

RISK MANAGEMENT SERVICES AGREEMENT

This Risk Management Services Agreement (“Agreement”) is between the undersigned Plan Sponsor (“Employer”) and John Alden Life Insurance Company, Fortis Insurance Company, Fortis Benefits Insurance Company or any of their affiliates (“Service Provider”). This Agreement shall become effective on the later of the date this Agreement is signed by the parties or the date of the approval of the Employer’s stop loss Insurance (the “Effective Date”). **WHEREAS**, Employer maintains a self-funded welfare benefit plan providing for the payment or reimbursement of certain medical expenses incurred by eligible employees of the Employer and their dependents; and **WHEREAS**, Service Provider is in the business of providing certain administrative services relating to self-funded welfare benefit plans; and **WHEREAS**, Service Provider and the Employer have determined it is in their best interests to enter into this Agreement pursuant to which Service Provider will render administrative services with respect to the Plan. **NOW, THEREFORE**, in consideration of the promises and mutual covenants and agreements set forth herein, the parties agree as follows:

SECTION 1 – DEFINITIONS

Agreement Period: Period of 12 months commencing on the Effective Date and each immediately succeeding 12-month period until the Agreement is terminated.

Employee: A current or former employee of the Employer.

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

Network Provider: Health care provider who participates in one of the Managed Care Networks.

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

Plan: The Employee Health Care Plan sponsored by Employer which is a self-funded plan governed by ERISA providing for the payment of certain medical expenses incurred by Participants.

Plan Administrator: “Administrator” or “Plan Administrator” as these terms are defined under ERISA and shall refer to the current or succeeding person, or entity designated as such by the terms of the instrument under which the Plan is operated, or by law.

Plan Sponsor: The person acting on behalf of the Plan who executes this Agreement.

Proprietary Business Information: Information about the Employer’s business or Service Provider’s business that is confidential, proprietary, trade secret or is not readily available to the general public; or, information that has been designated by the Employer or Service Provider as confidential or proprietary.

Provider Network: Network of Network Providers 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.

Self-Fund and Self-Funded: Means that the Employer has the sole responsibility to pay and provide funds for all Plan benefits; provided, however, that the Employer may require Participant contributions to the Plan and may obtain stop loss insurance with respect to the Plan.

Third Party Administrator (“TPA”): Means the licensed administrator which administers claims and other matters on behalf of the Plan.

SECTION 2 – EMPLOYEE BENEFIT PLAN

Section 2.1 Responsibility for the Plan. The Employer shall have responsibility for the Plan including its benefit design and compliance with any laws that apply to the Employer or the Plan, whether or not the Employer or someone the Employer designates is the Plan administrator. Service Provider is not the Plan Administrator or a fiduciary of the Plan.

Section 2.2 The Plan Document. The Employer or TPA will provide Service Provider with a copy of the Plan document.

Section 2.3 Plan Changes. The Employer or TPA will notify Service Provider in writing if the Employer changes the Plan’s benefits or other relevant Plan provisions, including termination of the Plan, within 60 days prior to the change becoming effective. Service Provider may give the Employer 30 days written notice of termination of this Agreement following Service Provider’s receipt of the Employer’s notice of such change(s). If Service Provider decides to continue providing services, the Employer will pay Service Provider for any reasonable costs that Service Provider incurs to implement the Plan changes. In addition, the fees the Employer is required to pay hereunder may be changed by Service Provider in accordance with Section 7 of this Agreement.

SECTION 3 – RECORDS, INFORMATION, AUDIT

Section 3.1 Records. Service Provider will keep records relating to the services it provides under this Agreement for as long as it is required to do so by law.

Section 3.2 Access to Information. If the Employer needs information for an audit or otherwise that Service Provider has in its possession to administer the Plan, Service Provider will give the Employer access to that information as long as the information relates to Service Provider’s services under this Agreement, and the Employer gives 60 days prior notice of the need for the information.

Section 3.3 Audits. During the term of the Agreement, and at any time within 6 months following its termination, the Employer or a mutually agreeable entity may audit Service Provider to determine whether Service Provider is fulfilling the terms of this Agreement. The Employer must give the Service Provider at least 60 days advance notice of Employer's intent to audit. The place, time, type, duration, and frequency of all audits must be reasonable and agreed to by Service Provider. All audits shall be limited to information relating to the calendar year in which the audit is conducted and/or the immediately preceding calendar year.

