. 164.314(a)(2)(i)(C).

d) with respect to any use or disclosure of Unsecured PHI not permitted by the Privacy Rule that is caused solely by Business Associate's failure to comply with one or

more of its obligations under this BAA, Covered Entity hereby delegates to Business Associate the responsibility for determining when any such incident is a Breach. In the event of a Breach, Business Associate shall (i) provide Covered Entity with written notification, and (ii) provide all legally required notifications to Individuals, HHS and/or the media, on behalf of Covered Entity, in accordance with 45 C.F.R. 164 (Subpart D) Business Associate shall pay for the reasonable and actual costs associated with those notifications.

e) in accordance with 45 C.F.R. 164.502(e)(1)(ii) and 45 C.F.R. 164.308(b)(2), ensure that any subcontractors of Business Associate that create, receive, maintain, or transmit PHI on behalf of Business Associate agree, in writing, to the same restrictions and conditions on the use and/or disclosure of PHI that apply to Business Associate with respect to that PHI.

f) make available its internal practices, books, and records relating to the use and disclosure of PHI to the Secretary for purposes of determining Covered Entity's compliance with the Privacy Rule.

g) after receiving a written request from Covered Entity or an Individual, make available, an accounting of disclosures of PHI about the Individual, in accordance with 45 C.F.R. 164.528.

h) after receiving a written request from Covered Entity or an Individual, provide access to PHI in a Designated Record Set about an Individual, in accordance with the requirements of 45 C.F.R. 164.524.

i) after receiving a written request from Covered Entity or an Individual, make PHI in a Designated Record Set about an Individual available for amendment and incorporate any amendments to the PHI, all in accordance with 45 C.F.R. 164.526.

j) comply with the applicable requirements of 42 CFR Part 2 to the extent Covered Entity, a Part 2 program or another lawful holder provides Part 2 Records to Business Associate in accordance with 42 CFR § 2.32 or Subpart D.

3. RESPONSIBILITIES OF COVERED ENTITY

In addition to any other obligations set forth in the Agreement, including in this BAA, Covered Entity:

a) shall provide, to Business Associate only the minimum PHI necessary to accomplish the Services.

b) shall notify Business Associate of any limitations in the notice of privacy practices of Covered Entity under 45 C.F.R. 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.

c) shall notify Business Associate of any changes in, or revocation of, the permission by an Individual to use or disclose his or her PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

d) shall notify Business Associate of any restriction on the use or disclosure of PHI that Covered Entity has agreed to or is required to abide by under 45 C.F.R. 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

e) In the event Covered Entity takes action as described in this Section, Business Associate shall decide which restrictions or limitations it will administer. In addition, if those limitations or revisions materially increase Business Associate's cost of providing Services under the Agreement, including this BAA, Covered Entity shall reimburse Business Associate for such increase in cost.

4. **PERMITTED USES AND DISCLOSURES OF PHI**

Unless otherwise limited in this BAA, in addition to any other uses and/or disclosures permitted or required by this BAA or the Agreement, Business Associate may:

a) make any and all uses and disclosures of PHI necessary to provide the Services to Covered Entity.

b) use and disclose PHI, if necessary, for proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate, on the condition that the disclosures are Required by Law or any third party to which Business Associates discloses PHI for those purposes provides written assurances in advance that: (i) the information will be held confidentially and used or further disclosed only for the purpose for which it was disclosed to the third party or as Required by Law; and (iii) the third party promptly will notify Business Associate of any instances of which it becomes aware in which the confidentiality of the information has been breached.

c) de-identify PHI received or created by Business Associate under this BAA in accordance with the Privacy Rule which de-identified information does not constitute PHI, is not subject to this BAA and may be used and disclosed on Business Associate’s own behalf.

d) provide Data Aggregation services relating to the Health Care Operations of the Covered Entity, in accordance with the Privacy Rule.

e) use and disclose PHI and data as permitted in 45 C.F.R 164.512 in accordance with the Privacy Rule.

f) use the PHI to create, use and disclose a Limited Data Set in accordance with the Privacy Rule.

