ADMINISTRATIVE SERVICES CONTRACT

between

Blue Cross & Blue Shield of Mississippi, a Mutual Insurance Company

(Hereinafter the "Claim Administrator")

Madison County Board of Supervisors

(Hereinafter the "Employer")

and

Employee Health Protection Plan for Madison County Board of Supervisors

(Hereinafter "GHP")

October 1, 2014

(the "Effective Date" of this agreement)

ADMINISTRATIVE SERVICES ONLY AGREEMENT

This Agreement is entered into on the Effective Date named above by and among Claim Administrator, Employer, and GHP ("Agreement"). The term of the Agreement is for a 12 month period, running October 1, 2014 to September 30, 2015. In consideration of the premises, the mutual understanding of the Claim Administrator, Employer, and GHP, as reflected in this Agreement, the parties agree to be bound by the following terms and conditions.

WITNESSETH AS FOLLOWS:

WHEREAS, Employer has established and maintains GHP as an employee welfare benefit plan as defined by Section 3(1) of the Employee Retirement Income Security Act of 1974 ("ERISA"), and described in GHP's Plan Document attached to this Agreement as Exhibit I; and

WHEREAS, the benefit programs offered by GHP, and sponsored by Employer, for eligible employees and their eligible dependents ("Covered Persons") include a comprehensive major medical program; and

WHEREAS, Claim Administrator has established and maintains its Comprehensive Major Medical Program; and

WHEREAS, Employer and GHP desire to retain Claim Administrator to establish and maintain a Comprehensive Major Medical Program for GHP to offer Covered Persons, and to provide certain administrative services with respect to GHP; and

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

PART 1—CLAIM ADMINISTRATOR'S RESPONSIBILITIES

I. SERVICES PROVIDED BY CLAIM ADMINISTRATOR

A. During the term of the Agreement, the Claim Administrator agrees to handle the administrative function involved with filing, processing, and payment of claims incurred on or after the Effective Date under the Plan. Claim Administrator's responsibilities under this Agreement are limited to those of a contract Claim Administrator rendering advice to and administering claims on behalf of GHP's administrator or fiduciary. As such, Claim Administrator is a service provider, and not a fiduciary with respect to GHP. Pursuant to this function the Claim Administrator will perform the following acts:

1. Prepare a write-up of the Plan and any changes thereto during the continuance of this Agreement utilizing the finalized Benefit Confirmation Report, Administrative Confirmation Report and any important documentation attached to Claims Administrator's Blue Form;

2. Prepare a standard electronic employee booklet outlining the Plan utilizing the finalized Benefit Confirmation Report and Administrative Confirmation Report. Claim Administrator will prepare an electronic copy of the initial employee booklet and revisions to the employee booklet at the time of the Group's renewal. This will be a part of the standard administrative fee. Any printed books or additional changes, including revisions to benefits or eligibility requirements requested by the Employer to the employee book after the initial employee booklet or outside of the GHP's renewal date must be approved by Claim Administrator in writing and will result in additional fees. The employee booklet will comply with all of the statutory and regulatory requirements applicable to Summary Plan Description as defined under the Employee Retiree Income Security Act of 1974 and the regulations promulgated thereunder (collectively "ERISA"), the Patient Protection and Affordable Care Act of 2010 as amended by the Health Care

Education and Reconciliation Act of 2010 and the regulations promulgated thereunder (collectively "PPACA"), and any other applicable laws and regulations;

3. Prepare a Summary of Benefits and Coverage in accordance with PPACA and maintain the same in an electronic format located on *my*AccessBlue and *my*Blue Member;

4. Provide suitable facilities, personnel, procedures, forms and instructions for the administration of claims under the Plan;

5. Receive, review, process and determine, in accordance with the Plan, the qualification for payment of claims submitted and make such investigation regarding claims as may be necessary;

6. Make payment of amounts due with respect to claims that qualify for payment under the Plan;

7. Provide access to customer service representatives;

8. Provide advice on disputed claims;

9. Send out notices of payment of benefits and denial of claims for non-covered services;

10. Coordinate benefits as outlined in the Coordination of Benefits section of the Plan;

11. Determine, in accordance with the Plan and based on information from GHP, the eligibility of employees and dependents for coverage under the Plan;

12. Identify, investigate and administer claims which may involve third party liability and for which there is a potential for collection under the terms of the Plan of amounts paid to, or on behalf of, covered employees and/or covered dependents through subrogation of their rights of reimbursement in connection with a claim for covered services. Claims Administrator will not be required to initiate court proceedings for the recovery of the third party liability. In the event this Contract is terminated, Claims Administrator will discontinue this service. Upon notification by the GHP of the name and address of the new Claims Administrator, Claims Administrator will forward a copy of any subrogation files to the new administrator;

13. Provide standard identification cards for covered employees and their covered dependents;

14. Make every reasonable effort to recover any overpayment or mistaken payment of claims, but will not be required to initiate court proceedings for such recovery or defend on GHP's behalf;

