BOARD OF TRUSTEES
AGENDA

☐	Workshop	x	Regular	☐	Special

(A) ☐ Report Only ☐ Recognition

Presenter(s):

Briefly describe the subject of the report or recognition presentation.

(B) x **Action Item**

Presenter(s): **ISMAEL MIJARES, DEPUTY SUPERINTENDENT FOR BUSINESS & FINANCE**
LUIS VELEZ, PURCHASING DIRECTOR

Briefly describe the action required.

CONSIDER AND TAKE APPROPRIATE ACTION ON THE REQUEST TO APPROVE THE SERVICE AGREEMENT FOR ELAP SERVICES, LLC AND THE BOARD DELEGATES THE SUPERINTENDENT OR DESIGNEE THE AUTHORITY TO MAKE RELATED BUDGETED PURCHASES OF GOODS OR SERVICES AS PER BOARD POLICY CH.

(C) **Funding source: Identify the source of funds if any are required.**

BUDGETED FUNDS

(D) **Clarification: Explain any question or issues that might be raised regarding this item.**

SEE ATTACHED

May 20, 2019

Gilberto Gonzalez
Superintendent of Schools
Eagle Pass Independent School District
1420 Edison Road
Eagle Pass, TX 78853

Re: Renewal of Services Agreement

Dear Mr. Gonzalez:

Attached please find for your review and execution an Amendment to the existing Core Services Agreement and Cost-Containment Services Agreement between Eagle Pass Independent School District (and its health plan) and ELAP Services, LCC.

This letter is to confirm our mutual understanding and agreement that in exchange for a go-forward five (5) year renewal commitment with ELAP Services, LLC and Group & Pension Administrators, Inc. ("GPA") specific to Eagle Pass Independent School District and its health plan only, ELAP and GPA will provide the following:

1. ELAP will send a renewal incentive payment of one-hundred and fifty thousand dollars ($150,000.00) to be used exclusively for the health plan's administrative expenses; and
2. GPA will provide a fifty thousand dollar ($50,000.00) credit from GPA for its administrative services to the health plan.

We value and appreciate your business. We look forward to continuing to build upon our solid relationship. Please sign the attached Amendment and this letter indicating your agreement as stated herein. Thank you for your collaboration.

Sincerely,

Jeffrey J. Norton, Vice President & General Counsel

cc: Steve McGilvery, ELAP Services, LLC (610) 249- 0741
Jeff McPeters, GPA (972) 689-4928

Agreed and Accepted by:

_____
Eagle Pass Independent School District

CORE SERVICES AND COST-CONTAINMENT SERVICES AGREEMENT AMENDMENT No. 1

The Core Services Agreement and Cost-Containment Services Agreement (the "Agreement") by and between Eagle Pass Independent School District and its health plan having its principal office at 1420 Edison Rd., Eagle Pass, TX 78853 (the "Employer") and ELAP Services, LLC ("ELAP") (each a "Party" and, together, the "Parties") are hereby amended as set forth below effective as of September 1, 2019.

WHEREAS, the Parties entered into a certain Core Services Agreement and a Cost-Containment Services Agreement dated September 1, 2018 pursuant to which the Parties agreed that ELAP would provide certain services to Employer related to Employer's sponsorship and administration of the Eagle Pass Independent School District Benefit Plan (the "Plan"). Employer and ELAP now desire to amend the terms and conditions as follows:

I. Amendment No. 1 to Core Services Agreement and Cost-Containment Services Agreement

The original Section 2.1 Term and Section 2.2(a) Termination Without Cause will be deleted and replaced with the following:

2.1 Term. The renewed initial term of this Agreement shall begin on September 1, 2019 ("Effective Date") and shall run for a period of five (5) years from the Effective Date ("Renewed Initial Term"). The Agreement shall renew automatically for additional one-year terms upon each annual anniversary of the Effective Date unless earlier terminated as provided herein.

2.2 Termination. The parties may terminate this Agreement as follows:

(a) **Termination Without Cause.** Either party may terminate the Agreement at any time by giving at least sixty (60) days prior written notice to the other party. The termination is effective no earlier than sixty (60) days from the date that either party provides notice of termination. The parties may agree to extend this Agreement beyond the effective date of termination for an agreed upon run-out period provided that the parties continue to perform their respective duties and obligations under the terms of this Agreement and provided further that no changes are made to the Plan Documents which would impair ELAP's ability to satisfy its duties and obligations under the terms of this Agreement.

Exhibit D, Fee Schedule of the Core Services Agreement, is hereby amended to add the following at the end of the Exhibit:

EXHIBIT D

Fee Schedule

Claim Review and Audit Program Services. Fees shall not exceed $7,500 for Claims in excess of $75,000.

Dialysis. In the limited instance a Plan Member has a routine, maintenance dialysis treatment at an outpatient dialysis facility or as a part of a self-care dialysis program ("Outpatient Dialysis") for End Stage Renal Disease ("ESRD") prior to becoming entitled to benefits under Medicare Part A and B solely under 42 U.S.C. §426-1 ("ESRD-based Medicare"), ELAP's compensation for auditing Outpatient Dialysis claims prior to Plan Member becoming entitled to ESRD-based Medicare shall be calculated in accordance with this Exhibit D, but ELAP's compensation shall be reduced, if necessary, such that it does not exceed the amount of the Allowable Claim Limit for each Outpatient Dialysis Health Benefit Claim subjected to the audit with an effective May 1, 2019 audit completion date or later.

On behalf of:

Eagle Pass Independent School District	**ELAP Services, LLC**
By: _____	By: _____
Name: _____	Name: _____
Title: _____	Title: _____

CORE SERVICES AGREEMENT

This Core Services Agreement (the "Agreement"), made as of September 1, 2018 (the "Effective Date"), by and among Eagle Pass Independent School District, having its principal office at 1420 Edison Rd., Eagle Pass, TX 78853 (the "Employer"), and ELAP Services, LLC, having its principal office at 1550 Liberty Ridge Drive, Wayne, PA 19087 ("ELAP");

WITNESSETH:

Whereas, the Employer has established or desires to establish Eagle Pass Independent School District Benefit Plan for the purpose of providing certain group-health plan benefits to eligible participants (the "Plan");

Whereas, ELAP is a service provider that offers and provides, through itself and/or its affiliates, claims-review services, claims-audit services, appeal review and determinations, and various other similar and related services;

Whereas, the Employer desires to engage ELAP to provide claims-review services, claims-audit services, appeal review and determinations and various other similar and related services to the Plan;

Whereas, the Employer desires to delegate certain powers and authorities it has under the Plan, as described in this Agreement, to ELAP and ELAP desires to accept such delegation upon the terms and conditions set forth in this Agreement; and

Now, therefore, in consideration of the mutual covenants and agreements hereinafter contained, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, and intending to be legally bound hereby, the parties hereto agree as follows:

ARTICLE 1. DEFINITIONS

Capitalized terms which are not otherwise defined in this Agreement (including any Exhibit to this Agreement) shall have the meanings set forth in the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), or in any other relevant and applicable agreement between the Employer and ELAP. As used herein, the following terms shall be defined as follows:

(a) **"Allowable Claim Limit"** shall have the meaning set forth in the Plan Documents and, to the extent not inconsistent with the Plan Documents, shall refer to the reimbursement limits established by the

Plan for health, wellness, medical services and supplies listed and included as Covered Benefits under the Plan.

(b) **"Charges"** shall mean the fees that a Medical Provider charged a Plan Participant or the Plan on a Claim.

(c) **"Claim"** shall mean a medical benefit claim submitted by a Plan Participant or Medical Provider, after the Plan Participant has received services from a Medical Provider, to the Plan for reimbursement, provided that, for purposes of this Agreement, the term "Claim" will be limited to only those medical benefit claims for reimbursement that have been submitted by the Plan Administrator, after the Plan Administrator (and/or their designee with regard to such functions) has made a determination with regard to Medical and Participant Eligibility, to ELAP for audit and determination of Allowable Claim Limit, provided such Claim was submitted for audit during the term of this Agreement.

(d) **"Claim Review and Repricing Service"** shall mean the services of ELAP described in Article 5.2(a) of this Agreement.

(e) **"Clean Claim"** shall mean a Claim for which ELAP has received all the information necessary to perform an audit and determine the Allowable Claim Limit provided that the Plan Administrator submitted the Claim to ELAP prior to payment and within three (3) business days of receipt. A Claim shall be considered a "Clean Claim" when ELAP receives (i) the form UB or the form CMS 1500; (ii) for claims of twenty five thousand dollars ($25,000) or greater, the itemized statement of charges and/or any Centers for Medicare & Medicaid Services ("CMS") forms; and (iii) if requested by ELAP, medical records and other documentation that substantiate or purport to substantiate the Charges.

