Access Plans Inc
Form 10-K/A
June 24, 2011

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K/A

(Amendment No. 2)
ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(D) OF THE SECURITIES EXCHANGE ACT OF 1934
For the fiscal year ended September 30, 2010
or
TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(D) OF THE SECURITIES EXCHANGE ACT OF 1934
For the transition period from _____ to _____
Commission File Number 000-30099

Access Plans, Inc.
(Exact name of registrant as specified in its charter)

OKLAHOMA	27-1846323
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)

900 36th Avenue NW, Suite 105, Norman, OK 73072
(Address of principal executive offices and zip code)

Registrant s telephone number, including area code: (405) 579-8525
Securities registered pursuant to Section 12 (b) of the Act: None Securities to be registered pursuant to Section 12 (g) of the Act:
Common Stock, $.001 Par Value
(Title of Class)

Indicate by check mark if registrant is a well-known seasoned issuer, as defined in Rule 505 of the Securities Act. Yes o No þ
Indicate by check mark whether the issuer is not required to file reports pursuant to Section 13 or 15(d) of the Exchange Act. Yes o No þ
Indicate by check mark whether the issuer (1) has filed all reports required to be filed by Section 13 or 15 (d) of the Securities Exchange Act during the preceding 12 months (or for such shorter periods that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes þ No o
Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes o No o
Indicate by check mark if disclosure of delinquent filers in response to Item 405 of Regulation S-K (Section 229.405) is not contained herein, and will not be contained, to the best of registrant s knowledge, in definitive proxy or information statements incorporated by reference in Parts III of this Form 10-K or any amendment to this Form 10-K. Yes o No þ
Indicate by check mark whether registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a small reporting company.

Large accelerated filer o Accelerated filer o Non-accelerated filer o

Smaller reporting company þ

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes o No þ

The aggregate market value of the voting and non-voting common equity held by non-affiliates of registrant, computed using the last sale price, or the average bid and asked price of such common equity as reported for the registrant s common stock on March 31, 2010 was $8,209,600.

As of December 16, 2010, 19,877,204 shares of the registrant s common stock, $0.001 par value were outstanding.

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PART I

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PART III

Explanatory Note

Access Plans, Inc. is filing this Amendment No. 2 on Form 10-K/A to our Annual Report on Form 10-K for the year ended September 30, 2010, initially filed with the Securities and Exchange Commission on December 22,2010.

The following sections of this Form 10-K/A have been amended:

Compliance with Section 16(a) of the Exchange Act was revised to disclose late reporting for Form 4 transactions.

The signature page date has been revised.

Exhibits 31.1, 31.2, 32.1 and 32.2 were revised to reflect current certification dates.

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ITEM 1. BUSINESS.

We are a leading provider of consumer membership plans, healthcare savings membership plans and a marketer for individual major medical health insurance products. For our membership plan products, through working with our wholesale and retail clients, we design and build membership plans that contain benefits aggregated from our vendors that appeal to our clients customers. For our major medical health insurance products, we offer and sell these products through a national network of independent agents. Our vision statement is Valued Benefits for Every Family .

Our current operations are organized under four operating segments.

Wholesale Plans

Our Wholesale Plans Division provides our clients, primarily rent-to-own and retail stores, customized membership marketing plans that leverage their brand name and customer relationships and typically their payment mechanism, plus offer benefits that appeal to their customers. These plans provide the consumer savings on medical services, discount savings on dining and entertainment, automotive, legal and financial, as well as insurance programs including leased property, involuntary unemployment, accidental death and dismemberment, and extended service plans.

The value provided by our plans to our clients, includes increased customer attraction and retention, plus incremental fee income with limited risk or capital cost. By implementing these plans repetitively, our management team is uniquely qualified to efficiently assist our clients in achieving their goals, while avoiding operational and marketing pitfalls.

Retail Plans

Our Retail Plans offerings primarily include healthcare savings plans and association memberships that provide insurance features. These healthcare savings plans are not insurance, but allow members access to a variety of healthcare networks to obtain discounts from usual and customary fees. We offer wellness programs, prescription drug, vision and dental discount programs, medical discount cards, and limited benefit insured plans. Our members pay providers the discounted rate at the time services are provided to them. These plans are designed to serve the markets in which individuals either have no health insurance or limited healthcare benefits.

Insurance Marketing

Our Insurance Marketing Division offers and sells individual major medical health insurance products and related benefit plans, including specialty insurance products, primarily through a national network of independent agents. We support our agents with access to proprietary and private label products, leads for new sales, commission advance programs, incentive programs, including an annual convention, web-based technology, and back-office support.

Corporate

Our Corporate segment includes salary and other expenses for individuals performing services for administration of overall operations of the Company. These expenses are not allocated to our other segments.

INDUSTRY OVERVIEW

Wholesale Plans

Our Wholesale Plans Division s products are primarily offered and distributed at rent-to-own retail stores pursuant to contractual arrangements. All of these rent-to-own retail stores are owned by rent-to-own industry participants who are unrelated and independent of us. Nationwide there are approximately 8,600 locations serving approximately 4.1 million households according to the Association of Progressive Rental Organizations (APRO). It is estimated that the two largest rent-to-own industry participants account for approximately 4,800 of the total number of stores, and the majority of the remainder of the industry consists of operations with fewer than 50 stores. The industry has been consolidating and that trend is expected to continue, resulting in an increased concentration of stores in the two largest rent-to-own industry participants.

The rent-to-own industry serves a highly diverse customer base. According to APRO, approximately 96% of rent-to-own customers have household incomes between $15,000 and $50,000 per year. The rent-to-own industry serves a wide variety of customers by allowing them to obtain merchandise that they might otherwise be unable to obtain due to insufficient cash resources or a lack of access to credit. APRO also estimates that 95% of customers have high school diplomas.

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Healthcare Industry

Our Retail Plans and Insurance Marketing Divisions offer healthcare solutions for individuals and families who are insured, underinsured (limited benefit insurance plans), and uninsured.

The uninsured. It is estimated that 16.7% of all people in America, or 50.7 million individuals, were without health insurance coverage in 2009, an increase of 4.4 million people compared to 2008. [Source: U.S. Census Bureau, Income, Poverty, and Health Insurance Coverage 2009 Report issued September 2010]. Furthermore, 9.1% of the uninsured have annual income over $75,000. [Source: U.S. Census Bureau, Income, Poverty, and Health Insurance Coverage 2009 Report issued September 2010].

The percentage of people working full-time without health insurance in 2009 was 15.2%, an increase from 14.6% in 2008. [Source: U.S. Census Bureau, Income, Poverty, and Health Insurance Coverage 2009 Report issued September 2010]. Nationally, healthcare expenditures are projected to have reached $2.5 trillion in 2009, up from $1.35 trillion in 2000. [Source: U.S. Centers for Medicare and Medicaid Services]. Costs of healthcare (in doctors offices and hospitals) for self-paying uninsured patients are often far higher than the amount an insured or his or her insurance company would pay for the same healthcare services. The number of people with health insurance in the U.S. decreased in 2009 for the first time since 1987, the first year that comparable health insurance data were collected.

The insured and underinsured. In 2009, 55.8% of the U.S. population participated in employer-sponsored medical insurance plans, showing a gradual year-by-year decrease from 58.5% in 2008. [Source: U.S. Census Bureau, Income, Poverty, and Health Insurance Coverage 2009 Report issued September 2010]. In addition, data from the Kaiser Family Foundation show that employers are requiring employees to contribute more in cost-sharing (premiums, deductibles and/or co-payments) for their health insurance. [Source: Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits, 2009 Annual Survey]. Between 2008 and 2009, premiums for employer-sponsored health insurance rose 5.0%, a rate that exceeds the 2009 inflation rate of -.4% and the 2009 decrease in national average wage index of 1.5%, and the overall average premiums for family coverage have increased 130% over the last 10 years. [Source: Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits, 2009 Annual Survey]. These increases are, in turn, hitting employees of small employers particularly hard because to keep premiums affordable, the benefit packages generally include higher cost-sharing levels through higher deductibles and copayments than packages offered by large employers. [America s Health Insurance Plans Center for Policy and Research Report, March 2009]. Therefore, higher costs are not only being felt by the employers, but also by their employees. The average monthly contribution by workers for single and family healthcare coverage rose from $8 and $52, respectively, in 1988 to $75 and $333, respectively, in 2010. The average cost of family coverage is now $13,770 per year, including worker contributions of $3,997. Not surprisingly, employers are looking for alternatives. In 2010, 69% of employers offered health benefits compared to 60% reported for 2009. The cost of health insurance remains the main reason cited by firms for not offering health benefits. [Source: Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits, 2009 Annual Survey].

Over-utilization, increasing regulation and legislation. Over-utilization of the healthcare system is one of the factors contributing to the increasing cost trends. American citizens are utilizing healthcare services at an ever-increasing rate. Behind this phenomenon is the fact that insurance plans and healthcare management organizations are structured to encourage usage. Small co-payments, that average $20 to $30 per office visit, encourage insured consumers to use the healthcare system more frequently because they do not perceive themselves ultimately as having to pay the full costs of the medical services received.

A number of insurers have discontinued offering their insurance products in certain states, due to state regulations that no longer provide for a viable operating environment. As a result of these health coverage cancellations, those formerly insured individuals and families are required to pay more for their insurance coverage, cannot obtain any coverage because of pre-existing conditions or simply remain uninsured for healthcare.

In addition, federal legislation provides for tax favorable Health Savings Accounts (HSAs). Individuals with high deductible health insurance coverage can deduct contributions to their HSA from their reported income for tax purposes. In 2010, the qualifying health insurance must have a deductible of at least $1,200 for individuals and $2,400

for families and the maximum amount that can be contributed is $3,050 for individuals and $6,150 for families. Amounts contributed to the HSAs can be used for certain uninsured medical expenses, but generally cannot be used to pay for the health insurance premium. Individuals can establish HSAs without regard to their income and amounts contributed to the HSAs do not have to be used within a certain time period. Because the higher deductible health insurance policies generally provide lower premium amounts, there is an increasing market for specialty plans that supplement or fill deductible or other gaps in coverage for millions of Americans.

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Self-employed and small businesses. In 2010, 68% of employers with between 3 and 199 workers provided health insurance, up from 59% in 2009. [Source: Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits, 2010 Annual Survey]. Small firms with fewer than 500 employees represent 99.9% of the 29.6 million U.S. businesses in 2008. [Source: U.S. Census Bureau, Statistics of U.S. Businesses]. In addition, small businesses have accounted for 64% of net new jobs annually over the last 15 years. [Source: Small Business Administration Office of Advocacy, September 2009]. Individuals working for such small businesses generally do not have access to group health insurance at affordable rates. As the number of uninsured individuals increases, we anticipate that the market for our non-insurance healthcare savings programs and economically priced small group insurance products will increase.

Senior population. The age 65 and over segment of the U.S. population is expected to grow from 40 million in 2010 comprising 13% of the population to 89 million by 2050, comprising 20% of the total population. [Source: U.S. Census Bureau, 2009]. While the federal Medicare program covers a portion of healthcare expenses for senior Americans, the gaps in coverage provide a significant market for supplemental plans.

HISTORY OF THE COMPANY

Access Plans, Inc. became a holding company of Alliance HealthCard and its subsidiaries and the registrant under the Securities Exchange Act of 1934 following approval by the shareholders of Alliance HealthCard, Inc. (Alliance HealthCard), effective December 7, 2009, Alliance HealthCard Acquisition Corp., a subsidiary of Access Plans, Inc., an Oklahoma corporation, also one of Alliance HealthCard s wholly-owned subsidiaries, merged into Alliance HealthCard. The shareholders of Alliance HealthCard exchanged their Alliance HealthCard common stock shares on a one-for-one basis for common stock shares of Access Plans, Inc.

Our subsidiary, Alliance HealthCard, was founded in 1998 as a provider of discount medical plans with a focus on creating, marketing, and distributing membership savings programs primarily to the underserved markets in the United States. Our original programs offered attractive savings in approximately 16 areas of health care, including physician visits, hospital stays, chiropractics, vision, dental, pharmacy, hearing, and patient advocacy, among others.

On February 28, 2007, we completed the merger-acquisition of BMS Holding Company, Inc. and its subsidiary, Benefit Marketing Solutions, LLC (BMS). BMS is one of the largest membership plan providers to dealers in the rental purchase industry market space. While we continue to market our health oriented programs, this merger-acquisition has greatly expanded our business scope to include programs that offer discount savings on dining and entertainment, automotive, legal and financial, as well as insurance programs including leased property, involuntary unemployment, accidental death and dismemberment, and extended service plans.

