

## GROUP AGREEMENT

between

Austin ISD

and

**BLUE CROSS AND BLUE SHIELD OF TEXAS,  
A DIVISION OF HEALTH CARE SERVICE CORPORATION**

**Group Number: 94007N**

This is a Group Agreement between Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation (hereinafter referred to as HMO) and Austin ISD (hereinafter referred to as Group).

In consideration of the Premium payments made by or on behalf of the Group, HMO agrees with Group to provide coverage for those Covered Services described in the Certificate of Coverage subject to the terms, conditions, rights and privileges as set forth in this Group Agreement and the Certificate of Coverage (hereinafter referred to as Certificate) which is attached to this Group Agreement, and fully incorporated herein by reference. The terms and conditions used in this Group Agreement have the same meaning given those terms as defined in the Certificate unless otherwise specifically defined in this Group Agreement. Refer to the Definitions section of the Certificate for the meaning of certain terms used in this Group Agreement. Members covered under this Group Agreement are subject to all the conditions and provisions contained herein. If any provision of this Group Agreement is deemed to be invalid or illegal, such provision shall be fully severable and the remaining provisions of this Group Agreement shall continue in full force and effect.

This Group Agreement is governed by applicable federal law and the laws of the state of Texas. The Group Agreement must be issued in the state of Texas.

Accordingly, the following is agreed upon by and between the parties:

1. This Group Agreement is effective 09/01/07 through 08/31/08 and requires the signatures of representatives of both parties. This Group Agreement is subject to the Certificate and applicable Riders, attachments and/or amendments, if any, at all times and in all respects.
2. Group is at all times acting as agent for Subscribers and Dependents. Notifications received from, or given to, Group by HMO fulfill all notice requirements of the applicable Certificate.
3. Group agrees that all Premiums are payable to HMO on or in advance of each Premium due date. The payment of any Premium shall not maintain coverage under the Group Agreement in force beyond the date when the next payment becomes due; however, a sixty (60) day Grace Period, during which time this Group Agreement will remain in force, shall be granted for payment of each amount due after the first Premium payment. The Group shall remain liable for the payment of the Premium for the time coverage was in effect during the Grace Period. Group is liable for Premiums from the time a Member ceases to be eligible for coverage until the end of the Contract Month in which Group notifies HMO that a Member is no longer part of the Group and eligible for coverage. The Group must notify HMO of Member's termination through electronic portal entry, in writing, or on a form satisfactory to HMO of the requested deletion within the Contract Month. Group is required to provide coverage for a Member covered under this Group Agreement until the end of the Contract Month in which termination notification is received by HMO. A check is not a payment until it is honored by a bank. HMO reserves the right to return a check issued against insufficient funds without resorting to a second deposit attempt.

Retroactive adjustments and/or terminations effective prior to the end of the Contract Month in which the termination notification was submitted to HMO may not be made to Group's previous month billings. Retroactive additions will be made at the discretion of HMO based upon eligibility guidelines, as detailed in this Group Agreement and in the Certificate, and are subject to the payment of all applicable Premiums. As between HMO and the Group, the Group is responsible for any claims paid by HMO with respect to a Member, to the extent HMO relied on the Group's submitted enrollment to confirm coverage where coverage was not valid.

4. The coverages set forth in Section 5 of this Group Agreement will be offered by Group to all individuals eligible under the conditions of this Group Agreement and must be offered in all of the designated rating areas as set forth below. Group agrees to furnish upon request to HMO such information as may be required for an underwriting or eligibility review.

Rating Areas Offered

**Austin**

5. Coverages available to Subscribers and Dependents in Group are fully described in the Group Certificate, Riders, attachments and/or amendments, if any, listed below, the provisions of which are incorporated herein. Reference is made to such Certificate, Riders, attachments and/or amendments, and revisions thereof, for definitive statements of coverage.