(f) **"Covered Benefits"** shall mean health, wellness, medical services and supplies, and other health benefits eligible for reimbursements in accordance with the provisions of the Plan.

(g) **"ELAP Covered Expenses"** shall mean the following expenses for the defense of a Disputed Audit or a Referred Appeal reviewed by ELAP: (i) the cost of consultations and/or reviews by experts, if such experts are retained by ELAP; (ii) attorneys' fees, if such attorneys are retained or approved by ELAP; (iii) other investigation, adjudication and defense costs and expenses with the prior written consent of ELAP ; and (iv) when the Plan is a party to a Direct Agreement, attorneys' fees and costs incurred by a Medical Provider if a court of competent jurisdiction finally determines that a Medical Provider is entitled to reimbursement of some portion or all of such fees and costs from the Plan Sponsor, the Plan Administrator and/or the Plan. ELAP Covered Expenses shall also include settlements that the ELAP elects to pay pursuant to Article 4(d).

(h) **"Direct Agreement"** shall mean the complete agreement between a Directly Contracted Provider and ELAP or any of the Plan Sponsor, the Plan Administrator and/or the Plan, which agreement contains the terms and conditions under which the Plan or a Plan Participant may access discounted fees and/or

negotiated or scheduled reimbursement rates, and which fees/rates the Plan adopts as Allowable Claim Limits for Claims submitted by such Directly Contracted Providers.

(i) **"Directly Contracted Provider"** shall mean a Medical Provider which has entered into a Direct Agreement with ELAP or any of the Plan Sponsor, the Plan Administrator and/or the Plan to provide certain medical services to Plan Participants at agreed upon Allowable Claim Limits.

(j) **"Disputed Audit"** shall mean a Claim reimbursed at the Allowable Claim Limit determined by ELAP, where such Claim is the subject of an appeal for additional reimbursement by a Plan Participant and/or a Medical Provider.

(k) **"Disputed Audit Appeal Services"** shall mean the services of ELAP described in Article 5.2(c) of this agreement.

(l) **"Excluded Benefits"** shall mean health benefits, medical services and supplies not covered under the Plan and/or not subject to reimbursement under the provisions of the Plan.

(m) **"HIPAA"** shall mean the Health Insurance Portability and Accountability Act of 1996, as amended (including amendments under the Health Information Technology for Economic and Clinical Health Act), and regulations and applicable guidance promulgated by the Secretary of the Department of Health and Human Services.

(n) **"Medical Eligibility"** shall mean the determination by the Plan Administrator (and/or their designee with regard to such functions) that medical services provided or to be provided by a Medical Provider to a Plan Participant are Covered Benefits under the terms of the Plan.

(o) **"Medical Provider"** shall mean any individual or facility, operating within the scope of a license (when licensure is required under applicable law), who furnishes, bills or is paid for health care in the normal course of business and includes, but is not limited to, a physician, nurse, hospital, ambulatory surgical center, ambulatory clinic, psychiatric hospital, community mental health center, residential treatment facility, substance abuse treatment center, alternative birthing center, home health care center, skilled nursing facility, ground and air ambulance, and any other such individual, professional group or facility that the Plan approves.

(p) **"Participant Eligibility"** shall mean the determination by the Plan Administrator (and/or their designee with regard to such functions) that the Plan Participant is eligible to receive Covered Benefits under the Plan.

(q) **"Plan Administrator"** shall mean the "administrator" of the Plan, within the meaning of Section 3(16)(A) of ERISA.

(r) **"Plan Documents"** shall mean the documents (including, but not limited to, the Summary Plan Description and any Summaries of Material Modification and any Amendments) establishing, governing, and setting forth eligibility criteria for Covered Benefits under the Plan.

(s) **"Plan Participant"** shall mean, with regard to any Referred Appeal, Disputed Audit or Clean Claim submitted to ELAP (and at the time such Referred Appeal or Clean Claim is submitted to ELAP), a person whom the Plan Administrator (and/or their designee with regard to such functions) determines is eligible for benefits under the Plan.

(t) **"Plan Sponsor"** shall mean the "plan sponsor" of the Plan, within the meaning of Section 3(16)(B) of ERISA.

(u) **"Referred Appeal"** shall mean the referral by the Plan Administrator to ELAP of a final appeal, made in accordance with the terms of the Plan by a Plan Participant or a Medical Provider, to review the benefits denied by the Plan Administrator (for services provided (or to be provided) by a Medical Provider) on the basis that (1) such services are not Covered Benefits under the Plan, or (2) that if such services are Covered Benefits, the Plan is not financially responsible for some or all of the payment amount. "Referred Appeal" shall not mean any appeal for any "claim involving urgent care" which is also a "pre-service claim" (both terms as defined in subsection (m) of 29 C.F.R. § 2560.503-1 (the "DOL Claims Regulations")), the adjudication of which shall be the sole responsibility of the Plan Administrator and any other person or entity to whom it may delegate such responsibility. "Referred Appeal" shall include appeals for an external review as defined in the Public Health Service Act (PHS Act) section 2719(b).

(v) **"Referred Appeal Services"** shall mean the services of the ELAP described in Article 5.1 of this agreement.

(w) **"Third Party Administrator"** shall mean any entity who, pursuant to a contractual arrangement with the Plan, Plan Sponsor and/or Plan Administrator, provides or will provide claims processing and/or other ministerial services to the Plan. Unless specifically indicated to the contrary, the term "Third Party Administrator" does not apply to ELAP.

ARTICLE 2. TERM AND TERMINATION

2.1 Term. The initial term of this agreement shall begin on the later of the Effective Date or the date that ELAP receives a signed copy of the Agreement (including, as appropriate, completed and/or executed copies of all applicable Exhibits) from the Employer, and shall run for a period of one (1) year from the Effective Date. The Agreement shall renew automatically for additional one-year terms upon each annual anniversary of the Effective Date unless earlier terminated as provided herein.

2.2 Termination. The parties may terminate this Agreement as follows:

(a) **Termination Without Cause.** Either party may terminate the Agreement at any time by giving at least sixty (60) days prior written notice to the other party. The termination is effective no earlier than sixty

(60) days from the date that either party provides notice of termination. The parties may agree to extend this Agreement beyond the effective date of termination for an agreed upon run-out period provided that the parties continue to perform their respective duties and obligations under the terms of this Agreement and provided further that no changes are made to the Plan Documents which would impair ELAP's ability to satisfy its duties and obligations under the terms of this Agreement.

(b) **Termination By ELAP.** ELAP may terminate this Agreement without prior notice at any time, and both this Agreement and all rights and obligations of the parties (other than (a) any rights or obligations of ELAP with regard to run-out services; and (b) any rights of ELAP under Articles 3, 7, 8 and 10 of this Agreement) shall immediately terminate, if the Plan Administrator fails to perform its responsibilities for payment of Claims and ELAP Fees under Article 8.4 of this Agreement.

(c) **Automatic Termination.** Upon the occurrence of any of the following events, both this Agreement and all rights and obligations of the parties shall terminate immediately:

1. A party's violation of or ongoing noncompliance with any material provision of this Agreement (provided that, in the event of any ongoing noncompliance by a party, the other party shall give the noncompliant party notice of such noncompliance and an opportunity to cure such noncompliance within thirty (30) days of such notice; if the noncompliance is not cured within this thirty (30) days, the Agreement and all rights and obligations of the parties shall be deemed to have automatically terminated as of the date of said notice);

2. A proceeding is commenced by a party or against a party under any provision of the United States Bankruptcy Code or under any other state or federal bankruptcy or insolvency law;

3. Proceedings are commenced seeking the appointment of a receiver, conservator, trustee, custodian or similar official for a party or for any substantial part of such party's property in relation to (or in conjunction with) proceedings seeking reorganization, arrangement, or other similar relief;

4. A party generally is not paying its debts as such debts become due (including any extensions and/or grace periods), or admits in writing its inability to pay such debts generally, or makes a general assignment for the benefit of creditors;

5. Commission by a party, as evidenced by commencement of judicial or administrative proceedings so alleging, of (i) a felony or a crime involving moral turpitude; (ii) an act or omission constituting fraud, dishonesty, or disloyalty, or (iii) professional misconduct; or

6. A party's violation, as reasonably determined by the affected party, of any material law, rule or regulation applicable to it or its business, including, without limitation, HIPAA.