5. **TERM, TERMINATION AND COOPERATION**

a) Termination. If Covered Entity knows of a pattern of activity or practice of Business Associate that constitutes a material breach or violation of this BAA then the Covered Entity shall provide written notice of the breach or violation to the Business Associate that specifies the nature of the breach or violation. Business Associate must cure the breach or end the violation on or before thirty (30) days after receipt of the written notice. In the absence of a cure reasonably satisfactory to Covered Entity within the specified timeframe, or in the event the breach is reasonably incapable of cure, then Covered Entity may terminate the Agreement and/or this BAA.

b) Effect of Termination or Expiration. After the expiration or termination or expiration for any reason of the Agreement and/or this BAA, Business Associate shall return or destroy all PHI, received from or created or received by Business Associate on behalf of the Covered Entity, if feasible to do so, including such PHI in possession of Business Associate’s subcontractors. In the event that Business Associate determines that return or destruction of the PHI is not feasible, Business Associate may retain the PHI and shall extend any and all protections, limitations and restrictions contained in this BAA to Business Associate’s use and/or disclosure of any PHI retained after the expiration or termination of the Agreement and/or this BAA, and shall limit any further uses or disclosures solely to the purposes that make return or destruction of the PHI infeasible.

c) Cooperation. Each party shall cooperate in good faith in all respects with the other party in connection with any request by a federal or state governmental authority for additional information and documents or any governmental investigation, complaint, action or other inquiry.

6. **MISCELLANEOUS**

a) Construction of Terms. The terms of this BAA to the extent they are unclear shall be construed to allow for compliance by Covered Entity and Business Associate with HIPAA.

b) No Third Party Beneficiaries. Nothing in this BAA shall confer upon any person other than the Parties and their respective successors or assigns, any rights, remedies, obligations, or liabilities whatsoever.

c) Survival. Sections 5.2, 5.3, 6.1, and 6.3 shall survive the termination for any reason or expiration of this BAA or the Agreement.

All Savers Insurance Company

A Stock Company

PO Box 19032, Green Bay, WI 54307-9032

Phone: 1-877-797-8812

All Savers Insurance Company ("Company") agrees to reimburse Westmoor Country Club ("Policyholder") as outlined under the provisions of this Excess Loss Insurance Policy ("Policy").

This Policy is legally binding between the Policyholder and All Savers Insurance Company. The consideration for this Policy includes, but is not limited to, the Application and the Payment of premiums as provided hereinafter.

The Policyholder is entitled to the reimbursement described in this Policy if the Policyholder is eligible for insurance under the provisions of this Policy. Reimbursement is subject to the terms and conditions of this Policy.

The first premium is due on the first (1st) day of the Policy Period. Subsequent monthly premiums are due on the first (1st) day of each month thereafter. The premium is not considered Paid until the Company receives the premium payment.

All periods of coverage will begin and end 12:01 a.m. local time at the principal office of the Policyholder.

This Policy is delivered in and is governed by the laws of the state of issue.

IN WITNESS WHEREOF All Savers Insurance Company has caused this Policy to be executed by its authorized Company officer.

Chief Executive Officer

EXCESS LOSS INSURANCE POLICY

All Savers Insurance Company

A Stock Company

PO Box 19032, Green Bay, WI 54307-9032

Phone: 1-877-797-8812

SCHEDULE OF BENEFITS

This Schedule of Benefits is only applicable to Excess Loss Insurance provided by the Company during the Policy Period shown below.

Policyholder: Westmoor Country Club

Policy Number: 1427074

Original Effective Date: April 1, 2022

Subsequent Policy Period Effective Date: April 1st of each year, beginning in 2023

Administrator: United Healthcare Services, Inc.

Coverage specified herein is applicable only during the Policy Period from April 01, 2022 to March 31, 2023, and is further subject to all terms and conditions of this Policy.

SPECIFIC EXCESS LOSS INSURANCE (X) Yes ( ) No

Incurred Benefit Period: From 04/01/2022 through 03/31/2023

Paid Benefit Period: From 04/01/2022 through 03/31/2027

Specific Deductible per Covered Person: $15,000

Specific Percentage Reimbursable: 100%

Maximum Specific Benefit per Covered Person: unlimited

Specific Excess Loss Insurance includes:

(X) Medical (X) Stand Alone Prescription Drug Program

Description: P4000i80LXES21	Rates
Employee	$256.39
Employee + Spouse	$620.46
Employee + Children	$464.06
Family	$853.77

AGGREGATE EXCESS LOSS INSURANCE (X) Yes ( ) No

Incurred Benefit Period: From 04/01/2022 through 03/31/2023

Paid Benefit Period: From 04/01/2022 through 03/31/2027

Aggregate Excess Loss Insurance includes:

(X) Medical (X) Stand Alone Prescription Drug Program ( ) Dental Care

( ) Weekly (Disability) Income ( ) Vision Care

Aggregate Percentage Reimbursable: 100%

Maximum Aggregate Benefit: unlimited

Minimum Annual Aggregate Deductible: N/A

Runout Deductible: 125% multiplied by the incurred but unreported Covered Expenses, determined as of the first day of the 4th month immediately following the last day of the Incurred Benefit Period.

