EXHIBIT
“A”

AGREEMENT FOR ADMINISTRATIVE AND CLAIMS PAYMENT SERVICES

THIS AGREEMENT entered into as of the 1st day of January, 2022, by and between the City of Round Rock (hereinafter referred to as “Company”) and United Concordia Companies, Inc. (hereinafter referred to as “Claims Administrator”).

WITNESSETH:

WHEREAS, the Company sponsors a self-insured employee dental benefit plan (“the Plan”);

WHEREAS, the Claims Administrator possesses the administrative capacity to assist the Plan in providing its Participants with dental benefits;

WHEREAS, the Company has designated a Plan Administrator to administer the Plan Benefits;

WHEREAS, the Company and the Plan Administrator have requested the Claims Administrator to furnish administrative and claims payment services for the Plan; and

WHEREAS, the Claims Administrator is willing to administer the claims for certain dental benefits for the Plan’s Participants.

NOW, **THEREFORE**, in consideration of the mutual undertakings herein stated, the Company and Claims Administrator, intending to be legally bound hereby, enter into this Agreement for the administration and claims payment services for certain dental benefits of the Plan.

ARTICLE I - DEFINITIONS

Definitions of words and terms as used in this Agreement:

A. **Bank -** Wells Fargo or such other institution as agreed to by Company and Claims Administrator.

B. **Covered Services -** those services for which Plan Benefits are provided under and subject to the terms and conditions of the Plan.

C. **Participant -** an employee, dependent, retiree or other beneficiary as defined in the Plan, who is duly enrolled by the Claims Administrator in accordance with Article II of this Agreement.

D. **Participating Provider -** any provider with whom Claims Administrator has a contract or arrangement with respect to payment for services performed for Participants enrolled in the Plan.

E. **Plan Administrator -** the entity or person designated by the Company as the Plan Administrator. The Claims Administrator is not the Plan Administrator.

F. **Plan Benefits -** all benefits of whatever nature payable to a Participant or a Participating Provider under and subject to the terms and conditions of the Plan.

G. **Provider -** any duly licensed dental care provider for whose services the Company is obligated to pay under the terms of the Plan.

H. **Summary Plan Description ("SPD") -** a document developed by and provided by the Claims Administrator that describes the terms and benefits to be administered by the Claims Administrator, which is marked as Exhibit B and attached hereto and incorporated herein by reference.

ARTICLE II - ENROLLMENT

A. **Eligibility Information.** Not less than monthly, Company will provide Claims Administrator with current information specifying individuals who are Participants. Company will provide Claims Administrator with notice of changes to such information timely, and Claims Administrator will post such changes no later than 10 business days after receipt thereof from Company. Changes involving termination of a Participant for Plan Benefits will be effective on a prospective basis only and will be effective at the end of the month in which proper notice is provided to the Claims Administrator by the Company. All information under this Article shall be provided in a mutually acceptable data processing medium and format. The Company is responsible for ensuring the accuracy of the information provided to the Claims Administrator.

B. **Identification Cards.** Claims Administrator shall be responsible for providing standard identification cards to Participants based on information provided to it by Company, pursuant to Article II, Paragraph A above. Customized identification cards are subject to additional fees.

C. **Enrollment Procedures.** Upon a determination by Company that an individual is a Participant in the Plan, Claims Administrator shall enroll the individual in a mutually agreed upon manner and pursuant to Article II., Paragraph A above.

D. **COBRA Compliance.** The Company and the Plan Administrator shall retain full responsibility for notifying Participants (or former Participants) of their termination of coverage and of their rights to continuation coverage, for administering the exercise of continuation rights and all related matters as required by the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended("COBRA"). Claims Administrator shall have no obligation to ensure that, among others, any instructions received by Participants (or former Participants) or the Company and the Plan Administrator comply with the requirements of such laws and shall be indemnified by the Company and the Plan Administrator from any and all liability arising from such Company's and Plan Administrator's failure to provide COBRA notices.

ARTICLE III - BENEFITS

A. **Payment Of Benefits.** During the term of this Agreement, Claims Administrator will administer the claims for Plan Benefits, subject to all of the terms and conditions set forth in the SPD.

1. Determination and Payment of Benefits - Claims Administrator will compute and verify Plan Benefits amounts and prepare and provide to Participants and Participating Providers, when applicable, statements reflecting the amount of Plan Benefits payable and the reasons why a claim has been denied in whole or in part. Claims Administrator will draw drafts and checks or initiate electronic funds transfers in payment of Plan Benefits.

2. Services of Claims Administrator's Participating Providers - If Covered Services are performed by a Participating Provider, Claims Administrator will make payment directly to the Participating Provider. Participating Providers have agreed to accept the Claims Administrator's payment as payment in full for Covered Services performed for Participants, except where certain maximums, copayments, co-insurance or deductibles are specified in the SPD, and which are the responsibility of the Participant.

3. Services of Non-Participating Providers - Any difference between the Non-Participating Provider's charge and the Claims Administrator's payment shall be the personal responsibility of the Participant. Claims Administrator's Payment will be made to the Participant or, if permitted by the Plan and if a valid assignment of the claim is in place, to the Non-Participating Provider.

4. Overpayment of Plan Benefits - The parties will cooperate fully to make every reasonable effort under the circumstances, considering the chances of successful recovery and the costs thereof, to recover any payment made to a Participant or Provider which is in excess of the amount which either was entitled to receive under the terms as listed in the SPD.

   Company assigns to Claims Administrator the authority to pursue recovery of overpayments and Claims Administrator will pursue all reasonable means of recovery of overpayments under the circumstances but will not be obligated to commence litigation, unless otherwise specifically agreed to by the parties. Claims Administrator will assume liability for an unrecovered overpayment only if and at such time as it is determined that: (a) the overpayment was caused by Claims Administrator's act or omission which was intentional, grossly negligent, fraudulent or criminal; (b) all reasonable means of recovery under the circumstances have been exhausted; and (c) Claims Administrator's acts or omissions were not undertaken at the express direction of the Company or Plan Administrator.

5. Banking – Unless otherwise agreed to in writing, Plan Benefits shall be made payable through the Bank. The Company, by execution of this Agreement, expressly authorizes Claims Administrator to issue and accept checks on behalf of the Company for the purpose of payment of Plan Benefits. Company agrees to provide funds in accordance with Exhibit A through its designated bank sufficient to satisfy all Plan Benefits upon notice from its designated account of the amount of checks approved and recorded by Claims Administrator. Company agrees to execute such documents as may be required by Claims Administrator or Bank from time to time to effectuate this provision.

B. **Amendments To Plan.** The Company may amend the Plan to change the dental benefits provided to its Participants, or the eligibility to participate in the Plan, at any time

during the term or any extension of this Agreement. Upon written confirmation that the Plan has been duly amended, the Claims Administrator shall administer claims to conform to the amendments to the Plan. The Company and the Plan Administrator assume all responsibility for communication of Plan amendments to the Participants or for other notices to Participants as required by any applicable law. Claims Administrator reserves the right to terminate this Agreement upon thirty (30) days written notice if the amendments to the Plan constitute a material change in the administration of Plan Benefits available to Participants under the Plan.

If any amendment increases or decreases the Claims Administrator's anticipated administrative costs, the parties shall, prior to the administration of the amendments to the Plan, agree to revise financial terms. If the parties fail to reach an agreement within thirty (30) days of commencement of negotiations, either party may terminate this Agreement by the giving of thirty (30) days prior written notice to the other party.