2.3 Effect of Termination. Upon termination, except as otherwise stated in this Agreement, the rights and obligations of the parties under this Agreement shall terminate and the authorities granted to ELAP shall be rescinded. For each Disputed Audit and/or Referred Appeal, the services that ELAP provides to the Employer and the Plan under Article 5 of this Agreement shall survive termination of this Agreement for a period extending from the date ELAP audited the Claim through a period of one (1) year post termination, including any agreed upon run-out period, and the Covered Expenses provided under Article 6 of this Agreement shall survive termination of this Agreement for a period of time not exceeding the statute of limitation for breach of contract applicable to collection of medical debt in the state in which the Plan is incorporated, provided that:

(a) The Plan and/or the Plan Sponsor paid the fees of ELAP in full;

(b) The Disputed Audit and/or Referred Appeal was submitted to ELAP one (1) year after termination of this Agreement and the Claim date of service was incurred when the Agreement was in effect.; and

(c) The services apply to Disputed Audits of Claims where:

1. ELAP audited the Disputed Audit and determined the Allowable Claim Limit prior to termination of this Agreement; and
2. The Plan reimbursed the Claim that was the subject of the Disputed Audit at the Allowable Claim Limit determined by ELAP.

ARTICLE 3. REPRESENTATIONS OF PARTIES

3.1 Representations of the Employer. The Employer hereby makes the following representations:

(a) The Employer is the Plan Sponsor of the Plan, and in that capacity, has the authority to enter into this Agreement and further has the authority to act, as appropriate, as "settlor" of the Plan;

(b) The Employer is the Plan Administrator of the Plan, and in that capacity, may act as a fiduciary with regard to and has authority for, among other matters, (i) the review of benefit claims under the Plan, and (ii) the proper and efficient operation of the Plan, including authority to audit claims;

(c) The Plan grants to the Plan Administrator the authority, consistent with applicable law, to delegate any or all of its powers and authorities under the Plan;

(d) The Plan Administrator has delegated certain of its administrative duties to the Third Party Administrator; and

(e) The Plan Sponsor, as "settlor", has amended the Plan to adopt certain provisions as designated in Exhibits A and B.

3.2 Representations of ELAP. ELAP hereby represents that it is a limited liability company, duly constituted and formed under the laws of the State of Delaware, and that ELAP maintains all current licenses and/or registrations as may be required under the laws of the Commonwealth of Pennsylvania.

ARTICLE 4. DELEGATION OF POWERS AND AUTHORITIES

The Plan Administrator hereby appoints ELAP as a co-fiduciary of the Plan, and ELAP accepts such appointment, solely for the following purposes and with full discretion and authority to accomplish the following:

(a) Review and, subject to the ultimate approval of the Plan Administrator (and/or the designee of the Plan Administrator), decide and negotiate the settlement of any and all Referred Appeals regarding issues which relate to Claims (including determining what services, supplies, care and treatments are Covered Benefits) and/or which relate to rights of Plan Participants;

(b) Determine Allowable Claim Limits in accordance with the provisions of the Plan for Claims it audits;

(c) Review and decide any and all Disputed Audits;

(d) Negotiate the settlement of any and all Disputed Audits;

(e) Negotiate and enter into Direct Agreements on behalf of the Plan;

(f) Use the services of third party consultants as it deems necessary in the exercise of the authorities granted in (a) to (d) above, provided that ELAP pays any fees associated therewith.

In carrying out its co-fiduciary responsibilities to the Plan as set forth above, ELAP shall act prudently and adhere to the applicable ERISA fiduciary standards of conduct as set forth in Sections 404(a)(1)(A), (a)(1)(B) and (a)(1)(D) (29 U.S.C. § 1104(a) (1) (A), (B) and (D)). The Plan Administrator shall have the authority to override any and all Claims decisions and/or determinations (including Disputed Audits and Referred Appeals) made by ELAP, provided, however, that to the extent that the Plan Administrator overrides any decision and/or determination made by ELAP, ELAP shall not be considered to be a fiduciary with regard to such decision and the Plan Administrator will fully indemnify and make whole ELAP with regard to any claims or disputes (and any expenses related to such claims and disputes) arising out of, or in any way related to, such decisions and/or determinations. Except as provided above, ELAP shall have no fiduciary authority over the Plan, shall not act as a fiduciary with respect to the Plan, and shall not be considered to be the "appropriate named fiduciary" of the Plan for purposes of Section 503 of ERISA and any and all regulations thereunder. For the avoidance of doubt (and without limiting the foregoing) when there is an override decision by the Plan Administrator, ELAP shall have no responsibility for notifying

Participants and/or Medical Providers of any claim or appeal decision (including external review rights) and is not providing external reviews of claims as may be required under the ACA.

ARTICLE 5. CORE SERVICES

In accordance with the powers and authorities delegated in Article 4 of this Agreement, ELAP shall provide the following services to the plan:

5.1 Referred Appeal Services. ELAP will review Referred Appeals in accordance with the terms of the Service Level Agreement ("SLA") appearing in Exhibit A (Referred Appeal Services SLA). In doing so, ELAP will review such Referred Appeals in accordance with the Plan's claims and appeals rules, to the extent such rules are not inconsistent with the requirements of the DOL Claims Regulations. ELAP will provide the Plan an external and independent assessment of the denial of benefits by the Plan Administrator for services provided or to be provided by a Medical Provider, and determine whether such services are Covered Benefits under the Plan and/or are the financial responsibility of the Plan.

5.2 Claim Review and Audit Program. ELAP will perform its services in accordance with the terms of the SLA appearing in Exhibit B (Claim Review and Audit Program SLA) and provide the Plan the following services:

(a) Claim Review and Repricing Service. ELAP will audit and review Claims from Directly and Non-Directly Contracted Providers in order to identify charges billed in error and/or charges for excessive or unreasonable fees, and to determine reimbursements in accordance with the Allowable Claim Limits established by the Plan.

(b) Direct Contract Services. ELAP will provide the Plan access to certain discounted fees and/or negotiated or scheduled reimbursement rates with specifically identified providers, under the terms of Direct Agreements it entered into with certain Directly Contracted Providers. On behalf of the Plan, ELAP may also negotiate terms of Direct Agreements between the Plan and Directly Contracted Providers and/or prospective Directly Contracted Providers, if and to the extent such opportunities may be presented. A list of Direct Agreements will be produced to the Plan upon request.

(c) Disputed Audit Appeal Services. ELAP will review additional information submitted by Plan Participants and/or Medical Providers for Disputed Audits and determine if the Plan should provide additional reimbursements for services received by Plan Participants above the Allowable Claim Limit that it originally determined.

ARTICLE 6. ELAP COVERED EXPENSES

The payment responsibilities of ELAP are solely as set forth in this Agreement.

6.1 ELAP Responsibility for ELAP Covered Expenses. ELAP shall be responsible for payment of all ELAP Covered Expenses (including ELAP Covered Expenses incurred by Plan Participants, provided that the Plan Participants have not pursued legal actions against the Plan and/or the Plan Sponsor with respect to Referred Appeals and/or Disputed Audits). Covered Expenses shall be paid by ELAP with ELAP solely approving the choice of legal counsel providing such legal services; provided that any ELAP liability for such legal services will end, and ELAP will have no further liability for any Covered Expenses, if the Plan refuses to cooperate with legal counsel, including refusing to assent to compromise of Claims and Referred Appeals where the proposed compromise would absolve the Plan of any liability for the disputed amount or benefit.

6.2 Exclusions.

(a) ELAP shall not be liable for any amount payable to a Medical Provider for medical services including any Disputed Audits, Referred Appeals, or any judgment or verdict arising from or compensating a Medical Provider for any Disputed Audit or Referred Appeal.

(b) ELAP shall not be liable for any ELAP Covered Expenses incurred by the Plan Sponsor, the Plan Administrator and/or the Plan in connection with any Disputed Audit or Referred Appeal, if and to the extent that such ELAP Covered Expenses are:

1. The result of disagreement between the Plan Administrator and ELAP that resulted in the Plan Administrator, in accordance with Article 4 of this Agreement, overriding the determinations made by ELAP with respect to a Referred Appeal or a Disputed Audit, or reimbursing a Claim at an amount other than the Allowable Claim Limit determined by ELAP;
2. The result of the Plan Administrator's failure to perform any of the responsibilities in Article 8 of this Agreement;
3. The result of negligence or willful misconduct by the Plan Sponsor, the Plan Administrator or the Third Party Administrator in performing its duties to the Plan and under this Agreement;
4. The result of language in the Plan Documents which is not in compliance with applicable law or which otherwise is unenforceable; or
5. The result of the Plan Sponsor's failure to provide timely funding necessary to pay a Claim as approved by ELAP.

ARTICLE 7. COMPENSATION OF ELAP

ELAP shall receive compensation for its services in accordance with this Article 7 as well as the fee schedule in Exhibit D.

