



**BlueCross BlueShield
of Texas**

ADMINISTRATIVE SERVICES AGREEMENT

The Effective Date of this Agreement is February 1, 2008.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the date and year specified below.

**BLUE CROSS AND BLUE SHIELD
OF TEXAS, a Division of Health Care
Service Corporation, a Mutual Legal
Reserve Company**

HIDALGO COUNTY

By: _____

By: _____

Title: Divisional Vice President

Title: _____

Date: _____

Date: _____

ADMINISTRATIVE SERVICES AGREEMENT

SECTION 1: APPOINTMENT 4

SECTION 2: AGREEMENT DEFINITIONS 4

SECTION 3: SERVICES TO BE PROVIDED BY THE CLAIM ADMINISTRATOR 5

SECTION 4: CERTAIN RESPONSIBILITIES OF THE EMPLOYER AND THE CLAIM ADMINISTRATOR 6

SECTION 5: THIRD PARTY DATA RELEASE 7

SECTION 6: REFERRAL OF CERTAIN CLAIMS/INQUIRIES 7

SECTION 7: CLAIM DISPUTE RESOLUTION 8

SECTION 8: FINAL DETERMINATION OF CLAIMS/INQUIRIES 8

SECTION 9: COOPERATION OF THE PARTIES 8

SECTION 10: CERTIFICATE OF CREDITABLE COVERAGE 8

SECTION 11: INDEMNIFICATION 8

SECTION 12: AUDIT AND CORRECTION OF AUDIT ERRORS 9

SECTION 13: TERM AND TERMINATION OF AGREEMENT 9

SECTION 14: RELATIONSHIP OF PARTIES 10

SECTION 15: ERISA 10

SECTION 16: PROPRIETARY MATERIALS 11

SECTION 17: ELECTRONIC DOCUMENTS 11

SECTION 18: RECORDS 11

SECTION 19: APPLICABLE LAW 12

SECTION 20: ENTIRE AGREEMENT 12

SECTION 21: NOTICE AND SATISFACTION 12

SECTION 22: LIMITATION OF LIABILITY 12

SECTION 23: DISPUTE RESOLUTION/ARBITRATION 12

SECTION 24: OBLIGATION TO CONTINUE PERFORMANCE 13

SECTION 25: NOTICES 13

SECTION 26: SEVERABILITY 13

Proprietary Information

Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third party representatives, except under written agreement.

SECTION 27: ENFORCEMENT	13
SECTION 28: FORCE MAJEURE	13
SECTION 29: NOTICE OF ANNUAL MEETING	13
EXHIBIT 1	
CLAIM ADMINISTRATOR SERVICES	14
EXHIBIT 2	
FEE SCHEDULE, FINANCIAL RESPONSIBILITIES & REQUIRED DISCLOSURES	16
SECTION 1: FEE SCHEDULE.....	16
SECTION 2: EXHIBIT DEFINITIONS.....	18
SECTION 3: COMPENSATION TO CLAIM ADMINISTRATOR	19
SECTION 4: CLAIM PAYMENTS	20
SECTION 5: TRANSFER PAYMENT	20
SECTION 6: CLAIM SETTLEMENTS	20
SECTION 7: LATE PAYMENTS AND REMEDIES	21
SECTION 8: FINANCIAL OBLIGATIONS UPON AGREEMENT TERMINATION.....	21
SECTION 9: REQUIRED DISCLOSURE PROVISIONS.....	22
SECTION 10: PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS:	22
SECTION 11: COVERED PERSON/PROVIDER RELATIONSHIP	22
SECTION 12: CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PRESCRIPTION DRUG PROVIDERS	22
SECTION 13: CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS	23
SECTION 14: BLUECARD	23
SECTION 15: SERVICING PLAN AGREEMENTS BETWEEN CLAIM ADMINISTRATOR AND OTHER BLUE CROSS AND BLUE SHIELD PLANS	24
SECTION 16: MEDICARE SECONDARY PAYER ("MSP") DATA MATCH	25
SECTION 17: REIMBURSEMENT PROVISION	26
EXHIBIT 3	
RECOVERY LITIGATION AUTHORIZATION	27

This Agreement made as of February 1, 2008 by and between Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (hereinafter referred to as the "Claim Administrator"), and Hidalgo County (hereinafter referred to as the "Employer"), for the Employer Group Number(s) 21185 set forth in the Fee Schedule of Exhibit 2 attached hereto, WITNESSETH AS FOLLOWS:

RECITALS

WHEREAS, the Employer's Group Health Plan has established and adopted an employee welfare benefit plan ("Plan") as described in its plan document, which shall be provided by the Employer to the Claim Administrator; and

WHEREAS, the Employer on behalf of the Group Health Plan desires to retain the Claim Administrator to provide certain administrative services with respect to the Plan; and

WHEREAS, it is desirable to set forth more fully the obligations, duties, rights and liabilities of the Claim Administrator and the Employer, as representative of the Group Health Plan, with respect to the Plan;

NOW, THEREFORE, in consideration of these premises and the mutual promises and agreements hereinafter set forth, the parties hereby agree as follows:

SECTION 1: APPOINTMENT

The Employer hereby retains and appoints the Claim Administrator to provide services as hereinafter described in connection with the administration of the Plan.

SECTION 2: AGREEMENT DEFINITIONS

- 2.1 **"Administrative Charge"** means the monthly service charge that is required by the Claim Administrator for the administrative services performed under this Agreement. The Administrative Charge(s) is indicated in the most current Fee Schedule specifications of Exhibit 2 of this Agreement.
- 2.2 **"Certificate of Creditable Coverage"** means a document which is generated for Covered Persons terminating coverage under the Plan. The certificate is provided to Covered Persons as evidence for credit of health coverage held under the Plan during the term of this Agreement.
- 2.3 **"Claim"** means notification in a form acceptable to the Claim Administrator that service has been rendered or furnished to a Covered Person. This notification must set forth in full the details of such service including, but not limited to, the Covered Person's name, age, sex and identification number, the name and address of the Provider, a specific itemized statement of the service rendered or furnished, the date of service, applicable diagnosis, the Claim Charge, and any other information which the Claim Administrator may request in connection for such service.
- 2.4 **"Claim Charge"** means the amount which appears on a Claim as the Provider's regular charge for service rendered to a patient, without further adjustment or reduction.
- 2.5 **"Claim Payment"** means the benefit calculated by the Claim Administrator, plus any related Surcharges, upon submission of a Claim, in accordance with the benefits specified in the Plan. All Claim Payments shall be calculated on the basis of the Provider's Eligible Charge for Covered Services rendered to the Covered Person.
- 2.6 **"Covered Employee"** shall have the same meaning as defined in the Employer's Plan.
- 2.7 **"Covered Person"** shall have the same meaning as defined in the Employer's Plan.
- 2.8 **"Covered Service"** means a service or supply specified in the Plan for which benefits will be provided.
- 2.9 **"ERISA"** means the Employee Retirement Income Security Act of 1974, as amended.
- 2.10 **"Fee Schedule"** means the specifications setting out certain particulars of this Agreement under Exhibit 2 of this Agreement including, but not limited to, the Administrative Charge and other service charges; or any such other subsequent set of specifications supplied by the Claim Administrator as a replacement to the Fee Schedule under Exhibit 2. The specifications or items of the Fee Schedule shall be applicable for the Fee Schedule Period noted therein, except that any item of the Fee Schedule may be changed in accordance with such Exhibit's "COMPENSATION TO CLAIM ADMINISTRATOR" provisions.
- 2.11 **"Fee Schedule Period"** means the period of time beginning and ending on the dates shown in the most current Fee Schedule under Exhibit 2 of this Agreement.

Proprietary Information

Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third party representatives, except under written agreement.

- 2.12 **"Group Health Plan"** means, as applied to this Agreement, the self-insured employee welfare benefit plan as defined by Section 160.103 of the Health Insurance Portability and Accountability Act of 1996.
- 2.13 **"HIPAA"** means the Health Insurance Portability and Accountability Act of 1996.
- 2.14 **"Network"** means identified Providers, including physicians, other professional health care providers, hospitals, ancillary providers, and other health care facilities, that have entered into agreements with the Claim Administrator (and, in some instances, with other participating Blue Cross and/or Blue Shield Plans) for participation in a participating provider option health benefit coverage program, if applicable to the Plan under this Agreement.
- 2.15 **"Provider"** means any hospital, health care facility, laboratory, person or entity duly licensed to render Covered Services to a Covered Person or any other provider of medical or dental services, products or supplies which are Covered Services.
- 2.16 **"Provider's Eligible Charge"** means (a) in the case of a Provider which has a written agreement with the Claim Administrator to provide care to Covered Persons at the time Covered Services are rendered, such Provider's Claim Charge for Covered Services and (b) in the case of a Provider which does not have a written agreement with the Claim Administrator to provide care to Covered Persons at the time Covered Services are rendered, such Provider's Claim Charge for Covered Services, not to exceed the allowable amount therefore as reasonably determined by the Claim Administrator.
- 2.17 **"Supplemental Charge"** means a charge for costs due and payable to the Claim Administrator by the Employer that is separate and apart from the service charges detailed in Exhibit 2 of this Agreement. A Supplemental Charge may be applied for any customized reports, forms or other materials or for any additional services or supplies not documented in the most current Fee Schedule of Exhibit 2. Such services and/or supplies and any applicable Supplemental Charge(s) are to be agreed upon by the parties in writing prior to the Claim Administrator's performance and/or provision of such.
- 2.18 **"Surcharges"** means state or federal taxes, surcharges or other fees, including, but not limited to World Access Fees, paid by the Claim Administrator which are imposed upon or resulting from this Agreement.
- 2.19 **"Timely"** means the following, unless an alternative standard is specified in this Agreement or is mutually agreed to by the parties in writing:
- a. With respect to all payments due the Claim Administrator by the Employer under this Agreement, within ten (10) calendar days of notification of the Employer by the Claim Administrator; or
 - b. With respect to all information due the Claim Administrator by the Employer concerning Covered Persons, within thirty-one (31) calendar days of a Covered Person's effective date of coverage or change in coverage status under the Plan; or
 - c. With respect to all Plan information due the Claim Administrator by the Employer, upon the effective date of this Agreement and at least ninety (90) calendar days prior to the effective date of change or amendment to the Plan thereafter.
- 2.20 **"World Access Fee"** means the Surcharge imposed upon the Claim Administrator under the BlueCard® Worldwide program for the administration of an international Claim.

SECTION 3: SERVICES TO BE PROVIDED BY THE CLAIM ADMINISTRATOR

- 3.1 **Subcontractors.** During the continuance of this Agreement, the Claim Administrator will perform such services as set forth in Exhibit 1 of this Agreement, attached hereto and made a part hereof. The Claim Administrator, at its sole discretion, may contract with other entities for performance of any of the services to be performed by the Claim Administrator hereunder; provided, however, the Claim Administrator shall remain fully responsible and liable for performance of any such services to be performed by the Claim Administrator but delegated to other entities.
- 3.2 **Subsidiaries.** Further, any of the services to be performed by the Claim Administrator under this Agreement may be performed by the Claim Administrator, or any of its subsidiaries (including any successor corporation, whether by merger, consolidation, or reorganization), without prior written approval by the Employer. Any reference in this Agreement to the Claim Administrator shall include its directors, officers and employees as well as the directors, officers and employees of any of its subsidiaries and the Claim Administrator shall be responsible and liable for all performance or failure to perform by such subsidiaries in connection with this Agreement.