15. If the Claim Administrator utilizes a third party to collect any overpayment or mistaken payment, a fee for the third party's services will be deducted from the amount that is collected. Only the net amount will be credited to the GHP;

16. Provide annually, upon the request of GHP:

a. an estimate of the Plan's incurred benefit costs, and

b. an analysis of Plan benefits and desirability of Plan modification ;

17. Make available for inspection by GHP or GHP's auditor for any three (3) years during the continuance of this Agreement and for three (3) years thereafter, the Claim Administrator's books and records that may have a bearing on this Agreement; provided, however, that any examination of individual benefit payment records will be conducted in a manner agreed to by GHP and the Claim Administrator to protect the confidentiality of the individual's medical information,;

18. Provide notification and tender the defense of any litigation where GHP is the real party in interest;

19. Fund all claims over the individual specific stop loss deductible amount as defined in GHP's Excess Risk Insurance Policy (hereinafter Reinsurance). This Section applies only when GHP has elected to have Claim Administrator fund all claims over the individual specific stop loss deductible amount as defined in GHP's Excess Risk Insurance Policy;

20. File aggregate and specific stop loss claims with Reinsurance carrier. This Section applies only when GHP has elected to have Claim Administrator file aggregate and specific stop loss claims with Reinsurance carrier. GHP and Employer acknowledge that while Claim Administrator will make reasonable efforts to file all specific loss claims with the Reinsurance Carrier prior to the end of the plan year, Claim Administrator cannot and does not guarantee that all aggregate and specific stop loss claims will be filed with the Reinsurance Carrier prior to the end of the plan year. GHP and Employer will hold Claim Administrator harmless for any damages, costs or expenses caused by aggregate and specific stop loss claim not being filed by the end of the plan year;

21. Provide in a timely manner to GHP the Claim Administrator's standard reporting package;

22. Follow the Claim Administrator's local plan practices unless GHP's policies and procedures are identified and approved in the Plan of Benefits;

23. Utilize the "Pay & Pursue" method when administering claims that involve a subrogation lien subject to local plan practice exceptions;

24. Provide a process for individual benefit determinations and appeal procedures in accordance with standards established by Claim Administrator. In the event GHP initiates an independent appeals process from the one established by the Claim Administrator, GHP assumes full responsibility for the process. GHP will also indemnify and hold harmless Claim Administrator from any damages, lawsuits, judgements or attorney fees incurred by Claim Administrator as a result of GHP's appeal decisions.

B. The Claim Administrator agrees to provide Utilization Management programs to ensure cost effective health care in the most appropriate setting. These programs include the following:

1. **Utilization Review**

   a. **Pre-admission Certification** of all elective hospital admissions and certification of emergency admissions within one working day.

   b. **Continued Stay Review** to determine the medical necessity of continued hospitalization beyond the initially approved length of stay.

   c. **Case Management** involving ongoing case reviews to identify the appropriateness of more cost-effective, but quality alternative care of high risk

and/or catastrophic cases. Alternative services include, but are not limited to, home infusion therapy, home health care and hospice care.

d. **Discharge Planning** on and during admission to promote timely discharge and help prevent unnecessary readmissions.

2. **Key Physician Network**

a. A program based on an agreement between the Claim Administrator and contracted physicians designed to assist in securing affordable health care services.

b. Physicians in the program agree to file claims on behalf of the patient and to accept the Claim Administrator payment, plus any applicable deductible or coinsurance/co-payment, as payment in full for covered services, holding the patient harmless for charges in excess of allowable charges.

3. **Prescription Drug Management Program**

a. **Community PLUS Pharmacy Network** - a network of independent and chain retail pharmacies that have entered into an agreement with the Claim Administrator for the purpose of more effectively managing prescription drug costs. Pharmacies participating in the network have agreed to a negotiated price that will be charged at the point of sale for prescription drug purchases.

b. **Formulary Rebate Program** - the Claim Administrator has prepared a Managed Care Drug Formulary listing preferred medications chosen for their therapeutic and economic advantages. The formulary is open; benefit payment for any medication is not determined by the presence or absence of the medication in the formulary. Manufacturers offer volume discounts in return for inclusion of their products in the formulary. These discounts or rebates are passed on to GHP.

4. **Participating Hospital Network**

a. A network of hospitals that have entered into a Participating Hospital Agreement with Claim Administrator for the purposes of providing access to affordable health care.

b. The Participating Hospital agrees to accept the Plan's payment plus the deductible and coinsurance as payment in full, support the Claim Administrator's Utilization Management programs and agree not to balance bill the Member.

c. Participating Providers agree to provide the necessary information for the Claim Administrator to perform retrospective reviews of Inpatient Admissions.

5. **Allied Provider Programs**

a. Several networks of "Allied Providers" agree to file claims for the patient, accept the Claim Administrator allowable as payment in full and support the Claim Administrator cost containment programs.

b. The Allied Provider Program includes, but is not limited to, the following: Ambulatory Surgical Care, Durable Medical Equipment, Home Infusion Therapy, Comprehensive Outpatient Rehabilitation Facilities.

c. Allied Providers in the program agree to accept the Plan's payment plus the deductible and coinsurance as payment in full, support the Claims Administrator's Utilization Management Program and agree not to balance bill the Member.

