BlueCross BlueShield of Texas

ADMINISTRATIVE SERVICES AGREEMENT

The Effective Date of this Agreement is from September 1, 2020 to August 21, 2023.

For Employer Group Number(s): As specified on the most current ASO BPA (as defined below).

Account Number: TX039993

IN WITNESS WHEREOF, the parties hereto have executed this Agreement and consent to all of its terms and conditions 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

By:

Title: Vice President and Chief Underwriter

Date: Effective Date of Coverage noted above

THE TEXAS A&M UNIVERSITY SYSTEM ("EMPLOYER")

By: _____

Title: Deputy Chancellor and Chief Financial Officer

Date: 12/2/2021 | 07:46:53 CST

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This Agreement made as of the Effective Date, by and between **Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company** ("Claim Administrator"), and The Texas A&M University System, an agency of the state of Texas ("Employer"), for Employer Group Number(s) set forth on page one (1) of this Agreement (each a "Party" and collectively, the "Parties"), WITNESSETH AS FOLLOWS:

RECITALS

WHEREAS, as part of Employer's benefit plan offered to its employees and their eligible dependents, Employer has established and adopted a Plan as defined herein; and

WHEREAS, Employer on behalf of the Plan has executed an Administrative Services Only Benefit Program Application ("ASO BPA") and Claim Administrator has accepted such ASO BPA attached hereto as Exhibit 4; and

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

WHEREAS, the Parties agree that it is desirable to set forth more fully the obligations, duties, rights and liabilities of Claim Administrator and Employer;

NOW, THEREFORE, in consideration of these premises and the mutual promises and agreements hereinafter set forth, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, Employer and Claim Administrator hereby agree as follows:

SECTION 1: CLAIM ADMINISTRATOR RESPONSIBILITIES

1.1 **Appointment.** Employer hereby retains and appoints Claim Administrator to provide the services set forth in Exhibit 1 in connection with the administration of the Plan ("Services"). Employer agrees that it will not perform or engage any other party to perform the Services with respect to any Covered Persons while this Agreement is in effect.

1.2 **Claim Administrator Responsibility.** Claim Administrator shall be responsible for and bear the cost of compliance with any federal, state or local laws that may apply to Claim Administrator's performance of its Services, including without limitation, HIPAA, except as otherwise provided in this Agreement. Claim Administrator does not have final authority to determine Covered Persons' eligibility or discretion to establish or construe the terms and conditions of the Plan. 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 Employer shall , to the extent authorized under Texas law, 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 that 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 Employer or by or through Claim Administrator.

1.3 **Claim Appeals.** Appeals of any determination made by the Claim Administrator will be reviewed with a new full and fair review. No deference will be given to the initial adverse determination. If the Claim Administrator denies all or part of a claim and the denial reason was due to medical necessity or experimental/investigational rationale, an explanation will be provided of the scientific or clinical judgment relied on in the determination and the appeal will be reviewed by a qualified Physician who had no involvement in the initial review or any prior reviews. If, pursuant to such review, the clinical decision is upheld, then the Covered Person may have the right to seek an independent external review by an independent third party. The decision of the Independent Review Organization ("IROs") will be final and binding, except to the extent that other remedies may be available under state or federal law.

1.4 **External Review Coordination.** If elected by Employer on the most current ASO BPA, Claim Administrator will coordinate, and Employer shall pay for, external reviews by Independent Review Organizations ("IROs") as described in Exhibit 1 and/or the most current ASO BPA, but in no event shall IROs be considered subcontractors of Claim Administrator under this Agreement.

1.5 **Claim Administrator Review of Eligibility Records.** During the term of this Agreement and within one hundred eighty (180) days after its termination, Claim Administrator may, upon at least thirty (30) days prior written notice to Employer, conduct reasonable reviews of Employer's membership records with respect to eligibility.

1.6 **Administrative Services.** In performing the Services, Claim Administrator, at its sole discretion, may contract with or delegate to other entities for performance of any of the Services; provided, however, Claim Administrator shall remain fully responsible and liable for performance of any such Services to be performed by Claim Administrator but contracted or delegated to other entities. Further, any of the Services may be performed by Claim Administrator, any subsidiary or affiliate of Claim Administrator, and any successor entity or entities to Claim Administrator, whether by merger, consolidation, or reorganization, without prior written approval by Employer; provided, however, Claims Administrator shall provide Employer prompt written notice of such successor entity or entities.

SECTION 2: EMPLOYER RESPONSIBILITIES

2.1 **Employer Responsibility.** Employer retains full and final authority and responsibility for the Plan, payment of claims under the Plan, determinations of eligibility under the Plan, and its operation. Notwithstanding the foregoing, Claim Administrator remains responsible for the performance of its obligations under the terms of this Agreement. Claim Administrator performs Services for Employer in connection with the Plan within the framework, practices, and procedures of Employer and only as expressly stated in this Agreement or as otherwise mutually agreed.

The Parties acknowledge and agree Claim Administrator does not insure or underwrite the liability of Employer under the Plan and has no responsibility for designing the terms of the Plan or the benefits to be provided thereunder.

2.2 **Employer's Direction as to Benefit Design.** Employer shall direct Claim Administrator as to the terms and scope of benefits under the Plan and such directions shall be documented in an automated benefit summary and similar documentation (collectively, "ABS"), and the ASO BPA. Employer agrees that Claim Administrator shall process claims in accordance with the ABS and the ASO BPA. Employer agrees Claim Administrator may rely on the most current version of the ABS and the ASO BPA as the authorized document that governs administration of Employer's Plan under this Agreement and will prevail in the event of any conflict with any other electronic or paper file.

2.3 **Eligibility.** Employer shall determine eligibility for coverage under the Plan. Employer is responsible for any benefits paid for a terminated Covered Person until Employer has notified Claim Administrator of such Covered Person's termination. Any clerical errors with respect to eligibility will not invalidate coverage that would otherwise be validly in force or continue coverage that would otherwise validly terminate. Such errors will be corrected according to Claim Administrator's reasonable administrative practices including, but not limited to, those related to Timely notification of a change in a Covered Person's status.

2.4 **Notices to Covered Persons.** Unless otherwise stated in this Agreement, Employer is responsible for all communications to Covered Persons, including as to the terms of the Plan. In addition, if this Agreement is terminated pursuant to Section 6, Employer agrees to notify all Covered Persons. Employer shall also communicate the provisions of Exhibit 3 to Covered Persons.

2.5 **Required Plan Information.** Employer shall furnish on a Timely basis to Claim Administrator information concerning the Plan and Covered Persons that Claim Administrator may require and request to perform its duties including, but not limited to, the following:

a. All documents by which the Plan is established and any amendments or changes to the Plan.

b. All data as may be required by Claim Administrator with respect to any Covered Persons.

Employer shall Timely notify Claim Administrator in an agreed format of any change in a Covered Person's status under this Agreement. Employer shall obtain any consent(s) from Covered Persons necessary for Claim Administrator to contact Covered Persons by telephone or text, including by pre-recorded message, artificial voice, or by use of an automatic telephone dialing system. Employer is responsible for ensuring that the terms of the Plan are consistent with the terms of this Agreement.

2.6 **Retiree Only Plans, Excepted Benefits and/or Self-Insured Non-federal Governmental Plans (If Applicable).** Only to the extent that Claim Administrator provides Services for any retiree only plans, excepted benefits and/or self-insured non-federal 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 this Agreement. 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. For the avoidance of doubt, as of the Effective Date, the Plan does not have exempt plan status.

2.7 **Summary of Benefits and Coverage ("SBC").** Unless otherwise provided in the applicable ASO BPA, Employer acknowledges and agrees that Employer will be responsible for the creation and distribution of the SBC as required by Section 2715 of the Public Health Service Act (42 USC 300gg-15) and SBC regulations (45 CFR 147.200), as supplemented and amended from time to time, and that in no event will Claim Administrator have any responsibility or obligation with respect to the SBC and Claim Administrator will not be obligated to respond to or forward misrouted calls, but may, at its option, provide participants and beneficiaries with Employer's contact information.

2.8 **Massachusetts Health Care Reform Act.** If elected on the applicable ASO BPA, Claim Administrator will provide in accordance with the Massachusetts Health Care Reform Act required written statements of creditable coverage to individuals residing in Massachusetts and submit applicable electronic reporting to the Massachusetts Department of Revenue, based on information provided to Claim Administrator by Employer and coverage under the Plan(s) during the term of this Agreement. Employer hereby certifies that, to the best of its knowledge, such coverage under the Plan(s) is "creditable coverage" in accordance with the Massachusetts Health Care Reform Act. Employer acknowledges that Claim Administrator is not responsible for verifying nor ensuring compliance with any tax and/or legal requirements related to this Service. Employer or its Covered Persons should seek advice from their legal or tax advisors as necessary. If not elected on the applicable ASO BPA, Employer acknowledges it will provide written statements and electronic reporting to the Massachusetts Department of Revenue as required by the Massachusetts Health Care Reform Act.

2.9 **Employer Audits Claim Administrator.** During the term of this Agreement and within one hundred eighty (180) days after its termination, Employer or an authorized agent of Employer (subject to Claim Administrator's reasonable approval) may, upon at least ninety (90) days prior written notice to Claim Administrator, conduct reasonable audits of records related to Claim Payments to verify that Claim Administrator's administration of the covered health care benefits is performed according to the terms of this Agreement. Contingency fee-based audits are not supported by Claim Administrator. Audit samples will be limited to no more than three hundred (300) Claims. If a pattern of errors is identified in an audit sample, Claim Administrator shall also identify Claims with the same errors and will reprocess such identified Claims in accordance with Claim Administrator policies and procedures. Notwithstanding anything in this Agreement to the contrary, in no event will Claim Administrator be obligated to reprocess Claims or reimburse Employer for alleged errors based upon audit sample extrapolation methodologies or inferred errors in a population of Claim Payments. Employer will be responsible for all of Employer's own and Employer's agent's costs associated with the audit. All such audits shall be subject to Claim Administrator's then current external audit policy and procedures, a copy of which shall be furnished to Employer upon request to Claim Administrator. The audit period will be limited to the current Agreement year and the immediately preceding Agreement year. No more than one (1) audit shall be conducted during a twelve (12) consecutive-month period, except as required by state or federal government agency or regulation. Employer and such agent that have access to the information and files maintained by Claim Administrator will agree not to disclose any Business Confidential Information, and to the extent allowed by Texas Law, to hold harmless and indemnify Claim Administrator in writing of any liability from disclosure of such Business Confidential Information by Employer and such agents by executing an Audit Agreement with Claim Administrator that sets forth the terms and conditions of the audit. Claim Administrator has the right to implement reasonable administrative practices in the administration of Claims. Employer agrees that it

is responsible for its own liability arising out of the disclosure of any Business Confidential Information provided to Employer or its agents during an audit.

2.10 Texas State Auditor. Acceptance of funds under this Agreement constitutes acceptance of the authority of the Texas State Auditor's Office, or any successor agency (collectively, "Auditor"), to conduct an audit or investigation in connection with those funds under Section 51.9335(c), Texas Education Code, separate and distinct from any audit rights of Employer. Claim Administrator shall cooperate with the Auditor in the conduct of the audit or investigation, including without limitation, providing all records requested.

SECTION 3: CONFIDENTIAL DATA, INFORMATION AND RECORDS

3.1 Confidentiality, Maintenance, Use, Disclosure, and Security of Covered Persons' Information. The Parties agree that they have entered into the Business Associate Agreement ("BAA") attached hereto as Exhibit 6. The Parties agree the BAA will govern the confidentiality, maintenance, use, disclosure, and security of any personally identifiable information ("PII"), including Protected Health Information as such term is defined in HIPAA ("PHI"), Claim Administrator may collect or receive. Notwithstanding anything to the contrary in the BAA, any reference to Protected Health Information or PHI in the BAA shall include PII.

3.2 Electronic Exchange of Information. If Employer and Claim Administrator exchange data and information electronically, Employer agrees to transfer on a Timely basis all required data to Claim Administrator via secure electronic transmission on the intranet and/or internet or otherwise, in a format agreed to by the Parties. Further, Employer is responsible for maintaining any enrollment applications and enrollment documentation, including any changes completed by Covered Persons and to allow Claim Administrator reasonable access to this information as needed for administrative purposes.

Employer authorizes Claim Administrator to submit reports, data and other information to Employer in the electronic format mutually agreed to by the Parties.

3.3 Providing Data to Employer's Vendor(s). If Employer provides written authorization to Claim Administrator to provide Employer Data (as defined in Section 7.12) directly to Employer's third party consultant and/or vendor ("Employer's Vendor"), Claim Administrator agrees to do so. If Employer directs Claim Administrator to provide other data containing Business Confidential Information of Claim Administrator, other Blue Cross and/or Blue Shield companies or Claim Administrator's subsidiaries, affiliates and/or vendors to Employer's Vendor, and Claims Administrator agrees in its sole discretion, then Employer acknowledges and agrees that it shall require Employer's Vendor(s) to execute Claim Administrator's then-current data exchange agreement as required by Claim Administrator. Employer hereby acknowledges that such data exchange agreement will require Employer's Vendor to acknowledge and agree:

a. That the requested documents, records and other information (for purposes of this Section 3, "Confidential Information") are proprietary and confidential in nature and that the release of the Confidential Information may reveal Claim Administrator's Business Confidential Information.

b. To maintain the confidentiality of the Confidential Information and any Business Confidential Information (for purposes of this Section 3, collectively, "Information") and to prevent unauthorized use or disclosure by Employer's Vendor(s) or unauthorized third parties, including those of its employees not directly involved in the performance of duties under its contract with Employer, to the same extent that it protects its own confidential information.

c. To use and limit the disclosure of the Information strictly for and to the minimum extent necessary to fulfill the purpose for which it is disclosed and consistent with the Inter-Plan provisions of this Agreement.

d. To maintain the Information at a specific location under its control and take reasonable steps to safeguard the Information.

e. To 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.

f. To not duplicate the Information furnished in written, pictorial, magnetic and/or other tangible form except as necessary to fulfill the purposes of this Agreement or as required by law.

g. To not sell, re-sell or lease the Information.

h. To securely return or securely destroy the Information at the direction of Claim Administrator or within a reasonable time after the termination of this Agreement, not to exceed sixty (60) days thereafter.

Employer shall provide Claim Administrator in writing the names of any Employer's Vendor(s) with whom Claim Administrator is authorized to release, disclose or exchange data and provide written authorization and specific directions with respect to such release, disclosure, or exchange. If Employer's Vendor(s) is under contract to perform services that involve the use, access or disclosure of PHI as defined by HIPAA, the identity of Employer Vendor(s) shall be documented within the BAA between Claim Administrator and Employer.

3.4 Business Confidential Information and Proprietary Marks. The Parties acknowledge that Claim Administrator has developed, acquired, or owns certain Business Confidential Information. Subject to the Texas Public Information Act, Employer shall not use or disclose such Business Confidential Information (BCI) to any third party without prior written consent of Claim Administrator, except that Employer may disclose BCI to Employer's agents, contractors, consultants, and other advisors (collectively, its "Representatives") in connection with the Services provided under this Agreement, who agree in writing to maintain such information confidential in accordance with this Section 3.4 and provided that Employer remains responsible for its Representatives' compliance with Employer's obligations under this Agreement as to such BCI. Employer agrees to provide, to the extent allowed by law, written notice to Claim Administrator if Employer believes it is required by law to disclose Business Confidential Information, to any entity or person, including but not limited to any Covered Person, any Covered Person's authorized representative, or any governmental entity, so that Claim Administrator has a reasonable opportunity to pursue appropriate process to prevent or limit the disclosure. If Employer complies with the terms of this Section 3.4, disclosure by Employer of that portion of the Business Confidential Information which Employer is legally required to disclose will not constitute a breach of this Agreement Employer will at all times remain liable for maintaining the confidentiality of the Business Confidential Information and shall ensure that any affiliated entities or third-party representatives to whom BCI is disclosed are bound in writing not to further disclose the BCI without the prior written consent of Claim Administrator. Neither Party shall use the name, symbols, trademarks or service marks ("Proprietary Marks") or copyrighted material of the other Party or the other Party's respective clients in advertising or promotional materials without prior written consent of the other Party; provided, however, that Claim Administrator may include Employer in its list of clients so long as such use, in context, is not misleading and does not imply any endorsement by Claim Administrator.

3.5 Proprietary Mark Ownership. Employer acknowledges that certain of Claim Administrator's Proprietary Marks and Business Confidential Information are utilized under a license from the Blue Cross and Blue Shield Association. Employer agrees not to contest (i) the Blue Cross and Blue Shield Association's ownership of, or the license granted by the Blue Cross and Blue Shield Association to Claim Administrator for use of, such Proprietary Marks and (ii) Claim Administrator's ownership of its Proprietary Marks or BCI. Claim Administrator agrees not to contest Employer and Employer's members' ownership of its Proprietary Marks.

3.6 Infringement. Claim Administrator agrees not to infringe upon, dilute or harm Employer's or Employer's members' rights in its Proprietary Marks. Employer agrees not to infringe upon, dilute or harm Claim Administrator's rights in its Proprietary Marks, including those Proprietary Marks owned by the Blue Cross and Blue Shield Association and utilized by Claim Administrator under a license with the Blue Cross and Blue Shield Association.

3.7 Records. For a period of five (5) years following the termination of this Agreement, Claim Administrator shall, upon the request of the Employer, provide Employer a copy of all Employer Data and Claim determination records, excluding any and all of the Business Confidential Information of Claim Administrator, other Blue Cross and/or Blue Shield companies, or Claim Administrator's subsidiaries, affiliates, and vendors in the possession of Claim Administrator. Such copy shall be transmitted in a form as agreed upon by the Parties with the cost of preparing the information for transmittal to be borne by

Employer. Claim Administrator shall retain all such Claim records for the time period required by Claim Administrator's records retention policy, which policy is subject to change by Claim Administrator, but in no case may such Claim records be retained for less than six years unless otherwise required by applicable laws. The failure to agree upon a retention period shall not constitute breach of this Agreement.