BMS was formed in February 2002 and is a national membership program benefit organization that designs, markets, and distributes membership programs for rental-purchase companies, financial organizations, employer groups, retailers and association-based organizations. These membership programs are sold as part of a point-of-sale transaction or through direct marketing efforts. The point-of-sale membership plans are sold through about 4,910 rent-to-own retail store locations in the U.S., Puerto Rico and Canada.

As part of the merger-acquisition of BMS Holding Company, Inc., we also acquired BMS Insurance Agency, LLC (BMS Agency) that was formed in January 2005. BMS Agency is licensed to offer life, accident and health, and property and casualty insurance.

On April 1, 2009, we completed our acquisition of Access Plans USA, Inc., (Access Plans USA). Access Plans USA markets health insurance and develops and distributes consumer driven discount plans on a variety of health related services including medical, dental, pharmacy and vision care and manages its own proprietary dental and vision networks.

BUSINESS OVERVIEW

We are a leading provider of consumer membership plans, healthcare savings membership plans and a marketer for individual major medical health insurance products. In partnership with our wholesale and retail clients, we design and build membership plans that contain benefits aggregated from our vendors that appeal to our clients customers. Our major medical health insurance products are offered and sold through a national network of independent agents.

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Our current operations are organized under three business Divisions.

Wholesale Plans

Our Wholesale Plans Division provides our clients customized membership marketing plans that leverage their brand name, customer relationships and typically their payment mechanism, plus offer benefits that appeal to their customers. The value provided by our plans to our clients, includes increased customer attraction and retention, plus incremental fee income with limited risk or capital cost. By implementing these plans repetitively, our management team is uniquely qualified to efficiently assist our clients in achieving their goals, while avoiding operational and marketing pitfalls.

This Division currently manages about 220 membership plans for our clients that include rental-purchase dealers, insurance companies, financial institutions, retail merchants, and consumer finance companies. At September 30, 2010, our wholesale plans were offered at approximately 4,910 locations. Of the locations at September 30, 2010, 2,880 locations were Rent-A-Center company owned locations operated under their brand. Rent-A-Center, Inc., a Nasdaq (symbol RCII) traded company, is the largest rent-to-own company in the United States, Puerto Rico and Canada. Our revenue attributable to the contractual arrangements with Rent-A-Center was approximately $11.9 million, (21% of total revenue) during the fiscal year ended September 30, 2010, compared to $11.6 million, (30% of total revenue) during the fiscal year ended September 30, 2009. Total revenue for our Wholesale Plans Division accounted for $22.4 million, (40% of total revenue) and $19.5 million, (50% of total revenue) during the fiscal years ended September 30, 2010 and September 30, 2009, respectively. Our growth in wholesale plans revenue is dependent in significant part on an increase in the number of rent-to-own locations at which these plans are offered and the selling efforts at those locations. Although we have long-term contracts with Rent-A-Center and other rent-to-own companies, the loss of these contractual arrangements, especially with Rent-A-Center would have a significant adverse impact on our revenues, profitability and our ability to negotiate discounts with our vendors.

Retail Plans

Our Retail Plans offerings include healthcare savings plans and association memberships that provide insurance features. These healthcare savings plans are not insurance, but allow members access to a variety of healthcare networks to obtain discounts from usual and customary fees. We offer wellness programs, prescription drug and dental discount programs, medical discount cards, and limited benefit insured plans. Our members pay providers the discounted rate at the time services are provided to them. These plans are designed to serve the markets in which individuals either have no health insurance or limited healthcare benefits. Our revenue attributable to retail plans was approximately $17.5 million, (32% of total revenue) and $12.8 million, (33% of total revenue) during the fiscal years ended September 30, 2010 and 2009, respectively.

This Division is comprised of the membership business of Alliance Healthcard, The Capella Group, Inc. (Capella) and Protective Marketing Enterprises, Inc. (PME). Capella and PME are subsidiaries of Access Plans USA, which we acquired on April 1, 2009 (*See Note 4. Mergers and Acquisitions*). PME also owns and manages proprietary networks of dental and vision providers that provide services at negotiated rates to certain members of our plans and other plans that have contracted with us for access to our networks.

Through our healthcare savings plans, we believe customers save an average of 35% on their medical costs and between 10% and 50% on services through other discount medical providers. These discounts for services that do not require the use of a medical PPO are more difficult to track because our members pay a discounted rate at point of service.

Operationally, this Division utilizes two platforms: the Affinity system that is operated under a license to PME and the Alliance system that is a proprietary system we developed. These systems are utilized primarily for the following functions:

- Maintaining member eligibility;
- Generate periodic reporting to contracted third party networks and other vendors;
- Paying commissions;
- Maintaining a database of providers and provider locator services; and
- Drafting or charging member accounts and tracking cash receipts.

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In addition to our wholesale and retail offerings, certain clients may choose to include our benefits with their own membership plan offering. In these instances, the client bears the cost of marketing and fulfillment, and we provide customer service. These offerings are designed to enhance our clients existing product and service offerings and improve their product value relative to their competition and in some instances to improve their customer retention. While these plans provide lower periodic member fees, we incur limited implementation costs and receive higher revenue participation rates. Our additional distribution channels also include network marketing representatives, independent agents and consumer direct sales call centers. We also market to internet portals and financial institutions.

In order to deliver our membership offerings, we contract with a number of different vendors to provide various products and services to our members. The majority of these vendor relationships involve the vendor providing our members access to their network or providers or their locations and our members obtain a discount at the time of service. We have vendor relationships with medical networks, automotive service companies, insurance companies, travel related entities and food and entertainment consumer discount providers. Our vendors value the relationship with us because we deliver many customers to them without incremental capital cost or risk on their part and these relationships are governed by multi-year agreements and aggregated volume scaling.

Insurance Marketing

Our Insurance Marketing Division offers and sells individual major medical health insurance products and related benefit plans, including specialty insurance products, primarily through a national network of independent agents. America s Healthcare/Rx Plan Agency (AHCP), also a subsidiary of Access Plans USA, is the centerpiece of the Insurance Marketing Division. AHCP distributes major medical, short term medical, critical illness and related health insurance products to small businesses, self-employed and other individuals and families through a network of approximately 7,420 independent agents which have carrier appointments through AHCP. The primary insurance carriers that we represent include: Golden Rule Insurance Company, World Insurance Company, Aetna and Colorado Bankers.

Access Plans USA was acquired on April 1, 2009. Operating results for 2009 are only for the six months ended September 30, 2009 (*See Note 4. Mergers and Acquisitions*).

We support our agents and recruit new agents via access to proprietary and private label products, leads for new sales, commission advance programs, incentive programs, including an annual convention, web-based technology, and back-office support. More specifically, our agent support and recruiting tools include:

- e-Agent Center provides agents with access to real-time rate quoting, on-line licensing and contracting, insurance application submission, access to brochures and other marketing materials.
- Lead Distribution we utilize an electronic system to connect agents with an on-line lead ordering and delivery system. Leads are also provided in certain situations as incentives to sell certain policies.
- Incentive programs to assist with agent motivation and recruitment, we provide paid annual convention trips and periodic sales contests.
- Agent advances with most of the major medical products we represent, agents are entitled to from three to nine months of advance commissions either funded by AHCP or our insurance carrier partner. Our ability to grow this segment will depend, in part, on our continued access to working capital to fund these advances.
- Home office support this includes agent and product training, marketing materials and agent communication. The training programs include both on-site and in-house schools, DVDs and webcasts covering product knowledge and sales techniques as well as market conduct and regulatory compliance issues. In addition, our support includes development and distribution of a wide variety of marketing materials including flyers, brochures, email blasts and letters. We also promote and inform our agents on important news and updates via a weekly newsletter.

Our strategy for the Insurance Marketing Division is to:

- continue working with insurance carriers in the development of proprietary products for our agents to represent;
- expand the number of carriers that we represent for more product choice for customers and expanded geographic representation; and

enhance our e-agent platforms in order to better serve our existing agents and improve attraction of new agents to sell insurance products we represent.

We generate most of our revenue in this Division from commissions paid to us by health insurance carriers whose health insurance policies and products we sell. Our revenue attributable to commission and fee revenue was approximately $20.6 million (37% of total revenue) and $11.4 million (29% of total revenue), respectively for the fiscal years ended September 30, 2010 and 2009.

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BUSINESS STRATEGY

Our focus is providing national membership program benefits to organizations that include rental-purchase companies, financial institutions, retail merchants, and consumer finance companies nationwide. For our major medical health insurance products, we offer and sell these products through a national network of independent agents. The strategy is to succeed in the marketplace by:

- expanding and improving relationships with our membership plans provider vendors and insurance carrier partners;
- maintaining and enhancing customer and agent satisfaction by providing high quality telephone and web support;
- continually enhancing existing programs and developing innovative solutions and products for our clients and agents; and
- assisting the market to understand how our offerings are different and superior.

Increase Market Penetration

We believe we have opportunities to expand our offerings to markets with similar operational and customer demographic characteristics to those we now serve. In addition, many of these markets may be substantially larger than our existing markets. We recently began exploring these new markets and plan to continue such efforts. Our tested and proven infrastructure allows us to serve substantially more customers without a significant increase in fixed costs.

Maintain and Enhance Customer Satisfaction

Our belief is that providing high-quality customer service to our customers, clients, agents and members is extremely important in order to encourage memberships and to strengthen the affinity of those members for the client that offered the service program. In order to achieve our anticipated growth and to ensure client, member and marketing representative loyalty, we continue to develop and invest significantly in our member service systems. All new member service representatives are required to complete a training course before beginning to take calls and attend on-the-job training thereafter. Through our training programs, systems and software, we seek to provide members with friendly, rapid and effective answers to questions. In addition, we continue to work closely with our clients customer service staffs to ensure that their representatives are knowledgeable in matters relating to membership service programs offered by us.

Continually Enhance Programs

We believe that we are well-positioned to increase market share by taking advantage of providing consumers distinctive and innovative membership programs. We will continue to enhance our programs and add, remove or restructure benefits to sustain this advantage. As we consider new markets, we seek opportunities to deliver competitive plans with innovative services or operational structures.

Manage Growth Effectively

We intend to grow by focusing our sales team on potential new accounts, while continuing to expand our existing customer base by tailoring new programs that will continue to complement and increase the customer s existing revenue sources. In addition, we continue to selectively consider acquisitions of membership program companies to improve our market share. We believe that we have the management team in place to manage this growth.

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SERVICES

We provide consumer membership plans, healthcare savings membership plans and are a marketer for individual major medical health insurance products. Our benefit categories include: Discount Medical, Food and Entertainment, Insurance, Automotive Discounts, Dealer Add-In Benefits and Miscellaneous Benefits.

Discount Medical

Physician Network Access
Dental Network Access
Vision Care & Eyewear Network Access
Pharmacy Network Discounts
Mail Order Pharmacy Discounts
Chiropractor Network Access
Hearing Aid Discounts
Vitamins & Nutritional Supplements

Automotive Discounts

Discounted Roadside Assistance
Automotive Service Provider Savings
Customer Trip Routing
Car Theft Reward
Rental Car Savings

Food and Entertainment

Grocery Coupon Savings
Restaurant Savings
Theme Park Discounts
Movie Theater Discounts

Insurance

Major Medical/Individual Health Insurance
Life Insurance
Accidental Death & Dismemberment
Involuntary Unemployment
Leased Property Insurance
Dental Insurance
Limited Medical Insurance
Critical Illness Insurance

Dealer Add-In Benefits

Lease Cancellation Benefits
Account Reinstatement
Points Program for On Time Payments

Miscellaneous Benefits

Kid Secure
Discounted Legal Services
Savings at Choice Hotels
Savings at 1-800Flowers.com
Product Service Plans

CUSTOMERS

Our Wholesale Plans Division currently manages about 220 membership plans for our clients that include rental purchase dealers, insurance companies, financial institutions, retail merchants, and consumer finance companies. Our Retail Plans are offered at over 7,000 retail locations. Our Insurance Marketing Division currently sells the products of approximately 12 insurance carriers.

Revenue attributable to two contracts in our Wholesale Plans and Insurance Marketing Divisions totaled $22,234,963 or 40% of total revenue for the fiscal year ended September 30, 2010.

Revenue attributable to one contract in our Wholesale Plans Division totaled $11,858,278 or 21% of total revenue for the fiscal year ended September 30, 2010.

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EMPLOYEES

As of September 30, 2010, we had 78 full-time employees in the following departments:

Department	Number of Employees
Customer Services and Client Support	40
Sales and Marketing	11
Executive and Administration	10
Finance and Accounting	10
Information Services	7

COMPETITION

Wholesale and Retail Plans Divisions

While there are numerous companies providing membership offerings, they compete for members by soliciting customers throughout various industries. We strive to maintain strong client relationships in order to mitigate the effects of such competition. There are a number of companies that compete with us. Our principal competitors include: New Benefits, Coverdell, MembersTrust, Affinion, Aegon and CAREINGTON International Corporation. Our other competitors include large retailers, financial institutions, insurance companies, preferred provider organization networks, and other organizations, which offer benefit programs to their customers.

