AGENDA ITEM or FINAL CONTRACT REVIEW SUBMITTAL FORM

Agenda Item:

Action Requested: Board of County Commissioners' Signature

Parties to the Agreement: Gunnison County, Colorado and ELAP Services, LLC.

Term Begins: 09/01/2017 **Term Ends:** **Grant Contract #:**

Summary:

Designated Decision Maker (DDM) Service agreement with ELAP to act as a fiduciary with respect to certain (facilities)health benefit appeals to reimbursement amounts for benefit claims in accordance with the Plan's provisions.

Fiscal Impact:

Submitted by: Cheryl Seling **Submitter's Email Address:** cseling@gunnisoncounty.org

Finance Review: (●) Required ( ) Not Required

Comments:
No concerns, ln

Reviewed by: GUNCOUNTY1\lNienhueser Discharge Date: 8/14/2017

County Attorney Review: (●) Required ( ) Not Required

Comments:
ok db 8/14/17

Reveiwed by: GUNCOUNTY1\dBaumgarten Discharge Date: 8/14/2017 Certificate of Insurance Required Yes ( ) No (●)

County Manager Review:

Comments:

Reveiwed by: GUNCOUNTY1\jost Discharge Date: 8/14/2017

( ) Consent Agenda (●) Regular Agenda ( ) Worksession Time Allotted: 5

Agenda Date: 8/15/2017

Revised April 2015

DDM SERVICE AGREEMENT

This DDM Service Agreement (the "Agreement")**,** made as of September 1, 2017 (the "Effective Date"), by and between Gunnison County, Colorado, having its principal office at 200 E Virginia Ave, Gunnison, CO 81230 (the "Employer"), and ELAP Services, LLC, having its principal office at 1550 Liberty Ridge Drive, Suite 330, Wayne, PA 19087 (the "Designated Decision Maker" or "DDM");

WITNESSETH:

Whereas, the Employer has established Gunnison County, Colorado Employee Medical Benefit Plan for the purpose of providing certain welfare benefits to eligible participants (the "Plan");

Whereas, the Employer is the Sponsor of the Plan ("Plan Sponsor") and as such is acting as the settlor of the Plan;

Whereas, the Employer is the Administrator of the Plan ("Plan Administrator") and as such acts in a fiduciary capacity and has authority for (i) the review of benefit claims under the Plan, and (ii) for the proper and efficient operation of the Plan including authority to audit claims;

Whereas, when the Employer is acting in its capacity as the sponsor of the Plan under this Agreement, it will be referred to as the Plan Sponsor, and when it is acting as the administrator of the Plan under this agreement, it will be referred to as the Plan Administrator;

Whereas, the Plan Administrator has authority to delegate its powers and authorities under the Plan;

Whereas, the Plan Administrator desires to delegate certain powers and authorities it has under the Plan to the DDM to act as a fiduciary with respect to certain health benefit appeals which are filed in accordance with the provisions of the Plan;

Whereas, the Plan Administrator desires to delegate certain powers and authorities it has under the Plan to the DDM to act as a fiduciary with respect to determining reimbursement amounts for benefit claims in accordance with the provisions of the Plan;

Whereas, the DDM desires to accept the delegation of certain powers and authorities of the Plan Administrator, and to provide such services to the Plan;

Whereas, the parties desire to set forth the services and the terms and conditions upon which the DDM will provide such services in this Agreement including Exhibits A and B, which are hereto attached and made a part hereof;

Whereas, the Plan has delegated certain of its administrative duties to a Third-Party Administrator;

Whereas, the DDM acknowledges that the Third-Party Administrator (as defined in Article 1(z)) will be responsible for performing certain administrative duties specified herein; and

Whereas, the Plan Sponsor has amended the Plan to name the DDM as a designated decision maker, and to adopt the provisions listed in Exhibit A.

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

ARTICLE 1. DEFINITIONS

As used herein, the following terms shall be defined as follows:

(a) **"Allowable Claim Limit"** shall have the meaning set forth in the Plan Documents and refer to the Reimbursement Limits established by the Plan for health, wellness, medical services and supplies listed and included as Covered Benefits under the Plan.

(b) **"Balance Bill"** shall mean a Medical Provider's invoice for Charges which were found to be in excess of the Allowable Claim Limit as determined by the DDM.

(c) **"Balance Bill Administration and Defense Services"** shall mean the services of the DDM described in Article 4 of this agreement.

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

(e) **"Claim"** shall mean a medical benefit claim submitted for reimbursement by a Medical Provider and/or Plan Participant where the request for reimbursement was submitted to the DDM for audit and determination of Allowable Claim Limit after the participant received services from a Medical Provider and after the Plan Administrator determined Medical and Participant Eligibility, provided such Claim was submitted for audit during the term of this Agreement.

(f) **"Claim Audit and Repricing Service"** shall mean the services of the DDM described in Article 4 of this agreement.

(g) **"Clean Claim"** shall mean a Claim for which the DDM has received all the information necessary to perform an audit and determine the Allowable Claim Limit provided that the Plan Administrator submitted the Claim to the DDM prior to payment and within three (3) business days of receipt. A Claim shall be considered a "Clean Claim" when the DDM receives the form UB or CMS 1500, and for claims of twenty-five thousand dollars ($25,000) or greater, the itemized statement of charges and/or

operative reports, and if requested by the DDM, medical records and other documentation that substantiate the Charges,

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

(i) **"Covered Expenses"** shall mean the following expenses for the defense of a Balance Bill or a Disputed Audit adjudicated by the DDM: (i) the cost of consultations and/or reviews by experts, if such experts are designated by the DDM; (ii) attorneys' fees, if such attorneys are designated or approved by the DDM; (iii) other investigation, adjudication and defense costs and expenses with the prior written consent of the DDM ; and (iv) attorneys' fees and costs incurred by a Plan Participant or a Medical Provider if a court of competent jurisdiction finally determines that such fees and costs are to be paid by the Plan Sponsor, the Plan Administrator and/or the Plan. Covered Expenses shall also include Covered Settlements that the DDM elects to pay pursuant to Article 3(d).

(j) **"Covered Settlement"** shall mean the amount paid or payable in settlement of Disputed Audits determined by the DDM under the authorities and powers delegated to the DDM in Article 3(d).

(k) **"Direct Agreement"** shall mean the complete agreement between a Directly Contracted Provider and the DDM which contains the terms and conditions for negotiated fees and/or negotiated or scheduled reimbursement rates for the Plan.

(l) **"Directly Contracted Provider"** shall mean a Medical Provider which has entered into a Direct Agreement with the DDM to provide certain medical services to Plan Participants at agreed upon terms.

(m) **"Direct Contract Services"** shall mean the services of the DDM described in Article 4 of this agreement.

(n) **"Disputed Audit"** shall mean a Claim reimbursed at the Allowable Claim Limit determined by the DDM that is the subject of an appeal for additional reimbursement by a Plan Participant or a Medical Provider. Disputed Audits exclude appeals by a Medical Provider or a Plan Participant for determination of whether a service provided or to be provided is a Covered Benefit under the provisions of the Plan and/or whether a Plan Participant is eligible to receive Covered Benefit in accordance with the provisions of the Plan.

(o) **"Disputed Audit Appeal Services"** shall mean the services of the DDM described in Article 4 of this agreement.

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

(q) **"HIPAA"** shall mean the Health Insurance Portability and Accountability Act of 1996, as amended by the Health Information Technology for Economic and Clinical Health Act, and regulations promulgated

by the Secretary of the Department of Health and Human Services, as well as any other applicable laws concerning the privacy and security of health information.