II. PAYMENT OF BENEFITS

A. Payment by the Claim Administrator of any claims under the Plan shall be in accordance with standard Claim Administrator's practice.

B. Claim Administrator shall send a Claims Billing Summary Report to GHP on a three-time-per-month billing cycle. The Claims Billing Summary Report will indicate:

1. the amount of reimbursement for Claim Administrator funds used in the payment of GHP's claims, and

2. the amount of the administrative and access fees for the Blue Card Program (see Article IV).

C. Payment of the total amount specified on the Claims Billing Summary Report will be made three times a month to the Claims Administrator on the 7th calendar day of the month following the billing cycle (if the 7th falls on a non-banking day, then payment will be initiated on the first banking day following the 7th). Payment will be made to Claims Administrator via ACH Direct Program from the GHP's bank account initiated by Claims Administrator.

D. Should the GHP fail to have the funds, as billed, available for payment on the 7th Calendar day following each billing cycle, the Claims Administrator may take the following action prior to the next billing cycle:

1. Claim Administrator may suspend all administrative services and utilization management programs outlined in Article I.

2. If the funds are not available by the 15th calendar day of the month following the billing cycle (if the 15th falls on a non-banking day, then funds must be available on the first banking day following the 15th), the Agreement will automatically terminate and GHP will be notified.

3. Should the administrative services be suspended more than once in any twelve month period, the Claims Administrator has the discretion to terminate the Agreement. The Agreement will not be reinstated.

4. The failure of Claim Administrator to suspend services or to terminate the Agreement due to GHP's failure to have the funds available in their bank account does not preclude the future suspension of services or the termination of the Agreement.

III. HOSPITAL SAVINGS

A. GHP Benefits

GHP shall be entitled to benefits from: (1) Participating Hospital Agreement applicable to administrative services groups, and (2) any Blue Card Program between Claim Administrator and a Blue Cross and Blue Shield Plan (see Article IV).

B. Calculation of Savings

Claim Administrator will calculate the total savings received by Plan on covered services rendered to any covered employee under GHP's Plan by any hospital that has signed a Participating Hospital Agreement with Claim Administrator. Of these savings, 100 percent will be passed on to GHP.

IV. ACCESS TO OUT-OF-STATE HOSPITAL SAVINGS THROUGH THE BLUE CARD PROGRAM

The Blue Card Program allows individuals covered under plans administered by the Claim Administrator to receive access to a nationwide network of participating providers outside of Mississippi. Under the BlueCard Program Blue Cross & Blue Shield of Mississippi, in its roll as a Home Licensee, is responsible for fulfilling its contractual obligations to the Group and to Members. Blue Cross and Blue Shield Licensees outside Mississippi ("Host Blues") are responsible for handling all interactions with their participating providers, including contracting with them. Benefits for these Covered Services will be based on the lower Benefit level (Non-Network), if the Individual covered under the Plan (hereinafter Member) fails to comply with the provisions of the Plan dealing with Non-Network Providers (in-state or out-of-state).

A. Host Blue Pricing

1. When a Member obtains health care services through the BlueCard Program outside the Blue Cross & Blue Shield of Mississippi service area, the Member's liability for Covered Services (Coinsurance, Deductibles, etc.) is usually calculated on the lower of:

   a. The providers Billed Charges for the Member's Covered Services, or

   b. The negotiated price that the Host Blue passes on to Blue Cross & Blue Shield of Mississippi.

2. When a Member obtains health care services through the BlueCard Program outside the Blue Cross & Blue Shield of Mississippi service area, the Group's liability for covered services is based on the negotiated price Blue Cross & Blue Shield of Mississippi pays the Host Blue.

3. The methods that Host Blues use to determine a negotiated price will vary based on the terms of each Host Blue's provider contracts. Thus, the "negotiated price" may represent either:

   a. a simple discount which reflects the actual price paid by the Host Blue, or

   b. an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with the Member's health care provider or with a specified group of providers, or

   c. Billed Charges for Covered Services reduced to reflect an average expected savings with the Member's health care provider or with a specified group of providers.

   The price that reflects average savings may result in greater variations (more or less) from the actual price paid than will the estimated price. The negotiated price will also be prospectively adjusted to correct for overestimation or underestimation of past prices. However, the amount the Member pays is considered a final price.

4. In addition, laws in a small number of states other than Mississippi may require Blue Cross and/or Blue Shield Plans ("Host Blues") to use a basis for calculating the

Member's liability for Covered Services that does not reflect the entire savings realized or expected to be realized on a particular claim or to add a surcharge. Should any state statutes mandate liability calculation on methods that differ from the negotiated price methodology outlined above or require a surcharge, the Host Blue will then calculate the Member's liability for any covered health care services in accordance with the applicable state statute in effect at the time the Member receives those services.

5. Due to the contractual arrangements of the out-of-state Blue Cross and/or Blue Shield Plan, methods to determine Negotiated Price for Covered Services may vary when the Member obtains health care services through the BlueCard Program.