To the extent changes in dental benefits necessitate modification or revision to the SPD or any booklet or information which constitutes a part thereof, the Company shall provide reasonable advance written notice of such amendment to the Claims Administrator.

C. **Interpretation of Plan.** The Company and the Plan Administrator delegate to the Claims Administrator the authority, responsibility and discretion to interpret and construe the provisions of the Plan, as necessary to:

1. administer all services specified in this Agreement;

2. determine the extent of the benefits to which any Participant is entitled under the Plan; and

3. make a full and fair review of each claim denial appealed by Participants.

Any function not specifically delegated to or assumed by the Claims Administrator pursuant to this Agreement shall remain the sole responsibility of the Company and the Plan Administrator.

D. **Nature of Services Provided.** Claims Administrator provides administrative and claims payment services only under this Agreement and does not assume any financial risk or obligations with respect to claims. Plan Benefits are funded entirely by the Company or the Plan Administrator. This Agreement shall not be deemed a contract of insurance or prepaid dental care for any reason under the laws and regulations of any jurisdiction where Claims Administrator may be called upon to act in fulfilling its obligations under this Agreement.

ARTICLE IV - SERVICES PROVIDED BY CLAIMS ADMINISTRATOR

A. **Advisory Services.** Claims Administrator shall consult with Company and Plan Administrator when requested to do so regarding Plan design and revisions, including questions regarding eligibility for participation and effective dates and cessation of coverage.

B. **Estimates of Costs and Liabilities.**

1. Estimates of Plan Benefit Costs and Fees - Claims Administrator will provide Company with an annual estimate, for budget purposes, of Plan Benefit costs, fees and other charges for subsequent Contract Periods.

2. Estimates of Costs of Proposed Plan Changes - Claims Administrator will provide Company with estimated Plan Benefit cost calculations for proposed changes in the Plan.

3. Estimates of Open and Unreported Claim Liability - Claims Administrator will provide Company with estimates of open and unreported claim liability following the close of each Contract Period.

C. **Standard Administrative Forms.** Claims Administrator will provide Company and Plan Administrator with standard forms which may be used for administration of the Plan, including those necessary to process enrollments in the Plan, designations of dependents, etc. Company will not use non-standard administrative forms without receiving Claims Administrator's written approval.

D. **Establishing Banking Arrangements.** Claims Administrator will assist Company in establishing banking arrangements for the reimbursement of Plan Benefits and payment of fees.

E. **Directories.** Claims Administrator will maintain provider directories on its website.

F. **Report Services.** Claims Administrator will furnish Company and/or Plan Administrator reports in accordance with Exhibit C, which is attached hereto and incorporated herein by reference, provided that the content of such reports may be modified or restricted to maintain compliance with claims administrator's privacy practices and procedures and applicable privacy law. It is understood and agreed that the Plan Administrator shall request and utilize such data for the limited purpose of satisfying "Plan Administrative Function" (as that term is defined in 45 C.F.R. § 164.504), which the Company may have with regard to the Plan.

G. **Additional Services.** No additional services are provided by the Claims Administrator other than those expressly agreed herein.

ARTICLE V - CLAIM EXPENSE AND OTHER CHARGES

A. The Company shall pay the Claims Administrator, as specified in Exhibit A, for all claims paid on behalf of the Plan's Participants plus the additional amounts set forth therein. The financial arrangement set forth in Exhibit A may be modified from time to time during the initial term or any extension of this Agreement as mutually agreed upon in writing by the parties.

B. Plan Benefits are entirely funded by the Company or the Plan Administrator. Claims Administrator provides administrative and claims payment services only. Notwithstanding the termination of this Agreement, and regardless of the reason for termination, Company shall be liable to Claims Administrator for the cost of any Plan Benefit paid by Claims Administrator pursuant to this Agreement. Any payment

obligation of Company to Claims Administrator shall survive termination of this Agreement; including, but not limited to, any Run Out Period provided for in Exhibit A.

ARTICLE VI - AUDIT

Company may audit Claims Administrator's administration of Plan Benefits hereunder, subject to the following conditions:

A. **Procedure**. In case of any audit under this Audit provision, Company will give Claims Administrator notice in writing of its desire to conduct an audit. Company and Claims Administrator will agree on the scope of any audit request in writing. The Company shall not request more than one audit per calendar year, no matter the type of audit. Audits shall be conducted only for a period no greater than the two most recently completed contract years. Audits shall be conducted during normal working business hours at the offices of the Claims Administrator by an auditor acceptable to the Claims Administrator and the Company, which approval shall not be unreasonably withheld by either party.

Claims Administrator shall provide appropriate records and documents for Company to evaluate the administration of the Plan. Company will discuss with Claims Administrator the operational details of the audit. Audits shall not be conducted for the same scope and time frame or portion of time of a previously conducted audit unless the Company is required by a governmental agency with which it has a contractual arrangement to audit a period or periods for which a final audit has been performed or in cases of fraud or suspected fraud or unless the audit identifies a systematic discrepancy in which event an audit or re-audit may be conducted of a period no greater than the four most recently completed contract years (including the current audit period) solely for the purpose of examining such systematic discrepancies.

B. **Confidential Information**. Prior to the commencement of any audit, Company and its outside auditor, if any, will execute a written agreement reasonably satisfactory to Claims Administrator to protect the confidentiality of patient specific dental care information and Claims Administrator's proprietary or confidential information, provided that Claims Administrator will in no event be required to disclose any information in violation of applicable law.

C. **Scope of Audits**.

1. Subject to the requirements of Paragraphs A and B of this Article VI. and all applicable laws, regulations and Claims Administrator's policies, audits shall be limited to an examination of claims and Claims Administrator's records of provider charges and reimbursements for Plan Benefits administered under this Agreement. Audit sampling methodology shall be mutually agreed to by the parties and must be based on the universe of claims under review.

2. Further, if any audit request requires more than 40 hours of personnel of Claims Administrator, the Company shall reimburse the Claims Administrator for personnel time in excess of such hours at the rate of $100 per hour. Company shall reimburse Claims Administrator for the actual cost of any computer time expended as a result of any audit request.

3. Audit reports prepared by Company or its representatives shall be reviewed by the Claims Administrator at least fifteen (15) business days prior to issuance.

4. The provisions of this Article VI. shall survive termination of this Agreement.

ARTICLE VII - LITIGATION

If litigation or arbitration proceedings are commenced by a Participant or Provider against Claims Administrator or Company, or both parties, in connection with payment of claims for Plan Benefits ("Claims Litigation"), unless otherwise agreed by the parties:

A. In actions asserted only against Claims Administrator:

1. Claims Administrator will provide written notice to Company as soon as practicable and will, at Company's written request, provide Company with information with respect to the ongoing status of the Claims Litigation; and

2. Claims Administrator will select and retain counsel.

B. In actions asserted against Claims Administrator and Company, unless a material conflict of interest arises between the parties, the parties will agree on a defense strategy for the action and Claims Administrator will select counsel reasonably satisfactory to Company to represent both parties.

C. In actions asserted against Claims Administrator and Company, where a material conflict of interest exists between the parties, each party will select and retain its own counsel.