(r) **"Maximum Limit of Liability"** shall mean an amount equal to One Million Dollars ($1,000,000) per Balance Bill and/or Disputed Audit.

(s) **"Limit of Liability"** shall mean an amount equal to twenty-five thousand dollars ($25,000) per Balance Bill and/or Disputed Audit.

(t) **"Medical Eligibility"** shall mean the determination by the Plan Administrator that medical services provided or to be provided by a Medical Provider to a Plan Participant are Covered Benefits under the terms of the Plan.

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

(v) **"Participant Eligibility"** shall mean the determination by the Plan Administrator that the Plan Participant is eligible to receive Covered Benefits under the Plan.

(w) **"Plan Documents"** shall mean the documents inclusive of the Summary Plan Description establishing, governing, and setting forth Covered Benefits under the Plan.

(x) **"Plan Participant"** shall mean a person whom the Plan Administrator determines is eligible for benefits under the Plan at the time a Disputed Audit or a Clean Claim is submitted to the DDM.

(y) **"Reimbursement Limits"** shall mean the amount that the Plan will pay for medical services and supplies.

(z) **"Third Party Administrator"** shall mean a person or organization, designated by DDM, who shall provide certain claims processing and other ministerial services at the time requests for approval of prospective medical services and Claims are submitted to the Plan.

ARTICLE 2. TERM AND TERMINATION

2.1 Term. The initial term of this agreement shall begin on the later of the Effective Date or the date the DDM receives a signed copy of the Agreement (including all Exhibits) from the Employer. The Agreement shall renew automatically for additional one-year terms upon each annual anniversary of the Effective Date unless earlier terminated as provided herein.

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

(a) **Termination Without Cause.** Either party may terminate the Agreement at any time by giving sixty (60) days prior written notice to the other party. The termination is effective sixty (60) days after either party provides notice of termination. The Plan Sponsor may elect to extend this Agreement beyond the effective date of termination for an agreed upon run-out period provided that the Plan Documents continue to name the DDM as a designated decision maker and the parties continue to perform their respective duties and obligations under the terms of this Agreement.

(b) **Termination by the DDM.** The DDM may resign without prior notice at any time, and except for the rights and obligations of the parties under Article 9, this Agreement along with the rights and obligations of the parties shall immediately terminate, if the Plan Administrator fails to perform its responsibilities under Article 7 of this Agreement.

(c) **Automatic Termination.** Upon the occurrence of any of the following events, except for the rights and obligations of the parties under Article 9, this Agreement along with the rights and obligations of the parties shall terminate immediately:

1. A party's inability for any reason to perform its responsibilities under this Agreement,
2. If (i) a proceeding is commenced by a party or against a party under any provision of the United States Bankruptcy Code or under any other state or federal bankruptcy or insolvency law, assignments for the benefit of creditors, formal or informal moratoria, compositions, extensions generally with creditors, proceedings seeking the appointment of a receiver, conservator, trustee, custodian or similar official for a party or for any substantial part of such Party's property proceedings seeking reorganization, arrangement, or other similar relief; or (ii) a party generally is not paying its debts as such debts become due, or admits in writing its inability to pay such debts generally, or makes a general assignment for the benefit of creditors;
3. Commission by a party of (i) a felony or a crime involving moral turpitude; (ii) an act or omission constituting fraud, dishonesty, disloyalty, or (iii) professional misconduct; and
4. A party's violation of any material law, rule or regulation or applicable to it, its business or this Agreement, including, without limitation, HIPAA, that could reasonably be expected to have an adverse effect on that party's business, this Agreement or the other party's reputation.

2.3 Effect of Termination. Upon termination, except for the rights and obligations of the parties under Article 9, the rights and obligations of the parties under this Agreement shall terminate, the authorities granted to the DDM shall be rescinded and the DDM's fiduciary obligations to the plan shall cease. For each Balance Bill and/or Disputed Audit, the Covered Expenses that the DDM provides to the Employer and the Plan under Article 5 of this Agreement shall survive termination of this Agreement for a period

from the date the DDM audited the Claim not exceeding the statute of limitations for breach of contract applicable to collection of medical debt in the state in which the Plan is incorporated, provided that

(a) The Plan and/or the Plan Sponsor paid the fees of the DDM;
(b) The Disputed Audit was submitted to the DDM prior to termination of this Agreement; and
(c) The Covered Expenses apply to Balance Bills and/or Disputed Audits of Claims that:
    1. The DDM audited and determined the Allowable Claim Limit prior to termination of this Agreement; and
    2. The Plan reimbursed at the Allowable Claim Limit determined by the DDM.

The Third-Party Administrator ("TPA") will continue to provide services based on run-out terms set forth in the TPA run-out agreement with the Plan. If the Plan purchases a run-in policy with a new TPA, the Parties will work together to coordinate such a run-in policy. The TPA shall fully notify the Plan of the consequences of not purchasing a run-out agreement, including the termination of TPA and DDM duties and obligations to the Plan.

ARTICLE 3. DELEGATION OF POWERS AND AUTHORITIES

The Plan Administrator hereby appoints the DDM as a fiduciary of the Plan solely for the purposes of and with the full discretionary authorities to

(a) Determine Allowable Claim Limits in accordance with the provisions of the Plan for Claims it audits;
(b) Review and decide any and all Disputed Audits;
(c) Use the services of third party consultants as it deems necessary in the exercise of the authorities granted in (a) to (d) above, provided that the DDM pays any fees associated therewith.

In carrying out its fiduciary responsibilities to the Plan, the DDM shall act prudently and adhere to the applicable standards of conduct, which are set forth in 29 U.S.C. § 1104(a) (1) (A), (B) and (D). The Plan Administrator hereby reserves the right to override the determinations made by the DDM.

ARTICLE 4. DDM SERVICES

In accordance with the powers and authorities delegated in Article 3 of this Agreement, the DDM shall provide the following services to the Plan:

4.1 Claim Review and Audit Program. The DDM will perform its services in accordance with the terms of the SLA appearing in Exhibit A (Claim Review and Audit Program SLA) and provide the Plan the following services:

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

(b) Direct Contract Services. The DDM will provide the Plan access to discounted fees and/or negotiated or scheduled reimbursement rates under the terms of Direct Agreements that ELAPS enters into with certain Directly Contracted Providers. The DDM will also negotiate terms of Direct Agreements as such opportunities may be presented. A list of Direct Agreements will be delivered to the Plan upon request.

(c) Disputed Audit Appeal and Defense Services. The DDM will review additional information submitted by Medical Providers for Disputed Audits and determine if the Plan should provide additional reimbursements for services received by Plan Participants above the Allowable Claim Limit originally determined. The DDM will defend the Plan and the Plan Sponsor with respect to any Disputed Audit.