7.1 Compensation for Additional Services. To the extent that the Plan or the Plan Sponsor seeks from ELAP the performance of additional services, beyond those described in this Agreement, the scope of such services, the responsibilities of each party with regard to such services, and the compensation due to ELAP for the performance of such services will be separately agreed to by the parties and will be memorialized in a separate agreement and/or an amendment or Exhibit to this Agreement.

7.2 Changes in Compensation Amounts. Notwithstanding anything to the contrary in this Agreement or in Exhibit D, ELAP may change the amount of fees stated in this Agreement and/or in Exhibit D by providing the Plan Sponsor with at least ninety (90) days advanced written notice, provided that (a) if Plan Sponsor rejects such fee change by written notice to ELAP no later than within five (5) business days of notice of such fee change, the existing fee structure will be retained and ELAP may, within ten (10) days of the fee-rejection notice from the Plan Sponsor, initiate a termination without cause (within the meaning of Article 2.2(a)) by giving the Plan Sponsor thirty (30) days prior written notice (with such termination effective thirty (30) days after such notice of termination is given); and (b) ELAP may initiate such fee change no more than once in any twelve (12) month period.

ARTICLE 8. RESPONSIBILITIES OF THE PLAN ADMINISTRATOR

The Plan Administrator shall be responsible for, and shall perform or shall cause the Third Party Administrator to perform the following responsibilities:

8.1 Plan Document and Summary Plan Description.

(a) Ensuring that the provisions adopted by the Plan with respect to the Plan document and/or the Summary Plan Description (including any current or prospective amendments and/or summaries of material modification) comply with the Patient Protection and Affordable Care Act (including any successor or replacement legislation) (collectively, the "ACA") and any other applicable laws and regulations, and are adopted by the Plan in a manner consistent with the internal amendment and/or restatement provisions of the Plan document and/or the Summary Plan Description;

(b) Ensuring that the Plan Documents are drafted to include definitions of and rules regarding both Covered Benefits and Excluded Benefits;

(c) Ensuring that provisions of the appropriate Plan Documents (including any applicable and enforceable Plan guidelines or policies) that describe Covered Benefits set forth Allowable Claim Limits, including discounted fees and/or negotiated or scheduled reimbursement rates of Direct Agreements;

(d) Ensuring that the appropriate Plan Documents describe the scope of the authority delegated to ELAP;

(e) Ensuring that all reporting and disclosure requirements under any other applicable laws are met, including with regard to any applicable filing deadlines and/or distribution timeframes; and

(f) Furnishing to ELAP copies of the Plan Documents (including any applicable and enforceable Plan guidelines or policies) together with any amendments or revisions (including any summaries of material modifications) thereto. Any amendments or revisions (including any summaries of material modifications) which are thereafter adopted shall be furnished to ELAP as soon as administratively practicable after adoption, but in no event later than the effective date of such amendment or revision.

8.2 Eligibility, Notification, Pre-Authorization and Participant Identification.

(a) Determining Medical Eligibility and Participant Eligibility;

(b) Pre-authorizing medical services to be provided to Plan Participants upon requests by Medical Providers;

(c) Keeping complete and current Patient Eligibility records, and making such eligibility records available to Medical Providers during normal business hours; and

(d) Furnishing to Plan Participants identification cards or other documentation sufficient to identify coverage under the Plan and participation in Direct Agreements.

8.3 Claims and Appeal Processing, Submission of Referred Appeals, Disputed Audits and Claims to ELAP.

(a) Complying with all requirements, including notices and disclosures to Plan Participants and Medical Providers, of the DOL Claims Regulations and the ACA, in the processing of Claims and appeals under the Plan. Further, the Plan Administrator shall review Claims and appeals of denied benefits in accordance with the terms of the Plan Documents and applicable laws;

(b) Complying with all provisions of Direct Agreements, including providing required notices, in the processing of Claims submitted under the Plan by Directly Contracted Providers;

(c) Forwarding Disputed Audits and/or Referred Appeals, including the entire file related to the Referred Appeal, to ELAP within three (3) business days of receipt, even if the Plan Participant or the Medical Provider also submits a copy to ELAP. A Disputed Audit or Referred Appeal is considered duly submitted to ELAP when the Plan Administrator provides both the Disputed Audit or Referred Appeal and the entire file relating to the Disputed Audit or Referred Appeal within the timeframe set forth in this paragraph; and

(d) Submitting, within three (3) business days of receipt, Clean Claims to ELAP for audit and determination of Allowable Claim Limit prior to payment being made to Medical Providers.

8.4 Payment of Claims and ELAP Fees.

(a) Ensuring that the Plan Sponsor provides adequate funding for payment of Claims;

(b) Ensuring that Claims are timely paid in accordance with the terms of the Plan documents and any applicable law;

(c) Paying Claims submitted by Directly Contracted Providers in accordance with the terms of the Direct Agreements. The Plan Administrator and the Plan Sponsor acknowledge and agree that failure to pay Claims within the timeframe specified by the Direct Agreements may result in the loss of any discounts and the Plan being responsible for payment of all Charges of the Directly Contracted Provider even if the Charges exceed the Allowable Claim Limits established by the Plan; and

(d) Paying ELAP fees in accordance with the provisions of Article 7 and Exhibit D of this agreement.

8.5 Notification to ELAP.

The Plan Administrator shall notify ELAP in writing within three (3) business days following the Plan Administrator having actual or constructive knowledge of (a) the commencement of any litigation relating to Referred Appeals or Disputed Audits or (b) the occurrence of any event which the Plan Administrator reasonably believes (or which a similarly situated plan administrator could reasonably believe) might give rise to litigation and/or liability of a Participant or the Plan. The commencement of any litigation or an occurrence, as used herein, shall refer to a service of complaint, writ of summons, initiation of arbitration proceedings, demand letter or letter of representation from an attorney for a plan participant or medical provider served on, or received by (or constructively received by), the Plan Sponsor and/or the Plan Administrator.

8.6 Administrative Safeguards.

The Plan Administrator shall provide ELAP, on its request, with a written description of the administrative safeguards which are in place to ensure consistent application of Plan provisions, in accordance with the requirements of the DOL Claims Regulations and in accordance with the terms of the Plan Documents; provided, however, that ELAP, in its sole discretion, may accept an oral description in lieu of the written description detailed above.

ARTICLE 9. RESPONSIBILITIES OF ELAP

In addition to performing its services in accordance with the terms of the Service Level Agreements included in Exhibits A and B, ELAP shall be responsible for the following:

9.1 Referred Appeals, Disputed Audits and Claims. ELAP shall review all Disputed Audits and Referred Appeals and audit and determine Allowable Claim Limit for all Claims submitted by the Plan Administrator provided that:

(a) The Plan Administrator submitted the Disputed Audit, Referred Appeals and/or the Claims in the manner and within the timeline described in Articles 8.3 (c) and (d) of this agreement;

(b) The Plan Documents applicable to the determination of Disputed Audits, Referred Appeals and/or Claims materially comply with, and have at all times materially complied with any other applicable law, and the Plan Administrator materially complies with, and has at all times materially complied with, any applicable reporting or disclosure obligations (under any other applicable law);

(c) Sufficient information is made available to ELAP, in a timely fashion, to review Disputed Audits, Referred Appeals and/or determine Allowable Claim Limits for Claims; and

(d) ELAP is satisfied that the Plan Administrator and/or Plan Sponsor has properly described in Plan Documents ELAP's role with respect to Disputed Audits, Referred Appeals and audit and determination of the Allowable Claim Limit for Claims.

9.2 Maintenance of Records. ELAP shall maintain all records it receives for adjudicating Referred Appeals and audit and determination of Allowable Claim Limit of Claims for a period not less than seven (7) years.

9.3 Payments to Third Party Experts. ELAP shall pay the fees and costs of third party experts it hires for the purpose of adjudicating Referred Appeals and/or auditing and determining Allowable Claim Limit for Claims submitted by the Plan Administrator.

9.4 Reimbursement to Third Party Administrators. ELAP shall reimburse the Third Party Administrator for a portion of its fees, under this agreement to offset expenses of the Third Party Administrator for claim-handling, legal compliance and other administrative expenses.

9.5 Direct Agreements. ELAP shall, upon written request by the Plan Administrator, provide the Plan Administrator a list of relevant Direct Agreements between ELAP and Directly Contracted Providers within the service territory of the Directly Contracted Provider.

ARTICLE 10. GENERAL INDEMNIFICATION

10.1 General Indemnification of the Plan, the Plan Sponsor, and the Plan Administrator. ELAP agrees to indemnify and hold harmless the Plan, the Plan Sponsor, and the Plan Administrator with respect

to any and all claims, suits, actions, penalties, liabilities and costs of any kind, including attorneys' fees, arising from

(a) ELAP's failure to perform its services in accordance with the terms of Exhibits A and B; and

(b) ELAP's alleged negligence or willful misconduct in the performance of its activities described herein unless it is determined that such claim, suit, action, penalty, liability or cost was caused by or resulted from the negligence or willful misconduct of the Plan, the Plan Sponsor, and/or the Plan Administrator.