D. In all litigation under this Article VII, Company shall reimburse Claims Administrator for all such legal fees, costs and disbursements, judgments or settlements unless such Claims Litigation was caused by acts of intentional misconduct or gross negligence by Claims Administrator in the performance of services under this Agreement.

E. In all Claims Litigation, the parties will provide each other with reasonable cooperation necessary in the defense of Claims Litigation;

F. Company shall be liable for the full amount of any Plan Benefits paid as a result of Claims Litigation. In no event will Claims Administrator be liable for any amount of Plan Benefits paid as a result of Claims Litigation or otherwise.

ARTICLE VIII – PRIVACY AND CONFIDENTIALITY

A. **Confidential Information.** Claims Administrator, Company and Plan Administrator acknowledge that in discharging their obligations under this Agreement they may disclose or make available to each other confidential information. Claims Administrator, Company and Plan Administrator agree to protect and preserve the confidential, proprietary and trade secret nature of each other's confidential information and further agree not to disclose the other's confidential information to any other person, firm or entity without obtaining the other's prior written consent unless otherwise required to comply with law, judicial process or governmental/regulatory requirements.

B. **Use of Individually Identifiable Health Information.** The use and disclosure of personally identifiable health information related to Participants ("Protected Health Information") is subject to various privacy laws, including state laws governing the privacy of personal financial and health information, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as supplemented by the Health Information Technology for Economic and Clinical Health Act as incorporated in the American Recovery and Reinvestment Act of 2009 (the "HITECH Act") and regulations adopted thereunder by the U.S. Department of Health and Human Services (45 CFR Parts 160, 162, 164 ("HIPAA Regulations") (HIPAA, HITECH Act and HIPAA Regulations, collectively, "HIPAA Rules"). The parties will treat all such information in accordance with those laws, and will use or disclose Protected Health Information received from the other only for the purposes stated in this Agreement, or to comply with law, judicial process or governmental/regulatory requirements.

C. **Business Associate Addendum.** Pursuant to the HIPAA Rules, Claims Administrator shall be a "Business Associate" of the Plan . Accordingly, Company shall, for and on behalf of the Plan, agree to the attached "Business Associate Addendum" coincident with its execution of this Agreement. The parties further agree that this Agreement along with the Business Associate Addendum shall thereafter govern Claims Administrator's obligations regarding the use and disclosure of Protected Health Information when performing its functions under this Agreement.

ARTICLE IX - TERMINATION AND RENEWAL

A. This Agreement shall continue until 12:00 midnight on the "Termination Date" specified in Exhibit A, at which time, unless changed or terminated as provided herein, it shall automatically renew for successive periods of twelve (12) consecutive months. Such initial period and each successive renewal period is hereinafter called a "Contract Period."

B. Upon at least thirty (30) days written notice to the other party prior to the end of any Contract Period, the Company or the Claims Administrator may request a change in the financial terms of this Agreement. If the parties are unable to agree upon such requested change within thirty (30) days of the written notice, this Agreement will automatically terminate at the end of the Contract Period in which the request for change is made, unless the parties agree in writing to an extension thereof.

C. The Company or the Claims Administrator may terminate this Agreement at the end of any Contract Period by the giving of no less than thirty (30) days written notice to the other party prior to the end of such Contract Period.

D. If the amount due the Claims Administrator pursuant to Exhibit A is not received by the end of two (2) business days from a payment due date, this Agreement may be terminated by the Claims Administrator following written notification to the Company. In the event of automatic termination of this Agreement under this paragraph, the Claims Administrator, at its option, may reinstate this Agreement or enter into a new agreement with the Company. Unless otherwise agreed, the new agreement or reinstated Agreement shall be on a month-to-month basis.

ARTICLE X - MISCELLANEOUS

A. **Amendments to Comply with Law.** Notwithstanding any provision contained herein to the contrary, the Company or the Claims Administrator shall have the right, for the purpose of complying with the provisions of any law, judicial process or government/regulatory requirements, to amend this Agreement, including any Exhibits hereto, or to increase, reduce or eliminate any of the benefits provided for in this Agreement for any one or more Participants who shall be enrolled under this Agreement, and each party will agree to any amendment of this Agreement which is necessary in order to accomplish such purpose. The Company also agrees to pay any change in the cost of any Plan Benefit and fees that result from such amendment. If the parties cannot agree to any such change or amendment, notwithstanding any provision of this Agreement to the contrary, the Company or the Claims Administrator may terminate this Agreement as of the end of the month by the giving of thirty (30) days written notice prior thereto.

B. **Other Amendments.** This Agreement shall be subject to amendment or modification only by mutual written agreement between the Claims Administrator and Company and Plan Administrator.

C. **Notices.** Unless otherwise provided herein, all notices required or permitted to be sent in accordance with this Agreement may be either personally delivered, or sent by regular U.S. mail or nationally recognized overnight courier service, to the following addresses:

To the Company at:

231 East Main Street, Ste. 100
Round Rock, TX 78664

Attention: Benefits Manager, Human Resources Department

To Claims Administrator at:

United Concordia Companies, Inc.
1800 Center Street
Camp Hill, PA 17011

Attention: President

The parties may change the address listed herein by sending notice of such change in writing to the other party in accordance with the method outlined in this Article.

D. **Choice of Law.** This Agreement is entered into pursuant to the laws of the Commonwealth of Pennsylvania and the State of Texas and shall be interpreted pursuant to such laws. If the Plan falls within the meaning of the Employee Retirement Income Security Act of 1974, as amended, (“ERISA”) state law controls to the extent that it is not preempted by ERISA.

E. **Severability.** In the event of the unenforceability or invalidity of any section or provision of this Agreement, such section or provision shall be enforceable to the fullest extent permitted by law, and such unenforceability or invalidity shall not

otherwise affect any other section or provision of this Agreement and this Agreement shall otherwise remain in full force and effect.

F. **Assignment.** Services to be provided by Claims Administrator under this Agreement may be performed in whole or in part by Claims Administrator, by any of its affiliates, or by any subcontractor selected by it or by such affiliates. Except as set forth in the preceding sentence, neither party may assign or delegate any of the rights and obligations hereunder to any third party without the prior written consent of an officer of the other party.

G. **Benefit of the Parties.** This Agreement is for the sole and exclusive benefit of the parties hereto and is not intended to nor does it confer any benefits or rights upon any third party.

H. **Entire Agreement**. This Agreement, together with its Exhibits, constitutes the entire agreement between the parties and supersedes all prior oral or written agreements or understandings between the parties regarding the subject matter hereof.

I. **Force Majeure**. A party shall not be liable for any failure in performance of this Agreement for the period that such failure or delay is due to causes beyond its reasonable control including, but not limited to, acts of God, war, strikes or labor disputes, government orders or any other force majeure type event.

J. **Damages**. In no event will Claims Administrator or its affiliates, subcontractors or assigns be liable to the Company or Plan Administrator (including the successors and/or assigns of each) for any consequential, incidental, indirect, punitive or special damages (including, but not limited to, loss of profits, data, business or goodwill) in connection with the performance of services under this Agreement.

K. **Non-waiver**. The failure of either party, in any one or more instances, to demand strict performance or compliance with any of the terms or conditions of this Agreement or to take advantage of any of its rights shall not operate or be construed as a waiver of any such terms or conditions or the relinquishment of any such rights. All such terms or conditions and rights shall continue and remain in full force and effect.