CERTIFICATE OF COVERAGE, LARGE GROUP HMO BENEFIT PLAN: **Austin ISD HMO Plan**

RIDERS, ATTACHMENTS, AND/OR AMENDMENTS (if any):

Serious Mental Illness:

- Serious Mental Illness Amendment  
(SAAOI - same as any other illness) – **Public Entities Only**

In Vitro Fertilization:

- Accept  
 Decline

Speech and Hearing Therapy:

- Accept (if accepted – SAAOI)  
 Decline

Optional HMO Riders/Amendments:

- |                                     |   |                              |
|-------------------------------------|---|------------------------------|
| <input checked="" type="checkbox"/> | Prescription Drug   | <b><u>\$15/\$30/\$45</u></b> |
| <input checked="" type="checkbox"/> | Inpatient Mental Health                                     | <b><u>IM1</u></b>            |
| <input type="checkbox"/>            | Vision Care <input checked="" type="checkbox"/> Vision Exam | <b><u>O2</u></b>             |
| <input checked="" type="checkbox"/> | Durable Medical Equipment                                   | <b><u>DME1</u></b>           |
| <input type="checkbox"/>            | Dental  |                              |
| <input type="checkbox"/>            | Patient Advocate Program                                    |                              |
| <input type="checkbox"/>            | Other: _____  |                              |

6. Persons eligible for enrollment as Subscribers through Group for the coverages described in Section 5 of this Group Agreement, are the proprietors actively managing the business enterprise and all of the employees of the business enterprise who meet the eligibility requirements for health care coverage as established by Group and agreed upon by HMO. Eligibility requirements are as listed below and in the Certificate.

**Newly Eligible Employees will be effective on the first day of the month following the date employees become eligible, provided they submit a completed enrollment application within thirty-one (31) days after becoming eligible.**

Members must work or reside in the Service Area.

Group represents, agrees, and warrants that no person who is not an eligible Subscriber through Group will be listed, named, or otherwise represented by it in any way, to be an eligible Subscriber through Group. Group will not make or remit Premium payments for any such person, or participate or assist in obtaining or maintaining a Certificate for such ineligible person.

Group specifications for age limits and effective dates that may vary from those shown in the Certificate are set forth below.

**A. ELIGIBILITY**

2d. Dependent Child Age Limit

- No change from the language in the Certificate
- Under age [26 – 30] \_\_\_\_\_

**C. EFFECTIVE DATE OF COVERAGE**

2. Newly Eligible Employees

- Effective on the first day of the month following the date employees become eligible
- Effective on the date of hire
- Effective on the date of eligibility and/or waiting period has been satisfied
- Effective as of the date of the event

3. Newly Eligible Dependents

- Marriage
- Birth
- Adoption
- Party in suit for adoption or guardianship

4. Other Enrollment Events – persons initially or newly eligible for enrollment who do not enroll within 31 days after eligibility – Late Enrollees

- a. Marriage – Coverage for Subscriber and Subscriber’s spouse  Effective on the first day of the month after enrollment forms are received
- b. Birth or adoption – Coverage for Subscriber, Subscriber’s spouse, newborn or newly adopted child  Effective on the date of birth, adoption, or becoming a party in suit for adoption
- c. Loss of Coverage – Coverage for Subscriber and/or Dependent(s)  Effective the day after prior coverage terminated when enrollment forms are received within 31 days of the qualifying event
- d. Court Ordered Child – Coverage for Subscriber and court ordered child(ren)  Effective on the date the Group receives notice of the court order

**A. TERMINATION – Paragraph 2**

- Terminate on the last day of the Contract Month in which Group notifies HMO of Member's termination

Premiums shall be paid in full for Members whose coverage is effective on the Premium due date or whose coverage terminates on the last day of the Contract Month.

Premiums for Members whose coverage is effective on a day other than the first day of a Contract Month or whose coverage terminates on a day other than the last day of the Contract Month shall be adjusted as follows:

- If membership is effective between the 1<sup>st</sup> through the 15<sup>th</sup> day of the Contract Month, inclusive, the Premium for the whole Contract Month is due. If membership is effective between the 16<sup>th</sup> through the last day of the Contract Month, inclusive, no Premium is due for the first Contract Month of membership.
7. Eligible enrolled individuals, both Subscribers and Dependents, may under certain circumstances continue coverage through Group. Detailed language is included in the Certificate.
  8. Enrollment changes may only take place during the annual Group Open Enrollment period or when a qualifying event occurs. Detailed language is included in the Certificate.
  9. Group agrees to the terms and conditions of this Group Agreement.
  10. This Group Agreement and any and all written addenda thereto supersede any previous contract between the parties.
  11. This Group Agreement may be terminated by the Group following sixty (60) days written notice or by HMO as set forth in the Certificate. In the event of notice of termination of this Group Agreement by HMO, Group shall mail a copy of such notice promptly to each of Group's affected Subscribers and furnish proof of such mailing to HMO.
  12. The Group Agreement may be amended by HMO following sixty (60) days written notice to Group. This Group Agreement may be terminated without prior written notice by HMO should Group fail to prepay the applicable Premiums for Subscribers and Dependents for a period which exceeds sixty (60) days. Should the applicable Premium not be paid for a period exceeding sixty (60) days, the individual Subscribers and Dependents shall be liable for payment of any services received by them during the sixty (60) day period. This Group Agreement may be canceled by Group upon sixty (60) days prior written notice to HMO in the event of any material change by HMO to any provisions required to be disclosed to Group or Subscribers pursuant to 28 TAC Chapter 11.
  13. Group agrees to remit the following monthly Premium amounts for its Subscribers, effective the date and year mentioned in Section 1 of this Group Agreement. The rates listed below are guaranteed for one (1) year from the effective date and year mentioned in Section 1 of this Group Agreement, subject to the provisions of Sections 14 and 15 below. HMO reserves the right to establish a revised schedule of Premium payments and to review and adjust the rates should additional rating areas be offered other than those set forth in Section 4 of this Group Agreement in accordance with the Certificate. The rates listed below are inclusive of the Certificate and all Riders, attachments and/or amendments, if any, listed in Section 5 of this Group Agreement.