Insurance Marketing Division

We compete in the highly competitive individual health insurance industry. The major medical products and services of the insurance companies that we offer compete with large national, regional and specialty health insurers, including Assurant, and various Blue Cross/Blue Shield companies. In addition, we and our insurance products compete with other companies and their insurance products among insurance agencies and their agents for the offering and sale of insurance products and financial services.

Many of our competitors in the insurance marketing industry have substantially greater financial resources, broader product lines, or greater experience than we do. We compete on the basis of price, reputation, diversity of product offerings and flexibility of coverage, ability to attract and retain agents, and the quality and level of services provided to the independent insurance agencies and their agents.

We face additional competition due to a trend among healthcare providers and insurance companies to combine and form networks in order to contract directly with small businesses and other prospective customers to provide healthcare services. In addition, because our products and services are marketed through independent agents, most of which represent and offer insurance products of multiple insurance companies, we compete for the marketing focus of each independent agent.

The environment within which we operate is intensely competitive and subject to rapid change. To maintain or increase our market share position, we must continually enhance our product offerings, introduce new product features and enhancements, and expand our client service capabilities. We currently compete principally on the basis of the specialized nature of our products and services.

GOVERNMENT REGULATION

We offer benefits including insurance products, extended service, discount medical and other discount programs through association-based membership programs that are sold by our clients as add-ons to the client s core business. We also sell our discount medical program as a stand-alone program directly to the public and through marketers. Through our subsidiary AHCP and its agents we offer insurance directly to the public and through association based programs. We also offer extended service contracts that we obtain from a licensed extended service company on a stand- alone basis through retail outlets.

Our association-based programs are offered through several different associations. For some of our Wholesale and Retail Division plans we administer claims for of our association-based insurance and service programs through our subsidiary, BMS Agency, an Oklahoma licensed insurance agency. Those association-based programs are offered through an Oklahoma association in accordance with the laws of Oklahoma. For other programs, including association-based programs offered through AHCP, our subsidiaries are not involved in the administration of the

claims.

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The laws and regulations and their interpretation relating to our insurance, service and discount medical business are subject to uncertainty and change. There is no assurance that a review of our current and proposed operations will not result in a determination that could materially and adversely affect our business, results of operations and financial condition. See Item 3. Legal Proceedings below. Moreover, regulatory requirements are subject to change from time to time and may in the future become more restrictive, thereby making compliance more difficult or expensive or otherwise affecting or restricting our ability to conduct our business as now conducted or proposed to be conducted. We are subject to the risk of challenges to the legality of selling insurance or other regulated products through our association based marketing program, including claims that our programs do not comply with a particular state s laws regarding the offering and licensing for a regulated product or administration of claims. We are subject to the risk that our discount programs will be determined to be regulated by the discount buying club laws or physician referral laws. In addition, the use of the internet in the marketing and distribution of our services is relatively new and presents issues. These issues include the limitations on an insurance regulator s jurisdiction and whether Internet service providers, gateways or cybermalls are engaged in the solicitation or sale of insurance policies or otherwise transacting business requiring licensure under the laws of one or more states.

Discount Medical Regulations

There are approximately 34 states that now have licensing laws and regulations for discount medical provider organizations (hereinafter referred to as DMPO). The regulations differ materially among states and are subject to amendment and reinterpretation by the agencies charged with their enforcement. Some states require a license to operate as a DMPO. We have three subsidiaries that operate as DMPOs. Alliance HealthCard of Florida, Inc. is registered or licensed, or has applications for licensing pending or in process in all states where required. Our other DMPOs are registered or licensed in all states where they are conducting business and licensing is required. There is also the risk that a state will adopt regulations or enact legislation restricting or prohibiting the sale of our medical discount programs in that state. In addition, California views our discount medical plans as managed healthcare and its Department of Managed Health Care has taken the position that we must seek and eventually obtain a license under the Knox-Keene Act. Capella, Inc., consistent with a previous settlement with the California Department of Managed Health Care, is in the process of obtaining a license under the Knox-Keene Act. Compliance with these regulations on a state-by-state basis has been expensive and cumbersome. See Item 3.Legal Proceedings below.

Compliance with federal and state regulations is generally our responsibility. The medical discount plan industry is especially susceptible to charges by the media of regulatory noncompliance and unfair dealing. As is often the case, the media may publicize perceived non-compliance with consumer protection regulations and violations of notions of fair dealing with consumers. Our failure to comply with current, as well as newly enacted or adopted, federal and state regulations could have a material adverse effect upon our business, financial condition and results of operations in addition to the following:

- non-compliance may cause us to lose licensing status or to become the subject of a variety of enforcement or private actions;
- compliance with changes in applicable regulations could materially increase the associated operating costs;
- non-compliance with any rules and regulations enforced by a federal or state consumer protection authority may subject us or our management personnel to fines or various forms of civil or criminal prosecution; and
- non-compliance, or alleged non-compliance may result in loss of contracts, negative publicity potentially damaging our reputation, network relationships, client relationships and the relationship with program members, representatives and consumers in general.

Insurance Regulations

Government regulation of insurance is a changing area of law and varies from state to state. Our insurance agency, our agents and the insurance companies from which we obtain our insurance products and financial services are subject to various federal and state regulations applicable to their operations. These insurance companies and we must comply with constantly evolving regulations and make changes occasionally to services, products, structure or operations in accordance with the requirements of those regulations.

Similar to the insurance companies providing products and services offered by us, we are unable to accurately predict additional government regulations, including health care reform currently pending at the

federal level, that may be enacted affecting the insurance industry and the offered products and service or how existing or future regulations might be interpreted.

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Additional governmental regulation or future interpretation of existing regulations may decrease the amount of commissions we can earn, eliminate some of the products we offer, increase the cost of compliance or materially affect the insurance products and services offered by us and our profitability.

We must rely on the insurance companies that provide the insurance products and financial services offered by us to carefully monitor state and federal legislative and regulatory activity as it affects their insurance products and services. We believe that the insurance products and financial services that we offer comply in all material respects with all applicable federal and state regulations.

Among the benefits afforded to the members of our association are varying forms of insurance. Our ability to offer insurance products that we are authorized to distribute to this association for inclusion in its benefit packages may be affected by governmental regulation or future interpretation of existing regulations that may increase the cost of regulatory compliance or affect the nature and scope of products that we may make available to such associations.

We are currently offering extended service contracts that we obtain from a service contract provider in three states through a retailer of electronics and appliances. Those three states regulate extended service contracts under the state insurance code. These laws generally regulate the disclosures, service contract provisions and require us to obtain insurance coverage for the cost of service. We contract with a third party vendor that provides the insurance and the customer contracts.

Healthcare Regulation and Reform

Government regulation and reform of the healthcare industry may also affect the manner in which we conduct our business. There continues to be diverse legislative and regulatory initiatives at the federal and state levels that may affect aspects of the nation s health care system some of which may decrease the amount of commissions we can earn, may eliminate some of the products we offer, increase the cost of compliance or adversely affect the insurance products and services offered by us and our profitability. The Health Care and Education Affordability Reconciliation Act of 2010 (Health Care Reform Law) which was signed into law on March 30, 2010 will reduce the amount of commission paid by health insurance carriers and may have other adverse consequences including those listed above in this paragraph.

The Gramm-Leach-Bliley Act mandated restrictions on the disclosure and safeguarding of our insured s financial information. The USA Patriot Act placed new federal compliance requirements relating to anti-money laundering, customer identification and information sharing.

In addition, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires certain guaranteed issuance and renew-ability of health insurance coverage for individuals and small employer groups and limits exclusions on pre-existing conditions. HIPAA mandated the adoption of extensive standards for the use and disclosure of health information. HIPAA also mandated the adoption of standards for the exchange of electronic health information in an effort to encourage overall administrative simplification and enhance the effectiveness and the efficiency of the healthcare industry.

HIPAA s security standards became effective April 20, 2005 and further mandated that specific requirements be met relating to maintaining the confidentiality and integrity of electronic health information and protecting it from anticipated hazards or uses and disclosures that are not permitted.

We believe that we are in compliance with these regulations. We plan to continually audit our compliance, and accordingly cannot give assurance that our costs of continuing to comply with HIPAA will not be material to us. Sanctions for failing to comply with standards issued pursuant to HIPAA include criminal penalties and civil sanctions.

In addition to federal regulation and reform, many states have enacted, or are considering, various healthcare reform statutes. These reforms relate to, among other things, managed care practices, prompt payment practices, health insurer liability and mandated benefits. Most states have also enacted patient confidentiality laws that prohibit the disclosure of confidential information. As with all areas of legislation, the federal regulations establish minimum standards and preempt conflicting state laws that are less restrictive but will allow state laws that are more restrictive. We expect that this trend of increased legislation and regulation will continue. We are unable to predict what state reforms will be enacted or how they would affect our business.

E-Commerce Regulation

We may be subject to additional federal and state statutes and regulations in connection with our product strategy that includes Internet services and products. On an increasingly frequent basis, federal and state legislators are proposing laws and regulations that apply to internet based commerce and communications. Areas being affected by this regulation include user privacy, pricing, content, taxation, copyright protection, distribution and quality of products, and services. To the extent that our products and services would be subject to these laws and regulations, the sale of our products and our business could be adversely affected.

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Network Marketing Regulation

Our network marketing system is subject to a number of federal and state regulations administered by the Federal Trade Commission and various state agencies. Our network marketing organization and activities are subject to scrutiny by various state and federal governmental regulatory agencies. These laws and regulations include securities, franchise investment, business opportunity and criminal laws prohibiting the use of pyramid or endless chain types of selling organizations. The compensation structure of these selling organizations is very complex, and compliance with all of the applicable laws is uncertain in light of evolving interpretation of existing laws and the enactment of new legislation and adoption of regulations pertaining to this type of product distribution.

We seek legal advice, regarding the structure and operation of our network marketing to ensure that it complies with all of the applicable laws and regulations pertaining to network sales organizations. Based on these efforts and the experience of our management, we believe that we are in compliance with all applicable federal and state regulatory requirements.

Legislative Development

In addition to the Health Care Reform Law, numerous proposals to reform the current healthcare system have been introduced in the U.S. Congress and in various state legislatures. Proposals have included, among other things, modifications to the existing employer-based insurance system, a quasi-regulated system of managed competition among health insurers, and a single-payer, public program. Changes in healthcare policy could significantly affect our business. Legislation has been introduced from time to time in the U.S. Congress that could result in the federal government assuming a more direct role in regulating insurance companies.

We are unable to evaluate new legislation that may be proposed and when or whether any legislation will be enacted and implemented. However, many of the proposals, if adopted, could have a material adverse effect on our business, financial condition or results of operations; while others, if adopted, could potentially benefit our business.

Privacy Laws

Certain of our services are based upon the collection, distribution and protection of sensitive private data. Our contracts with certain clients require our protection of certain confidential information and to compliance with certain provisions of privacy laws including the Gramm-Leach-Bliley Act. Unauthorized users might access that data, and human error or technological failures might cause the wrongful dissemination of that data. If we experience a security breach, the integrity of certain of our services may be affected and the breach could violate certain of our client agreements. We have incurred, and may continue to incur, significant costs to protect against the threat of a security breach. We may also incur significant costs to alleviate problems that may be caused by future breaches. Any breach or perceived breach could subject us to government fines or sanctions, legal claims from clients or customers under that govern the security non-public personal information. There is no assurance that we would prevail in the event of such litigation. Moreover, any public perception that we have engaged in the unauthorized release of, or have failed to adequately protect private information could adversely affect our ability to attract and retain members and end-customers. In addition, unauthorized third parties might alter information in our databases that may adversely affect both our ability to market our services and the credibility of our information.

ITEM 1A. RISK FACTORS.

The matters discussed below and elsewhere in this report should be considered when evaluating our business operations and strategies. Additionally, there may be risks and uncertainties that we are not aware of or that we currently deem immaterial, which may become material factors affecting our operations and business success. Many of the factors are not within our control. We provide no assurance that one or more of these factors will not:

adversely affect the market price of our common stock,
adversely affect our future operations,
adversely affect our business,
adversely affect our financial condition,
adversely affect our results of operations,

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require significant reduction or discontinuance of our operations,
require us to seek a merger partner, or
require us to sell additional stock on terms that are highly dilutive to our shareholders.

THIS REPORT CONTAINS CAUTIONARY STATEMENTS RELATING TO FORWARD LOOKING INFORMATION.