L. **Acts and Omissions by Others.** Claims Administrator shall not be liable for any acts or omissions of the Company or the Plan Administrator, its agents or employees or any other person or organization which the Company or Plan Administrator has made, or hereafter shall make, arrangements for the performance of services related to this Agreement.

M. **Counterparts.** This Agreement may be executed in any number of counterparts, each of which shall be deemed an original and constitute one and the same instrument.

N. **Independent Contractors.** In fulfilling its obligations in connection with this Agreement and the Plan, Claims Administrator acts in the capacity of independent contractor as to Company and Plan Administrator.

O. **Headings.** Headings in this Agreement have been inserted for convenience and shall not be used to interpret or construe its provisions.

P. **Performance Guarantees.** The parties agree that the Services provided hereunder are subject to the performance guarantees as set forth in Exhibit D.

Q. **Compliance with Laws.** The parties shall comply with all applicable federal and state laws. In accordance with Chapter 2271, Texas Government Code, a governmental entity may not enter into a contract with a company for goods and services unless the contract contains written verification from the company that it: (1) does not boycott Israel; and (2) will not boycott Israel during the term of the contract. The signatory executing this Agreement on behalf of Claims Administrator verifies that Claims Administrator does not boycott Israel and will not boycott Israel during the term of this Agreement.

IN WITNESS WHEREOF, the parties intending to be legally bound have caused this Agreement to be executed the day and the year first above written.

City of Round Rock

By:______________________________________

Name: Craig Morgan

Title: Mayor

United Concordia Companies, Inc.

By: ______________________________________

Title:_____________________________________

EXHIBIT A

Group: City of Round Rock

Account No: 0228442

Group No: 923517-000; 923517-001; 923517-099

A. Effective Date: January 1, 2022

B. Termination Date: December 31, 2024

C. Remittance Period: Weekly

D. Payment Procedure & Fees:

1. Claims Administrator (or the designated agent of Claims Administrator) will notify the Company by the last business day of each Remittance Period of the amount due under this Agreement to fund Plan Benefits and to pay the Network Access Fee. The "Network Access Fee" is twelve percent (12%) of the difference between the amount billed by a Participating Provider for a Covered Service and the allowed amount negotiated by Claims Administrator with the Participating Provider for the Covered Service (without regard to deductible, co-pay, co-insurance or other member cost share amount). The Company will remit the payment within two (2) business days of notice from the Claims Administrator per an agreed upon payment method. This Agreement will be terminated in accordance with Article IX of this Agreement if the Company fails to make timely payment. Claims Administrator shall have no obligation to pay any claims, regardless of the date of service, after termination, except as otherwise provided in Section F. of this Exhibit A.

2. Company shall pay Claims Administrator an amount equal to $1.20 per employee per month ("Administrative Fee"), which shall be due on the date specified on the invoice. Claims Administrator (or the designated agent of Claims Administrator) will bill Company for the Administrative Fee every month.

3. Claims Administrator shall pay Customer an implementation credit in the amount of $30,000.00. The implementation credit is due and payable to Customer upon full execution of this Agreement. In the event that Customer does not become effective with Claims Administrator as of January 1, 2022, or otherwise cancels this Agreement prior to December 31, 2024, Customer will reimburse Claims Administrator the full amount of the implementation credit, that was paid by Claims Administrator to Company, within ten (10) days of notice to Claims Administrator of cancellation or termination of this Agreement.

4. Claims Administrator reserves the right to recalculate the Network Access Fee and/or the Administrative Fee listed above at any time if any of the following occurs:

(a) Change in Employee Count. 10% or greater aggregated change per Contract Period, positive or negative, in the number of employees from those assumed in Claims Administrator's quotation or renewal quotation.

(b) Change in Plan. A material change in the Plan initiated by Company or in response to any law, judicial process or government/regulatory requirements.

(c) Change in Claims Administration. A material change in claim payment requirements or procedures, account structure, or any other change materially affecting the manner or cost of paying benefits.

5. A late fee of one and one half percent (1 1/2%) per month will be charged on any unpaid balance.

E. Taxes.

In the event any state or any political subdivision thereof presently or hereafter imposes any tax payable by the Claims Administrator with respect to the services provided hereunder or with respect to the gross receipts derived hereunder, any amounts payable by the Company to the Claims Administrator shall be increased sufficiently to cover any such tax imposed with respect to the services or gross receipts involved.

F. Settlement Upon Termination of Agreement.

Upon termination of this Agreement for any reason other than non-payment by Company of any money due Claims Administrator, and provided that Company has paid an advance deposit to Claims Administrator, Claims Administrator will administer claims incurred by Participants prior to termination for sixty (60) days (the "Run Out Period"). Claims Administrator shall bill Company, and Company shall pay Claims Administrator in accordance with the Agreement and this Exhibit A as if the Agreement was still in effect. If Company fails to make timely payment to Claims Administrator, Claims Administrator may apply the advance deposit to amounts owed and may, in its sole discretion, terminate the Run Out Period immediately upon notice to Company. If the advance deposit is not sufficient to cover all amounts due, Company shall make payment within five (5) business days of notice from Claims Administrator. If Company has paid all amounts due Claims Administrator, Claims Administrator shall return the advance deposit to Company within a reasonable time after the end of the Run Out Period.

EXHIBIT B

[Summary Plan Description to be Provided]

EXHIBIT C

REPORT SERVICES

A. Standard Reports:

Claims Administrator will furnish to Company and/or Plan Administrator the following reports at no additional charge:

Report	Frequency
INVOICE NOTIFICATION	WEEKLY, MONTHLY OR SEMI-MONTHLY DEPENDING ON REMITTANCE PERIOD
CLAIMS DETAIL	WEEKLY, available via e-Bill
ESCHEATMENT REPORT	ANNUALLY, IF NECESSARY
CLAIMS UTILIZATION REPORT	ANNUALLY, UPON REQUEST

B. Other Reports:

Reports, other than those listed in this Exhibit C, requested by Company or Plan Administrator will be produced upon agreement with Claim Administrator and for additional fees billed and payable.

EXHIBIT D

Performance Guarantees

Category	Standard	Proposed Penalty
Implementation	Standards to be agreed upon between City of Round Rock and United Concordia. United Concordia will provide City of Round Rock with a post implementation survey within 30 days of the effective date.	$10,000
Account Management	Standards to be agreed upon between City of Round Rock and United Concordia.	$10,000
Customer Service		
Average Speed to Answer*	30 seconds or less	1%
Abandonment Rate*	3% or less	1%
First Call Resolution*	90%	1%
Claims Administration		
Turnaround Time**	90% of non-investigated claims finalized within 14 calendar days	1%
	98% of non-investigated claims finalized within 30 calendar days	1%
Financial Accuracy**	99% of dollars paid accurately	1%
Procedural Accuracy**	98% of claims paid accurately	1%
Total	Maximum payout not to exceed	10% of the administrative fee

Standard measured against United Concordia's total designated customer service department.
****Standard measured against United Concordia's total commercial book of business.***
We report performance guarantees quarterly.
Penalties for any missed guarantees will be based upon annual performance results.
Amounts at risk are not inclusive of our proposed network access fees.