SECTION 4: CERTAIN RESPONSIBILITIES OF THE EMPLOYER AND THE CLAIM ADMINISTRATOR

- 4.1 **Employer responsibility.** The Employer retains full and final authority and responsibility for the Plan and its operation. The Claim Administrator is empowered to act on behalf of the Employer in connection with the Plan only as expressly stated in this Agreement or as mutually agreed to in writing by the parties hereto.
- 4.2 **Claim Administrator responsibility.** The Claim Administrator shall have no responsibility for or liability with respect to the compliance or non-compliance of the Plan with any applicable federal, state and local rules, laws and regulations; and the Employer shall have the sole responsibility for and shall bear the entire cost of compliance with all federal, state and local rules, laws and regulations, including, but not limited to, any licensing, filing, reporting, modification requirements and disclosure requirements as may apply to the Plan, and all costs, expenses and fees relating thereto; provided, however, the Claim Administrator shall have the responsibility for and bear the cost of compliance with any federal, state or local laws as may apply to the Claim Administrator in connection with the performance of its obligations under this Agreement.
- 4.3 **Litigation.** Each party shall, to the extent possible, advise the other party of any legal actions against it or the other party which involve the Plan or the obligations of either party under the Plan or this Agreement. The Employer shall undertake the defense of such action and be responsible for the costs of defense; provided, however, that the Claim Administrator shall have the option, at its sole discretion, to employ attorneys selected by it to defend any such action, the costs and expenses of which shall be the responsibility of the Claim Administrator. It is further agreed that each party (provided no conflicts of interest exist) shall fully cooperate with the other party in the defense of any action arising out of matters related to the Plan or this Agreement.
- 4.4 **Claim overpayments.** The Employer acknowledges that unintentional administrative errors may occur. When the Claim Administrator becomes aware of a Claim overpayment, the Claim Administrator will make a diligent attempt to recover any such payment. The Claim Administrator, however, will not be required to enter into litigation to obtain a recovery, unless specifically provided for elsewhere in this Agreement, nor will the Claim Administrator be required to reimburse the Plan, except for gross negligence or intentional acts by the Claim Administrator.
- 4.5 **Required Plan information.** The Employer shall furnish on a Timely basis to the Claim Administrator certain information concerning the Plan and Covered Persons as may from time to time be required by the Claim Administrator for the performance of its duties including, but not limited to, the following:

- a. All documents by which the Plan is established and any amendments or changes to the Plan.
- b. All data as may be required by the Claim Administrator regarding Covered Persons who are to be covered under this Agreement.

It is the Employer's obligation to timely notify the Claim Administrator of any change in a Covered Person's status under this Agreement. All such notifications by the Employer to the Claim Administrator (including, but not limited to, forms and tapes) must be furnished in a format mutually agreed to by the parties and must include all information reasonably required by the Claim Administrator to effect such changes.

- 4.6 **Plan eligibility errors.** Clerical errors in keeping or reporting data relative to coverage under this Agreement will not invalidate coverage that would otherwise be validly in force or continue coverage which would otherwise validly terminate. Such errors will be corrected by the Claim Administrator subject to the terms and conditions of this Agreement and the Claim Administrator's reasonable administrative practices in the administration of the Plan including, but not limited to, those related to Timely notification of a change in a Covered Person's status. The Employer is liable for any benefits paid for a terminated Covered Person until the Employer has notified the Claim Administrator of such Covered Person's termination.
- 4.7 **Claim information disclosure.** The Claim Administrator will disclose Claim information in accordance with HIPAA privacy regulations and the Business Associate Agreement entered into by the parties.
- 4.8 **Electronic exchange of information.** In the event the Employer and the Claim Administrator exchange various data and information electronically, the Employer agrees to transfer on a Timely basis all required data to the Claim Administrator via electronic transmission on the intranet and/or internet or otherwise, in a format mutually agreed to by the parties. Further, the Employer is responsible for maintaining any enrollment applications and change forms completed by Covered Persons and to allow the Claim Administrator reasonable access to this information as needed for administrative purposes.

The Employer authorizes the Claim Administrator to submit reports, data and other information to the Employer in the electronic format mutually agreed to by the parties. In the event the Employer is unable or unwilling to transfer data in the electronic format mutually agreed to by the parties, the Claim Administrator is under no obligation to receive or transmit data in any other format.

Proprietary Information

Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third party representatives, except under written agreement.

SECTION 5: THIRD PARTY DATA RELEASE

- 5.1 Types of data.** In the event the Employer directs the Claim Administrator to provide data directly to its third party consultant and/or vendor, the Employer acknowledges and agrees, and will cause its third party consultant and/or vendor to acknowledge and agree:
- a. The personal and confidential nature of the requested documents, records and other information (for purposes of this Section 5, "Confidential Information").
 - b. Release of the Confidential Information may also reveal the Claim Administrator's confidential, business proprietary and trade secret information (for purposes of this Section 5, "Proprietary Information").
 - c. To maintain the confidentiality of the Confidential Information and any Proprietary Information (for purposes of this Section 5, collectively, "Information").
- 5.2 Third party obligations.** The third party consultant and/or vendor shall:
- a. Use the Information only for the purpose of complying with the terms and conditions of its contract with the Employer.
 - b. Maintain the Information at a specific location under its control and take reasonable steps to safeguard the Information and to prevent unauthorized disclosure of the Information to third parties, including those of its employees not directly involved in the performance of duties under its contract with the Employer.
 - c. Advise its employees who receive the Information of the existence and terms of these provisions and of the obligations of confidentiality herein.
 - d. Use, and require its employees to use, at least the same degree of care to protect the Information as is used with its own proprietary and confidential information.
 - e. Not duplicate the Information furnished in written, pictorial, magnetic and/or other tangible form except for purposes of this Agreement or as required by law.
 - f. Not to use the name, logo, trademark or any description of each other or any subsidiary of each other in any advertising, promotion, solicitation or otherwise without the express prior written consent of the consenting party with respect to each proposed use.
 - g. Execute the Claim Administrator's then-current confidentiality agreement.
- 5.3 Employer obligations.** The Employer shall:
- a. Designate the third party consultant and/or vendor on the appropriate HIPAA documentation.
 - b. Provide the Claim Administrator with the appropriate authorization and specific written directions with respect to data release or exchange with the third party consultant and/or vendor.
 - c. Indemnify, defend (at the Claim Administrator's request) and hold harmless the Claim Administrator and its employees, officers, directors and agents against any and all losses, liabilities, damages, penalties and expenses, including attorneys' fees and costs, or other cost or obligation resulting from or arising out of claims, lawsuits, demands, settlements or judgments brought against the Claim Administrator in connection with any claim based upon the Claim Administrator's disclosure to the third party consultant and/or vendor of any information and/or documentation regarding any Covered Person at the direction of the Employer or breach by the third party consultant and/or vendor of any obligation described in this Agreement.

SECTION 6: REFERRAL OF CERTAIN CLAIMS/INQUIRIES

As provided in this Agreement, the Claim Administrator will receive eligibility information, review and process Claims, and respond to customer inquiries; however, the Claim Administrator does not have final authority to determine Covered Persons' eligibility or to establish or construe the terms and conditions of the Plan. Therefore, in certain instances, the Claim Administrator may refer certain Claims to the Employer for review and final decision. Such referral shall be at the sole discretion of the Claim Administrator.

SECTION 7: CLAIM DISPUTE RESOLUTION

- 7.1 After exhaustion of all remedies offered by the Claim Administrator, a Covered Person may appeal all adverse determinations with the Employer. The Claim Administrator will cooperate in providing Claim information pursuant to Section 4 above.
- 7.2 On occasion the Claim Administrator may deny all or part of submitted Claims. The Claim Administrator will provide a full and fair review of any determination of a Claim, any determination of a request for pre-authorization, and any other determination made in accordance with the benefits and procedures detailed in the Plan.

SECTION 8: FINAL DETERMINATION OF CLAIMS/INQUIRIES

The Employer retains the final authority and responsibility to establish and construe the terms and conditions of the Plan and to determine Covered Persons' eligibility. Certain claims and/or inquiries will be referred to the Employer for final review and determination in the following instances:

- 8.1 When Claims for services do not appear to qualify for payment under the Plan, claims or inquiries where there is a question of eligibility, claims where there is a question as to the amount of payment due, and claims involving litigation or the threat of litigation; and
- 8.2 When a Covered Person chooses to appeal adverse determinations with the Employer after exhaustion of all remedies offered by the Claim Administrator.

SECTION 9: COOPERATION OF THE PARTIES

The parties shall use their best efforts to cooperate with and assist each other, as applicable, in the performance of their duties under this Agreement.

SECTION 10: CERTIFICATE OF CREDITABLE COVERAGE

The Claim Administrator, at the direction of the Employer, shall issue a Certificate of Creditable Coverage consistent with the requirements under HIPAA. The Certificate of Creditable Coverage shall be based upon coverage under the Plan during the term of this Agreement and information provided to the Claim Administrator by the Employer.

SECTION 11: INDEMNIFICATION

- 11.1 *Claim Administrator indemnifies Employer.* The Claim Administrator hereby agrees to indemnify and hold harmless the Employer and its directors, officers and employees against any and all loss, liability, damages, penalties and expenses, including attorneys' fees, or other cost or obligation resulting from or arising out of claims, lawsuits, demands, settlements or judgments with respect to the Plan or this Agreement resulting from or arising out of any acts or omissions of the Claim Administrator or its directors, officers or employees which have been adjudged to be (i) grossly negligent, dishonest, fraudulent or criminal or (ii) in material breach of the terms of this Agreement; provided, however, notwithstanding anything herein to the contrary pursuant to Section 12.2 below, the Claim Administrator shall be responsible for the correction of Claim Payment errors by the Claim Administrator.
- 11.2 *Employer indemnifies Claim Administrator.* The Claim Administrator does not insure or underwrite the liability of the Employer under the Plan and has no responsibility for designing the terms of the Plan or the benefits to be provided thereunder. The Employer retains the ultimate responsibility for claims under the Plan and all expenses incident to the Plan, except as specifically undertaken in this Agreement by the Claim Administrator. To the extent allowed by Texas law, the Employer agrees to indemnify and hold harmless the Claim Administrator and its directors, officers and employees against any and all loss, liability, damages, penalties and expenses, including attorneys' fees, or other cost or obligation resulting from or arising out of claims, lawsuits, demands, settlements or judgments brought against the Claim Administrator in connection with the design or administration of the Plan, unless the liability therefore was the direct consequence of the acts or omissions of the Claim Administrator or its directors, officers or employees and is adjudged to be (i) grossly negligent, dishonest, fraudulent or criminal or (ii) in material breach of the terms of this Agreement; provided, however, notwithstanding anything herein to the contrary pursuant to Section 12.2 below, the Claim Administrator shall be responsible for the correction of Claim Payment errors by the Claim Administrator.