10.2 General Indemnification of ELAP. The Plan, the Plan Sponsor and the Plan Administrator agree to indemnify and hold harmless ELAP with respect to any and all claims, suits, actions, penalties, liabilities and costs of any kind, including attorneys' fees, arising from:

(a) The Plan Sponsor and/or the Plan Administrator overriding the decisions of ELAP with respect to Referred Appeals, Disputed Audits, and/or determination of Allowable Claim Limits (as described in Article 4);

(b) The failure of the Plan Administrator to perform its responsibilities under this Agreement (including, but not limited to, the Plan Administrator's responsibilities under Article 8 of this Agreement);

(c) The Plan Sponsor and/or the Plan Administrator's alleged negligence or willful misconduct in the performance of their activities described herein unless it is determined that such claim, suit, action, penalty, liability or cost was caused by or resulted from the negligence or willful misconduct of ELAP; and

(d) Actions of ELAP taken at the direction of a representative of the Plan, Plan Sponsor or Plan Administrator, provided such representative is either expressly authorized by the Plan, Plan Sponsor and/or Plan Administrator to give such directions, or provided that ELAP reasonably believes that the representative has authority to give such direction.

10.3 Satisfaction of General Indemnity. The party entitled to indemnification (the "Indemnified Party") shall promptly notify, in writing, the party obligated to provide such indemnification (the "Indemnifying Party") of any claim for which the Indemnified Party seeks indemnification hereunder. The Indemnifying Party shall have the exclusive right and authority to conduct the defense or settlement of any such claim at the Indemnifying Party's sole expense and the Indemnified Party shall cooperate with the Indemnifying Party in connection therewith.

ARTICLE 11. OTHER PROVISIONS

11.1 Compliance with Privacy and Security Laws. Each party shall comply at all times with the requirements of HIPAA and other applicable state and federal laws pertaining to the privacy and security

of Plan Participants' individually identifiable information. Each party further agrees to execute the business associate agreement included in Exhibit C to this Agreement.

11.2 Compliance with Other Laws. The parties shall comply at all times with all other applicable federal, state, and local laws and regulations in the performance of this Agreement and their duties contemplated hereunder.

11.3 Headings. All headings and captions used in this Agreement are purely for convenience or reference only, and shall not affect the interpretation of this Agreement.

11.4 Governing Law. To the extent not preempted by ERISA or other federal law, this Agreement shall be governed by and construed in accordance with the laws of the Commonwealth of Pennsylvania, exclusive of its conflict of law principles.

11.5 Dispute Resolution. The parties agree to submit any disputes or claims arising out of or related to this Agreement to binding arbitration pursuant to the commercial arbitration rules of the American Arbitration Association and to conduct such arbitration in the city of Philadelphia, Pennsylvania. There shall be a single arbitrator chosen by both parties within thirty (30) days after notice to arbitrate a claim is received by the party against whom arbitration is sought. If the parties are unable to agree upon a single arbitrator within that thirty (30) day period, the arbitrator shall be appointed by the American Arbitration Association. Judgment may be entered upon the award of the arbitrator. Cost of the arbitration shall be borne equally by the parties unless the arbitrator's award directs otherwise.

11.6 Choice of Venue. ELAP has substantial facilities in the Commonwealth of Pennsylvania and many of the services provided under this Agreement are provided from these facilities. The exclusive venue for any actions or claims arising under or relating to this Agreement shall be in the US District Court for the Eastern District of Pennsylvania (or, to the extent an action or claim raises solely state-law based claims or matters) in the Court of Common Pleas for the County of Chester, Pennsylvania.

11.7 Amendments. Apart from a change in ELAP's compensation as described in Article 7.2, this Agreement may not be amended, modified, changed, released or discharged except by a writing signed by a duly authorized representative of each party. Notwithstanding the foregoing, this Agreement may be terminated in accordance with the terms of Article 2 without such mutually executed writing.

11.8 Severability. If any provision of this Agreement is held to be invalid, illegal or unenforceable, the validity, legality and enforceability of the remaining provisions shall in no way be affected or impaired.

11.9 Waiver. The failure of any party at any time to require full performance by the other of any provision of this Agreement shall in no way affect that party's right to enforce such provision, nor shall

the waiver by any party of any breach of any provision of this Agreement be taken or held to be a waiver of any further breach of the same provision or any other provision.

11.10 Notices. Notices given under this Agreement shall be in writing and shall be deemed to have been given and delivered three business days after posted with the United States Postal Service, with proper postage prepaid; the next business day following deposit with Federal Express, United Parcel Service or similar carrier (for overnight delivery); or upon successful transmission of electronic mail (as evidenced by a "Delivery Receipt" or "Read Receipt"), in each case properly addressed as follows:

If to ELAP:

Lisa Getzfrid
Vice President of Client and Member Services
1550 Liberty Ridge Drive
Suite 330
Wayne, PA 19087
610-321-1030 (ext. 115)
lgetzfrid@elapservices.com

With copy to:
Jeffrey J. Norton
General Counsel
1550 Liberty Ridge Drive
Suite 330
Wayne, PA 19087
610-321-1030 (ext. 206)
jnorton @elapservices.com

If to Plan Sponsor:

Ismael Mijares
Eagle Pass Independent School District
1420 Edison Rd.
Eagle Pass, TX 78853
830-773-5181
imijares@eaglepassisd.com

If to Plan Administrator: Ismael Mijares
Eagle Pass Independent School District
1420 Edison Rd.
Eagle Pass, TX 78853
830-773-5181
imijares@eaglepassisd.com

Or to such other address provided to the other party by written notification in accordance with this section

11.11 CONFIDENTIALITY. THE PLAN SPONSOR AND THE PLAN ADMINISTRATOR EXPRESSLY AGREE THAT THE TERMS OF THIS AGREEMENT (INCLUDING ALL EXHIBITS AND ATTACHMENTS TO THIS AGREEMENT) AND THE TERMS OF THE DIRECT AGREEMENTS BETWEEN ELAP AND DIRECTLY CONTRACTED PROVIDERS ("ELAP DIRECT AGREEMENTS"), INCLUDING, BUT NOT LIMITED TO, THE REIMBURSEMENT RATES AND METHODOLOGY, REPRESENT CONFIDENTIAL AND PROPRIETARY INFORMATION WHICH MAY NOT BE DISCLOSED EXCEPT AS REQUIRED FOR PLAN MANAGEMENT AND ADMINISTRATION. WHEN DISCLOSURE IS REQUIRED FOR PLAN MANAGEMENT AND ADMINISTRATION, THE PLAN SPONSOR AND PLAN ADMINISTRATOR SHALL (A) NOTIFY ELAP SERVICES, LLC OF SUCH DISCLOSURE AND THE REASONS FOR SUCH DISCLOSURE, AND (B) CAUSE THE RECIPIENTS, INCLUDING BUT NOT LIMITED TO, AGENTS, CONSULTANTS AND VENDORS, TO KEEP THE TERMS OF THIS AGREEMENT AND ANY ELAP DIRECT AGREEMENTS IN STRICTEST CONFIDENCE. THE PLAN SPONSOR AND THE PLAN ADMINISTRATOR FURTHER AGREE THAT THE TERMS OF EITHER THIS AGREEMENT OR ANY ELAP DIRECT AGREEMENTS SHALL NOT OTHERWISE BE DISCLOSED WITHOUT THE EXPRESS WRITTEN CONSENT OF ELAP SERVICES, LLC UNLESS REQUIRED BY STATUTE, REGULATION, OR COURT OR REGULATORY AGENCY ORDER OR SUBPOENA AND, IN THAT EVENT, THE PLAN SPONSOR AND THE PLAN ADMINISTRATOR SHALL TAKE ALL REASONABLE ACTION TO PRESERVE THE CONFIDENTIALITY OF THE TERMS OF THIS AGREEMENT OR THE ELAP DIRECT AGREEMENT AND SHALL NOTIFY ELAP SERVICES, LLC PRIOR TO PRODUCTION OF THIS AGREEMENT OR SUCH ELAP DIRECT AGREEMENTS, OR, IF PRIOR NOTICE IS NOT POSSIBLE, WITHIN THREE (3) BUSINESS DAYS AFTER SUCH PRODUCTION (UNLESS SUCH ORDER OR SUBPOENA SPECIFICALLY FORBIDS NOTIFICATION OF ELAP SERVICES, LLC).