3.8 **Industry Improvement, Research and Safety.** Notwithstanding any other provision of this Agreement, Claim Administrator may use and/or disclose de-identified data for purposes of providing the Services under this Agreement and for other purposes required or permitted by applicable law (the "Permitted Purposes" as defined herein). For purposes of this paragraph, "Permitted Purposes" means the studies, analyses or other activities that are designed to promote quality health care outcomes, manage health care and administrative costs, and enhance business and performance, including, but not limited to, utilization studies, cost analyses, benchmarking, modeling, outcomes studies, medical protocol development, normative studies, quality assurance, credentialing, network management, network development, fraud and abuse monitoring or investigation, administrative or process improvement, cost comparison studies, or reports for actuarial analyses. For purposes of this paragraph, "de-identified" means both member de-identification (as defined by HIPAA) and Employer de-identification (unless the work is being done in connection with Employer's Plan). Solely for the Permitted Purposes, Claim Administrator may release, or authorize the release of, de-identified data to a third-party data aggregation service or data warehouse and its customers. Such data warehouse and data aggregation service providers may charge their customers a fee for access to such data. Nothing in the paragraph is intended to expand or limit the terms and conditions of the BAA with respect to the permitted use or disclosure of PHI. The foregoing notwithstanding, the Blue Cross and Blue Shield Association and its support vendors are permitted to have internal access to Claim Administrator's assigned Employer Group and Identification number. In the event that Claim Administrator desires to use and/or disclose a "limited data set" as such term is defined in HIPAA, the Parties will in good faith negotiate a separate data use agreement governing the use and/or disclosure of such limited data set, provided that Employer will be under no obligation to enter into any such data use agreement with Claim Administrator.

SECTION 4: LITIGATION, LEGAL PROVISIONS, ERRORS AND DISPUTE RESOLUTION

4.1 **Litigation.** Employer accepts this Section 4.1 only to the extent authorized by the laws of the State of Texas and subject to the consent of the Attorney General of the State of Texas. Each Party shall, to the extent practical, advise the other party of any legal actions brought by any third party against one or both Parties that specifically or directly concern (a) the terms of or administration of the Plan, or (b) the obligations of either Party under the Plan and this Agreement. The Employer shall undertake the defense of such action, excluding any action alleging only claims based on a breach of this Agreement, negligence, or intentional misconduct by Claim Administrator, (as opposed to any action that may assert such claims but also includes a dispute over the payment or availability of benefits). In the event legal action alleges liability that is the direct consequence of negligent, fraudulent or criminal acts or omissions of the Claim Administrator in its performance of its responsibilities under this Agreement, as opposed to an action that includes any underlying dispute over the payment or availability of benefits, Employer may request that Claim Administrator undertake defense of any such action and be responsible for the costs of defense; provided, however, that the Claim Administrator shall have the option, at its sole discretion, to employ attorneys selected by it to defend any such action, the costs and expenses of which shall be the responsibility of the Claim Administrator. It is further agreed that each Party (provided no conflicts of interest exist and subject to the consent of the Attorney General of the State of Texas) shall fully cooperate with the other Party in the defense of any action arising out of matters related to the Plan or this Agreement.

4.2 **Claim Overpayments.** Employer acknowledges that unintentional administrative errors may occur. If Claim Administrator becomes aware of a Claim Overpayment to a Provider or Covered Person, Claim Administrator will make a diligent attempt to recover any such payment by following its recovery processes, including, but not necessarily limited to, those items described below ("Recovery Process(es)"). Claim Administrator, however, will not be required to enter into litigation to obtain a recovery, unless specifically provided for elsewhere in this Agreement, nor will Claim Administrator be required to reimburse the Plan, except for when gross negligence or intentional misconduct by Claim Administrator caused the Overpayment.

Recovery Process. Claim Administrator, on behalf of Employer, or on behalf of itself as an insurer, has the right to obtain a refund of an Overpayment from a Provider or a Covered Person. Unless otherwise agreed upon between Claim Administrator and the Provider, when a Provider fails to return an Overpayment to Claim Administrator, Claim Administrator has the right to utilize the following mechanisms to recover the Overpayment:

For purposes of Sections a. – e. below, "Other Plan(s)" or "Another Plan" means any health benefit plan, including, but not limited to, individual and group plans or policies administered or insured by Claim Administrator.

a. **Reductions from Future Payments to Network Providers.** Claim Administrator has the right to offset future payments owed to the Provider: (i) from the Plan, or, (ii) if the Provider is a Network Provider, from Other Plans, up to an amount equal to the Overpayment (collectively, "Offset").

b. **Cross-Plan Offsets for Network Providers.** Claim Administrator has the right to reduce Another Plan's payment to a Network Provider by the amount necessary to recover the Plan's Overpayment to the same Network Provider and to remit the recovered amount to Employer (net of fees, if any). Likewise, Claim Administrator has the right to reduce the Plan's payment to a Network Provider by the amount necessary to recover Another Plan's Overpayment to the same Network Provider and to remit the recovered amount to the Other Plan (each, a "Cross-Plan Offset").

c. **Division of Recovery for Multiple Plans.** If Claim Administrator has made Overpayments to a Network Provider for more than one (1) Other Plan, Claim Administrator has the right to Offset two (2) or more of the Overpayments collectively, against future payments owed to Another Plan as part of a single transaction, resulting in an Overpayment recovery amount which shall be applied based on the age of the Overpayments, beginning with the oldest outstanding Overpayment, or has the right to Offset as otherwise set forth in this Section 4.

d. **Employer Authorization for Offsets and Cross-Plan Offsets.** Employer authorizes and directs Claim Administrator to perform Offsets and Cross-Plan Offsets. Cross-Plan Offsets will be carried out consistent with the terms of the Provider contract. Notwithstanding the foregoing, Employer acknowledges and agrees that claims processed through Inter-Plan arrangements with other Blue Cross and/or Blue Shield licensees operate under rules and procedures issued by the Association, and the recovery policies and procedures of each Blue Cross and/or Blue Shield independent licensee may apply.

e. **No Independent Right of Recovery.** Subject to the exception(s) set forth in this Section 4, Employer agrees that Claim Administrator will recover Overpayments in accordance with its Recovery Process and that Employer has no separate or independent right to recover any Provider Overpayment from Claim Administrator, Providers, or Another Plan.

4.3 **Third-Party Recovery Vendors and Outside Attorneys.** To assist in the recovery of payments, Claim Administrator may engage a third party to assist in identification or collection of recovery amounts related to Claim Payments made under the Agreement. In such event, the recovered amounts will be applied according to Claim Administrator's refund recovery policies. Claim Administrator may also engage a third party to assist in the review of Providers' Claim coding or billing to identify discrepancies post Claim Payment. Third-parties' fees associated with such assistance and Claim Administrator's fee for its related administrative expenses to support such third-party recovery identification and collection will be paid by Employer and are separate from and in addition to the Reimbursement Fees set forth in the ASO BPA.

4.4 **Claim Administrator Indemnifies Employer.** Claim Administrator hereby agrees to indemnify and hold harmless Employer and its directors, officers and employees against any and all loss, liability, damages, penalties and expenses, including reasonable attorneys' fees, or other cost or obligation resulting from or arising out of claims, lawsuits, demands, settlements or judgments with respect to this Agreement resulting from or arising out of any acts or omissions of Claim Administrator or its directors, officers or employees (other than acts or omissions of Claim Administrator done at Employer's express direction) which have been adjudged to be (i) grossly negligent, dishonest fraudulent or criminal or (ii) in material breach of the terms of this Agreement.

4.5 **Employer Indemnifies Claim Administrator.** To the extent permitted by applicable Texas law, Employer agrees to indemnify and hold harmless Claim Administrator and its directors, officers and employees against any and all loss, liability, damages, fines, penalties, taxes and expenses, including attorneys' fees

and costs, or other cost or obligation to the extent resulting from or arising out of claims, lawsuits, demands, governmental inquiries or actions, settlements or judgments brought or asserted against Claim Administrator in connection with the design, operation, or administration of the Plan, including but not limited to (a) the Plan's grandfathered health plan status, if applicable, (b) the Plan's exempt plan status, if applicable, (c) any provision of inaccurate information to Claim Administrator, (d) any disclosure of information Employer directs Claim Administrator to make to Employer Vendor(s) or (e) selection of Employer's Essential Health Benefits benchmark for the purpose of ACA; unless the liability therefor was the direct consequence of the acts or omissions of Claim Administrator or its directors, officers or employees (other than acts or omissions of Claim Administrator done at Employer's direction) and the acts or omissions are adjudged to be (i) grossly negligent, dishonest, fraudulent or criminal or (ii) in material breach of the terms of this Agreement. Notwithstanding the above, Employer agrees that it is responsible, to the extent permitted under Texas law, for its own acts or omissions related to this Contract.

4.6 **Assignment.** Except as otherwise permitted by Section 1 of this Agreement, no part of this Agreement, or any rights, duties or obligations described herein, shall be assigned, transferred, or delegated, directly or indirectly, without the prior express written consent of both Parties. Any such attempted assignment in the absence of the prior written consent of the Parties shall be null and void. Claim Administrator's contractual arrangements for the acquisition and use of facilities, services, supplies, equipment and personnel shall not constitute an assignment or delegation under this Agreement. This Agreement shall, however, be binding on any permitted assignees, delegates or successors to the Parties.

4.7 **Applicable Law.** This Agreement shall be governed by and construed in accordance with applicable federal laws and the laws of the State of Texas without regard to any state choice–of–law statutes. Texas. Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of the Services.

4.8 **Notice and Satisfaction.** Unless specifically stated otherwise in this Agreement or in any written Exhibit or Addenda thereto, Employer and Claim Administrator agree to give one another written notice (in accordance with this section) 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, including but not limited to initiation of Dispute Resolution under Section 4.9 below. The written notice shall provide a description of the complaint or concern in such reasonable detail as to allow the notified Party the opportunity to make the necessary modifications within the agreed upon term. All notices given under this Agreement shall be deemed to have been given for all purposes when personally delivered and received or when deposited in the United States mail, first–class postage prepaid, and addressed to the Parties' respective contact names at their respective addresses or when transmitted by facsimile via their respective facsimile numbers as indicated on the most current ASO BPA. Each Party may change such notice mailing and/or transmission information upon prior written notification to the other Party. Each Party may also provide such notices electronically, to the extent permitted by applicable law.

4.9 **Limitation of Liability.** To the extent permitted by the laws of the State of Texas, no action or dispute shall be brought to recover under this Agreement after the expiration of three (3) years from the date the cause of action accrued. As part of the consideration for services provided by Claim Administrator and for the fees paid by Employer under this Agreement, except as otherwise agreed below or otherwise prohibited by Law and excluding Claim Administrator's obligations under Section 4.4, Claim Administrator's liability (whether in contract, tort, or any other liability at law or equity) for any errors or omissions by Claim Administrator (or its officers, directors, employees, agents or independent contractors) in connection with this Agreement shall not exceed the maximum benefits which should have been paid under the terms of the Plan had the errors or omissions not occurred (plus Claim Administrator's share of any dispute resolution expenses incurred), unless any such errors or omissions are adjudged to be the result of intentional misconduct, gross negligence, material breach of this Agreement, fraud or criminal actions by Claim Administrator.

4.10 **Dispute Resolution.** Any dispute arising out of or related to this Agreement shall be resolved in accordance with the procedures specified in this section, which shall be the sole and exclusive procedures for the resolution of any such disputes.

a. **Initial Notice and Negotiation.** Employer or Claim Administrator shall give written notice to the other party of the existence of a dispute. Within sixty (60) days of receipt of the written notice, the Parties shall seek to resolve that dispute through informal discussions between authorized

representatives of the Parties with appropriate authority to approve any resolution. All negotiations pursuant to this section are confidential and shall be treated as compromise and settlement negotiations for purposes of applicable rules of evidence.

b. **Claim Administrator Contends that Employer is in Breach.** Contract Administrator shall use, to the extent applicable, the dispute resolution process provided in Chapter 2260, *Texas Government Code*, and the related rules adopted by the Texas Attorney General to attempt to resolve any claim for breach of contract made by Contract Administrator that cannot be resolved in the ordinary course of business. Contract Administrator shall submit written notice of a claim of breach of contract under this chapter to Employer's designated official, who will examine Contract Administrator's claim and any counterclaim and negotiate with Contract Administrator in an effort to resolve the claim.

c. **Employer Contends that Claim Administrator is in Breach.** If Employer contends that Claim Administrator is in breach of this Agreement, Employer may notify Claim Administrator in writing that Employer is submitting the dispute to mediation. Within 15 days after such notice, the Parties shall select a mutually acceptable mediator in Texas, and neither Party may unreasonably withhold consent to the selection of a mediator. The Parties shall share equally the costs of the mediator. The Parties shall use reasonable efforts to conduct the mediation within 60 days after retention of the mediator. The mediation will be a compromise negotiation for purposes of Rule 408 of the Federal Rules of Evidence and Texas Rules of Evidence and is an alternative dispute resolution procedure subject to Section 154.073 of the Texas Civil Practice & Remedies Code. Nothing in this Paragraph 4.9c prevents a Party from resorting to judicial proceedings (i) solely for obtaining necessary injunctive relief; (ii) if the other party refuses to engage in good faith selection of a mediator or to attend mediation, or (iii) or if the duly appointed mediator declares an impasse.

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

SECTION 5: NON-ERISA GOVERNMENT REGULATIONS

5.1 **In Relation to the Plan.** Although Employer has advised Claim Administrator that Employer's Plan is currently not covered by ERISA, Employer hereby acknowledges (i) its employee benefit plan is established and maintained through a plan document, 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 Employer, Employer agrees that Claim Administrator does not and will not accept any allocation or delegation of any responsibilities under the Plan or any other plan document of Employer and no such allocation or delegation is effective with respect to or accepted by Claim Administrator. Employer will promptly notify Claim Administrator in the event Employer's Plan is no longer exempt from ERISA.

5.2 **In Relation to the Plan Administrator/Named Fiduciary(ies).** Claim Administrator is not the plan administrator of Employer's employee benefit plan and is not a fiduciary of Employer, the plan administrator or of the Plan.

5.3 **In Relation to Claim Administrator's Responsibilities.** 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 Employer's Plan. As such, the Parties intend for Claim Administrator to be a service provider but not a fiduciary with respect to Employer's employee benefit plan. Employer acknowledges and agrees that Claim Administrator may render advice with respect to claims and administer claims on behalf of the plan administrator of Employer's benefit plan. Claim Administrator has no other authority or responsibility with respect to Employer's employee benefit plan. Employer will promptly notify Claim Administrator in the event Employer's Plan is no longer exempt from ERISA.

SECTION 6: OTHER PROVISIONS

6.1 **Term and Termination.** This Agreement will continue in full force and effect from the effective date through the end of the term specified on the first page of this Agreement unless terminated as provided herein. At the end of the current period, with satisfactory performance and renegotiation of fees agreed to by both Parties, this Agreement may be renewed for up to an additional three-year period. This Agreement may be terminated as follows:

- **a.** By either Party at the end of any month after the end of the Fee Schedule Period indicated in the Fee Schedule specifications of the most current ASO BPA with ninety (90) days prior written notice to the other party; or
- **b.** By both Parties on any date agreed to in writing; or
- **c.** By either Party, in the event of conduct by the other Party constituting fraud, misrepresentation of material fact or material breach of the terms of this Agreement, upon written notice and following expiration of the cure period as provided under Section 4.7 above; or
- **d.** By Claim Administrator, if Employer fails to pay Timely all amounts due under this Agreement i as provided in Section 7.1 of Exhibit 2 of this Agreement.

6.2 **Relationship of the Parties and Non-Parties.** Claim Administrator is an independent contractor with respect to Employer. Neither Party shall be construed, represented or held to be an agent, partner, associate, joint venturer nor employee of the other. Nothing in this Agreement shall create or be construed to create the relationship of employer and employee between Claim Administrator and Employer; nor shall Employer's agents, officers or employees be considered or construed to be employees of Claim Administrator for any purpose whatsoever. 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 Employer and their dependents.

Claim Administrator or its subsidiaries or affiliates may also have ownership interests in certain providers who provide Covered Services to Covered Persons, and/or in vendors or other third parties who provide services related to this Agreement or provide services to certain providers. Upon Employer request (not more than once per calendar year), Claim Administrator will provide a list of such entities to Employer.

6.3 **Entire Agreement.** This Agreement, including all Exhibits and Addenda of this Agreement, represents the entire agreement and understandings of the Parties with respect to the subject matter of this Agreement. All prior or contemporaneous agreements, understandings, representations, promises, or warranties, whether written or oral, in regard to the subject matter of this Agreement, including any and all proposal documents submitted by Claim Administrator to Employer (collectively, the "Prior Communications") are superseded, except as otherwise expressly incorporated into this Agreement. The provisions of this Agreement shall prevail in the event of a conflict with any Prior Communications that either Party or a third party asserts to be a component of the Agreement between the Parties.

The Exhibits and Addenda of this Agreement are:

- **a.** Exhibit 1 - Claim Administrator Services
- **b.** Exhibit 2 - Fee Schedule and Financial Terms
- **c.** Exhibit 3 - Notices/Required Disclosures
- **d.** Exhibit 4 - ASO Benefit Program Application ("ASO BPA")
- **e.** Exhibit 5 – Blue Cross Blue Shield Association Disclosures and Provisions
- **f.** Exhibit 6 – Business Associate Agreement

6.4 **Amending.** This Agreement may be amended only by mutual written agreement of the Parties. Notwithstanding the foregoing, (i) any amendments required by law, regulation or order ("Law") or (ii) if in the opinion of Claim Administrator, relying on the advice of legal counsel, an amendment is necessary to ensure compliance to requirements under Claim Administrator's licensing agreement with the Blue Cross and Blue Shield Association, may be implemented by Claim Administrator upon sixty (60) calendar days' prior notice to Employer or such time period as may be required by law, provided that any amendment referenced in subsection (ii) does not materially change the Services provided by Claim Administrator under this Agreement. For an amendment referenced in subsection (ii), upon request by Employer Claim

Administrator will provide an opinion of its legal counsel addressed to Employer confirming the necessity of the Amendment, if in Claim Administrator's sole opinion, the Amendment creates a material change to the Services provided under this Agreement. Amendments required by Law shall be effective retroactively, if applicable, as of the date required by such Law. If Employer objects to such amendment within sixty (60) days of receipt of notice of such amendment, the Parties shall then engage in good faith negotiations to amend the amendment. If the Parties cannot agree on terms of the amendment in a satisfactory manner, either Party shall be allowed to proceed to dispute resolution, as set forth in Section 4.