Examples of such actions brought against the Claim Administrator in connection with the design and administration of the Plan include, but are not limited to, the following:

- a. Any claim in connection with a claim for benefits under the Plan.
- b. Any claim based upon the disclosure of any information regarding a Covered Person by the Claim Administrator to the Employer.
- c. Any claim in connection with un-Timely and/or inaccurate eligibility data or Claim information data provided by the Employer to the Claim Administrator, or any such data provided by the Employer in a format not approved by the Claim Administrator.
- d. Any claim arising out of the electronic transfer of data i) from the Employer or the Employer's third party consultant and/or vendor to the Claim Administrator; or ii) from the Claim Administrator to the Employer or, pursuant to Section 5 of this Agreement, the Employer's third party consultant and/or vendor; including liability arising out of erroneous, misdirected, intercepted, incomplete or otherwise defective information and transfers of information, including, but not limited to, garbled transmissions, transmissions to third parties, and intercepted transmissions.
- e. Any claim arising from the Employer's use or posting of electronic files on the intranet and/or internet pursuant to Section 17 below.
- f. Any claim that may arise from or in connection with the Claim Administrator's suspension of Claim Payments due to the Employer's failure to pay when due any amounts owed the Claim Administrator under this Agreement and/or the termination of this Agreement in accordance with Section 13.2 below.
- g. Any claim arising from the Employer's directive to the Claim Administrator to print Employer-assigned unique identification numbers on membership identification cards or to otherwise use such assigned numbers in violation of any applicable federal, state and local rules, laws and regulations.
- h. Any claim based upon Medicare Secondary Payer ("MSP") laws or regulations.
- i. Any claim that may arise from or in connection with the Claim Administrator's issuance of Certificate(s) of Creditable Coverage based upon un-Timely and/or inaccurate data provided by the Employer to the Claim Administrator with respect to individuals whose coverage under this Agreement terminates.

SECTION 12: AUDIT AND CORRECTION OF AUDIT ERRORS

- 12.1 *Employer audits Claim Administrator.*** During the term of this Agreement and within one hundred eighty (180) days after its termination, the Employer or an authorized agent of the Employer (as mutually agreed to by the Claim Administrator and the Employer) may, upon at least ninety (90) days prior written notice to the Claim Administrator, conduct reasonable audits of the Claim Administrator's records in regard to Claim Payments made under the Agreement. The Employer and such agent that have access to the information and files maintained by the Claim Administrator will agree not to disclose any proprietary or confidential information, and to hold harmless and indemnify the Claim Administrator in writing of any liability from disclosure of such information. Audits performed on a contingency fee basis will not be allowed or supported by the Claim Administrator. The Employer will be responsible for all costs associated with the inspection or audit. All such audits shall be subject to the Claim Administrator's external audit policy and procedures, a copy of which shall be furnished to the Employer upon request to the Claim Administrator. The audit period will be limited to the most recent twenty-four (24) months and no more than one (1) audit shall be conducted during a twelve (12) consecutive-month period.
- 12.2 *Errors identified.*** The Claim Administrator shall be responsible only for the correction of errors identified in specific Claim Payments subject to the terms and conditions of the Agreement and shall not be responsible for errors calculated to exist in a population of Claim Payments on the basis of a sample drawn from that population. Further, the Claim Administrator has the right to implement reasonable administrative practices in the administration of this Agreement.
- 12.3 *Claim Administrator audits Employer.*** During the term of this Agreement and within one hundred eighty (180) days after its termination, the Claim Administrator may, upon at least thirty (30) days prior written notice to the Employer, conduct reasonable audits of Employer's membership records with respect to eligibility.

SECTION 13: TERM AND TERMINATION OF AGREEMENT

- 13.1 *Term.*** This Agreement will continue in full force and effect from the effective date and continue from year to year unless terminated as provided herein.

13.2 Termination. This Agreement may be terminated as follows:

- a. By either party at the end of any month after the end of the Fee Schedule Period specified in the most current Fee Schedule of Exhibit 2 upon forty-five (45) days prior written notice to the other party; or
- b. By both parties on any date mutually agreed to in writing; or
- c. By either party, in the event of fraud, misrepresentation of a material fact or not complying with the terms of this Agreement, upon written notice as provided under Section 21 below.
- d. By the Claim Administrator, upon the Employer's failure to pay all amounts due under this Agreement including, but not limited to, all amounts pursuant to and in accordance with the specifications of the most current Fee Schedule under Exhibit 2.

13.3 Notice of termination to Covered Employees. If this Agreement is terminated pursuant to this Section 13, the Employer agrees to notify all Covered Employees. The parties agree that the Employer will give such notice because the Employer maintains direct and ongoing communication with, and maintains current addresses for, all such Covered Employees.

SECTION 14: RELATIONSHIP OF PARTIES

14.1 Regarding the parties. The Claim Administrator is an independent contractor with respect to the Employer. Neither party shall be construed, represented or held to be an agent, partner, associate, joint venturer nor employee of the other.

Further, nothing in this Agreement shall create or be construed to create the relationship of employer and employee between the Claim Administrator and the Employer; nor shall the Employer's agents, officers or employees be considered or construed to be considered employees of the Claim Administrator for any purpose whatsoever.

14.2 Regarding non-parties. It is understood and agreed that nothing contained in this Agreement shall confer or be construed to confer any benefit on persons who are not parties to this Agreement including, but not limited to, employees of the Employer and their dependents.

14.3 Exclusivity. The Employer agrees not to engage any other party to perform the same services that the Claim Administrator performs hereunder while this Agreement is in effect, unless the Employer gives notice of termination pursuant to the terms of this Agreement.

14.4 Assignment. Notwithstanding anything to the contrary in Section 3 above, no part of this Agreement, or any rights, duties or obligations described herein, shall be assigned or delegated without the prior express written consent of both parties. Any such attempted assignment shall be null and void. The Claim Administrator's standing contractual arrangements for the acquisition and use of facilities, services, supplies, equipment and personnel shall not constitute an assignment under this Agreement.

SECTION 15: ERISA

15.1 In relation to the Plan. The Employer hereby acknowledges (i) that an employee welfare benefit plan must be established and maintained through a separate plan document which may include the terms hereof or incorporate the terms hereof by reference, and (ii) an employee welfare benefit plan document may provide for the allocation and delegation of responsibilities thereunder. However, notwithstanding anything contained in the Plan or any other employee welfare benefit plan document of the Employer, the Employer agrees that no allocation or delegation of any fiduciary or non-fiduciary responsibilities under the Plan or any other employee welfare benefit plan of the Employer is effective with respect to or accepted by the Claim Administrator.

15.2 In relation to the Plan Administrator/Named Fiduciary(ies). The Claim Administrator is not the plan administrator of the Employer's separate employee welfare benefit plan as defined under ERISA. It is understood and agreed that (i) the Employer has a named Plan Administrator and a Named Fiduciary within the meaning of § 414(g) of the Internal Revenue Code of 1986, as amended; (ii) said Plan Administrator serves within the meaning of § 3(16)(A) of ERISA; and (iii) the Claim Administrator is not a fiduciary of the Employer, the Plan Administrator or of the Plan.

15.3 In Relation to the Claim Administrator's Responsibilities. The Claim Administrator's responsibilities hereunder are intended to be limited to those of a contract claims administrator rendering advice to and administering claims on behalf of the plan administrator of the Employer's plan. As such, the Claim Administrator is intended to be a service provider but not a fiduciary with respect to the Employer's ERISA employee welfare benefit plan. The Employer represents that its ERISA employee welfare benefit plan contains the plan procedure described above regarding the designation of responsibilities under a plan and, accordingly, the Claim Administrator may, pursuant to Sections 402(c)(2) and 405(c)(1)(B) of ERISA, render advice with respect to claims and administer claims on behalf of the plan administrator of the Employer's ERISA welfare benefit plan. The Claim Administrator has no other authority or responsibility with respect to Employer's ERISA employee welfare benefit plan.

SECTION 16: PROPRIETARY MATERIALS

- 16.1 Types of materials as used by the parties.** The parties acknowledge that each party has developed operating manuals, certain symbols, trademarks, service marks, designs, data, processes, plans, procedures and information, all of which are proprietary information ("Business Proprietary Information"). Neither party shall use or disclose to any third party Business Proprietary Information without prior written consent of the other party. Neither party shall use the name, symbols, copyrights, trademarks or service marks ("Proprietary Marks") of the other party or the other party's respective clients in advertising or promotional materials without prior written consent of the other party; provided, however, that the Claim Administrator may include the Employer in its list of clients.
- 16.2 Claim Administrator/Association ownership.** The Employer acknowledges that the Claim Administrator's Proprietary Marks and Business Proprietary Information are the sole property of the Blue Cross and Blue Shield Association or of the Claim Administrator and agrees not to contest the Blue Cross and Blue Shield Association's or the Claim Administrator's ownership or the license granted to the Claim Administrator for use of such Proprietary Marks.
- 16.3 Infringement.** The Claim Administrator agrees not to infringe upon, dilute or harm the Employer's rights in its Proprietary Marks. The Employer agrees not to infringe upon, dilute or harm the Blue Cross and Blue Shield Association's ownership rights or the Claim Administrator's rights as a licensee in its Proprietary Marks.

SECTION 17: ELECTRONIC DOCUMENTS

- 17.1 Employer's consent/intended use.** The Employer consents to receive via an electronic file or access to an electronic file any document the Employer requests from the Claim Administrator describing the benefits under, or the administration of, the Plan. In the event the Claim Administrator provides to the Employer such an electronic file for the Employer's use, including, but not limited to the Employer's posting of such documents on the intranet and/or internet, the Employer acknowledges and agrees that such electronic file is not intended to meet the Employer's requirements for compliance under ERISA.
- 17.2 Employer acknowledgement/responsibilities.** The Employer further acknowledges and agrees that it is solely responsible for providing employees access, via the intranet, internet, or otherwise, to the most current version of any electronic file provided to the Employer by the Claim Administrator at the Employer's request. In addition, in all instances, the electronic file of the most current document issued to the Employer by the Claim Administrator for use by the Employer is the legal document used to administer the Employer's Plan and will prevail in the event of any conflict between such electronic file and any other electronic or paper file. The Employer is solely responsible for any and all claims for loss, liability or damages, arising either directly or indirectly from the use or posting of the electronic file on the intranet and/or internet.

SECTION 18: RECORDS

All Claim records, excluding any and all Business Proprietary Information, in the possession of the Claim Administrator are and shall remain the property of the Employer upon termination of this Agreement. The Claim Administrator shall return such property upon request in a form as agreed upon by the parties at the cost of preparing such property for transmittal to be borne by the Employer. All such Claim records shall be retained by the Claim Administrator until the Claim Administrator receives a request from the Employer for transmittal or for a period of ten (10) years from the date of a Claim's adjudication, whichever occurs first.

SECTION 19: APPLICABLE LAW

This Agreement shall be governed by, and shall be construed in accordance with, the laws of the state of Texas without regard to any state choice-of-law statutes, and any applicable federal law. All disputes arising out of this Agreement will be resolved in Texas.

SECTION 20: ENTIRE AGREEMENT

- 20.1 Definition.** This Agreement, including all Exhibits and Addenda, represents the entire agreement and understandings of the parties hereto and all prior agreements, understandings, representations and warranties, whether written or oral, in regard to the subject matter hereof, including any proposal document submitted by the Claim Administrator to the Employer pursuant to this Agreement, are and have been merged herein to the extent applicable. In the event of a conflict, the provisions of this Agreement and the Exhibits and Addenda of this Agreement shall prevail.
- 20.2 Components.** The Exhibits and Addenda of this Agreement as of the Agreement's effective date are:
- a. Exhibit 1 - Claim Administrator Services
 - b. Exhibit 2 - Fee Schedule, Financial Responsibilities & Required Disclosures
 - c. Exhibit 3 - Recovery Litigation Authorization
- 20.3 Amending.** This Agreement may be amended or altered in any of its provisions, including the addition or deletion of any Exhibits and/or Addenda as provided herein, by the parties hereto and any such change shall become effective when reduced to writing and signed by an authorized representative of the parties or at such time as said amendment may provide.