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

B. **Access Fees and Administrative Fees**

The GHP agrees to pay certain fees and compensation to Blue Cross & Blue Shield of Mississippi as a result of its obligation under BlueCard to pay to the Host Blue, to the Blue Cross Blue Shield Association, or to the BlueCard Vendors. The aforementioned fees and compensation may be revised from time to time without the GHP prior approval in accordance with the standard procedures for revising fees and compensation under BlueCard. Some of these fees and compensation are charged each time a claim is processed through BlueCard and include, but are not limited to, access fees, administrative expense allowance fees, Central Financial Agency Fees, ITS Transaction Fees, an 800 number fee and a fee for providing PPO provider directories. Also, some of these claim-based fees, such as the access fees, may be passed on to the GHP as an additional claim liability. If the GHP does not have a complete listing, or wants an updated listing, of these types of fees or the amount of these fees that the GHP pays directly, the GHP should contact the Claims Administrator. The following administrative fees and access fees apply to the Blue Card Program:

1. When an individual covered under the Plan receives services from an out-of-state provider, payment to the provider will be based on the agreement between the Blue Cross and Blue Shield Plan in that state and the provider. These Blue Cross and Blue Shield Plans may charge a fee to access any savings made available as a result of the aforementioned agreements on claims incurred by covered individuals.

2. When an access fee is required by the out-of-state Blue Cross and Blue Shield Plan, Claim Administrator will pass the charge along to GHP as a claims expense. If the Claim Administrator receives an access fee credit, GHP will receive a claims expense credit.

3. The out-of-state Blue Cross and Blue Shield Plan may charge an administrative fee for each original claim submitted to the Claim Administrator.

4. When an administrative fee is required by the out-of-state Blue Cross and Blue Shield Plan, Claim Administrator will pass the charge along to GHP.

C. In certain instances, the out-of-state Blue Cross and Blue Shield Plans' practices may require greater level of benefits to access savings. Claim Administrator will adhere to the out-of-state Blue Cross and Blue Shield Plans' practices to obtain savings.

D. In the event the contract terminates, GHP will still be responsible for any claims incurred before the termination date. GHP will be required to remit the funds in a timely manner to Claim Administrator. GHP should be aware that Claims Administrator's compensation for administrative services does not include the administrative fee for the Blue Card Program.

PART 2—GROUP HEALTH PLAN'S RESPONSIBILITIES

V. RESPONSIBILITIES OF GHP

A. GHP agrees to furnish any information required by the Claim Administrator as a result of state or federal law.

B. GHP accepts full responsibility and liability for granting any appeal rights to a denied claimant beyond those appeal rights provided for under the GHP.

C. GHP has full discretionary authority to determine eligibility for benefits and/or to construe the terms of the Plan.

D. In the event GHP retroactively cancels the coverage of an employee or dependent after claims have been processed for the individual, GHP agrees to provide funds for the payment of the claims.

E. GHP shall enter into the "Assignment of Benefits" agreement (Amending Reinsurer Excess Risk Insurance Policy with Policyholder). By way of this Agreement, GHP will assign Individual Specific Stop Loss benefits to the Claim Administrator for reimbursement of Claim Administrator funds utilized for claims over GHP's Individual Specific Stop Loss amount.

F. GHP acknowledges the Claim Administrator will process and administer claims in accordance with GHP's Plan of Benefits as well as the Claim Administrator's Medical Policy. In the event GHP instructs Claim Administrator to provide benefits that are outside the scope of GHP's Plan of Benefits or in conflict with Claim Administrator's Medical Policy, GHP agrees to accept full responsibility for the decision. Additionally, GHP agrees to hold harmless Claim Administrator, its affiliates and their respective directors, officers and employees against any damages, lawsuits, judgements, expenses and attorney fees arises from GHP's decision on extra contractual benefits.

G. GHP acknowledges that any decisions on their part to pay benefits that are not covered under GHP's Plan of Benefits may result in reinsurance issues with their respective reinsurance carriers. GHP accepts full responsibility for these decisions.

H. Employer is solely responsible for ensuring that the GHP is in compliance with Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Employer's Plan Administrator (who is not the Claims Administrator) is responsible for administering the GHP in accordance with COBRA provisions.

I. GHP accepts full responsibility for the distribution of Summaries of Benefits and Coverage to Employer's employees and their dependents under the Plan in accordance with PPACA and/or guidelines and regulations set forth by the U.S. Department of Labor, the U.S. Department of Health and Human Services and the U.S. Department of the Treasury.

J. GHP agrees that it will provide Claims Administrator with the reinsurance terms and contingencies, as agreed to between GHP and its reinsurance carrier, no later than the effective date of the reinsurance agreement. If GHP fails to furnish the reinsurance terms and contingencies to Claims Administrator by the effective date of the reinsurance agreement, all administrative services listed in Part I may be suspended by Claims Administrator.