(d) Balance Bill Administration and Defense Services. The DDM will administer and use its best efforts to resolve Balance Bills that Medical Providers charge Plan Participants. The DDM will provide assistance to any Plan Participant who requests the services described herein and is contacted by a Medical Provider or by any debt collector, as that term is defined in 15 U.S.C. §1692a (6), on behalf of a Medical Provider for payment of a Balance Bill that exceeds the Plan Participant's normal out-of-pocket expenses including deductibles and copayments under the Plan. Such assistance shall include appropriate actions to protect the Plan Participant from payment of the Balance Bill Amount and to prevent adverse credit information from being reported to a consumer reporting agency, as that term is defined in 15 U.S.C. §1681a(f). Further, in the event the Medical Provider, an attorney for the Medical Provider or a debt collector threatens legal action against the Plan Participant for the Balance Bill Amount, the DDM shall offer to provide competent legal counsel to the Plan Participant to protect the Plan Participant against payment, and to take all available and reasonable actions to prevent adverse credit information being reported to any consumer reporting agency. The legal services shall be provided at no cost to the Plan Participant and the entire cost of the legal services shall be paid by the DDM so long as the DDM approves the choice of legal counsel providing the legal services. The legal services for the Plan Participant shall not be terminated until the Medical Provider or debt collector agrees not to pursue the Plan Participant for any of the Balance Bill Amount and all available and reasonable actions have been performed to seek the removal of any negative credit information from

the Plan Participant's consumer report, as that term is defined in 15 U.S.C. §1681a(d), that relates to the Balance Bill Amount. The DDM's assistance to Plan Participants under this provision is subject to the same limits of the Covered Expenses it provides to the Employer under Article 5 of this Agreement. The DDM's assistance to Plan Participants shall exclude assisting Plan Participants with respect to any appeal to the Plan for additional benefits or payments.

(e) Negotiate the settlement of any and all Disputed Audits and Balance Bills.

The Claim Review and Audit Program service includes Covered Expenses as set forth in Article 5 of this Agreement.

ARTICLE 5. DDM COVERED EXPENSES

The DDM shall be responsible for all Covered Expenses incurred by Plan Participants provided that the Plan Participants have not pursued legal actions against the Plan and/or the Plan Sponsor with respect to Balance Bills and/or Disputed Audits, provided, however, that DDM's total liability under this provision is limited to the Maximum Limit of Liability.

5.1 Responsibilities of Plan and/or Plan Sponsor. The Parties agree that responsibility for any Covered Expenses in excess of the Maximum Limit of Liability shall be that of the Plan Sponsor, the Plan Administrator and/or the Plan.

5.2 Exclusions. The DDM shall not be liable for any Covered Expenses incurred by the Plan Sponsor, the Plan Administrator and/or the Plan in connection with any Balance Bill, or Disputed Audit, if and to the extent that such Covered Expenses are:

(a) The result of disagreement between the Plan Administrator and the DDM that resulted in the Plan Administrator overriding the determinations made by the DDM with respect to a Disputed Audit or reimbursing a Claim at an amount other than the Allowable Claim Limit determined by the DDM;

(b) The result of the Plan Administrator's failure to perform any of the responsibilities in Article 7 of this Agreement;

(c) The result of negligence or willful misconduct by the Plan Sponsor, the Plan Administrator or the Third-Party Administrator in performing its duties to the Plan and under this Agreement;

(d) The result of language in the Plan Documents which is not in compliance with applicable law or which otherwise is unenforceable; or

(e) The result of the Plan Sponsor's failure to provide timely funding necessary to pay a Health Benefit Claim as approved by the DDM; or

(f) The result of a court order or judgment following a trial and/or appeal.

ARTICLE 6. COMPENSATION OF THE DDM

The DDM shall receive for its services an amount equal to:

6.1 Claim Review and Audit Program Services. Twelve percent (12%) of the Charges billed for Claims from non-Directly Contracted Providers audited under the Claim Review and Audit Program, and six percent (6%) of Charges billed for Claims from Directly Contracted Providers. Such amount shall be due upon receipt of an invoice issued by the DDM for its services. If the combined amount of the Allowable Claim Limit and the fees due to the DDM is greater than the Charges billed by a Directly Contracted Provider, the compensation for the DDM will default to fifteen percent (15%) of the amount of Charges in excess of the Allowable Claim Limit.

ARTICLE 7. RESPONSIBILITIES OF THE PLAN ADMINISTRATOR

The Plan Administrator shall perform or shall cause the Third-Party Administrator to perform the following responsibilities:

7.1 Plan Document and Summary Plan Description. The Plan Administrator shall be responsible for:

(a) Ensuring that the provisions adopted by the Plan, the Plan Document, Summary Plan Description and current and prospective amendments comply with any applicable laws and regulations, and are adopted by the Plan in a manner consistent with the internal amendment and/or restatement provisions of the Plan, the Plan Document and the Summary Plan Description;

(b) Ensuring that the Plan Documents describe Covered Benefits and Excluded Benefits in such a way so as to be enforceable;

(c) Ensuring that provisions of the Plan that describe Covered Benefits stipulate Allowable Claim Limits, including discounted fees and/or negotiated or scheduled reimbursement rates of Direct Agreements;

(d) Ensuring that the Plan Documents name the DDM as designated decision maker and describe the scope of the authorities delegated to the DDM;

(e) Ensuring that Plan Documents and amendments thereto are furnished to Plan Participants in such a way and within such a timeframe so as to make the terms of the Plan enforceable; and

(f) Furnishing to the DDM copies of the Plan Documents together with any amendments thereto. Any amendments which are thereafter adopted shall be furnished to the DDM no later than the effective date of such amendment.

7.2 Eligibility, Notification, Pre-Authorization and Participant Identification. The Plan Administrator shall be responsible for:

(a) Determining Medical and Patient Eligibility;
(b) Pre-authorizing medical services to be provided to Plan Participants upon requests by Medical Providers;
(c) Keeping complete and current Patient Eligibility records, and making such eligibility records available to Medical providers during normal business hours; and
(d) Furnishing to Plan Participants identification cards or other documentation sufficient to identify coverage under the Plan and participation in Direct Agreements.

7.3 Claims and Appeal Processing, Submission of Disputed Audits and Clean Claims to the DDM. The Plan Administrator shall be responsible for:

(a) Complying with all requirements, including notices to Plan Participants and Medical Providers, of the DOL Claim Procedures Regulations and the Patient Protection and Affordable Care Act, as amended, in the processing of Claims and appeals under the Plan. Further, the Plan Administrator shall adjudicate Claims and appeals of denied benefits in accordance with the terms of the Plan Documents and applicable laws;
(b) Complying with all provisions of Direct Agreements including providing required notices, in the processing of Claims submitted under the Plan by Directly Contracted Providers;
(c) Forwarding Disputed Audits to the DDM within three (3) business days of receipts, even if the Plan Participant or the Medical Provider submits a copy to the DDM. A Disputed Audit is considered duly submitted to the DDM when the Plan Administrator provides the entire file relating to the Disputed Audit within the timeframe set forth in this paragraph; and
(d) Submitting Clean Claims to the DDM for audit and determination of Allowable Claim Limit prior to payment being made to Medical Providers and within three (3) business day of receipt.

7.4 Payment of Claims and DDM Fees. The Plan Administrator shall be responsible for:

(a) Ensuring that the Plan Sponsor provides adequate funding for payment of Claims;
(b) Paying Claims in accordance with and within the timeline specified by DOL Claim Procedures Regulations and the Patient Protection and Affordable Care Act, as amended;
(c) Paying Claims submitted by Directly Contracted Providers in accordance with the terms of the Direct Agreements. The Plan Administrator and the Plan Sponsor understand that failure to pay Claims within the timeframe specified by the Direct Agreements may result in the loss of any discounts and the Plan

paying all Charges of the Directly Contracted Provider even if the Charges exceed the Allowable Claim Limits established by the Plan; and

(d) Paying the DDM fees in accordance with the provisions of Article 6 of this agreement.