SECTION 21: NOTICE AND SATISFACTION

Unless specifically stated otherwise in this Agreement, the Employer and the Claim Administrator agree to give one another written notice (pursuant to Section 25 Notices below) of any complaint or concern the other party may have about the performance of obligations under this Agreement and to allow the notified party thirty (30) days in which to make necessary adjustments or corrections to satisfy the complaint or concern prior to taking any further action with regard to such.

SECTION 22: LIMITATION OF LIABILITY

Liability for any errors or omissions by the Claim Administrator (or its officers, directors, employees, agents or independent contractors) in the administration of this Agreement, or in the performance of any duty or responsibility contemplated by this Agreement, shall be limited to the maximum benefits which should have been paid under this Agreement had the errors or omissions not occurred (including the Claim Administrator's share of any arbitration expenses incurred), unless any such errors or omissions are adjudged to be the result of intentional misconduct, gross negligence or intentional breach of a duty under this Agreement by the Claim Administrator.

SECTION 23: DISPUTE RESOLUTION/ARBITRATION

- 23.1 Initial Negotiation.** Any dispute arising out of or relating to this Agreement shall be resolved in accordance with the procedures specified in this Section 23, which shall be the sole and exclusive procedures for the resolution of any such disputes. All negotiations pursuant to this Section 23 are confidential and shall be treated as compromise and settlement negotiations for purposes of applicable rules of evidence.
- 23.2 Deferring to arbitration/selecting an arbitrator.** In the event the parties fail to agree with respect to any matter covered herein, the question in dispute shall be submitted for arbitration in Texas. The arbitrator shall be selected as follows:
- a. Upon declaration by one of the parties hereto that a deadlock exists, the parties shall select an arbitrator;
 - b. If no appointment is made within thirty (30) days after the deadlock is declared and the amount in contest is in excess of \$200, the American Arbitration Association shall recommend an arbitrator; or
 - c. If no appointment is made within thirty (30) days after the deadlock is declared and the amount in question is \$200 or less, the Claim Administrator shall select an independent third party to be the arbitrator.

23.3 Expectations. The arbitrator will submit a decision within thirty (30) days after appointment or as soon as reasonably feasible and such decision shall be binding on the parties hereto. Arbitration expenses will be shared by the parties. All other expenses (legal, incidental, etc.) shall be borne by the losing party or, if both parties prevail, be apportioned by the arbitrator to each party. Arbitration proceedings will be governed by the Rules of the American Arbitration Association then in effect.

SECTION 24: OBLIGATION TO CONTINUE PERFORMANCE

Except as provided otherwise in this Agreement, each party is required to continue to perform its obligations under this Agreement pending final resolution of any dispute arising out of or relating to this Agreement.

SECTION 25: NOTICES

25.1 How to notify. All notices given under this Agreement must be in writing and shall be deemed to have been given for all purposes when personally delivered and received or when deposited in the United States mail, first-class postage prepaid, and addressed to the parties at their respective addresses or when transmitted by facsimile via their respective facsimile numbers as indicated in the most current Fee Schedule specifications of Exhibit 2 of this Agreement.

25.2 Change of address. Each party may change such notice mailing and/or transmission information upon Timely prior written notification to the other party.

SECTION 26: SEVERABILITY

Should any provision(s) contained in this Agreement be held to be invalid, illegal, or otherwise unenforceable, the remaining provisions of the Agreement shall be construed in their entirety as if separate and apart from the invalid, illegal or unenforceable provision(s) unless such construction were to materially change the terms and conditions of this Agreement.

SECTION 27: ENFORCEMENT

Any delay or inconsistency in the enforcement of any part of this Agreement shall not constitute a waiver of any rights with respect to the enforcement of this Agreement at any future date nor shall it limit any remedies which may be sought in any action to enforce any provision of this Agreement.

SECTION 28: FORCE MAJEURE

Neither party shall be liable for any failure to Timely perform its obligations under this Agreement if prevented from doing so by a cause or causes beyond its commercially reasonable control including, but not limited to, acts of God or nature, fires, floods, storms, earthquakes, riots, strikes, wars or restraints of government.

SECTION 29: NOTICE OF ANNUAL MEETING

The Employer is hereby notified that it is a Member of Health Care Service Corporation (HCSC), a Mutual Legal Reserve Company, and is entitled to vote either in person, by its designated representative, or by proxy at all meetings of Members of said Company. The annual meeting is held at its principal office at 300 East Randolph Street, Chicago, Illinois each year on the last Tuesday in October at 12:30 P.M.

For purposes of this Agreement, the term "Member" means the group, trust, association or other entity with which this Agreement has been entered. It does not include Covered Employees or Covered Persons under the Plan.

EXHIBIT 1
CLAIM ADMINISTRATOR SERVICES

- **CLAIMS ADJUDICATION**

Examination of Claims and determination of payment levels, including data entry of Claims by Claims departments, maintenance of Claims experience files, use of medical consultants, review of utilization and allowable amounts and Coordination of Benefits (COB).

- **EXPLANATION OF BENEFITS (EOB)**

Preparation of EOBs.

- **CLAIMS/MEMBERSHIP INQUIRIES**

Handling of inquiries — written, phone or in-person — related to membership, benefits, and Claim Payment or denial.

- **ENROLLMENT SERVICE**

Upon Employer request, assist Employer, in accordance with Claim Administrator's standard procedures, in initial enrollment activities, including education of Covered Persons about benefits, the enrollment process, selection of health care providers and how to file a Claim for benefits; issue Claim submission instructions on behalf of Employer to health care providers who render services to Covered Persons.

- **CLIENT SERVICES AND MATERIALS**

Provision of those items as elected by Employer from listing below:

- a. *Enrollment Materials.* Implementation materials to be provided by Claim Administrator's Marketing Administration Division during the enrollment process; any custom designed materials may be subject to Supplemental Charge.
- b. *Standard Identification Cards.* Provision of identification cards appropriate to health benefit Plan coverage(s) selected.
- c. *Standard Provider Directories.* Access to Network Provider directories and periodic updates to such, if applicable to the health benefit Plan coverage(s) under the Agreement.
- d. *Customer Service.* Access to toll-free customer service telephone number.
- e. *Medical Pre-authorization Helpline.* For those services determined by Employer and provided in writing to Claim Administrator that require pre-authorization, advance Claim Administrator review of medical necessity of such services covered under the Plan; access to toll-free medical pre-authorization helpline for Covered Persons and their health care providers to call for assistance.

- **MEMBERSHIP VALIDATION**

Verification of membership by wire, listing, electronic on-line query or other method prior to or during adjudication.

- **MEMBERSHIP FILE UPDATES**

Maintenance of membership status files, processing of inter-plan transfers and processing of contract changes.

- **OTHER MEMBERSHIP SERVICES**

Contact Employer and/or Covered Employees regarding adding, changing or renewing coverage.

- **STANDARD REPORTS**

Make available Claim data, Claim Settlement statements (as outlined in Exhibit 2, Section 6) and periodic reports in Claim Administrator's standard format(s) in accordance with Claim Administrator's standard reporting policy.

- **STOP LOSS COORDINATION**

Coordinate all necessary reporting, tracking, notification and other similar financial and/or administrative services pursuant to settlements under stop loss policy(ies) purchased from Claim Administrator in conjunction with the Agreement. For stop loss coverage purchased from entity(ies) other than Claim Administrator, such coordination is limited to this Exhibit's STANDARD REPORTS to be made available to Employer subject to the Agreement's disclosure requirements.

- **REPORTING SERVICES**
Preparation and filing of annual Internal Revenue Service (IRS) 1099 forms for the reporting of payments to health care providers who render services to Covered Persons and who are reimbursed by the Plan for those services.
- **ACTUARIAL AND STATISTICAL**
Determination of claims projections and pricing of administrative services and stop-loss coverage.
- **FINANCIAL SERVICES**
Financial functions such as cash receipts, cash disbursements, payroll and general ledger processing, general accounting, preparation of financial statements, billing, group settlement and wire transfers.
- **FRAUD DETECTION AND PREVENTION**
Identify and investigate suspected fraudulent activity by Providers and/or Covered Persons and inform Employer of findings and proof of fraud; address any related recovery litigation as set forth in Exhibit 3 of the Agreement.
- **BLUE ACCESS FOR EMPLOYERS**
Provides Employer on-line access to conduct a variety of secure membership, enrollment, reporting, administrative and billing transactions faster, more accurately and in real-time.
- **BLUE ACCESS FOR MEMBERS**
An on-line resource for personalized information about a Covered Person's health care coverage, including, but not limited to, Claims status, email notification when a Claim has been finalized, access to health and wellness information from Mayo Clinic, verification of dependents covered on their plan and health risk assessment and such other services as become available.
- **PROVIDER NETWORK(S)**
If applicable to the health benefit Plan coverage(s) under the Agreement, establish, arrange and maintain a Network(s) through contractual arrangements with Providers within the designated service area(s).
- **CERTIFICATE OF CREDITABLE COVERAGE**
At the direction of Employer, issuance of Certificates of Creditable Coverage.
- **ADDITIONAL SERVICES NOT SPECIFIED**
Claim Administrator may provide additional services not specified in the Agreement; such services will be mutually agreed upon between the parties in writing prior to their performance and may be subject to Supplemental Charge.

EXHIBIT 2
FEE SCHEDULE, FINANCIAL RESPONSIBILITIES & REQUIRED DISCLOSURES

SECTION 1: FEE SCHEDULE

Service charges and other Fee Schedule specifications in this Section 1 are to apply for the period(s) of time indicated herein and shall continue in full force and effect until the earlier of: i) the end of the Fee Schedule Period noted below; ii) the date this Section 1 Fee Schedule is amended or replaced in its entirety; and iii) the date the Agreement is terminated.

1.1 FEE SCHEDULE PERIOD

Fee Schedule specifications in this Section 1 are for the **Fee Schedule Period** commencing on **February 1, 2008** and ending on end of day **January 31, 2009**.

1.2 EMPLOYER GROUP NUMBER(S)

For the Fee Schedule Period noted above, the Agreement shall apply to the following Employer Group Number(s): **21185**.

1.3 ADMINISTRATIVE CHARGES AND CREDITS

- a. The **Administrative Charge**, calculated monthly, shall be equal to the sum of the amounts obtained by multiplying the total number of Covered Employees by category by the appropriate factors shown below.

Composite	2008
Base Administrative Charge (Medical)	\$28.08
Commissions	\$1.80
Rx Rebate Credit	\$-5.90
Total	\$23.98

- b. The **Termination Administrative Charge** applicable to the Run-Off Period shall be equal to the sum of the amounts obtained by multiplying the total number of Covered Employees by category during the three (3) months immediately preceding the date of termination by the appropriate factors shown below.

	2008
Medical Run-off Administration Charge	\$7.27

- c. The **Prescription Drug Program Rebate Credit** is \$-5.90 per Covered Employee per month. Expected rebate amounts to be received by the Claim Administrator are passed back to the Employer with one hundred percent (100%) of the expected amount applied as a credit on the monthly billing statement on a per Covered Employee per month basis. The rebate credits are paid prospectively to the Employer and shall not continue after termination of the Prescription Drug Program. (Further information concerning this credit is included in Section 13 of this Exhibit, titled "CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS.")