UNITED CONCORDIA® DENTAL
Protecting More Than Just Your Smile®

Partners
Updates for eBill Clients
Instructions for Completing the Client Specification Form

These instructions are designed to assist you in completing the client specification form. The Client Specification Form, along with the attached Business Associate Contract, must be completed and returned to United Concordia Finance. After the forms are returned, it takes approximately 10 business days to set up your account. If you have any questions while completing these forms, please contact your United Concordia Sales Representative.

1) Please provide your company name. City of Round Rock, Texas.

2) United Concordia will complete this information.

3) United Concordia will complete this information.

4) Funding Method is based on claims utilization.

5) United Concordia will complete this information.

6) You have the option to fund claims weekly (Mon or Fri), monthly (last business day of the month) or semi-monthly (15th & last business day). Administrative (Admin) Invoices are always generated monthly. You may choose to use eBill for Claims, or for Admin, or for both Claims and Admin. If you do not want one of the options, simply do not check a billing frequency for the undesired billing type.

7) The method of transferring funds to United Concordia will be accomplished via a Client-Initiated ACH Debit. The payment process will begin at the time you choose to make a payment within the eBill application. After that, United Concordia will draw funds from your bank account for your specified payment amount.

   Claims payments are due within 48 business hours of receipt of the invoice notification.

8) The invoice notification will be sent via email. Within eBill, an Invoice Summary and Claims Detail are available. Carefully review your company needs in regard to who shall review your invoice and/or its supporting data. Claims Detail contains Protected Health Information (PHI). As a result, only HIPAA reviewers or HIPAA payers may see such reports.

   Any/all of the HIPAA payers will be considered as client contacts. Therefore, only these contacts may be contacted by UCCI regarding account setup or payment questions. At least two users are recommended.

9) For new clients, United Concordia requires a prefund equal to the proposed frequency of funding (weekly or monthly) based on your company's claims history. The prefund may be waived under certain circumstances, including the requirement of choosing to fund and pay claims on a weekly basis (Friday or Monday only) on eBill. United Concordia will use an ACH debit to complete the prefund funds transfer. The prefund balance will not be used to pay any run-out claims. The total prefund amount will be held in the United Concordia ASO account until the termination of the agreement. Please indicate the prefund amount discussed with your United Concordia Sales Representative. Also, choose whether or not you will need an invoice created and sent to you for the prefund amount. The prefund amount is due 10 days prior to your company's effective date of coverage.

10) **For new clients,** United Concordia considers claims information, like that included in the Claims Detail Report, to be Protected Health Information (PHI). As a result, for all ASO customers, United Concordia requires a signed copy of the attached Business Associate Contract with names specified under Exhibit B, Designation of Representatives. Please note that United Concordia cannot distribute any **reports without this signed document**.

    a. On page 1 of the Business Associate Contract, insert group name as "Plan Sponsor".
    b. Insert effective date in space provided after PART V, Section C.
    c. On last page of Business Associate Contract, please fill in all information (Corporate Name, Signature, Printed Name, Title, Date, Address, and Fax Number). **Please make sure contract is signed by a company representative with the authority to execute a contract on the company's behalf.**
    d. Under Exhibit B, list all representatives **(complete name and title)** that are approved to receive PHI data; insert address and date.

UNITED CONCORDIA® DENTAL

Protecting More Than Just Your Smile®

For current clients, who have a Business Associate Contract on file, United Concordia considers claims information, like that included in the Claims Detail Report, to be Protected Health Information (PHI). As a result, for all ASO customers, United Concordia requires a completed and signed copy of Exhibit B, of the attached Business Associate Contract. This Exhibit B should reflect additional representatives authorized to receive PHI data. In this case, complete Exhibit B with all names, both previous and new representatives; insert address and date. **If there is no Business Associate Contract currently on file, United Concordia requires a completed and signed copy of the attached Contract, including Exhibit B.**

Once completed, please mail or fax the forms to the address or fax number listed below. Again, if you have any questions completing these forms, please contact your United Concordia Sales Representative.

The completed forms can be emailed to ASOClaims@ucci.com

United Concordia Sales Representative: Steve Kowalski____

Phone Number: (214) 346-2583

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ASO/Partners
Client Specifications

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1) Company Name: City of Round Rock, Texas________________________________

2) Client ID: ________________________________ (UCCI's use only)

3) eBill Effective Date: __________________ (UCCI's use only)

OR

New Customer Contract Effective Date: 01/01/2022_________________ (UCCI's use only)

4) Funding is based on claims utilization

5) Network Access Fee (NAF): _____ % (supply percentage) or ______ N/A (check if not applicable) (UCCI's use only)

6) Funding Invoice Triggers:
Note invoice frequency choice for Claims:

(X) Weekly M F ( ) Monthly ( ) Semi-Monthly

7) Funding payment method is Client-Initiated ACH Debit when paying with eBill. UCCI Ebill Originator #: U251687586
Please be sure:

(X) Update debit blocks at your bank in order to authorize United Concordia to debit your account
( ) Any debit limits need to be removed and/or increased due to varying amounts of claims expense

8) eBill Users Required Information:

***User Type Information:**

- Users prefaced with the term of 'HIPAA' means that they are permitted to see claim detail
- All HIPAA users must be included on Exhibit B, as Group Health Plan Designated Representatives (GHPDR)
- Only HIPAA payer(s) may be contacted by UCCI

FIRST USER

Name: Tyler Jarl Email tjarl@roundrocktexas.gov

Phone # 512-341-3143 Security ?—City where user was Born: Austin, TX

Choose one user type*:
(X)HIPAA Reviewer ( )Non-HIPAA Reviewer (X)HIPAA Payer ( )Non-HIPAA Payer

Choose type of billing; check **all that apply**: (X)Claims (X)Admin.

Existing eBill user with any Highmark company? Y or N If YES, note user id: __________________

Existing user of United Concordia AMP group portal? Y or N If YES, note user id: __________________

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SECOND USER

Name: Valerie Francois Email vfrancois@roundrocktexas.gov

Phone # 512-218-5494 Security ?—City where user was Born: Alexandria, VA

Choose one user type*:
(X)HIPAA Reviewer ( )Non-HIPAA Reviewer (X)HIPAA Payer ( )Non-HIPAA Payer

Choose type of billing; check **all that apply**: (X)Claims (X)Admin.

Existing eBill user with any Highmark company? Y or N If YES, note user id: __________________

Existing user of United Concordia AMP group portal? Y or N If YES, note user id: __________________

THIRD USER

Name: _________________________ Email______________________

Phone # ________________________ Security ?—City where user was Born: ____________________

Choose one user type*:
( )HIPAA Reviewer ( )Non-HIPAA Reviewer ( )HIPAA Payer ( )Non-HIPAA Payer

Choose type of billing; check **all that apply**: ( )Claims ( )Admin.

Existing eBill user with any Highmark company? Y or N If YES, note user id: __________________

Existing user of United Concordia AMP group portal? Y or N If YES, note user id: __________________

FOURTH USER

Name: _________________________ Email______________________

Phone # ________________________ Security ?—City where user was Born: ____________________

Choose one user type*:
( )HIPAA Reviewer ( )Non-HIPAA Reviewer ( )HIPAA Payer ( )Non-HIPAA Payer

Choose type of billing; check **all that apply**: ( )Claims ( )Admin.

Existing eBill user with any Highmark company? Y or N If YES, note user id: __________________

Existing user of United Concordia AMP group portal? Y or N If YES, note user id: __________________

9) <u>Prefund is waived for all customers who bill & pay weekly on Ebill (Friday or Monday)</u>. For all other customers:

The prefund amount is $ ___________________

I (WILL / WILL NOT) need an invoice sent for the prefund amount.