We have included some forward-looking statements in this section and other places in this report regarding our expectations. These forward-looking statements involve known and unknown risks, uncertainties and other factors that may cause our actual results, levels of activity, performance or achievements, or industry results, to be materially different from any future results, levels of activity, performance or achievements expressed or implied by these forward-looking statements. Some of these forward-looking statements can be identified by the use of forward-looking terminology including believes, expects, may, will, should or anticipates or the negative ther other variations thereon or comparable terminology, or by discussions of strategies that involve risks and uncertainties. You should read statements that contain these words carefully because they:

discuss our future expectations,
contain projections of our future operating results or of our future financial condition, or
states other forward-looking information.

We believe it is important to discuss our expectations. However, it must be recognized that events may occur in the future over which we have no control and which we are not accurately able to predict. Any forward-looking statements contained in this report represent our judgment as of the date of this report. We disclaim, however, any intent or obligation to update these forward-looking statements. As a result, the reader is cautioned not to place undue reliance on these forward-looking statements.

A SIGNIFICANT PORTION OF OUR REVENUE IS DEPENDENT ON TWO CLIENTS.

Revenue attributable to two clients in our Wholesale Plans and Insurance Marketing Divisions totaled $22,234,963 or 40% of total revenue for the fiscal year ended September 30, 2010.

For the fiscal year ended September 30, 2010, revenue attributable to a client in our Wholesale Plans Division totaled $11,858,278 or 21% of total revenue. Although we have long-term contracts with these clients, loss of either or both of these clients would have a significant adverse affect on our revenues, profitability and our ability to negotiate discounts with vendors.

A PORTION OF OUR EXPENSES ARE DEPENDENT ON FACTORS THAT WE DO NOT CONTROL.

Some of our expenses, especially those related to unemployment waiver and extended service, are dependent on factors that we do not control such as the national unemployment rate or changes in product design or reliability. As a consequence, those factors may adversely change causing us to incur additional expenses that we may not be able to manage or reduce. Any negative change in our expenses could reduce our profitability and we may not be able to pass those costs on to our clients or customers without losing business.

WE DEPEND ON VARIOUS THIRD-PARTY VENDORS TO SUPPLY CERTAIN PRODUCTS AND SERVICES THAT WE MARKET.

We depend on various third-party vendors to supply the products and services that we market. As a result, the quality of service they provide is not entirely within our control. If any third-party vendor were to cease operations, or terminate, breach or not renew its contract with us, or suffer interruptions, delays or quality problems, we may not be able to substitute a comparable third-party vendor on a timely basis or on favorable terms. With respect to the insurance programs and products that we offer, we are dependent on the insurance carriers that underwrite the insurance to obtain appropriate regulatory approvals. If we were required to use an alternative insurance carrier, it may materially increase the time required to bring alternative or substitute insurance related product to market. We are generally obligated to continue providing our products and services to our customers even if we lose the vendor providing the products or services. A disruption in our product offerings could harm our reputation and result in customer or agent dissatisfaction. Replacing existing third-party vendors may not be accomplished in a timely manner and may be with more expensive third-party vendors resulting in increased costs and reduced profitability.

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WE FACE COMPETITION FOR CLIENTS TO MARKET OUR PROGRAMS AS WELL AS COMPETITIVE OFFERINGS OF BENEFIT PROGRAMS.

There is significant competition for agents, clients and members in our industries. We offer programs that provide products and services similar to or directly in competition with products and services offered by our competitors as well as the providers of such products and services through other channels of distribution.

We provide no assurance that our competitors will not provide products or benefit programs comparable or superior to our products and programs at lower membership prices or adapt more quickly to evolving industry trends or changing industry requirements. Increased competition may result in price reductions, reduced gross margins, and loss of market share, any of which could adversely affect our business, financial condition and results of operations. There is no assurance that we will be able to compete effectively with current and future competitors.

WE HAVE MANY COMPETITORS AND MAY NOT BE ABLE TO COMPETE EFFECTIVELY WHICH MAY LEAD TO A LACK OF REVENUES AND DISCONTINUANCE OF OUR OPERATIONS.

We compete with numerous well-established companies that design and implement membership programs and other healthcare programs. Some of our competitors may be companies that have programs that are functionally similar or superior to our programs. Most of our competitors possess substantially greater financial, marketing, personnel and other resources than us.

Due to competitive market forces, we may experience price reductions, reduced gross margins and loss of market share in the future, any of which would result in decreases in sales and revenues. These decreases in revenues would adversely affect our business and results of operations and could lead to discontinuance of operations. There can be no assurance that:

- we will be able to compete successfully;
- our competitors will not develop programs that render our programs less marketable or even obsolete; or
- we will be able to successfully enhance our programs when necessary.

THE COST OF COMPLIANCE WITH DISCOUNT MEDICAL PROGRAM ORGANIZATION LAWS AND REGULATIONS MAY ADVERSELY AFFECT OUR PROFITABILITY.

In recent years, several states have enacted laws and adopted regulations that govern discount medical program organizations (DMPO) similar to those we offer and organize. The laws and regulations vary in scope, ranging from registration to a comprehensive licensing process with oversight over all aspects of the program, including the manner, by which discount medical programs are sold, the price at which they are sold, and the DMPO licenses or registrations. Because a significant number of states have not enacted laws governing discount medical programs we cannot predict whether those states will similarly enact these laws and if they do, we do not know the full consequence of their enactment upon our business. We do not know whether we will be able to maintain all necessary licenses and registrations. Our need to comply with these laws and regulations may adversely affect or limit our future operations. The cost of complying with these laws and regulations has and will likely continue to have a material adverse effect on our results of operations and financial position.

THE EFFECT OF THE HEALTH CARE REFORM ON THE INSURANCE INDUSTRY AND OUR INSURANCE MARKETING DIVISION IS UNCERTAIN.

Government regulation of health and life insurance, annuities and healthcare coverage and health plans is a changing area of law and varies from state to state. At the federal level, The Health Care and Education Affordability Reconciliation Act of 2010 (Health Care Reform Law) was signed into law on March 30, 2010. Although much of the regulatory interpretation of the new law has yet to be proposed and adopted, beginning in 2010 insurers are required to implement a number of changes related to major medical insurance policies. These changes include: changes to required coverage, elimination of most preexisting condition exclusions and a minimum loss ratio of 80-85%. The minimum loss ratio requires health insurance companies to expend 80% of the premium on medical service reimbursements (85% for group health). The law will require certain people to purchase health insurance and will set up subsidies to assist certain people in purchasing health insurance and allows certain people to obtain insurance from the federal government. The Health Care Reform Law could impact the number of health insurance customers purchasing health insurance and the amount and nature of the health insurance they purchase. We are unable to predict

whether this law will increase or decrease the number of people purchasing health insurance or the amount of insurance purchased. As a result of the Health Care Reform Law, commissions on the sale of individual major medical insurance policies will be reduced beginning in 2011 and that will result in a significant reduction in our revenue. Because most of our commission revenue is ultimately paid to our agents, we anticipate that the potential reduction in revenue will not necessarily cause a reduction in our profitability in the same proportion. However, the reduction in commission could cause our agents to stop selling health insurance or cause them to sell other products with high commission levels to make up for the loss of their revenues.

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IN ADDITION TO THE RECENTLY ENACTED HEALTH CARE REFORM ACT, ADDITIONAL HEALTH CARE REFORM LEGISLATION CONTINUES TO BE CONSIDERED, THE NATURE AND CONSEQUENCE OF WHICH ARE CURRENTLY INDETERMINABLE.

Other proposals to reform the current healthcare system have been introduced in the U.S. Congress and in various state legislatures. Proposals have included, among other things, modifications to the existing employer-based insurance system, a quasi-regulated system of managed competition among health insurers, and a single-payer, public program. Changes in healthcare policy could significantly affect our business. Government regulation and reform of the healthcare industry may also affect the manner in which we conduct our business in the future. The legislative and regulatory initiatives at both the federal and state levels to effect changes and cost containment in the nation s health care system may decrease the amount of commissions we can earn, eliminate some of the products we currently and may offer, increase the cost of compliance or materially affect the insurance products and services offered by us and our profitability.

INSURANCE PRODUCTS AND THE SALE OF THOSE PRODUCTS ARE HIGHLY REGULATED AND THE COST OF COMPLIANCE MAY INCRASE AND LIMIT THE INSURANCE PRODUCTS WE OFFER.

Although we are not an insurance company, the insurance companies from which we obtain our products and financial services are subject to various federal and state laws and regulations applicable to their operations. These insurance companies must comply with constantly evolving regulations and make changes occasionally to services, products, structure or operations in accordance with the requirements of those laws and regulations. We may also be limited in manner in which we market and distribute our products and financial services as a result of these laws and regulations.

OUR MEMBERSHIP ASSOCIATIONS MAY BECOME SUBJECT TO INCREASED REGULATION, THROUGH REGULATORY LICENSING REQUIREMENTS, OR REGULATORY ENFORCEMENT, RESULTING IN RESTRICTION OF THE MANNER OF DISTRIBUTION AND RESULTING IN INCREASED REGULATORY COMPLIANCE COSTS AND PENALTIES.

We market memberships in associations that have been formed to provide various consumer benefits to their members. These associations may include in their benefit packages unemployment waivers, extended service and insurance products that are issued under group or blanket policies covering the association s members. Most states insurance laws and regulations allow these membership programs that contain insurance products to be sold under certain circumstances without a licensed insurance agent making each sale. If a state were to determine that our sales of these program memberships do not comply with their laws or regulations, it would result in a material adverse effect on our results of operations and financial position. Our ability to continue selling these memberships would be adversely affected, and we may be subject to fines and penalties and may have to issue refunds or provide restitution to the associations and their members.

OUR BUSINESS PRACTICES AND COMPENSATION ARRANGEMENTS WITH INSURANCE COMPANIES AND AGENTS MAY BE SCRUTINIZED BY GOVERNMENTAL REGULATORS AND SUBJECT TO CONSUMER LITIGATION.

The business practices and compensation arrangements of the insurance intermediary industry, including our practices and arrangements, are subject to uncertainty due to investigations by various government authorities and related private litigation. The legislatures of various states may adopt new laws addressing contingent commission arrangements, including laws prohibiting these arrangements, and addressing disclosures of these arrangements to the insured. Various state departments of insurance may also adopt new regulations addressing these matters. While it is not possible to predict the outcome of the government inquiries and investigations into the insurance industry s commission payment practices or the response by the market and government regulators, any material decrease in our profit-sharing contingent commissions is likely to have an adverse effect on our results from operations.

WE MAY HAVE EXPOSURE AND LIABILITY RELATING TO NON-COMPLIANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 AND THE COST OF COMPLIANCE COULD BE MATERIAL.

In April 2003 privacy regulations promulgated by The Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA imposes extensive restrictions on the use and disclosure of individually identifiable health information by certain entities. Also as part of HIPAA, the

Department of Health and Human Services has regulations standardizing electronic transactions between health plans, providers and clearinghouses. Healthcare plans, providers and claims administrators are required to conform their electronic and data processing systems to HIPAA electronic transaction requirements. While we believe we are currently compliant with these regulations, we cannot be certain of the extent to which the enforcement or interpretation of these regulations will affect our business. Our continuing compliance with these regulations, therefore, may have a significant adverse effect on our business operations and may be at material cost in the event we are subject to these regulations. Sanctions for failing to comply with standards issued pursuant to HIPAA include criminal and civil sanctions.

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OUR FAILURE TO COMPLY WITH FEDERAL AND STATE REGULATION COULD RESULT IN ENFORCEMENT ACTION AND IMPOSITION OF PENALTIES, MODIFICATION OF OUR OPERATIONS, AND NEGATIVE PUBLICITY.

Our operations are regulated by federal and state laws and regulations administered by various state agencies. These laws and regulations cover the areas of insurance, discount medical plans, associations, and extended service. Compliance with all of the applicable regulations and laws is uncertain because of the evolving interpretations of existing laws and regulations, and the enactment of new laws and regulations.

Accordingly, there is the risk that our operations could be found to not comply with applicable laws and regulations that could

result in enforcement action and imposition of penalty,
require modification of our operations or programs,
result in negative publicity.

Any of these consequences could have a material adverse effect on our results of operations as well as our financial condition.

THE RECORDED GOODWILL ASSOCIATED WITH OUR ACQUISITION OF ACCESS PLANS USA AND OUR MERGER-ACQUISITION OF BMS HOLDING COMPANY MAY BECOME IMPAIRED AND REQUIRE A SUBSTANTIAL WRITEDOWN AND THE RECOGNITION OF AN IMPAIRMENT EXPENSE.