Maximum Covered Expenses per Covered Person accumulating toward the Maximum Aggregate Benefit: N/A

P4000i80LXES21

Monthly Aggregate Factors:	
	Medical and Prescription Drugs
Employee	$112.62
Employee + Spouse	$272.54
Employee + Children	$203.84
Family	$375.02

P4000i80LXES21

Aggregate Excess Loss Premium	
	Medical and Prescription Drugs
Employee	$25.03
Employee + Spouse	$60.57
Employee + Children	$45.30
Family	$83.35

SPECIAL CONDITIONS: N/A

DEFINITIONS

ADMINISTRATOR means a firm or person who has been retained by the Policyholder to provide administrative services on behalf of the Policyholder/Plan. An Administrator shall, at all times, be the agent of the Policyholder and shall not be deemed to be an agent of the Company.

ANNUAL AGGREGATE DEDUCTIBLE for any one Policy Period means the greater of: (a) sum of the Monthly Aggregate Deductibles; or (b) the Minimum Annual Aggregate Deductible.

BENEFIT PERIOD means the period of time specified in the Schedule of Benefits.

COVERED EXPENSE means medical or other expenses under the Plan to which this Policy applies, as shown in the Schedule of Benefits, and which are not specifically excluded by the terms of this Policy. Covered Expense does not include any payment for the cost of administrating the Plan or other Policyholder contracted services.

This Policy will reimburse, as a Covered Expense, the patient services tax as imposed by the New York Care Reform Act of 1996 (HCRA) or the surcharge imposed by the Massachusetts Uncompensated Care Pool. Any other tax or surcharge levied by any state or other governmental subdivision will not be considered a Covered Expense under this Policy.

COVERED PERSON(S) means each person covered under the Plan.

COVERED UNITS(S) means the types of Covered Units and the factors and premium rates for each type as shown in the Schedule of Benefits.

EFFECTIVE DATE is the date set forth in the applicable Schedule of Benefits.

INCURRED means with respect to medical services or supplies, the date on which the services are rendered or supplies are purchased by the Covered Person.

INCURRED BENEFIT PERIOD means the period of time specified in the Schedule of Benefits in which a Covered Expense must be Incurred by the Covered Person to be eligible for reimbursement under this Policy. This period does not alter the Effective Date, Policy Period, or waive this Policy's eligibility requirements.

MONTHLY AGGREGATE DEDUCTIBLE means, with respect to a particular month, the total number of Covered Units for that given Policy month multiplied by the corresponding Monthly Aggregate Factors as specified in the Schedule of Benefits.

PAID BENEFIT PERIOD means the period of time specified in the Schedule of Benefits in which a Covered Expense that has been Incurred by a Covered Person during the Incurred Benefit Period must be Paid by the Plan to be eligible for reimbursement under this Policy. This period does not alter the Effective Date, Policy Period, or waive this Policy's eligibility requirements.

PAY, PAID, PAYMENT means under the Specific Excess Loss, on the date the Policyholder's check of Payment of a Plan benefit is issued by the Administrator or when a credit of funds for Payment of a Plan benefit has been debited by the Policyholder's bank account. Under the Aggregate Excess Loss, on the date the Policyholder's check for Payment of a Plan benefit has been presented through the collecting bank and reported to the Administrator or when a credit of funds for Payment of a Plan benefit has been debited by the Policyholder's bank account.

PLAN means the self-funded health care plan established by the plan sponsor to provide certain benefits to Covered Persons.

PLAN DOCUMENT means the written document approved by the Policyholder. A copy of the Plan Document in effect on the Effective Date is attached to the application for Excess Loss Insurance.

POLICY PERIOD means the specified period in the Schedule of Benefits, however beginning no earlier than the Effective Date of this Policy and continuing until coverage terminates in accordance with the Termination Provisions.

SPECIFIC DEDUCTIBLE is set forth in the Schedule of Benefits. The Specific Deductible will apply separately to each Benefit Period.