7.5 Notification to DDM. The Plan Administrator shall notify the DDM in writing of the commencement of any litigation relating to Disputed Audits and/or Balance Bills or the occurrence of any event which might give rise to liability of a Plan Participant or the Plan that it becomes aware of within three (3) business days following such commencement or occurrence. The commencement of any litigation or an occurrence, as used herein, shall refer to a service of complaint, writ of summons, initiation of arbitration proceedings, or letter of representation from an attorney for a plan participant or medical provider served on, or received by, the Plan Sponsor and/or the Plan Administrator.

7.6 Administrative Safeguards. The Plan Administrator shall provide the DDM, on its request, with a description of the administrative safeguards which are in place to ensure consistent application of Plan provisions, in accordance with the requirements of the DOL Processing Regulations and in accordance with the terms of the Plan Documents.

ARTICLE 8. RESPONSIBILITIES OF THE DDM

In addition to performing its services in accordance with the terms of the Service Level Agreements included in Exhibit A, the DDM shall be responsible for:

8.1 Disputed Audits and Claims. The DDM shall adjudicate all Disputed Audits and audit and determine Allowable Claim Limit for all Clean Claims submitted by the Plan Administrator provided that:

(a) The Plan Administrator submitted the Disputed Audits and/or the Clean Claims in the manner and within the timeline described in Articles 7.3 (c) and (d) of this agreement; and

(b) In the DDM's opinion, the provisions of the Plan applicable to the determination of Disputed Audits and/or Clean Claims

  (i) Comply with any applicable laws and regulations,

  (ii) Are written in such a manner that they are enforceable, and

  (iii) Have been furnished to Plan Participants in a manner and within a timeframe to be enforceable;

(c) Sufficient information is available to adjudicate Disputed Audits and/or determine Allowable Claim Limits for Clean Claims; and

(d) The DDM is named as a designated decision maker with respect to Disputed Audits and audit and determination of Allowable Claim Limit for Clean Claims.

8.2 Maintenance of Records. The DDM shall maintain all records it receives for adjudicating Disputed Audits and auditing and determination of Allowable Claim Limit of Clean Claims for a period not less than applicable federal and/or state statutes of limitation.

8.3 Payments to Third Party Experts. The DDM shall pay the fees and costs of third party experts it hires for the purpose of auditing and determining Allowable Claim Limit for Clean Claims submitted by the Plan Administrator.

8.4 Payments to TPAs. The DDM shall pay the Third-Party Administrator a portion of its fees under this agreement to offset expenses of the Third-Party Administrator for claim-handling, legal compliance and other time sensitive expenses.

8.5 Copies of Direct Agreements. The DDM shall provide the Plan Administrator a complete list of Direct Agreements between the DDM and Directly Contracted Providers, and complete copies of such agreements containing the terms and conditions that are applicable to the Plan, the Plan Administrator, and/or the Third-Party Administrator.

8.6 Copy of Policy with ELAP Insurance Company, LLC. Upon written request by the Plan Sponsor, the Plan Administrator and/or the Third-Party Administrator, the DDM shall provide a copy of the Policy with ELAP Insurance Company, LLC, provided that the Plan Sponsor elected to become an additional insured under the policy written by ELAP Insurance Company, LLC.

ARTICLE 9. GENERAL INDEMNIFICATION

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

(a) The DDM's failure to perform its services in accordance with the terms of the Service Agreement included in Exhibit A; and
(b) The DDM's alleged negligence or willful misconduct in the performance of its activities described herein unless it is determined that such claim, suit, action, penalty, liability or cost was caused by or resulted from the negligence or willful misconduct of the Plan, the Plan Sponsor, the Plan Administrator and/or Plan Participants.

9.2 General Indemnification of the DDM. Without waiving any provision of the Colorado Governmental Immunity Act, the Plan Sponsor and the Plan Administrator agree to indemnify and hold harmless the DDM

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

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

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

ARTICLE 10. OTHER PROVISION

10.1 Compliance with Privacy and Security Laws. Each party shall comply at all times with the requirements of HIPAA and other applicable state and federal laws pertaining to the privacy and security of Plan Participants' individually identifiable information. Each party further agrees to execute the business associate agreement included in Exhibit B to this Agreement.

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

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

10.4 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the Commonwealth of Pennsylvania, exclusive of its conflict of law principles.

10.5 Choice of Venue. DDM has substantial facilities in the Commonwealth of Pennsylvania and many of the services provided under this Agreement are provided from these facilities. The exclusive venue for any actions or claims arising under or relating to this Agreement shall be in the US District Court for the Eastern District of Pennsylvania, or in the Court of Common Pleas for the County of Chester Pennsylvania.

10.6 Amendments, etc. This Agreement may not be amended, modified, changed, released or discharged except by a writing signed by a duly authorized representative of the parties. Notwithstanding the

foregoing, this Agreement may be terminated in accordance with its Terms without such mutually executed writing.

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

10.8 Waiver. The failure of any party at any time to require full performance by the other of any provision of this Agreement shall in no way affect that party's right to enforce such provision, nor shall the waiver by any party of any breach of any provision of this Agreement be taken or held to be a waiver of any further breach of the same provision or any other provision.

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

If to ELAP:

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

If to Plan Sponsor:

Cheryl Seling
Gunnison County, Colorado
200 E Virginia Ave
Gunnison, CO 81230
970-641-7962
cseling@gunnisoncounty.org

If to Plan Administrator:

Cheryl Seling
Gunnison County, Colorado
200 E Virginia Ave
Gunnison, CO 81230
970-641-7962

cseling@gunnisoncounty.org

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

10.10 CONFIDENTIALITY. THE PLAN SPONSOR AND THE PLAN ADMINISTRATOR EXPRESSLY AGREE THAT THE TERMS OF DIRECT AGREEMENTS BETWEEN THE DDM AND DIRECTLY CONTRACTED PROVIDERS ("ELAP DIRECT AGREEMENTS"), INCLUDING, BUT NOT LIMITED TO, THE REIMBURSEMENT RATES AND METHODOLOGY, REPRESENT CONFIDENTIAL AND PROPRIETARY INFORMATION WHICH MAY NOT BE DISCLOSED EXCEPT AS REQUIRED FOR PLAN MANAGEMENT AND ADMINISTRATION. WHEN DISCLOSURE IS REQUIRED FOR PLAN MANAGEMENT AND ADMINISTRATION, THE PLAN SPONSOR AND PLAN ADMINISTRATOR SHALL CAUSE THE RECIPIENTS, INCLUDING BUT NOT LIMITED TO, AGENTS, CONSULTANTS AND VENDORS, TO KEEP THE TERMS OF THIS AGREEMENT IN STRICTEST CONFIDENCE. THE PLAN SPONSOR AND THE PLAN ADMINISTRATOR FURTHER AGREE THAT THE TERMS OF THE ELAP DIRECT AGREEMENT SHALL NOT OTHERWISE BE DISCLOSED WITHOUT THE EXPRESS WRITTEN CONSENT OF ELAP SERVICES, LLC UNLESS REQUIRED BY STATUTE, REGULATION, OR COURT OR REGULATORY AGENCY ORDER OR SUBPOENA AND, IN THAT EVENT, THE PLAN SPONSOR AND THE PLAN ADMINISTRATOR SHALL TAKE ALL REASONABLE ACTION TO PRESERVE THE CONFIDENTIALITY OF THE TERMS OF THE ELAP DIRECT AGREEMENT.