11.12 Assignment. This Agreement is nonassignable without the written consent of the other Party, except that ELAP (a) may assign this Agreement to a ELAP affiliate; or (b) assign or delegate some or all of the

ELAP's responsibilities under this Agreement to any contractor, provided that the ELAP will in such instances retain ultimate responsibility for the satisfactory performance of such assigned or delegated responsibilities. Except as provided in this Article 11.11, any attempted assignment without such consent shall be void.

11.13 Counterparts. This Agreement may be executed in one or more counterparts and each fully executed counterpart shall be deemed an original. This Agreement may be signed by facsimile or other electronic signature, with such signature binding the signer with full force of law.

11.14 Entire Agreement. This Agreement, along with all exhibits contemplated herein, constitutes the entire agreement between the parties hereto with respect to the subject matter hereof. No provision of this Agreement may be modified, except in writing, signed by the parties or as may otherwise be provided in this Agreement.

IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed as of the day and year first above written.

Eagle Pass Independent School District	ELAP Services, LLC
By: _____	By: _____
Print Name: GILBERTO GONZALEZ	Print Name: Lisa Getzfrid
Title: SUPERINTENDENT OF SCHOOLS	Title:

EXHIBIT A

REFERRED APPEAL SERVICES SLA

ELAP shall use its best efforts to perform its duties under this Referred Appeal Services Service Level Agreement ("SLA") within a period of time that provides the Plan Administrator a reasonable amount of time to meet the compliance time limits set forth in the DOL Claims Regulations (provided that the determination of whether or not a period of time as described above is a "reasonable amount of time" will be determined by ELAP in its sole discretion). The terms of this Exhibit A shall not apply to any appeal for any "claim involving urgent care" which is also a "pre-service claim" (both terms as defined in subsection (m) of 29 C.F.R. § 2560.503-1), which shall be the sole responsibility of the Plan Administrator and any other person or entity to whom it may delegate such responsibilities. ELAP will review Referred Appeals in accordance with the following provisions:

1. ELAP will provide the Plan an external and independent assessment of the denial of benefits by the Plan Administrator for services provided or to be provided by a Medical Provider;
2. ELAP will engage at its own cost the services of an independent review organization (IRO) accredited by URAC or a similar nationally recognized accrediting organization for the purpose of conducting an independent and unbiased review in accordance with the Plan's appeal review procedures;
3. The IRO review procured by ELAP will review Referred Appeals and determine the applicability of Plan terms (including, but not limited to, Covered Benefits and Excluded Benefits) in accordance with the terms contained in the Plan Documents;
4. In the event that medical services provided or to be provided by a Medical Provider are not explicitly listed as Covered Benefits under the Plan, the IRO should evaluate Medical Eligibility as set forth herein (to the extent such terms are incorporated into Plan Documents). In determining Medical Eligibility for services not explicitly listed as Covered Benefits, the IRO should consider whether all three of the following criteria (which such criteria are or shall be incorporated into Plan Documents) have been met:
    a. The treatment is recommended or performed by an eligible provider for the diagnosis or treatment of an illness or injury
    b. The prevailing opinion within the appropriate specialty of the United States medical profession is that the treatment is safe and effective for its intended use; and
    c. The treatment is the most appropriate level of service or supply considering the potential benefits and possible harm to the patient.

5. ELAP shall ensure that its review of Referred Appeals is completed within the time period for notifying Plan Participants of appeal determination, as stated in the provisions of the Plan governing final appeals.

6. For the avoidance of doubt, unless otherwise agreed to by the Third Party Administrator, ELAP is considered to have the exclusive authority under the terms of the Plan to review and make recommendations with regard to Referred Appeals. Unless explicitly indicated to the contrary by the Plan Administrator, this Exhibit A is deemed to be incorporated into the Plan document.

EXHIBIT B

CLAIM REVIEW AND AUDIT PROGRAM SLA

ELAP will audit and review Claims submitted for reimbursement by any of the following Medical Providers:

1. Hospitals,
2. Ambulatory Health and Surgical Centers,
3. Dialysis Clinics, and
4. Other licensed health-care facilities and professional individuals or groups for inpatient and outpatient services.

CLAIM REVIEW AND AUDIT GUIDELINES

ELAP shall review and audit Clean Claims to ensure that Medical Providers comply with industry standard coding logic and National Correct Coding Initiative ("NCCI") and Centers for Medicare and Medicaid Services ("CMS") coding standards. The Claim Review and Audit procedures that ELAP performs shall include but shall not be limited to:

1. Errors. Verifying that Clean Claims do not include any identifiable billing mistakes including, but not limited to, upcoding, duplicate charges, and charges for services not performed. Additionally, verifying that Clean Claims do not include charges that are required to treat injuries sustained or illnesses contracted, including infections and complications, which, in the opinion of the Plan Administrator can be attributed to medical errors by the Medical Provider.

2. Unbundling. Verifying that Clean Claims do not include charges for any items billed separately that are customarily included in a global billing procedure code in accordance with the American Medical Association's CPT® (Current Procedural Terminology) and/or the Healthcare Common Procedure Coding System (HCPCS) codes used by CMS.

3. Itemized Bill Audit. Reviewing itemized bills for Clean Claims for inpatient and outpatient services of $25,000 or greater, in order to identify whether Billed Charges include charges for services or supplies that are not consistent with the patient's diagnoses based upon the CPT, HCPCS, and ICD-9/ICD-10 codes (diagnostic codes) reflected in the invoices submitted by the Medical Provider.

4. Operative Report. Reviewing operative reports for Clean Claims of $25,000 or greater for ambulatory health and surgical centers in order to identify whether Billed Charges include charges for services or

supplies that are not consistent with the patient's diagnoses based upon the CPT, HCPCS, and ICD-9/ICD-10 codes (diagnostic codes) reflected in the invoices submitted by the Medical Provider.

5. Medical Records Audit. Determining, in its sole discretion, that an audit of the provider's medical records is appropriate and necessary to assess whether certain charges for services and supplies were rendered or provided as billed and either conducting such audit directly or arranging for such audit to be conducted. An audit may be performed in determination of the Allowable Claim Limit or during any retrospective review of charges, including Disputed Audits, apart from the override of any ELAP determination (as described in Article 4 of the Agreement). Medical records for this purpose will include, but not be limited to, x-ray and laboratory tests, operating room and other facility usage, charts of medications dispensed and supplies provided, physician visits and other professional services. In the event that ELAP requests the medical records, the Plan Administrator acknowledges that (a) ELAP may, consistent with HIPAA and any other applicable privacy protections, request the assistance of the patient or Plan participant, and/or medical care providers, in verifying the results of a medical records audit, provided, however, that the patient/Plan participant may refuse to provide assistance without such lack of cooperation itself jeopardizing or prejudicing any Claims of the patient/Plan participant; and (b) to the extent that any agreements between the Plan, Plan Sponsor and/or Plan Administrator and any Third Party Administrator contain audit rights, ELAP shall have the right to utilize such audit rights as if such agreement applied directly to ELAP.

ALLOWABLE CLAIM LIMIT GUIDELINES

In determining Allowable Claim Limits, ELAP shall adhere to the following guidelines (which guidelines have been or shall be adopted by the Plan):

1. Errors, Unbundled and/or Unsubstantiated Charges Guidelines. ELAP shall exclude the following from amounts paid under the Allowable Claim Limits:

a. Charges that ELAP identifies as improperly coded, duplicated, unbundled and/or for services not performed;
b. Charges for treating injuries sustained or illnesses contracted, including infections and complications, which, in the opinion of the Plan Administrator can be attributed to medical errors by the Medical Provider;
c. Charges that ELAP is unable to identify or understand; and
d. If ELAP requests and audits medical records, charges that cannot be verified from the requested medical records.