PART 3—EMPLOYER'S RESPONSIBILITIES

VI. EMPLOYER'S OBLIGATIONS

A. Employer to Control GHP

Employer retains full and final authority and responsibility for GHP and its operation. Claim Administrator is empowered to act on behalf of GHP only as stated in this Agreement, or as mutually agreed in writing by Employer and Claim Administrator.

Employer will have the sole responsibility for and will bear the entire cost of compliance with all federal, state and local laws, rules, and regulations, including any licensing, filing, reporting, and disclosure requirement, that may apply to GHP. Claim Administrator will have no responsibility for or liability with respect to GHP's compliance or non-compliance with any applicable federal, state, or local law, rule, or regulation.

B. Underwriting and Benefits Determinations

Employer retains the ultimate responsibility for Claims under GHP and all expenses incident to GHP, except as Claim Administrator has specifically undertaken in this Agreement. Claim Administrator does not insure or underwrite the liability of Employer or GHP, and has no responsibility for determining the terms of or the benefits to be provided under GHP.

C. Enrollment Information

Employer is solely responsible for furnishing the information that is required by Claim Administrator. This includes, but is not limited to, any information that is necessary to enroll employees and their dependents under the Plan, process terminations, and effect changes in family and membership status. Employer acknowledges and agrees that such information may be collected and transmitted electronically, including internet transmission.

D. Information Required by Law

Employer agrees to furnish any information required by the Claim Administrator as a result of state or federal law.

E. Membership Notification

All notification of membership or coverage changes must be on forms, or electronic transmission, approved by Claim Administrator and include all information required by Claim Administrator to affect changes.

F. Accuracy of Information

Employer warrants the accuracy of the information transmitted to Claim Administrator and understands that Claim Administrator will rely on this information. Employer agrees to supply or allow inspection of personnel records to verify eligibility as requested by Claim Administrator.

G. Indemnification for Untimely or Inaccurate Information

Employer further agrees to indemnify Claim Administrator for all expenses it incurs, if any, as a result of Employer's failure to transmit the information, failure to transmit it in the time period required by Claim Administrator, or failure of correct information being transmitted to Claim Administrator.

H. Summary of Benefits and Coverage

Employer acknowledges and agrees that GHP will furnish and distribute Summaries of Benefits and Coverage to Employer's employees and their dependents under the Plan in accordance with PPACA and/or guidelines and regulations set forth by the U.S. Department of Labor, the U.S. Department of Health and Human Services and the U.S. Department of the Treasury.

VII. DIRECT PAYMENT TO MEMBER AND PARTICIPATION IN FAVORABLE REIMBURSEMENT AGREEMENTS

GHP agrees that all benefits payable under the Plan and any Amendatory Rider thereto are not assignable in whole or in part by the employees or dependents covered under the Plan. The Claim Administrator will make payment to those Hospitals, Physicians or other providers that have entered into an agreement for direct reimbursement with Claim Administrator. Otherwise, all benefits will be payable to the covered employee or covered dependent and any assignment of such benefits will not be honored.

PART 4—CLAIM ADMINISTRATOR'S COMPENSATION

VIII. COMPENSATION FOR CLAIM ADMINISTRATION

A. During the term of this Agreement, GHP agrees to pay the Claim Administrator a monthly administrative services fee. The Claim Administrator's compensation shall be based on GHP's enrollment as of the date the final bill preparation is completed by Claims Administrator. Note: The aforementioned fees are for claims processing and other services performed in that month only.

1. The monthly administrative service fee is $37.00 for each employee covered in the Plan on or after October 1, 2014. The fee includes the services specified in Article I.

B. The due date of the monthly administrative services fee is the first day of each month.

1. On the 7th calendar day of the month (if the 7th falls on a non-banking day, then the payment will be initiated on the first banking day following the 7th) payment will be made to the Claims Administrator via ACH Direct Payment from the GHP's bank account initiated by Claims Administrator. If funds are not available on the 7th calendar day of the month, all administrative services listed in Article I may be suspended by the Claims Administrator.

2. If the Funds are still not available in the GHP's bank account by the 15th calendar day of the month (if the 15th day falls on a non-banking day, then payment will be initiated on the first banking day following the 15th) the Administrative Services Contract may be terminated immediately by the Claims Administrator.

C. GHP will pay the total monthly administrative fee as referenced on the invoice received by GHP. Any adjustments to the administrative fee due to changes in coverage (e.g. additions, deletions, etc.) will be adjusted on GHP's invoice for the following month.

D. Should the expense of administrative services increase due to benefit changes or other mutually agreed upon changes in services or procedures provided under this Agreement, the Claim Administrator may adjust the administrative fee accordingly, such adjustment to be effective on the date the changes take effect, subject to prior approval from GHP. Changes in administrative services and procedures will not be implemented until GHP agrees to the adjustment in the administrative fees. GHP will not unreasonably withhold approval for the adjustment of the administrative fee. In the event GHP fails to approve the increase in the administrative fee within

thirty (30) days after receipt of a notice to increase from the Claim Administrator, Claim Administrator, at its discretion, may immediately terminate the Agreement without any additional notice to GHP; provided, however, that the Claim Administrator shall give written notice of any such termination to GHP immediately thereafter.