In connection with our acquisition of Access Plans USA in 2009 and our merger-acquisition of BMS Holding Company in 2007, we recorded goodwill that had a net aggregate asset value of $1,842,186 and $2,534,152, respectively at September 30, 2010. In the event that the goodwill is determined to be impaired for any reason, we will be required to write-down or reduce the value of the goodwill and recognize an impairment expense. The impairment expense may be substantial in amount and, in such case, adversely affect the results of our operations for the applicable period and may negatively affect the market value of our common stock.

OUR FAILURE TO PROTECT PRIVATE DATA COULD SUBJECT US TO PENALTIES, DAMAGE OUR REPUTATION, CAUSE US TO BE IN BREACH OF CONTRACTS AND CAUSE US TO EXPEND CAPITAL AND OTHER RESOURCES TO PROTECT AGAINST FUTURE SECURITY BREACHES.

Certain of our services are based upon the collection, distribution and protection of sensitive private data. Our contracts with certain clients place a duty on us to protect certain confidential information and to comply with certain provisions of privacy laws including the Gramm-Leach-Bliley Act. Unauthorized users might access that data, and human error or technological failures might cause the wrongful dissemination of that data. If we experience a security breach, the integrity of certain of our services may be affected and such a breach could violate certain of our client agreements. We have incurred, and will continue to incur, significant costs to protect against a security breach. We may also incur significant costs to alleviate problems that may be caused by a security breach. Any breach or perceived breach could subject us to government fines or sanctions, legal claims from clients or customers under that govern the security non-public personal information. There is no assurance that we would prevail in litigation. Moreover, any public perception that we have engaged in the unauthorized release of, or have failed to adequately protect, private information could adversely affect our ability to attract and retain members and end-customers. In addition, unauthorized third parties might alter information in our databases that would adversely affect both our ability to market our services and the credibility of our information.

WE RELY ON OUR INSURANCE CARRIER PARTNERS AND THIRD PARTIES TO ACCURATELY AND REGULARLY PREPARE COMMISSION REPORTS, AND IF THESE REPORTS ARE INACCURATE OR NOT SENT TO US IN A TIMELY MANNER, OUR RESULTS OF OPERATIONS COULD SUFFER.

Our Insurance Marketing Division generates revenues primarily from the receipt of commissions paid to us by insurance companies based upon the insurance policies sold to consumers through agents with whom we have contracted. Our processing and recording of commission revenues earned and commission expenses payable to agents are key determinants of material revenues and expenses reported in our financial statements. Our failure to receive such commission information in a timely, complete and accurate fashion could adversely impact our ability to pay commissions in a timely and accurate manner or to state revenues or expenses in our financial statements in a materially correct manner. These revenues are in the form of first year and renewal commissions that vary by

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company and product. We rely on data not under our control, including data provided to us by the insurance company and premium collection and payment service providers engaged by the insurance company to timely and accurately calculate and pay commissions including advance payment of agent commissions. Some of the commission information is processed for us by outside third party service bureaus or administrators. Some of those third party service bureaus or administrators have not had their controls evaluated by independent registered accountants and they have not received SAS 70 reports on their controls. We have performed limited reviews of their controls and have preliminarily determined that they have insufficient information technology general controls. Accordingly, the commission information we receive may fluctuate as the insurance company or its collection and payment service providers make adjustments to their reports of policies sold. We have implemented our own processes to evaluate the data that we receive to help confirm that it is consistent with the number and types of policies that we believe have been sold. However, it is difficult for us to independently determine whether carriers are reporting all commissions due to us, primarily because the majority of our members terminate their policies by discontinuing their premium payments to the carrier instead of informing us of the cancellation. Because we cannot always rely on the accuracy or timeliness of the data that we receive from the insurance company or its payment service providers, our financially reported commissions are subject to adjustment and we may not collect and realize the full amount of the reported revenue which may adversely affect our business, operating results and financial condition.

OUR REVENUES IN THE RETAIL PLANS DIVISION ARE LARGELY DEPENDENT ON THE INDEPENDENT MARKETING REPRESENTATIVES, WHOSE REDUCED SALES EFFORTS OR TERMINATION MAY RESULT IN SIGNIFICANT LOSS OF REVENUES.

Part of our success and growth depends in part upon our ability to attract, retain and motivate the network of independent marketing representatives who principally market our USA Healthcare Savings and Care Entrée medical savings programs. Our independent marketing representatives typically offer and sell these programs on a part-time basis, and may engage in other business activities. These marketing representatives may give higher priority to other products or services, reducing their efforts devoted to marketing our programs. Also, our ability to attract and retain marketing representatives could be negatively affected by adverse publicity relating to our programs and operations. Under our network marketing system, the marketing representatives down line organizations are headed by a relatively small number of key representatives who are responsible for a substantial percentage of our total revenues. The loss of a significant number of marketing representatives, including any key representatives, for any reason, could adversely affect our revenues and operating results, and could impair our ability to attract new distributors.

A LARGE PART OF OUR RETAIL PLANS DIVISION REVENUES ARE DEPENDENT ON KEY RELATIONSHIPS WITH A FEW PRIVATE LABEL RESELLERS AND WE MAY BECOME MORE DEPENDENT ON SALES BY A FEW PRIVATE LABEL RESELLERS.

Our revenues from sales of our independent marketing representatives have declined and continue to decline. As a result, we have become more dependent on sales made by private label resellers to whom we sell our discount medical programs. If sales made by our independent marketing representatives continue to decline or if our efforts to increase sales through private label resellers succeed, we may become more dependent on sales made by our private label resellers. Because a large number of these sales may be made by a few resellers, our revenues and operating results may be adversely affected by the loss of our relationship with any of those private label resellers.

THE FAILURE OF OUR NETWORK MARKETING ORGANIZATION TO COMPLY WITH FEDERAL AND STATE REGULATION COULD RESULT IN ENFORCEMENT ACTION AND IMPOSITION OF PENALTIES, MODIFICATION OF OUR NETWORK MARKETING SYSTEM, AND NEGATIVE PUBLICITY.

Our network marketing organization is subject to federal and state laws and regulations administered by the Federal Trade Commission and various state agencies. These laws and regulations include securities, franchise investment, business opportunity and criminal laws prohibiting the use of pyramid or endless chain types of selling organizations. These regulations are generally directed at ensuring that product and service sales are ultimately made to consumers (as opposed to other marketing representatives) and that advancement within the network marketing organization is based on sales of products and services, rather than on investment in the company or other non-retail sales related criteria. The compensation structure of a network marketing organization is very complex. Compliance with all of the applicable regulations and laws is uncertain because of

the evolving interpretations of existing laws and regulations, and
the enactment of new laws and regulations pertaining in general to network marketing organizations and product and service distribution.

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Accordingly, there is the risk that our network marketing system could be found to not comply with applicable laws and regulations that could

result in enforcement action and imposition of penalty,
require modification of the marketing representative network system,
result in negative publicity, or
have a negative effect on distributor morale and loyalty.

Any of these consequences could have a material adverse effect on our results of operations as well as our financial condition.

THE LEGALITY OF OUR NETWORK MARKETING ORGANIZATION IS SUBJECT TO CHALLENGE BY OUR MARKETING REPRESENTATIVES, WHICH COULD RESULT IN SIGNIFICANT DEFENSE COSTS, SETTLEMENT PAYMENTS OR JUDGMENTS, AND COULD HAVE A MATERIAL ADVERSE EFFECT ON OUR RESULTS OF OPERATIONS AND FINANCIAL CONDITION.

Our network marketing organization is subject to legality challenge by our marketing representatives, both individually and as a class. Generally, these challenges would be based on claims that our marketing network program was operated as an illegal pyramid scheme in violation of federal securities laws, state unfair practice and fraud laws and the Racketeer Influenced and Corrupt Organizations Act. Proceedings resulting from these claims could result in significant defense costs, settlement payments, or judgments, and could have a material adverse effect on us.

ADVERTISING AND PROMOTIONAL ACTIVITIES OF OUR INDEPENDENT MARKETING REPRESENTATIVES AND PRIVATE-LABEL CUSTOMERS ARE SUBJECT TO AND MAY VIOLATE FEDERAL AND STATE REGULATION CAUSING US TO BE SUBJECT TO THE IMPOSITION OF CIVIL PENALTIES, FINES, INJUNCTIONS AND LOSS OF STATE LICENSES.

The Federal Trade Commission (FTC) and most states regulate advertising, product claims, and other consumer matters, including advertising of our healthcare savings products. All advertising, promotional and solicitation materials used by our independent marketing representatives and private label customers must be approved by us prior to use. While we have not been the target of FTC enforcement action, there can be no assurance that the FTC will not question our advertising or other operations in the future. In addition, there can be no assurance that a state will not interpret our product claims presumptively valid under federal law as illegal under that state s regulations, or that future FTC regulations or decisions, will not restrict the permissible scope of the claimed savings. We are subject to the risk of claims by our independent marketing representatives and private label customers and those under private label arrangements may file actions on their own behalf, as a class or otherwise, and may file complaints with the FTC or state or local consumer affairs offices. These agencies may take action on their own initiative against us for alleged advertising or product claim violations. A complaint because of a practice of one independent marketing representative or private label customer, whether or not that practice was authorized by us, could result in an order affecting some or all of our independent marketing representatives and private label customers in the particular state, and an order in one state could influence courts or government agencies in other states considering similar matters. Proceedings resulting from these complaints may result in significant defense costs, settlement payments or judgments and could have a material adverse effect on our operations.

DISRUPTIONS IN OUR OPERATIONS DUE TO OUR RELIANCE ON OUR MANAGEMENT INFORMATION SYSTEM MAY OCCUR AND COULD ADVERSELY AFFECT OUR CLIENT RELATIONSHIPS.

We manage certain information related to our Retail Plans Division membership on an administrative proprietary information system. Because it is a proprietary system, we do not rely on any third party for its support and maintenance. There is no assurance that we will be able to continue operating without experiencing any disruptions in our operations or that our relationships with our members, marketing representatives or providers will not be adversely affected or that our internal controls will not be adversely affected.

THE AVAILABILITY OF OUR INSURANCE PRODUCTS AND FINANCIAL SERVICES ARE DEPENDENT ON OUR STRATEGIC RELATIONSHIPS WITH VARIOUS INSURANCE COMPANIES AND THE UNAVAILABILITY OF THOSE PRODUCTS AND SERVICES FOR ANY REASON MAY RESULT IN SIGNIFICANT LOSS OF REVENUES.

We are not an insurance company and only market and distribute insurance products and financial services developed and offered by insurance companies. We must develop and maintain relationships with insurance companies that

provide products and services for a particular market segment (the elderly, the young family, etc.) that we in turn make available to the independent agents with whom they have contracted to sell the products and services to the individual consumer. We are dependent on a relatively small number of insurance companies to provide product and financial services for sale through our channels.

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Development and maintenance of relationships with the insurance companies may in part be based on professional relationships and the reputation of our management and marketing personnel. Consequently, the relationships with insurance companies may be adversely affected by events beyond our control, including departures of key personnel and alterations in professional relationships. Our success and growth depend in large part upon our ability to establish and maintain these strategic relationships, contractual or otherwise, with various insurance companies to provide their products and services, including those insurance products and financial services that may be developed in the future. The loss or termination of these strategic relationships could adversely affect our revenues and operating results. Furthermore, the loss or termination may also impair our ability to maintain and attract new insurance agencies and their agents to distribute the insurance products and services that we offer.

WE ARE DEPENDENT UPON INDEPENDENT INSURANCE AGENCIES AND THEIR AGENTS TO OFFER AND SELL OUR INSURANCE PRODUCTS AND FINANCIAL SERVICES.

We are principally dependent upon independent insurance agencies and their agents to offer and sell the insurance products and financial services that we offer and distribute. These insurance agencies and their agents may offer and distribute insurance products and financial services that are competitive with ours. These independent agencies and their agents may give higher priority and greater incentives (financial or otherwise) to other insurance products or financial services, reducing their efforts devoted to marketing and distribution of the insurance products and financial services that we offer. Also, our ability to attract and retain independent insurance agencies could be negatively affected by adverse publicity relating to our products and services or our operations.

We are dependent on a small number of independent insurance agencies for a very significant percentage of our total insurance products and financial services revenue. Development and maintenance of the relationships with independent insurance agencies and their agents may in part be based on professional relationships and the reputation of our management and marketing personnel. Consequently, these relationships may be adversely affected by events beyond our control, including departures of key personnel and alterations in professional relationships. The loss of a significant number of the independent insurance agencies (and their agents), as well as the loss of a key agency or its agents, for any reason, could adversely affect our revenue and operating results, or could impair our ability to establish new relationships or continue strategic relationships with independent insurance agencies and their agents.