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

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

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, terrorism, cybersecurity crimes or restraints of government (each a "Force Majeure Event"), so long as (a) that Party uses reasonable efforts to perform those obligations, (b) that Party's inability to perform those obligations is not due to its failure to (1) take reasonable measures to protect itself against events or circumstances of the same type as that Force Majeure Event or (2) develop and maintain a reasonable contingency plan to respond to events or circumstances of the same type as that Force Majeure Event, and (3) that Party complies with its obligations under this paragraph. If a Force Majeure Event occurs, the noncomplying Party shall promptly notify the other Party of the occurrence of that Force Majeure Event, its effect on performance, and how long the noncomplying Party expects it to last. Thereafter the noncomplying Party shall update that information as reasonably necessary. During a Force Majeure Event, the noncomplying Party shall use reasonable efforts to limit damages to the other party and to resume its performance under this Agreement.

Certain provisions of this Agreement survive expiration or termination of the Agreement, whether expressly or by their nature. These include, but are not limited to, the following: Section 1 "Claim Administrator Responsibilities"; Section 2 "Employer Responsibilities"; Section 3 "Confidential Data, Information and Records"; Section 4 "Litigation, Legal Provisions, Errors and Dispute Resolution" (for acts or omissions occurring during the term of the Agreement or under Section 8 of Exhibit 2); and Section 8 of Exhibit 2 "Financial Obligations Upon Agreement Termination."

6.6 Notice of Annual Meeting. Employer is hereby notified that it is a member of Health Care Service Corporation ("HCSC"), a Mutual Legal Reserve Company, and is entitled to vote either in person, by its designated representative, or by proxy at all meetings of members of said Company, consistent with HCSC bylaws. The annual meeting is scheduled to be held at its principal office at 300 East Randolph Street, Chicago, Illinois, each year on the last Tuesday in October at 12:30 P.M. For purposes of this Section, the term "member" means the group, trust, association or other entity with which this Agreement has been entered. It does not include Covered Employees or Covered Persons under the Plan. Employer is also hereby notified that, from time to time, Claim Administrator pays indemnification or advances expenses to a director, officer, employee or agent consistent with HCSC's bylaws then in force and as otherwise required by applicable law.

6.7 **Access by Individuals with Disabilities.** Claim Administrator represents and warrants that the electronic and information resources and all associated information, documentation, and support that it provides to Employer under this Agreement (collectively, the "EIRs") comply with the applicable requirements set forth in Title 1, Chapter 213 of the Texas Administrative Code and Title 1, Chapter 206, §206.70 of the Texas Administrative Code (as authorized by Chapter 2054, Subchapter M of the Texas Government Code). To the extent Claim Administrator becomes aware that the EIRs, or any portion thereof, do not comply, then Claim Administrator shall, at no cost to Employer, either (1) perform all necessary remediation or (2) replace the EIRs with new EIRs. In the event that Claim Administrator fails or is unable to do so, then Employer may terminate this

Agreement and Claim Administrator will refund to Employer all amounts Employer has paid under this Agreement within thirty (30) days after the termination date.

6.8 **Certification as to Contracts with Companies Boycotting Israel.** If this Agreement has a value of $100,000 or more and if Claim Administrator is a company, other than a sole proprietorship, with ten or more fulltime employees, then pursuant to Texas Government Code § 2271.002, Claim Administrator certifies that Claim Administrator does not boycott Israel and will not boycott Israel during the term of this Agreement. For purposes of this provision, "company" and "boycott Israel" have the meanings provided in Texas Government Code § 808.001.

6.9 **Certification as to Business with Certain Countries and Organizations.** Pursuant to Chapter 2252, Texas Government Code, Claim Administrator certifies that Claim Administrator is not engaged in business with Iran, Sudan, or a foreign terrorist organization. Employer may terminate this Agreement if this certification is inaccurate.

6.10 **Certification as to Contracts Related to Persons Involved in Human Trafficking.** Pursuant to Section 2155.0061, Texas Government Code, Claim Administrator certifies that Claim Administrator is not ineligible to enter into this Agreement due to financial participation by a person who, during the five-year period preceding the date of this Agreement, has been convicted of any offense related to the direct support or promotion of human trafficking, and acknowledges that Employer may terminate this Agreement and withhold payment if this certification is inaccurate.

6.11 **Conflict of Interest.** Claim Administrator and each person signing on behalf of Claim Administrator certifies, and in the case of a sole proprietorship, partnership or corporation, each party thereto certifies as to its own organization, that to the best of their knowledge and belief, no member of Employer or Employer's Board of Regents, nor any employee or person whose salary is payable in whole or in part by Employer, has direct or indirect financial interest in the award of this Agreement, or in the services to which this Agreement relates, or in any of the profits, real or potential, thereof.

6.12 **Debts or Delinquencies.** Pursuant to Section 2252.903, Texas Government Code, any payments owing to Claim Administrator under this Agreement may be applied directly toward certain debts or delinquencies that Claim Administrator owes the State of Texas or any agency of the State of Texas regardless of when they arise, until such debts or delinquencies are paid in full.

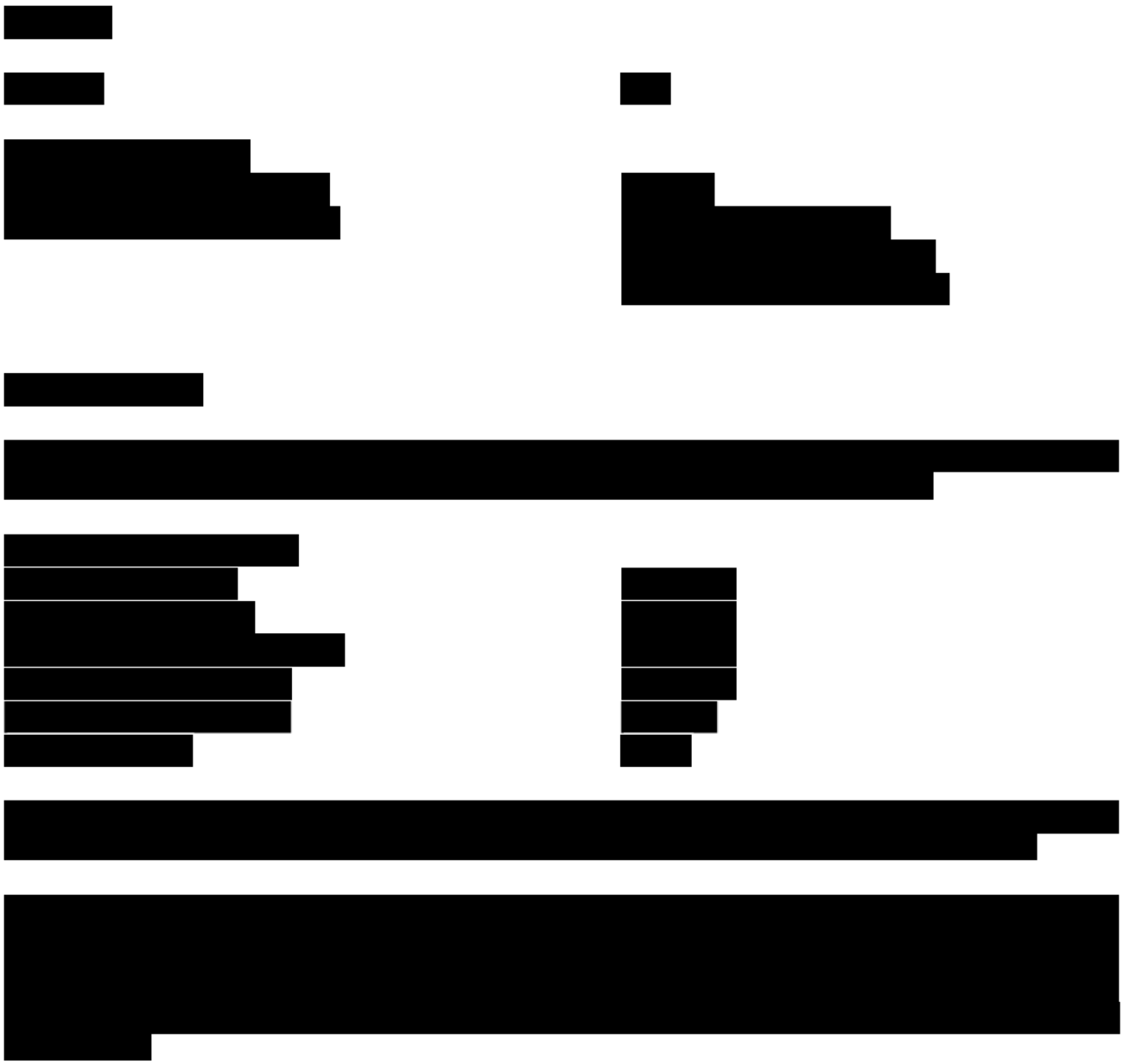
6.13 **Delinquent Child Support Obligations.** A child support obligor who is more than 30 days delinquent in paying child support and a business entity in which the obligor is a sole proprietor, partner, shareholder, or owner with an ownership interest of at least 25% is not eligible to receive payments from state funds under an agreement to provide property, materials, or services until all arrearages have been paid or the obligor is in compliance with a written repayment agreement or court order as to any existing delinquency. The Texas Family Code requires the following statement: "Under Section 231.006, Texas Family Code, the vendor or applicant certifies that the individual or business entity named in this contract, bid, or application is not ineligible to receive the specified grant, loan, or payment and acknowledges that this contract may be terminated, and payment may be withheld if this certification is inaccurate."

6.14 **Not Eligible for Rehire.** Claim Administrator shall ensure that its employees performing services under this Agreement have not been designated by Employer as Not Eligible for Rehire as defined in Employer Policy 32.02, Section 4. Employer shall, upon request from Claim Administrator, verify the Not Eligible for Rehire status of Claim Administrator employees.

6.15 **Public Information.** Claim Administrator acknowledges that Employer is obligated to strictly comply with the Public Information Act, Chapter 552, Texas Government Code, in responding to any request for public information pertaining to this Agreement, as well as any other disclosure of information required by applicable Texas law. Upon Employer's written request, Claim Administrator shall provide specified public information exchanged or created under this Agreement that is not otherwise excepted from disclosure under Chapter 552, Texas Government Code, to Employer in a non-proprietary format acceptable to Employer. As used in this provision, "public information" has the meaning assigned in Section 552.002, Texas Government Code, but only includes information to which Employer has a right of access. Claim Administrator acknowledges that Employer may be required to post a copy of the fully-executed Agreement on Employer's website in compliance with Section 2261.253(a)(1), Texas Government Code.

6.16 **Records Retention.** Claim Administrator shall preserve all contracting information, as defined under Texas Government Code Section 552.003(7), related to this Agreement for the duration of this Agreement and for seven years after the conclusion of this Agreement.

6.17 **Insurance**. Claim Administrator shall obtain and maintain, for the duration of this Agreement or longer, the minimum insurance coverage set forth below. All coverage shall be underwritten by companies authorized to do business in the State of Texas or eligible surplus lines insurers operating in accordance with the Texas Insurance Code and have a financial strength rating of A- or better and a financial strength rating of VII or better as measured by A.M. Best Company or otherwise acceptable to Employer. By requiring such minimum insurance, Employer shall not be deemed or construed to have assessed the risk that may be applicable to Claim Administrator under this Agreement. Claim Administrator shall assess its own risks and if it deems appropriate and/or prudent, maintain higher limits and/or broader coverage. Claim Administrator is not relieved of any liability or other obligations assumed pursuant to this Agreement by reason of its failure to obtain or maintain insurance in sufficient amounts, duration, or types. No policy will be canceled without written notice to Employer at least ten days before the effective date of the cancellation.



Claim Administrator will deliver to Employer evidence of insurance on a Texas Department of Insurance approved certificate evidencing types and limits agreed to in this section. Evidence of insurance will be provided on a Texas Department of Insurance approved certificate form verifying the continued existence of all required insurance no later than 30 days after each annual insurance policy renewal.

Commercial general liability and auto liability shall list The Board of Regents for and on behalf of The Texas A&M University System and Employer as Additional Insureds. Commercial General Liability shall be on a primary and non-contributory basis.

Commercial general liability, auto liability, and workers compensation policies shall provide a waiver of subrogation in favor of The Board of Regents of The Texas A&M University System and Employer.

Certificates of Insurance required by this Agreement will be mailed, faxed, or emailed to the following Employer contact:

Name: Sheri Meyer

Address: 301 Tarrow Street, 5th Floor, College Station, TX 77845

Facsimile Number: (979) 458-6247

Email Address: s-meyer@tamus.edu

The insurance coverage required by this Agreement will be kept in force until all services have been fully performed and accepted by Employer in writing.

SECTION 7: DEFINITIONS

Capitalized terms used in this Agreement shall have the meanings set forth in this Section 7, unless otherwise provided in the Agreement.

7.1 **"Administrative Charge"** means the monthly service charge that is required by Claim Administrator for the administrative services performed under this Agreement. The Administrative Charge(s) is set forth in the Fee Schedule.

7.2 "**Allowable Amount**" means the maximum amount determined by Claim Administrator to be eligible for consideration of payment for a Covered Service in accordance with the type of medical and dental benefits coverage(s) elected on the most current ASO BPA.

a. [redacted]

[redacted]

7.3 **"Business Confidential Information"** means, but is not limited to, intellectual property, trade secrets, inventions, applications, tools, methodologies, software, operating manuals, technology, technical documentation, techniques, product or services specifications or strategies, operational plans and methods, automated claims processing systems, payment systems, membership systems, privacy and security measures, cost or pricing information (including but not limited to provider discounts and rates), business

plans and strategies, company financial planning and financial data, prospect and customer lists, contracts, vendor and supplier lists and information, symbols, designs, copyrights, know-how, data, databases, processes, plans, procedures, and any other information developed, acquired or owned by Claim Administrator, its subsidiaries and affiliates, and its contracted vendors, including information acquired from other Blue Cross and Blue Shield licensees through Inter-Plan arrangements, that reasonably should be understood to be confidential, whether developed or acquired before or after the Effective Date of this Agreement. Business Confidential Information also includes modifications, enhancements, derivatives and improvements of the Business Confidential Information described in the preceding sentence. Business Confidential Information does not include (a) any information that must be disclosed to a requestor in the determination of the Open Records Division pursuant to the Texas Public Information Act; (b) this Agreement, unless the information is excepted from disclosure under the Texas Public Information Act; (c) information that: (1) is or becomes publicly known or available other than as a result of a breach of this Agreement by Employer; (2) was already in the possession of Employer as the result of disclosure by an individual or entity that was not then obligated to keep that information confidential; (3) Claim Administrator had disclosed or discloses to an individual or entity without confidentiality restrictions; or (4) Employer had developed or develops independently without benefit of the information whether the equivalent information is disclosed before or after by Claim Administrator to the Employer; or (d) any information that Employer is obligated to provide to a Covered Person under the Plan.

7.4 **"Claim"** means a properly completed notification in a form acceptable to Claim Administrator, including but not limited to, form and content required by applicable law, that service has been rendered or furnished to a Covered Person. This notification must set forth in full the details of such service including, but not limited to, the Covered Person's name, age, sex and identification number, the name and address of the Provider, a specific itemized statement of the service rendered or furnished (including appropriate codes), the date of service, applicable diagnosis (including appropriate codes), the Claim Charge, and any other information which Claim Administrator may request in connection for such service.

7.5 **"Claim Charge"** means the amount which appears on a Claim as the Provider's regular charge for service rendered to a patient, without further adjustment or reduction.

7.6 **"Claim Payment"** means the benefit calculated by Claim Administrator, plus any related Surcharges, upon submission of a Claim, in accordance with the benefits specified in the Plan for which Claim Administrator has agreed to provide administrative services. All Claim Payments shall be calculated on the basis of the Provider's Allowable Amount, in accordance with the benefit coverage(s) elected on the most current ASO BPA, for Covered Services rendered to the Covered Person. The term "Claim Payment" also includes Employer's share of Alternative Provider Compensation Arrangement Payments, whether billed to Employer as part of a Claim or billed separately, as described in the definition of "Alternative Provider Compensation Arrangement Payments."

7.7 **"Coinsurance"** means a percentage of an eligible expense that a Covered Person is required to pay toward a Covered Service.

7.8 **"Copayment"** means a specified dollar amount that a Covered Person is required to pay toward a Covered Service.

7.9 **"Covered Employee"** shall have the same meaning as defined in Employer's Plan to the extent consistent with the applicable ASO BPA.

7.10 **"Covered Person"** shall have the same meaning as defined in Employer's Plan to the extent consistent with the applicable ASO BPA.

7.11 **"Covered Service"** means a service or supply specified in the Plan for which benefits will be provided and for which Claim Administrator has agreed to provide administrative services under this Agreement.

7.12 **"Employer Data"** includes any data with respect to Employer and related to Covered Persons that is provided by Employer to Claims Administrator or that is developed by Claim Administrator on behalf of Employer, excluding any and all of the Business Confidential Information of Claim Administrator, other Blue Cross and/or Blue Shield companies, or Claim Administrator's subsidiaries, affiliates, and vendors ("Employer Data"), in the possession of Claim Administrator are and will remain the property of the Employer.

7.13 **"ERISA"** means the Employee Retirement Income Security Act of 1974, as amended.

7.14 **"Fee Schedule"** means the fees and charges specified in the initial ASO BPA, including but not limited to, the Administrative Charge and other service charges; or subsequent fees and charges set forth in a subsequent ASO BPA as replacement or supplement to the initial ASO BPA. 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 Exhibit 2.

7.15 **"Fee Schedule Period"** means the period of time indicated in the Fee Schedule and, if applicable, the PBM Fee Schedule Addendum of the most current ASO BPA.

7.16 **"HIPAA"** means the Health Insurance Portability and Accountability Act and its implementing regulations (45 C.F.R. Parts 160-164) and the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009, and its implementing regulations, each as amended, and their respective implementing regulations, as issued and amended by the Secretary of Health and Human Services.

7.17 **"Home Health Agency"** means a business that provides Home Health Care and is licensed, approved, or certified by the appropriate agency of the state in which it is located or is certified by Medicare as a supplier of Home Health Care.