The Employer will pay any audit-related expenses, and will be charged an additional fee, determined by Service Provider, for more than one audit every 12 months or for any on-site audit visit not completed within 5 business days. The Employer also will pay any unanticipated expenses Service Provider incurs and all expenses incurred by Service Provider on any audit initiated after this Agreement is discontinued. The Employer will provide Service Provider with a copy of any audit reports.

Section 3.4 – Confidential Participant health information shall be used solely according to the terms set forth in the Business Associate Agreement, attached as Exhibit 1.

SECTION 4 – INDEMNIFICATION

Section 4.1 The Employer Indemnifies Service Provider. The Employer will indemnify Service Provider and hold Service Provider harmless against any and all losses, liabilities, penalties, fines, costs, damages, and expenses Service Provider incurs, including reasonable attorney's fees, except where there has been a finding of gross negligence or willful misconduct, in the performance of Service Provider's obligations under this Agreement or where there has been material breach of this Agreement by Service Provider, as determined by a court or other tribunal having jurisdiction of the matter.

Section 4.2 Service Provider Indemnifies the Employer. Service Provider will indemnify the Employer and hold the Employer harmless against any and all losses, liabilities, penalties, fines, costs, damages, and expenses Service Provider incurs, including reasonable attorney's fees, where there has been a finding of Service Provider's gross negligence or willful misconduct, in the performance of Service Provider's obligations under this Agreement or Service Provider's material breach of this Agreement, as determined by a court or other tribunal having jurisdiction of the matter.

SECTION 5 – PLAN BENEFITS LITIGATION

Section 5.1 Litigation Against Service Provider. If a demand is asserted or litigation or administrative proceedings are commenced by a Participant or health care provider against Service Provider, or against the Plan and Service Provider jointly, to recover Plan benefits ("Plan Benefits Litigation"), Service Provider will select and retain defense counsel to represent Service Provider's interest. In actions asserted against both the Employer and Service Provider, and provided no conflict of interest arises between the parties, Service Provider will agree to joint defense counsel. All legal fees and costs Service Provider incurs in defense of the litigation will be paid by the Employer, except as provided in Section 4.2. The failure to seek payment of Service Provider's legal fees and costs does not relieve the Employer of the Employer's obligations to indemnify Service Provider for other amounts as provided in Section 4.1. The failure to provide notice of Plan Benefits Litigation does not relieve the Employer of the Employer's obligations to pay Service Provider's legal fees and costs. Both parties will cooperate fully with each other in the defense of the Plan Benefits Litigation. In all events, the Employer is responsible for the full amount of any Plan benefits paid as a result of such litigation.

Section 5.2 Litigation Against the Employer. If litigation or administrative proceedings are commenced against the Employer and/or the Plan, the Employer will select and retain counsel and the Employer will have the responsibility for all legal fees and costs in connection with such litigation, unless otherwise required under section 4.2 of this Agreement. Service Provider will cooperate fully in the defense of litigation arising out of matters relating to this Agreement.

SECTION 6 – ELIGIBILITY AND FINANCIAL INFORMATION

Section 6.1 Eligibility Information. The Employer or TPA shall provide Service Provider a list of the Employer's employees, their dependents and/or other persons who are eligible to be Participants. This information must be accurate and provided to Service Provider in an agreed to format. The Employer will notify Service Provider promptly of any changes. Service Provider shall be entitled to rely on the most current information in Service Provider's possession regarding eligibility of Participants in providing services under this Agreement.

Section 6.2 Financial Information. At Service Provider's request, the Employer or TPA will provide all financial information that Service Provider needs to perform its services hereunder.

SECTION 7 – SERVICE FEES

Section 7.1 Service Fees. The Employer will pay to Service Provider a monthly service fee equal to: (a) .2658 times the sum of the Employer's monthly Stop Loss Premium plus the Aggregate Monthly Attachment Point as defined under the Stop Loss Policy issued to the Employer by Service Provider, minus (b) the monthly fee paid by the Employer to Key Benefits Administrators under their Administrative Services Agreement. Such fees will be paid to the TPA which will in turn remit the fees to Service Provider.

Section 7.2 Changes in Service Fees. Service Provider can change the service fees: (1) on each Agreement Period anniversary; (2) any time there are changes made to this Agreement or the Plan; (3) when there are changes in laws or

regulations which affect the services provided under this Agreement; or (4) to reflect changes in enrollment under the Plan. In such a case, the new service fee shall be effective upon 30 days prior written notice.