WE FACE INTENSE COMPETITION IN THE MARKETPLACE FOR OUR PRODUCTS AND SERVICES AS WELL AS COMPETITION FOR INSURANCE AGENCIES AND THEIR AGENTS FOR THE MARKETING OF THE PRODUCTS AND SERVICES OFFERED.

Instead of utilizing captive or wholly-owned insurance agencies for the offer and sale of our products and services, we utilize independent insurance agencies and their agents as the principal marketing and distribution channel. Competition for independent insurance agencies and their agents is intense. Also, competition from products and services similar to or directly in competition with the products and services that we offer is intense, including those products and services offered and sold through the same channels utilized for distribution of our insurance products and financial services. Under arrangements with the independent insurance agencies, the agencies and their agents may offer and sell a variety of insurance products and financial services, including those that compete with the insurance products and financial services that we offer.

Thus, our business operations compete in two channels of competition. First, we compete based upon the insurance products and financial services offered. This competition includes products and services of insurance companies that compete with the products and services of the insurance companies that we offer and sell. Second, we compete with all types of marketing and distribution companies throughout the U.S. for independent insurance agencies and their agents. Many of our competitors have substantially larger bases of insurance companies providing products and services, and longer-term established relationships with independent insurance agencies and agents for the sale and distribution of products and services, as well as greater financial and other resources.

There is no assurance that our competitors will not provide insurance products and financial services comparable or superior to those products and services that we offer at lower costs or prices, greater sales incentives (financial or otherwise) or adapt more quickly to evolving insurance industry trends or changing industry requirements. Increased competition may result in reduced margins on product sales and services, less than anticipated sales or reduced sales, and loss of market share, any of which could materially adversely affect our business and results of operations. There

can be no assurance that we will be able to compete effectively against current and future competitors.

ITEM 1B. UNRESOLVED STAFF COMMENTS.

We do not have any unresolved and outstanding comments of the Staff of the U.S. Securities and Exchange Commission.

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ITEM 2. PROPERTIES

We lease the space for our corporate offices and Wholesale Plans Division in Norman, Oklahoma under a lease that expires September 30, 2011. The total space consists of approximately 6,523 square feet. The lease agreement is with Southwest Brokers, Inc., a company owned by Brett Wimberley, one of our Directors, President and Chief Financial Officer. This lease was executed on May 1, 2005, amended on August 1, 2006, August 1, 2008, September 30, 2009 and September 30, 2010. The lease expires on September 30, 2011. In the event we are required to move from our current Norman, Oklahoma office facilities, the terms and cost of occupancy may be substantially different than those under which our office space is currently occupied and the rental rate may be substantially greater.

Our Retail Plans and Insurance Marketing Divisions lease office space in Irving, Texas under a lease agreement with an unaffiliated third party that expires November 15, 2011. The total space consists of approximately 17,612 square feet. We lease an additional 7,412 square feet from the same unaffiliated third party under a separate lease that expires November 30, 2011.

We believe that our current office space facilities are adequate for our current operations.

ITEM 3. LEGAL PROCEEDINGS

The following legal proceedings involve the subsidiaries of Access Plans USA which we acquired on April 1, 2009.

William Andrew Rivell, M.D. and Alan B. Whitehouse, M.D., individually and on behalf of all persons similarly situated, v. Private Health Care Systems and The Capella Group, Inc.; Civil Action File No: CV106-176 was filed and remains pending in the United States District Court for the Southern District of Georgia, Augusta Division. The plaintiffs in this case allege that the contracts entered into by medical providers with our subsidiary, The Capella Group, Inc. (Capella) through Capella s relationship with the Private Health Care Systems network of providers (PHCS) did not allow for the use of the providers names to market a discount medical plan whereby payment for services is made at the point of service by the consumer, and not by a third-party payor such as an insurance company. We vigorously contest this assertion and intend to defend this case. The Plaintiffs are, however, seeking certification of this case as a class action on behalf of all similarly-situated physicians nationwide. If the plaintiffs succeed with such certification and ultimately prevail in the case, it could have a material adverse affect on our financial condition and our results of operation. The case was originally instituted on November 17, 2006, but was thereafter dismissed by the District Court. The United States Court of Appeals for the Eleventh Circuit vacated such dismissal and remanded the case to the District Court on March 24, 2008. In August of 2009 the District Court denied Plaintiffs Amended Motion for Class Certification. In September of 2009 Plaintiffs filed their Motion for Reconsideration of Order Denying Amended Motion for Class Certification, asking the District Court to certify a smaller class. On September 30, 2010 the Court issued a ruling denying Plaintiff s Motion for Reconsideration of Order Denying Amended Motion for Class Certification.

On October 30, 2008 The Hartford Accident and Indemnity Co. assumed payment of defense costs pursuant to a reservation of rights letter issued on that date. The Hartford s duty to defend was litigated in Hartford Accident and Indemnity Insurance Company v. The Capella Group, Inc. D/b/a Care Entrée**;** Civil Action File No: 4:09-cv-295 which was filed on May 27, 2009. The Court on December 21, 2009 issued a memorandum opinion granting our motion for summary judgment denying the summary judgment motion of Hartford on the duty to defend issue, ruling that the Hartford was obligated to provide a defense in the Rivell action. The Court denied our motion for attorney s fees related to the summary judgment motions and ruled that a decision on the issue of whether Hartford had a duty to indemnify in the Rivell action was premature. The court dismissed all remaining claims for declaratory relief by either party.

Zermeno v Precis, Inc. The case styled Manuela Zermeno, individually and on behalf of the general public; and Juan A. Zermeno, individually and on behalf of the general public v Precis, Inc., and Does 1 through 100, inclusive was filed on August 14, 2003 in the Superior Court of the State of California for the County of Los Angeles under case number BC 300788. The Zermeno plaintiffs are former members of the Care Entrée discount healthcare program who allege that they (for themselves and for the general public) are entitled to injunctive, declaratory, and equitable relief under Section 445 of the California Health and Safety Code. That Section governs medical referral services. The plaintiffs also sought relief under Section 17200 of the Business and Professions Code, California s Unfair Competition Law. On December 21, 2007, we received a favorable verdict based on the court s finding that the

Plaintiffs did not have standing to sue since they were no longer customers of Precis. The plaintiffs appealed and on December 23, 2009 the Court of Appeals reversed the trial court s ruling on standing and remanded the case to the trial court for a ruling on the merits. On November 1, 2010 the Court issued a Statement of Decision in which it ruled that Section 445 applied to the Care Entrée program and that Section 445 had been violated. Following the ruling, the parties have briefed the issue of scope of injunctive relief. Precis, Inc. has the right to appeal the Statement of Decision or any injunctive relief that is issued once the Court issues a ruling on injunctive relief. An adverse outcome in this case would have a material affect our financial condition and would limit our ability (and that of other healthcare discount programs) to do business in California. We believe that we have complied with all California statues and regulations. Although we believe the Plaintiffs claims are without merit, we cannot provide any assurance regarding the outcome or results of this litigation.

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At September 30, 2010, we accrued $36,000 for defense costs of the above matters and other pending litigation matters. While it is possible that we may incur costs in excess of this amount, we are unable to provide a reasonable estimate of the range of additional costs that may be incurred.

ITEM 4. (Removed and Reserved)

PART II.

ITEM 5. MARKET FOR REGISTRANT S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

Our common stock is quoted on the OTC Bulletin Board under the symbol APNC . As of December 6, 2010, there were 352 holders of record of our common stock. The table below sets forth for the periods indicated the high and low price per share (using the closing average of best bid and best ask price) of our common stock as reported on the OTC Bulletin Board. These quotations also reflect inter-dealer prices without retail mark-ups, mark-downs or commissions, and may not necessarily represent actual transactions.

	Price Per Common Share	
	High	Low
Year Ended September 30, 2010:		
First Quarter ended December 31, 2009	$ 1.18	$ 0.75
Second Quarter ended March 31, 2010	$ 1.22	$ 1.00
Third Quarter ended June 30, 2010	$ 1.25	$ 0.83
Fourth Quarter ended September 30, 2010	$ 0.97	$ 0.85
Year Ended September 30, 2009:		
First Quarter ended December 31, 2008	$ 1.05	$ 0.30
Second Quarter ended March 31, 2009	$ 0.95	$ 0.55
Third Quarter ended June 30, 2009	$ 0.89	$ 0.36
Fourth Quarter ended September 30, 2009	$ 1.00	$ 0.40

DIVIDEND POLICY

We have never paid cash dividends or made other cash distributions to common stock shareholders, and do not expect to declare or pay any cash dividends in the foreseeable future.

We intend to retain future earnings, if any, for working capital and to finance current operations and expansion of its business. Payments of dividends in the future will depend upon growth, profitability, financial condition and other factors that our Board of Directors may deem relevant.

ISSUANCE OF UNREGISTERED SECURITIES

On September 30, 2010, one of our former executive officers and directors exercised stock option for the purchase of 100,000 common stock shares for $.83 per share. The common stock shares were not registered under the Securities Act of 1933, as amended (the Securities Act). The shares were issued without payment of commissions or any other form of remuneration and pursuant to Rule 506 of Regulation D promulgated under the Securities Act.

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SECURITIES AUTHORIZED FOR ISSUANCE UNDER EQUITY COMPENSATION PLANS

The following table sets forth as of September 30, 2010, information related to each category of equity compensation plan approved or not approved by our shareholders, including individual compensation arrangements with our non-employee directors. The equity compensation plans approved by our shareholders is our 2009 Equity Option Plan. All stock options and rights to acquire our equity securities are exercisable for or represent the right to purchase our common stock.

On October 13, 2009, our board of directors approved and adopted the Alliance HealthCard, Inc. 2009 Equity Compensation Plan. The 2009 Plan became effective on December 7, 2009.

Our 2000 Stock Option Plan was terminated on December 7, 2009.

Plan category	Number of Securities to be issued upon exercise of outstanding options, warrants and rights	Weighted-average exercise price of outstanding options, warrants and rights	Number of securities remaining available for future issuance under equity compensation plans
Equity compensation plans approved by security holders:			
2009 Stock Option Plan	2,270,111	$ 1.11	279,889
Equity compensation plans not approved by security holders:			
2000 Stock Option Plan			
Total	2,270,111		279,889

ITEM 6. SELECTED FINANCIAL DATA.

We are a smaller reporting company as defined in Rule 12b-2 of the Exchange Act and as such, are not required to provide the information required by Item 301 of Regulation S-K with respect to Selected Financial Data.

ITEM 7. MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS.

Overview

Access Plans, Inc. became a holding company of Alliance HealthCard and its subsidiaries and the registrant under the Securities Exchange Act of 1934 following approval by the shareholders of Alliance HealthCard, Inc. (Alliance HealthCard), effective December 7, 2009, Alliance HealthCard Acquisition Corp., a subsidiary of Access Plans, Inc., an Oklahoma corporation, also one of Alliance HealthCard s wholly-owned subsidiaries, merged into Alliance HealthCard. The shareholders of Alliance HealthCard exchanged their Alliance HealthCard common stock shares on a one-for-one basis for common stock shares of Access Plans, Inc.

Our subsidiary, Alliance HealthCard formed in 1998 is a provider of discount medical plans with a focus on creating, marketing, and distributing membership savings programs primarily to the underserved markets in the United States. Our original programs offered attractive savings in approximately 16 areas of healthcare, including physician visits, hospital stays, chiropractics, vision, dental, pharmacy, hearing, and patient advocacy, among others. In February 2007,

we completed the reverse merger-acquisition of BMS Holding Company, Inc., and its subsidiaries, Benefit Marketing Solutions, L.L.C. (BMS) and BMS Insurance Agency, L.L.C., (BMS Agency), Alliance HealthCard being deemed as the legal acquirer and BMS Holding Company as the accounting acquirer. As a result of this accounting treatment, intangible assets and goodwill totaling $4,791,945 were recorded reflecting the fair market value of Alliance HealthCard in excess of its identifiable net tangible assets as of the date of the merger. While we continue to market our health oriented programs, this merger-acquisition has greatly expanded our business scope to include programs that offer discount savings on dining and entertainment, automotive, legal and financial, as well as insurance programs including leased property, involuntary unemployment, accidental death and dismemberment, and product service plans. We sell our membership savings programs to retailers, insurance companies, finance companies, banks, employer groups and association-based organizations through direct sales or independent marketing consultants.

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BMS designs, markets, and distributes membership programs for rental-purchase companies, financial organizations, employer groups, retailers and association-based organizations on a nation-wide basis. These membership programs are sold as part of a point-of-sale transaction or through direct marketing efforts. The point-of-sale membership plans are sold through more than 4,800 locations in the U.S. and Canada.