SUBMITTED means the date the Covered Person's claim for a benefit is submitted to and date stamped by the Administrator provided the claim is for a Covered Expense and promptly Paid under the terms of the Plan.

REIMBURSEMENT PROVISIONS

NOTICE OF COVERED EXPENSE The Policyholder authorizes the Administrator to file claims on its behalf under this Policy. The Policyholder authorizes the Company to reimburse Covered Expenses to the Administrator for deposit into the bank account maintained by the Policyholder for the funding of benefits under the Plan.

PAYMENT BY PLAN While the determination of benefits under the Plan is the sole responsibility of the Policyholder, the Company reserves the right to interpret the terms and conditions of the Plan Document as it applies to this Policy. The Company will have the sole authority to reimburse or deny reimbursement under this Policy.

SPECIFIC EXCESS LOSS INSURANCE

The Schedule of Benefits indicates whether Specific Excess Loss Insurance is provided under this Policy. If, while this Policy is in effect, the Covered Expenses for a Covered Person for the applicable Benefit Period exceed the Specific Deductible, the Company will reimburse the Policyholder, subject to the terms and conditions of this Policy including the limits set forth in the Schedule of Benefits.

The amount of the reimbursement will be equal to the Specific Percentage Reimbursable times the amount by which Covered Expenses exceed the Specific Deductible amount, but will not exceed the Maximum Specific Benefit.

Covered Expenses for any Covered Person during the Policy Period will be determined according to the Benefit Period described in the Schedule of Benefits.

If Specific Excess Loss Insurance terminates before the end of the Policy Period, the Specific Deductible will not be reduced.

AGGREGATE EXCESS LOSS INSURANCE

The Schedule of Benefits indicates whether Aggregate Excess Loss Insurance is provided under this Policy. If the Covered Expenses for the applicable Benefit Period exceed the Annual Aggregate Deductible for the Policy Period, the Company will reimburse the Policyholder, subject to the terms and conditions of this Policy including the limits set forth in the Schedule of Benefits.

With respect to the Incurred Benefit Period, the amount of the reimbursement will be equal to the Aggregate Percentage Reimbursable times the amount by which Covered Expenses exceed the Annual Aggregate Deductible amount.

During the portion of the Paid Benefit Period that begins on the first day of the 4th month immediately following the last day of the Incurred Benefit Period, if Covered Expenses do not exceed the Annual Aggregate Deductible, but exceed the Runout Deductible, the Company will reimburse the Policyholder. The amount of the reimbursement will be equal to the Aggregate Percentage Reimbursable times the amount by which Covered Expenses exceed the Runout Deductible.

The total Aggregate Excess Loss Insurance reimbursement will not exceed the Maximum Aggregate Benefit. Covered Expenses will not include any amounts reimbursed by the Company under any other provision of this Policy. If the Policyholder’s coverage terminates before the end of the Policy Period, the accumulated Annual Aggregate Deductible will apply.

PREMIUMS AND FACTORS PROVISIONS

PAYMENT OF PREMIUMS For coverage to remain in effect, any subsequent monthly premium must be received by the Company by the first (1st) day of each month. Premiums are not considered Paid until the Company receives the premium payment. Premiums or other payments made by the Policyholder to their Administrator or Agent or Broker shall not be deemed or considered payments to the Company until actually received by the Company. The entire amount of the applicable premium shall be paid when due. The Company is not obligated to accept or apply any premium paid which is less than the entire amount due for any period. Premium payments shall be credited first to any past due and unpaid premium, in the order in which due.

A late payment charge may be assessed for any premiums not received within ten (10) calendar days following the due date. A service charge will be assessed for any non-sufficient-fund check received in payment of premiums. The Policyholder will reimburse the Company for any attorney's fees and any other costs related to collecting delinquent premiums.

GRACE PERIOD A Grace Period of thirty-one (31) days from the due date will be allowed for the payment of each premium after the first. During the Grace Period, the coverage will remain in effect provided the full premium is Paid before the end of the Grace Period. With ten (10) days prior written notice, coverage will terminate as of the end of the Grace Period. The Company will subtract the premium due for the Grace Period from any benefits payable.

PREMIUM AMOUNT The premiums will be calculated using rates determined by the Company as set forth in the Schedule of Benefits. The amount of total premium due each month is the sum obtained by multiplying the applicable premium rates shown in the Schedule of Benefits by the actual number of appropriate Covered Units.

