



**BlueCross BlueShield  
of Texas**

**AMENDMENT TWO (2) TO THE  
ADMINISTRATIVE SERVICES AGREEMENT**

THIS AMENDMENT to the Administrative Services Agreement is effective as of **January 1, 2014** 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 **January 1, 2012**, as 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 ADMINISTRATIVE SERVICE AGREEMENT, SECTION 2, AGREEMENT DEFINITIONS, is expanded to include the following:**

**"Surcharges"** means local, state or federal taxes, surcharges or other fees or amount, including, but not limited to World Access Fees and amounts due in connection with the Affordable Care Act Transitional Reinsurance Programs (or successor or alternate program amounts) (the "Reinsurance Contribution"), paid by the Claim Administrator which are imposed upon or resulting from this Agreement or are otherwise payable by or through Claim Administrator. Upon request, the Employer shall furnish to the Claim Administrator in a timely manner all information necessary for the calculation or administration or any surcharges. Surcharges may or may not be related to a particular claim for benefits. In no event will the Claim Administrator be responsible for the Reinsurance Contribution.

- B. Under ADMINISTRATIVE SERVICE AGREEMENT, SECTION 4, CERTAIN RESPONSIBILITES OF THE EMPLOYER AND THE CLAIM ADMINISTRATOR, Subsection 4.2 *Claim Administrator responsibility* is expanded to include the following:**

**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, including but not limited to local, state or federal taxes, penalties, surcharges or other fees or amounts regardless of whether payable directly by the Employer or by or through the Claim Administrator; 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.

- 1 -

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

ASA Amd 11/13

C. Under **ADMINISTRATIVE SERVICE AGREEMENT, SECTION 13, TERM AND TERMINATION OF AGREEMENT**, Subsection 13.2 *Termination* is expanded to include the following:

e. By the Claim Administrator on any date that the actual number of Covered Employees (in total, by product, or by benefit plan), the Single/Family mix, or the Medicare/Non-Medicare mix varies +/- 10% from Claim Administrator's projections, or the information upon which Claim Administrator's projections were based (benefit levels, census/demographics, commissions, etc.) becomes outdated or inaccurate.

D. Under **ADMINISTRATIVE SERVICE AGREEMENT, SECTION 16, PROPRIETARY MATERIALS**, is expanded to include the following:

**16.4 Disclosures in Account Contracts.** The Employer on behalf of itself and its Covered Persons hereby expressly acknowledges its understanding this Agreement constitutes a contract solely between the Employer and the Claim Administrator, which is an independent corporation operating under a license from the Blue Cross and Blue Cross Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting the Claim Administrator to use the Blue Cross and Blue Shield Service Mark, and that the Claim Administrator is not contracting as the agent of the Association. The Employer on behalf of itself and its Covered Persons further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than the Claim Administrator and that no person, entity, or organization other than the Claim Administrator shall be held accountable or liable to the Employer for any of the Claim Administrator's obligations to the Employer created under this Agreement. This subsection shall not create any additional obligations whatsoever on the part of the Claim Administrator other than those obligations created under other provisions of this Agreement.

**16.5 Administrative Services Only, Network Only.** The Claim Administrator must disclose that it does not underwrite or assume any financial risk with respect to Claims liability; and disclose the nature of the services and/or network access the Claim Administrator is providing. Such disclosures must be made to the Employer, the Employer's Covered Persons, and Providers and must include, at a minimum, disclosure on identification cards, benefit booklets, Employer contracts and Explanation of Benefits documentation.

E. Under **EXHIBIT 1, CLAIM ADMINISTRATOR SERVICES**, the following bulleted item is updated as follows:

▪ **BLUE CARE CONNECTION PROGRAM**

A program that may include utilization management, case management, condition management, lifestyle management, predictive modeling, Well on Target, 24/7 nurseline and access to a personal health manager or such other features as determined by the Employer.

F. Under **EXHIBIT 2, SECTION 3: COMPENSATION TO CLAIM ADMINISTRATOR**, Subsection 3.3 **Changing service charges**, is expanded to include the following:

d. On any date that the actual number of Covered Employees (in total, by product or by benefit plan), the Single/Family mix, or the Medicare/Non-Medicare mix varies +/- 10% from Claim Administrator's projections;

e. The information upon which Claim Administrator's projections were based (benefit levels, census/demographics, commissions, etc.) becomes outdated or inaccurate; or

G. Under EXHIBIT 2, FEE SCHEDULE, FINANCIAL RESPONSIBILITIES & REQUIRED DISCLOSURES, SECTION 5., EMPLOYER PAYMENT, the following Subsection is added:

5.3 Federal Regulation of the Employer. Beginning in 2014 (or such other date required by law), the Employer will be responsible for contributing to the funding of the Transitional Reinsurance Programs established by the Affordable Care Act. In no event will the Claim Administrator be responsible for the reinsurance contribution. If required by applicable law, The Employer will promptly forward to the Claim Administrator all such contributions (or successor or alternate program amounts) and all information necessary for the calculation or administration of such contributions (or successor or alternate program amounts).