1.4 REPORTS

The Claim Administrator will make available to the Employer Standard Reports and other Reporting Services as set forth in Exhibit 1 - CLAIM ADMINISTRATOR SERVICES of the Agreement in accordance with its standard reporting policy at no additional charge. Any additional reports required by the Employer must be mutually agreed upon by the parties in writing prior to their development and may be subject to a Supplemental Charge.

1.5 CHARGES FOR ADDITIONAL SERVICES

The following Additional Services shall be furnished:

Reimbursement 25% of any recovered amounts*

**The indicated Reimbursement fee is based on the net recovery after attorney's fees, if any, have been paid.*

BlueCard Program/Network access feesavailable upon request

1.6 PLAN DESIGN MATERIALS

Benefit Booklets: Cost has been included in Administrative Charge

Accept/Decline

- | | | | |
|-------------------------------------|-------------------------------------|-----------------------------|--|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | Benefit Booklets | <input checked="" type="checkbox"/> No additional charge |
| | | | <input type="checkbox"/> <u>Supplemental Billing*</u> |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | Customized Benefit Booklets | <input type="checkbox"/> No additional charge |
| | | | <input type="checkbox"/> <u>Supplemental Billing*</u> |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | Customized Covers | <input type="checkbox"/> No additional charge |
| | | | <input type="checkbox"/> <u>Supplemental Billing*</u> |

Subscriber Identification (ID) Cards: Cost has been included in Administrative Charge

Accept/Decline

- | | | | |
|-------------------------------------|-------------------------------------|---------------------|--|
| <input checked="" type="checkbox"/> | <input type="checkbox"/> | Subscriber ID Cards | <input checked="" type="checkbox"/> No additional charge |
| | | | <input type="checkbox"/> <u>Supplemental Billing*</u> |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | Customized ID Cards | <input type="checkbox"/> No additional charge |
| | | | <input type="checkbox"/> <u>Supplemental Billing*</u> |

- | | |
|-------------------------------------|--|
| Network Provider Directories | <input checked="" type="checkbox"/> No additional charge |
| | <input type="checkbox"/> <u>Supplemental Billing*</u> |

- | | |
|---|--|
| Claim Forms, Application Forms, Enrollment Materials | <input checked="" type="checkbox"/> No additional charge |
| | <input type="checkbox"/> <u>Supplemental Billing*</u> |

Special Mailings:

- | | | | | |
|---|-----|-------------------------------------|----|-------------------------------------|
| Cost has been included in Administrative Charge: | Yes | <input checked="" type="checkbox"/> | No | <input type="checkbox"/> |
| Identification Cards mailed to home addresses | Yes | <input checked="" type="checkbox"/> | No | <input type="checkbox"/> |
| Provider Directories mailed to home addresses | Yes | <input type="checkbox"/> | No | <input checked="" type="checkbox"/> |

**Any customized materials or additional services or supplies not documented in this Fee Schedule may be subject to Supplemental Billing upon mutual agreement of the parties.*

1.7 BROKER/CONSULTANT COMPENSATION

The Employer acknowledges that if any broker/consultant acts on its behalf for purposes of purchasing services in connection with the Employer's Plan under the Agreement, the Claim Administrator may pay the Employer's broker/consultant a commission and/or other compensation in connection with such services under the Agreement. If the Employer desires additional information regarding commissions and/or other compensation paid the broker/consultant by the Claim Administrator in connection with services under the Agreement, the Employer should contact its broker/consultant.

1.8 TRANSFER PAYMENT PERIOD

The **Transfer Payment Period** by which payments under Section 5 of this Exhibit are to be made is weekly.

1.9 CLAIM SETTLEMENT PERIOD

The **Claim Settlement Period** by which settlements under Section 6 of this Exhibit are to be made is monthly.

1.10 RUN-OFF PERIOD

The **Run-Off Period** immediately following termination of the Agreement during which the Claim Administrator will accept Run-Off Claims submitted for payment is twelve-(12) months.

1.11 PLAN COVERAGE

Coverage under the Employer's Plan includes the following:

- Managed Health Care Coverage PPO
- Traditional (Out-of-Area) Indemnity Coverage
- Prescription Drug Program/Mail Service Prescription Drug Program coverage

1.12 NOTICE MAILING AND TRANSMISSION INFORMATION

Each party's address and facsimile number for the issuance of notices in accordance with Section 25 of the Agreement are shown below.

If to the Claim Administrator:

Blue Cross and Blue Shield of Texas
901 South Central Expressway
Richardson, Texas 75080
Attention: Mary McColgan
Fax: 361-878-1619

If to the Employer:

Hidalgo County
2818 S. Business Hwy 281
Edinburg, Texas 78537
Attention: Fred Reyna II
Fax: 956-318-2633

1.13 RISK SHARING OF NETWORK DISCOUNT

The parties agree to share in the risk of anticipated savings by utilization of the Provider Networks established by the Claim Administrator and other Blue Cross and Blue Shield Plans. The details of this risk sharing program are contained in the Network Discount Guarantee Exhibit ("Exhibit ND") attached to and made part of this Agreement.

SECTION 2: EXHIBIT DEFINITIONS

Other definitions applicable to this Exhibit are contained in Section 2 AGREEMENT DEFINITIONS of the Agreement.

- 2.1 "**Copayment**" means a specified dollar amount that a Covered Person is required to pay toward a Covered Service.
- 2.2 "**Coshare**" means a percentage of an eligible expense that a Covered Person is required to pay toward a Covered Service.
- 2.3 "**Inpatient**" means the Covered Person is a registered bed patient and treated as such in a health care facility.
- 2.4 "**Medicare Secondary Payer ("MSP")**" means those provisions of the Social Security Act set forth in 42 U.S.C. §1395 y (b), and the implementing regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain employers may offer group health care coverage to Medicare-eligible employees, their spouses and, in some cases, dependent children. (See Section 16 of this Exhibit titled "MEDICARE SECONDARY PAYER ("MSP") DATA MATCH.")
- 2.5 "**Run-Off Claim**" means a Claim incurred prior to the termination of the Agreement that is submitted for payment during the Run-Off Period.

- 2.6 **“Run-Off Period”** means the time period immediately following termination of the Agreement, as specified in the most current Fee Schedule specifications of this Exhibit, during which the Claim Administrator will accept Run-Off Claims submitted for payment.
- 2.7 **“Termination Administrative Charge”** means the consideration that is required by the Claim Administrator upon termination of the Agreement, notwithstanding any services that may be performed by the Claim Administrator during the Run-Off Period.
- 2.8 **“Transfer Payment”** means a payment in the amount outlined in Section 5 of this Exhibit, via wire, draft, electronic fund transfer (EFT) or such other method as mutually agreed to by the parties in writing.

SECTION 3: COMPENSATION TO CLAIM ADMINISTRATOR

- 3.1 **Intent of service charges.** The Employer will pay service charges to the Claim Administrator, in accordance with the most current Fee Schedule specifications of Section 1 of this Exhibit, as compensation for the processing of Claims and administrative and other services provided to the Employer.
- 3.2 **Determining service charges.** The service charges, which are guaranteed for the Fee Schedule Period indicated in the most current Fee Schedule specifications of Section 1 of this Exhibit, have been determined in accordance with the Claim Administrator’s current regulatory status and the Employer’s existing benefit program.
- 3.3 **Changing service charges.** The service charges shall be subject to change by the Claim Administrator as follows:
- a. At the end of the Fee Schedule Period indicated in the most current Fee Schedule specifications of Section 1 of this Exhibit, provided that sixty (60) days prior written notice is given by the Claim Administrator;
 - b. On the effective date of any changes or benefit variances in the Plan, its administration, or the level of benefit valuation which would increase the Claim Administrator’s cost of administration;
 - c. On any date changes imposed by governmental entities increase expenses incurred by the Claim Administrator, provided that such increases shall be limited to an amount sufficient to recover such increase in expenses;
 - d. On any date that the number of Covered Employees enrolled in the Plan changes by an amount equal to ten percent (10%) or more of total enrollment over a one (1) month period or twenty-five percent (25%) or more of total enrollment over a three (3) month period; or
 - e. On any date an affiliate, subsidiary, or other business entity is added or dropped by the Employer.
- 3.4 **Service charges upon termination.** In the event the Agreement is terminated in accordance with the “TERM AND TERMINATION” provisions of the Agreement, the Employer will Timely pay the Claim Administrator the Termination Administrative Charge indicated in the most current Fee Schedule specifications of Section 1 of this Exhibit.
- 3.5 **Additional service charges.** In addition to the amounts due and payable each month in accordance with the most current Fee Schedule specifications of Section 1 of this Exhibit, the Claim Administrator may charge the Employer for:
- a. Any applicable Supplemental Charge(s);
 - b. Reasonable fees for the reproduction or return of Claim records requested by the Employer, a governmental agency or pursuant to a court order; and/or
 - c. Any other fees that may be assessed by third parties for services rendered to the Employer and/or any other fees for services mutually agreed upon by the parties in writing.
- 3.6 **Effect of Plan enrollment.** Administrative Charges will be paid based upon information the Claim Administrator receives regarding current Plan enrollment as of the first day of each month. Appropriate adjustments will be made for enrollment variances or corrections.
- 3.7 **Timely payment.** Performance of all duties and obligations of the Claim Administrator under the Agreement are contingent upon the Timely payment of any amount owed the Claim Administrator by the Employer.

SECTION 4: CLAIM PAYMENTS

- 4.1 **Claim Administrator's Payment.** Upon receipt of a Claim, the Claim Administrator will make a Claim Payment provided that all payments due the Claim Administrator under the terms of the Agreement are paid when due.
- 4.2 **Employer's Liability.** Any reasonable determination by the Claim Administrator in adjudicating a Claim under the Agreement that a Covered Person is entitled to a Claim Payment is conclusive evidence of the liability of the Employer to the Claim Administrator for such Claim Payment pursuant to Section 6 below titled "CLAIM SETTLEMENTS."
- 4.3 **Cessation of Claim Payments.** If the Employer has failed to pay when due any amount owed the Claim Administrator, the Claim Administrator shall be under no obligation to make any further Claim Payments until such default is cured.

SECTION 5: TRANSFER PAYMENT

- 5.1 **Intent.** In consideration of the Claim Administrator's obligations as set forth in the Agreement and at the end of each Transfer Payment Period, the Employer shall transfer to the Claim Administrator's account an amount equal to the Transfer Payment Period's Claim Payments plus the applicable service charges. The Transfer Payment Period shall be as indicated in the most current Fee Schedule specifications of Section 1 of this Exhibit.
- 5.2 **Notification of Amount Due.** The Claim Administrator shall advise the Employer's Financial Division by email or facsimile (at an email address or facsimile number to be furnished by the Employer prior to the effective date of the Agreement) of the amount of Claim Payments pursuant to the Agreement for which reimbursement has not been previously made by the Employer to the Claim Administrator, plus the applicable service charges.
- 5.3 **When Due.** Transfer Payment must be made within twenty-four (24) hours of the Employer's notification by the Claim Administrator. If any day on which a Transfer Payment is due is a holiday, such payment will be made on the next business day. Late payments are subject to the penalties outlined in Section 7 of this Exhibit.