IX. REINSURANCE PREMIUMS

A. Timely payment of the reinsurance premiums is the responsibility of the GHP. Claims Administrator will collect the reinsurance premiums from the GHP and distribute the premiums to the reinsurance carrier in a timely manner; however the responsibility of timely payment of the premiums belongs to the GHP. Claims Administrator will not be held responsible for GHP's failure to pay the reinsurance premium in a timely manner.

B. The due date of the monthly premium is the first day of each month.

1. On the 7th calendar day of the month (if the 7th falls on a non-banking day, then payment will be initiated on the first banking day following the 7th), payment will be made to the Claims Administrator via ACH Direct Payment from the GHP's bank account initialized by the Claims Administrator. If funds are not available on the 7th day of the month for which the premiums are due, all administrative services listed in Article I may be suspended by the Claims Administrator.

2. If the Funds are still not available by the 15th calendar day of the month (if the 15th day falls on a non-banking day, then the activity will be initiated on the first banking day following the 15th), Claims Administrator may not be able to distribute the premiums to the reinsurance carrier in the allowed time period. GHP's reinsurance may be terminated for non-payment.

3. Should the reinsurance premiums change, the Claims Administrator will adjust the billing accordingly, such adjustment to be effective on the date of the change.

PART 5—MISCELLANEOUS

X. TERMINATION

A. Termination With or Without Cause

Any party may terminate this Agreement, with or without cause, upon thirty (30) days prior written notice. This provision does not supersede the Claims Administrator's rights to automatically terminate this Agreement for the GHP's failure to remit funds as outlined in Section II.D, above.

B. GHP Plan Termination

The Claims Administrator may terminate this Agreement on the date GHP's Plan is terminated.

XI. LIABILITY AND INDEMNITY

A. GHP is contracting with the Claim Administrator only for the administrative services specifically listed in Article I of this Agreement. GHP retains the final authority for the payment of claims filed under the Plan, it being understood that the Claim Administrator functions in an administrative capacity only subject to the direction of GHP. The parties agree that the Claim Administrator does not underwrite or insure the participants in the Plan and that the Claim Administrator is subject to the direction of GHP with respect to any questions regarding eligibility for payment, the amount of payment, and any controversy involving employees and dependents

with respect to the Plan. GHP also retains the ultimate responsibility for all expenses incident to the Plan and for compliance with all federal and state laws except as specifically assumed in this Agreement by the Claim Administrator.

B. GHP agrees to defend, indemnify and hold harmless the Claim Administrator, its affiliates and their respective directors, officers and employees against all claims for premium taxes on Plan payments if any, and for any damages, lawsuits, judgements, expenses and attorneys' fees incurred by Claim Administrator, as a result of the performance of its duties under this Agreement except where the liability therefor is the direct result of gross negligence, dishonesty, fraud or criminal conduct on the part of the Claim Administrator, its employees, officers or directors.

C. The Claim Administrator agrees to defend, indemnify and hold harmless GHP for any damages, lawsuits, judgements, expenses and attorney fees resulting from or arising out of dishonesty, fraud, criminal conduct or gross negligence with respect to this Agreement on the part of the Claim Administrator, its employees, officers or directors.

XII. LAW AND VENUE

This Agreement shall be construed and interpreted under the laws of the State of Mississippi except where preempted by federal law.

XIII. AMENDMENTS TO THIS AGREEMENT

This Agreement may be amended by written agreement between the Claims Administrator, Employer, and GHP.

XIV. MULTIPLE ORIGINALS

This Agreement has been executed in multiple originals, any one of which may be used for any purpose without the necessity of accounting for the others.

XV. INDEPENDENT CORPORATION

GHP and Employer each on behalf of itself and its participants hereby expressly acknowledge their understanding that this Agreement constitutes a contract solely between GHP and Blue Cross & Blue Shield of Mississippi, as the Claims Administrator. The Claims Administrator is an independent corporation operating under a license from the Blue Cross and Blue Shield Association (hereinafter referred to as the Association), an association of independent Blue Cross and Blue Shield Plans, permitting the Claims Administrator to use the Blue Cross and Blue Shield Service Marks in the State of Mississippi, and that the Claims Administrator is not contracting as the agent of the Association. GHP and Employer further acknowledge and agree that they have not entered into this Agreement based upon the representations by any person other than the Claims Administrator and that no person, entity, or organization other than the Claims Administrator shall be held accountable or liable to GHP or Employer for any of the Claims Administrator's obligations created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of Claims Administrator other than those obligations created under other provisions of this Agreement.

XVI. TRADEMARKS AND TRADENAMES

Each party to this Agreement reserves the right to the control and use of its name, symbols, trademarks, tradenames, service marks, and copyrights presently existing or later established. No party to this Agreement shall use another party's name, symbols, trademarks, tradenames, or service marks in advertising, promotional materials, or otherwise, without the prior written consent of such other party. Any permitted use shall terminate upon the termination of such consent or upon termination of this Agreement, whichever first occurs.

