COMMISSIONERS' COURT
OF WINKLER COUNTY, TEXAS
REGULAR MEETING

TIME: 9:00 O'CLOCK A.M.
DATE: MONDAY, SEPTEMBER 21, 2020
PLACE: VIRTUAL MEETING

Notice is hereby given that at the Meeting of the above named Commissioners' Court the following subjects will be discussed and appropriate action taken. These subjects may or may not be discussed in the order shown. *All items listed below as part of the called "Consent Agenda Items" require no deliberation by the Court. Each Court member has the prerogative of removing an item from this agenda so that it may be considered separately.*

Pursuant to the Suspension Order by Governor Abbott, the Commissioners Court meeting will be closed to protect the public, staff and members from potential exposure to the Coronavirus (COVID-19). The public may participate in the meeting through the following video conference link: Zoom – Meeting ID# 4050268443 Password: cc

1. Call Meeting to Order.

9:00 A.M.

2. Public hearing on the proposed 2020 tax rate.

3. Consider, discuss, and approve health insurance plan changes as set in proposed budget workshop.

4. Consider for approval proposal by Otis Elevator Company to repair brake coil in the amount of $6,375.48 from budgeted funds.

5. Consider for approval payment to Kermit Motor Co., Inc., for one (1) 2020 Ford 350 Supercab XL LWB VIN 1FTX3ATLEE22162 for Precinct 2 in the amount of $34,560.00 ($42,560.00 less trade-in of 2005 F150 Reg Cab $2,300.00 and 2005 Chev 3500 $5,700.00) from budgeted funds.

6. Budget Workshop.

7. Adjourn.

Benefit Program Application ("ASO BPA")

Application to Administrative Services Only (ASO) Group Accounts

administered by Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, hereinafter referred to as the "Claim Administrator" or "HCSC"

Group Status: Renewing ASO Account

Employer Account Number (6-digits): 106943 Group Number(s): 106943 Section Number(s): All

Legal Employer Name: County of Winkler

(Specify the Employer or the employee trust applying for coverage. Names of subsidiary or affiliated companies to be covered must also be named below. AN EMPLOYEE BENEFIT PLAN *MAY NOT* BE NAMED)

ERISA Regulated Group Health Plan*: ☐ Yes ☒ No

Is your ERISA Plan Year* a period of 12 months beginning on the Anniversary Date specified below? ☐Yes

If not, please specify your ERISA Plan Year*: Beginning Date __/__/__ End Date __/__/__ (month/day/year)

ERISA Plan Administrator*: _____ Plan Administrator's Address: _____

If you maintain that ERISA is not applicable to your group health plan, give legal reason for exemption:
Non-Federal Governmental Plan (Public Entity) ; if applicable, specify other: _____

Is your Non-ERISA Plan Year* a period of 12 months beginning on the Anniversary Date specified below? ☐Yes

If not, please specify your Non-ERISA Plan Year*: Beginning Date __/__/__ End Date __/__/__ (month/day/year)

For more information regarding ERISA, contact your Legal Advisor.

*All as defined by ERISA and/or other applicable law/regulations

Effective Date of Coverage: (Month/day/Year) 10 / 01 / 2020

Anniversary Date: (Month/Day/Year) 10 / 01 / 2021

Account Information ☒ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS

Standard Industry Code (SIC): _____ Employer Identification Number (EIN): _____

Address: _____

City: _____ State: _____ ZIP: _____

Administrative Contact: _____ Title: _____

Email Address: _____ Phone Number: _____ Fax Number: _____

☐ Mailing address is different from primary address

Mailing Address: _____

City: _____ State: _____ ZIP: _____

Mailing Contact: _____ Title: _____

Email Address: _____ Phone Number: _____ Fax Number: _____

☐ Billing address is different from primary address

Billing Address: _____

City: _____ State: _____ ZIP: _____

Billing Contact: _____ Title: _____

Email Address: _____ Phone Number: _____ Fax Number: _____

Wholly Owned Subsidiaries to be covered: _____

Affiliated Companies to be covered: _____ Employer Identification Number (EIN): _____

(If Subsidiaries or Affiliated Companies listed above are to be covered, Employer hereby confirms that Employer and the listed Subsidiaries and/or Affiliates are treated as a single employer under Internal Revenue Code Section 414(b), (c) or (m).)

Subsidiary / Affiliate Address: _____

City: _____ State: _____ ZIP: _____

Subsidiary / Affiliate Contact: _____ Title: _____

Email Address: _____ Phone Number: _____ Fax Number: _____

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Blue Access for Employers (BAE) Contact: _____ Title: _____
(The BAE Contact is the Employee authorized by the Employer to access and maintain the Employer's account in BAE.)
Email Address: _____ Phone Number: _____ Fax Number: _____

☐ The Employer or other company listed in this BPA is a is a public Entity or governmental agency/contractor

Producer of Record ☒ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS

Effective: _____

If applicable, the below-named producer(s) or agency(ies) is/are recognized as the Employer's Producer of Record (POR) to act as representative in negotiations with and to receive commissions from Blue Cross and Blue Shield of Texas, a division of Health Care Service Corporation (HCSC), a Mutual Legal Reserve Company, and HCSC subsidiaries for Employer's employee benefit programs. This statement rescinds any and all previous POR appointments for the Employer. The POR is authorized to perform membership transactions on behalf of the Employer. This appointment will remain in effect until withdrawn or superseded in writing by Employer.