SECTION 8 – TERM OF THE AGREEMENT

This Agreement will be in effect for an initial Agreement Period commencing on the Effective Date and will automatically continue, unless this Agreement is terminated.

SECTION 9 – TERMINATION OF THE AGREEMENT

This Agreement will terminate when: (1) the Plan terminates; (2) both parties agree to terminate the Agreement; (3) after the initial Agreement Period, either party gives the other party at least 30 days prior written notice; (4) Service Provider gives the Employer notice of termination because the Employer did not pay the fees or other amounts the Employer owed Service Provider under this Agreement; (5) either party is in material breach of this Agreement, other than by non-payment or late payment by the Employer of fees owed, and does not correct the breach within thirty (30) days after being notified in writing by the other party; (6) the Employer gives Service Provider notice of termination pursuant to Section 7.2; or (7) any state or other jurisdiction penalizes a party for administering the Plan under the terms of this Agreement, or (8) Employer's Stop Loss Insurance issued by the Service Provider terminates or any applicable run out period concludes, whichever event occurs later. Notice must be given to the other party when reasonably practical. The Agreement will continue to apply in all other states or jurisdictions. Notwithstanding any provision of this Agreement, if Employer does not accept or is not approved for Stop Loss Insurance by the an insurer acceptable to the Service Provider this Agreement shall be deemed to have never taken effect.

SECTION 10 - SERVICES PROVIDED

Section 10.1 Network Services. Service Provider will make available to Participants a Provider Network, located in agreed to geographical sites with Network Providers. Service Provider will provide the Employer with continuing access to directory information as an aid to covered persons in locating Network Providers. Providers participating in the network can change at any time without notice. Service Provider will update directory information to reflect changes as soon as reasonably possible. Network Providers are not employees, agents or partners of Service Provider. Network Providers participate in the Provider Network only as independent contractors. Network Providers and the Participants are solely responsible for any health care serviced rendered to Participants.

Section 10.2 Medical Management Services. Service Provider will review health care services and supplies to determine whether they are payable based on the applicable Plan provisions (e.g., preadmission review of proposed hospital confinements, prospective and concurrent review of certain services).

Section 10.3 Case Management Services. Service Provider will identify cases that may be appropriate for case management services, based on Service Provider's established standard criteria. Service Provider will work with Participants who satisfy the criteria to develop a program of benefit coverage with medically necessary, appropriate and cost-effective health care services and supplies for the diagnosis and/or treatment of the Participant's condition. If the Participant and health care provider are not willing to participate in the process, Service Provider will not provide these services.

Section 10.4 Risk Management, Underwriting and Funding. Service Provider will assist the Employer in determining the anticipated expenses to be paid under the Plan and to establish the proper funding for the Plan including, but not limited to, the determination of the monthly or other periodic advanced funding amounts necessary pursuant to the Employer's agreement with the TPA.

SECTION 11 – MISCELLANEOUS

Section 11.1 Subcontractors. Service Provider may use its affiliates or other subcontractors to perform its services under this Agreement. However, Service Provider will be responsible for those services to the same extent that it would have been had it performed those services without the use of an affiliate or subcontractor.

Section 11.2 Assignment. Except as provided in this Section, neither party can assign this Agreement or any rights or obligations under this Agreement to anyone without the other party's written consent, which shall not be unreasonably withheld. Notwithstanding, Service Provider may assign this Agreement, including all its rights and obligations to its affiliates, to an entity controlling, controlled by, or under common control with Service Provider, or a purchaser of all or substantially all of Service Provider's assets, subject to notice to the Employer of the assignment.

Section 11.3 Governing Law. This Agreement is governed by the laws of the State of Wisconsin and without application of any choice of law principles.

Section 11.4 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 11.5 Amendment. Except as may otherwise be set forth in this Agreement, the Agreement may be amended only by both parties agreeing to the amendments in writing, executed by a duly authorized person of each party.

Section 11.6 Waiver. 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 wavier of any other.

SECTION 12 – NOTICES

Section 12.1 Notices. Any notices to be given pursuant to the terms and provisions of this Agreement shall be in writing and shall be sent to the following named persons at the following addresses, by certified mail, return receipt requested, postage prepaid, (or by FedEx or other nationally recognized overnight air express mail service).

To Service Provider: Assurant Health, 501 West Michigan Avenue, Milwaukee, WI 53203, Attn: Senior Vice-President, Secretary and General Counsel

To Employer: Employer’s last address shown in Service Provider’s records.