2. Additional Guidelines. ELAP shall use the following guidelines when determining Allowable Claim Limits:

i. a. **Hospital Guidelines.** The Allowable Claim Limit for Claims by a hospital facility and by facilities which are owned and operated by a hospital shall be the greater of (I) 112% of the hospital's most recent departmental cost ratio, reported to CMS and published in the American Hospital Directory as the "Medicare Cost Report" (the "CMS Cost Ratio"), or (II) the Medicare allowed amount for the services in the geographic area plus an additional 20%. In the event that insufficient information is available to identify either one of the hospital's most recent departmental cost ratio or the Medicare allowed amount, the Allowable Claim Limit shall be either (I) or (II) herein, to the extent that it can be identified. In the event that insufficient information is available to identify both the hospital's most recent department cost ratio and the Medicare allowed amount, ELAP shall determine the Allowable Claim Limit, in its sole discretion and in accordance with Section 2.d. or 2.e., below.

b. **Ambulatory Health Care Centers Guidelines.** The Allowable Claim Limit for ambulatory health care centers, including ambulatory surgery centers which are independent facilities, shall be the Medicare allowed amount for the services in the geographic area plus an additional 20%. In the event that insufficient information is available to identify the Medicare allowed amount, the Allowable Claim Limit for such services shall be, to the extent available, either the outpatient or inpatient Medicare allowed amount for the service, plus an additional 20%, provided that if such Medicare allowed amounts are unavailable ELAP shall determine the Allowable Claim Limit in its sole discretion and in accordance with Sections 2.d. or 2.e., below.

c. **Directly Contracted Providers Guidelines.** The Allowable Claim Limits for Directly Contracted Providers shall be the negotiated rate as agreed under the Direct Agreement.

d. **Guidelines Where There is Insufficient Information to Determine Allowable Claim Limit.** In the event that ELAP determines that insufficient information is available to determine Allowable Claim Limits for specific services or supplies using the guidelines listed in 2.a., 2.b., or 2.c. above, as may be applicable, ELAP may apply the following guidelines:

i. **General Medical and/or Surgical Services.** The Allowable Claim Limit for any covered services may be calculated based upon published and publicly available fee and cost lists and comparisons, or any combination of such resources.

ii. **Pharmaceuticals.** The Allowable Claim Limit for pharmacy charges by a provider may be determined by applying the Average Wholesale Price (AWP) as defined by REDBOOK

at the rate of 112% of AWP.

iii. **Medical and Surgical Supplies, Implants, Devices.** The Allowable Claim Limit for charges for medical and surgical supplies made by a provider may be based upon the invoice price (cost) to the provider, plus an additional 12%. The documentation used as the resource for this determination will include, but not be limited to, invoices, receipts, cost lists or other documentation.

iv. **Physician Medical and Surgical Care, Laboratory, X-ray, and Therapy.** The Allowable Claim Limit for these services may be determined based upon the fees for comparable services in the geographic region at the 90th percentile of the Physician Fee Reference ("PFR"), or, if higher, the highest percentile reflected in the PFR.

e. **Comparable Services or Supplies Guidelines.** In the event that ELAP determines that insufficient information is available to determine Allowable Claim Limits for specific services or supplies using the guidelines listed in 2.a., 2.b., 2.c. and 2.d.i. to 2.d.iv. above, ELAP shall use the most comparable services or supplies, as determined by ELAP in its sole discretion and judgment based upon comparative severity and/or geographic area, to determine the Allowable Claim Limit.

Notwithstanding anything to the contrary above or elsewhere in this Agreement, in the event that a determination of Allowable Claim Limit in accordance with the above guidelines for a Claim results in an amount that exceeds the actual Charges billed for the services and/or supplies, the Allowable Claim Limit for that Claim shall be deemed to be equal to (and may not exceed) the actual Charges billed for the Claim.

COMPLETED AUDIT RESULTS

For each completed audit, ELAP will identify and report any charges that are improperly coded, duplicated, unidentified, unbundled and/or found to exceed the Allowable Claim Limits. ELAP will return the completed review and audit results to the Plan Administrator or Third Party Administrator for the adjudication of the Claims based upon the determination of Allowable Claim Limits by ELAP. ELAP shall use its best efforts to perform its duties under this Claim Review and Audit Program SLA within a period of time that provides the Plan Administrator a reasonable amount of time to meet the compliance time limits set forth in the DOL Claims Regulations (provided that the determination of whether or not a period of time as described above is a "reasonable amount of time" will be reasonably determined by ELAP in its sole discretion).

MAINTENANCE OF RECORDS

ELAP shall maintain records it receives and transmit records containing Protected Health Information (PHI) for each Clean Claim it audits in accordance with the terms of the Business Associate Agreement (BAA) included in Exhibit C of this Agreement.

PLAN DOCUMENT

For the avoidance of doubt, unless otherwise agreed to by the Third Party Administrator, ELAP is considered to have the authority under the terms of the Plan to audit and review Claims submitted for reimbursement by Medical Providers, as provided in this Exhibit B. Unless explicitly indicated to the contrary by the Plan Administrator, this Exhibit B is deemed to be incorporated into the Plan document.

EXHIBIT C

HIPAA BUSINESS ASSOCIATE AGREEMENT

This HIPAA Business Associate Agreement (this "Agreement") dated and effective as of September 1, 2018 is by and between Eagle Pass Independent School District having its principal office located at 1420 Edison Rd., Eagle Pass, TX 78853 (the "Plan" or "Covered Entity") and ELAP Services, LLC, located at 1550 Liberty Ridge Drive, Wayne, Pennsylvania 19087 ("Business Associate"). This Agreement amends and is incorporated by reference into the Administrative Service Agreement for Core Services between the Plan and Business Associates, dated September 1, 2018.

In consideration of the mutual promises below and the exchange of information provided for herein, the Parties agree as follows:

TERMS

A. Effective Date. Except as specifically stated otherwise in this Agreement, the Effective Date shall be the date that first appears above in the introductory paragraph to this Agreement.

B. Definitions. Unless otherwise defined, terms used in this Agreement have the same meaning as those terms in the Standards for Privacy of Individually Identifiable Health Information or the HIPAA Security Standards ("HIPAA Privacy & Security Rules"), found at 45 CFR Parts 160-164.

(a) *Agreement* means this Business Associate Agreement.

(b) *Business Associate* means ELAP Services LLC.

(c) *Covered Entity* means *Eagle Pass Independent School District.*

(d) *HITECH Act* means the HITECH Act of the American Recovery and Reinvestment Act of 2009 (Title XIII, Subtitle D of P.L. 111-5), enacted February 17, 2009 (codified at 42 USC § 17921 et seq.).

(e) *PHI* means Protected Health Information created, received, maintained or transmitted by ELAP on behalf of Covered Entity.

(e) *Services Agreement* means the Core Services Agreement, DDM Agreement and/or Cost Containment Agreement between Covered Entity and Business Associate, dated as of September 1, 2018.

D. Obligations of Covered Entity. Covered Entity shall be responsible for using appropriate safeguards to maintain and ensure the confidentiality, privacy and security of PHI transmitted to Business Associate pursuant to this Agreement, in accordance with the standards and requirements of HIPAA and other federal and/or state law governing the confidentiality, privacy and security of Individually Identifiable Health Information (collectively, "Applicable Privacy Laws"), until such PHI is received by Business Associate.

E. Obligations and Activities of Business Associate.

(a) Use or Disclosure of Protected Health Information - Business Associate agrees not to Use or Disclose PHI, other than as permitted or required by the Agreement or as Required By Law.

(b) Safeguards - Business Associate agrees to use appropriate safeguards to prevent Use or Disclosure of the PHI other than as provided for by this Agreement.

(c) Duty to Mitigate - Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a Use or Disclosure of PHI by Business Associate in violation of the requirements of this Agreement.

(d) Duty to Report Violations - Business Associate agrees to report to Covered Entity any Use or Disclosure of the PHI not provided for by this Agreement of which it becomes aware, including, where there is a Breach of PHI, the identity of any individual whose PHI was breached.

(e) Subcontractors - In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), Business Associate agrees to ensure that any Subcontractors that create, receive, maintain, or transmit PHI on behalf of Business Associate agree to the same restrictions, conditions, and requirements that apply to Business Associate with respect to such information. To the extent not inconsistent with the foregoing, Business Associate shall further ensure that any Subcontractors agree to comply with such additional terms and restrictions as are necessary to allow Business Associate to meet its obligations under this Agreement.

(f) Access to Secretary - Business Associate agrees to make internal practices, books, and records, including HIPAA policies and procedures relating to its Use and Disclosure of PHI available to the Secretary of the U.S. Department of Health and Human Services (the "Secretary") for purposes of the Secretary determining Covered Entity's or Business Associate's compliance with the HIPAA Privacy & Security Rules.

(g) Access to Individuals - Business Associate shall provide individuals with access to their PHI maintained in a Designated Record Set by Business Associate in order to enable Covered Entity to meet its obligations under 45 CFR 164.524.

(h) Amendment of Protected Health Information - Business Associate agrees to make any amendment(s) to PHI it holds in a Designated Record Set, as directed by the Covered Entity pursuant to 45 CFR 164.526.

(i) Accounting of Disclosures - Business Associate agrees to document and provide a description of any disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR 164.528. Business Associate agrees to provide such information to Covered Entity, or to an Individual at the direction of the Covered Entity, in order for Covered Entity to comply with the accounting requirements in 45 CFR 164.528.

(j) Prohibited Uses and Disclosures –

1. Business Associate shall not directly or indirectly accept remuneration in exchange for using or disclosing any of Covered Entity's PHI in connection with sales or marketing; however, Business Associate may accept remuneration from Covered Entity in exchange for services or functions performed pursuant to this Agreement and the Services Agreement. Business Associate shall not Use or disclose Covered Entity's PHI for sales or marketing except for, or on behalf of, Covered Entity with Covered Entity's express written consent and the Individual's Authorization.