Producer or Agency to whom commissions are to be paid*: _____

Texas Producer #: _____ NPN: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____ Email: _____
Is Producer/Agency appointed with HCSC in Texas? ☐ Yes ☐ No General Agent? ☐ Yes ☐ No
Affiliated with General Agent? ☐ Yes ☐ No
Is there a secondary Producer or Agency to whom commissions are to be paid? ☐ Yes ☐ No

If Yes, Producer or Agency to whom commissions are to be paid*:** _____

Texas Producer #: _____
NPN: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____ Email: _____
Is Producer /Agency appointed with HCSC in Texas? ☐ Yes ☐ No General Agent? ☐ Yes ☐ No
Affiliated with General Agent? ☐ Yes ☐ No

If commission split**, designate percentage for each producer/agency (total commissions paid must equal 100%):

Producer /Agency 1: _____% Producer /Agency 2: _____%

Multiple Location Agency(ies): If servicing agency is not listed above as primary or secondary Producer or Agency above, specify location below:

_____

* The Producer or agency name(s) above to whom commissions are to be paid must exactly match the name(s) on the appointment application(s).

** If commissions are split, please provide the information requested above on both producers/agencies. **Both** must be appointed to do business with HCSC in Texas.

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Schedule of Eligibility ☒ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS

Employer has made the following eligibility decisions

1. **Eligible Person means**:
   - ☐ A full-time employee of the Employer.
   - ☐ A full-time employee of the Employer who is a member of: (*name of union*)
   - ☐ A part-time employee of the Employer.
   - ☐ A retiree of the Employer. Define criteria: _____
   - ☐ Other:

   Are any classes of employees to be excluded from coverage? ☐ Yes ☐ No

   If yes, please identify the classes and describe the exclusion: _____

2. **Employee definition**:

   Full-Time Employee means:
   - ☐ A person who is regularly scheduled to work a minimum of _____ hours per week and who is on the permanent payroll of the Employer.
   - ☐ Other:

   Part-Time Employee means:
   - ☐ A person who is regularly scheduled to work a minimum of _____ hours per week and who is on the permanent payroll of the Employer.
   - ☐ Other:

3. **The Effective Date of termination for a person who ceases to meet the definition of Eligible Person**:
   - ☐ The date such person ceases to meet the definition of Eligible Person.
   - ☐ The last day of the calendar month in which such person ceases to meet the definition of an Eligible Person.
   - ☐ Other:

4. Select an effective date rule for a person who becomes an Eligible Person after the Effective Date of the Employer's health care plan (The effective date must not be later than the 91st calendar day after the date that a newly eligible person becomes eligible for coverage, unless otherwise permitted by applicable law).
   - ☐ The date of employment.
   - ☐ The _____ day of employment.
   - ☐ The _____ day of the month following _____ month(s) of employment.
   - ☐ The _____ day of the month following _____ days of employment.
   - ☐ The _____ day of the month following the date of employment.
   - ☐ Other: _____

   Is the waiting period requirement to be waived on initial group enrollment? ☐ Yes ☐ No

   Are there multiple new hire waiting periods? ☐ Yes ☐ No

   If yes, please attach eligibility and contribution details for each section.

5. **Domestic partners covered**: ☐ Yes ☐ No

   If yes, a domestic partner is eligible to enroll for coverage.

   If yes, are domestic partners eligible for continuation of coverage? ☐ Yes ☐ No

   If yes, are dependents of domestic partners eligible to enroll for coverage? ☐ Yes ☐ No

   If yes, are dependents of domestic partners eligible for continuation of coverage? ☐ Yes ☐ No

   The Employer is responsible for providing notice of possible tax implications to those Covered Employees with coverage for domestic partners.

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6. **Are unmarried grandchildren eligible for coverage**? ☐ No ☐ Yes (answer the question below)

   Must the grandchild be dependent on the employee for federal income tax purposes at the time application is made? ☐ Yes ☐ No

7. **Limiting Age for covered children**: Twenty-six (26) years, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage, or any combination of those factors. Other:

8. **Termination of coverage upon reaching the Limiting Age**:
   - ☐ The last day of coverage is the day prior to the birthday.
   - ☐ The last day of coverage is the last day of the month in which the limiting age is reached.
   - ☐ The last day of coverage is the last day of the billing month.
   - ☐ The last day of coverage is the last day of the year (12/31) in which the limiting age is reached.
   - ☐ The last day of coverage is the day prior to the Employer's Anniversary Date.

   Automatically cancel dependents when they reach the day their coverage terminates? ☐ Yes ☐ No

   Will coverage for a child who is medically certified as disabled and dependent on the employee terminate upon reaching the Limiting Age even if the child continues to be both disabled and dependent on the employee?

   ☐ Yes ☐ No

   However, such coverage shall be extended in accordance with any applicable federal or state law. The Employer will notify HCSC of such requirements.