7.18 **"Home Health Care"** means the health care services for which benefits are provided under the Plan when such services are provided during a visit by a Home Health Agency to patients confined at home due to a sickness or injury requiring skilled health services on an intermittent, part-time basis.

7.19 **"Hospital"** means a duly licensed institution for the care of the sick which provides service under the care of a Physician including the regular provision of bedside nursing by registered nurses. It does not mean health resorts, rest homes, nursing homes, skilled nursing facilities, convalescent homes, custodial homes of the aged or similar institutions.

7.20 **"Inpatient"** means the Covered Person is a registered bed patient and treated as such in a health care facility.

7.21 **"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 Claim Administrator (and, in some instances, with other participating Blue Cross and/or Blue Shield Plans) for participation in a participating provider option and/or point–of–service managed care health benefits coverage program(s), if applicable to the Plan under this Agreement.

7.22 **"Outpatient"** means a Covered Person's receiving of treatment while not an Inpatient. Services considered Outpatient include, but are not limited to, services in an emergency room regardless of whether the Covered Person is subsequently registered as an Inpatient in a health care facility.

7.23 **"Overpayment"** means a payment to a Provider or a Covered Person that was more than it should have been, or a payment that was made in error.

7.24 **"Physician"** means a physician duly licensed to practice medicine in any of its branches recognized by applicable state law.

7.25 **"Plan**" means, as applied to this Agreement, the separate self-insured group health plan as defined by Section 160.103 of HIPAA.

7.26 **"Primary Care Physician"** means a Physician who is a Network Provider at the time Covered Services are rendered who is selected by or assigned to a Covered Person to coordinate and arrange for the Covered Person's medical care and who provides medical care within the scope of a license permitting him/her to legally practice medicine in one of the recognized areas of pediatrics, obstetrics and gynecology (if applicable), internal medicine and family practice.

7.27 **"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.

7.28 **"Reminder Notice"** means a notice sent when claims have not been paid within ten (10) days.

7.29 **"Supplemental Charge"** means a fee or charge payable to Claim Administrator by Employer in addition to the fees and charges set forth in the Fee Schedule specifications of the most current 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 applicable Fee Schedule specifications of

the most current ASO BPA. Such services and/or supplies and any applicable Supplemental Charge(s) are to be agreed upon by the parties in advance.

7.30 **"Surcharges"** means local, state or federal taxes, surcharges or other fees or amounts, including, but not limited to, Blue Cross Blue Shield Global Core Access Vendor 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 Claim Administrator which are imposed upon or resulting from this Agreement, or are otherwise payable by or through Claim Administrator. Upon request, Employer shall furnish to Claim Administrator in a Timely manner all information necessary for the calculation or administration of any Surcharges. Surcharges may or may not be related to a particular claim for benefits. In no event will Claim Administrator be responsible for the Reinsurance Contribution.

7.31 **"Timely"** means the following:

a. With respect to all payments due Claim Administrator by Employer under this Agreement, weekly claim invoices are due within forty-eight (48) business hours of notification to Employer by Claim Administrator, monthly fees (e.g. Administrative Charges) are due within thirty (30) calendar days of notification to Employer by Claim Administrator; or

b. With respect to all information due Claim Administrator by Employer concerning Covered Persons, within sixty (60) 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 Claim Administrator by 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; or

d. With respect to any information requested by Claim Administrator, within thirty-one (31) calendar days of the request.

EXHIBIT 1
CLAIM ADMINISTRATOR SERVICES

- **CLAIMS ADJUDICATION**

  Determination of payment levels of Claims according to Employer's directions on applicable benefit plan terms and design, including determination of pre-service or prior authorization of services. Employer agrees that Claim Administrator will apply Claim Administrator's standard medical and utilization management criteria and policies and Coordination of Benefits (COB) processes for self-funded customers, unless otherwise provided on the ASO BPA.

- **EXPLANATION OF BENEFITS ("EOB")**

  Preparation of EOBs.

- **CLAIMS/MEMBERSHIP INQUIRIES**

  Providing responses to 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.

- **DISABLED DEPENDENT VERIFICATION**

  Determine the disabled status of any dependent children of Covered Persons, for purposes of administering the Group's age limit for eligibility. Determination will be made based on Claim Administrator's review of clinical information received by Claim Administrator from the Covered Person or the dependent's medical provider(s).

- **CLIENT SERVICES AND MATERIALS**

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

  a. ***Enrollment Materials.*** Claim Administrator's Marketing Administration Division will provide implementation materials during the enrollment process; any custom designed materials may be subject to Supplemental Charge.

  b. ***Standard Identification Cards.*** Prepare 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 a toll–free customer service telephone number.

  e. ***Medical Prior-Authorization Service Telephone Number.*** For those services determined by Employer and provided in writing to Claim Administrator that require prior authorization, advance Claim Administrator review of medical necessity, based on Claim Administrator's standard medical and utilization management criteria and policies, of such services covered under the Plan; access to toll–free medical prior-authorization service telephone number for Covered Persons and their health care Providers to call for assistance.

- **INTERNAL APPEALS**

  Determination of properly filed internal appeal requests received by Claim Administrator from a Covered Person or a Covered Person's authorized representative.

- **MEMBERSHIP**

  Using membership information provided to Claim Administrator by Employer to make claim and appeal determinations and for other purposes as described in the Agreement.

- **STANDARD REPORTS**

  Make available Claim data, Claim settlements (as outlined in Exhibit 2, Section 6) and periodic reports in Claim Administrator's standard format(s) in accordance with Claim Administrator's standard reporting processes at no additional charge. Any additional reports required by Employer must be mutually agreed upon by the Parties in writing prior to their development and may be subject to a Supplemental Charge.

- **STOP LOSS COORDINATION**

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

- **REPORTING SERVICES**

  Preparation and filing of annual Internal Revenue Service ("IRS") 1099 forms for the reporting of payments to health care Providers who render services to Covered Persons and who are reimbursed under the Plan for those services.

- **ACTUARIAL AND UNDERWRITING**

  Provide Claims projections and pricing of administrative services and stop–loss coverage. Actuarial analysis of changes in benefit design and relevant demographic and economic factors in the form of projected costs to enable the Employer to establish contribution levels.

- **FINANCIAL SERVICES**

  Financial functions such as cash receipts, cash disbursements, payroll and general ledger processing, general accounting, preparation of financial statements, billing, group settlement and wire transfers.

- **FRAUD DETECTION AND PREVENTION**

  Identify and investigate suspected fraudulent activity by Providers and/or Covered Persons and inform Employer of findings and proof of fraud applying Claim Administrator's standard processes.

- **EMPLOYER PORTAL (currently called "BLUE ACCESS® FOR EMPLOYERS")**

  Provide Employer with an on-line resource that allows employer the ability to perform a variety of plan administrative functions, currently managing membership and enrollment, inquiring about claims status, generating reports, and receiving billing information. Functions may be changed or added as they become available.

- **MEMBER PORTAL (currently called "BLUE ACCESS® FOR MEMBERS")**

  Provide Member with an on-line resource that allows individuals access to information about their healthcare coverage and benefits, currently verifying the status of finalized claims, receiving email notifications, accessing health and wellness information, verifying dependents coverage, and taking a health risk assessment. Information may be changed or added as it becomes available.

- **PROVIDER NETWORK(S)**

  If applicable to the health benefit Plan coverage(s) under the Agreement, establish, arrange and maintain a Network(s) through contractual arrangements with Providers.

- **MSP INFORMATION REPORTING**

  Pursuant to Exhibit 3, Section 7 entitled "Medicare Secondary Payer Information Reporting", reporting preparation and filing as required of Claim Administrator as Responsible Reporting Entity ("RRE") for the Plan as that term is defined in Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007.

- **UNCASHED FUNDS**

  Regarding outstanding funds that are or become "stale" (over three hundred and sixty-five (365) days old), issue notification letters to payees and upon completion of notification process, reissue such funds to payees based upon payee response, if any. When fund reissuance is not possible and unless stated otherwise in the Agreement, escheat such funds to state of payee's last known address on behalf of Employer or escheat amounts pursuant to such funds to Employer, as elected by Employer, less any amount(s) owed by payee to Claim Administrator, in accordance with Claim Administrator's established procedures and/or the applicable state's unclaimed property law.

- **ADDITIONAL SERVICES NOT SPECIFIED**

  Claim Administrator may provide additional services not specified in the Agreement; such services will be mutually agreed upon between the Parties in writing prior to their performance and may be subject to Supplemental Charge.

- **ACTIVITIES THAT ARE NOT CONSIDERED SERVICES**

  Claim Administrator does not provide Employer with software, facilities, phone systems, computers, database or information management, quality or security services, and the term "Services" does not include backroom operations such as support functions.

THE FOLLOWING IF ELECTED ON THE MOST CURRENT BPA

- **EXTERNAL REVIEW COORDINATION**

  Claim Administrator will coordinate external reviews of certain adverse benefit determinations for Employer as described and for the fee set forth in the most current ASO BPA and/or this Agreement. If elected on the ASO BPA, Claim Administrator's coordination includes reviewing external review requests to assess whether they meet eligibility requirements, referring requests to IROs, and reversing the Plan's determinations if so indicated by the IRO. External reviews shall be performed by an IRO and not Claim Administrator. Amounts received by Claim Administrator and IROs may be revised from time to time and may be paid each time an external review is undertaken.

- **WELLBEING MANAGEMENT**

  Provide a program that may include holistic health care management, including behavioral health care management, utilization management, maternity management, and 24/7 nurseline, and access to Well on Target digital tools and resources as determined by Employer and agreed to by Claim Administrator.

- **MASSACHUSETTS STATEMENTS OF CREDITABLE COVERAGE AND ELECTRONIC REPORTING**

  At the written direction of Employer, issuance of written statements of creditable coverage and related electronic reporting to the Massachusetts Department of Revenue with respect to Covered Persons subject to the Massachusetts Health Care Reform Act.

- **REFERENCE BASED PRICING ("RBP")**

  Assist Employer with establishing a maximum coverage amount for specified imaging, inpatient, and outpatient procedures derived from a pricing method based on either the Employee's or Provider's location, as elected by Employer in the most current ASO BPA.

- **VIRTUAL VISITS PROGRAM MANAGEMENT**

  Provide or arrange for a program that allows Covered Persons to access benefits for certain Covered Services remotely from virtual visit participating Providers via (i) interactive audio communication (via telephone or similar technology) and/or (ii) interactive audio/video examination and communication (via online portal, mobile app or similar technology), where available.

- **SUMMARY OF BENEFITS AND COVERAGE ("SBC")**

  Create SBCs for benefits Claim Administrator administers under this Agreement and provide SBCs to Employer and Covered Persons as described in the ASO BPA.

- **HEALTH ADVOCACY SOLUTIONS**

  Provide a program that may include utilization management, concierge customer service for Covered Persons from Health Advocates, behavioral health care management, incentives for Covered Persons, maternity benefit management, access by Covered Persons to digital tools and resources, or such other or alternative features as determined by Employer and agreed to by Claim Administrator.

EXHIBIT 2
FEE SCHEDULE AND FINANCIAL TERMS

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 ASO BPA. 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; or (iii) the date the Agreement is terminated (or, if applicable, in the case of the PBM Exhibit, the date such Exhibit is terminated).

Inter-Plan Arrangement Fees:

1.1 **BlueCard® Program/Network Access Fees* (as applicable):** Additional information is available upon request; included in the Claim Charge, if applicable;

1.2 **Negotiated Arrangement/Custom Fees (as applicable):** Additional information is available upon request; included in the medical Administrative Charge(s) noted in the ASO BPA and in any Termination Administrative Charge(s) noted in the ASO BPA calculated on the basis of such medical Administrative Charge(s);

1.3 **For Non-Participating Healthcare Providers Outside Claim Administrator's Service Area/processing fees (as applicable):** Additional information is available upon request; included in the medical Administrative Charge(s) noted in the ASO BPA and in any Termination Administrative Charge(s) noted in the ASO BPA calculated on the basis of such medical Administrative Charge(s).

**If applicable, such fees may not exceed the lesser of the applicable annual percentage of the discount (dependent upon group size) permitted under the BlueCard Program or $2,000 per Claim.*

SECTION 2: EXHIBIT DEFINITIONS

Other definitions applicable to this Exhibit are contained in Section 7 DEFINITIONS of the Agreement.

2.1 **"Employer Payment"** means the amount owed or payable to Claim Administrator by Employer for a given Employer Payment Period in accordance with Section 5 of this Exhibit which is the sum of Claim Payments made plus applicable service charges incurred during that Employer Payment Period.

2.2 **"Employer Payment Method"** means the method elected in the Fee Schedule specifications of the most current ASO BPA by which Employer Payments will be made.

2.3 **"Employer Payment Period"** means the time period indicated in the Fee Schedule specifications of the most current ASO BPA.

2.4 **"Medicare Secondary Payer ("MSP")"** means those provisions of the Social Security Act set forth in 42 U.S.C. §1395 y (b), and the implementing regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain employers may offer group health care coverage to Medicare–eligible employees, their spouses and, in some cases, dependent children. (See Exhibit 3 Section 7 titled "Medicare Secondary Payer Information Reporting.")

2.5 **"Run–Off Claim"** means a Claim incurred prior to the termination of the Agreement that is submitted for payment during the Run–Off Period.

2.6 **"Run–Off Period"** means the time period immediately following termination of the Agreement, indicated in the Fee Schedule specifications of the most current ASO BPA, during which Claim Administrator will accept Run-Off Claims submitted for payment.

2.7 **"Termination Administrative Charge"** means the consideration indicated in the Fee Schedule specifications of the most current ASO BPA that is required by Claim Administrator upon termination of the

Agreement, or the termination of Covered Employees but not the Agreement, including any services that may be performed by Claim Administrator during the Run–Off Period indicated on such ASO BPA.

SECTION 3: COMPENSATION TO CLAIM ADMINISTRATOR

3.1 ***Intent of Service Charges.*** Employer will pay service charges to Claim Administrator in accordance with the Fee Schedule specifications of the most current ASO BPA and PBM Exhibit, if applicable, as compensation for the processing of Claims and administrative and other services provided to Employer.

3.2 ***Determining Service Charges.*** The service charges, which are for the Fee Schedule Period indicated in the Fee Schedule specifications of the most current ASO BPA and PBM Exhibit, if applicable, have been determined in accordance with Claim Administrator's current regulatory status and Employer's existing benefit program.

3.3 ***Changing Service Charges.*** Such service charges shall be subject to change by Claim as follows:

a. At the end of the Fee Schedule Period indicated in the Fee Schedule specifications of the most current ASO BPA, provided that one hundred and twenty (120) days prior written notice is given by Claim Administrator;

b. On the effective date of any changes or benefit variances in the Plan, its administration by Employer, or the level of benefit valuation which would increase Claim Administrator's cost of administration;

c. On any date changes imposed by governmental entities increase expenses incurred by Claim Administrator, provided that such increases shall be limited to an amount sufficient to recover such increase in expenses;

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

e. The information upon which Claim Administrator's projections were based (benefit levels, census/demographics, producer/broker fees, etc.) becomes outdated or inaccurate; or On any date an affiliate, subsidiary, or other business entity is added or dropped by Employer.

3.4 ***Service Charges upon Termination.*** In the event the Agreement is terminated in accordance with the "Term and Termination" provisions of the Agreement, Employer will Timely pay Claim Administrator the Termination Administrative Charge indicated in the Fee Schedule specifications of the most current ASO BPA.

3.5 ***Additional Service Charges.*** In addition to the amounts due and payable each month in accordance with the Fee Schedule specifications of the most current ASO BPA, Claim Administrator may charge Employer for:

a. Any applicable Supplemental Charge(s);

Reasonable fees for the reproduction or return of Claim records requested by Employer, a governmental agency or pursuant to a court order, and/or

b. Any other fees that may be assessed by third parties for services rendered to Employer, a portion of which may be retained by Claim Administrator as compensation for Claim Administrator's support of such services; and/or

c. Any other fees for services agreed upon by the Parties in writing.

3.6 ***Effect of Plan Enrollment.*** Administrative Charges will be paid based upon information Claim Administrator receives regarding current Plan enrollment as of the first day of each month. Appropriate adjustments will be made for enrollment variances or corrections.

3.7 ***Timely Payment.*** Performance of all duties and obligations of Claim Administrator under the Agreement are contingent upon the Timely payment of any amount owed Claim Administrator by Employer.

SECTION 4: CLAIM PAYMENTS

4.1 ***Claim Administrator's Payment.*** Upon receipt of a Claim, Claim Administrator will make a Claim Payment provided that all payments due Claim Administrator under the terms of the Agreement are paid when due.

4.2 ***Employer's Liability.*** Any reasonable determination by Claim Administrator in adjudicating a Claim under the Agreement that a Covered Person is entitled to a Claim Payment is conclusive evidence of the liability of Employer to Claim Administrator for such Claim Payment pursuant to Section 6 below titled "Claim Settlements." Further, if a Covered Person is an Inpatient at the time his or her coverage under the Plan terminates, the Plan shall provide benefits for Covered Services which are provided by and regularly charged for by a Hospital or other facility Provider until the Covered Person is discharged ("Extended Benefits"). Employer shall be liable to Claim Administrator for all Claim Payments, and the applicable service charges for such Extended Benefits.

4.3 ***Covered Person's Certain Liability.*** Under certain circumstances, if Claim Administrator pays the healthcare Provider amounts that are the responsibility of the Covered Person under this Agreement, Claim Administrator may collect such amounts from the Covered Person.

4.4 ***Cessation of Claim Payments.*** If Employer has failed to pay when due any amount owed Claim Administrator, Claim Administrator shall be under no obligation to make any further Claim Payments until such default is cured.

SECTION 5: EMPLOYER PAYMENT

5.1 ***Intent.*** In consideration of Claim Administrator's obligations as set forth in the Agreement and at the end of each Employer Payment Period, Employer shall pay to Claim Administrator or shall provide access for Claim Administrator to obtain, Employer Payment amount due for that Employer Payment Period.