10) Contracts for NEW Clients:

A signed Business Associate Contract and Exhibit B for GHPDR are included. (X) Yes ( ) No

Contracts for CURRENT Clients:

A signed Exhibit B for GHPDR is included, and a Business Associate Contract is included, or already on file with United Concordia. ( ) Yes ( ) No

The completed forms can be mailed or faxed to UCCI Finance at the following:
Attn: Financial Reporting
United Concordia Companies, Inc.
1800 Center Street
Camp Hill, PA 17011

Form Complete By: ____ Date: ________________

Contact Number: ______________________________

BUSINESS ASSOCIATE CONTRACT WITH DESIGNATION OF REPRESENTATIVES

This Business Associate Contract (“Contract”) is by and between Claims Administrator (as identified below) and the City of Round Rock (“Plan Sponsor”) acting on its own behalf and on behalf of its group health plan(s) (“GHP”).

RECITALS

WHEREAS, GHP is a “Group Health Plan” as defined in Section 160.103 of the regulations implementing the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 45 C.F.R. Parts 160 and 164 (the “Privacy Rule”).

WHEREAS, Claims Administrator provides services related to the administration of GHP under an administrative services only agreement or cost-plus arrangement by and between Claims Administrator and Plan Sponsor (“Benefits Contract”); and

WHEREAS, Plan Sponsor and Claims Administrator mutually agree to incorporate the terms of this Contract into the Benefits Contract in order to comply with the requirements of the implementing regulations of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), as modified by the Health Information Technology for Economic and Clinical Health Act (the “HITECH Act”) (“HIPAA Rules”),

NOW, THEREFORE, in consideration of these premises and the mutual promises and agreements hereinafter set forth, Plan Sponsor and Claims Administrator hereby agree as follows:

PART I. - CLAIMS ADMINISTRATOR’S OBLIGATIONS

A. Permitted Uses and Disclosures. Claims Administrator is permitted or required to Use or Disclose Protected Health Information it creates or requests for, or receives from, Plan Sponsor or GHP only as follows:

1. Functions and Activities on Behalf of GHP. Claims Administrator is permitted to Use, Disclose, create or receive Protected Health Information in furtherance of its administrative duties on behalf of GHP as set forth in this Contract, the Benefits Contract and Exhibit A hereto, and consistent with the Privacy Rule and any implementing regulations..

2. Data Aggregation Services. Claims Administrator may perform Data Aggregation services as defined in the Privacy Rule, subject to any limitations imposed by the Benefits Contract and the Privacy Rule.

3. Uses for Claims Administrator’s Operations. Claims Administrator is permitted to Use Protected Health Information: (a) as necessary for Claims Administrator’s proper management and administration; and, (b) to carry out Claims Administrator’s legal responsibilities.

4. Disclosures for Claims Administrator’s Operations. Claims Administrator may Disclose Protected Health Information for Claims Administrator’s proper management and administration or to carry out Claims Administrator’s legal responsibilities, but only if the following conditions are met: (a) the Disclosure is Required by Law; or (b) Claims Administrator obtains reasonable assurances from any

person or organization to which Claims Administrator will Disclose such Protected Health Information that the person or organization will: (i) hold such Protected Health Information in confidence and Use or further Disclose it only for the purpose for which Claims Administrator Disclosed it to the person or organization or as Required by Law; and, (ii) notify Claims Administrator (who will in turn notify GHP) of any instance of which the person or organization becomes aware in which the confidentiality of such Protected Health Information was breached.

5. Other Uses and Disclosures. Claims Administrator may make any Use and/or Disclosure of Protected Health Information permitted under 45 C.F.R. §§ 164.506(c), 164.508 and 164.510, as well as under Claims Administrator's Notice of Privacy Practices ("NPP").

6. Creation of Limited Data Sets and De-Identified Health Information
Claims Administrator may use Group Health Plan's PHI to create (or have created on its behalf) Limited Data Sets, in conformance with 45 C.F.R. § 164.514(e) (2), and De-Identified Health Information, in conformance with 45 C.F.R. § 164.514(b). Claims Administrator may use such Limited Data Sets for public health, research and health care operations purposes permitted by the Privacy Rule.

7. Additional Uses and Disclosures. In addition to uses and disclosures authorized by Sections I.A. 1-6 hereof, Claims Administrator may use or disclose data collected in the performance of services under Benefits Contract or any other Agreement between the Parties, so long as: (i) the data is de-identified in a manner consistent with the requirements of HIPAA; or (ii) the data is used or disclosed for research, health oversight activities or other purposes permitted by law; or (iii) a Member has consented to the release of his or her individually identifiable data. The data used or disclosed shall be used for a variety of lawful purposes, including, but not limited to, research, monitoring, and benchmarking of industry and health care trends.

B. Minimum Necessary and Limited Data Set. Claims Administrator will apply policies and procedures intended to assure that it will Use, Disclose, or request only the minimum necessary amount of Protected Health Information to accomplish the intended purpose as required under 45 C.F.R. §§ 164.502(b) and 164.514(d) , and will use a Limited Data Set, as defined by the Privacy Rule, if practicable.

C. Sale of PHI. Claims Administrator shall not directly or indirectly receive remuneration in exchange for PHI except where permitted by the Contract and consistent with applicable law.

D. Use of PHI for Marketing Purposes. Claims Administrator shall not directly or indirectly receive payment for any use or disclosure of PHI for marketing purposes except where permitted by the Agreement and consistent with applicable law.

E. Disclosure to Claims Administrator's Subcontractors and Agents. Claims Administrator shall require any of its agents or subcontractors to provide reasonable assurance, evidenced by written contract that the agent or subcontractor will comply with the same privacy and security obligations as Claims Administrator with respect to Protected Health Information of GHP.

F. Disclosure Pursuant to Audits. No provision of this Contract is intended in any way to limit or expand the party's rights or obligations with respect to audits as set forth in the Benefits Contract.

G. Duty to Mitigate. Claims Administrator will mitigate to the extent practicable any harmful effect of which Claim Administrator is aware that is caused by any use or disclosure of GHP's Protected Health Information in violation of this Contract.

H. Reporting of Improper Use or Disclosure. Claims Administrator will promptly report to GHP any Use or Disclosure of Protected Health Information not permitted by this Contract or in violation of the Privacy Rule when Claims Administrator learns of such non-permitted Use or Disclosure. In addition, Claims Administrator will report any "Breach" of "Unsecured Protected Health Information" (as these terms are defined by the Breach Notification Regulation, 45 C.F.R. §164.402), following discovery and without unreasonable delay, but in no event later than thirty (30) days. Claims Administrator shall cooperate with Plan in investigating the Breach and in meeting the Plan's obligations under the Breach Notification Regulation and any other applicable, security breach notification laws.

Any such report shall include the identification (if known) of each individual whose Unsecured Protected Health Information has been, or is reasonably believed by Claims Administrator to have been, accessed, acquired, or disclosed during such Breach. Claims Administrator's report to Plan will at the least:

1. Identify the nature of the non-permitted access, use or disclosure, including the date of the event and the date of discovery of the Breach;

2. Identify the Protected Health Information accessed, used or disclosed (e.g., full name, social security number, date of birth, etc.);

3. Identify generally who made the non-permitted access, use or disclosure and who received the non-permitted disclosure;

4. Identify what corrective action Claims Administrator took or will take to prevent further non-permitted access, uses or disclosures; and

5. Identify what Claims Administrator did or will do to mitigate any deleterious effect of the non-permitted access, use or disclosure.