The Policyholder will be liable for any premium taxes, fees or other charges assessed at any time against the Company or paid on behalf of the Plan, beyond any taxes, fees or other charges which may be payable on the premium received by the Company.

All requests for adjustments, credits or refunds because of overpayment of premiums shall be reported, in writing, with accompanying detail within sixty (60) days after termination of the applicable Policy Period

The Company will not refund any portion of the premiums Paid if this Policy terminates during this Policy Period. The Company shall be entitled to reduce the reimbursements due the Policyholder under this Policy against any premiums due and unpaid, any overpayments or other reimbursements made in error or upon incorrect information, and any other amounts due the Company.

PREMIUM RATE AND MONTHLY AGGREGATE FACTOR CHANGE The Company may change the Policyholder's premium rates or factors for any of the following:

a) the date when the terms of this Policy are changed;

b) the date the Plan Document changes are accepted by the Company;

c) the date the Policyholder adds or deletes subsidiary or affiliated companies or divisions;

d) the date the number of Covered Units on any premium due date varies more than ten percent (10%) from the number of Covered Units as of the first month of the Policy Period, or

e) the date the Policyholder changes its Administrator.

TERMINATION PROVISIONS

This Policy and coverage provided hereunder will terminate upon the earliest of:

a) the premium due date of any premium which remains unpaid at the end of the Grace Period;

b) the premium due date next following receipt by the Company of written notice from the Policyholder that this Policy is to be terminated;

c) the date of termination of the Plan;

d) the date the Policyholder suspends active business operations or dissolves;

e) the end of the Policy Period; or

f) after a 10 day written notice is sent to the Policyholder.

This Policy may also be terminated, at the Company's option on the earliest of:

a) the last day of the second (2nd) consecutive month during which there are less than five (5) employees enrolled in the Plan, unless the Company agrees, in writing, to continue coverage; or

b) the date the Policyholder fails to comply with the terms of this Policy.

This Policy may also be terminated on the Policy anniversary date by the Company giving sixty (60) days advance written notice that this Policy will end, or such other notice as required by law.

The Company will not refund any portion of the premiums paid if this Policy is terminated during the Policy Period.

SUBSEQUENT POLICY PERIOD PROVISIONS

At the end of a Policy Period, this Policy may have a Subsequent Policy Period only by mutual agreement of the Policyholder and the Company and provided that the Company has not given a sixty (60) day termination notice or such other termination notice as required by law. The Subsequent Policy Period may be subject to new premium rates, factors, new underwriting terms, new Benefit Period and other new Policy terms. The terms and conditions for a subsequent Policy Period will be evidenced by the issuance of a new Schedule of Benefits by the Company, which shows the new premium rates, Benefit Period and other new terms.

GENERAL PROVISIONS

ADMINISTRATOR The Policyholder may retain an Administrator to act as an agent for the Policyholder in performing any or all of the duties as designated by the Policyholder. Without waiving any of its rights under this Policy, and without making the designated Administrator a party to this Policy, the Company agrees to recognize the Administrator as an agent of the Policyholder. The Policyholder will immediately notify the Company in writing if the agreement between the Policyholder and the Administrator terminates.

ASSIGNMENT The Policyholder may not assign the Policyholder's interest in or reimbursement under this Policy, and the Company will not recognize any such assignment.

AUDITS The Company will have the right: (a) to inspect and audit all records and procedures of the Policyholder and Administrator, developed and maintained for the Plan, that are applicable to the administration of this Policy; and (b) to require, upon request, proof satisfactory to the Company that Payment has been made to the Covered Person or the provider of such services or benefits which are the basis for any Loss by the Policyholder hereunder.

CHANGES TO THE PLAN DOCUMENT If the Plan Document in effect on the Effective Date is subsequently amended, notice of the amendment will be given to the Company prior to the effective date of the change. If the Company does not give written acceptance of the amendment, the Company will only provide coverage under this Policy consistent with the Plan Document prior to amendment. The Company's reimbursement will be made according to the amended Plan, once the notice is received and accepted.

CHANGES TO THE POLICY Only the President, a Vice President, or the Secretary of the Company have the authority to alter this Policy, or to waive any of the Company's rights and then only in writing. No such alteration of this Policy shall be valid unless endorsed and attached to this Policy. No agent, broker, or Administrator has the authority to alter this Policy or to waive any of its provisions.