XVII. AGREEMENT

This Agreement and any referenced attachments (attached hereto and incorporated by reference herein) contain the entire agreement between the parties relating to the subjects addressed herein. Any prior agreement, promise, negotiation, or representation, either oral or written, relating to the subject matter of this Agreement and not expressly set forth in this Agreement shall be of no force or effect.

XVIII. SEVERABILITY

If any provision of this Agreement is rendered invalid or unenforceable by the decision of any court of competent jurisdiction, that invalid or unenforceable provision shall be severed from this Agreement and all other provisions of this Agreement shall remain in full force and effect.

XIX. WAIVER OF BREACH

Waiver of breach of any provision of this Agreement shall not be deemed a waiver of any other breach of the same or a different provision.

XX. DISCLOSURE OF CONFIDENTIAL CLAIMS DATA

During the term of this Agreement, either GHP or Employer may request that Claims Administrator provide individually specific claims information or data to GHP, Employer and/or their designated representatives. The parties agree that Claims Administrator will provide individually identifiable specific claims data only as permitted under the terms of this Agreement and as permitted by law.

GHP and Employer each agrees that they will maintain any and all such information or data provided by Claims Administrator that constitutes protected health information in compliance with the HIPAA Privacy Rules and any other applicable state or Federal law. GHP and Employer each agrees to use such information solely for legally permissible purposes pursuant to the requirements of various federal and state laws and regulations, whether now existing or hereafter enacted. GHP and Employer represent that they and/or their designated representatives have specific legally permissible purposes for requesting any information from Claims Administrator. GHP and Employer warrant that they and/or their designated representatives have in effect internal procedures to prevent the unauthorized and/or legally impermissible disclosure and/or use of such claims data.

GHP and Employer agree to defend, indemnify and hold harmless the Claims Administrator, its officers, directors, employees and agents against any and all claims, lawsuits, judgments, attorney fees, costs and expenses of whatever kind and nature arising out of or resulting from Claims Administrator's release of this information containing medical or other data of a confidential nature to GHP, Employer and/or their designated representatives.

XXI. NOTICES

Any notices required to be given pursuant to the terms and provisions of this Agreement shall be in writing and shall be sent by certified mail, return receipt requested, postage prepaid, to Claim Administrator at, Post Office Box 1043, Jackson, Mississippi 39215-1043, and to GHP at P.O. Box 608, Canton, MS 39046. Notice shall be effective on the date indicated on the return receipt.

XXII. DEFINITIONS

The following terms when used in this Agreement have the following meanings:

A. **"Blue Card Program"** - A reciprocal agreement between Claim Administrator and other Blue Cross and Blue Shield Plans that provides the opportunity to utilize local Blue Cross and Blue Shield provider agreements in other states.

B. **"Claim"** - means notification in a form acceptable to Claim Administrator that service has been rendered or furnished to a Covered Person.

C. **"Covered Employee"** - means the person to whom coverage under the Plan has been extended by GHP and to whom Claim Administrator has directly or indirectly issued an identification card bearing GHP's Number. For purposes of providing benefits under the Plan, Covered Employee does not mean a person who has selected Medicare as primary coverage.

D. **"Covered Person"** - means the Covered Employee and the Covered Employee's legal spouse and/or dependent children as specified in the Plan.

E. **"Participating Hospital"** - A hospital that is licensed by the State Department of Health to provide general acute inpatient and outpatient hospital services and that is a party to a Participating Hospital Agreement that is applicable to administrative services only groups.

F. **"Participating Hospital Agreement"** - An agreement between Claim Administrator and a Participating Hospital.

G. **"Payment"** means any of the following activities of a health plan, such as GHP, as relates to a Covered Person (*see* 45 Code of Federal Regulations § 164.501):

1. Obtaining premium payments;

2. Determining or fulfilling responsibility for coverage and provision of benefits under the health plan;

3. Determining an enrollee's eligibility or coverage;

4. Coordinating benefits, determining cost sharing amounts, adjudicating or subrogating health benefit claims;

5. Adjusting risk amounts due based on enrollee health status or demographic characteristics;

6. Engaging in billing, claims management, issuance of explanations of benefits, collection activities, and related health care data processing;

7. Obtaining payment under a contract of reinsurance (including stop-loss insurance and excess of loss insurance);

8. Reviewing health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;

9. Conducting utilization review, precertification and preauthorization of services, and concurrent and retrospective review of services; and

10. Disclosure to consumer reporting agencies not more than the demographic data permitted by 45 Code of Federal Regulations § 164.501 ("Payment" ¶ 2(vi)).

H. **"Plan"** - the Plan of Benefits adopted by GHP as follows: Employee Health Protection Plan for Madison County Board of Supervisors, Contract Type C615 (Exhibit "I").

I. **"Protected Health Information"** - means Individually Identifiable Health Information that is transmitted or maintained electronically, on paper, orally or in any other form or medium.

SIGNATURES

In witness whereof, the parties hereto have caused this Agreement to be executed by their respective Officer who has been duly authorized to execute this Agreement.