Effective Date: 09/01/07

Rating Area	Tier of Coverage	Monthly Premium Rates	Group Contribution
<u>Austin</u>	Employee	<u>\$418.00</u>	<u>100%</u>
	Employee/Spouse	<u>\$962.00</u>	_____
	Employee Child(ren)	<u>\$837.00</u>	_____
	Family	<u>\$1,255.00</u>	_____
_____	Employee	_____	_____
	Employee/Spouse	_____	_____
	Employee Child(ren)	_____	_____
	Family	_____	_____
_____	Employee	_____	_____
	Employee/Spouse	_____	_____
	Employee Child(ren)	_____	_____
	Family	_____	_____
_____	Employee	_____	_____
	Employee/Spouse	_____	_____
	Employee Child(ren)	_____	_____
	Family	_____	_____
_____	Employee	_____	_____
	Employee/Spouse	_____	_____
	Employee Child(ren)	_____	_____
	Family	_____	_____
_____	Employee	_____	_____
	Employee/Spouse	_____	_____
	Employee Child(ren)	_____	_____
	Family	_____	_____

The minimum Group contribution must be at least 50% of the employee only Premium rates or 50% of the employee and Dependent Premium rates for the enrolled employees. However, in no event can the amount of the employee contribution required exceed the amount of the employee contribution required for any other health benefit plan offered by more than 5%.

Premium rates are based upon the amount of taxes currently in effect by various governmental agencies. If taxes are increased during the Contract Year, HMO reserves the right to adjust the Premium rates to reflect the tax adjustment on the effective date of the tax increase.

Premium rates do not include any future mandated benefit changes. If there are mandated benefit changes made per applicable law or regulation during the Contract Year, HMO reserves the right to adjust the Premium rates coinciding with the effective date of the mandated benefit change.

Premium rates are based upon 0% commissions. If the amount of commission is changed, HMO reserves the right to adjust the Premium rates commensurately coinciding with the effective date of the commission change.

If HMO gives a minimum of sixty (60) days prior written notice to Group, HMO may change the Premiums:

- Upon the first day of a renewal of this Group Agreement; or
- Upon the effective date of any applicable law or regulation having a direct and material impact on the cost of providing coverage to Group.

Payment of the applicable Premium on and after that date shall constitute acceptance of those changes by Group, individually and on behalf of all Members enrolled under this Group Agreement.

## Exhibit A

### BlueCard

Like all Blue Cross and Blue Shield Licensees, HMO participates in a program called "BlueCard." Whenever Members access health care services outside HMO's Service Area, the claim for those services may be processed through BlueCard and presented to HMO for payment in conformity with network access rules of the BlueCard Policies then in effect ("Policies"). Under BlueCard, when Members receive Covered Services within the geographic area served by an on-site Blue Cross and/or Blue Shield Licensee ("Host Blue"), HMO will remain responsible to the Group for fulfilling HMO's contract obligations. However, the Host Blue will only be responsible, in accordance with applicable BlueCard Policies, if any, for providing such services as contracting with its Participating Providers and handling all interaction with its Participating Providers. The financial terms of BlueCard are described generally below.

### Liability Calculation Method Per Claim

The calculation of the Member's liability on claims for Covered Services, other than those Covered Services subject to a fixed dollar Copayment, incurred outside HMO's Service Area and processed through BlueCard will be based on the lower of the Provider's billed charges or the negotiated price HMO pays the Host Blue.