5.2 ***Confirmation or Notification of Amount Due and Payment Due Date.*** Employer shall confirm with Claim Administrator or Claim Administrator shall notify Employer's financial division, of Employer Payment for each Employer Payment Period and when such payment is due. Confirmation or notification shall be in accordance with Employer Payment Method elected in the Fee Schedule specifications of the most current ASO BPA and the following:

a. ***If Employer Payment Method is by Check,*** Claim Administrator shall issue Employer a settlement statement which will include Claim Administrator's mailing address for check remittance and the date payment is due.

b. ***If Employer Payment Method is other than Check,*** Employer shall confirm on-line the amount due by accessing Claim Administrator's "Blue Access for Employers" (as provided in Exhibit 1); or Claim Administrator shall advise Employer by email or facsimile (at an email address or facsimile number to be furnished by Employer prior to the effective date of the Agreement) or by such other method mutually agreed to by the Parties, of the amount due. Employer Payment must be made or obtained within forty-eight (48) hours of confirmation by Employer or Employer's notification by 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.

5.3 ***Federal Regulation of Employer.*** Employer will be responsible for payment of any applicable contributions to the funding of the Transitional Reinsurance Programs established by the Affordable Care Act. Under no circumstances will Claim Administrator be responsible for payment of Reinsurance Contributions.

5.4 ***Late Payments.*** Late payments are subject to the penalties outlined in Section 7.3 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 ASO BPA. The Claim settlement shall reflect the sum of the following:

a. Claim Payments paid by Claim Administrator in the particular Claim settlement period.

b. Claim Payments paid by Claim Administrator in prior Claim settlement periods that have not been included in a prior Claim settlement.

c. The Administrative Charges and credits, Surcharges, and other applicable service charges as indicated in the Fee Schedule specifications of the most current 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 Employer Payments, Employer will pay the difference to Claim Administrator. The Claim settlement will be determined within sixty (60) days from the last day of the Claim settlement period. Claim Administrator will notify Employer in writing of the results of the Claim settlement. Any sums due Claim Administrator will be paid Timely by Employer.

6.3 ***Employer Overpayment.*** If, within the Claim settlement period, Employer Payments exceed the Claim Settlement Total, Claim Administrator may, at its option, pay such difference to Employer, apply the difference against amounts then owed Claim Administrator by Employer or authorize a reduction equal to such difference from the next Claim Settlement Total due Claim Administrator from Employer.

SECTION 7: LATE PAYMENTS AND REMEDIES

7.1 ***When Employer Fails to Pay.*** If Employer fails to pay when due any amount required to be paid to Claim Administrator under the Agreement, and such default is not cured within ten (10) days of the due date, a Reminder Notice will be sent to the Employer via email. If payment is not received within ten (10) days of the date the Reminder Notice is sent, Claim Administrator reserves the right to consider the Employer delinquent according to its procedures. If defaults are not cured following written notice to Employer, 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 6.5 "Severability; Enforcement; Force Majeure; Survival" of the Agreement, Claim Administrator's failure to provide 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 Employer.

7.3 ***Late Charge.*** If Employer fails to make any payment required by the Agreement on a Timely basis, Claim Administrator, at its option, may assess a daily charge for the late remittance from the due date of any amount(s) payable to Claim Administrator by Employer. This daily charge shall be an amount equal to the amount resulting from multiplying the amount due times the lesser of:

a. [redacted].

7.4 ***Insolvency.*** In addition, if Employer becomes insolvent, however evidenced, or is in default of its obligation to make any Employer Payment as provided hereunder, or if any other default hereunder has occurred and is continuing, then any indebtedness of Claim Administrator to Employer (including any and all contractual obligations of Claim Administrator to Employer) may be offset and/or recouped and applied toward the payment of Employer's obligations hereunder, whether or not such obligations, or any part thereof, shall then be due Employer.

7.5 ***Texas Prompt Payment Act.*** In the event of any conflict between the terms of this Agreement and the Texas Prompt Payment Act (Texas Government Code Chapter 2251), the Texas Prompt Payment Act will control.

SECTION 8: FINANCIAL OBLIGATIONS UPON AGREEMENT TERMINATION

8.1 ***Run–Off Claims.*** Employer hereby acknowledges that on the date of termination of the Agreement in accordance with the provisions of either Section 7 of this Exhibit or Section 6 of the Agreement, there may be an undetermined but substantial number of Claims for services rendered or furnished prior to that date which have not been submitted to Claim Administrator for reimbursement and also an undetermined but substantial number of Claims submitted for reimbursement which have not been paid by Claim Administrator ("Run–Off Claims"). Employer shall be responsible for the reimbursement of all Run–Off Claims, whether or not such Claims have been submitted, or whether or not Claim Payments for such Claims have been made by Claim Administrator, as of the date of termination or termination of Covered Employees but not the Agreement, including, but not limited to, Claim Payments made in accordance with MSP laws, and for the payment of the Termination Administrative Charge and any other applicable service charges indicated in the Fee Schedule specifications of the most current ASO BPA and any applicable Supplemental Charge(s) pursuant to the processing of such Claims after the Agreement's termination date or date of termination of Covered Employees but not the Agreement.

8.2 ***Corresponding Employer Payments.*** In consideration of Claim Administrator's continuing to make Claim Payments in accordance with Section 4 of this Exhibit for Run–Off Claims, Employer shall continue to make Employer Payments for all such Claims paid by Claim Administrator up to the final settlement outlined below.

8.3 ***Final Settlement.*** A final settlement shall be made within sixty (60) days after the last day of the Run–Off Period. This final settlement shall compare Employer Payments against the Claim Settlement Totals for all Run–Off Claims paid up to the date of the final settlement. The difference shall be paid or applied as set forth in Section 6 of this Exhibit. However, if Employer Payments exceed the Claim Settlement Totals for all Run–Off Claims paid up to the final settlement, Claim Administrator shall pay such difference to Employer after applying the difference against amounts, if any, then owed to Claim Administrator by Employer. After the final settlement, Claim Administrator shall be released from any further liability for Claim Payments and Claim adjustments under this Agreement, and as of the date Employer shall assume full liability and responsibility for all further administration of Claim Payments. Further, after the final settlement, any refunds resulting from Claim adjustments for Overpayments, regardless of when such adjustments occurred shall be retained by Claim Administrator and Employer shall have no liability for any charges associated with any adjustments

8.4 ***Uncashed Funds.*** As of the date of termination of the Agreement and during the Run-Off Period, any outstanding funds that are or become "stale" (over 365 days old) will be escheated to the state of payee's last known address by Claim Administrator, on Employer's behalf, less any amount(s) owed by such funds' payees to Claim Administrator, in accordance with Claim Administrator's established procedures and/or the applicable state's unclaimed property law.

EXHIBIT 3
NOTICES/REQUIRED DISCLOSURES

SECTION 1: PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

1.1 **Claim Payment.** All payments by Claim Administrator for the benefit of any Covered Person may be made directly to any Provider furnishing Covered Services for which such payments are due, and Claim Administrator is authorized by such Covered Person to make such payments directly to such Providers. However, Claim Administrator reserves the right to pay any benefits that are payable under the terms of the Plan directly to the Covered Person or to the Provider furnishing Covered Services at Claim Administrator's option and in its sole discretion. Claim Administrator's decision to pay a Provider directly is not intended to waive and shall not constitute a waiver of the prohibition on assignment described in 1.3, below. All benefits payable to the Covered Person that remain unpaid at the time of the death of the Covered Person will be paid to the estate of the Covered Person.

1.2 **Claim Dispute.** Once Covered Services are rendered by a Provider, the Covered Person has no right to request 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, Claim Administrator will have no liability to the Covered Person or any other person because of its rejection of such request.

1.3 **Invalidity of Assignments.** Neither coverage under the Plan nor a Covered Person's claims or rights under the Plan, including but not limited to claims for payment of benefits, are assignable in whole or in part to any person or entity at any time, and any such assignments shall be considered void. Coverage under the Plan is expressly non–assignable and 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. If 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 Claim Administrator will have no obligation to pursue recovery of such payment; however, once the invalid assignment or transfer has been identified and Claim Administrator has acknowledged the situation, Claim Administrator will pursue recoveries as described in Section 4.2 "Claim Overpayments."

SECTION 2: COVERED PERSON/PROVIDER RELATIONSHIP

2.1 **Relationship to a Provider.** The choice of a Provider is solely the choice of the Covered Person, and Claim Administrator will not interfere with the Covered Person's relationship with any Provider. Each Provider provides Covered Services only to Covered Persons and does not otherwise interact with or provide any services to Employer (except to the extent Employer is a Covered Person) or the Plan.

2.2 **Claim Administrator's Role.** It is expressly understood that Claim Administrator does not itself undertake to furnish Hospital, medical or dental service, but acts solely to make Claim Payments to a Provider for the Covered Services received by Covered Persons. 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 that can only be legally performed by a Provider are not provided by Claim Administrator. Any contractual relationship between a Provider and Claim Administrator shall not be construed to mean that Claim Administrator is providing professional service. Any reference or statement by Claim Administrator to a Provider shall in no way be construed as a representation, recommendation, referral, inference, or other statement by Claim Administrator as to the ability or quality, positive or negative, of such Provider.

SECTION 3: LIMITED BENEFITS FOR NON–NETWORK PROVIDERS

Regarding any comprehensive major medical coverage with access to Network Providers elected on the most current ASO BPA. Employer acknowledges that when Covered Persons elect to utilize the services of a non–Network Provider for a Covered Service in non–emergency situations, benefit payments to such non–Network Provider are not based upon the amount billed. The basis of the benefit payment will be determined

according to the Plan's Fee Schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined under the Plan. Non–Network Providers may bill the Plan's Covered Person for any amount up to the billed charge after Claim Administrator has paid the Plan's portion of the bill. Network Providers have agreed to accept discounted payments for services with no additional billing to the Covered Person other than Coinsurance, Copayments, and deductible amounts. A Covered Person may obtain further information about the Network status of Providers and information on out–of–pocket expenses by calling the toll–free number on their identification card.

SECTION 4: CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PRESCRIPTION DRUG PROVIDERS

4.1 For Covered Services provided by Participating Prescription Drug Providers under the prescription drug benefit, all amounts payable to Claim Administrator by Employer for Claim Payments provided by Claim Administrator and applicable service charges pursuant to the terms of the Agreement shall be calculated on the basis of an amount mutually agreed upon by Employer and Claim Administrator. For Covered Services provided by the Participating Prescription Drug Providers under the prescription drug benefit, required deductible and Coinsurance amounts under the Agreement shall be calculated on the basis of the Allowable Amount, Section 7.2(b), above. All (a) amounts payable to Claim Administrator by Employer for Claim Payments provided by Claim Administrator for Covered Services provided by Non-Participating Prescription Drug Providers under the prescription drug benefit, and (b) required deductible and Coinsurance amounts for Covered Services provided by Non-Participating Prescription Drug Providers under the prescription drug benefit shall be calculated on the basis of the Allowable Amount, Section 7.2(b), above.

4.2 Claim Administrator hereby informs 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 Claim Administrator is a party, including the Covered Persons under the Agreement, and that pursuant to Claim Administrator's contracts with Participating Prescription Drug Providers, under certain circumstances described therein, Claim Administrator may receive discounts for prescription drugs dispensed to Covered Persons under the Agreement. Actual Network savings achieved for Covered Persons will vary. Some rates are currently based on benchmark prices including, but not limited to, Wholesale Acquisition Cost ("WAC"), Average Sales Price ("ASP") and Average Wholesale Price ("AWP"), which are determined by third parties and are subject to change.

4.3 Employer understands that Claim Administrator may receive such discounts during the term of the Agreement. Neither 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. The drug fees/discounts that Claim Administrator has negotiated with Prime Therapeutics LLC ("Prime") through the Pharmacy Benefit Management ("PBM") Agreement, will be used to calculate Covered Persons deductibles and Coinsurance for both retail and mail/specialty drugs, except as otherwise mutually agreed to by the Parties. Except for mail/specialty drugs, the PBM Agreement requires that the fees/discounts that Prime has negotiated with pharmacies (or other suppliers) are passed-through to Claim Administrator. For the mail-order pharmacy and specialty pharmacy program, which as of the Effective Date are partially owned by Prime and administered through Prime affiliates, Prime retains the difference between its acquisition cost and the negotiated prices as its fee for the various administrative services provided as part of the mail-order pharmacy and/or specialty pharmacy program. Claim Administrator pays a fee to Prime for pharmacy benefit services, which may be included in the Administrative Charge charged by Claim Administrator to Employer. A portion of Prime's PBM fees are tied to certain performance standards, including, but not limited to, Claims processing, customer service response, and mail-order processing.

4.4 "Weighted Paid Claim" refers to the methodology of counting claims for purposes of determining Claim Administrator's fee payment to Prime. Each retail (including claims dispensed through PBM's specialty pharmacy program) paid claim will be weighted according to the days' supply dispensed. A paid claim is weighted in thirty-four (34) day supply increments so a 1-34 days' supply is considered one (1) weighted

claim, a 35-68 days' supply is considered two (2) weighted claims, and the pattern continues up to six (6) weighted claims for one hundred seventy one (171) or more days' supply. Claim Administrator pays Prime a Program Management Fee ("PMF") on a per weighted claim basis.

4.5 The amounts received by Prime from Claim Administrator, pharmacies, manufacturers or other third parties may be revised from time to time. Some of the amounts received by Prime may be charged each time a claim is processed (or, in some instances, requested to be processed) through Prime and/or each time a prescription is filled, and include, but are not limited to, administrative fees charged by Prime to Claim Administrator (as described above), administrative fees charged by Prime to pharmacies, and administrative fees charged by Prime to pharmaceutical manufacturers. Currently, none of these fees will be passed on to Employer as expenses, or accrue to the benefit of Employer, unless otherwise specifically set forth in the Agreement.

SECTION 5: CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS

5.1 Claim Administrator hereby informs Employer and all Covered Persons that it owns a significant portion of the equity of Prime and that Claim Administrator has entered into one or more agreements with Prime or other entities (collectively referred to as "Pharmacy Benefit Managers"), for the provision of, and payment for, prescription drug benefits to all persons entitled to prescription drug benefits under individual certificates, group health insurance policies and contracts to which Claim Administrator is a party, including the Covered Persons under the Agreement. Pharmacy Benefit Managers have agreements with pharmaceutical manufacturers to receive rebates for using their products. In addition, the mail-order pharmacy and specialty pharmacy operate through an affiliate partially owned by Prime Therapeutics, LLC.

5.2 The Pharmacy Benefit Manager(s) ("PBM") negotiates rebate contracts with pharmaceutical manufacturers and has agreed to provide rebates made available pursuant to such contracts to Claim Administrator under the PBM's agreement with Claim Administrator. Claim Administrator may also negotiate rebate contracts with pharmaceutical manufacturers. This negotiation is conducted by the PBM (or Claim Administrator, as applicable) for the benefit of Claim Administrator and not for the benefit of Employer or Covered Persons. The PBM collects the rebates from the pharmaceutical manufacturers, for drugs covered under both the prescription drug program and medical benefit, and forwards the entire amount collected to Claim Administrator (other than any interest or late fees earned on rebates received from manufacturers, which the PBM retains). Each year, Claim Administrator will calculate a projection of the amount of rebates it expects to receive from the PBM and Claim Administrator's own rebate contracts with pharmaceutical manufacturers. Such projections are referred to as the "Expected Rebates". Expected Rebates are calculated based on a number of factors and projections for the Fee Schedule Period, which may include Employer-specific demographics, retail, mail-order pharmacy and specialty pharmacy utilization, cost of prescription drugs, Employer's benefit design, and rebate arrangements entered into by the PBM, none of which Claim Administrator directly controls, and rebate arrangements between Claim Administrator and pharmaceutical manufacturers. Claim Administrator's estimate of the Expected Rebates is set forth in the proposal or renewal packet, as appropriate, which is hereby incorporated into this Agreement. Rebates, like all Claim Administrator assets and revenue sources, are utilized by Claim Administrator in various ways to enable Claim Administrator to provide cost-effective products and services. Claim Administrator may provide Employer with a rebate credit, the amount of which is set forth in the ASO BPA (the "Rebate Credit"). The Rebate Credit provided to Employer will be provided from Claim Administrator's own assets and may or may not equal the entire amount of rebates provided to Claim Administrator by the PBM or pharmaceutical manufacturers. Employer acknowledges that it has negotiated for the specific Rebate Credit included as part of this Agreement and that it and its group health plan have no right to, or legal interest in, any portion of the rebates provided by the PBM or such manufacturers to Claim Administrator and consents to Claim Administrator's retention of all such rebates. Rebate Credits shall not continue after termination of the prescription drug program.

5.3 As of the Effective Date, the maximum that a PBM has disclosed to Claim Administrator that the PBM will receive from any pharmaceutical manufacturer for manufacturer administrative fees is five and one-half percent (5.5%) of the Wholesale Acquisition Cost ("WAC") for all products of such manufacturer dispensed during any given calendar year to members of Claim Administrator and to members of the other Blue Cross

and/or Blue Shield operating divisions of Health Care Service Corporation or for which Claims are submitted to PBM at Claim Administrator's Request; provided, however, that Claim Administrator will advise Employer if such maximum has changed.

SECTION 6: MEDICARE SECONDARY PAYER INFORMATION REPORTING

6.1 For the purposes of mandatory reporting requirements for group health plan ("GHP") arrangements under Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (P.L.110-173), Claim Administrator shall serve as the Responsible Reporting Entity ("RRE") and shall report information to the Centers for Medicare & Medicaid Services ("CMS") about individuals enrolled in the GHP who are also covered by Medicare so that CMS and Claim Administrator can effectively coordinate health care payments consistent with the MSP rules. Employer hereby authorizes and directs Claim Administrator to disclose to CMS, periodically, information pertaining to Medicare–eligible Covered Persons under the Plan so that Claim Administrator may make accurate primary/secondary MSP determinations. Employer agrees to Timely and accurately respond to Claim Administrator's requests for information.

6.2 It shall be Employer's responsibility to notify Claim Administrator promptly as may be required for such continuing accuracy, of any change in the number of individuals employed by Employer or status of its employees that might affect the order of payment under the MSP statute, such as information regarding working–aged persons who retire and changes in the number of individuals employed by Employer that place it in, or take it out of, the scope of the MSP statute.

6.3 **Disclosure Statement:** Employer acknowledges that 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 7: REIMBURSEMENT PROVISION

Applicable only if this service is elected in the Fee Schedule specifications of the most current Exhibit 4 - ASO Benefit Program Application ("ASO BPA")

7.1 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.** Claim Administrator on behalf of Employer has the right to reimbursement for all benefits 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 or guardians 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 Allowable Amount for Covered Services for which Claim Administrator has provided benefits to the Covered Person.
- **b.** Claim Administrator is assigned the right to recover from the third party, or the third party's insurer, to the extent of the benefits Claim Administrator provided for that sickness or injury.