H. Under EXHIBIT 2, SECTION 14: INTER-PLAN ARRANGEMENTS, 14.2 Bluecard Program, item a, Liability Calculation Method Per Claim, is updated as follows:

In some instances federal law or the laws of a small number of states require Host Blues either (i) to use a basis for determining 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 (ii) to add a surcharge.

Should either federal law or the law of the state in which healthcare services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, Claim Administrator would then calculate Covered Person's liability and Employer's liability in accordance with applicable law.

I: ATTACHMENTS TO THIS AMENDMENT

The following Exhibits/Addendum are attached to and are made a part of this Amendment:

- ASO Benefit Program Application (ASO BPA)
- Exhibit Performance Guarantees

Except as herein modified and amended, the provisions, conditions and terms of the Agreement shall remain in full force and effect.

IN WITNESS WHEREOF, the parties hereto have executed this Amendment 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

By: Scott Lilg

By: \_\_\_\_\_

Title: Chief Underwriter DSVP

Title: \_\_\_\_\_

Date: December 18, 2013

Date: \_\_\_\_\_



**EXHIBIT-PG**  
**EMPLOYER NAME: HIDALGO COUNTY**

**Employer Group Number(s): 21185**

Effective for the Settlement Period beginning January 1, 2014, and ending December 31, 2014

Effective for the Settlement Period beginning January 1, 2015, and ending December 31, 2015

Effective for the Settlement Period beginning January 1, 2016, and ending December 31, 2016

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 3,300 Covered Employees. Performance measurement will begin January 1, 2014. Performance Guarantees are measured and settled annually.

SERVICE - Medical	Defined Performance Guarantees	Performance Guarantee	Percentage of the Administrative Charge at Risk
Account Management	Account Management means the Employer's satisfaction with Account Management and will be measured by the Employer, using the Claim Administrator's Account Management Client Satisfaction Survey.	Composite Score 3.0 - 5.0 0 - 2.9	0% 1%
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"> <li>1. Coding - incorrect claim data entry.</li> <li>2. Failure to adhere to the Employer's health care benefit program design.</li> <li>3. Failure to adhere to the administrative procedures.</li> <li>4. System generated errors, benefit programming errors, calculation errors.</li> <li>5. Excluding:               <ol style="list-style-type: none"> <li>a. Any administrative inaccuracies that do not impact claims disposition or customer reporting;</li> <li>b. Errors entered by providers of service;</li> </ol> </li> </ol>	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
	<p>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> <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>		
Claim Financial Accuracy	<p><b>Claim Financial Accuracy</b> 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><b>Inquiry Resolution</b> is defined as number of days it takes to resolve a participant inquiry, beginning with the date the inquiry is received to the resolution date. All written and telephone inquiries will be measured. The standard is measured as a percent processed within 14 calendar days on an Employer-specific basis.</p> <p><b>Average Speed of Answer of Telephone Calls</b>, 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</p>	<p>95.0% - 100% 94.0% - 94.9% 0% - 93.9%</p> <p>0-30 seconds 31-60 seconds 61 seconds or more</p>	<p>0% 1% 2%</p> <p>0% 1% 2%</p>

SERVICE - Medical	Defined Performance Guarantees	Performance Guarantee	Percent of Administrative Charge at Risk
	<p>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><b>Abandoned Calls</b> 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%-3.0% 3.1%-5.0% 5.1%-100%</p>	<p>0% 1% 2%</p>
<b>Total Medical</b>			<b>12%</b>

**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: Chief Underwriter DSVP

Date: December 18, 2013

By: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

ASO

**Benefit Program Application ("ASO BPA")**

Application to Administrative Services Only (ASO) Group Accounts  
Administered by 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" or "HCSC"

Group Status: Renewing ASO Account

Employer Account Number: 21185 Group Number(s): 021185

Section Number(s): ALL Effective Date: 01/01/2014 Anniversary Date (AD): 01/01

Legal Employer Name: Hidalgo County

Specify the employer or the employee trust applying for coverage. AN EMPLOYEE BENEFIT PLAN MAY NOT BE NAMED.