SECTION 6: CLAIM SETTLEMENTS

- 6.1 **Determining what Employer owes.** A Claim Settlement shall be determined for each Claim Settlement Period indicated in the most current Fee Schedule specifications of Section 1 of this Exhibit. The Claim Settlement shall reflect the sum of the following:
 - a. All Claim Payments paid by the Claim Administrator in the particular Claim Settlement Period.
 - b. All Claim Payments paid by the Claim Administrator in prior Claim Settlement Periods that have not been included in a prior Claim Settlement.
 - c. The Administrative Charges and Credits and other applicable service charges as indicated in the most current Fee Schedule specifications of Section 1 of this Exhibit and any applicable Supplemental Charge(s).

The sum of a., b., and c. above shall be referred to as the Claim Settlement Total.

- 6.2 **Employer underpayment.** If, within the Claim Settlement Period, the Claim Settlement Total exceeds the Transfer Payments, the Employer will pay the difference to the Claim Administrator. The Claim Settlement will be determined within sixty (60) days from the last day of the Claim Settlement Period. The Claim Administrator will notify the Employer in writing of the results of the Claim Settlement. Any sums due the Claim Administrator will be paid Timely by the Employer.
- 6.3 **Employer overpayment.** If, within the Claim Settlement Period, the Transfer Payments exceed the Claim Settlement Total, the Claim Administrator may, at its option, pay such difference to the Employer, apply the difference against amounts then owed the Claim Administrator by the Employer or authorize a reduction equal to such difference from the next Claim Settlement due the Claim Administrator from the Employer.

SECTION 7: LATE PAYMENTS AND REMEDIES

- 7.1 *When Employer Fails to Pay.* If the Employer fails to pay when due any amount required to be paid to the Claim Administrator under the Agreement, and such default is not cured within ten (10) days of written notice to the Employer, the Claim Administrator may, at its option:
- Suspend Claim Payments; or
 - Terminate the Agreement as of the effective date specified in such notice.
- 7.2 *When Claim Administrator Fails to Timely Notify.* Pursuant to Section 27 "ENFORCEMENT" of the Agreement, the Claim Administrator's failure to provide the Employer with timely notice of any amount due hereunder shall not be considered a waiver of payment of any amount which may otherwise be due hereunder from the Employer.
- 7.3 *Late Charge.* If the Employer fails to make any payment required by the Agreement on a Timely basis, the Claim Administrator, at its option, may assess a daily charge for the late remittance from the due date of any amount(s) payable to the Claim Administrator by the Employer. This daily charge shall be an amount equal to the amount resulting from multiplying the amount due times the lesser of:
- The rate of .0329% per day which equates to an amount of twelve percent (12%) per annum; or
 - The maximum rate permitted by state law.
- 7.4 *Insolvency.* In addition, if the Employer becomes insolvent, however evidenced, or is in default of its obligation to make any Transfer Payment as provided hereunder, or if any other default hereunder has occurred and is continuing, then any indebtedness of the Claim Administrator to the Employer (including any and all contractual obligations of the Claim Administrator to the Employer) may be offset and/or recouped and applied toward the payment of the Employer's obligations hereunder, whether or not such obligations, or any part thereof, shall then be due the Employer.

SECTION 8: FINANCIAL OBLIGATIONS UPON AGREEMENT TERMINATION

- 8.1 *Run-Off Claims.* The Employer hereby acknowledges that on the date of termination of the Agreement in accordance with the provisions of either Section 7 of this Exhibit or Section 13 of the Agreement, there may be an undetermined but substantial number of Claims for services rendered or furnished prior to that date which have not been submitted to the Claim Administrator for reimbursement and also an undetermined but substantial number of Claims submitted for reimbursement which have not been paid by the Claim Administrator ("Run-Off Claims"). The Employer shall be responsible for the reimbursement of all Run-Off Claims, whether or not such Claims have been submitted, or whether or not Claim Payments for such Claims have been made by the Claim Administrator, as of the date of termination, including, but not limited to, Claim Payments made in accordance with MSP laws, and for the payment of the Termination Administrative Charge and any other applicable service charges as indicated in the most current Fee Schedule specifications of Section 1 of this Exhibit and any applicable Supplemental Charge(s) pursuant to the processing of such Claims after the Agreement's termination date.
- 8.2 *Corresponding Transfer Payments.* In consideration of the Claim Administrator's continuing to make Claim Payments in accordance with Section 4 of this Exhibit for Run-Off Claims, the Employer shall continue to make Transfer Payments for all such Claims paid by the Claim Administrator up to the Final Settlement outlined below.
- 8.3 *Final Settlement.* A Final Settlement shall be made within sixty (60) days after the last day of the Run-Off Period. This Final Settlement shall compare the Transfer Payments against the Claim Settlement Totals for all Run-Off Claims paid up to the date of the Final Settlement. The difference shall be paid or applied as set forth in Section 6 of this Exhibit. However, if the Transfer Payments exceed the Claim Settlement Totals for all Run-Off Claims paid up to the Final Settlement, the Claim Administrator shall pay such difference to the Employer after applying the difference against amounts, if any, then owed to the Claim Administrator by the Employer.

SECTION 9: REQUIRED DISCLOSURE PROVISIONS

The Employer represents that it acknowledges and has communicated the provisions stated in each of the following sections of this Exhibit 2 to its Covered Persons.

SECTION 10: PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS:

- 10.1 Claim payment assignment.** All payments by the Claim Administrator for the benefit of any Covered Person may be made directly to any Provider furnishing Covered Services for which such payment is due, and the Claim Administrator is authorized by such Covered Person to make such payments directly to such Providers. However, the Claim Administrator reserves the right in its sole discretion to pay any benefits that are payable under the terms of the Plan directly to the Covered Person or Provider furnishing Covered Services. All benefits payable to the Covered Person which remain unpaid at the time of the death of the Covered Person will be paid to the estate of the Covered Person.
- 10.2 Claim dispute.** Once Covered Services are rendered by a Provider, the Covered Person has no right to request the Claim Administrator not to pay the Claim submitted by such Provider and no such request by a Covered Person or his agent will be given effect. Furthermore, the Claim Administrator will have no liability to the Covered Person or any other person because of its rejection of such request.
- 10.3 Plan coverage assignment.** Neither the Plan nor a Covered Person's claims for payment of benefits under the Plan are assignable in whole or in part to any person or entity at any time. Coverage under the Plan is expressly non-assignable or non-transferable and will be forfeited if a Covered Person attempts to assign or transfer coverage or aids or attempts to aid any other person in fraudulently obtaining coverage under the Plan. However, if the Claim Administrator makes payment because of a person's wrongful use of the identification card of a Covered Person, such payment will be considered a proper payment and the Claim Administrator will have no obligation to pursue recovery of such payment.

SECTION 11: COVERED PERSON/PROVIDER RELATIONSHIP

- 11.1 Choosing a Provider.** The choice of a Provider is solely the choice of the Covered Person and the Claim Administrator will not interfere with the Covered Person's relationship with any Provider.
- 11.2 Claim Administrator's role.** It is expressly understood that the Claim Administrator does not itself undertake to furnish hospital, medical or dental service, but solely to make payment to a Provider for the Covered Services received by Covered Persons. The Claim Administrator is not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to a Covered Person. Professional services which can only be legally performed by a Provider are not provided by the Claim Administrator. Any contractual relationship between a Provider and the Claim Administrator shall not be construed to mean that the Claim Administrator is providing professional service.
- 11.3 Intent of terminology.** The use of an adjective such as Approved, Administrator, Participating, In-Network or Network in modifying a Provider shall in no way be construed as a recommendation, referral or any other statement as to the ability or quality of such Provider. In addition, the omission, non-use or non-designation of Approved, Administrator, Participating, In-Network, Network or any similar modifier or the use of a term such as Non-Approved, Non-Administrator, Non-Participating, Out-of-Network or Non-Network should not be construed as carrying any statement or inference, negative or positive, as to the skill or quality of such Provider.
- 11.4 Provider's role.** Each Provider provides Covered Services only to Covered Persons and does not deal with or provide any services to the Employer (other than as an individual Covered Person) or the Plan.

SECTION 12: CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PRESCRIPTION DRUG PROVIDERS

- 12.1** All amounts payable to the Claim Administrator by the Employer for Claim Payments provided by the Claim Administrator and applicable service charges pursuant to the terms of the Agreement and all required Copayment, deductible and Coshare amounts under the Agreement shall be calculated on the basis of the Provider's Eligible Charge or the agreed upon cost between the Participating Prescription Drug Provider as defined below, and the Claim Administrator, whichever is less.

- 12.2 The Claim Administrator hereby informs the Employer and all Covered Persons that it has contracts, either directly or indirectly, with prescription drug Providers ("Participating Prescription Drug Providers") for the provision of, and payment for, prescription drug services to all persons entitled to prescription drug benefits under individual certificates, group health insurance policies and contracts to which the Claim Administrator is a party, including the Covered Persons under the Agreement, and that pursuant to the Claim Administrator's contracts with Participating Prescription Drug Providers, under certain circumstances described therein, the Claim Administrator may receive discounts for prescription drugs dispensed to Covered Persons under the Agreement.
- 12.3 The Employer understands that the Claim Administrator may receive such discounts during the term of the Agreement. Neither the Employer nor Covered Persons hereunder are entitled to receive any portion of any such discounts except as such items may be indirectly or directly reflected in the service charges specified in the Agreement.

SECTION 13: CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS

- 13.1 The Claim Administrator hereby informs the Employer and all Covered Persons that it owns a significant portion of the equity of Prime Therapeutics LLC and that the Claim Administrator has entered into one or more agreements with Prime Therapeutics LLC or other entities (collectively referred to as "Pharmacy Benefit Managers"), for the provision of, and payment for, prescription drug benefits to all persons entitled to prescription drug benefits under individual certificates, group health insurance policies and contracts to which the Claim Administrator is a party, including the Covered Persons under the Agreement. Pharmacy Benefit Managers have agreements with pharmaceutical manufacturers to receive rebates for using their products. Pharmacy Benefit Managers may share a portion of those rebates with the Claim Administrator.
- 13.2 Based upon previous experience with such rebates, the Claim Administrator has estimated that any drug rebate for the Employer would be based on an average dollar amount per prescription ("Expected Rebate"). One-hundred percent (100%) of the Expected Rebate is shared with employers based upon the benefit design and the retail and mail order usage rate. The Expected Rebate passed back to the Employer is determined by multiplying the sum of the estimated dollars times the expected number of annual prescriptions dispensed, then divided by the expected number of Covered Employees, then divided by twelve (12) months. The Expected Rebate amount is reflected as a prescription drug rebate credit per Covered Employee per month.
- 13.3 The Employer understands that the Claim Administrator may receive such rebates during the term of the Agreement. Neither the Employer nor Covered Persons hereunder are entitled to receive any portion of any such rebates except as such items may be indirectly or directly reflected in the service charges specified in the Agreement.

SECTION 14: BLUECARD

- 14.1 Like all Blue Cross and Blue Shield Licensees, the Claim Administrator participates in a program called "BlueCard." Whenever Covered Persons access health care services outside the Claim Administrator's service area, the Claims for those services may be processed through BlueCard and presented to the Claim Administrator for payment in conformity with network access rules of the BlueCard Policies then in effect ("Policies"). Under BlueCard, when Covered Persons receive Covered Services within the geographic area served by an on-site Blue Cross and/or Blue Shield Licensee ("Host Blue"), the Claim Administrator will remain responsible to the Employer for fulfilling the Claim Administrator's contract obligations.
- 14.2 However, the Host Blue will only be responsible, in accordance with applicable BlueCard Policies, if any, for providing such services as contracting with its participating Providers and handling all interaction with its participating Providers. The financial terms of BlueCard are described generally below.
- 14.3 **Liability Calculation Method Per Claim**

The calculation of a Covered Person's liability on Claims for Covered Services incurred outside the Claim Administrator's service area and processed through BlueCard will be based on the lower of the Provider's billed charges or the negotiated price the Claim Administrator pays the Host Blue.