I. Compliance with Standard Transactions. If Claims Administrator conducts on behalf of GHP communications that are required to meet the Standards for Electronic Transactions as set forth in 45 C.F.R. Part 162 ("Standard Transactions"), Claims Administrator will comply, and will require any subcontractor or agent involved with the conduct of such Standard Transactions to comply with each applicable requirement of 45 C.F.R. Part 162.

J. Information Safeguards. Claims Administrator will develop, implement, maintain and use reasonable and appropriate administrative, technical and physical safeguards to preserve the privacy, integrity, confidentiality and availability of Protected Health Information, and to prevent non-permitted Use or Disclosure of Protected Health Information. When so required:

1. The safeguards must reasonably protect group health plan's Protected Health Information from any intentional or unintentional use or disclosure in violation of the Privacy Rule, 45 C.F.R. Part 164, Subpart E and this Contract, and limit incidental uses or disclosures made pursuant to a use or disclosure otherwise permitted by this Contract.

2. Such safeguards shall be consistent with applicable requirements of 45 C.F.R. Part 164, Subpart C, pertaining to the security of Electronic Protected Health Information ("EPHI"), and as required by the HITECH Act. Claims Administrator also shall develop and implement policies and procedures and maintain documentation of such policies and procedures to assure compliance with the Security Rule standards as required by the HITECH Act;

3. Claims Administrator will ensure that any agent, including a subcontractor, to whom it provides EPHI agrees to implement reasonable and appropriate safeguards to protect it; and

4 Claims Administrator will report any security incident of which it becomes aware to the group health plan. For purposes of this paragraph a reportable security incident shall be any security incident (as defined in 45 C.F.R. § 164.304) that Claims Administrator reasonably determines to be a threat or hazard to the security or integrity of the group health plan's EPHI.

K. Administration of Individual Rights

1. Access. Upon GHP's written request, or the direct request of an individual, Claims Administrator will provide access to Protected Health Information about an Individual in Claims Administrator's custody or control contained in a Designated Record Set, so that GHP may meet its access obligations under 45 C.F.R. § 164.524.. Such access shall be provided in a time and manner consistent with Claims Administrator's procedures for access, which Claims Administrator hereby represents comply with the requirements of 45 C.F.R. § 164.524. All fees related to this access shall be borne by the Individual, as determined by Claims Administrator in accordance with 45 C.F.R. § 164.524. Claims Administrator shall make such information available in an electronic format where directed by GHP.

2. Amendment. Upon GHP's written request, or the direct request of an Individual, Claims Administrator will, on behalf of GHP, amend Protected Health Information as required by 45 C.F.R. § 164.526 on GHP's behalf. Claims Administrator will amend such Protected Health Information according to its own procedures for such amendment, which procedures Claims Administrator represents comply with applicable requirements of 45 C.F.R. § 164.526.

3. Disclosure Accounting. Claims Administrator agrees to record each disclosure, not excepted from Disclosure accounting under 45 C.F.R. § 164.528(a)(1) in accordance with the requirements of 45. C.F.R. § 164.528(b). Upon GHP's written request or the direct request of an Individual, Claims Administrator will, on behalf of GHP, provide a Disclosure Accounting in accordance with its own procedures for Disclosure Accounting, which Claims Administrator represents comply with 45 C.F.R. § 164.528..

4. Request for Restrictions and Confidential Communications. To the extent that communications are within the control of Claims Administrator, Claims Administrator will, on behalf of GHP, evaluate and determine whether to grant requests for restrictions and confidential communications in connection with the Use or Disclosure of Protected Health Information within the custody and control of Claims Administrator pursuant to 45 C.F.R. § 164.522. Claims Administrator will evaluate and determine whether to grant such requests according to its own procedures for such requests, and shall implement such appropriate operational steps as required by its own procedures. Claims Administrator represents that its procedures for evaluation and determination regarding such requests comply with the requirements of 45 C.F.R. § 164.522. Group Health Plan shall not agree to

Requests for Restriction that could affect Claim Administrator's operations without first obtaining Claim Administrator's agreement to the Restriction.

L. Inspection of Books and Records. Claims Administrator will make its internal practices, books, and records relating to its Use and Disclosure of Protected Health Information available to the U.S. Department of Health and Human Services in a time and manner designated by that agency for the purpose of determining GHP's compliance with the Privacy Rule and the Security Rule.

M. In any case in which Claims Administrator has been engaged to perform any obligation of GHP that is described in 45 C.F.R. Part 64, Subpart E, it shall comply with all requirements of that Subpart that would apply to GHP in the performance of that obligation.

PART II – PRIVACY NOTICES

A. Claims Administrator's Notice of Privacy Practices ("NPP"). Unless otherwise directed by GHP, Claims Administrator will distribute its NPP to each Individual enrolled in the GHP at the time of the distribution. Thereafter, Claims Administrator shall distribute its NPP to each new enrolled Individual, and any material revisions to its NPP to all Individuals in accordance with its policies and procedures. Claims Administrator represents that its policies and procedures regarding the distribution of the NPP comply with 45 C.F.R. § 164.520(c). The practices and procedures set forth in Claims Administrator's NPP will apply to all Protected Health Information within the custody and control of Claims Administrator.

B. GHP's Notice of Privacy Practices. GHP shall be responsible for the preparation and distribution of its NPP as required by the Privacy Rule. If requested, Claims Administrator shall provide GHP with its NPP that GHP may use as the basis for its own NPP.

PART III – PLAN SPONSOR'S PLAN ADMINISTRATION FUNCTIONS

A. Communication of Protected Health Information. Except as specifically agreed upon by Claims Administrator and Plan Sponsor in compliance with the Privacy Rule, all Disclosures of Protected Health Information by Claims Administrator pursuant to this Contract shall be made to GHP, except for disclosures related to enrollment or disenrollment in GHP.

B. Summary Health Information. Upon Plan Sponsor's written request for the purpose either (i) to obtain premium bids for providing health insurance coverage under GHP, or (ii) to modify, amend, or terminate GHP, Claims Administrator is authorized to provide Summary Health Information regarding Individuals enrolled in GHP to Plan Sponsor.

C. Disclosure to Plan Sponsor. GHP will not Disclose any Protected Health Information to the Plan Sponsor unless GHP has first ensured: (i) that its Plan Document has been amended as required by 45 C.F.R. § 164.504(f)(2), and (ii) that the Plan Sponsor has delivered the certification required by 45 C.F.R. § 164.504(f)(2)(ii). If GHP should require Claims Administrator to Disclose Protected Health Information directly to the Plan Sponsor, GHP shall authorize such disclosure by written instruction, accompanied by the Plan Sponsor's certification required by 45 C.F.R. § 164.504(f)(2)(ii). Claims Administrator may rely on Plan Sponsor's certification and GHP's written instruction, and will have no obligation to verify that the Plan Documents have been amended to comply with 45 C.F.R. § 164.504(f)(2) or that Plan Sponsor is complying with such amendments.