ERISA Regulated Group Health\* Plan:  Yes  No

If you maintain that ERISA is not applicable to your group health plan, please give legal reason for exemption:

Non-Federal Governmental Plan (Public Entity)

Is your Non-ERISA Plan Year a period of 12 months beginning on the Anniversary Date specified above?

Yes  No

For more information regarding ERISA, contact your Legal Advisor.

\*All as defined by ERISA and/or other applicable law/regulations.

NO CHANGES

**ACCOUNT INFORMATION**

Is there a designated Producer of Record?  Yes  No

NO CHANGES

**PRODUCER OF RECORD INFORMATION**

NO CHANGES

**SCHEDULE OF ELIGIBILITY**

**CURRENT EMPLOYEE ELIGIBILITY INFORMATION**

SEE ADDITIONAL PROVISIONS

Current Number of Employees Enrolled:

3784

NO CHANGES

**LINES OF BUSINESS**

Will COBRA Administration Services be renewed?

Yes  No

## FINANCIAL DOCUMENT ADMINISTRATION

**NO CHANGES**

### Payment Specifications

**NO CHANGES**

### Fee Schedule

**See Additional Comments**

Fee Schedule Period:       12 Months       Other

**Fees**

#### Administrative per Employee per Month (PEPM) Charges

Product / Service:	PPQ							
Base Administrative Charge (Medical)	\$	34.12						
*Prescription Drug Rebate Credit	\$	-6.35						
Other: <u>Select Service Category</u> List Service:	\$							
Other: <u>Select Service Category</u> List Service:	\$							
Misc.: <u>Commissions</u>	\$	1.82						
<b>Total:</b>	<b>\$</b>	<b>29.57</b>						

\*Prescription Drug Rebate Credit per Covered Employee per month is the guaranteed Prescription Drug Rebate savings reflected as a Prescription Drug Rebate credit. 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. 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 the governing Administrative Services Agreement to which this ASO BPA is attached under the section titled "CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS.")

Administrative Line Item Charges	Frequency	Amount
Other: <u>Select Service Category</u> List Service:	<u>Select Billing Frequency</u>	\$
Misc.:	<u>Select Billing Frequency</u>	\$
<b>Total:</b>		<b>\$</b>

**Note:** Additional services and/or fees may be itemized in the "Miscellaneous" fields above or in the Additional Comments section below.

Product / Service:								
Dental:	\$							
Misc.:	\$							
<b>Total:</b>	<b>\$</b>							

**Additional Comments:**

Traditional RX Pricing

**NO CHANGES**

### Termination Administrative Charge

**See Additional Comments**

**Termination Administrative Charge**

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 (*per Covered Employee per individual or family composite*) during the three (3) months immediately preceding the date of termination by the appropriate factors shown below.

Product / Service:		PPQ							
Medical Run-off Administration Charge:	\$	13.68							
Misc.:	\$								
<b>Total:</b>	<b>\$</b>	<b>13.68</b>							
Product / Service:									
Dental Run-off Administration Charge:	\$								
Misc.:	\$								
<b>Total:</b>	<b>\$</b>								

**Additional Comments:**

Administrative fee includes Standard Blue Care Connection and Value Base Insurance Design

1. BlueCard Program/Network access fee: \$ (Available upon request)

2. Not applicable to Grandfathered Plans

External Review Coordination:

Employer acknowledges and agrees: (i) to a fee of \$700 for each external review requested by a Covered Person that the Claim Administrator coordinates for the Employer in relation to the Employer's Plan; (ii) that the Claim Administrator's coordination shall include reviewing external review requests to ensure that they meet eligibility requirements, referring requests to accredited external independent review organizations, and reversing the Plan's determinations if so indicated by external independent review organizations; and (iii) that the external reviews shall be performed by an independent third party entity or organization and not the Claim Administrator. Amounts received by Claim Administrator and external independent review organizations may be revised from time to time and may be paid each time an external review is undertaken. Further, Employer elects for external reviews to be performed under the Federal Affordable Care Act external review process.

3. Will Claim Administrator perform third party liability recovery (Reimbursement Services)?  Yes  No

If yes: It is understood and agreed that in the event the Claim Administrator makes a recovery on a third-party liability case, the Claim Administrator will retain 25% of any recovered amounts other than recovery amounts received as a result of or associated with any Workers' Compensation Law.