On April 1, 2009, we completed our acquisition of Access Plans USA. Access Plans USA markets health insurance and develops and distributes consumer driven discount plans on a variety of health related services such as medical, dental, pharmacy and vision care and manages its own proprietary dental and vision networks. We issued 6,800,578 shares of our common stock in exchange for the outstanding common stock of Access Plans USA. The aggregate purchase price of Access Plans USA was determined to be $4,768,500 based on the fair market value of the 6,800,578 shares determined on November 13, 2008, the date of the acquisition agreement. In connection with our acquisition of Access Plans USA, we recorded goodwill that had a net aggregate asset value of $1,842,186 at September 30, 2010.

The Company s operations are currently organized under four segments:

Wholesale Plans Division plan offerings are customized membership marketing plans primarily offered at rent-to-own retail stores.

Retail Plans Division plan offerings are primarily healthcare savings plans. These plans are not insurance, but allow members access to a variety of healthcare networks to obtain discounts from usual and customary fees.

Insurance Marketing Division markets individual major medical health insurance and other insurance products through a national network of independent agents.

Corporate includes salary and other expenses for individuals performing services for administration of overall management and operations of the Company. These expenses are not allocated to our other segments.

Wholesale Plans

Our Wholesale Plans Division provides our clients with customized membership marketing plans that leverage their brand names, customer relationships and typically their payment mechanism, plus offer benefits that appeal to their customers. The value provided by our plans to our clients, includes increased customer attraction and retention, plus incremental fee income with limited risk or capital cost.

Our plans are primarily offered at rent-to-own retail stores. Nationwide there are approximately 8,600 locations serving approximately 4.1 million households according to the Association of Progressive Rental Organizations (APRO). It is estimated that the two largest rent-to-own industry participants, account for approximately 4,800 of the total number of stores, and the majority of the remainder of the industry consists of operations with fewer than 50 stores. The industry has been consolidating and is expected to continue, resulting in an increased concentration of stores in the two largest rent-to-own industry participants.

The rent-to-own industry serves a highly diverse customer base. According to the APRO, approximately 96% of rent-to-own customers have household incomes between $15,000 and $50,000 per year. The rent-to-own industry serves a wide variety of customers by allowing them to obtain merchandise that they might otherwise be unable to obtain due to insufficient cash resources or a lack of access to credit. APRO also estimates that 95% of customers have high school diplomas.

We currently manage about 220 membership plans for our clients that include rental purchase dealers, insurance companies, financial institutions, retail merchants, and consumer finance companies. At September 30, 2010, our wholesale plans were offered at approximately 4,910 locations. Of the locations at September 30, 2010, 2,880 locations were Rent-A-Center owned locations operated under their brand. Rent-A-Center, Inc., a Nasdaq (symbol RCII) traded company, is the largest rent-to-own company in the United States, Puerto Rico and Canada. Our revenue attributable to the contractual arrangements with Rent-A-Center was approximately $11.9 million, (21% of total revenue) during the fiscal year ended September 30, 2010, compared to $11.6 million, (30% of total revenue) during the fiscal year ended September 30, 2009. Revenue attributable to our Wholesale Plans Division accounted for $22.4 million, (40% of total revenue) during the fiscal year ended September 30, 2010 and $19.5 million, (50% of total revenue) during the fiscal year ended September 30, 2009. Our growth in wholesale plans revenue is dependent in significant part on an increase in the number of rent-to-own locations at which these plans are offered and the sales efforts of those locations. Although we have long-term contracts with Rent-A-Center and other rent-to-own

companies, loss of either, especially Rent-A-Center would have a significant impact on our revenues, profitability and our ability to negotiate discounts with our vendors.

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Retail Plans

Our Retail Plans Division offerings include healthcare savings plans and association memberships that provide insurance features. These healthcare savings plans are not insurance, but allow members access to a variety of healthcare networks to obtain discounts from usual and customary fees. We offer wellness programs, prescription drug and dental discount programs, medical discount cards, and limited benefit insured plans. Our members pay providers the discounted rate at the time services are provided to them. These plans are designed to serve the markets in which individuals either have no health insurance or limited healthcare benefits. Our revenue attributable to retail plans was approximately $17.5 million (32% of total revenue) and $12.8 million (33% of total revenue) during the fiscal year ended September 30, 2010 and 2009, respectively.

This Division is comprised of the membership business of Alliance Healthcard, The Capella Group, Inc. (Capella) and Protective Marketing Enterprises, Inc. (PME). Capella and PME are subsidiaries of Access Plans USA which was acquired on April 1, 2009. PME also owns and manages proprietary networks of dental and vision providers that provide services at negotiated rates to certain members of our plans and other plans that have contracted with us for access to our networks.

Through our healthcare savings plans, we believe customers save an average of 35% on their medical costs and between 10% and 50% on services through other discount medical providers. These discounts for services that do not require the use of a medical PPO are more difficult to track because our members pay a discounted rate at point of service.

In addition to our wholesale and retail offerings, certain clients may choose to include our benefits with their own membership plan offering. In these instances, the client bears the cost of marketing and fulfillment, and we provide customer service. These offerings are designed to enhance our clients existing offering and improve their product value relative to their competition and in some instances to improve their customer retention. While these plans provide lower periodic member fees, we incur limited implementation costs and receive higher revenue participation rates. Our additional distribution channels also include network marketing representatives, independent agents and consumer direct sales call centers. We also market to internet portals and financial institutions.

In order to deliver our membership offerings, we contract with a number of different vendors to provide various products and services to our members. The majority of these vendor relationships involve the vendor providing our members access to their network or providers or their locations and our members obtain a discount at the time of service. We have vendor relationships with medical networks, automotive service companies, insurance companies, travel related entities and food and entertainment consumer discount providers. Our vendors value the relationship with us because we deliver many customers to them without incremental capital cost or risk on their part and these relationships are governed by multi-year agreements and aggregated volume scaling.

Insurance Marketing

Our Insurance Marketing Division offers and sells individual major medical health insurance products and related benefit plans, including specialty insurance products, primarily through a national network of independent agents. America s Healthcare/Rx Plan Agency (AHCP) is the centerpiece of the Insurance Marketing Division. AHCP is a subsidiary of Access Plans USA which was acquired on April 1, 2009. AHCP distributes major medical, short term medical, critical illness and related health insurance products to small businesses, self-employed and other individuals and families through a network of approximately 7,420 independent agents which have carrier appointments through AHCP. The primary insurance carriers that we represent include: Golden Rule Insurance Company, World Insurance Company, Aetna and Colorado Bankers.

We support our agents and recruit new agents via access to proprietary and private label products, leads for new sales, commission advance programs, incentive programs, including an annual convention, web-based technology, and back-office support. More specifically, our agent support and recruiting tools include:

e-Agent Center provides agents with access to real-time rate quoting, on-line licensing and contracting, insurance application submission, access to brochures and other marketing materials.

Lead Distribution we utilize an electronic system to connect agents with an on-line lead ordering and delivery system. Leads are also provided in certain situations as incentives to sell certain policies.

Incentive programs to assist with agent motivation and recruitment, we provide paid annual convention trips and periodic sales contests.

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Agent advances with most of the major medical products we represent, agents are entitled to from 3 to 9 months of advance commissions either funded by AHCP or our insurance carrier partner. Our ability to grow this segment will depend, in part, on our continued access to working capital to fund these advances.

Home office support this includes agent and product training, marketing materials and agent communication. The training programs include both on-site and in-house schools, DVDs and webcasts covering product knowledge and sales techniques as well as market conduct and regulatory compliance issues. In addition, our support includes development and distribution of a wide variety of marketing materials including flyers, brochures, email blasts and letters. We also promote and inform our agents on important news and updates via a weekly newsletter.

Our strategy for the Insurance Marketing Division is to:

Continue working with insurance carriers in the development of proprietary products for our agents to represent;

Expand the number of carriers that we represent for more product choice for customers and expanded geographic representation; and

Enhance our e-agent platforms in order to better serve our existing agents and improve attraction to new agents to sell plans we represent.

The revenue of our Insurance Marketing Division is from earned sales commissions paid by the insurance companies this Division represents. These sales commissions are generally a percentage of premium revenue. Our revenue attributable to the Insurance Marketing Division was approximately $20.6 million (37% of total revenue) and $11.4 million (29% of total revenue) during the fiscal year ended September 30, 2010 and 2009 respectively. Growth for our commission revenue is based on continued recruitment efforts of agents and the resulting penetration of the individual, family and small business health insurance markets, driving a corresponding growth in the number of policies in force. We estimate that as of September 30, 2010 we had approximately 25,200 policies in force compared to an estimated 24,000 policies in force at September 30, 2009.

The Health Care and Education Affordability Reconciliation Act of 2010 (Health Care Reform Law) was enacted on March 30, 2010. Although much of the regulatory interpretation of the new law has yet to be proposed and adopted, beginning in 2010 insurers are required to implement a number of changes related to major medical insurance policies. These changes include, but are not limited to: changes to required coverage, elimination of most preexisting condition exclusions and a minimum loss ratio of 80%. The minimum loss ratio requires health insurance companies to maintain premium levels such that 80% of the premium is utilized for claims on medical services and related expenses (85% for group health). The Health Care Reform Law will require certain people to purchase health insurance and will set up subsidies to assist certain people in purchasing health insurance and allows certain people to obtain insurance from the federal government. It is possible that this law will impact the products we currently offer or change the number of customers or potential customers for our products. As a result of the minimum loss ratio requirement in the Health Care Reform Law, it is likely that commissions on the sale of individual major medical insurance policies will be reduced in January 2011 and, if that happens, it could result in a significant reduction in our revenue. Because most of our commission revenue is ultimately paid to our agents we anticipate that the potential reduction in revenue will not necessarily cause a reduction in our profitability in the same proportion. However, the anticipated reduction in commissions could cause our agents to stop selling health insurance because of the reduced commissions or cause them to sell other products to make up for the loss of their revenues.

In response to the anticipated effect of the Health Care Reform Law, we are endeavoring to expand the portfolio of health related insurance products that we provide to our agents. These new and expanded products will furnish our agents a means to mitigate the possible financial impact that may result from the new law.

Critical Accounting Policies

Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the amounts reported in the financial statements and the accompanying notes. Actual results may differ from those estimates and the differences may be material. Certain significant estimates are required in the evaluation of goodwill and intangible assets for impairment, valuation of stock

based compensation, allowances for doubtful recoveries of advanced agent commissions, deferred income taxes, accounts and notes receivable and the waiver reimbursements liability. Actual results could differ from those estimates and the differences could be material.

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Goodwill and Intangible Assets

Goodwill from acquisitions represents the excess of the cost of a business acquired over the net of the amounts assigned to assets acquired, including identifiable intangible assets and liabilities assumed. GAAP specifies criteria to be used in determining whether intangible assets acquired in a business combination must be recognized and reported separately from goodwill. Amounts assigned to goodwill and other identifiable intangible assets are based on independent appraisals or internal estimates.

Intangible assets deemed acquired in connection with Access Plans USA, were valued at $3,000,000 and are being amortized over the estimated useful life of those assets (*See Note 4 Mergers and Acquisitions)* of the financial statements appearing elsewhere in this report. Amortization expense totaled $465,000 during the fiscal year ended September 30, 2010 and $232,500 for the six months ended September 30, 2009. Access Plans USA was acquired on April 1, 2009 and financial results are only for the six months ended September 30, 2009.

Customer lists acquired in an acquisition are capitalized and amortized over the estimated useful lives of the customer lists. Customer lists acquired in 2007 were valued at $2,500,000 and are being amortized over 60 months, the estimated useful life of the list. Amortization expense totaled $500,000 during each of the fiscal years ended September 30, 2010 and 2009.

The Company evaluates the impairment of goodwill as of the end of each fiscal year and the recoverability of other intangible assets whenever events or changes in circumstances indicate that an intangible asset s carrying amount may not be recoverable. These circumstances include:

- a significant decrease in the market value of an asset;
- a significant adverse change in the extent or manner in which an asset is used; or
- an accumulation of costs significantly in excess of the amount originally expected for the acquisition of an asset

We measure the carrying amount of the asset against the estimated undiscounted future cash flows associated with it. Should the sum of the expected future net cash flows be less than the carrying value of the asset being evaluated, an impairment loss would be recognized. The impairment loss would be calculated as the amount by which the carrying value of the asset exceeds its fair value. The fair value is measured based on quoted market prices, if available. If quoted market prices are not available, the estimate of fair value is based on various valuation techniques, including the discounted value of estimated future cash flows. The evaluation of asset impairment requires us to make assumptions about future cash flows over the life of the asset being evaluated. These assumptions require significant judgment and actual results may differ from assumed and estimated amounts. As of September 30, 2010 and 2009, we determined that the recorded value of our goodwill and other intangibles were not impaired.