2. Business Associate shall not Use or further Disclose Covered Entity's PHI other than as permitted or required by this Agreement, or as otherwise Required By Law.

3. Business Associate shall comply with the terms of 45 C.F.R. 164.502(b) in Using and further Disclosing only the minimum necessary amount of Covered Entity's PHI, except that Business Associate shall not be required to comply with this minimum necessary limitation if neither Business Associate nor Covered Entity is required to limit the Use or Disclosure to the minimum necessary, in accordance with 45 C.F.R. 164.502(b), with respect to particular PHI.

(k) Covered Entity's Right to Restrict – Business Associate agrees to comply, upon written communication by Covered Entity, with any restrictions to the Use or Disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR 164.522.

(l) HIPAA Security Standards - Business Associate agrees to comply with the HIPAA Privacy & Security Rules with respect to PHI created, received, maintained or transmitted by Business Associate on behalf of Covered Entity.

1. Business Associate agrees to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to Electronic Protected Health Information to prevent Use or Disclosure of Protected Health Information other than as provided for by the Agreement.

2. Business Associate agrees to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of Covered Entity, as required in the HIPAA Privacy & Security Rules.

3. Business Associate agrees to ensure that any Subcontractor, to whom it provides PHI agrees in writing to implement the same safeguards to protect such information that Business Associate is required to implement pursuant to this Agreement.

4. Business Associate agrees to report to Covered Entity any Security Incident involving PHI of which it becomes aware. Notwithstanding the foregoing, Covered Entity and Business Associate acknowledge the ongoing existence of attempted but unsuccessful Security Incidents that are inconsequential and harmless in nature, such as pings and port scans, and Business Associate shall not provide Covered Entity with separate notice of unsuccessful Security Incidents of this type. However, to the extent that Business Associate becomes aware of a pattern or an unusually high number of such unsuccessful Security Incidents involving PHI resulting from the repeated acts of a single entity, Business Associate shall provide Covered Entity with information known by Business Associate related thereto.

(m) Responsibilities If Breach. Business Associate shall notify Covered Entity immediately upon discovery of a Breach, and in no event more than ten (10) days following discovery, by either Business Associate or one of its Subcontractors of Unsecured PHI as defined in, and consistent with, the HITECH Act and any regulations or guidance issued thereunder, including 45 CFR Part 164, Subpart D. Such notification shall:

1. Be made in writing to the Covered Entity's Privacy Officer or such other specific party, as designated by the Covered Entity, who will be responsible for receiving Breach notifications on behalf of Covered Entity.

2. Include the names of the individuals whose PHI was breached, the circumstances surrounding the Breach, the date of the Breach and date of discovery, the type of PHI involved,

any steps Individuals should take to protect themselves, the steps Business Associate (or its Subcontractor) is taking to investigate the Breach, mitigate losses, and protect against future Breaches, and a contact person for more information.

If requested by Business Associate, Covered Entity shall allow Business Associate to approve the content of any Breach notification to Individuals or to the Secretary or other government authority, and the content of any published media or website notification, in advance of notification or publication.

If requested by Covered Entity, Business Associate shall notify the individuals involved, or the media or the Secretary, as applicable, in accordance with the HITECH Act, and regulations or guidance issued thereunder, including 45 CFR Part 164, Subpart D, provided that Covered Entity will reimburse Business Associate for any reasonable costs related to such notices.

F. Permitted Uses and Disclosures by Business Associate

(a) Disclosures Generally. Except as otherwise provided in this Agreement, Business Associate may Use or Disclose PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Services Agreement, provided that such Use or Disclosure would not violate the HIPAA Privacy & Security Rules if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity.

(b) To Carry Out Covered Entity Obligations. To the extent Business Associate is to carry out one or more of Covered Entity's obligations under Subpart E of 45 CFR Part 164, as an independent contractor and not as an agent, Business Associate agrees to comply with the requirements of Subpart E that apply to the Covered Entity in the performance of such obligations.

(c) Management & Administration.

1. Business Associate may use Protected Health Information for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate.

2. Business Associate may disclose PHI for the proper management and administration of Business Associate, provided that disclosures are: (a) Required by Law or (b) Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and be used or further disclosed only as Required by Law or for the purpose

for which it is disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

(d) Data Aggregation & De-Identification. Except as otherwise limited in this Agreement, Business Associate may Use PHI to provide Data Aggregation services to Covered Entity or to de-identify PHI. Once information is de-identified this Business Associate Agreement shall not apply.

(e) Required By Law. Business Associate may Use or Disclose PHI as Required By Law.

G. Term and Termination

(a) Term. Upon termination of the Services Agreement, Business Associate will destroy or return to Covered Entity any PHI it holds in any form and shall request the destruction or return of any PHI maintained by its Subcontractors. If Business Associate reasonably can show that it is infeasible to return or destroy PHI, Business Associate shall extend the protections under this Agreement to such PHI and only may further Use or Disclose such information for those purposes that make the return or destruction infeasible.

(b) Termination for Cause. Upon Covered Entity's knowledge of a material breach of this Agreement by Business Associate, Covered Entity is authorized to terminate this Agreement and the Services Agreement. Upon Business Associate's knowledge of a material breach of this Agreement by Covered Entity, Business Associate is authorized to terminate this Agreement and Services Agreement, or, if termination is not feasible, to report the problem to HHS. For the purposes of the foregoing, a "material breach of this Agreement" shall include, but shall not be limited to, the naming of either party as a defendant in a criminal proceeding for a violation of HIPAA and/or HITECH, or a finding or stipulation (made in any administrative or civil proceeding in which a party has been joined) that a party has violated any standard or requirement of HIPAA and/or HITECH.

(c) Survival. The rights and obligations of Business Associate under this Agreement will survive the termination of this Agreement.

H. Amendment. The Parties acknowledge that state and federal laws relating to electronic data security and privacy are rapidly evolving and that amendment of this Agreement may be required to provide for procedures to ensure compliance with such developments. The Parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, HITECH and any other applicable privacy laws. ELAP may unilaterally amend this Agreement to comply with more restrictive obligations agreed upon with a Covered Entity.

I. Miscellaneous.

(a) Mutual Negotiation. Each and every provision of this Agreement has been mutually negotiated, prepared and drafted and, in connection with the construction of any provisions hereof, no consideration shall be given to the issue of which Party actually prepared, drafted, requested or negotiated any provision of this Agreement, or its deletion.

(b) Interpretation. The Parties agree that any ambiguity in this Agreement shall be resolved in favor of a meaning that complies and is consistent with HIPAA.

(c) Compliance with Laws and Regulations. The HITECH Act requires federal agencies to establish rules and regulations regarding the privacy and security of Protected Health Information. Business Associate will ensure that its privacy and security procedures are compliant with the HITECH Act and any rules and regulations issued thereunder with respect to Covered Entity's PHI. The parties agree to amend this Agreement to comply with applicable requirements of the HITECH Act, where necessary.

(d) Relationship of Parties. The parties intend that Business Associate is an independent contractor and not an agent of Covered Entity.

(e) No Third Party Beneficiaries. Nothing express or implied in this Agreement is intended to confer, nor shall anything in this Agreement confer, upon any person other than Covered Entity and Business Associate and their respective heirs, representatives, successors and assigns, any rights, remedies, obligations or liabilities whatsoever, whether as creditor beneficiary, donor beneficiary or otherwise.

IN WITNESS WHEREOF, the Parties hereto have duly executed this Agreement on the day and year first above written:

Eagle Pass Independent School District	ELAP Services, LLC
By: _____	By: _____
Print Name: GILBERTO GONZALEZ	Print Name: Lisa Getzfrid
Title: SUPERINTENDENT OF SCHOOLS	Title:

EXHIBIT D

Fee Schedule

Referred Appeal Services. For Referred Appeal Services provided under this Agreement, one dollar ($1.00) per employee enrolled in the Plan per month. Such amount shall be due on the first of each month during the term of this Agreement.

Claim Review and Audit Program Services. Ten percent (10%) of the Charges billed for Claims from non-Directly Contracted Providers audited under the Claim Review and Audit Program, and five percent (5%) of Charges billed for Claims from Directly Contracted Providers. Such amount shall be due upon receipt of an invoice issued by ELAP for its services. For Directly Contracted Providers, if the combined amount of the Allowable Claim Limit and the fees due to ELAP is greater than the Charges billed by the Medical Provider, the compensation for ELAP will default to fifteen percent (15%) of the amount of Charges that are in excess of the Allowable Claim Limit.