PART IV - TERM, TERMINATION AND AMENDMENT

A. Term. The term of this Contract shall be co-extensive with the term of the Benefits Contract, including any run-out or settlement period.

B. Termination for Breach. GHP shall have the right to terminate the Benefits Contract if Claims Administrator, by pattern or practice, materially breaches any provision of this Contract. Before terminating under this section, GHP shall provide Claims Administrator with an opportunity to cure any identified breach. If efforts to cure are unsuccessful, as determined by GHP, in its reasonable discretion, Plan Sponsor shall terminate the Benefits Contract and this Contract, as soon as administratively feasible.

C. Effect of Termination: Return or Destruction of Protected Health Information. Upon cancellation, termination, expiration or other conclusion of the Benefits Contract ("Termination"), Claims Administrator will, if feasible and lawful, return to GHP or destroy all Protected Health Information, in whatever form or medium, then held by Claims Administrator. Claims Administrator will complete such return or destruction as promptly as practical after the effective date of the Termination.

D. Effect of Termination: Return or Destruction of Protected Health Information Not Feasible. GHP acknowledges that certain information may not feasibly be returned or destroyed, including, but not limited to, de-identified data, data used for Data Aggregation purposes, and data subject to regulatory data retention requirements. Accordingly, upon Termination, Claims Administrator will identify to GHP any Protected Health Information that cannot feasibly or lawfully be returned to GHP or destroyed. After Termination, Claims Administrator will continue to protect such information as required by this Contract and limit its further Use or Disclosure of such information to those purposes that make its return or destruction infeasible.

E. Continuing Privacy Obligation. Claims Administrator's obligation to protect the privacy of Protected Health Information that cannot feasibly or lawfully be returned or destroyed will survive Termination for as long as Claims Administrator retains any Protected Health Information governed by this Contract.

F. Agreement to Amend. The parties acknowledge that federal rules relating to HIPAA are evolving ("New HIPAA Rules") and, thus, may require amendment to this Contract to ensure continuing compliance. The parties agree to amend this Contract to add terms, conditions or assurances required by any New HIPAA Rule. Should the parties fail to adopt amendments by the effective date of any New HIPAA Rule, this Contract will be deemed to be automatically be amended on such effective date to require both parties to comply with the requirements of such New HIPAA Rule.

PART V – GENERAL PROVISIONS

A. Conflict. The provisions of this Contract will override and control any conflicting provision of the Benefits Contract. All non-conflicting provisions of the Benefits Contract will remain in full force and effect.

B. Definitions and Interpretation. Capitalized terms used in this Contract, unless otherwise defined herein, have the meanings ascribed to them under the HIPAA Privacy Rule, the HIPAA Security Rule, the Breach Notification Rule and the HITECH Act. For purposes of this Contract, the term "Individual" shall

include an Individual's personal representative. In the event of ambiguity, this Contract shall be interpreted so as to make all activities conducted hereunder compliant with the Privacy Rule, the Security Rule and any applicable state law or regulation governing the privacy of Individuals' health information.

C. Documentation. Unless otherwise provided under the HITECH Act, all documentation that is required by this Contract or by the Privacy Rule will be retained by Claims Administrator for six (6) years from the date of creation or when it was last in effect, or for such longer period as may be required by any applicable law.

IN WITNESS WHEREOF, Plan Sponsor, for and on behalf of GHP and Claims Administrator execute this Contract in multiple originals to be effective on January 1, 2022.

PLAN SPONSOR
City of Round Rock
Corporate Name

SIGNED BY: ______________________

NAME: Craig Morgan

TITLE: Mayor

DATE: September 9, 2021

ADDRESS:221 E. Main St.

Round Rock, Texas 78864

CLAIMS ADMINISTRATOR
United Concordia Dental
Corporate Name

SIGNED BY:

NAME: Thomas J. Palmer

TITLE: Senior Vice President Sales

DATE: ______________________________

ADDRESS: 1800 Center Street

Camp Hill, PA 17011

EXHIBIT A

PERMITTED USES AND DISCLOSURES

Claims Administrator is permitted to receive, create, Use or Disclose Protected Health Information ("PHI") on behalf of GHP for the following:

1. **Health Care Operations.** To conduct Health Care Operations activities to the full extent permitted of GHP under the Privacy Rule.

2. **Payment Activities.** To conduct Payment activities to the full extent permitted of GHP under the Privacy Rule.

3. **Treatment, Payment and Health Care Operation Activities of Other Covered Entities.** To assist another Covered Entity in its Treatment, Payment and Health Care Operation activities to the full extent permitted of GHP under the Privacy Rule.

4. **As Authorized by an Individual.** As may be authorized by an Individual pursuant to a written authorization in the form described in 45 C.F.R. § 164.508.

5. **When an Authorization or an Opportunity to Reject or Agree is Not Required.** To the full extent permitted of GHP, when an authorization or an opportunity to reject or agree is not required under 45 C.F.R. § 164.512.

6. **Use of Limited Data Set.** For permitted purposes, i.e. Research, Public Health and Health Care Operations, under the Privacy Rule.

7. **Other Permitted Uses and Disclosures of PHI by Claims Administrator:** Without limiting the generality of the foregoing, and by way of example only, Claims Administrator shall be permitted to Use, Disclose, create or receive PHI on behalf of GHP to the extent permitted under the Privacy Rule in performing or accomplishing activities related to:

    - Accounting
    - Actuarial and Rating
    - Administration of Claims (Initial, Appeals and Related Disputes or External Appeal Procedures)
    - Claims and Financial Audits
    - Benefit Design and Management
    - Billing
    - Blues on Call
    - Case Management
    - Issuance of Certificates of Creditable Coverage
    - Claims Payment and Processing
    - Collection Activities (including those related to the recovery of Overpayments)
    - Communications (oral and written) with Members, Providers, Subcontractors and Designated Agents
    - Compliance with Other Laws and Regulations and Related Records and Reports

- Consulting and Related Analysis
- Coordination of Benefits
- Credentialing
- Customer Service
- Data Analysis
- Enrollment, Disenrollment, Coverage and Eligibility
- Experts and Consultants
- Government Filings
- Issuance and Creation of ID Cards and Benefits Booklets
- Inter-Plan Payment Activities including the BlueCard Program
- Managed Care Services and Supplies
- Marketing
- Overpayment Recoveries and Activities
- Participant Meetings
- Litigation
- Public Health Activities
- Quality Management
- Reimbursements
- Reporting, Standard and Non-Standard (claims, eligibility, health conditions)
- Risk Adjusting
- Settlements (annual, financial, litigation, etc.)
- Subrogation
- Utilization Management

Or other purposes that may be permitted under the Benefit Contract. .

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EXHIBIT B

Designation of Representatives

By this document, Group Health Plan designates the individuals named below as its representatives to receive information from United Concordia relating to administration of the Benefit Contract.

REPRESENTATIVES (Name and job title): Date:September 9, 2021

David Gibson, Vice President – Client Service

Kaitlyn Beaird, Account Manager

Jason Newman, Sr. Client Service Consultant

____

REPRESENTATIVES MAILING ADDRESS :

____

____

____

____

Signature ____

Title Mayor

Date September 9, 2021

Group Health Plan agrees to promptly notify United Concordia of any changes in its designation of representatives to receive protected health information on its behalf.

(If Client sponsors more than one Group Health Plan; please provide addresses and representative's names for additional plans on an attachment.)