4. Claim Administrator's Third Party Recovery Vendor:

It is understood and agreed that in the event the Claim Administrator's Third Party Recovery Vendor makes a recovery on a claim, the Employer will pay no more than 25% of any recovered amount.

NO CHANGES

OTHER PROVISIONS

SEE ADDITIONAL PROVISIONS

1. Will BCBSTX issue Certificates of Creditable Coverage (COCCs)?  Yes  No

If yes: The Employer directs the Claim Administrator to issue to individuals, whose coverage under the Plan terminates during the term of the Administrative Services Agreement to which this ASO BPA is attached, a Certificate of Creditable Coverage, if required by applicable law. The Certificate of Creditable Coverage shall be based upon information required for issuance of a Certificate of Creditable Coverage to be provided to the Claim Administrator by the Employer and coverage under the Plan during the term of the Administrative Services Agreement.

2. Summary of Benefits & Coverage

Will Claim Administrator create Summary of Benefits & Coverage (SBC)?  Yes  No

If yes: Will Claim Administrator distribute Summary of Benefits & Coverage (SBC) to participants and beneficiaries?

No Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Agreement) and provide SBC to Employer in electronic format. Employer will then distribute SBC to participants and beneficiaries (or hire a third party to distribute) as required by law.

See the attached SBC Addendum to the BPA.

3. Does Employer have any Employees that reside in Massachusetts?  Yes  No

4. Employer contribution

Employer Contribution - Medical	
% of Employee's premium	or \$
% of Dependent's premium	or \$

Employer Contribution - Dental	
% of Employee's premium	or \$
% of Dependent's premium	or \$

Comments:

5. EHB Election:

Employer elects EHBs based on the following:

- 1. EHBs based on a HCSC state benchmark: Texas
- 2. EHBs based on benchmark of a state other than IL, MT, NM, OK and TX  
If so, indicate the state's benchmark that Employer elects:
- 3. Other EHB, as determined by Employer

In the absence of an affirmative selection by Employer of its EHBs, then Employer is deemed to have elected the EHBs based on the Texas benchmark plan.

- 6. **This ASO Benefit Program Application (ASO BPA) is incorporated into and made a part of the Administrative Services Agreement with both such documents to be referred to collectively as the "Agreement" unless specified otherwise.**
  - Also included in the above Agreement is the Summary of Benefits and Coverage Addendum To ASO Benefit Program Application (ASO BPA).

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### ADDITIONAL PROVISIONS

- A. **Grandfathered Health Plans:** Employer shall provide Claim Administrator with written notice prior to renewal (and during the plan year, at least 60 days advance written notice) of any changes that would cause any benefit package of its group health plan(s) (each hereafter a "plan") to not qualify as a "grandfathered health plan" under the Affordable Care Act and applicable regulations. Any such changes (or failure to provide timely notice thereof) can result in retroactive and/or prospective changes by Claim Administrator to the terms and conditions of administrative services. In no event shall Claim Administrator be responsible for any legal, tax or other ramifications related to any plan's grandfathered health plan status or any representation regarding any plan's past, present and future grandfathered status. The grandfathered health plan form ("Form"), if any, shall be incorporated by reference and part of the BPA and Agreement, and Employer represents and warrants that such Form is true, complete and accurate.
- B. **Retiree Only Plans, Excepted Benefits and/or Self-Insured Nonfederal Governmental Plans:** If the BPA includes any retiree only plans, excepted benefits and/or self-insured nonfederal governmental plans (with an exemption election), then Employer represents and warrants that one or more such plans is not subject to some or all of the provisions of Part A (Individual and Group Market Reforms) of Title XXVII of the Public Health Service Act (and/or related provisions in the Internal Revenue Code and Employee Retirement Income Security Act) (an "exempt plan status"). Any determination that a plan does not have exempt plan status can result in retroactive and/or prospective changes by Claim Administrator to the terms and conditions of administrative services. In no event shall Claim Administrator be responsible for any legal, tax or other ramifications related to any plan's exempt plan status or any representation regarding any plan's exempt plan status.
- C. Employer shall indemnify and hold harmless Claim Administrator and its directors, officers and employees against any and all loss, liability, damages, fines, penalties, taxes, expenses (including attorneys' fees and costs) or other costs or obligations resulting from or arising out of any claims, lawsuits, demands, governmental inquiries or actions, settlements or judgments brought or asserted against Claim Administrator in connection with (a) any plan's grandfathered health plan status, (b) any plan's exempt plan status, (c) any plan's design (including but not limited to any directions, actions and interpretations of the Employer), (d) any provision of inaccurate information, and/or (e) the SBC, and/or (f) selection of Employer's EHB benchmark for the purposes of ACA. Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of administrative services.