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

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

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

ATTEST: **THE EMPLOYER**

_____ By:_____

Its Duly Authorized _____

ATTEST: **ELAP Services, LLC**

_____ By:_____

Its Duly Authorized _____

EXHIBIT A

CLAIM REVIEW AND AUDIT PROGRAM SLA

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

1. Hospitals,
2. Ambulatory Health and Surgical Centers,
3. Dialysis Clinics, and
4. Other facilities for inpatient and outpatient services.

CLAIM REVIEW AND AUDIT GUIDELINES

The DDM shall review and audit Clean Claims ensuring that Medical Providers comply with industry standard coding logic and National Correct Coding Initiative ("NCCI") and Center for Medicare and Medicaid Services ("CMS") coding standards. The Claim Review and Audit procedures that the DDM perform shall include but are not limited to:

1. Errors. Verifying that Clean Claims do not include any identifiable billing mistakes including, but not limited to, upcoding, and duplicate charges. Additionally, verifying that Clean Claims do not include charges that are required to treat Injuries sustained or Illnesses contracted, including infections and complications, which, in the opinion of the Plan Administrator can be attributed to a medical error by the provider.

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

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

4. Operative Report. Reviewing operative report for Clean Claims of $25,000 or greater for Ambulatory Health and Surgical Centers in order to identify whether Billed Charges include charges for services or supplies that are not consistent with the patient's diagnoses based upon the CPT, HCPCS, and ICD-9/ICD-10 codes (diagnostic codes) reflected in the invoices submitted by the Medical Provider.

5. Medical Records Audit. Determining, in its sole discretion, that an audit of the provider's medical records is appropriate and necessary to assess whether certain charges for services and supplies were rendered or provided as billed. Medical records for this purpose will include, but not be limited to, x-ray and laboratory tests, operating room and other facility usage, charts of medications dispensed and supplies provided, physician visits and other professional services. In the event the DDM requests the medical records, the Plan Administrator acknowledges that the DDM may request the assistance of the patient or Plan participant, and/or medical care providers in verifying the results of a medical records audit.

ALLOWABLE CLAIM LIMIT GUIDELINES

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

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

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

2. Guidelines. The DDM shall use the following guidelines when determining Allowable Claim Limits:

a. **Hospital.** The Allowable Claim Limit for Claims by a hospital facility and by facilities which are owned and operated by a hospital shall be determined as the greater of (I) 112% of the hospital's most recent departmental cost ratio, reported to the Centers for Medicare and Medicaid Services ("CMS") and published in the American Hospital Directory as the "Medicare Cost Report" (the "CMS Cost Ratio"), or (II) the Medicare allowed amount for the services in the geographic area plus an additional 20%. In the event that insufficient information is available to identify either the hospital's most recent departmental cost ratio or the Medicare allowed amount, the Allowable Claim Limit shall be either (I) or (II) herein that can be identified.
b. **Ambulatory Health Care Centers.** The Allowable Claim Limit for ambulatory health care centers, including ambulatory surgery centers, which are independent facilities shall be the

Medicare allowed amount for the services in the geographic area plus an additional 20%. In the event that insufficient information is available to identify the applicable Medicare allowed amount, the Allowable Claim Limit for such services shall be to the extent available either the outpatient or inpatient Medicare allowed amount for the service, plus an additional 20%.

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

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

   i. **General Medical and/or Surgical Services.** The Allowable Claim Limit for any covered services may be calculated based upon published and publicly available fee and cost lists and comparisons, or any combination of such resources that in the opinion of the Plan Administrator results in the determination of a reasonable expense under the Plan.

   ii. **Pharmaceuticals.** The Allowable Claim Limit for pharmacy charges by a provider may be determined by applying the Average Wholesale Price (AWP) as defined by REDBOOK at the rate of 112% of AWP.

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

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

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

Notwithstanding the above guidelines, in the event that a determination of Allowable Claim Limit for a Claim exceeds the actual Charges billed for the services and/or supplies, the actual Charges billed for the Claim shall be the Allowable Claim Limit.

COMPLETED AUDIT RESULTS

For each completed audit, the DDM will identify and report any charges that are improperly coded, duplicated, unidentified, unbundled and/or found to exceed the Allowable Claim Limits. The DDM will return the completed review and audit results to the Plan Administrator or Third Party Administrator for the adjudication of the Clean Claims based upon the determination of Allowable Claim Limits by the DDM. DDM shall use its best efforts to perform its duties under this Claim Review and Audit Program SLA within the compliance time limits set forth in the DOL Claim Processing Regulations.

MAINTENANCE OF RECORDS

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

EXHIBIT B

HIPAA BUSINESS ASSOCIATE AGREEMENT

This HIPAA Business Associate Agreement (this "Agreement") dated September 1, 2017 is by and between Gunnison County, Colorado having its principal office located at 200 E Virginia Ave, Gunnison, CO 81230 ("Covered Entity") and ELAP Services, LLC**,** located at 1550 Liberty Ridge Drive, Suite 330, Wayne, PA 19087 ("Business Associate") related to the work to be performed as described below (Covered Entity and Business Associate, each a "Party" and collectively, the "Parties").

BACKGROUND

I. Covered Entity has engaged Business Associate for the purpose of assisting Covered Entity, pursuant to the contract between the Parties made as of September 1, 2017 entitled ["DDM Service Agreement"] (hereinafter, the "BA Services Contract"), in providing certain functions and activities for and on behalf of Covered Entity (the "BA Services").

II. Covered Entity wishes to disclose information to Business Associate pursuant to the terms of this Agreement, some of which may constitute Protected Health Information ("PHI"), including electronic protected health information ("e-PHI") (PHI and e-PHI are, collectively, referred to hereinafter as "Covered Entity's PHI") in order for Business Associate to perform the BA Services.

III. Covered Entity and Business Associate intend to protect the privacy and provide for the security of PHI disclosed to Business Associate in connection with the BA Services Contract and pursuant to this Agreement in compliance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as amended (the "HIPAA Statute"), and its related "Privacy Rule" (45 CFR Parts 160 and 164, Subpart E) and "Security Rule" (45 CFR Part 160 and 164, Subpart C) promulgated by the Secretary of Health and Human Services ("HHS") (collectively, the HIPAA Statute, the Privacy Rule and the Security Rule and are referred to, hereinafter, as "HIPAA"), all as amended by the Health Information Technology for Economic and Clinical Health Act enacted on February 17, 2009 (the "HITECH Statute"), and any regulations promulgated thereunder (collectively, the "HITECH Rules," and together with the HITECH Statute, referred to hereinafter as "HITECH"), the Genetic Information Nondiscrimination Act of 2008, as may be amended (hereinafter, "GINA"), as well as any other applicable laws concerning the privacy and security of health information. Together, HIPAA and HITECH are at times referred to hereinafter as "HIPAA"

IV. Under HIPAA, Covered Entity must document the required satisfactory assurances through a written agreement with Business Associate that meets the applicable requirements of HIPAA, as well as

incorporate into such agreement those requirements that relate to privacy and security that are applicable to Business Associate, and the Parties now wish to enter into the Agreement in order to comply with such requirements and to set forth more specifically each Party's respective obligations in connection therewith.

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

TERMS

A. Incorporation of Background. The "Background" paragraphs set forth above are incorporated herein and made a part of the terms of this Agreement as if set forth herein in full.

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

C. Definitions. Any capitalized terms not otherwise specifically defined in this Agreement shall have the meanings ascribed to them in HIPAA.