The methods employed by a Host Blue to determine a negotiated price will vary among Host Blues based on the terms of each Host Blue's Provider contracts. The negotiated price paid to a Host Blue by HMO on a claim for health care services processed through BlueCard may represent:

- (1) The actual price paid on the claim by the Host Blue to the health care Provider ("Actual Price"), or
- (2) An estimated price, determined by the Host Blue in accordance with BlueCard Policies, based on the Actual Price increased or reduced to reflect aggregate payments expected to result from settlements, withholds, any other contingent payment arrangements and non-claims transactions with all of the Host Blue's health care Providers or one or more particular Providers ("Estimated Price"), or
- (3) An average price, determined by the Host Blue in accordance with BlueCard Policies, based on a billed charges discount representing the Host Blue's average savings expected after settlements, withholds, any other contingent payment arrangements and non-claims transactions for all of its Providers or for a specified group of Providers ("Average Price"). An Average Price may result in greater variation to the Member and the Group from the Actual Price than would an Estimated Price.

Host Blues using either the Estimated Price or an Average Price will, in accordance with BlueCard Policies, prospectively increase or reduce the Estimated Price or Average Price to correct for over- or underestimation of past prices. However, the amount paid by the Member is a final price and will not be affected by such prospective adjustment.

Statutes in a small number of states may require a Host Blue either (1) 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 (2) to add a surcharge. Should any state statutes mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, the Host Blue would then calculate the Member's liability for any Covered Services consistent with the applicable state statute in effect at the time the Member received those Covered Services.

### Return of Overpayments

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.

In the event of non-payment of any amount due, HMO shall be entitled to all remedies provided for in law and in equity.

Premium rates are based on HMO's standard programs with standard membership, eligibility, administration, claims processing and standard network. Standard provisions and definitions apply. Any costs associated with special services or custom material provided by HMO will be supplemental billed to the Group separate and apart from the Premium rates outlined herein.

14. Group agrees to contribute the amount or percent of the monthly Premium rate as indicated above. When there is a change in Group's contribution level, HMO reserves the right to change the monthly Premium rates, upon sixty (60) days prior written notice.
15. When a substantial change occurs in the number or composition of Subscribers covered, HMO can change Premium rates upon sixty (60) days prior written notice. A substantial change will be deemed to have occurred when the number of Subscribers covered changes by 10% or more over a thirty (30) day period or 25% or more over a ninety (90) day period.
16. During Group Open Enrollment Period, eligible Members are permitted on an annual basis to elect HMO coverage. Persons joining Group between Group Open Enrollment Periods will be offered the opportunity to enroll in HMO at the time they meet Group's eligibility requirements.
17. This Group Agreement shall be executed by HMO and the Group once the Group Agreement is completed. However, payment of the applicable Premium before, on and after the effective date of this Group Agreement shall constitute execution of this Group Agreement by the Group.
18. Group, on behalf of itself and its Subscribers and Dependents, hereby expressly acknowledges its understanding this Group Agreement constitutes a contract solely between Group and HMO, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting HMO to use the Blue Cross and Blue Shield Service Marks in the State of Texas, and that HMO is not contracting as the agent of the Association. Group, on behalf of itself and its Subscribers and Dependents, further acknowledges and agrees that it has not entered into this Group Agreement based upon representations by any person other than HMO and that no person, entity, or organization other than HMO shall be held accountable or liable to Group for any of HMO's obligations to Group created under this Group Agreement. This paragraph shall not create any additional obligations whatsoever on the part of HMO other than those obligations created under other provisions of this Group Agreement. Information concerning the "Associations" BlueCard Program is set forth in Exhibit A.
19. Group is hereby notified that it is a member of Health Care Service Corporation, a Mutual Legal Reserve Company, and is entitled to vote either in person, by its designated representative or by proxy at all meetings of members of said Company. The annual meeting is held at its principal office at 300 East Randolph Street, Chicago, Illinois each year on the last Tuesday in October at 12:30 p.m. For purposes of the aforementioned paragraph the term "member" means the group, trust, association or other entity to which this Group Agreement has been issued. It does not include Subscribers or Dependents under the Certificate. Further, for purposes of determining the number of votes to which Group may be entitled, any reference in the Group Agreement or Certificate to "premium(s)" shall mean "charge(s)."

FOR HMO:

Name: BJ Karkela

Title: Senior Mkt Mgmt Acct Mgmt

Date: 1-29-08

FOR GROUP: **Austin ISD**

Group Number: 94007N

By: Larry R. Shran

Title: AISD - CFO

Date: October 4, 2007