CLAIM ADMINISTRATOR:

BLUE CROSS & BLUE SHIELD OF MISSISSIPPI, A
MUTUAL INSURANCE COMPANY

By: _____
John H. Proctor III,
Corporate Secretary

Date: _____

EMPLOYER:

MADISON COUNTY BOARD OF SUPERVISORS

By: _____

Title: _____

Date: _____

GROUP HEALTH PLAN:

EMPLOYEE HEALTH PROTECTION PLAN FOR
MADISON COUNTY BOARD OF SUPERVISORS

By: _____

Title: _____

Date: _____

BlueCross BlueShield of Mississippi

Committed to a Healthier Mississippi.

GROUP NAME: Madison County BOS

EFFECTIVE DATE: October 1, 2014

ADMINISTRATIVE SERVICES (Per Employee Per Month)	$ 37.00
Broker/Consultant Fee	$ 7.50
Optional Services	$ 1.00 Risk Pool
Total	$ 45.50

Networks
- Participating Hospital
- Key Physician
- Diagnostic Imaging Centers
- Comprehensive Outpatient Rehabilitation
- Durable Medical Equipment
- Home Infusion Therapy
- Chiropractor
- Podiatry
- Renal Dialysis Facilities
- Psychiatric/CDU
- Pharmacy Network
- Ambulatory Surgical Facilities
- Physical/Occupational Therapy
- Optometrist
- Nurse Practitioner

Services
- Creditable Coverage Certificates
- Standard Blue Cross & Blue Shield of Mississippi ID Cards
- Prescription Drug Management Program
- Furnish Explanation of Benefits
- Online Access to Reporting
- Other Party Liability Program
- Employee Booklets(Summary Plan Descriptions)
- Annual Renewal
- Electronic Claims Processing
- Appeals
- Utilization Management
- Reinsurance Monitoring
- Local Customer Service
- Online Access to Claims Viewing

BLUECARD PROGRAM FEES:

Administrative Fees – An out-of-state Blue Cross and Blue Shield Plan may charge an administrative fee for each original claim filed with that plan. These fees will be passed to the group as a claims expense.

Network Access Fees – Certain Blue Cross and Blue Shield Plans charge a network access fee for use of their networks and access to their savings. These fees will be passed to the group as a claims expense.

ENROLLMENT REQUIREMENTS:

- Electronic Enrollment
- Bank Draft Authorization for Claims and Premiums

OPTIONAL ADMINISTRATIVE SERVICES:

Dental – Basic (Not Part of the Health Plan) $ _____

Administrative Services, Reinsurance & Assignment of Benefits Confirmation

☐ **New Group** ☒ **Renewal**

1. Effective Date: 10/1/2014
2. Medical Administrative Fee Per Employee Per Month: $37.00
3. Dental Administrative Fee Per Employee Per Month: $
4. Agent/Broker Commission Per Employee Per Month: $ 7.50
5. Optional Services: (Risk Pool) $1.00
6. Specific Stop-Loss Reinsurance Carrier (if applicable): _____
   A. Specific Stop-Loss Deductible: $_____
   B. Aggregating Specific Deductible: $_____
   C. Specific Stop-Loss Rates: Single $_____ Family $_____ Composite $_____
   D. Claims Basis: (Paid, 15/12 etc.) _____
7. Aggregate Stop Loss: ☐ Yes ☐ No Aggregate Rate: _____ Basis: _____
   Aggregate Monthly Factor: $_____ Annualized Attachment point: $_____

Group Name: Madison County BOS **By:** _____

Title: _____

Date: _____

Assignment of Benefits
Amending
Reinsurer Excess Risk Insurance Policy with Policyholder

☒ **Applicable** ☐ **Not Applicable**

This Agreement is made by and between, Madison County BOS, the Policyholder and Blue Cross & Blue Shield of Mississippi, a Mutual Insurance Company. This Amended Assignment of Benefits will become effective on October 1, 2014.

In consideration of the fact that Blue Cross & Blue Shield of Mississippi has agreed to advance to the Policyholder any and all benefit payments due under the terms of the policy between _____ (Reinsurance Carrier) and Policyholder, Policyholder acknowledges and agrees, that by affixing an authorized signature to this form, that all benefits due under the terms of said policy, a copy of which is attached and made a part hereto, are hereby assigned to Blue Cross & Blue Shield of Mississippi.

_____ (Reinsurance Carrier) and Madison County BOS (Policyholder) explicitly agree that any and all provisions directing payment of benefits to Policyholder and/or preventing assignment of such benefits are hereby amended to reflect that benefits will be paid to Blue Cross & Blue Shield of Mississippi.

IN WITNESS WHEREOF, the parties hereto have caused this Assignment to be executed by their respective officers who have been duly authorized to execute this Assignment.

_____ (Reinsurance Carrier)	Madison County BOS (Policyholder)	Blue Cross & Blue Shield of Mississippi
By: _____	By: _____	By: _____
Title: _____	Title: _____	Title: _____
Date: _____	Date: _____	Date: _____