Any such Notice shall be deemed given and effective on the date delivered or refused.

This Agreement may be signed by the parties in counterparts.

IN WITNESS WHEREOF, this Agreement has been executed on the date shown below.

PLAN SPONSOR

SERVICE PROVIDER

By _____

By _____

Authorized Signature

Authorized Signature

Print Name _____

Print Name Kevin Borchert

Print Title _____

Print Title Vice President, Development

Date _____

EXHIBIT 1 -- BUSINESS ASSOCIATE AGREEMENT

I. PREAMBLE

Pursuant to the Health Insurance Portability and Accountability act ("HIPAA") of 1996, and its implementing regulation, the Standards for Privacy of Individually Identifiable Health Information, 65 Fed. Reg. 82,462 *et seq.* (Dec. 28, 2000) (hereinafter the "HIPAA Privacy Rule"), the Employer (named in the Risk Management Services Agreement to which this document is attached) and the Service Provider (named in the Risk Management Services Agreement to which this document is attached) (jointly "the Parties") wish to enter into an Agreement that addresses the requirements of the HIPAA Privacy Rule with respect to "business associates," as that term is defined in the HIPAA Privacy Rule.

The Employer Plan is responsible for entering into contracts with business associates to ensure that business associates will establish and implement appropriate safeguards (including certain administrative requirements) for "Protected Health Information" that business associates may create, receive, use, or disclose in connection with certain functions, activities, or services (collectively "services") to be provided by that business associate to the Employer Plan. The Parties acknowledge that the Service Provider is a business associate. The services to be provided by Service Provider are identified in a separate agreement between the Parties entitled "Risk Management Services Agreement." Specifically, this Agreement is intended to do that.

The Parties acknowledge and agree that in connection with the services to be provided, Service Provider will create, receive, use or disclose Protected Health Information. As set forth in the HIPAA Privacy Rule and as used herein, Protected Health Information ("PHI") is defined as individually identifiable health information maintained or transmitted in any form or medium, including, without limitation, all information (including demographic, medical, and financial information), data, documentation, and materials that relate to: (i) the past, present, or future physical or mental health or condition of an individual; (ii) the provision of health care to an individual; or (iii) the past, present, or future payment for the provision of health care to an individual. PHI does not include health information that has been de-identified in accordance with the standards for de-identification provided for in the HIPAA Privacy Rule.

In connection with Service Provider's creation, receipt, use or disclosure of PHI, Service Provider and Covered entity agree as follows:

II. GENERAL TERMS

- a. All capitalized term of this Agreement shall have the meanings set forth in the HIPAA Privacy Rule, unless otherwise defined herein.
- b. In the event of an inconsistency between the provisions of this Agreement and the mandatory terms of the HIPAA Privacy Rule, as may be expressly amended from time to time by the Department of Health and Human Services (HHS) or as a result of interpretations by HHS, a court, or another regulatory agency with authority over the Parties, the interpretation of HHS, such court or regulatory agency shall prevail. In the event of a conflict among the interpretations of these entities, the conflict shall be resolved in accordance with rules of precedence.
- c. Where provisions of this Agreement are different from those mandated by the HIPAA Privacy Rule, but are nonetheless permitted by the Rule, the provisions of the Agreement shall control.
- d. Except as expressly provided in the HIPAA Privacy Rule or this Agreement, this Agreement does not create any rights in third parties.

III. SPECIFIC REQUIREMENTS

- a. Service Provider agrees to create, receive, use, or disclose PHI only in a manner that is consistent with this Agreement and the HIPAA Privacy Rule and only in connection with providing the services to Covered Entity identified in the Service Agreement. Accordingly, in providing services to or for the Covered Entity, Business Associate, for example, will be permitted to use and disclose PHI for "treatment, payment and health care operations" in accordance with the HIPAA Privacy Rule. Additionally, under the HIPAA Privacy Rule, Service Provider also may use or disclose PHI received by Service Provider in its capacity as a Business Associate to the Covered Entity if:

(i) the use relates to: (1) the proper management and administration of Service Provider or to carry out legal responsibilities of the Business Associate, or (2) data aggregation services relating to the health care operations of the Covered Entity; or

(ii) the disclosure of information received in such capacity will be made in connection with a function, responsibility, or service identified in (i)(1), *and* such disclosure is required by law or Service Provider obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidential and the person agrees to notify Service Provider of any breaches of confidentiality.