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

E. Obligations of Business Associate.

1) Permitted Uses and Disclosures. Business Associate may use and/or disclose any and all of Covered Entity's PHI received by Business Associate from Covered Entity, or created or obtained by Business Associate on behalf of Covered Entity as follows:

a) *Purpose and Type of Information*: Business Associate may use Covered Entity's PHI to provide or perform the BA Services, as set forth in the BA Services Contract. Business Associate may use any and all information made available by Covered Entity and necessary for Business Associate to provide the BA Services to Covered Entity.

b) *Scope of Use*: Business Associate may use and further disclose Covered Entity's PHI to the extent permitted by and in accordance with this Agreement, HIPAA and as otherwise Required by Law.

c) *Use for Management and Administration*: Business Associate may use

Covered Entity's PHI for the proper management and administration of Business Associate, if such disclosure is necessary: (1) for the proper management and administration of Business Associate; or (2) to carry out the legal responsibilities of Business Associate.

d) *Disclosure for Management and Administration*: Business Associate may disclose Covered Entity's PHI for the proper management and administration of Business Associate if: (1) the disclosure is Required by Law; or (2) Business Associate discloses Covered Entity's PHI to a third party, as permitted under the BA Services Agreement, and Business Associate obtains from the third party a written agreement stating that: (i) Covered Entity's PHI will be held in compliance with HIPAA and used or further disclosed as Required by Law or for the purpose for which it was disclosed to such third party; and (ii) to notify Business Associate, without unreasonable delay, of any instance in which such third party becomes aware of a Breach of or Security Incident (as hereinafter defined) involving Covered Entity's PHI. **In no event**, however, shall Business Associate disclose Covered Entity's PHI for the foregoing purposes to any such third party not within the borders and jurisdiction of the United States of America without the prior written consent of Covered Entity, which may be withheld in Covered Entity's sole and unfettered discretion.

e) *Uses or Disclosures Requiring Prior Authorization*: Business Associate agrees and understands that, except as expressly provided in this Agreement, or permitted under HIPAA and state law, it shall not use or disclose Covered Entity's PHI to any other person or entity without first having received a HIPAA-compliant authorization ("Authorization"). Business Associate shall retain a copy of each Authorization obtained, and the information provided in response to the Authorization, for six (6) years.

f) *Business Associate's Agents*. Business Associate shall assure that any agent to whom it provides Covered Entity's PHI agrees to comply with all HIPAA requirements that apply to Business Associate and with the terms, requirements and conditions of this Agreement. Business Associate shall further ensure that any subcontractor of such agent agrees to comply such additional terms and restrictions as are necessary to allow Business Associate to meet its

obligations under this Agreement, including its obligation to comply with the terms and conditions set forth in Paragraph E., Section 8 with respect to subcontractors.

g) *Transmission of Reports at Direction of Covered Entity*. At the direction of Covered Entity, Business Associate shall transmit reports containing PHI created, received, maintained or transmitted in connection with Business Associate's performance of services under the BA Services Contract to a third party identified by Covered Entity, provided that: (1) Covered Entity has provided Business Associate with the specific information set forth in Attachment 1 to this Agreement; and (2) Covered Entity confirms that it has entered into a HIPAA-compliant Business Associate Agreement with such third party. The parties acknowledge and agree that, in transmitting reports containing PHI to a third party at the direction of Covered Entity, Business Associate is not disclosing PHI to a subcontractor as described in 45 C.F.R. 164.502(e)(1)(ii), and Business Associate shall not be required or expected by Covered Entity to enter into a Business Associate Agreement or subcontractor agreement with such third party prior to transmitting the report. It shall be Covered Entity's sole responsibility to enter into a Business Associate Agreement with any such third party prior to directing Business Associate to disclose Covered Entity's PHI to the specified organization and/or individual.

h) *Prohibited Uses and Disclosures*:

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

2) *Nondisclosure*: Business Associate shall not use or further disclose Covered Entity's PHI other than as permitted or required by this Agreement, or as otherwise Required by Law or permitted by law.

3) *Minimum Necessary*: Business Associate shall comply with the terms of 45 C.F.R. 164.502(b) in using and further disclosing only the minimum necessary amount of Covered Entity's PHI, except that Business Associate shall not be required to comply with this minimum necessary limitation if neither Business Associate nor Covered Entity

is required to limit the use or disclosure to the minimum necessary with respect to particular PHI.

2) Security Safeguards

a) *General*. Business Associate shall, as of the Effective Date of this Agreement, implement and use appropriate administrative, physical and technical safeguards to provide for the security of Covered Entity's PHI, including:

- Implementing policies and procedures to prevent, detect and contain, and correct security violations;
- Limiting physical access to electronic information systems that maintain PHI and the facility or facilities in which they are housed, while ensuring that properly authorized access is allowed; and
- Implementing technical policies and procedures for electronic information systems that maintain PHI to allow access only to those persons or software programs that have been granted access rights as specified in 45 CFR 164.308(a)(4).

b) *Administrative Safeguards*. Business Associate shall implement and maintain a written security program that includes administrative, technical and physical safeguards appropriate to the size and complexity of Business Associate's operations and the nature and scope of its activities.

(i) *Implementation Specifications*. Business Associate shall implement all of the "*Required*" and "*Addressable*" (as such terms are defined in the Security Rule) Implementation Specifications in the Security Rule, unless Business Associate and Covered Entity agree otherwise, and Business Associate documents: (i) the rationale why a particular Addressable Implementation Specification is not "reasonable and appropriate," and (ii) Business Associate implements an alternative measure agreed to in writing by Covered Entity.

(ii) *Documentation*. Business Associate shall maintain the policies and procedures implemented to comply with the Security Rule in written (which may be electronic) form; and to the extent that an action, activity or assessment that relates to this Agreement is required under the Security Rule to be documented, Business Associate shall maintain a written (which may be electronic) record

of the action, activity or assessment. Any such documentation created shall be retained by Business Associate and made available to Covered Entity upon request for a period of six (6) years from the date of its creation, or the date when it last was in effect, whichever is later.

(iii) *HHS Guidance*. Business Associate shall implement and comply with any requirements set forth in any guidance issued by HHS concerning Business Associate compliance with HIPAA.

3) Accounting of Disclosures. Business Associate shall maintain and make available documentation as required under 45 C.F.R. 164.528 to allow Covered Entity to respond to an Individual's request for an accounting of disclosures by Covered Entity. Business Associate shall provide such information as may be necessary in order for Covered Entity to respond to an Individual's request for accounting of disclosures in compliance with HIPAA.

4) Access Rights to PHI. Business Associate shall provide Individuals with access to and copies of the Individual's PHI in accordance with 45 C.F.R. 164.524. Business Associate's compliance with Individuals' access rights under 45 C.F.R. 164.524shall be at Business Associate's cost. Notwithstanding the immediately preceding sentence, Business Associate may, with Covered Entity's written consent, which shall not be unreasonably withheld, charge a fee to the Individual as permitted under HIPAA and applicable state law.

5) Requested Restrictions. Business Associate acknowledges that Covered Entity is required under HIPAA to comply with an Individual's requested restriction regarding his or her PHI (unless the disclosure is otherwise Required by Law) if: (1)the disclosure is to a health plan for purposes of carrying out payment or health care operations (but not treatment); and (2)Covered Entity's PHI pertains solely to a health care item or service for which the health care provider has been paid out-of-pocket in full by the individual. Business Associate agrees to comply with any such requested restriction of which Business Associate is made aware in writing by Covered Entity.