The calculation of the Employer's liability on Claims for Covered Services incurred outside the Claim Administrator's service area and processed through BlueCard will be based on the negotiated price the Claim Administrator pays the Host Blue.

The methods employed by a Host Blue to determine a negotiated price will vary among Host Blues based on the terms of each Host Blue's Provider contracts. The negotiated price paid to a Host Blue by the Claim Administrator on a Claim for Covered Services processed through BlueCard may represent:

- a. The actual price paid on the Claim by the Host Blue to the health care Provider ("Actual Price"), or
- b. An estimated price, determined by the Host Blue in accordance with BlueCard Policies, based on the Actual Price increased or reduced to reflect aggregate payments expected to result from settlements, withholds, any other contingent payment arrangements and non-Claims transactions with all of the Host Blue's health care Providers or one or more particular Providers ("Estimated Price"), or
- c. An average price, determined by the Host Blue in accordance with BlueCard Policies, based on a billed charges discount representing the Host Blue's average savings expected after settlements, withholds, any other contingent payment arrangements and non-Claims transactions for all of its Providers or for a specified group of Providers ("Average Price"). An Average Price may result in greater variation to the Covered Person and the Employer from the Actual Price than would an Estimated Price.

Host Blues using either the Estimated Price or Average Price will, in accordance with BlueCard Policies, prospectively increase or reduce the Estimated Price or Average Price to correct for over- or underestimation of past prices. However, the amount paid by the Covered Person and the Employer is a final price and will not be affected by such prospective adjustment. In addition, the use of a liability calculation method of Estimated Price or Average Price may result in some portion of the amount paid by the Employer being held in a variance account by the Host Blue, pending settlement with its participating Providers. Because all amounts paid are final, the funds held in a variance account, if any, do not belong to the Employer and are eventually exhausted by Provider settlements and through prospective adjustments to the negotiated prices.

Statutes in a small number of states may require a Host Blue either a) to use a basis for calculating a Covered Person's liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular Claim or b) to add a surcharge. Should any state statutes mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, the Claim Administrator would then calculate the Covered Person's liability and the Employer's liability for any Covered Services consistent with the applicable state statute in effect at the time the Covered Person received those services.

14.4 Return of Overpayments

Under BlueCard, recoveries from a Host Blue or from participating Providers of a Host Blue can arise in several ways, including, but not limited to, anti-fraud and abuse audits, Provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage third parties to assist in discovery or collection of recovery amounts. The fees of such a third party are netted against the recovery. Recovery amounts, net of fees, if any, will be applied in accordance with applicable BlueCard Policies, which generally require correction on a Claim-by-Claim or prospective basis.

14.5 BlueCard Fees and Compensation

The Employer understands and agrees a) to pay certain fees and compensation to the Claim Administrator which the Claim Administrator is obligated under BlueCard to pay to the Host Blue, to the Blue Cross and Blue Shield Association, or to the BlueCard vendors and b) that fees and compensation under BlueCard may be revised from time to time without the Employer's prior approval in accordance with the standard procedures for revising fees and compensation under BlueCard. Some of these fees and compensation are charged each time a Claim is processed through BlueCard and include, but are not limited to, access fees, administrative expense allowance fees, Central Financial Agency Fees, and ITS Transaction Fees. Also, some of these Claim-based fees, such as the access fee and the administrative expense allowance fee, may be passed on to the Employer as an additional Claim liability. Other fees include, but are not limited to, a toll-free phone number fee and a fee for providing certain Provider directories. If you do not have a complete listing, or want an updated listing, of these types of fees or the amount of these fees paid directly by the Employer, you should contact the Claim Administrator's representative.

SECTION 15: SERVICING PLAN AGREEMENTS BETWEEN CLAIM ADMINISTRATOR AND OTHER BLUE CROSS AND BLUE SHIELD PLANS

- 15.1 In some instances, the Claim Administrator has entered into agreements with other Blue Cross and Blue Shield Plans (hereinafter called the "Servicing Plans") to provide, on the Claim Administrator's behalf, Claim Payments and certain administrative services for those Covered Persons of the Employer residing in the state and/or service area of the Servicing Plans. Pursuant to the agreement between the Claim Administrator and the Servicing Plans, the Claim

Administrator has agreed to reimburse each Servicing Plan for all Claim Payments made on the Claim Administrator's behalf for those Covered Persons of the Employer residing in the state and/or service area of such Servicing Plan.

- 15.2 The Claim Administrator hereby informs the Employer, and the Employer shall advise its Covered Persons, that certain Servicing Plans may have contracts with certain Providers ("Servicing Plan Providers") in their service area for the provision of, and payment for, health care services to persons entitled to health care benefits under health policies and contracts to which the Servicing Plan is a party, including the Covered Persons covered under the Administrative Services Agreement, and that pursuant to the Servicing Plan's contracts with its Servicing Plan Providers, under certain circumstances described therein, the Servicing Plan may receive substantial payment from Servicing Plan Providers with respect to services rendered to such persons for which the Servicing Plan was obligated to pay the Servicing Plan Provider, or the Servicing Plan may pay Servicing Plan Providers less than their billed charges for services, by discounts or otherwise, or may receive from Servicing Plan Providers other allowances under the Servicing Plan's contracts with them. The Employer acknowledges that in negotiating the service charge set forth in the Agreement, it has taken into consideration that, among other things, the Servicing Plan may receive such payments, discounts and/or other allowances during the term of its agreement with the Claim Administrator. Further, all amounts payable to the Servicing Plan by the Claim Administrator for Claim Payments made by the Servicing Plan and applicable service charges thereon pursuant to the terms of its agreement with the Claim Administrator (and with respect to most Servicing Plans, any required deductible and Coshare amounts under the Employer's Plan) shall be calculated on the basis of the Servicing Plan Provider's Claim Charge for Covered Services rendered to a Covered Person, irrespective of any separate financial arrangement between the Servicing Plan Provider and the Servicing Plan as referred to herein. However, the Employer acknowledges that the Claim Administrator, under its contract with each Servicing Plan, may be required to reimburse the Servicing Plan only for Claim Payments which have been discounted pursuant to an agreement between the particular Servicing Plan and its Servicing Plan Providers including the service charges thereon. In any event the Employer shall reimburse the Claim Administrator the amount paid by the Claim Administrator to the Servicing Plan for Claim Payments plus any service charges payable by the Claim Administrator to the Servicing Plan, in addition to applicable service charges of the Claim Administrator hereunder.
- 15.3 The Claim Administrator hereby informs the Employer, and the Employer acknowledges, that the Claim Administrator's, the Host Plans' and the Servicing Plans' Provider contracting arrangements, operational practices and procedures, and the policies and procedures governing software used to process Claims for services rendered by the Claim Administrator's Providers, Host Plans' Providers and the Servicing Plans' Providers may result in minor deviations in Claim processing and/or pricing of Claims for same services.

SECTION 16: MEDICARE SECONDARY PAYER ("MSP") DATA MATCH

- 16.1 In an effort to facilitate the processing of Claims consistent with the requirements of the MSP statute, and to assist in meeting the statutory obligations, certain Blue Cross and Blue Shield Plans together with the Centers for Medicare & Medicaid Services ("CMS"), formerly known as Health Care Financing Administration ("HCFA"), the federal government agency which administers Medicare, have developed a new enrollment and membership system. The system, also referred to as the "Data Match," is aimed at obtaining, in a Timely and current fashion, information necessary for the Claim Administrator to identify dual coverage situations which fall within the MSP statute, and to determine whether primary or secondary payment should be made for a particular Claim.
- 16.2 Under the system, the Claim Administrator will provide basic information to CMS about individuals enrolled in Group Health Plans who are also covered by Medicare so that CMS can better detect dual coverage situations.
- 16.3 The Employer hereby authorizes and directs the Claim Administrator to disclose to CMS periodically, information pertaining to Medicare-eligible Covered Persons under the Plan.
- 16.4 The Employer agrees that the Claim Administrator's ability to make accurate primary/secondary MSP determinations depends on the breadth and accuracy of the Claim Administrator's files concerning Covered Persons. The Employer agrees to use best efforts in responding promptly and accurately to the Claim Administrator's requests for information and to require and facilitate its Covered Persons' cooperation in responding promptly and accurately to such requests.
- 16.5 Further, to assure the continuing accuracy of the Claim Administrator's files, the Employer agrees that it is the Employer's responsibility to notify the Claim Administrator promptly of any change in the size of the Employer's work force or status of its employees that might affect the order of payment under the MSP statute, such as information regarding working-aged persons who retire and changes in the size of the Employer's work force that place it in, or take it out of, the scope of the MSP statute. If the Claim Administrator does not receive such information from the Employer, the Claim Administrator will assume that all relevant factors remain unchanged and will process Claims accordingly. The group acknowledges and agrees that the Claim Administrator will be using the information provided

by the Employer and Covered Persons to update the Claim Administrator's files, and will also forward this information to CMS so that CMS can revise its file to reflect relevant changes in primary/secondary status.

- 16.6 The Claim Administrator may, in its sole discretion, discontinue its participation in the Data Match system as described above. Nothing in the Agreement shall be construed as obligating the Claim Administrator to continue its participation in the Data Match system.
- 16.7 **Disclosure Statement:** The Employer acknowledges that the Claim Administrator has furnished it with a copy of a pamphlet entitled "Information Regarding the Medicare Secondary Payer Statute" (also referred to as the "Disclosure Statement"), prepared by the Blue Cross and Blue Shield Association and reviewed by CMS, which administers Medicare.

SECTION 17: REIMBURSEMENT PROVISION

- 17.1 If a Covered Person incurs expenses for sickness or injury that occurred due to the negligence of a third party and benefits are provided for Covered Services described in the Plan, the following provisions will apply:
- a. The Claim Administrator on behalf of the Employer has the right to reimbursement for all benefits the Claim Administrator provided from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by the Covered Person, the Covered Person's parents, if the Covered Person is a minor, or the Covered Person's legal representative as a result of that sickness or injury, in the amount of the Provider's Eligible Charge for Covered Services for which the Claim Administrator has provided benefits to the Covered Person.
 - b. The Claim Administrator is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits the Claim Administrator provided for that sickness or injury.
- 17.2 The Claim Administrator shall have the right to first reimbursement out of all funds the Covered Person, the Covered Person's parents, if the Covered Person is a minor, or the Covered Person's legal representative is or was able to obtain for the same expenses for which the Claim Administrator has provided benefits as a result of that sickness or injury. The Covered Person is required to furnish any information or assistance or provide any documents that the Claim Administrator may reasonably require in order to obtain its rights under this provision. This provision applies whether or not the third party admits liability.