7.2 Claim Administrator shall have the right to first reimbursement out of all funds the Covered Person, the Covered Person's parents or guardians if the Covered Person is a minor, or the Covered Person's legal representative, is or was able to exercise for the same expenses for which 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 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.

SECTION 8: MEMBER DATA SHARING

A Covered Person may, under certain circumstances, as specified below, apply for and obtain replacement coverage, subject to the replacement coverage's applicable terms and conditions. The replacement coverage will be that which is offered by Claim Administrator, or, if Covered Person does not reside in Claim Administrator's service area, by the Host Blue(s) whose service area covers the geographic area in which the Covered Person resides. The circumstances mentioned above may arise from involuntary termination of Covered Person's health coverage sponsored by Employer but solely as a result of a reduction in force, plan/office closing(s) or group health plan termination (in whole or in part), or when a Covered Person approaches the age of Medicare eligibility. If the Covered Person does not reside in Claim Administrator's service area, Claim Administrator may facilitate a Covered Person's right to apply for and obtain such replacement coverage, subject to applicable eligibility requirements, from the Host Blue in which the Covered Person resides. To do this, Claim Administrator or the Host Blue may communicate directly with the Covered Persons to provide resources and replacement coverage options available to them. Claim Administrator's provision of information about replacement coverage is not part of the Services provided to Employer under the Agreement, and neither Employer nor the Plan has any responsibility for replacement coverage information provided by Claim Administrator in accordance with this Section 8.

EXHIBIT 4
ASO BENEFIT PROGRAM APPLICATION ("ASO BPA")

EXHIBIT 5
BLUE CROSS BLUE SHIELD ASSOCIATION DISCLOSURES AND PROVISIONS

SECTION 1: INTER-PLAN ARRANGEMENT DEFINITIONS

Other definitions applicable to this Exhibit are contained in Section 7 DEFINITIONS of the Agreement.

1.1 **"Accountable Care Organization"** means a group of healthcare Providers who agree to deliver coordinated care and meet performance benchmarks for quality and affordability to manage the total cost of care for their member populations.

1.2 **"Alternative Provider Compensation Arrangements"** means the arrangements described in the definition of "Alternative Provider Compensation Arrangement Payments."

1.3 **"Alternative Provider Compensation Arrangement Payments"** means a payment Claim Administrator makes to Network Providers for any services, including but not limited to, any capitation payments, performance-based payments, Care Coordination payments, Value-Based Program payments, Accountable Care Organization payments, Global Payments/Total Cost of Care payments, Patient-Centered Medical Home payments, Provider Incentives or other incentives or bonus payments, Shared Savings payments and any other alternative funding arrangement payments as described in Claim Administrator's arrangement with the Network Provider, all as further described in Section 4.4 of this Exhibit. If the actual amount of an Alternative Provider Compensation Arrangement Payment (for purposes of this Section 1.3, a "Payment") is not known at the time Claim Administrator bills Employer under this Agreement, then Claim Administrator may bill Employer in advance for expected Payments to Network Providers (the "Expected Payments"). Such Expected Payments will be calculated for each member in each specific Alternative Provider Compensation Arrangement on a per member per month ("PMPM") basis or on another agreed upon compensation mechanism between Participating Healthcare Provider and Claim Administrator, in the same manner as methodologies described in Section 4.4 of this Exhibit. Where such Alternative Provider Compensation Arrangements include a PMPM Payment structure, the calculation of the Expected Payments will be made using (i) the estimated number of members involved in a particular Arrangement (as of the end of the month preceding the calculation), and (ii) the estimated Payments for all such Covered Persons, unless an alternate calculation method is used (in the same manner as described in Section 4.4 of this Exhibit. Expected Payment may vary from Member to Member. For the purposes of this Section 1.3, a "Member" means all of the members in a health benefit plan insured or administered by Claim Administrator, including but not limited to Employer's Covered Persons. Employer will be billed for its share of the Expected Payment, calculated based on (i) the number of Employer's Covered Persons participating (or expected to participate) in an Alternative Provider Compensation Arrangement per month and/or (ii) the number and/or cost of the Covered Services received (or expected to be received) by Employer's Covered Persons per month. Any difference (surplus or deficit) between the Expected Payments and actual Payments will be factored into Claim Administrator's calculation of future Expected Payments. Interest on such difference (surplus or deficit) will be credited (or charged) to Employer and included in the calculation of future Expected Payments. Claim Administrator may recalculate the PMPM amounts and any other applicable expected Payments or charges from time to time in a manner consistent with this Agreement. In the case of any modification to the PMPM or Expected Payments, Claim Administrator shall inform Employer of such modifications. Thereafter, Employer will be deemed to have approved the modifications, which will become part of this Agreement.

1.4 **"Blue Cross Blue Shield Global Core Access Vendor Fees"** means the charges to Claim Administrator for the transaction fees through Blue Cross Blue Shield Global Core which are payable to the medical assistance vendor for assisting Covered Persons traveling or living outside of the United States, Puerto Rico, and U.S. Virgin Islands to obtain medical services.

1.5 **"Care Coordination"** means organized, information-driven patient care activities intended to facilitate the appropriate responses to Covered Person's healthcare needs across the continuum of care.

1.6 **"Care Coordinator"** means an individual within a Provider organization who facilitates Care Coordination for patients.

1.7 **"Care Coordinator Fee"** means a fixed amount paid by a BlueCross and/or Blue Shield Plan to Providers periodically for Care Coordination under a Value-Based Program.

1.8 **"Global Payment/Total Cost of Care"** means a payment methodology that is defined at the patient level and accounts for either all patient care or for a specific group of services delivered to the patient such as Outpatient, Physician, ancillary, Hospital services, and prescription drugs.

1.9 **"Host Blue"** means a local Blue Cross and/or Blue Shield licensee outside the geographic area that Claim Administrator serves.

1.10 **"Negotiated Arrangement"** means an agreement negotiated between one or more Blue Cross and/or Blue Shield Plans for any national account that is not delivered through the BlueCard Program.

1.11 **"Non-Participating Healthcare Provider"** means a healthcare Provider that does not have a contractual agreement with a Host Blue.

1.12 **"Participating Healthcare Provider"** means a healthcare Provider that has a contractual agreement with a Host Blue.

1.13 **"Patient-Centered Medical Home"** means a model of care in which each patient has an ongoing relationship with a Primary Care Physician who coordinates a team to take collective responsibility for patient care and, when appropriate, arranges for care with other qualified Physicians.

1.14 **"Provider Incentive"** means an additional amount of compensation paid to a healthcare Provider by a Blue Cross and/or Blue Shield Plan, based on the Provider's compliance with, or participation in, agreed-upon procedural and/or outcome measures, joint-initiatives, including but not limited to any measures or initiatives related to a particular population of Covered Persons.

1.15 **"Shared Savings"** means a payment mechanism in which the Provider and the Blue Cross and/or Blue Shield Plan share cost savings achieved against a target cost budget based upon agreed-upon terms and may include downside risk.

1.16 **"Value-Based Program"** means a payment arrangement and/or a Care Coordination model facilitated through one or more Providers that may utilize one (1) or more of the following metrics: (i) Covered Person health outcomes; (ii) Covered Person Care Coordination; (iii) quality of Covered Services; (iv) cost of Covered Services; (v) Covered Person access; (vi) Covered Person experience with a Provider; or (vii) joint initiatives to increase collaboration in the provision of Covered Services to Covered Persons, and which payment arrangement is reflected in one (1) or more Provider payments, including but not limited to Alternative Provider Compensation Arrangement Payments.

SECTION 2: ADMINISTRATIVE SERVICES ONLY, NETWORK ONLY

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 Claim Administrator is providing. Such disclosures must be made to Employer, 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.

SECTION 3: DISCLOSURES IN ACCOUNT CONTRACTS

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

EXHIBIT 6
BUSINESS ASSOCIATE AGREEMENT

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement (this "**Agreement**") by and between The Texas A&M University System, an agency of the State of Texas ("**Covered Entity**") and Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company ("**Business Associate**"), shall be effective as of September 1, 2020 (the "**Effective Date**").

WHEREAS, Covered Entity and Business Associate have entered into, are entering into, or may subsequently enter into, agreements or other documented arrangements (collectively, the "**Business Arrangements**") pursuant to which Business Associate may provide products and/or services for Covered Entity that require Business Associate to access, create, maintain, and use health information that is protected by state and/or federal law.

WHEREAS, pursuant to the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("**HIPAA**"), the U.S. Department of Health & Human Services ("**HHS**") promulgated the Standards for Privacy of Individually Identifiable Health Information (the "**Privacy Standards**"), at 45 C.F.R. Parts 160 and 164, requiring certain individuals and entities subject to the Privacy Standards (each a "**Covered Entity**", or collectively, "**Covered Entities**") to protect the privacy of certain Protected Health Information or PHI (as defined below).

WHEREAS, pursuant to HIPAA, HHS issued the Security Standards (the "**Security Standards**"), at 45 C.F.R. Parts 160, 162 and 164, for the protection of Electronic Protected Health Information ("**EPHI**") (as defined below).

WHEREAS, in order to protect the privacy and security of PHI, including EPHI, created or maintained by or on behalf of the Covered Entity, the Privacy Standards and Security Standards require a Covered Entity to enter into a "business associate agreement" with certain individuals and entities providing services for or on behalf of the Covered Entity if such services require the use or disclosure of PHI or EPHI.

WHEREAS, Health Information Technology for Economic and Clinical Health Act and its implementing regulations (the "**HITECH Act**") impose certain privacy and security obligations on Covered Entities in addition to the obligations created by the Privacy Standards and Security Standards.

WHEREAS, the HITECH Act revises many of the requirements of the Privacy Standards and Security Standards concerning the confidentiality of PHI and EPHI, including extending certain HIPAA and HITECH Act requirements directly to Business Associates.

WHEREAS, the HITECH Act requires that certain of its provisions be included in business associate agreements, and that certain requirements of the Privacy Standards be imposed contractually upon Covered Entities as well as Business Associates.

WHEREAS, the Texas Legislature has adopted certain privacy and security requirements that are more restrictive than those required by HIPAA and HITECH, and such requirements are applicable to Business Associates as "Covered Entities" as defined by Texas law.

NOW THEREFORE, in consideration of the mutual promises set forth in this Agreement and the applicable Business Arrangements, and other good and valuable consideration, the sufficiency and receipt of which are hereby acknowledged, the parties hereby agree as follows:

I. Definitions

a. All capitalized terms used in this Agreement and not otherwise defined shall have the meanings ascribed to them in HIPAA.

b. "**Business Associate**" shall have the same meaning as the term "business associate" at 45 CFR Section 160.103, and in reference to the party to this Agreement, shall mean Blue Cross and Blue Shield of Texas.

c. "**Breach**" shall mean the acquisition, access, use or disclosure of Protected Health Information in a manner not permitted by the HIPAA Privacy Rule that compromises the security or privacy of the Protected Health Information as defined, and subject to the exceptions set forth, in 45 CFR Section 164.402.

d. "**Covered Entity**" shall have the same meaning as the term "covered entity" at 45 CFR Section 160.103, and in reference to the party to this Agreement, shall mean The Texas A&M University System.

e. "**Data Aggregation Services**" shall mean the combining of PHI or EPHI by Business Associate with the PHI or EPHI received by Business Associate in its capacity as a business associate of another covered entity, to permit data analyses that relate to the health care operations of, payment to, and treatment of patients by the respective covered entities.

f. "**Electronic Protected Health Information**" shall mean Protected Health Information that is transmitted or maintained in Electronic Media.

g. "**HIPAA Breach Notification Rule**" shall mean the federal breach notification regulations, as amended from time to time, issued under HIPAA and set forth in 45 CFR Part 164 (Subpart D).

h. "**HIPAA Privacy Rule**" shall mean the federal privacy regulations, as amended from time to time, issued under HIPAA and set forth in 45 CFR Parts 160 and 164 (Subparts A & E).

i. "**HIPAA Security Rule**" shall mean the federal security regulations, as amended from time to time, issued under HIPAA and set forth in 45 CFR Parts 160 and 164 (Subparts A & C).

j. "**Protected Health Information of PHI**" shall mean Protected Health Information, as defined in 45 CFR Section 160.103, and is limited to the Protected Health Information received,

maintained, created or transmitted on behalf of, Covered Entity by Business Associate in performance of the Underlying Services.

k. "**Underlying Services**" shall mean, to the extent and only to the extent they involve the creation, maintenance, use, disclosure or transmission of Protected Health Information, the services performed by Business Associate for Covered Entity pursuant to the Underlying Services Agreement.

l. "**Underlying Services Agreement**" shall mean the written agreement(s) (other than this Agreement) by and between the parties pursuant to which Business Associate has access to, receives, maintains, creates or transmits PHI for or on behalf of Covered Entity in connection with the provision of the services described in that agreement(s) by Business Associate to Covered Entity or in performance of Business Associate's obligations under such agreement(s).

II. Business Associate Obligations.

Business Associate may receive from Covered Entity, or create or receive or maintain on behalf of Covered Entity, health information that is protected under applicable state and/or federal law, including without limitation, PHI and EPHI. All references to PHI herein shall be construed to include EPHI. Business Associate agrees not to use or disclose (or permit the use or disclosure of) PHI in a manner that would violate the Privacy Standards, Security Standards, the HITECH Act, or Texas law, including without limitation the provisions of Texas Health and Safety Code Chapters 181 and 182 as amended by HB 300 (82nd Legislature), effective September 1, 2012, in each case including any implementing regulations as applicable (collectively referred to hereinafter as the "**Confidentiality Requirements**") if the PHI were used or disclosed by Covered Entity in the same manner.

III. Use of Protected Health Information

Except as otherwise required by law, Business Associate shall use PHI in compliance with 45 C.F.R. Section 164.504(e). Furthermore, Business Associate shall use PHI (i) solely for Covered Entity's benefit and only for the purpose of performing services for Covered Entity as such services are defined in Business Arrangements, (ii) for Data Aggregation Services (as herein defined), and (iii) as necessary for the proper management and administration of the Business Associate or to carry out its legal responsibilities, provided that such uses are permitted under federal and state law. For avoidance of doubt, under no circumstances may Business Associate sell PHI in such a way as to violate Texas Health and Safety Code, Chapter 181.153, as amended by HB 300 (82nd Legislature), effective September 1, 2012, nor shall Business Associate use PHI for marketing purposes in such a manner as to violate Texas Health and Safety Code Section 181.152, or attempt to re-identify any information in violation of Texas Health and Safety Code Section 181.151, regardless of whether such action is on behalf of or permitted by the Covered Entity. To the extent not otherwise prohibited in the Business Arrangements or by applicable law, use, creation and disclosure of de-identified health information, as that term is defined in 45 CFR § 164.514, by Business Associate is permitted.

IV. Disclosure of Protected Health Information

Subject to any limitations in this Agreement, Business Associate may disclose PHI to any third party persons or entities as necessary to perform its obligations under the Business Arrangement and as permitted or required by applicable federal or state law. Business Associate recognizes that under the HIPAA/HITECH Omnibus Final Rule, Business Associates may not disclose PHI in a way that would be prohibited if Covered Entity made such a disclosure. Any disclosures made by Business Associate shall comply with minimum necessary requirements under the Privacy Rule and related regulations.

Business Associate shall not, and shall provide that its directors, officers, employees, subcontractors, and agents do not, disclose PHI to any other person (other than members of their respective workforce), unless such disclosure is required by law or authorized by the person whose PHI is to be disclosed. Any such disclosure other than as specifically permitted in the immediately preceding sentences shall be made only if such disclosee has previously signed a written agreement that:

a.) Binds the disclosee to the provisions of this Agreement pertaining to PHI, for the express benefit of Covered Entity, Business Associate and, if disclosee is other than Business Associate, the disclosee;

b.) Contains reasonable assurances from disclosee that the PHI will be held confidential as provided in this Agreement, and only disclosed as required by law for the purposes for which it was disclosed to disclosee; and,

c.) Obligates disclosee to immediately notify Business Associate of any breaches of the confidentiality of the PHI, to the extent disclosee has obtained knowledge of such breach.

Business Associate shall not disclose PHI to any member of its workforce, and shall provide that its subcontractors and agents do not disclose PHI to any member of their respective workforces, unless Business Associate or such subcontractor or agent has advised such person of Business Associate's obligations under this Agreement and of the consequences for such person and for Business Associate or such subcontractor or agent of violating them as memorialized in a business associate agreement pursuant to the HIPAA/HITECH Omnibus Final Rule. Business Associate shall take, and shall provide that each of its subcontractors and agents take, appropriate disciplinary action against any member of its respective workforce who uses or discloses PHI in contravention of this Agreement

In addition to Business Associate's obligations under Section IX of this Agreement, Business Associate agrees to mitigate, to the extent commercially practical, harmful effects that are known to Business Associate and result from the use or disclosure of PHI by Business Associate or its subcontractors or agents in violation of this Agreement.

V. Access to and Amendment of Protected Health Information

Business Associate shall (i) provide access to, and permit inspection and copying of, PHI by Covered Entity, and (ii) amend PHI maintained by Business Associate as requested by Covered Entity. Any such amendments shall be made in such a way as to record the time and date of the change, if feasible, and in accordance with any subsequent requirements promulgated by the Texas Medical Board with respect to amendment of electronic medical records. Business Associate shall respond to any request

from Covered Entity for access by an individual within fourteen (14) business days of such request and shall make any amendment requested by Covered Entity within twenty (20) days of the later of (a) such request by Covered Entity or (b) the date as of which Covered Entity has provided Business Associate with all information necessary to make such amendment. Business Associate may charge a reasonable fee based upon the Business Associate's labor costs in responding to a request for electronic information (or the fee approved by the Texas Medical Board for the production of non-electronic media copies). Business Associate shall notify Covered Entity within five (5) days of receipt of any request for access or amendment by an individual. Covered Entity shall determine whether to grant or deny any access or amendment requested by the individual. Prior to responding to an Individual's request for amendment, Covered Entity will verify that Business Associate created the PHI maintained in the designated record set. Business Associate shall have a process in place for requests for amendments and for appending such requests and statements in response to denials of such requests to the Designated Record Set, as requested by Covered Entity.