CLERICAL ERROR Clerical errors, whether by the Policyholder or by the Company, in keeping or transmitting any records pertaining to the coverage, will not invalidate or limit coverage otherwise validly in force nor continue coverage otherwise validly terminated. Clerical error does not include any failure of the Policyholder, the Administrator or any agent of the Policyholder: (a) to comply with the requirements relating to notice of claims or payment of claims; or (b) to disclose underwriting information requested by the Company, whether or not intentional and regardless of the actual knowledge of the person providing the information.

CONFORMITY WITH LAW If any provision of this Policy is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements of such law.

ENTIRE CONTRACT The Entire Contract between the Company and the Policyholder will consist of this Policy, Schedule of Benefits, application, approved amendments or endorsements, and a copy of the Plan Document, which is on file with the Company.

INSOLVENCY Nothing in this Policy shall either relieve an insolvent or bankrupt Policyholder from the obligation to pay premiums when due or delay or abate cancellation of this Policy for failure to do so. The insolvency, bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors, or dissolution of the Policyholder or the Policyholder's Administrator will not impose upon the Company any liability other than the liability defined in this Policy. In particular, the insolvency of the Policyholder will not make the Company liable to the creditors of the Policyholder, including Covered Persons under the Plan.

LEGAL ACTION The Policyholder cannot file suit until sixty (60) days after the date on which proof of loss is given to the Company. The Policyholder cannot file suit more than three (3) years after the date on which the Policyholder must give the Company proof of Loss.

LIABILITY The Company will have neither the right nor the obligation under this Policy to directly pay any Covered Person or provider of professional or medical services. The Company's sole liability is to the Policyholder, subject to the terms and conditions of this Policy. Nothing in this Policy shall be construed to permit a Covered Person to have a direct right of action against the Company. The Company will not be considered a party to the Plan of the Policyholder, or to any supplement or amendment to it.

MISSTATED DATA, CONCEALMENT, FRAUD The Company has relied on the information provided by the Policyholder, the Administrator or any agent of the Policyholder, in the issuance of this Policy, or for any Subsequent Policy Period. In the event of a misrepresentation, concealment or omission of a fact, or a mistake of fact (whether or not a mutual mistake), any of which materially affect the underwriting, premium, rating or terms and conditions of this Policy, the Company may, at its option:

a) increase premium rates, attachment points and/or otherwise change the terms and conditions of this Policy. Such increase or change to be effective retroactively to the Effective Date or as of any premium due date thereafter, or

b) terminate this Policy as of the next premium due date.

The Company may declare this Policy null and void in its inception if, whether before or after a claim, the Policyholder, Administrator or any agent of the Policyholder, has willfully or intentionally misrepresented, concealed, omitted any material fact affecting terms, conditions, or underwriting of this Policy. In such event, the Company's liability under this Policy shall be limited to refunding premiums paid by the Policyholder after deducting therefrom the amount of any Covered Expenses reimbursed by the Company to the Policyholder prior to the date of termination. If the amount of the Covered Expenses reimbursed by the Company to the Policyholder exceeds the premiums paid by the Policyholder, the Policyholder shall pay the Company the difference within thirty (30) days of the date the Company notifies the Policyholder of such difference.

NOTICE FROM THE COMPANY TO THE POLICYHOLDER For the purpose of any notice required from the Company under the provisions of this Policy, notice to the Policyholder's Administrator shall be considered notice to the Policyholder and notice to the Policyholder shall be considered notice to the Policyholder's Administrator.

NOTICE OF COMPLAINT, APPEAL, LEGAL ACTION As a condition precedent to the Company reimbursing the Policyholder in any settlement or judgment for a disputed Covered Expense, the Policyholder shall immediately inform the Company of any notice of appeal, notice of legal action, or objection, demand or complaint which the Policyholder received regarding any Covered Expense that may be reimburse under this Policy.

OTHER COVERAGE The reimbursement provided by this Policy is in excess of other coverage such as group insurance, excess insurance, insurance, plan benefits, including insurance or plan benefits established by any federal, state, or local law.

PARTIES TO THE POLICY The parties to this Policy are the Policyholder and the Company. The Company's sole liability under this Policy is to the Policyholder. This Policy does not create any right or legal relation between the Company and a Covered Person under the Plan. This Policy will not be deemed to make the Company a party to any agreement between the Policyholder and the Administrator.