Stock Based Compensation

We measure stock based compensation expense using the modified prospective method. Under the modified prospective method, stock-based compensation cost is measured at the grant date based on the fair value of the award and is recognized as expense over the requisite service or vesting period.

Income Taxes

We use a liability approach to calculating deferred income taxes. The objective is to measure a deferred income tax liability or asset using the tax rates expected to apply to taxable income in the periods in which the deferred income tax liability or asset is expected to be settled or realized. Any resulting net deferred income tax assets should be reduced by a valuation allowance sufficient to reduce such assets to the amount that is more likely than not to be realized.

The Company recognizes the effect of income tax positions only if those positions are more likely than not of being sustained. Recognized income tax positions are measured at the largest amount that is greater than 50% likely of being realized. Changes in recognition or measurement are reflected in the period in which the change in judgment occurs. The Company records interest and penalties related to unrecognized tax benefits as a component of income tax expense.

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Revenue Recognition

We recognize revenue when four basic criteria are met:

persuasive evidence of an arrangement exists;
delivery has occurred or services have been rendered;
the seller s price to the buyer is fixed or determinable; and
collectability is reasonably assured.

Our revenue recognition varies based on source. Membership fees of the Wholesale and Retail Plans Divisions are paid on a weekly, monthly or annual basis and fees paid in advance are recorded as deferred revenue and recognized monthly over the applicable membership term. Our wholesale and private label partners bill their customers for the membership fees and periodically remit our portion of the fees to us. For our retail members that are typically billed directly, the billed amount is almost entirely collected by electronic charge to the member s credit card, automated clearinghouse or electronic check.

Revenue of the Insurance Marketing Division reflects commissions and fees reported to us by insurance companies for policies sold by the Division s agents. Commissions and fees collected are recognized as earned on a monthly basis until the underlying contract is reported to the Division as terminated. Our commission rates vary by insurance carrier, the type of policy purchased by the policyholder and the amount of time the policy has been active, with commission rates typically being higher during the first 12 months of the policy period. Revenue also includes interest income earned on commissions advanced to the Division s agents.

Unearned commissions comprise commission advances received from insurance carriers but not yet earned or collected. These advances are subject to repayment back to the carrier in the event that the policy lapses before the advanced commissions are earned and collected. Additionally, fees received are recorded as deferred revenue and amortized over the expected weighted average life of the policies sold which currently approximates 18 months. Deferred revenue is reported net of related policy acquisition costs, principally lead and marketing credits, which are capitalized and amortized over the same weighted average life, to the extent such deferred costs do not exceed the related gross deferred revenue. Any excess costs are expensed as incurred.

Commission Expense

Commission expense is based on the applicable rates applied to membership revenues billed or insurance commissions collected, and are recognized as incurred on a monthly basis until such time as the underlying program member or insurance policy is terminated.

The Insurance Marketing Division advances agent commissions, up to nine months, for certain insurance programs. The advance commissions to our agents are funded partly by the insurance carriers we represent and partly by us. These commissions advanced to agents are reflected on our balance sheet as advanced agent commissions. Collection of the commissions advanced (plus accrued interest) is accomplished by withholding amounts earned by the agent on the policy upon which the advance was made. In the event of early termination of the underlying policy, the Division seeks to recover the unpaid advance balance by withholding advanced and earned commissions on other policies sold by the agent. This Division also has the contractual right to pursue other sources of recovery, including recovery from the agents managing the agent to whom advances were made.

The Retail Plans Division advances agent commissions for certain retail plan programs. The advance commissions to the Company s agents are funded by the Company and are reflected on the balance sheet as advanced agent commissions. Collection of the commissions advanced is accomplished by withholding amounts earned by the agent on the memberships upon which the advance was made. In addition, certain membership persistency levels must be maintained.

Advanced agent commissions are reviewed and an allowance is provided for those balances where recovery is considered doubtful. This allowance requires judgment and is based primarily upon estimates of the recovery of future commissions expected to be earned by the agents with outstanding balances and, where applicable, the agents responsible for their management. Advances are written off when determined to be non-collectible.

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Recent Accounting Pronouncements

In December 2007, the Financial Accounting Standards Board (FASB) issued SFAS No. 160, *Non-controlling Interests in Consolidated Financial Statements*, an Amendment of ARB 51, which was subsequently incorporated into ASC Topic 810, Consolidation. ASC Topic 810 establishes new accounting and reporting standards for non-controlling interests in a subsidiary and for the deconsolidation of a subsidiary. ASC Topic 810 requires entities to classify non-controlling interests as a component of stockholders equity and requires subsequent changes in ownership interests in a subsidiary to be accounted for as an equity transaction. Additionally, ASC Topic 810 requires entities to recognize a gain or loss upon the loss of control of a subsidiary and to re-measure any ownership interest retained at fair value on that date. ASC Topic 810 also requires expanded disclosures that clearly identify and distinguish between the interests of the parent and the interests of the non-controlling owners. ASC Topic 810 is effective on a prospective basis for fiscal years, and interim periods within those fiscal years, beginning on or after December 15, 2008, except for the presentation and disclosure requirements, which are required to be applied retrospectively. The adoption of ASC Topic 810 was effective for us beginning October 1, 2009. Because all of our subsidiaries are wholly-owned, ASC Topic 810 did not have a material impact on our financial condition or results of operations.

In April 2008, the FASB issued an update to Codification Topic 350, *Intangible- Goodwill and Other*, which amends the factors that should be considered in developing renewal or extension assumptions used to determine the useful life of a recognized intangible asset. This amendment became effective on a prospective basis to all intangible assets acquired and for disclosures on all intangible assets recognized on or after the beginning of the first annual period subsequent to December 15, 2008. Early adoption was prohibited. The amendment to Codification Topic 350 was effective for us beginning October 1, 2009 and did not have a material impact on our determination of the useful life of our intangible assets, financial condition or results of operations.

In May 2009, the FASB issued authoritative guidance on subsequent events, which was codified in ASC 855, *Subsequent Events.* ASC 855 establishes general standards of accounting for and disclosure of events that occur after the balance sheet date but before financial statements are issued or are available to be issued. We adopted these provisions of ASC 855 on June 30, 2009. On February 24, 2010, the FASB updated the guidance to address certain implementation issues related to an entity s requirement to perform and disclose subsequent event procedures. Effective upon its issuance, the update exempts registrants reporting under the Securities Exchange Act of 1934 from disclosing the date through which subsequent events have been evaluated. As the update affected disclosure only, the adoption of the update did not have an impact on our consolidated financial statements.

In January 2010, the FASB issued Accounting Standards Update No. 2010-06 (ASU 2010-06), *Fair Value Measurements and Disclosures (Topic 820) Improving Disclosures about Fair Value Measurements*. ASU 2010-06 requires expanded fair value disclosures of transfers into and out of Levels 1 and 2 fair value measurements and clarifies existing fair value disclosures about the level of disaggregation and about inputs and valuation techniques used to measure fair value. ASU 2010-06 is effective for us beginning January 1, 2010. The adoption of this accounting standard update did not have a material impact on our financial position, results of operations, cash flows and disclosures.

Recently Issued Accounting Pronouncements Not Yet Adopted

In July 2010, the FASB issued Accounting Standards Update No. 2010-20 (ASU 2010-20), *Receivables (Topic 310) Disclosures about the Credit Quality of Financing Receivables and the Allowance for Credit Losses*. ASU 2010-20 requires disclosures about the nature of the credit risk in an entity s financing receivables, how that risk is incorporated into the allowance for credit losses, and the reasons for any changes in the allowance. Disclosure is required to be disaggregated at the level at which an entity calculates its allowance for credit losses. ASU 2010-20 is effective for us beginning December 31, 2010. The adoption of this accounting standard is not expected to have a material impact on our financial position, results of operations, cash flows and disclosures.

Results of Operations

Introduction

We are a leading provider of consumer membership plans, healthcare savings membership plans and a marketer for individual major medical health insurance products. Through working with our wholesale and retail clients, we design

and build membership plans that contain benefits aggregated from our vendors that appeal to our client s customers. For our major medical health insurance products, we offer and sell these products through a national network of independent agents.

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The following table sets forth selected results of our operations for the fiscal years ended September 30, 2010 and 2009. We operate in four reportable business segments: Wholesale Plans, Retail Plans, Insurance Marketing and Corporate. The Wholesale Plans Division includes the operations of our customized membership marketing plans primarily offered at rent-to-own retail stores. The Retail Plans Division includes the operations from our healthcare savings plans designed to serve the markets in which individuals either have no health insurance or limited healthcare benefits. The Insurance Marketing Division offers and sells individual major medical health insurance products and related benefit plans. The following information was derived and taken from our audited financial statements appearing elsewhere in this report.

	For the Years Ended September 30,		
($ in thousands)	**2010**	**2009**	**% Change**
Net revenues	$ 55,349	$ 39,081	42%
Direct costs	39,044	26,469	48%
Operating expenses	11,474	8,324	38%
Operating income	4,831	4,288	13%
Net other income (expense)	(21)	200	(111%)
Income before income taxes	4,810	4,488	7%
Income taxes, net	1,762	1,049	68%
Net income	**$ 3,048**	**$ 3,439**	**(11%)**

The following tables set forth revenue, gross margin and operating income by segment.

	For the Years Ended September 30,		
($ in thousands)	**2010**	**2009**	**% Change**
Net revenues by segment			
Wholesale Plans	$ 22,372	$ 19,522	15%
Retail Plans (a)	17,458	12,838	36%
Insurance Marketing	20,641	11,432	81%
Corporate			
Intercompany Eliminations	(5,122)	(4,711)	9%
Total	$ **55,349**	$ **39,081**	**42%**
Gross margin by segment			
Wholesale Plans (a)	$ 5,997	$ 3,884	54%
Retail Plans (a)	7,035	6,710	5%
Insurance Marketing	3,273	2,018	62%
Corporate			
Total	$ **16,305**	$ **12,612**	**29%**
Operating income by segment			

Wholesale Plans (a)	$ 4,034	$ 2,030	99%
Retail Plans (a)	1,844	2,734	(33%)
Insurance Marketing	161	482	(67%)
Corporate	(1,208)	(958)	(26%)
Total	$ **4,831**	$ **4,288**	**13%**

(a) Gross of intercompany eliminations

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Discussion of Years Ended September 30, 2010 and 2009

Net revenues increased $16.2 million (a 41% increase) during the 2010 fiscal year to $55.3 million from $39.1 million in 2009. The increase in net revenues was primarily due to:

- The acquisition of Access Plans USA on April 1, 2009 which resulted in an increase of revenue of approximately $12.9 million;
- Growth in our Wholesale Plans Division of approximately $2.9 million attributable to additional rent to own locations offering our plans and an increase in member acceptance rates among our clients; and
- Growth in our existing Retail Plans Division of approximately $.9 million attributable to new business beginning in the second quarter 2010 and an existing client whose membership acceptance rates continue to increase; and
- Other changes of $(.4) million. See the Segment Analysis below for additional information.

Direct costs increased $12.5 million (a 47% increase) during the 2010 fiscal year to $39.0 million from $26.5 million in 2009. The increase in direct costs was attributable to the following:

- The acquisition of Access Plans USA on April 1, 2009 which resulted in an increase in cost of sales of $12.4 million;
- Our Wholesale Plans Division experienced an increase of $.8 million primarily attributable to revenue growth due to additional rent to own locations offering our plans and an increase in member acceptance rates among our clients; and an increase in product service expenses attributable to increased program membership, increases in the average number of product that members have eligible for service and a slight increase in the average cost per incident; and
- Our existing Retail Plans Division experienced a decrease of $.2 million primarily attributable to a decrease of compensation expense resulting from the centralization of operations for our Retail Plans Division during the fiscal 2010 1st quarter ended December 31, 2009; and
- Other changes of $(.4) million. See Segment Analysis below for additional information.

Operating expenses increased $3.2 million (a 39% increase) during the 2010 fiscal year to $11.5 million from $8.3 million in 2009. The increase in operating expenses was primarily attributable to the acquisition of Access Plans USA on April 1, 2009 which resulted in an increase in operating expenses of $3.2 million. See the Segment Analysis below for additional information.

Net other income decreased $.2 million during the 2010 fiscal year. The decrease was primarily attributable to income earned from a non-recurring transaction during 2009.

Provision for income taxes, *net* increased by $.8 million during the 2010 fiscal year to $1.8 million from $1.0 million in 2009. For the 2010 fiscal year we recorded an income tax provision of $1.8 million consisting of income tax expense of $1.3 million and deferred income expense of $.5 million. The net increase consisted of tax refunds of $.5 million for federal and state income taxes for prior fiscal years.

Net income was approximately $3.0 million (6% of net revenue) during the 2010 fiscal year compared to $3.4 million (9% of net revenue) during 2009.

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Wholesale Plans Division