9. Will extension of benefits due to temporary layoff, disability or leave of absence apply?

   ☐ Yes (specify number of days below) ☐ No

   Temporary Layoff: days Disability: days Leave of Absence: days

   However, benefits shall be extended for the duration of an Eligible Person's leave in accordance with any applicable federal or state law. The Employer will notify HCSC of such requirements.

10. **Enrollment**:

    Special Enrollment: An Eligible Person may apply for coverage, Family coverage or add dependents within thirty-one (31) days of a Special Enrollment qualifying event if he/she did not previously apply prior to his/her Eligibility Date or when otherwise eligible to do so. Such person's Coverage Date, Family Coverage Date, and/or dependent's Coverage Date will be the effective date of the qualifying event or, in the event of Special Enrollment due to marriage or termination of previous coverage, then no later than the first day of the Plan Month following the date of receipt of the person's application of coverage.

    An Eligible Person may apply for coverage within sixty (60) days of a Special Enrollment qualifying event in the case either of a loss of coverage under Medicaid or a state Children's Health Insurance program, or eligibility for group coverage where the Eligible Person is deemed qualified for assistance under a state Medicaid or CHIP premium assistance program.

    Open Enrollment: An Eligible Person may apply for coverage, family coverage or add dependents if he/she did not apply prior to his/her Eligibility Date or did not apply when eligible to do so, during the Employer's Open Enrollment Period. Such person's Coverage Date, family Coverage Date, and/or dependent's Coverage Date will be a date mutually agreed to by the Claim Administrator and the Employer. Such date shall be subsequent to the Open Enrollment Period. Specify Open Enrollment Period: _____

    Late Enrollment: An Eligible Person may apply for coverage, family coverage or add dependents if he/she did not apply prior to his/her Eligibility Date or did not apply when eligible to do so. Such person's Coverage Date, family Coverage Date, and/or dependent's Coverage Date will be a date mutually agreed to by the Claim Administrator and the Employer.

    Select one of the provisions below:

    - ☐ Open Enrollment – Late applicants may only apply during Open Enrollment.
    - ☐ Late Entrant – Late applicants may apply at any time – coverage effective date is determined by the receipt date and the off cycle allowed rules.

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11. * Does COBRA Auto Cancel apply? ☐ Yes ☐No
Member's COBRA/Continuation of coverage will be automatically cancelled at the end of the member's eligibility period.
**Not recommended for accounts with automated eligibility*

CURRENT ELIGIBILITY INFORMATION

☒ **NO CHANGES** ☐ **Current number of Employees enrolled** _____ ☐ **SEE ADDITIONAL PROVISIONS**
Current Employee Eligibility Information only applies to new accounts. If your account is renewing, please just indicate the current number of enrolled employees (above).

Total number of Employees/Subscribers:

1. on payroll _____
2. total number of employees presently eligible for coverage _____
3. on COBRA continuation coverage _____
4. with retiree coverage (if applicable) _____
5. who work part-time _____
6. serving the new hire waiting period _____
7. declining because of other **group** coverage (e.g., other commercial group coverage, Medicare, Medicaid, TRICARE/Champus) _____
8. declining coverage (not covered elsewhere) _____

Lines of Business (Check all applicable services)	☐ **NO CHANGES** ☒ **See *Additional Provisions***
Medical Plan Services: ☒ PPO: Plan Name: BA 0001- PPO Plan Plan Name: _____ Plan Name: _____ Plan Name: _____ Plan Name: _____ ☐ HMO: Plan Name: ☐ Prescription Drug Option: Select From List ☐ No Prescription Drug Option ☐ EPO: Plan Name: _____ ☐ POS: Plan Name: _____ ☐ Blue Directions (Private Exchange) (*If selected, the Blue Directions Addendum must be attached and made a part of the Agreement.)* ☐ Blue Care Connection®	**Consumer Driven Health Plan (BlueEdge)** ☐ HCA, (*if selected, complete separate HCA Benefit Program Application*) ☐ HSA, (*if selected, provide HSA Administrator or trustee name:* Select Vendor) ☐ FSA (vendor: Select Vendor) **Traditional Coverage:** ☐ Out-of-Area (Indemnity) ☐ Benefit Offering **Prescription Drugs:** *(If selected, the PBM Fee Schedule Addendum must be attached and is part of this BPA.)* Pharmacy Network (Select one): ☒ Traditional Select Network ☐ Advantage Network ☐ Preferred Network ☐ Elite Network ☐ Network on PBM Fee Schedule Addendum Drug List: Balanced Drug List Other (please specify): Cohort D

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☐ **Dental Plan Services** Plan Name: _____ Select From List Plan Name: _____ Select From List Plan Name: _____ Select From List Plan Name: _____ Select From List Plan Name: _____ Select From List ☒ **Stop Loss Coverage** (*If selected, complete separate Stop Loss exhibit*) ☐ **Life or Disability Insurance provided by separate carrier** (*If selected, complete separate Life application*) ☒ **COBRA Administrative Services** (*If selected, complete separate COBRA Administrative Services*	☐ **Vision Plan Services** ☐ **In-Hospital Indemnity (IHI)** ☐ **Wellness Incentives** ☐ Health Advocacy Solutions ☒ Wellbeing Management ☐ Limited Fiduciary Services for Claims and Appeals ☐ Other Select Product ☐ Other Select Product ☐ Other Select Product ☐ Other Select Product ☐ Other ☐ Other

FEE SCHEDULE

Employer shall pay amounts Claim Administrator bills Employer for benefit claims Claim Administrator processes on Employer's behalf as well as administrative fees as set forth in this Fee Schedule.