EXHIBIT 3
RECOVERY LITIGATION AUTHORIZATION

The Employer hereby acknowledges and agrees that the Claim Administrator may, at its election, pursue claims of the Employer and/or the Plan, which are related to claims that the Claim Administrator pursues on its own behalf, subject to the following terms and conditions:

- 1.1 The Claim Administrator shall have the right to select and retain legal counsel.
- 1.2 Any lawsuit filed or arbitration initiated by the Claim Administrator will be done in the name of the Claim Administrator for its own benefit, as well on behalf of the Employer and possibly other parties. The Claim Administrator will not cause any litigation to be filed or arbitration to be initiated in the name of the Employer and/or the Plan without the Employer's express advance consent. With such permission, any such litigation can be filed or arbitration initiated in the name of the Employer and/or the Plan with attorneys identified as counsel for the Employer or in the name of two or more parties, including the Employer and the Claim Administrator, with attorneys identified as counsel for the Employer, the Claim Administrator and possibly other parties.
- 1.3 The parties agree to cooperate with each other in pursuit of recovery efforts pursuant to the provisions of this Exhibit, including, providing appropriate authority to communicate with the Employer concerning issues pertaining to any class actions and pursuant to which the Employer specifically declines representation by class litigation counsel.
- 1.4 The Claim Administrator shall control any recovery strategy and decisions, including decisions to mediate, arbitrate or litigate.
- 1.5 The Claim Administrator shall have the exclusive right to approve any and all settlements of any claims being mediated, arbitrated or litigated.
- 1.6 Any and all recoveries, net of all investigative and other expenses relating to the recovery, including costs of settlement, mediation, arbitration or litigation including attorney's fees, made through any means pursuant to the provisions of this Exhibit, including, but not limited to, settlement, mediation, arbitration or trial, will be prorated based upon each party's percentage interest in the recoverable compensatory monetary damages, which allocation shall be done by the Claim Administrator on any reasonable basis it deems appropriate.
- 1.7 Any and all information, documents, communications or correspondence provided to or obtained by attorneys from either party, as well as communications, correspondence, conclusions and reports by or between attorneys and either party, shall be and are intended to remain privileged and confidential. Each party intends that the attorney-client and work product privileges shall apply to all information, documents, communications, correspondence, conclusions and reports to the full extent allowed by state or federal law. The Claim Administrator shall be permitted to make such disclosures of such privileged and confidential information to law enforcement authorities as it deems necessary or appropriate in its sole discretion. The Employer shall not waive the attorney-client privilege or otherwise disclose privileged or confidential information received in connection with the provisions of this Exhibit or cooperative efforts pursuant to the provisions of this Exhibit without the express written consent of the Claim Administrator.
- 1.8 The discharge of attorneys by one party shall not disqualify or otherwise ethically prohibit the attorneys from continuing to represent the other party pursuant to the provisions of this Exhibit.
- 1.9 Nothing in the provisions of this Exhibit shall require the Claim Administrator to assert any claims on behalf of the Employer and/or the Plan.
- 1.10 Nothing in the provisions of this Exhibit and nothing in attorneys' statements to either party and/or the Plan will be construed as a promise or guarantee about the outcome of any particular litigation, mediation, arbitration or settlement negotiation; therefore, the Employer acknowledges that the efforts of the Claim Administrator may not result in recovery or in full recovery in any particular case.
- 1.11 The terms and conditions described herein shall survive the expiration or termination of the Agreement; however, nothing herein shall require the Claim Administrator to assert any claims on the Employer's and/or the Plan's behalf following the termination of the Agreement. If the Agreement is terminated after the Claim Administrator has asserted a claim on behalf of the Employer and/or the Plan but before any recovery, the Claim Administrator may in its sole discretion continue to pursue the claim or discontinue the claim.
- 1.12 If the Employer should desire to participate in a class or multi-district settlement rather than defer to the Claim Administrator, the Employer may reverse the exercise of discretion authorized herein by affirmatively opting into a class settlement and by notifying the Claim Administrator of its decision in writing, immediately upon making such determination as provided for under Section 25 NOTICES of the Agreement.

Proprietary Information

**Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies
and third party representatives, except under written agreement.**

- 1.13 The Employer further acknowledges and agrees that, unless it notifies the Claim Administrator to the contrary in writing as provided for under Section 25 NOTICES of the Agreement, it consents to the terms and conditions of this Exhibit and authorizes the Claim Administrator, on behalf of the Employer and/or the Plan, to:
- a. Pursue claims that the Claim Administrator pursues on its own behalf in class action litigation, federal multi-district litigation, or otherwise, including, but not limited to, antitrust, fraud, unfair and deceptive business or trade practice claims pursuant to and in accordance with the provisions of this Exhibit effective immediately;
 - b. Opt out of any class action settlement or keep the Employer and/or the Plan in the class, if the Claim Administrator believes it is in the best interest of the parties to do so;
 - c. Investigate and pursue recovery of monies unlawfully, illegally or wrongfully obtained from the Plan.
- 1.14 The Employer further acknowledges and agrees that the Claim Administrator's decision to pursue recovery in connection with particular claims shall be in the Claim Administrator's sole discretion and the Claim Administrator does not enter into this undertaking as a fiduciary of the Plan or its Covered Persons, but only in connection with its undertaking to pursue recovery of claims of the Employer and/or the Plan when, as, and if the Claim Administrator determines that such claims may be pursued in the common interest of the parties.
- 1.15 The parties agree in the event that the language in the Agreement shall be in conflict with this Exhibit, the provisions of this Exhibit shall prevail.



**BlueCross BlueShield
of Texas**

**AMENDMENT February 1, 2009 TO THE
ADMINISTRATIVE SERVICES AGREEMENT**

THIS AMENDMENT to the Administrative Services Agreement is effective as of **February 1, 2009**, and is attached to and made a part of the Administrative Services Agreement by and between **Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company** (hereinafter referred to as the "Claim Administrator"), and **Hidalgo County** (hereinafter referred to as the "Employer"), WITNESSETH AS FOLLOWS:

WHEREAS, the Claim Administrator and the Employer have entered into an Administrative Services Agreement (hereinafter referred to as the "Agreement") which was effective as of February 1, 2008, as may have been amended; and

WHEREAS, the parties desire to amend the Agreement as described herein;

NOW, THEREFORE, in consideration of these premises and the mutual promises and agreements hereinafter set forth, the parties hereby agree to amend the Agreement as follows:

- A. Under **EXHIBIT 2 - FEE SCHEDULE, FINANCIAL RESPONSIBILITIES AND REQUIRED DISCLOSURES**, **Section 1.1 FEE SCHEDULE PERIOD** is deleted in its entirety and replaced with the following:

1.1 FEE SCHEDULE PERIOD

Fee Schedule specifications in this Section 1 are for the **Fee Schedule Period** commencing on **February 1, 2009** and ending on end of day **January 31, 2010**.

- B. Under **EXHIBIT 2 - FEE SCHEDULE, FINANCIAL RESPONSIBILITIES AND REQUIRED DISCLOSURES**, **Section 1.3 ADMINISTRATIVE CHARGES AND CREDITS** is deleted in its entirety and replaced with the following:

1.3 ADMINISTRATIVE CHARGES AND CREDITS

- a. The **Administrative Charge**, calculated monthly, shall be equal to the sum of the amounts obtained by multiplying the total number of Covered Employees by category by the appropriate factors shown below.

Composite	2009
Base Administrative Charge (Medical)	\$29.63
Commissions	\$1.80*
Rx Rebate Credit	TBD
Total	TBD

* For purposes of this Amendment, it is assumed that the commission level will not change in 2009.

Proprietary Information
Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third party representatives, except under written agreement.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
An Independent Licensee of the Blue Cross and Blue Shield Association

- b. The **Termination Administrative Charge** applicable to the Run-Off Period shall be equal to the sum of the amounts obtained by multiplying the total number of Covered Employees by category during the three (3) months immediately preceding the date of termination by the appropriate factors shown below.

	2009
Medical Run-off Administration Charge	\$7.63

- c. The **Prescription Drug Program Rebate Credit** is \$TBD per Covered Employee per month. Expected rebate amounts to be received by the Claim Administrator are passed back to the Employer with one hundred percent (100%) of the expected amount applied as a credit on the monthly billing statement on a per Covered Employee per month basis. The rebate credits are paid prospectively to the Employer and shall not continue after termination of the Prescription Drug Program. (Further information concerning this credit is included in Section 13 of this Exhibit, titled "CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS.")

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the date and year specified below.

**BLUE CROSS AND BLUE SHIELD
OF TEXAS, a Division of Health Care
Service Corporation, a Mutual Legal
Reserve Company**

HIDALGO COUNTY

By: _____

By: _____

Title: Divisional Vice President

Title: _____

Date: _____

Date: _____



**BlueCross BlueShield
of Texas**

**AMENDMENT February 1, 2010 TO THE
ADMINISTRATIVE SERVICES AGREEMENT**

THIS AMENDMENT to the Administrative Services Agreement is effective as of **February 1, 2010**, and is attached to and made a part of the Administrative Services Agreement by and between **Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company** (hereinafter referred to as the "Claim Administrator"), and **Hidalgo County** (hereinafter referred to as the "Employer"), WITNESSETH AS FOLLOWS:

WHEREAS, the Claim Administrator and the Employer have entered into an Administrative Services Agreement (hereinafter referred to as the "Agreement") which was effective as of February 1, 2008, as may have been amended; and

WHEREAS, the parties desire to amend the Agreement as described herein;

NOW, THEREFORE, in consideration of these premises and the mutual promises and agreements hereinafter set forth, the parties hereby agree to amend the Agreement as follows:

A. Under EXHIBIT 2 - FEE SCHEDULE, FINANCIAL RESPONSIBILITIES AND REQUIRED DISCLOSURES, Section 1.1 FEE SCHEDULE PERIOD is deleted in its entirety and replaced with the following:

1.1 FEE SCHEDULE PERIOD

Fee Schedule specifications in this Section 1 are for the **Fee Schedule Period** commencing on **February 1, 2010** and ending on end of day **January 31, 2011**.

B. Under EXHIBIT 2 - FEE SCHEDULE, FINANCIAL RESPONSIBILITIES AND REQUIRED DISCLOSURES, Section 1.3 ADMINISTRATIVE CHARGES AND CREDITS is deleted in its entirety and replaced with the following:

1.3 ADMINISTRATIVE CHARGES AND CREDITS

a. The **Administrative Charge**, calculated monthly, shall be equal to the sum of the amounts obtained by multiplying the total number of Covered Employees by category by the appropriate factors shown below.

Composite	2010
Base Administrative Charge (Medical)	\$33.44
Commissions	\$1.80*
Rx Rebate Credit	TBD
Total	TBD

*** For purposes of this Amendment, it is assumed that the commission level will not change in 2010.**

Proprietary Information
Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third party representatives, except under written agreement.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
An Independent Licensee of the Blue Cross and Blue Shield Association

- b. The **Termination Administrative Charge** applicable to the Run-Off Period shall be equal to the sum of the amounts obtained by multiplying the total number of Covered Employees by category during the three (3) months immediately preceding the date of termination by the appropriate factors shown below.

	2010
Medical Run-off Administration Charge	\$8.01

- c. The **Prescription Drug Program Rebate Credit** is \$TBD per Covered Employee per month. Expected rebate amounts to be received by the Claim Administrator are passed back to the Employer with one hundred percent (100%) of the expected amount applied as a credit on the monthly billing statement on a per Covered Employee per month basis. The rebate credits are paid prospectively to the Employer and shall not continue after termination of the Prescription Drug Program. (Further information concerning this credit is included in Section 13 of this Exhibit, titled "CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS.")

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the date and year specified below.

**BLUE CROSS AND BLUE SHIELD
OF TEXAS, a Division of Health Care
Service Corporation, a Mutual Legal
Reserve Company**

HIDALGO COUNTY

By: _____

By: _____

Title: Divisional Vice President

Title: _____

Date: _____

Date: _____