VI. Accounting of Disclosures

Business Associate shall make available to Covered Entity in response to a request from an individual, information required for an accounting of disclosures of PHI with respect to the individual in accordance with 45 CFR Section 164.528, as amended by Section 13405(c) of the HITECH Act and any related regulations or guidance issued by HHS in accordance with such provision.

VII. Records and Audits

Business Associate shall make available to HHS or its agents, its internal practices, books, and records relating to the use and disclosure of PHI received from, created, or received by Business Associate on behalf of Covered Entity for the purpose of determining Covered Entity's compliance with the Confidentiality Requirements or the requirements of any other health oversight agency, in a time and manner designated by the Secretary.

VIII. Implementation of Security Standards; Notice of Security Incidents

Business Associate will use appropriate safeguards to prevent the use or disclosure of PHI other than as expressly permitted under this Agreement. Business Associate will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the PHI that it creates, receives, maintains or transmits on behalf of Covered Entity. Business Associate acknowledges that the HITECH Act requires Business Associate to comply with 45 C.F.R. Sections 164.308, 164.310, 164.312 and 164.316 as if Business Associate were a Covered Entity, and Business Associate agrees to comply with these provisions of the Security Standards and all additional security provisions of the HITECH Act.

Furthermore, to the extent feasible, Business Associate will use commercially reasonable efforts to secure PHI through technology safeguards that render such PHI unusable, unreadable and indecipherable to individuals unauthorized to acquire or otherwise have access to such PHI in accordance with HHS Guidance published at 74 Federal Register 19006 (April 17, 2009), or such later regulations or guidance promulgated by HHS or issued by the National Institute for Standards and Technology ("**NIST**") concerning the protection of identifiable data such as PHI. Lastly,

Business Associate will promptly but in no event later that ten (10) business days, report to Covered Entity any successful Security Incident of which it becomes aware. At the request of Covered Entity, Business Associate shall identify the date of the Security Incident, the scope of the Security Incident, the Business Associate's response to the Security Incident and the identification of the party responsible for causing the Security Incident, if known.

IX. Data Breach Notification and Mitigation

HIPAA Data Breach Notification and Mitigation. Business Associate agrees to implement reasonable systems for the discovery and prompt reporting to Covered Entity of any Breach of "unsecured PHI" (as such term is defined by 45 C.F.R. Section 164.402). A Breach is presumed to have occurred unless there is a low probability that the PHI has been compromised based on a risk assessment of at least the factors listed in 45 C.F.R. Section 164.402(2)(i)-(iv) (hereinafter a "HIPAA Breach"). The parties acknowledge and agree that 45 C.F.R. Section 164.404 governs the determination of the date of discovery of a Breach. In addition to the foregoing and notwithstanding anything to the contrary herein, Business Associate will also comply with applicable state law, including without limitation, Section 521 Texas Business and Commerce Code, as amended by HB 300 (82nd Legislature), or such other laws or regulations as may later be amended or adopted. In the event of any conflict between this section, the Confidentiality Requirements, Section 521 of the Texas Business and Commerce Code, and any other later amended or adopted laws or regulations, the most stringent requirements shall govern.

Discovery of Breach. Business Associate will, following the discovery of a Breach, notify Covered Entity without unreasonable delay and in no event later than the earlier of the maximum of time allowable under applicable law or ten (10) business days after Business Associate discovers such Breach, unless Business Associate is prevented from doing so by 45 C.F.R. Section 164.412 concerning law enforcement investigations. For purposes of reporting a Breach to Covered Entity, the discovery of a Breach shall occur as of the first day on which such Breach is known to the Business Associate's Privacy Office or, by exercising reasonable diligence, would have been known to the Business Associate. Business Associate will be considered to have had knowledge of a Breach if the Breach is known, or by exercising reasonable diligence would have been known, to any person (other than the person committing the Breach) who is an employee, officer or other agent of the Business Associate.

Reporting a Breach. Without unreasonable delay and no later than the earlier of the maximum of time allowable under applicable law or ten (10) business days following a Breach, Business Associate shall provide Covered Entity with sufficient information to permit Covered Entity to comply with the HIPAA breach notification requirements set forth at 45 C.F.R. Section 164.400 et seq. Specifically, if the following information is known to (or can be reasonably obtained by) the Business Associate, Business Associate will provide Covered Entity with:

a.) contact information for individuals who were or who may have been impacted by the Breach (e.g., first and last name, mailing address, street address, phone number, email address);

b.) a brief description of the circumstances of the Breach, including the date of the Breach and date of discovery;

c.) a description of the types of unsecured PHI involved in the Breach (e.g., names, social security number, date of birth, addressees, account numbers of any type, disability codes, diagnostic and/or billing codes, and similar information);

d.) a brief description of what the Business Associate has done or is doing to investigate the Breach, mitigate harm to the individual(s) impacted by the Breach, and protect against future Breaches; and,

e.) appoint a liaison and provide contact information for same so that Covered Entity may ask questions or learn additional information concerning the Breach.

Following a Breach, Business Associate will have a continuing duty to inform Covered Entity of new information learned by Business Associate regarding the Breach, including but not limited to the information described above.

X. Covered Entity Obligations

Covered Entity shall identify and document any limitation(s) in the Covered Entity's Notice of Privacy Practices, as required by 45 CFR § 164.520 or any changes to their privacy policies, procedures or practices that may affect Business Associate's Use or Disclosure of PHI on Attachment 1 ("Attachment 1").

Covered Entity is responsible for responding to restriction requests and confidential communications requests in accordance with 45 CFR § 164.522 (a) and (b). Prior to responding or approving any restriction or confidential communication requests, Covered Entity shall consult with Business Associate for information on the feasibility of implementing or accommodating the request.

Covered Entity shall provide Business Associate the necessary information to fulfill Business Associate's obligations under this Agreement, including but not limited to, a written statement of the restrictions for the Disclosure of PHI by Business Associate to the Covered Entity. Covered Entity certifies that the Covered Entity's benefit plan documents have been amended in compliance with 45 CFR § 164.314(b) and 45 CFR § 164.504(f) and that information from the applicable amendments shall be included in the written statement provided to Business Associate.

Covered Entity shall identify its Business Associates and Covered Entity's employees on Attachment 1 of this Agreement to whom Business Associate is permitted to directly Disclose PHI. Covered Entity shall provide information on any limitations or restrictions on Business Associate's Disclosure to a specific Business Associate or Covered Entity's employee.

XI. Termination

This Agreement shall commence on the Effective Date.

Upon the termination of the applicable Business Arrangement, either Party may terminate this Agreement by providing written notice to the other Party.

Upon termination of this Agreement for any reason, Business Associate agrees:

a.) to return to Covered Entity or to destroy all PHI received from Covered Entity or otherwise through the performance of services for Covered Entity, that is in the possession or control of Business Associate or its subcontractors or agents. Business Associate agrees that all paper, film, or other hard copy media shall be shredded or destroyed such that it may not be reconstructed, and EPHI shall be purged or destroyed concurrent with NIST Guidelines for media sanitization at http://www.csrc.nist.gov/; or,

b.) in the case of PHI which is not feasible to "return or destroy," to extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI. Business Associate further agrees to comply with other applicable state or federal law, which may require a specific period of retention, redaction, or other treatment of such PHI.

XII. Miscellaneous

Notice. All notices, requests, demands and other communications required or permitted to be given or made under this Agreement shall be in writing, shall be effective upon receipt or attempted delivery, and shall be sent by (i) personal delivery; (ii) certified or registered United States mail, return receipt requested; (iii) overnight delivery service with proof of delivery; or (iv) facsimile with return facsimile acknowledging receipt. Notices shall be sent to the addresses below. Neither party shall refuse delivery of any notice hereunder.

Covered Entity:
The Texas A&M University System
Attn: Adam Davidson, Director, Human Resources
Moore/Connally Building
301 Tarrow
College Station, TX 77840

Business Associate:
Blue Cross and Blue Shield of Texas

Waiver. No provision of this Agreement or any breach thereof shall be deemed waived unless such waiver is in writing and signed by the party claimed to have waived such provision or breach. No waiver of a breach shall constitute a waiver of or excuse any different or subsequent breach.

Assignment. Neither party may assign (whether by operation or law or otherwise) any of its rights or delegate or subcontract any of its obligations under this Agreement without the prior written consent of the other party. Notwithstanding the foregoing, Covered Entity shall have the right to assign its rights and obligations hereunder to any entity that is an affiliate or successor of Covered Entity, without the prior approval of Business Associate.

Severability. Any provision of this Agreement that is determined to be invalid or unenforceable will be ineffective to the extent of such determination without invalidating the remaining provisions of this Agreement or affecting the validity or enforceability of such remaining provisions.

Entire Agreement. This Agreement constitutes the complete agreement between Business Associate and Covered Entity relating to the matters specified in this Agreement, and supersedes all prior representations or agreements, whether oral or written, with respect to such matters. In the event of any conflict between the terms of this Agreement and the terms of the Business Arrangements or any such later agreement(s), the terms of this Agreement shall control unless the terms of such Business Arrangements are more strict with respect to PHI and comply with the Confidentiality Requirements, or the parties specifically otherwise agree in writing. No oral modification or waiver of any of the provisions of this Agreement shall be binding on either party; provided, however, that upon the enactment of any law, regulation, court decision or relevant government publication and/or interpretive guidance or policy that the Covered Entity believes in good faith will adversely impact the use or disclosure of PHI under this Agreement, Covered Entity may amend the Agreement to comply with such law, regulation, court decision or government publication, guidance or policy by delivering a written amendment to Business Associate which shall be effective thirty (30) days after receipt. No obligation on either party to enter into any transaction is to be implied from the execution or delivery of this Agreement. This Agreement is for the benefit of, and shall be binding upon the parties, their affiliates and respective successors and assigns. No third party shall be considered a third-party beneficiary under this Agreement, nor shall any third party have any rights as a result of this Agreement.

Governing Law. This Agreement shall be governed by and interpreted in accordance with the laws of the state of Texas. Venue for any dispute relating to this Agreement shall be in Brazos County, Texas.

Nature of Agreement; Independent Contractor. Nothing in this Agreement shall be construed to create (i) a partnership, joint venture or other joint business relationship between the parties or any of their affiliates, or (ii) a relationship of employer and employee between the parties. Business Associate is an independent contractor and not an agent of Covered Entity. This Agreement does not express or imply any commitment to purchase or sell goods or services.

Interpretation. Any conflict between the terms of this Agreement and any other agreement between the Parties concerning the Covered Entity's health welfare benefits plan shall be resolved so the terms of this Agreement supersede and replace the relevant terms of any such other agreement concerning the use and disclosure of PHI, except for uses and disclosures permitted under the Underlying Agreement or other agreements between the Parties. The foregoing notwithstanding, the Parties also acknowledge and agree that if Business Associate's Business Confidential Information (as defined in the Underlying Agreement) is imbedded in the PHI data, then Business Associate retains its ownership of such Business Confidential Information.

Counterparts. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same document. In making proof of this Agreement, it shall not be necessary to produce or account for more than one such counterpart executed by the party against whom enforcement of this Agreement is sought. Signatures to this Agreement transmitted by facsimile transmission, by electronic mail in portable document format (".pdf") form, or by any other electronic means intended to preserve the original graphic and pictorial appearance of a document, will have the same force and effect as physical execution and delivery of the paper document bearing the original signature.

IN WITNESS WHEREOF, the parties have executed this Agreement as of the Effective Date.

COVERED ENTITY:	**BUSINESS ASSOCIATE:**
THE TEXAS A&M UNIVERSITY SYSTEM	**BLUE CROSS AND BLUE SHIELD OF TEXAS a Division of Health Care Service Corporation, a Mutual Legal Reserve Company**
Name: Billy Hamilton Title: Deputy Chancellor and Chief Financial Officer	Name: Jim Springfield Title: President Texas Division

ATTACHMENT 1: ADDITIONAL INFORMATION FORM

ATTACHMENT 2 – ADDITIONAL INFORMATION FORM

Self-Funded Accounts

This replaces and amends any existing Additional Information Form

(Please print or type and complete the form in its entirety)

Employer or Plan Sponsor:	**Texas A&M University System**
BCBSTX Account number:	[redacted]
BCBSTX group number(s):	
[redacted]	

Primary Privacy Contact	**Additional Privacy Contact (required)**
Name: Judy Cato	**Name: Jessica Palacios**
Title: Director	**Title: Associate Director**
Phone # 979-458-6171	**Phone # 979-458-6170**
FAX # 979-458-6247	**FAX # 979-458-6247**
Mailing Address:	**Mailing Address:**
Texas A&M System Bldg	**Texas A&M System Bldg**
301 Tarrow St. 5th FL	**301 Tarrow St. 5th FL**
City, State, Zip:	**City, State, Zip:**
College Station, TX	**College Station, TX**
78840	**78840**
e-Mail Address:	**e-Mail Address:**
jcato@tamus.edu	**jpalacios@tamus.edu**

Authorized Signatory (Form should only be signed by authorized employee of the account.)

Name of individual completing this form:

Title of individual completing this form:

Signature: _ _____ Date: _____

Limitations

Please identify any limitations in any of the following documents that may affect BCBSTX's use or disclosure of PHI in the GHP's:

(List the limitation or indicate "none")

a. **Notice of Privacy Practices (NoPP): None**
b. **GHP Plan Document: None**
c. **Other: _ _**

Employer or Plan Sponsor:	**Texas A&M University System**
BCBSTX Account number:	[redacted]
BCBSTX group number(s):	

Responding to Individual Requests

When BCBSTX receives a request from an individual related to one of these rights under HIPAA, please identify who should respond to the member.

Please select Employer/GHP OR BCBSTX (not Both)

1)	**Access Request:**	☐ - Employer/GHP	☒ - BCBSTX
2)	**Disclosure Accounting Request:**	☐ - Employer/GHP	☒ - BCBSTX
3)	**Amendment Request:**	☐ - Employer/GHP	☒ - BCBSTX
4)	**Compliant Response:**	☐ - Employer/GHP	☒ - BCBSTX

Group Health Plan Authorizations

Identify the employees within your organization that work on behalf of the GHP that BCBSTX is authorized to release PHI to for Plan Administration functions. Use a different line for each employee and include the following information:

JOB TITLE, NAME (optional) and any LIMITATIONS or RESTRICTIONS on the data release.

Financial Analyst II	**Eligibility and Claims**
Director	**Eligibility and Claims**
Associate Director	**Eligibility and Claims**
Assistant Director	**Eligibility and Claims**
Insurance Specialist	**Eligibility and Claims**
Sr Employee Benefits Rep	**Eligibility and Claims**
HR Representative	**Eligibility and Claims**
HR Directors	**Eligibility and Claims**
HR Officers	**Eligibility and Claims**
Benefits Rep	**Eligibility and Claims**
HR Generalist	**Eligibility and Claims**
Senior Office Assistant	**Eligibility and Claims**
HR Specialist	**Eligibility and Claims**
HR Advisor	**Eligibility and Claims**
Business Administrator 1	**Eligibility and Claims**
Financial Specialist II	**Eligibility and Claims**
Business Coordinator II	**Eligibility and Claims**
Associate Director, Workday Services	**Eligibility and Claims**

Business Associate Authorizations
Identify your Business Associates and employees at that Business Associate that BCBSTX is authorized to release PHI to on your behalf. Use a different line for each Business Associate and include the following information: **COMPANY NAME, JOB TITLE, NAME (optional) and any LIMITATIONS or RESTRICTIONS on the data release.**
[redacted]
***A&M System holds BAA**
****BCBSTX holds BAA**

Note: The GHP is responsible for notifying BCBSTX if any information listed on this form changes.

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"

☐ ☐ ☒

Account Information	NO CHANGES	SEE ADDITIONAL PROVISIONS

☐ ☐

Producer of Record NO CHANGES SEE ADDITIONAL PROVISIONS

Effective: _____

If applicable, the below-named producer(s) or agency(ies) is/are recognized as the Employer's Producer of Record (POR) to act as representative in negotiations with and to receive commissions from Blue Cross and Blue Shield of Texas, a division of Health Care Service Corporation (HCSC), a Mutual Legal Reserve Company, and HCSC subsidiaries for Employer's employee benefit programs. This statement rescinds any and all previous POR appointments for the Employer. The POR is authorized to perform membership transactions on behalf of the Employer. This appointment will remain in effect until withdrawn or superseded in writing by Employer.