Payment Specifications ☒ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS

Employer Payment Method: ☐ **Online Bill Pay** ☐ **Electronic** ☐ **Auto Debit** ☐ **Check**

Employer Payment Period: ☐ **Weekly** (cannot be selected if Check is selected as payment method above)
☐ **Semi Monthly** ☐ **Monthly**

Claim Settlement Period: ☐ **Monthly**

Run-Off Period: Employer Payments are to be made for _____ months following the end of the Fee Schedule Period. *Standard is twelve (12) months.*

Fee Schedule Period: To begin on Effective Date of Coverage and continue for 12 months. If other than 12 months, please specify: Months.

Administrative Per Employee per Month (PEPM) Charges ☐ NO CHANGES ☒ SEE ADDITIONAL PROVISIONS

	Composite			
Administrative Fee	$64.02	$_____	$_____	$_____
Dental	$_____	$_____	$_____	$_____
Limited Fiduciary Services	$_____	$_____	$_____	$_____
*Rebate Credit for the Prescription Drug Program	$(53.70)	$_____	$_____	$_____
Outpatient Imaging Management Services	$_____	$_____	$_____	$_____
Management of the Virtual Visits Program	$Included	$_____	$_____	$_____
Blue Care Connection®	$_____	$_____	$_____	$_____

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Wellbeing Management	**$Included**	$_____	$_____	$_____
Health Advocacy Solutions	$_____	$_____	$_____	$_____
Commissions	**$Included**	$_____	$_____	$_____
Other: Select Service Category List Service: _____	$_____	$_____	$_____	$_____
Other: Select Service Category List Service: _____	$_____	$_____	$_____	$_____
Other: Select Service Category List Service: _____	$_____	$_____	$_____	$_____
Miscellaneous: _____	$_____	$_____	$_____	$_____
Miscellaneous: _____	$_____	$_____	$_____	$_____
Total	**$10.32**	$_____	$_____	$_____

*The Rebate Credit is a per Covered Employee per month credit applied to the monthly billing statement. The Employer and Claim Administrator have agreed to the Rebate Credit and Employer agrees that it and its group health plan have no right to, or legal interest in, any portion of the rebates, either under the pharmacy benefit or the medical benefit, actually provided by the Pharmacy Benefit Manager ("PBM") or a pharmaceutical manufacturer to Claim Administrator and consents to Claim Administrator's retention of all such rebates. The Rebate Credit will be provided from Claim Administrator's own assets and may or may not equal the entire amount of rebates actually provided to Claim Administrator by the PBM or expected to be provided. Rebate Credits shall not continue after termination of the Prescription Drug Program. Employer agrees that any provision in the governing Administrative Services Agreement to the contrary is hereby superseded.

Administrative Line Item Charges	Frequency	Amount
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____	$_____
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____	$_____
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____	$_____
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____	$_____
Miscellaneous: _____	Select Billing Frequency If applicable, describe other: _____	$_____
Miscellaneous: _____	Select Billing Frequency If applicable, describe other: _____	$_____
	Total:	$_____

Other Service and/or Program Fee(s) ☒ **NO CHANGES** ☐ **SEE ADDITIONAL PROVISIONS**

Not applicable to Grandfathered Plans

External Review Coordination: ☐ Yes ☐ No

If yes, coordination fee: $700 for each external review requested by a Covered Person that the Claim Administrator coordinates for the Employer in relation to the Employer's Plan. Employer elects for external reviews to be performed under the Federal Affordable Care Act external review process.

Reimbursement Service: ☐ Yes ☐ No

If yes: It is understood and agreed that in the event BCBSTX makes a recovery on a third-party liability claim, BCBSTX will

retain 25% of any recovered amounts other than recovery amounts received as a result of or associated with any Workers' Compensation Law.

Third-Party Recovery Vendors and Law Firms Provisions (other than Reimbursement Services): Employer will pay no more than 25% of any recovered amount made by BCBSTX's Third-Party Recovery Vendor or up to 25% of any recovered amount will be deducted from the amount distributed according to established allocation processes. Employer will pay no more than 35% of any recovered amount made by BCBSTX's third-party law firm or up to 35% of any recovered amount will be deducted from the amount distributed according to established allocation processes.

Alternative Compensation Arrangements: Employer acknowledges and agrees that Claim Administrator has Alternative Compensation Arrangements with contracted providers, including but not limited to Accountable Care Organizations and other Value Based Programs. Further information concerning Employer's payment for covered services under such Arrangements is described in the Administrative Services Agreement.

Virtual Visits Program: ☐ Yes ☐ No If yes, Covered Persons would be able to obtain certain Covered Services remotely via interactive video and/or interactive audio/video (where available) capability from Providers participating in the Virtual Visit program.