b. Service Provider shall require that its agents or subcontractors, if PHI is to be disclosed to the agents or subcontractors, agree to the same restrictions and conditions on the use and disclosure of PHI that are set forth in this Agreement.

c. Service Provider shall maintain safeguards as necessary to ensure that PHI is not used or disclosed except as provided for by this Agreement.

d. Service Provider shall report to Covered Entity any use or disclosure of PHI that is not provided for in this Agreement.

e. In accordance with 45 C.F.R. § 164.524 of the HIPAA Privacy Rule, Service Provider will make available to those individual who are subjects of PHI, their PHI in Designated Record Sets by providing the PHI to Covered Entity (who then will share the PHI with the individual), by forwarding the PHI directly to the individual, or by making the PHI available to such individual at a reasonable time and at a reasonable location.

f. Service Provider shall make available the information necessary to provide an accounting of disclosures of PHI as provided for in 45 C.F.R. § 164.528 of the HIPAA Privacy Rule.

g. Service Provider shall make available PHI for amendment and incorporate any amendment to PHI in accordance with 45 C.F.R. § 164.526 of the HIPAA Privacy Rule.

h. Upon the termination or expiration of this Agreement, Service Provider agrees to return the PHI to Covered Entity, destroy the PHI (and retain no copies), or further protect the PHI if return or destruction is not feasible.

i. Service Provider shall make available to the HHS or its agents the Service Provider's internal practices, books and records relating to the use and disclosure of PHI.

j. The Parties agree that Covered Entity shall have the right to terminate this Agreement or seek other remedies if Service Provider violates a material term of this Agreement.

IV. APPLICATION OF THE STANDARDS FOR ELECTRONIC TRANSACTIONS

a. In connection with the services to be provided Covered Entity as identified in the Service Agreement, Service Provider agrees that if it (or an agent or subcontractor) conducts an electronic transmission for which the secretary of the Department of Health and Human Services has established a "standard transaction," Service Provider (or its agent or subcontractor) shall comply with the requirements of the Standards for Electronic Transactions (45 C.F.R. parts 160 and 162). Service Provider shall attain compliance no later than the regulatory compliance date prescribed by the Department of Health and Human Services, which is now October 16, 2003.

b. Service Provider agrees that, in connection with the transmission of standard transactions, it will not (and will not permit any business associate, agent, or subcontractor with which it might contract to):

1. change the definition, data condition, or use of a data element or segment in a standard transaction;
2. add any data elements or segments to the maximum defined data set;
3. use any code or data elements that are either marked "not used" in the standard's implementation specification or are not in the standard's implementation specification; or
4. change the meaning or intent of the standard's implementation specification(s).

V. SPECIFIC ACTIVITIES IN CONNECTION WITH STANDARD TRANSACTIONS

- a. Service Provider agrees and understands that there exists the possibility that Covered Entity might request an exception from the uses of a standard as permitted by 45 C.F.R. § 162.940, and, if such an exception is sought, Service Provider may, but shall not be required to agree to participate in a test modification.
- b. Service Provider understands and agrees that from time-to-time the Department of Health and Human Services might modify the standard transactions now identified in 45 C.F.R. §§ 162.1101 through 162.1802. Service Provider (and any agent or subcontractor) agrees to abide by any changes to such standard transactions that might be applicable to the services to be supplied in connection with the Service Agreement with Covered Entity.

VI. COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS

- a. Covered Entity agrees that its Employee Group Health Plans (“Plans”) will at all times be in compliance with the Electronic Security Standards requirements of 45 C.F.R. § 164.314(b)(1) and (2) of HIPAA and its implementing regulations, 45 C.F.R. parts 160,162, and 164.
- b. Service Provider shall develop, document, implement, maintain and use appropriate administrative, technical, and physical safeguards to preserve the integrity and confidentiality of, and to prevent non-permitted use or disclosure of, PHI (both electronic and non-electronic) created or received from Covered Entity’s Plans.
- c. Service Provider agrees that with respect to electronic PHI, its safeguards, at a minimum, shall meet the requirements of the HIPAA Security Standards applicable to Business Associates. Service Provider shall meet those Security Standards in effect on the April 21, 2005 compliance date of the Standards as such standards may be amended by the U.S. Department of Health and Human Services prior to the compliance date.
- d. As a part hereof Service Provider agrees that it shall implement administrative, physical, and technical safeguards that reasonably protect the confidentiality, integrity, and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan as required under the Privacy and Security Regulations.