6) Availability of Information to Covered Entity. Business Associate shall make available to Covered Entity such information as Covered Entity may require to fulfill Covered Entity's obligations to provide access to, provide a copy of, and account for disclosures with respect to Covered Entity's PHI pursuant to HIPAA pursuant to 45 CFR 164.524 and 164.528. Nothing in this provision shall be construed to preclude or limit Business Associate's obligations under the

law, specifically with respect to the provision of access to Individuals of their PHI and the provision of an accounting of disclosures to individuals of their PHI.

7) Amendment of PHI. Business Associate shall make Covered Entity's PHI available to Covered Entity as Covered Entity may require to fulfill Covered Entity's obligations to amend Covered Entity's PHI pursuant to and 45 CFR 164.526, and Business Associate shall, as directed by Covered Entity, incorporate any amendments to Covered Entity's PHI into copies of such PHI maintained by Business Associate. Nothing in this provision shall be construed to preclude or limit Business Associate's obligations under the law, specifically with respect to the amendment of Covered Entity's PHI by Business Associate.

8) Business Associate's Subcontractors. Business Associate shall ensure that any subcontractors to whom it provides Covered Entity's PHI agree in writing to the same restrictions and conditions that apply to Business Associate with respect to Covered Entity's PHI. Business Associate shall not disclose any of Covered Entity's PHI to any subcontractor that is not within the borders and jurisdiction of the United States of America without the prior written consent of Covered Entity, which may be withheld in Covered Entity's sole and unfettered discretion.

9) Internal Practices. Business Associate shall make its internal practices, books and records relating to the use and disclosure of Covered Entity's PHI available to the HHS for purposes of determining Covered Entity's compliance with HIPAA.

10) Security Breach Notification.

a) *Compliance*. Business Associate shall comply with the standards and requirements that relate to notifications required in the event of a breach of information in accordance with the Breach Notification Laws (as defined herein below). For purposes of this Agreement, the term "Breach Notification Laws" shall include, collectively, those provisions concerning breach notification obligations set forth in HIPAA.

b) *Securing PHI*. Business Associate shall secure any and all of Covered Entity's PHI that it accesses, maintains, retains, modifies, records, stores, destroys, or otherwise holds, uses, or discloses for or on behalf of Covered Entity by implementing such technologies and methodologies (e.g., encryption) that are specifically identified in the Breach Notification Laws and which render Covered Entity's PHI unusable, unreadable and indecipherable. If Business Associate and Covered Entity otherwise agree that it is not reasonable or possible for Business Associate to implement such technologies and methodologies to secure certain of Covered Entity's PHI, then Business Associate shall implement reasonable alternative methods, as

agreed to in writing by Covered Entity in its sole and unfettered discretion, to safeguard the information.

c) *Business Associate's Obligations in the Event of a Breach*.

(1) Duty to Discover and Report Breaches to Covered Entity. Business Associate shall promptly notify Covered Entity of any Breach or Security Incident that has or is reasonably likely to result in the unauthorized use or disclosure of Covered Entity's PHI as soon as reasonably possible and in no case later than ten (10) business days following the date of discovery of the Breach or Security Incident. Notwithstanding the foregoing, for purposes of reporting a Security Incident, the term "Security Incident" shall not include any inconsequential incidents that occur on a frequent basis, such as scans, "pings" or other unsuccessful attempts to penetrate computer networks or servers maintained by Business Associate. For purposes of this Agreement, a Breach shall be deemed "discovered" by Business Associate as of the earlier of: (i) the first day on which such Breach is actually known to any person, other than the person committing the Breach, who is an employee, officer or other agent (determined in accordance with the Federal common law of agency) of Business Associate; or (ii) the first day on which, by exercising reasonable diligence, such Breach should have been known to any person described in (i). Business Associate shall take all reasonable steps (e.g., audits; anonymous internal reporting, etc.) to allow it to discover Breaches involving Covered Entity's PHI.

(2) Reporting Contact. Business Associate shall notify Covered Entity's Privacy Officer and/or Security Officer, or their designee, either in person or by telephone at a number to be provided by Covered Entity of any discovered Breach.

(3) Presumption of Breach. Any acquisition, access, use or disclosure of Covered Entity's PHI in a manner not permitted under HIPAA is presumed to be a Breach unless Business Associate determines, at its sole cost and expense, that there is a low probability that the PHI has been compromised based on a risk assessment conducted in accordance with 45 C.F.R. 164.402.

(4) Information To Be Provided. Business Associate shall provide Covered Entity with the following information in connection with the Breach:

- a brief description of what happened;
- the date of the Breach and the date of discovery of the Breach, if known;
- what type of unsecured PHI was involved in the Breach (e.g., name; SSN, etc.);
- identification of each individual whose unsecured PHI has been, or reasonably believed by Business Associate to have been, breached;
- what Business Associate is doing to investigate, mitigate and protect against further Breaches of a similar or dissimilar nature;
- contact information at Business Associate (specific for the Breach), including toll-free number, e-mail address, Web site, or postal address where individuals may contact Business Associate directly for further information about the Breach; and
- any additional information that Covered Entity may require for purposes of furnishing required notices under the Breach Notification Laws.

In the event that some or all of the foregoing information is not readily available when the Breach is discovered, Business Associate shall still promptly notify Covered Entity of the Breach and may provide the additional information required under this paragraph (iii) as soon as possible thereafter, but without unreasonable delay and in no case longer than thirty (30) days after the Breach is discovered.

d) *Agreement to Cooperate and Assist*. Business Associate shall cooperate with Covered Entity and provide such assistance as Covered Entity may need in order to comply with HIPAA. With respect to any Breach of Covered Entity's PHI that results from an act or omission of Business Associate, including any of Business Associate's employees, owners, directors, or agents, Business Associate shall provide administrative support and other resources as may be requested by Covered Entity in order to furnish written notices to individuals affected by the Breach and otherwise comply with the HIPAA. Covered Entity agrees to consult with Business Associate in the preparation of the written notices to individuals affected by the Breach. In the event that Business Associate does not provide such requested

assistance and resources in a timely manner, Business Associate shall reimburse Covered Entity for all costs and expenses (e.g., postage, supplies, administrative staff time, etc.) incurred by Covered Entity in its efforts to comply with the notification requirements under HIPAA.

F) Red Flags Rule. With respect to Business Associate's access to, use or handling of information in connection with Covered Entity's "Covered Accounts" (as defined under the Federal Trade Commission's Red Flags Rule (the "Red Flags Rule") and identified by Covered Entity), Business Associate shall, as of the Effective Date of this Agreement:

1) Implement reasonable administrative, physical and technical policies and procedures to detect, prevent and mitigate the risk of identity theft at Business Associate;

2) Cooperate with and take such steps as are reasonably necessary to assist Covered Entity with compliance with its Identity Theft Prevention Program; and

3) Promptly report to Covered Entity any specific Red Flags, as identified in Covered Entity's Red Flag policies, which Business Associate detects, and, as appropriate, respond to, or reasonably assist Covered Entity in responding to, such Red Flags in accordance with Covered Entity's policies and procedures.

G) Audits, Inspection and Enforcement. Covered Entity may, upon reasonable notice, inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement. Business Associate shall promptly remedy any violation of any term of this Agreement and notify Covered Entity of the outcome.

H) Termination

1) Noncompliance. If either Party notifies (the "Notifying Party") the other Party regarding an activity or practice that constitutes a material breach or violation of such other Party's obligation under this Agreement, HIPAA and HITECH (the "Breaching Party"), and such Breaching Party does not take reasonable steps to or otherwise does not successfully cure the breach or end the violation, as applicable, within a reasonable timeframe as agreed to by the Parties, the Notifying Party is permitted to either:

(a) If feasible, terminate this Agreement and the BA Services Contract; or

(b) If termination is not feasible, report the problem to HHS.