Termination Administrative Charges

As applies to the Run-Off Period indicated in the Payment Specifications section above:

The Termination Administrative Charge applicable to the Run-Off Period shall be equal to the sum of the amounts obtained by multiplying the total number of Covered Employees by category *(per Covered Employee per individual or family composite)* during the three (3) months immediately preceding the date of termination by the appropriate factors shown below.

Service	Composite			
Medical Run-off Administration Charge	$15.44	$_____	$_____	$_____
Dental Run-off Administration Charge	$_____	$_____	$_____	$_____
Miscellaneous	$_____	$_____	$_____	$_____
Miscellaneous	$_____	$_____	$_____	$_____
Total:	$_____	$_____	$_____	$_____

Other Provisions ☒ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS

1. **Summary of Benefits & Coverage**:
   a. Will Claim Administrator create Summary of Benefits & Coverage (SBC)?
      ☐ Yes. (Please answer question b. The SBC Addendum is attached.)
      ☐ No. (If No, then skip question b and refer to the Administrative Services Agreement for further information.)
   b. Will Claim Administrator distribute the Summary of Benefits & Coverage (SBC) to participants and beneficiaries?
      ☐ No. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Agreement) and provide SBC to Employer in electronic format. Employer will then distribute SBC to participants and beneficiaries (or hire a third party to distribute) as required by law.
      ☐ Yes. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Agreement) and provide SBC to Employer in electronic format. Employer will then distribute to participants and beneficiaries as required by law, except that Claim Administrator will send the SBC in response to the occasional request received directly from individuals.
      ☐ Yes. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Agreement) and distribute SBC to participants and beneficiaries via regular hardcopy mail or electronically. Distribution Fee for hardcopy mail is $1.50 per package. The distribution fee will not apply to SBCs that Claim Administrator sends in response to the occasional request received directly from individuals.

2. **Massachusetts Health Care Reform Act**:
   Does the Employer direct Claim Administrator to provide written statements of creditable coverage to its Covered Employees who reside, or have enrolled dependents who reside, in Massachusetts and file electronic reports to the Massachusetts Department of Revenue in a manner consistent with the requirements under the Massachusetts Health Care Reform Act? ☐ Yes ☐ No

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If no: The Employer acknowledges it will provide written statements and electronic reporting to the Massachusetts Department of Revenue as required by the Massachusetts Health Care Reform Act.

3. **Alternative Care Management Program** (this is a component of the purchased medical management program):
☐ Yes ☐ No
The undersigned representative authorizes provision of alternative benefits for services rendered to Covered Persons for Utilization Management, Case Management, including but not limited to Behavioral Health, and other health care management programs.

4. **Prior Authorization** (this is a component of the purchased medical management program): Employer acknowledges and agrees to utilize Claim Administrator's standard list of services and supplies for which pre-notification or preauthorization is required: ☐ Yes ☐ No
If no, Employer authorizes Claim Administrator to post Employer's pre-notification or preauthorization requirements on Claim Administrator's Website: ☐ Yes ☐ No

5. **Essential Health Benefits ("EHB") Election**:
Employer elects EHBs based on the following:
1. ☐ EHBs based on a HCSC state benchmark:
☐ Illinois ☐ Oklahoma ☐ Montana ☐ Texas ☐ New Mexico
2. ☐ EHBs based on benchmark of a state other than IL, MT, NM, OK and TX
If so, indicate the state's benchmark that Employer elects: ___
3. ☐ Other EHB, as determined by Employer

In the absence of an affirmative selection by Employer of its EHBs, then Employer is deemed to have elected the EHBs based on the Texas benchmark plan.

6. **Employer contribution**:

Employer Contribution – Medical	Employer Contribution – Dental
_____ % of Employee's premium, or $_____	_____ % of Employee's premium, or $_____
_____ % of Dependent's premium, or $_____	_____ % of Dependent's premium, or $_____

Comments: _____

7. This ASO BPA is binding on both parties and is incorporated into and made a part of the Administrative Services Agreement with both such documents to be referred to collectively as the "Agreement" unless specified otherwise.

8. **Producer/Consultant Compensation:** The Employer acknowledges that if any producer/consultant acts on its behalf for purposes of purchasing services in connection with the Employer's Plan under the Administrative Services Agreement to which this ASO BPA is attached, the Claim Administrator may pay the Employer's producer/consultant a commission and/or other compensation in connection with such services under the Agreement. If the Employer desires additional information regarding commissions and/or other compensation paid the producer/consultant by the Claim Administrator in connection with services under the Agreement, the Employer should contact its producer/consultant.

Additional Provisions: Effective 10/01/2020: County of Winkler is renewing with the following benefit changes:

* Increase Out of Pocket Individual Max to $5,000

* Increase Out of Pocket Family Max to $10,000;

* Increase Specialist Copay to $50;

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* Add a $200 family RX dedcutible that applies to all RX tiers except Generic;

* Change to Balance RX list

* Add Utilization Management programs of Step Therapy and Prior Authorization.