Producer or Agency to whom commissions are to be paid*: _____

Texas Producer #: _____ NPN: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____ Email: _____

Is Producer/Agency appointed with HCSC in Texas? ☐ Yes ☐ No General Agent? ☐ Yes ☐ No

Affiliated with General Agent? ☐ Yes ☐ No

Is there a secondary Producer or Agency to whom commissions are to be paid? ☐ Yes ☐ No

If Yes, Producer or Agency to whom commissions are to be paid*:** _____

Texas Producer #: _____

NPN: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Fax: _____ Email: _____

Is Producer /Agency appointed with HCSC in Texas? ☐ Yes ☐ No General Agent? ☐ Yes ☐ No

Affiliated with General Agent? ☐ Yes ☐ No

If commission split**, designate percentage for each producer/agency (total commissions paid must equal 100%):

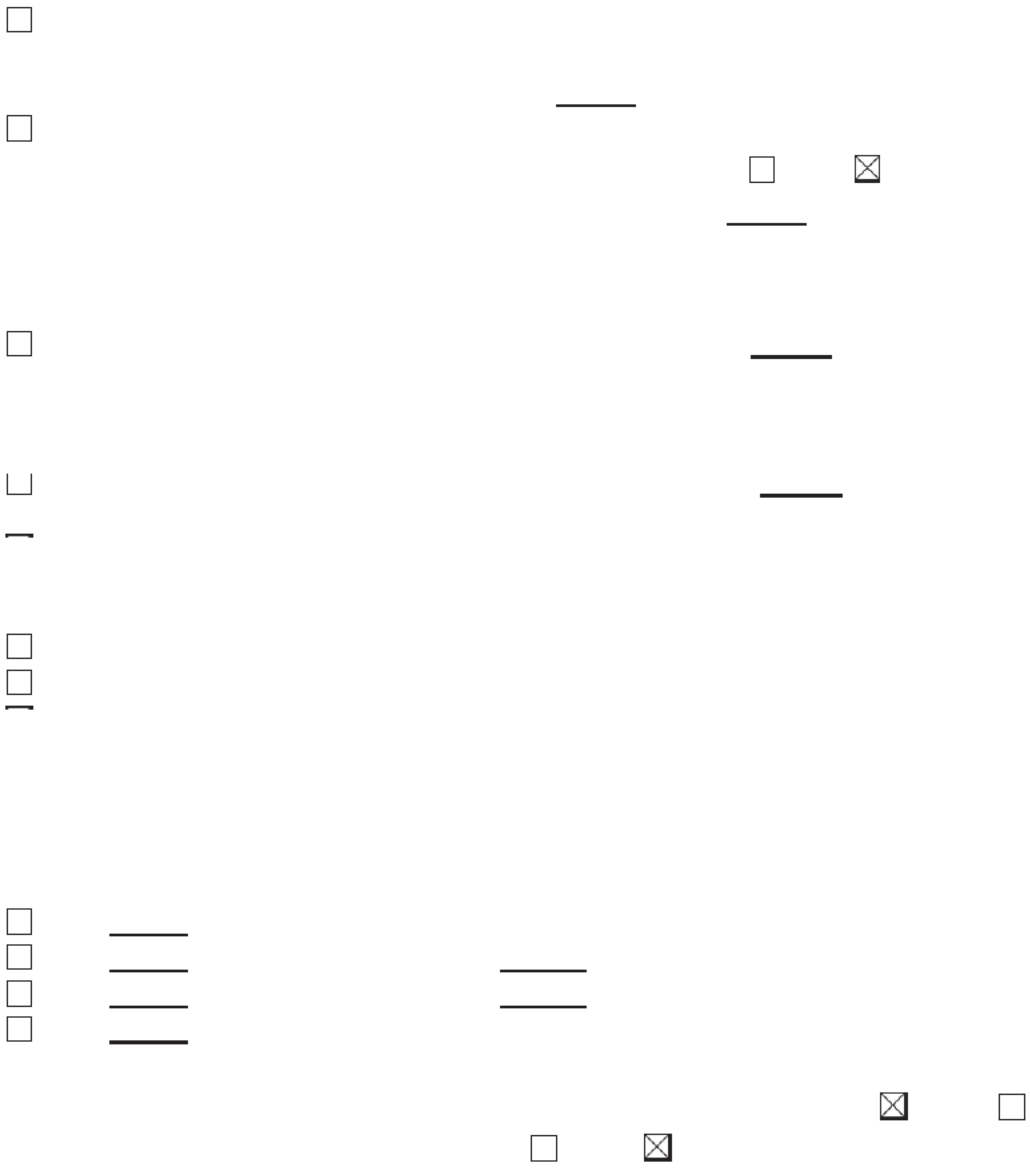
Producer /Agency 1:_____% Producer /Agency 2:_____%

Multiple Location Agency(ies): If servicing agency is not listed above as primary or secondary Producer or Agency above, specify location below:

* The Producer or agency name(s) above to whom commissions are to be paid must exactly match the name(s) on the appointment application(s).

** If commissions are split, please provide the information requested above on both producers/agencies. **Both** must be appointed to do business with HCSC in Texas.

Schedule of Eligibility ☐ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS



5. **Domestic partners covered**: ☐ Yes No
   If yes, a domestic partner is eligible to enroll for coverage.
   If yes, are domestic partners eligible for continuation of coverage? ☐ Yes ☐ No
   If yes, are dependents of domestic partners eligible to enroll for coverage? ☐ Yes ☐ No
   If yes, are dependents of domestic partners eligible for continuation of coverage? ☐ Yes ☐ No

   The Employer is responsible for providing notice of possible tax implications to those Covered Employees with coverage for domestic partners.

date and the off cycle allowed rules.

Member's COBRA/Continuation of coverage will be automatically cancelled at the end of the member's eligibility period.
**Not recommended for accounts with automated eligibility*

CURRENT ELIGIBILITY INFORMATION

☐ **NO CHANGES** ☐ **Current number of Employees enrolled_____** ☐ **SEE ADDITIONAL PROVISIONS**
Current Employee Eligibility Information only applies to new accounts. If your account is renewing, please just indicate the current number of enrolled employees (above).

Total number of Employees/Subscribers:

1. on payroll _____
2. total number of employees presently eligible for coverage _____
3. on COBRA continuation coverage _____
4. with retiree coverage (if applicable) _____
5. who work part-time _____
6. serving the new hire waiting period _____
7. declining because of other **group** coverage (e.g., other commercial group coverage, Medicare, Medicaid, TRICARE/Champus) _____
8. declining coverage (not covered elsewhere) _____

Lines of Business (Check all applicable services)	☐ **NO CHANGES** ☐ **See *Additional Provisions***
☒ ☐ ☐ ☐ ☐ _____ ☐ _____ ☐ ☐	☐ ☐ ☐ ☐ ☒ ☐ ☐ ☐ ☐ ☐ _____

FEE SCHEDULE

Payment Specifications	NO CHANGES	SEE ADDITIONAL PROVISIONS
☐ ☐ ☒ ☐ ☒ ☐ ☐		

please specify: Months.

Administrative Per Employee per Month (PEPM) Charges	NO CHANGES	☒ SEE ADDITIONAL PROVISIONS		
	Acitves/ Pre 65	MDCR		
Administrative Fee	$		$____	$____
Dental	$____	$____	$____	$____
Limited Fiduciary Services	$____	$____	$____	$____
*Rebate Credit for the Prescription Drug Program	$____	$____	$____	$____
Outpatient Imaging Management Services	$____	$____	$____	$____
Management of the Virtual Visits Program	$____	$____	$____	$____
Blue Care Connection®	$____	$____	$____	$____
Wellbeing Management	$____	$____	$____	$____

Health Advocacy Solutions	$_____	$_____	$_____	$_____
Commissions	$_____	$_____	$_____	$_____
Other: Other Services List Service: Evive			$_____	$_____
Other: Select Service Category List Service: BVA		$_____	$_____	$_____
Other: Other Services List Service: MD Live			$_____	$_____
Miscellaneous: WBM Empower +		$_____	$_____	$_____
Miscellaneous: PEPM will be added to Admin Fee. Hinge Health, Livongo, NS, and Omada	$_____		$_____	$_____
Total			$_____	$_____

*The Rebate Credit is a per Covered Employee per month credit applied to the monthly billing statement. The Employer and Claim Administrator have agreed to the Rebate Credit and Employer agrees that it and its group health plan have no right to, or legal interest in, any portion of the rebates, either under the pharmacy benefit or the medical benefit, actually provided by the Pharmacy Benefit Manager ("PBM") or a pharmaceutical manufacturer to Claim Administrator and consents to Claim Administrator's retention of all such rebates. The Rebate Credit will be provided from Claim Administrator's own assets and may or may not equal the entire amount of rebates actually provided to Claim Administrator by the PBM or expected to be provided. Rebate Credits shall not continue after termination of the Prescription Drug Program. Employer agrees that any provision in the governing Administrative Services Agreement to the contrary is hereby superseded.

Administrative Line Item Charges	Frequency	Amount
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____	$_____
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____	$_____
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____	$_____
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____	$_____
Miscellaneous: _____	Select Billing Frequency If applicable, describe other: _____	$_____
Miscellaneous: _____	Select Billing Frequency If applicable, describe other: _____	$_____
	Total:	$_____

Other Service and/or Program Fee(s) ☐ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS

Not applicable to Grandfathered Plans No

Reimbursement Service ☒ ☐

If yes: It is understood and agreed that in the event BCBSTX makes a recovery on a third-party liability claim, BCBSTX will

Third-Party Recovery Vendors and Law Firms Provisions (other than Reimbursement Services):

Alternative Compensation Arrangements:

Termination Administrative Charges				
As applies to the Run-Off Period indicated in the Payment Specifications section above: 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.				
Service				
Medical Run-off Administration Charge	$____	$____	$____	$____
Dental Run-off Administration Charge	$____	$____	$____	$____
Miscellaneous	$____	$____	$____	$____
Miscellaneous	$____	$____	$____	$____
Total:	$____	$____	$____	$____

Other Provisions ☐ **NO CHANGES** ☐ **SEE ADDITIONAL PROVISIONS**

1. **Summary of Benefits & Coverage**:

2. **Massachusetts Health Care Reform Act**:

If no: The Employer acknowledges it will provide written statements and electronic reporting to the Massachusetts Department of Revenue as required by the Massachusetts Health Care Reform Act.

3. **Alternative Care Management Program** (this is a component of the purchased medical management program):

4. **Prior Authorization** (this is a component of the purchased medical management program): Employer acknowledges and agrees to utilize Claim Administrator's standard list of services and supplies for which pre-notification or preauthorization is required: Yes No ☐
   If no, Employer authorizes Claim Administrator to post Employer's pre-notification or preauthorization requirements on Claim Administrator's Website: ☐ Yes ☐ No

5. **Essential Health Benefits ("EHB") Election**:
   Employer elects EHBs based on the following:

6. **Employer contribution**:

Employer Contribution – Medical	Employer Contribution – Dental
of Employee's premium, or $_____	_____ % of Employee's premium, or $_____
of Dependent's premium, or $_____	_____ % of Dependent's premium, or $_____

Comments: _____

7. This ASO BPA is binding on both parties and 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.

8. **Producer/Consultant Compensation:** The Employer acknowledges that if any producer/consultant acts on its behalf for purposes of purchasing services in connection with the Employer's Plan under the Administrative Services Agreement to which this ASO BPA is attached, the Claim Administrator may pay the Employer's producer/consultant a commission and/or other compensation in connection with such services under the Agreement. If the Employer desires additional information regarding commissions and/or other compensation paid the producer/consultant by the Claim Administrator in connection with services under the Agreement, the Employer should contact its producer/consultant.

Additional Provisions: Not applicable renewal and non ERISA account

3 Year Communications Credit

3 Year Evive 360 Credit):

I UNDERSTAND AND AGREE THAT:

1. **Only complete for new accounts:** Receipt by HCSC of the advance administrative fee (where applicable), in the amount of $; 0, and completed enrollment forms does not constitute approval and acceptance by the HCSC Home Office.
2. HCSC will report the value of all remuneration by HCSC 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.

Signature

PROXY

The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members is scheduled to be held each year in the corporate headquarters on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice provided to the member not less than thirty (30) nor more than sixty (60) days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least twenty (20) days prior to any meeting of members or by attending and voting in person at any annual or special meeting of members.

From time to time, HCSC pays indemnification or advances expenses to directors, officers, employees or agents consistent with HCSC's bylaws then in force and as otherwise required by applicable law.

Group No.: _____ By: Texas Government funded entities can not sign Proxy
Print Signer's Name Here

➡ _____
Signature and Title

Group Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Dated this _____ day of _____
Month Year

EXHIBIT-PG

ADDENDUM PG
PERFORMANCE GUARANTEES

IN WITNESS WHEREOF, the parties have executed this Exhibit-PG to remain in effect for the indicated period of time.

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

TEXAS A&M UNIVERSITY SYSTEMS

ATTACHMENT 2 – ADDITIONAL INFORMATION FORM

Self-Funded Accounts

This replaces and amends any existing Additional Information Form

(Please print or type and complete the form in its entirety)

Note: The GHP is responsible for notifying BCBSTX if any information listed on this form changes.

[redacted]

Target Claims Information

Target Claim Cost Formula - Age/Gender/Dependent Status Factor Adjustment – See the attached illustrative workbook

EO = Employee Only
EC = Employee and One or more Children
ES = Employee and Spouse
ESC = Employee, Spouse, and One or more Children

	FACTORS								
Employee Age	**15 - 29**	**30 - 39**	**40 - 44**	**45 - 49**	**50 - 54**	**55 - 59**	**60 - 64**	**65 - 69**	**70+**
Male									
EO									
EC									
ES									
ESC									
Female									
EO									
EC									
ES									
ESC									

[redacted]

Target Claims Information

Additions to EO rates for EC, ES, and ESC are independent of employee age and gender. Note: The above is to be used for comparison ratios only. Be sure that the same age-definition basis is used for both portions of the comparison (e.g., age last birthday.

Target Claims Information

[redacted]

The actual incurred claims for the plan year will be compared against the TCC for that plan year. Payouts will be determined based on the following payment schedule:

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

);

Target Claims Information

[redacted]

[redacted]

(None)

Electronic Record and Signature Disclosure:
Accepted: 9/24/2021 9:58:30 AM
ID: d3676ba8-5fea-44af-8cf5-2145d19e0df9

ELECTRONIC RECORD AND SIGNATURE DISCLOSURE

From time to time, The Texas A&M University System (we, us or Company) may be required by law to provide to you certain written notices or disclosures. Described below are the terms and conditions for providing to you such notices and disclosures electronically through your DocuSign, Inc. (DocuSign) Express user account. Please read the information below carefully and thoroughly, and if you can access this information electronically to your satisfaction and agree to these terms and conditions, please confirm your agreement by clicking the 'I agree' button at the bottom of this document.

Getting paper copies

At any time, you may request from us a paper copy of any record provided or made available electronically to you by us. For such copies, as long as you are an authorized user of the DocuSign system you will have the ability to download and print any documents we send to you through your DocuSign user account for a limited period of time (usually 30 days) after such documents are first sent to you. After such time, if you wish for us to send you paper copies of any such documents from our office to you, you will be charged a $0.00 per-page fee. You may request delivery of such paper copies from us by following the procedure described below.

Withdrawing your consent

If you decide to receive notices and disclosures from us electronically, you may at any time change your mind and tell us that thereafter you want to receive required notices and disclosures only in paper format. How you must inform us of your decision to receive future notices and disclosure in paper format and withdraw your consent to receive notices and disclosures electronically is described below.

Consequences of changing your mind

If you elect to receive required notices and disclosures only in paper format, it will slow the speed at which we can complete certain steps in transactions with you and delivering services to you because we will need first to send the required notices or disclosures to you in paper format, and then wait until we receive back from you your acknowledgment of your receipt of such paper notices or disclosures. To indicate to us that you are changing your mind, you must withdraw your consent using the DocuSign 'Withdraw Consent' form on the signing page of your DocuSign account. This will indicate to us that you have withdrawn your consent to receive required notices and disclosures electronically from us and you will no longer be able to use your DocuSign Express user account to receive required notices and consents electronically from us or to sign electronically documents from us.

All notices and disclosures will be sent to you electronically

Unless you tell us otherwise in accordance with the procedures described herein, we will provide electronically to you through your DocuSign user account all required notices, disclosures, authorizations, acknowledgements, and other documents that are required to be provided or made available to you during the course of our relationship with you. To reduce the chance of you inadvertently not receiving any notice or disclosure, we prefer to provide all of the required notices and disclosures to you by the same method and to the same address that you have given us. Thus, you can receive all the disclosures and notices electronically or in paper format through the paper mail delivery system. If you do not agree with this process, please let us know as described below. Please also see the paragraph immediately above that describes the consequences of your electing not to receive delivery of the notices and disclosures electronically from us.

How to contact The Texas A&M University System:
You may contact us to let us know of your changes as to how we may contact you electronically, to request paper copies of certain information from us, and to withdraw your prior consent to receive notices and disclosures electronically as follows:
To contact us by email send messages to: identity@tamu.edu

To advise The Texas A&M University System of your new e-mail address
To let us know of a change in your e-mail address where we should send notices and disclosures electronically to you, you must send an email message to us at identity@tamu.edu and in the body of such request you must state: your previous e-mail address, your new e-mail address. We do not require any other information from you to change your email address..
In addition, you must notify DocuSign, Inc to arrange for your new email address to be reflected in your DocuSign account by following the process for changing e-mail in DocuSign.

To request paper copies from The Texas A&M University System
To request delivery from us of paper copies of the notices and disclosures previously provided by us to you electronically, you must send us an e-mail to identity@tamu.edu and in the body of such request you must state your e-mail address, full name, US Postal address, and telephone number. We will bill you for any fees at that time, if any.

To withdraw your consent with The Texas A&M University System
To inform us that you no longer want to receive future notices and disclosures in electronic format you may:

i. decline to sign a document from within your DocuSign account, and on the subsequent page, select the check-box indicating you wish to withdraw your consent, or you may;
ii. send us an e-mail to identity@tamu.edu and in the body of such request you must state your e-mail, full name, IS Postal Address, telephone number, and account number. We do not need any other information from you to withdraw consent.. The consequences of your withdrawing consent for online documents will be that transactions may take a longer time to process..

Required hardware and software

Operating Systems:	Windows2000? or WindowsXP?
Browsers (for SENDERS):	Internet Explorer 6.0? or above
Browsers (for SIGNERS):	Internet Explorer 6.0?, Mozilla FireFox 1.0, NetScape 7.2 (or above)
Email:	Access to a valid email account
Screen Resolution:	800 x 600 minimum
Enabled Security Settings:	•Allow per session cookies •Users accessing the internet behind a Proxy Server must enable HTTP 1.1 settings via proxy connection

** These minimum requirements are subject to change. If these requirements change, we will provide you with an email message at the email address we have on file for you at that time providing you with the revised hardware and software requirements, at which time you will have the right to withdraw your consent.

Acknowledging your access and consent to receive materials electronically
To confirm to us that you can access this information electronically, which will be similar to other electronic notices and disclosures that we will provide to you, please verify that you were able to read this electronic disclosure and that you also were able to print on paper or electronically save this page for your future reference and access or that you were able to e-mail this disclosure and consent to an address where you will be able to print on paper or save it for your future reference and access. Further, if you consent to receiving notices and disclosures exclusively in electronic format on the terms and conditions described above, please let us know by clicking the 'I agree' button below.
By checking the 'I Agree' box, I confirm that:

- I can access and read this Electronic CONSENT TO ELECTRONIC RECEIPT OF ELECTRONIC RECORD AND SIGNATURE DISCLOSURES document; and

- I can print on paper the disclosure or save or send the disclosure to a place where I can print it, for future reference and access; and

- Until or unless I notify The Texas A&M University System as described above, I consent to receive from exclusively through electronic means all notices, disclosures, authorizations, acknowledgements, and other documents that are required to be provided or made available to me by The Texas A&M University System during the course of my relationship with you.