2) Judicial or Administrative Proceedings. Either Party may terminate this Agreement and the BA Services Contract, effective immediately, if

(a) the other Party is named as a defendant in a criminal proceeding for a violation of HIPAA; or

(b) a finding or stipulation that the other Party has violated any standard or requirement of HIPAA and HITECH or other security or privacy laws is made in any administrative or civil proceeding in which the Party has been joined.

3) Effect of Termination. Except for the purpose of complying with its surviving obligations under the BA Services Contract, upon termination of the BA Services Contract for any reason, Business Associate shall return to Covered Entity and destroy all of Covered Entity's PHI that Business Associate still maintains in any form, and shall retain no copies of such PHI, or if return or destruction is not feasible, Business Associate agrees, at Covered Entity's reasonable expense, to continue to extend the protections of this Agreement to such information, and limit further use of such PHI to those purposes that make the return or destruction of such PHI infeasible.

I) Indemnification. Business Associate will indemnify, hold harmless and defend the other Party to this Agreement from and against any and all claims, losses, liabilities, costs and other expenses, including court costs and reasonable attorney's fees and disbursements, incurred as a result of, or arising directly or indirectly out of or in connection with:

1) any misrepresentation, breach of warranty or non-fulfillment of any undertaking on the part of the Party under this Agreement; and

2) any claims, demands, awards, judgments, actions and proceedings made by any person or organization arising out of or in any way connected with the Party's performance under this Agreement.

J) Disclaimer. Covered Entity makes no warranty or representation that compliance by Business Associate with this Agreement, HIPAA and Applicable Privacy Laws will be adequate or satisfactory for Business Associate's own purposes or that any information in Business Associate's possession or control, or transmitted or received by Business Associate, is or will be secure from unauthorized use or disclosure. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI.

K) Amendment. The Parties acknowledge that state and federal laws relating to electronic data security and privacy are rapidly evolving and that amendment of this Agreement may be required to provide for procedures to ensure compliance with such developments. The Parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA Applicable Privacy

Laws. The Parties understand and agree that Covered Entity must receive satisfactory written assurance from Business Associate that Business Associate will adequately safeguard all PHI that it receives or creates pursuant to the delivery of BA Services and this Agreement. Upon either Party's request, both Parties agree to promptly enter into negotiations concerning the terms of an amendment to this Agreement embodying written assurances consistent with the standards and requirements of HIPAA Applicable Privacy Laws. Either Party may terminate the BA Services upon 30 days written notice in the event:

1) the other Party does not promptly enter into negotiations to amend this Agreement when requested by a Party pursuant to this Section; or

2) the other Party does not enter into an amendment to this Agreement providing assurances regarding the safeguarding of PHI sufficient to satisfy the standards and requirements of HIPAA.

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

M) Interpretation. This Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA and Applicable Privacy Laws.

N) Independent Contractor. Nothing contained herein shall be deemed or construed by the Parties hereto or by any third party as creating the relationship of employer and employee, principal and agent, partners, joint ventures or any similar relationship, between the Parties hereto. Covered Entity and Business Associate acknowledge and agree that Business Associate is an independent contractor, and not an agent of Covered Entity, and Business Associate shall be solely liable for the payment of all income, unemployment, workers compensation, Social Security insurance or similar taxes or assessments on the fees or other remuneration paid or to be paid to Business Associate by Covered Entity.

O) Miscellaneous.

1) *Entire Agreement*. This Agreement supersedes all previous agreements between Covered Entity and Business Associate and contains the entire understanding and agreement between the Parties with respect to the subject matter hereof.

2) *Headings*. The headings in this Agreement are for convenience of reference only and shall not be used to interpret or construe its provisions.

3) *Governing Law*. This Agreement shall be construed in accordance with and governed by the laws of the Commonwealth of Pennsylvania without regard to conflicts of laws principles.

4) *Choice of Venue.* Business Associate has substantial facilities in the Commonwealth of Pennsylvania and many of the services provided under this Agreement are provided from these facilities. The exclusive venue for any actions or claims arising under or relating to this Agreement shall be in the US District Court for the Eastern District of Pennsylvania, or in the Court of Common Pleas for the County of Chester Pennsylvania.

5) *Binding Effect*. This Agreement shall be binding upon, and inure to the benefit of, each Party hereto and their respective successors and assigns.

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

7) *Notices*. All notices, demands and other communications to be made hereunder ("Notice") shall be given in writing and shall be deemed to have been duly given if personally delivered or sent by confirmed facsimile transmission, recognized overnight courier service which provides a receipt against delivery, or certified or registered mail, postage prepaid, return receipt requested, to the other Party at the address set forth in the first paragraph of this Agreement. Notice shall be deemed effective, if personally delivered, when delivered; if sent by confirmed facsimile transmission, when sent; if sent via overnight delivery, on the first business day after being sent, and if mailed, at midnight on the third business day after deposit in the U.S. mail.

8) *Modification*. This Agreement may be amended, superseded, terminated or extended, and the terms hereof may be waived, only by a written instrument signed by all of the Parties or, in the case of a waiver, signed by the Party waiving compliance.

9) *Preservation of Rights*. No delay on the part of any Party in exercising any right, power or privilege hereunder shall operate as a waiver thereof, nor shall any waiver on the part of any Party of any such right, power or privilege, nor any single or partial exercise of any right, power or privilege, preclude any further exercise thereof or the exercise of any other such right, power or privilege. The rights and remedies herein provided are cumulative and are not

exclusive of any rights or remedies that any Party may otherwise have at law, in equity or otherwise.

10) *Provisions Severable*. The provisions of this Agreement are independent of and severable from each other. No provisions will be affected or rendered invalid or unenforceable by virtue of the fact that for any reason any one or more of any of the provisions hereof may be invalid or unenforceable in whole or in part.

11) *Counterparts*. This Agreement may be executed by the Parties hereto in separate counterparts, each of which when so executed and delivered shall be an original, but all such counterparts shall together constitute one and the same instrument. Each counterpart may consist of a number of copies hereof each signed by less than all, but together signed by all of the Parties hereto.

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

IN WITNESS WHEREOF, the Parties hereto have duly executed this Agreement on the day and year below written: Gunnison County, Colorado Covered Entity

By: _____

Print Name:

Date:

EIN:

ELAP Services, LLC

By: _____

Print Name: Lisa Getzfrid

Date:

EIN: 27-1535521

EXHIBIT B – ATTACHMENT 1

LIST OF AUTHORIZED PHI RECIPIENTS

A. Transmission of reports to designated individual at Plan Sponsor:

Authorized Individual

Name: _____

Title: _____

Email Address: _____

Authorized Individual

Name: _____

Title: _____

Email Address: _____

B. Transmission of reports to designated organization:

Authorized Organization

Name: _____

Address: _____

Authorized Individual

Name: _____

Title: _____

Email Address: _____

EXHIBIT B – ATTACHMENT 1

LIST OF AUTHORIZED PHI RECIPIENTS

A. Transmission of reports to designated individual at Plan Sponsor:

Authorized Individual

Name:	Cheryl Seling
Title:	Gunnison County Human Resources Manager
Email Address:	cseling@gunnisoncounty.org

B. Transmission of reports to designated organization:

Authorized Organization

Name:	N/A
Address:	

Authorized Individual

Name:	N/A
Title:	
Email Address:	