I UNDERSTAND AND AGREE THAT:

1. **Only complete for new accounts:** Receipt by HCSC of the advance administrative fee (where applicable), in the amount of $_____, and completed enrollment forms does not constitute approval and acceptance by the HCSC Home Office.
2. HCSC will report the value of all remuneration by HCSC to ERISA plans with 100 or more participants for use in preparation of ERISA Form 5500 schedules. Reporting will also be provided upon request to non-ERISA plans or plans with fewer than 100 participants. Reporting will include base commissions, bonuses, incentives, or other forms of remuneration for which your Producer/consultant is eligible for the sale or renewal of self-funded and/or insured products.

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Signature

Zac Hammond (9442 Capital of TX Highway N Suite 500, Arboretum Plaza II Austin, TX 78759)
Sales Representative

029
512-349-4805 / 512-349-4884
District Phone & FAX Numbers

DAL WATSON
Producer Representative

INSURANCE ONE MANAGEMENT
Producer Firm

1309 W WALL STREET; MIDLAND TX 79701
Producer Address

432-687-0213
Producer Phone & FAX Numbers

dalw@doncrawford.com
Producer Email Address

752120143
Tax I.D. No.

X
Signature of Authorized Purchaser

Print Name CHARLES M. WOLF

Title COUNTY JUDGE

Date

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PBM Fee Schedule Addendum to the Benefit Program Application

Employer Name: County of Winkler	
Term: 10/01/2020-09/30/2021	**Employees:** 166
Guaranteed Traditional Aggregate Pricing Arrangement D[1]* Traditional Select Network and Balanced Drug List	
RETAIL	
Brand	**Generic**
AWP minus	**AWP minus**
18.50%	79.00%
DISPENSING FEE	
Brand	**Generic**
$1.15	$1.15
MAIL	
Brand	**Generic**
AWP minus	**AWP minus**
20.50%	83.00%
DISPENSING FEE:	$0.00
EXTENDED SUPPLY NETWORK ("ESN") (If Applicable)	
Brand	**Generic**
AWP minus	**AWP minus**
19.75%	80.50%
DISPENSING FEE:	$0.00
Aggregate Specialty Discount	
Pricing based on Employer's use of the Prime Specialty network	AWP minus: 17.00%
DISPENSING FEE:	**$0.00**

Rebate Credits to Employer:	
PEPM Rebate Credits to Employer:	($53.70)

Employer Administration Fees:	
PBM Administration Fees PEPM:	$0.00

Additional Provisions:

[1] Employer will be billed for retail brand and retail generic prescriptions, mail brand and mail generic prescriptions, ESN brand and ESN generic, and Specialty pharmacy claims (excluding compound prescriptions) based on the lesser of (a) U&C or (b) PBM's adjudication rate schedule(s) that is/are intended to achieve, on an aggregate calendar-year basis, the AWP discounts and Dispensing Fees shown above for all of Claim Administrator's group customers that have purchased the above specific pricing arrangement ("Groups with the Pricing Arrangement") and use the above Network (the "Employer's Contract Rates").

For purposes of setting Employer's Contract Rates and calculating whether the AWP discounts and Dispensing Fees have been achieved:

a. "Brand" products include "Brand Drugs" as defined in the PBM Exhibit and also include generic products that are available from no greater than three (3) generic manufacturers; and
b. "Generic" products include all products not defined in (a), above, as "Brand" products.

Employer acknowledges and agrees that Employer's Contract Rates may vary based on market influences and as necessary to achieve the AWP discounts and Dispensing Fees shown above, on an aggregate calendar year basis, for Groups with the Pricing Arrangement that use the above Network. However, such variation for Brand products in each of the Retail, Mail, and ESN categories (on an aggregate annual basis) may only vary by +/-3% from the applicable AWP discount shown above.

Employer will be billed the above Dispensing Fee (such Fee may be included in the amount billed to Employer) unless the Employer is billed based on the U&C price. If the Employer is billed based on the U&C price, then the Dispensing Fee is included in such U&C price.

Employer will be billed for Compound Drug claims based on the applicable discounted rate in the Network Contract.

Employer will be billed for Foreign Claims based on an amount equal to the amount billed by the pharmacy.

Employer will be billed for out-of-network claims based on the pricing set forth in the Administrative Services Agreement and/or PBM Exhibit, as applicable.

If the AWP discounts and Dispensing Fees shown above are not achieved for a particular calendar year, for Groups with the Pricing Arrangement that use the above Network, then Employer will be credited, no later than 180 days after the end of each calendar year during the Term, an amount calculated as follows:

- First, the total aggregate shortfall dollar amount for the calendar year for Groups with the Pricing Arrangement that use the above Network will be calculated by comparing the actual performance of each of the above categories (Retail, Mail, ESN, and Specialty) with the corresponding AWP discounts and Dispensing Fees shown above for each category. The amount of any performance in any category that exceeds the above AWP discounts and Dispensing Fees will be used to offset any and all shortfall(s) in any or all categories. The above aggregate shortfall, if any, is then divided by total claims for Groups with the Pricing Arrangement that use the above Network, and did not terminate their Addendum prior to their anniversary date, for the calendar year ("Per Claim Amount"). Then the Per Claim Amount will be multiplied by Employer's total claims for that calendar year to calculate the reconciliation credit. However, if Employer terminates this Addendum prior to its anniversary date and the above Guaranteed Traditional Aggregate Pricing Arrangement is not achieved, then Employer will not be eligible to receive such credit.