POLICYHOLDER REQUIREMENTS The Policyholder agrees to provide funds for Payment of all eligible expenses under the Plan. If the Policyholder fails to provide funds for timely Payment (a) coverage under this Policy will immediately terminate; after ten (10) days prior written notice and (b) any Aggregate and/or Specific Deductible will be deemed not satisfied.

RECORDS The Policyholder will maintain records of all Covered Persons under the Plan during the Policy Period and for a period of seven (7) years after the end of the Policy Period. The

Policyholder will make all such records available to the Company as needed to evaluate its liability under this Policy.

The Policyholder will maintain a separate record of any and all amounts Paid in excess of benefits eligible under the Plan.

SEVERABILITY CLAUSE Any clause deemed void, invalid, or otherwise unenforceable, whether or not such a provision is contrary to public policy, will not render any of the remaining provisions of this Policy invalid.

TERMINATION OF THE POLICYHOLDER'S PLAN The Policyholder will immediately notify the Company, if the Plan is terminated.

THIRD PARTY RECOVERY The Policyholder shall cause the Plan to undertake to pursue any and all valid claims the Plan or a Covered Person may have against third parties arising out of any occurrence resulting in a payment by the Plan or reimbursement by the Company. The Policyholder will account for and pay to the Company any amounts recovered which are reimbursable by the Company to the Policyholder under this Policy, regardless of whether this Policy is still in force on the date of recovery. Third party shall mean a person, entity or insurance company other than the Plan, the Policyholder or a Covered Person. An insurance company shall include insurance companies providing third party liability coverage, or other insurance coverage; i.e. no fault, uninsured, under insured or other similar coverage.

The Policyholder or Administrator shall notify the Company immediately upon discovering that a claim against a third party may exist. Should the Policyholder or the Administrator fail to pursue any valid claims against a third party, the Policyholder shall cause the Plan to assign its subrogation and third party recovery rights to the Company so as to allow the Company to pursue third party recoveries for Covered Expenses reimbursable to the Policyholder. In the event of such assignment, the Company shall have to exercise and enforce all of the Policyholders and/or Plan's rights against such third party. The Policyholder shall furnish such information, assistance, cooperation and execute and deliver such instruments, all as are necessary for the Company to pursue third party recoveries pursuant to this provision.

The Company's right to third party recoveries, as provided for in this provision, shall constitute and impose a trust and first-priority lien arising from any cause of action, settlement, judgment or arbitration award against a third party.

The Policyholder shall pay the Company all amounts recovered, whether by suit, settlement, alternative dispute resolution, including but not limited to arbitration or mediation, or otherwise, from any third party or their insurer to the extent of Covered Expenses regardless of whether such recovery shall be a full or partial recovery. If a third party recovery received by the Plan or Policyholder is less than the total amount paid by the Plan on behalf of the Covered Person, the Company shall be entitled to recover first, in full, any Covered Expense reimbursed by the Company under this Policy. The Company's recovery shall not be reduced by any attorney's fees incurred by the Policyholder, Plan or Covered Person unless the Company otherwise agrees in writing. All remaining amounts shall be paid to the Policyholder.

WAIVER Failure of the Company to strictly enforce its rights under this Policy shall not waive any such right, regardless of the frequency or similarity of the circumstances.

GENERAL EXCLUSIONS PROVISIONS

The Company will not reimburse the Policyholder for any of the following:

a) Any payment which does not strictly comply with the terms and conditions of the Plan Document;

b) Any payment or expense caused by or resulting from war, declared or undeclared or international armed conflict;

c) Any payment for litigation costs and expenses, extra-contractual damages, compensatory damages, interest, exemplary and punitive damages or liabilities, including but not limited to those resulting from negligence, intentional wrongs, fraud, bad faith or strict liability on the part of the Policyholder, Plan, Administrator or any agent or representative of the Policyholder, Plan or Administrator;

d) Any payment for occupational accidents or illnesses which are also eligible expenses covered by Workers' Compensation or Occupational Disease law, or similar legislation, whether or not coverage under such law is actually in force.

MISSTATED DATA ENDORSEMENT

Policyholder: Westmoor Country Club

Effective Date: April 01, 2022

The Policy is modified as described in this Endorsement.