The provisions of paragraphs A-C (directly above) shall be in addition to (and do not take the place of) the other terms and conditions of administrative services between the parties.

**Additional provisions for Current Employee Eligibility Information Section:**

**Additional provisions may apply as follows:**

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**I UNDERSTAND AND AGREE THAT:**

- The proposed fees are effective for 12 months, subject to contract provisions, and are based on the information and conditions stated. Final fees are subject to review based on actual enrollment results. If there is a 10% or greater variance in the enrollment and/or less than the minimum enrollment requirement of 75% BCBSTX reserves the right to review the final fees. The information provided in this application is complete and accurate to the best of knowledge. If this information is incomplete or inaccurate, BCBSTX may re-rate the plan, withdraw the proposal or cancel the contract.
- BCBSTX will report the value of all remuneration by BCBSTX to ERISA plans with 100 or more participants for use in preparation of ERISA Form 5500 schedules. Reporting will also be provided upon request to non-ERISA plans or plans with fewer than 100 participants. Reporting will include base commissions, bonuses, incentives, or other forms of remuneration for which your Producer/consultant is eligible for the sale or renewal of self-funded and/or insured products.

Ramon Garcia

County Judge

\_\_\_\_\_  
Name of Authorized Company Official

\_\_\_\_\_  
Title of Authorized Company Official

*Ramon Garcia*  
\_\_\_\_\_  
Signature of Authorized Company Official

\_\_\_\_\_  
11/12/2013

\_\_\_\_\_  
Date

Tita Iruegas

Account Executive

\_\_\_\_\_  
Authorized BCBSTX Representative

\_\_\_\_\_  
Title

956-581-5615

\_\_\_\_\_  
11/12/2013

\_\_\_\_\_  
BCBSTX Telephone Number

\_\_\_\_\_  
Date

**Summary of Benefits and Coverage Addendum  
To ASO Benefit Program Application (ASO BPA)**

First Date of Employer's Open Enrollment Period for the next Plan Year (the "First Open Enrollment Date"):  
11/12/2013

The Affordable Care Act ("ACA") requires group health plans to create and distribute a Summary of Benefits and Coverage (or alternate format permitted by ACA) (the "SBC"), to participants and beneficiaries in certain specified situations (the "SBC Requirements"). In accordance with the Employer's election indicated on the most current ASO BPA, to have Blue Cross and Blue Shield of Texas (BCBSTX) create and/or distribute the SBC, as of the First Open Enrollment Date, the Employer acknowledges and agrees:

1. BCBSTX's SBC services do not include the creation or distribution of coverage information for benefits it does not administer under the Agreement, unless otherwise agreed to in the ASO BPA or this Addendum.
2. Employer is responsible for the proper synthesizing of information from its various insurers and administrative service providers it uses for its group health plan (or providing multiple partial SBCs if permitted by law).
3. The Employer is responsible for SBC services performed by Employer's third party vendors.
4. The Employer must review and approve the SBC prior to distribution and is responsible for the content of the SBC. Nothing in this Addendum or in the ASO BPA relieves the Employer or its group health plan of their respective legal and regulatory obligations with respect to the SBC.
5. ACA and the SBC regulatory and sub-regulatory guidance (the "Guidance") are new (and subject to change) and the regulatory agencies and industry interpretations thereof are evolving; therefore, BCBSTX's operations shall not be considered to be in breach of the Agreement to the extent BCBSTX has worked diligently and in good faith to implement a reasonable interpretation of then-current SBC-related ACA provisions and Guidance, in a manner consistent with the SBC Requirements.
6. Employer agrees to furnish to BCBSTX in a timely manner all information necessary for the timely distribution of SBCs, including but not limited to names and addresses for: (i) any person currently enrolled in any plan administered or insured by BCBSTX, and (ii) any person the employer tells us is eligible or may become eligible. Employer's failure to furnish such information, to agree to an implementation plan or to promptly review/approve SBCs may substantially delay and/or jeopardize BCBSTX's SBC services and BCBSTX is relieved of its SBC obligations.
7. Employer shall indemnify and hold harmless BCBSTX and its directors, officers and employees against any and all loss, liability, damages, fines, penalties, taxes, expenses (including attorneys' fees and costs) or other costs or obligations resulting from or arising out of any claims, lawsuits, demands, governmental inquiries or actions, settlements or judgments brought or asserted against BCBSTX in connection with the SBC (and Employer's or Its vendors' distribution of the SBC).