- For purposes of determining if a shortfall exists, claims billed to Employer based on the U&C price will be considered to have $0.00 Dispensing Fees.

- Compound Drug claims, Foreign Claims, reversed claims, and out-of-network claims are excluded from the calculation of whether the AWP discounts and Dispensing Fees shown above have been achieved and also are excluded from the calculation of any shortfall credit for Employer.

- If the AWP discounts and Dispensing Fees shown above are exceeded for Groups with the Pricing Arrangement that use the above Network, then Employer will not receive any credit, and there will not be a year-end settlement.

- Under the Guaranteed Traditional Aggregate Pricing Arrangement any particular group customer's experience relative to the pricing guarantees will not determine its eligibility for a credit. Group customer's eligibility for a credit is determined based on the aggregate experience of all group customers that have purchased the Pricing Arrangement and use the above Network. As such, an individual group customer may have experience that does not meet, or exceeds, the AWP discounts and Dispensing Fees shown above. In addition, when there is a reconciliation credit, it is allocated in a manner described above and not based on any particular group's experience (other than number of claims).

Proprietary and Confidential Information
Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third party representatives, except with written permission of Claim Administrator.

PBM uses Medi-Span as the pricing source to establish AWP, for purposes of calculating whether the above AWP discounts have been achieved.

Members' cost share is the applicable copayment, deductible, and/or coinsurance, which coinsurance is calculated based on the Employer's Contract Rate or the applicable out-of-network pricing. Zero balance logic is not employed.

AWP discounts are based on the actual NDC-11 dispensed.

AWP discounts do not include savings from drug utilization review or other clinical or medical management programs.

The above Guaranteed Traditional Aggregate Pricing Arrangement, Rebate Credits and Administrative Fees may be subject to change if the Employer's claims include 340B pricing.

In addition to the rights of the parties under the PBM Exhibit, if changes occur within the pharmacy benefit management marketplace which lead to a significant deviation from the current economic environment, both parties agree to engage in good faith negotiations to amend this Addendum to make impact on both parties commercially reasonably economically neutral. If the parties cannot agree on the terms of the amendment, either party shall be allowed to (a) proceed to dispute resolution, as set forth in the Administrative Services Agreement or (b) terminate this Addendum with 90 days' prior written notice to the other party. Failure to reach agreement on the amendment shall not be a breach of contract.

The above Guaranteed Traditional Aggregate Pricing Arrangement, Rebate Credits and Administrative Fees are based on the Network and Drug List shown above.

Unless otherwise specified in this Addendum, capitalized terms used in this Addendum shall have the meanings set forth in the Administrative Services Agreement or the PBM Exhibit, as applicable.

* Employer Payments to Claim Administrator for Covered Services provided by Network Participants are calculated based on the pricing terms set forth in this Addendum which shall remain in effect for the term of this Addendum to the extent described in the Administrative Services Agreement. Such pricing may or may not equal the amounts actually paid to the Network Participants or received from drug manufacturers (e.g., rebates), or the amounts paid or received between Claim Administrator and the PBM. As a result, the PBM or Claim Administrator may realize positive margin on prescriptions filled at retail, mail order, ESN or specialty pharmacies or prescription drug rebates. Employer acknowledges that it has negotiated for the specific traditional pricing terms set forth in this Addendum, and that it and its group health plan have no right to, or legal interest in, any portion of any positive margin retained by Claim Administrator or PBM and consents to Claim Administrator's and PBM's retention of all such amounts.

Signature of Authorized Purchaser

Print Name

Title

Date

Proprietary and Confidential Information
Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third party representatives, except with written permission of Claim Administrator.

BlueCross BlueShield of Texas

[redacted]

APPLICATION FOR STOP LOSS COVERAGE

Employer Group Name: County of Winkler
Employer Group Address: 100 East Winkler
City: Kermit **State of Situs:** TX **Zip Code:** 79745
Account Number: 106943
Employer Group Number(s): 106943
Current Effective Date of Policy 10/01/2020
Current Policy Period: These specifications are for the Policy Period commencing on 10/01/2020 and ending on 09/30/2021

The specifications below shall become effective on the first day of the Policy Period specified above and shall continue in full force and effect until the earliest of the following dates: (1) The last day of the Policy Period; (2) The date the Policy terminates; or (3) The date this Application is superseded in whole or in part by a later executed Application.

A. Aggregate Stop Loss Coverage: ☒ Yes ☐ No
If yes, complete items 1 through 9 below.

1. ☐ New Coverage ☒ Renewal of Existing Coverage
2. Stop Loss Coverage during the current Policy Period:

☐ New Coverage (Select one from below):

☐ Incurred and paid during the Policy Period: Claims incurred and paid from _____ to _____

☐ Incurred with Run-Out: Claims incurred from _____ to _____
and Claims paid from _____ to _____

☐ Run-in coverage: Claims incurred from _____ to _____
and Claims paid from _____ to _____

If coverage is for claims incurred prior to the effective date of the Policy and paid by Policyholder's prior claim administrator, then such claims must be reported by the Policyholder to the Company (Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company) and paid by the Policyholder's prior claim administrator by the end of the current Policy Period.