The following provision replaces the provision in the Policy in the General Provisions section:

MISSTATED DATA, CONCEALMENT, FRAUD The Company has relied on the information provided by the Policyholder, the Administrator, any agent of the Policyholder, or any Covered Person under the Plan in the issuance of this Policy, or for any Subsequent Policy Period. In the event of a misrepresentation, concealment or omission of a fact, or a mistake of fact (whether or not a mutual mistake), any of which materially affect the underwriting, premium, rating or terms and conditions of this Policy, the Company may, at its option:

a.) increase premium rates, attachment points and/or otherwise change the terms and conditions of this Policy. Such increase or change to be effective retroactively to the Effective Date or as of any premium due date thereafter, or

b.) terminate this Policy as of the next premium due date.

The Company may declare this Policy null and void in its inception if, whether before or after a claim, the Policyholder, Administrator, any agent of the Policyholder, or any Covered Person under the Plan has willfully or intentionally misrepresented, concealed, omitted any material fact affecting terms, conditions, or underwriting of this Policy. In such event, the Company?s liability under this Policy shall be limited to refunding premiums paid by the Policyholder after deducting therefrom the amount of any Covered Expenses reimbursed by the Company to the Policyholder prior to the date of termination. If the amount of the Covered Expenses reimbursed by the Company to the Policyholder exceeds the premiums paid by the Policyholder, the Policyholder shall pay the Company the difference within thirty (30) days of the date the Company notifies the Policyholder of such difference.

All other provisions of the Excess Loss Insurance Policy remain unaffected by this Endorsement.

Mary Zarn, Chief Executive Officer

All Savers Insurance Company

BY:

Title:

Date:

AGGREGATE ACCOMMODATION ENDORSEMENT

Policyholder: Westmoor Country Club

Effective Date: April 01, 2022

In consideration for the premium shown in the Schedule of Benefits, the Company will provide advance Aggregate Excess Loss Insurance subject to the special terms and conditions of this provision. This Endorsement will continue in full force and effect for the duration of that Policy Period and each subsequent Policy Period.

Covered Expenses will be determined on the same basis as under the Aggregate Excess Loss Insurance, the Company will provide an advance to the Policyholder equal to the amount by which Covered Expenses exceed the Aggregate Accumulated Accommodation Point, less the amount of any prior advances not repaid.

Aggregate Accumulated Accommodation Point for any one Policy Period means the greater of:

a.) the sum of the Monthly Aggregate Deductibles to date, calculated by multiplying the Monthly Aggregate Factors as set forth in the Schedule of Excess Loss times the monthly Covered Units, or

b.) the Minimum Annual Aggregate Deductible as shown in the Schedule of Excess Loss and as prorated by the number of expired months of the Policy Period.

TERMS AND CONDITIONS Any advance provided under this provision will at all times be considered funds of the Company. Except as set forth in this provision, all terms, conditions, and provisions of the Policyholder's Excess Loss Insurance will apply.

The advance includes an obligation of repayment by the Policyholder to the Company under the terms and conditions as provided in the Repayment Provision.

No advance will be paid during any month until all premium due for the month has been received by the Company.

REPAYMENT PROVISION If the Policyholder's Covered Expenses under the Aggregate Excess Loss Insurance are less than the Aggregate Accumulated Accommodation Point, the Policyholder must promptly make repayment to the Company equal to the amount that the Aggregate Accumulated Accommodation Point exceeds the Policyholder's Covered Expenses under the Aggregate Excess Loss Insurance.

After an advance is made, and until it is fully repaid, the Policyholder's repayment will be considered outstanding in any month during which the Policyholder's Covered Expenses under the Aggregate Excess Loss Insurance are less than Aggregate Accumulated Accommodation Point.

The Company will have preference over all other claimants for the return of any advance made under this provision. Further, the Policyholder will be liable for all costs and expenses (including reasonable attorney fees) incurred in the collection of any advance outstanding. If the Policyholder fails to make repayment when due, the Company, at its option, may;

a.) deduct the outstanding advance due from any reimbursement due from the Policyholder's Specific or Aggregate Excess Loss Insurance; or

b.) terminate this provision, or at the Company's option, terminate the Excess Loss Insurance Policy.

At the end of the Policy Period, the Policyholder's repayment obligation to the Company will equal the sum of all advances made during the Policy Period less the amount due under the Policyholder's Aggregate Excess Loss Insurance. A final repayment of any balance due must be made within thirty (30) days of the end of the Policy Period.

All other provisions of the Excess Loss Insurance Policy remain unaffected by this Endorsement.

Mary Zarn, Chief Executive Officer

All Savers Insurance Company

BY:

Title:

Date: