



BlueCross BlueShield
of Texas

Memorandum

TO: Hidalgo County
Vangie Garcia

DATE: April 15, 2011

FROM: Tita Iruegas
Account Executive

PHONE: 956-581-5615

FAX: 312-540-3104

SUBJECT: #021185 Hidalgo County – ASA and PG

The ASO Agreement for Hidalgo County, effective February 1, 2011 is attached. Please review the document carefully, and let me know if you have any changes.

Documents require the client to execute for 2011:

The signature block for Blue Cross and Blue Shield of Texas has been signed and dated. If Hidalgo County is in agreement with the attached document, please execute **two sets** of the Document. One fully executed Document is to be retained for your records. Please return the other fully executed Document to me, for internal distribution and retention.

Performance Guarantee – Exhibit PG, signature required, once signed return copy for my files

If any questions, feel free to call me @ 956-581-5615 or 1-800-829-4120.

Sincerely

Tita Iruegas
Account Executive
tita_iruegas@bcbstx.com
Fax 312-540-3104

/ti
Attachments



BlueCross BlueShield
of Texas

ADMINISTRATIVE SERVICES AGREEMENT

The Effective Date of this Administrative Services Agreement (the "Agreement") is the effective February 1, 2011

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

Account #21185

Approved by Commissioners' Court
on 11/9/10 [Signature]

By: Scott Nilg

Title: Vice President and Chief Underwriter

Date: March 1, 2011

By: [Signature]

Title: Hidalgo County Judge

Date: 5-20-11

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

ADDENDUM PG PERFORMANCE GUARANTEES

The Performance Guarantees described herein shall apply to the Administrative Services Agreement (the "Agreement") to which this Addendum is attached and have the same force and effect as the Agreement's most current Fee Schedule, unless amended, replaced, or terminated by the parties to the Agreement in writing.

All obligations, definitions, terms, conditions, promises, agreements, and language in the Agreement and its most current Fee Schedule apply equally to the obligations, terms, conditions, promises, agreements, and language in this Addendum PG and its most current Exhibit-PG.

SECTION I TIMING

- A. The period for which the Claim Administrator's performance will be measured and for which Employer may receive a refund is referred to as the Settlement Period and is indicated on the most current Exhibit-PG.
- B. The measurement of Performance Guarantees will begin on the date indicated on the most current Exhibit-PG provided all of the requirements listed below are completed. The requirements are as follows:
 - 1. Benefit information and claims administrative procedures have been provided by Employer to the Claim Administrator,
 - 2. All accumulation totals, if applicable, have been received from the prior carrier and have been loaded onto the Claim Administrator's claims processing system,
 - 3. Accurate and complete membership information has been received and loaded onto the Claim Administrator's claims processing system, and
 - 4. Transfer Payment procedures have been established in accordance with the Agreement.

SECTION II DETERMINATION

- A. The Claim Administrator agrees to guarantee performance levels as indicated on the most current Exhibit-PG. In the event that the Claim Administrator's level of performance is determined to be less than any of the standards described in the most current Exhibit-PG during a Settlement Period for which the Claim Administrator's performance shall be evaluated for any reason, except any disaster or epidemic which substantially disrupts the Claim Administrator's normal business operation, the Claim Administrator will be responsible for reimbursing Employer a portion of the Administrative Charge.
- B. The Claim Administrator will measure Performance Guarantees and report the measurement results to Employer, and any refund amounts due in accordance with this

Addendum PG within 120 days following the close of all measurement periods necessary to finalize Performance Guarantee results for the Settlement Period.

- C. The Claim Administrator will not be obligated to measure Performance Guarantees and will not be obligated to refund Employer based thereon until the Administrative Services Agreement (including the most current Exhibit-PG) has been executed and is on file with the Claim Administrator by the close of the applicable Settlement Period.
- D. The Claim Administrator will not be obligated to measure Performance Guarantees and will not be obligated to refund Employer based thereon for any portion of the Settlement Period in which the Employer:
 - 1. Fails to provide the Claim Administrator with Timely changes in enrollment or membership information or any other reports or information as may be necessary for the Claim Administrator to perform its administrative duties, including but not limited to identification or certification of claimants eligible for benefits, dates of eligibility, number of employees and dependents covered under the Plan; or
 - 2. Fails to pay Administrative Charges in accordance with the terms of the Agreement or comply with all established Transfer Payment procedures.
- E. The Claim Administrator will not be obligated to measure any Performance Guarantee impacted by changes requested in writing by Employer during the time period required to modify the Claim Administrator's system and to complete all other tasks necessary to achieve the same qualitative standard of execution that existed before the change was requested. All changes or amendments to the Plan must be submitted to the Claim Administrator in accordance with the Agreement.
- F. If for any reason there is a significant change in the benefit structure or the administrative procedures of the benefit coverage administered by the Claim Administrator, Medicare payment systems, or if the enrollment of the Plan's benefit coverage administered by the Claim Administrator varies in number of enrolled Covered Employees as indicated in the most current Exhibit-PG attached to and made a part of this Addendum during any Settlement Period, the Claim Administrator reserves the right to re-evaluate and renegotiate the level of performance and/or the Administrative Charges at risk in this Addendum PG and the attached Exhibit-PG.
- G. If for any reason the Agreement is terminated prior to the end of any Settlement Period, the Performance Guarantees will not be measured and Employer will not receive any refund, based on that part of the Settlement Period in which the Administrative Services Agreement was in effect.
- H. If (i) changes to the formula, methodology or manner in which a third-party benchmark (such as AWP) is calculated or reported take effect, or (ii) such third party ceases to publish such benchmark, then the performance guarantees and/or standards based on such benchmark in this Agreement, if any, shall be re-evaluated and adjusted or converted to an alternative benchmark by Claim Administrator or its designee at the time of such change to return the parties to their respective economic positions with respect to such guarantees and/or standards as they existed under the Agreement immediately prior to such change.

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- 2.10 “Fee Schedule”** means the specifications setting out certain particulars of this Agreement as set forth in Exhibit 4 – ASO BPA 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 set forth in a subsequent ASO BPA as replacement to the initial Exhibit 4 – ASO BPA. The specifications or items of the Fee Schedule shall be applicable to the Fee Schedule Period therein, except that any item of the Fee Schedule may be changed in accordance with such Exhibit 2’s “COMPENSATION TO CLAIM ADMINISTRATOR” provisions.
- 2.11 “Fee Schedule Period”** means the period of time indicated in the Fee Schedule specifications of the most current Exhibit 4 – ASO BPA of this Agreement.
- 2.12 “Group Health Plan”** means, as applied to this Agreement, the self-insured employee 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, or if dental benefits coverage is elected on the most current Exhibit 4 – ASO BPA of this Agreement, therefor 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 the Fee Schedule specifications of the most current Exhibit 4 – ASO BPA 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 Fee Schedule specifications of the most current Exhibit 4 – ASO BPA. 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.

- 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 unless required by law to do so. In the event garbled or intercepted transmissions occur, the parties agree to redirect the information via another mutually agreeable means.

SECTION 5: THIRD PARTY DATA RELEASE

- 5.1 Types of data and use.** In the event the Employer directs the Claim Administrator to provide data directly to its third party consultant and/or vendor and the Claim Administrator accepts, 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").
 - d. 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.
- 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. Execute the Claim Administrator's then-current confidentiality agreement.

SECTION 10: HIPAA/CERTIFICATE OF CREDITABLE COVERAGE

10.1 HIPAA requirement. The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) requires the preparation and distribution of a Certificate of Creditable Coverage to individuals who terminate coverage under the Employer's Group Health Plan.

10.2 Responsible party. In accordance with the Employer’s election indicated on the most current Exhibit 4 – ASO BPA of this Agreement:

- a. *If the Employer elects the Claim Administrator to issue certificates*, the Claim Administrator 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.
- b. *If the Employer does not elect the Claim Administrator to issue certificates*, the Employer acknowledges that the Claim Administrator is not the Group Health Plan issuer offering group coverage under the Group Health Plan nor the plan administrator and, therefore, the Claim Administrator has no obligation to prepare or distribute a Certificate of Creditable Coverage. The Employer further acknowledges that the obligation to provide such Certificate of Creditable Coverage is the obligation of 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 permitted by 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 therefor 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 from the Employer’s use or posting of electronic files on the intranet and/or internet pursuant to Section 17 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 Fee Schedule of the most current Exhibit 4 – ASO BPA..

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 of this Agreement, 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: NON ERISA GOVERNMENT REGULATIONS

15.1 In relation to the Plan. Although the Employer is exempt from ERISA, the Employer hereby acknowledges (i) its employee benefit plan is established and maintained through a separate plan document which may include the terms hereof or incorporate the terms hereof by reference, and (ii) its employee benefit plan document may provide for the allocation and delegation of responsibilities thereunder. However, notwithstanding anything contained in the Plan or any other employee 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 plan document 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 benefit plan and 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 employee benefit plan. The Employer acknowledges and agrees that the Claim Administrator may render advice with respect to claims and administer claims on behalf of the plan administrator of the Employer's benefit plan. The Claim Administrator has no other authority or responsibility with respect to Employer's employee benefit plan.

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
- d. Exhibit 4 – ASO Benefit Program Application (ASO BPA)

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: LIMITATIONS

No civil action shall be brought to recover under this Agreement after the expiration of three (3) years from the date the cause of action accrued, except to the extent that a later date is permitted under Section 413 of ERISA.

SECTION 22: 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 26 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 23: 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 24: DISPUTE RESOLUTION

24.1 Initial Negotiation. Any dispute arising out of or relating to this Agreement shall be resolved in accordance with the procedures specified in this Section 24, which shall be the sole and exclusive procedures for the resolution of any such disputes. All negotiations pursuant to this Section 24 are confidential and shall be treated as compromise and settlement negotiations for purposes of applicable rules of evidence.

In the event the parties fail to agree with respect to any matter covered herein, the question in dispute shall be resolved as contain in this section 24.

24.2 Deferring to mediation/selection mediators. Each party will name at least two and no more than three potential mediators (complete with resume) who are located in Texas. If the parties cannot mutually agree on a single mediator,

SECTION 29: 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.

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; or if dental benefits coverage is elected on the most current Exhibit 4 – ASO BPA, use of dental consultants and review of 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 Claim 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; and, if elected in the Fee Schedule specifications of the most current Exhibit 4 – ASO BPA, processing of contract conversions, subject to conversion fee as set forth therein..

- **OTHER MEMBERSHIP SERVICES**

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

EXHIBIT 2 FEE SCHEDULE, FINANCIAL RESPONSIBILITIES & REQUIRED DISCLOSURES

SECTION 1: FEE SCHEDULE

Service charges and other service specifications applicable to the Agreement are set forth in the Fee Schedule section of the most current Exhibit 4 – ASO BPA of the agreement. They are to apply for the period(s) of time indicated therein and shall continue in full force and effect until the earlier of: i) the end of the Fee Schedule Period noted on such ASO BPA; ii) the date a Fee Schedule is amended or replaced in its entirety by the execution of a subsequent ASO BPA; and iii) the date the Agreement is terminated.

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 **“Employer Payment”** means the amount owed or payable to the Claim Administrator by the Employer for a given Employer Payment Period in accordance with Section 5 of this Exhibit which is the sum of Net Claim Payments made plus applicable service charges incurred during that Employer Payment Period.
- 2.4 **“Employer Payment Method”** means the method elected in the Fee Schedule specifications of the most current Exhibit 4 – ASO BPA of the Agreement by which Employer Payments will be made.
- 2.5 **“Employer Payment Period”** means the time period indicated in the Fee Schedule specifications of the most current Exhibit 4 – ASO BPA of the Agreement.
- 2.6 **“Inpatient”** means the Covered Person is a registered bed patient and treated as such in a health care facility.
- 2.7 **“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.”)
- 2.8 **“Run-Off Claim”** means a Claim incurred prior to the termination of the Agreement that is submitted for payment during the Run-Off Period.
- 2.9 **“Run-Off Period”** means the time period immediately following termination of the Agreement, as indicated in the Fee Schedule specifications of the most current Exhibit 4 ASO BPA of the Agreement, during which the Claim Administrator will accept Run-Off Claims submitted for payment.
- 2.10 **“Termination Administrative Charge”** means the consideration indicated in the Fee Schedule of the most current Exhibit 4 – ASO BPA of the Agreement 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 indicated on such ASO BPA.

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 Fee Schedule specifications of the most current Exhibit 4 – ASO BPA of the Agreement, 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 Fee Schedule specifications of the most current Exhibit 4 – ASO BPA of the Agreement, have been determined in accordance with the Claim Administrator’s current regulatory status and the Employer’s existing benefit program.

5.2 Confirmation or notification of amount due and payment due date. The Employer shall confirm with the Claim Administrator or the Claim Administrator shall notify the Employer's Financial Division of the Employer Payment for each Employer Payment Period and when such payment is due. Confirmation or notification shall be in accordance with the Employer Payment Method elected in the Fee Schedule specifications of the most current Exhibit 4 – ASO BPA of the Agreement and the following:

- a. **If the Employer Payment Method is by check**, the Claim Administrator shall issue the Employer a settlement statement to include the Claim Administrator's mailing address for check remittance and the date payment is due.
- b. **If the Employer Payment Method is other than check**, the Employer shall confirm on-line the amount due by accessing the Claim Administrator's "Blue Access for Employers" (as provided in Exhibit 1 of the Agreement) or the Claim Administrator shall advise the Employer by email, facsimile (at an email address or facsimile number to be furnished by the Employer prior to the effective date of the Agreement) or by such other method mutually agreed to by the parties of the amount due. The Employer Payment must be made or obtained within forty-eight (48) hours of confirmation by the Employer or the Employer's notification by the Claim Administrator. If any day on which an Employer Payment is due is a holiday, such payment will be made or obtained 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 Fee Schedule specifications of the most current Exhibit 4 – ASO BPA of the Agreement. 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 Fee Schedule specifications of the most current Exhibit 4 – ASO BPA of the Agreement 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 Employer 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 Employer 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 Total 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:

- a. Suspend Claim Payments; or
- b. Terminate the Agreement as of the effective date specified in such notice.

7.2 When Claim Administrator Fails to Timely Notify. Pursuant to Section 28 "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.

- 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.

- 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 Agreement, and that

- 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

Applicable only if this service is elected in the Fee Schedule specifications of the most current Exhibit 4 – ASO BPA.

- 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.

- 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 26 NOTICES of the 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 26 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.

EXHIBIT-PG
EMPLOYER NAME: HIDALGO COUNTY
Employer Group Number(s): 21185
Effective for the Settlement Period beginning February 01, 2011 and ending December 31, 2011

Performance guarantees are contingent upon adherence to the terms and conditions of Addendum-PG to which this Exhibit is attached and maintaining an enrollment in the Plan medical benefit coverage administered by Claim Administrator of not less than 3,000 Covered Employees. Performance measurement will begin February 01, 2011. Performance Guarantees are measured and settled annually.

SERVICE - Medical	Defined Performance Guarantees	Performance Guarantee	Percentage of the Administrative Charge at Risk
Implementation Activities	<p>Identification (ID) Cards - Initial issuance of standard health ID cards will be mailed prior to the effective date, if complete and accurate electronic eligibility data is received by December 20. If after December 20, ID cards will be mailed within 30 business days of receipt of complete and accurate eligibility data. Measurement: BlueSTAR ID Card Statistical Report</p> <p>Implementation Satisfaction - Claim Administrator will complete the account implementation to the Employer's satisfaction. Claim Administrator's performance will be evaluated by the Employer based on results of the Claim Administrator Implementation Report Card to be determined based on implementation meetings.</p>	<p>Met Not Met</p> <p>Composite Score 3.0 - 5.0 0 - 2.9</p>	<p>0% 1%</p> <p>0% 1%</p>
Account Management	<p>Account Management means the Employer's satisfaction with Account Management and will be measured by the Employer, using the Claim Administrator's Account Management Report Card or through a web-based survey. Performance will be measured in the following areas:</p> <ol style="list-style-type: none"> 1. Provides effective support in preparing for, and conducting, open enrollment events/sessions. 2. Provides client with timely notification of issues impacting members. 3. Responds to issues & questions in a timely, comprehensive manner. 4. Develops, follows through on action plans; effective coordination to resolve open issues. 5. Is accessible and attends scheduled meetings 6. Delivers agreed upon reports and communication of program results in a timely manner. 	<p>Composite Score 3.0 - 5.0 0 - 2.9</p>	<p>0% 1%</p>

SERVICE - Medical	Defined Performance Guarantees	Performance Guarantee	Percentage of the Administrative Charge at Risk
Claims Processing Turnaround Time – All Claims	<p>Claims Processing Turnaround Time means the period beginning on the date the Claim Administrator or Host Blue Plan receives a Claim for processing through the date the Claim passes all system edits and benefits are approved or denied by the Claim Administrator. The performance guarantee is measured as a percent of all Claims processed within 30 calendar days.</p> <p>Method of Measurement: The number of Claims processed in 30 calendar days divided by the total number of claims. Measurement is based on Employer-specific Claims.</p>	97.0% - 100% 0% - 96.9%	0% 1%
Claim Processing Accuracy	<p>Claim Processing Accuracy is defined as the percent of Claims processed accurately in accordance with the provisions of the medical benefit coverage administered by the Claim Administrator. Claim Processing Accuracy refers to Claims without processing errors such as:</p> <ol style="list-style-type: none"> 1. Coding - incorrect claim data entry; 2. Failure to adhere to the Employer's health care benefit program design. 3. Failure to adhere to the administrative procedures. 4. System generated errors, benefit programming errors, calculation errors. 5. Excluding: <ol style="list-style-type: none"> a. Any administrative inaccuracies that do not impact claims disposition or customer reporting; b. Errors entered by providers of service; c. Benefits provided to an ineligible claimant due to the Employer's failure to provide timely and accurate eligibility information to the Claim Administrator. <p>Method of measurement: The accuracy rate is determined from a statistically valid random stratified sample audit of all Claims processed during the settlement period. A Claim Processing Accuracy percentage is calculated for each stratum by dividing the number of accurately processed Claims by the number of Claims selected in the stratum. Each accuracy percentage is then weighted according to the total claim population. The Claim Processing Accuracy rate is determined by summing the weighted accuracy from each stratum. Measurement is based on an audit of Claims processed for those customers assigned to the Unit.</p>	97.0% - 100% 95.0% - 96.9% 0% - 94.9%	0% 1% 2%

SERVICE - Medical	Defined Performance Guarantees	Performance Guarantee	Percentage of the Administrative Charge at Risk
Claim Financial Accuracy	<p>Claim Financial Accuracy means the percent of dollars paid accurately in accordance with the provisions of the medical benefit coverage administered by the Claim Administrator.</p> <p>Method of measurement: The accuracy rate is determined from a statistically random stratified sample audit of all Claims paid during the Settlement Period. Total dollars overpaid and total dollars underpaid are projected over each stratum. Claim Financial Accuracy is computed by summing the projected overpayments and the projected underpayments (<i>absolute value</i>) from each stratum and dividing by the total dollars paid in the population. The end result is subtracted from one for the accuracy rate. Measurement is based on an audit of Claims processed for those customers assigned to the Unit.</p>	<p>98.0% - 100% 97.0% - 97.9% 0% - 96.9%</p>	<p>0% 1% 2%</p>
Customer Service	<p>Average Speed of Answer of Telephone Calls, calculated over the complete business day, is defined as the time a caller spends on hold until a Customer Advocate becomes available.</p> <p>Method of measurement: The average speed of answer will be calculated by dividing the total length of time for all calls, measured from the time a call is queued by the automated telephone system for the next available Customer Advocate until the time the caller is connected with a Customer Advocate, by the total number of calls connected with a Customer Advocate during the Settlement Period. The Average Speed to Answer is provided by telephone reports that compute the average number of seconds that Callers spend on hold waiting for their Call to be answered. Standard is measured using member calls on an Employer-specific basis.</p> <p>Abandoned Calls are defined as calls, calculated over the complete business day, that reach the facility and are placed in a queue, but are not answered because the caller hangs up before a Customer Advocate becomes available. Any calls abandoned or terminated by the caller prior to 30 seconds will not be counted as Abandoned Calls. Standard is measured using member calls on an Employer-specific basis.</p>	<p>0-30 seconds 31-60 seconds 61 seconds or more</p> <p>0%-3.0% 3.1%-5.0% 5.1%-100%</p>	<p>0% 1% 2%</p>
Customer Service	<p>Member Confirmation of Inquiry Resolution is defined as the percentage of member telephone inquiries resolved on first contact from the member's point of view.</p> <p>Method of measurement: Post Call Survey responses from those customers assigned to the Unit.</p>	<p>80.0% - 100% 79.0% - 79.9% 0% - 78.9%</p>	<p>0% 1% 2%</p>

SERVICE - Medical	Defined Performance Guarantees	Performance Guarantee	Percentage of the Administrative Charge at Risk
	<p>Inquiry Resolution Agreement is defined as the percentage of time the member and the Customer Advocate agree that the inquiry was resolved on the first call. Method of measurement: Post Call survey responses will be compared to the Customer Advocate call record to determine agreement on resolution. The total number of positive survey responses with a corresponding closed call record divided by the total number of positive survey responses from those customers assigned to the Unit.</p> <p>A positive survey response means the inquiry was resolved to the caller's satisfaction. Corresponding call records closed within 3 business days are considered in agreement with a positive survey response.</p> <p>Direct and Correct Access is defined as the percentage of time that members reach the right person the first time.</p> <p>Method of measurement: All calls received that do not need to be transferred divided by all calls received. Measurement is based on calls received for those customers assigned to the Unit. Transfers to medical management areas are excluded.</p> <p>Outstanding Experience is defined from the member's perspective, as the percentage of time that the Customer Advocate showed the desire and the ability to address the member's questions.</p> <p>Method of measurement: Post Call Survey responses from those customers assigned to the Unit.</p>	<p>90%- 100% 89.0% - 89.9% 0% - 88.9%</p> <p>95% - 100% 94.0% - 94.9% 0% - 93.9%</p> <p>90% - 100% 89.0% - 89.9% 0% - 88.9%</p>	<p>0% 1% 2%</p> <p>0% 1% 2%</p> <p>0% 1% 2%</p>
Total Medical			20%

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

Hidalgo County
Account #21185

By: 

Title: Vice President and Chief Underwriter

Date: April 5, 2011

By: 

Title:

Date:

Approved by Commissioners' Cert
on 4/9/10

ADDENDUM PG PERFORMANCE GUARANTEES

The Performance Guarantees described herein shall apply to the Administrative Services Agreement (the "Agreement") to which this Addendum is attached and have the same force and effect as the Agreement's most current Fee Schedule, unless amended, replaced, or terminated by the parties to the Agreement in writing.

All obligations, definitions, terms, conditions, promises, agreements, and language in the Agreement and its most current Fee Schedule apply equally to the obligations, terms, conditions, promises, agreements, and language in this Addendum PG and its most current Exhibit-PG.

SECTION I TIMING

- A. The period for which the Claim Administrator's performance will be measured and for which Employer may receive a refund is referred to as the Settlement Period and is indicated on the most current Exhibit-PG.
- B. The measurement of Performance Guarantees will begin on the date indicated on the most current Exhibit-PG provided all of the requirements listed below are completed. The requirements are as follows:
 - 1. Benefit information and claims administrative procedures have been provided by Employer to the Claim Administrator,
 - 2. All accumulation totals, if applicable, have been received from the prior carrier and have been loaded onto the Claim Administrator's claims processing system,
 - 3. Accurate and complete membership information has been received and loaded onto the Claim Administrator's claims processing system, and
 - 4. Transfer Payment procedures have been established in accordance with the Agreement.

SECTION II DETERMINATION

- A. The Claim Administrator agrees to guarantee performance levels as indicated on the most current Exhibit-PG. In the event that the Claim Administrator's level of performance is determined to be less than any of the standards described in the most current Exhibit-PG during a Settlement Period for which the Claim Administrator's performance shall be evaluated for any reason, except any disaster or epidemic which substantially disrupts the Claim Administrator's normal business operation, the Claim Administrator will be responsible for reimbursing Employer a portion of the Administrative Charge.
- B. The Claim Administrator will measure Performance Guarantees and report the measurement results to Employer, and any refund amounts due in accordance with this

6. **AI-23748** Acceptance and approval of request for payment of Invoice #1020-001R in the amount of \$592,650.00 submitted by AshBritt in connection with water relocation services rendered to Hidalgo County for the period from 07/01/10 to 07/09/10 as a result of flood water attributed to Hurricane Alex.

On motion of Commissioner Flores, seconded by Commissioner Cuellar, the Court made a UNANIMOUS vote of approval.

7. **AI-23881** a. Presentation by Alamo Insurance Group, (Hidalgo County Health Insurance Consultant) of the scoring/evaluation grid with recommendations for the responses received in response to the County's RFP: "Third Party Administration, Individual Stop Loss and Aggregate Stop Loss for Self-Fund Medical Plan, Group Term Life and Accidental Death and Dismemberment", Project No. 2010-228-09-22-YZV:

Provider	Score/Grade	Rank
1. Blue Cross Blue Shield	94.7	
2. Aetna	92.1	
3.		

Presentation by Martha L. Salazar, Purchasing Agent, and Gary Looney with Alamo Insurance on items 21.A.7.a.1, 2 & 3.

b. Acceptance and approval of consultant's recommendations so as to proceed with formal ranking by Commissioner's Court;

Mr. Gary Looney recommended Blue Cross Blue Shield as the provider of services for third party Administration and stop loss insurances for year 2011.

1). Blue Cross Blue Shield @ 94.7 and 2). Aetna @ 92.1

On motion of Commissioner Flores, seconded by Commissioner Palacios, the Court made a UNANIMOUS vote of approval to rank the proposals in the order of their scores.

c. Authority for consultant to finalize a contract including all negotiated items (terms/conditions/rates/fees and BAFO) with the number one (1) ranked provider for award; or, if applicable;

NO ACTION taken on this item.

d. Award with acceptance and approval of negotiated final contract with the number one (1) ranked provider (as negotiated by consultant); and, if applicable or necessary,

On motion of Commissioner Flores, seconded by Commissioner Cuellar, the Court made a UNANIMOUS vote of approval.

e. Presentation by consultant of scoring grid and recommendations on the responses received for: Group Term Life-Accidental Death and Dismemberment so as to proceed with formal ranking by Commissioner's Court:

Provider	Score	Rank
1. _____	: _____	: _____ ;
2. _____	: _____	: _____ ;
3. _____	: _____	: _____ ;

NO ACTION taken on items 21.A.7e.1, 2 & 3.

f. Approval of award to the number one (1) ranked firm of _____ for: Group Term Life-Accidental Death and Dismemberment.

NO ACTION taken on this item.

B. Pct. 1

- 1. AI-23813 Requesting approval to advertise for Hidalgo County Precinct No.1-Mile 17 Proposed Road Improvements, the "Construction Of Phase I Of Mile 17 Road From FM 1015 West To Mile 4 (Yellow Jacket Drive) in connection to Work Authorization No. 1 (previously approved by CC on 07/20/10 with Contract No. C-10-235-07-20-J.E. Saenz & Associates.

On motion of Commissioner Cuellar, seconded by Commissioner Flores, the Court made a UNANIMOUS vote of approval.

C. Pct. 2

- 1. AI-23876 a. Requesting exemption from competitive bidding requirements under the Texas Local Government Code, Section 262.024 (A)(4) a professional service/engineering services;

On motion of Commissioner Cuellar, seconded by Commissioner Flores, the Court made a UNANIMOUS vote of approval.

b. Presentation of scoring grid (for the purposes of ranking by CC) of the firms graded & evaluated through the County's approved "pool" of engineers in connection with "On-call Engineering Services" for Pct. #2;

1st. Quintanilla Headly & Associates Engineering @ 97 ; 2nd. R. Gutierrez @ 94 ;

3rd. Rodriguez Engineering @ 75 ;

On motion of Commissioner Cuellar, seconded by Commissioner Flores, the Court made a UNANIMOUS vote of approval to rank in the order of their scores.

c. Authority for the Purchasing Department to negotiate a professional engineering services contract with the No.1 ranked firm of Gutierrez Engineering for the provision of "On-call Engineering Services" for Pct. #2.

On motion of Commissioner Flores, seconded by Commissioner Cuellar, the Court made a UNANIMOUS vote of approval.

- 2. AI-23885 Requesting approval of Change Order No.1 increase in the amount of \$45,723.00 with D. Wilson Construction Co. (Contract #C-09-037C-11-17), in connection with he "Construction of the

APPROVED

AI-23881

21.A.7.

Third party administration, individual stop loss & aggregate stop loss for self-funded medical plan, group term life & accidental death & disbursement

CC REGULAR

Date: 11/09/2010

Submitted By: Angela Garcia, BUDGET & MANAGEMENT

Department: BUDGET & MANAGEMENT

Agenda Category: Purchasing Department

Sub-category: Hidalgo County

Information

CAPTION

a. Presentation by Alamo Insurance Group, (Hidalgo County Health Insurance Consultant) of the scoring/evaluation grid with recommendations for the responses received in response to the County's RFP: "Third Party Administration, Individual Stop Loss and Aggregate Stop Loss for Self-Fund Medical Plan, Group Term Life and Accidental Death and Dismemberment", Project No. 2010-228-09-22-YZV:

Provider	Score/Grade	-Rank
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

b. Acceptance and approval of consultant's recommendations so as to proceed with formal ranking by Commissioner's Court;

c. Authority for consultant to finalize a contract including all negotiated items (terms/conditions/rates/fees and BAFO) with the number one (1) ranked provider for award; or, if applicable;

d. Award with acceptance and approval of negotiated final contract with the number one (1) ranked provider (as negotiated by consultant); and, if applicable or necessary,

e. Presentation by consultant of scoring grid and recommendations on the responses received for: Group Term Life-Accidental Death and Dismemberment so as to proceed with formal ranking by Commissioner's Court:

Provider	Score	Rank
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____