☒ Renewal of Existing Coverage:

☒ Claim Administrator's Claims: Claims incurred on or after the original Effective Date of Policy and paid during the Policy Period.

☐ Incurred with Run-Out: Claims incurred from _____ to _____
and Claims paid from _____ to _____

3. Aggregate Stop Loss Coverage shall apply to:

☒ Medical Claims

☒ Outpatient Prescription Drug Claims with Company's Pharmacy Benefit Manager

☐ Outpatient Prescription Drug Claims with Policyholder's Pharmacy Benefit Manager: _____

☐ Dental Claims

☐ Other (please specify): _____

4. Average Claim Value: $1,041.22 (per Employee per Month)

Attachment Factor: 125% of the Average Claim Value

5. Aggregate Claim Liability and Run-Off Claim Liability Factors

a. Employer's Claim Liability for each Policy Period shall be the sum of the Monthly amounts obtained by multiplying the number of Individual and Family Coverage Units for each Month by the following factors:

$1,301.53 for each Coverage Unit

$1,301.53 for each Family Coverage Unit

Please use the continuous text field directly below for any other structure (leaving the fields above blank). Note: you can use the "return" key to create additional rows, if needed:

_____

b. Employer's Run-Off Claim Liability shall be calculated by multiplying the sum average of the total of all Coverage Units during each of the three calendar Months immediately preceding termination by the factors shown below. Settlement for the final accounting period will be described in the section of the Policy entitled SETTLEMENTS.

$348.42 for each Coverage Unit

$348.42 for each Family Coverage Unit

Please use the continuous text field directly below for any other structure (leaving the fields above blank). Note: you can use the "return" key to create additional rows, if needed:

_____

6. CAP Arrangement ☐ Yes ☒ No

7. Aggregate Stop Loss Claims

a. The amount of Paid Claims during the current Policy Period, less:

i. Individual (Specific) Stop Loss Claims

ii. Any claims in excess of the Individual (Specific) Stop Loss Claims per Covered Person per Lifetime Maximum

iii. Any claims in excess of the Individual (Specific) Stop Loss Claims maximum Point of Attachment

that exceeds the Aggregate Point of Attachment. The Aggregate Point of Attachment shall equal the sum of the Employer's Claim Liability amounts calculated Monthly as described in item A.5.a. above for the current Policy Period.

b. In the event of termination at the end of a Policy Period, the Final Settlement Aggregate Point of Attachment shall equal the sum of the Employer's Claim Liability amount for the Final Policy Period and the Employer's Run-Off Claim Liability calculated as described in item A.5.b. above. However, for the current Policy Period the minimum Aggregate Point of Attachment shall be $2,333,374.

8. Stop Loss Premium (Select one):

☐ Annual Premium (Due on the first day of the current Policy Period): $_____.

☒ Monthly Premium shall be equal to the amounts obtained by multiplying the number of Individual and Family Coverage Units for a particular Month by:

$21.47 for each Coverage Unit

$21.47 for each Family Coverage Unit

Please use the continuous text field directly below for any other structure (leaving the fields above blank). Note: you can use the "return" key to create additional rows, if needed:

_____

9. The premium is based upon a current membership of 90 Individual Coverage Units and 76 Family Coverage Units.

B. Individual (Specific) Stop Loss Coverage: ☒ Yes ☐ No

If yes, complete items 1 through 6 below.

1. ☐ New Coverage ☒ Renewal of Existing Coverage

2. Stop Loss Coverage Period:

☐ New Coverage (Select one from below):

☐ Incurred and paid during the Policy Period: Claims incurred and paid from _____ to _____

☐ Incurred with Run-Out: Claims incurred from _____ to _____ and Claims paid from _____ to _____

☐ Run-in coverage: Claims incurred from _____ to _____ and Claims paid from _____ to _____

If coverage is for claims incurred prior to the effective date of the Policy and paid by Policyholder's prior claim administrator, then such claims must be reported by the Policyholder to the Company (Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company) and paid by the Policyholder's prior claim administrator by the end of the current Policy Period.

☒ Renewal of Existing Coverage:

☒ Claim Administrator's Claims: Claims incurred on or after the original Effective Date of Policy and paid during the Policy Period.

☐ Incurred with Run-Out: Claims incurred from _____ to _____ and Claims paid from _____ to _____

3. Individual (Specific) Stop Loss Coverage shall apply to:

☒ Medical Claims

☒ Outpatient Prescription Drug Claims with Company's Pharmacy Benefit Manager

☐ Outpatient Prescription Drug Claims with Policyholder's Pharmacy Benefit Manager: _____

☐ Dental Claims

☐ Vision Claims

☐ Other (please specify): _____

4. Individual (Specific) Stop Loss Claims

   a. For N/A who is identified by the health identification (ID) number N/A, the amount of Paid Claims during the current Policy Period in excess of the Individual Point of Attachment of $N/A. Such amount shall apply for the current Policy Period.

   b. For each other Covered Person:
   The amount of Paid Claims during the current Policy Period in excess of the Individual Point of Attachment of $70,000 per Covered Person but not to exceed a maximum Point of Attachment of $ Unlimited per Policy Period. Paid Claims in excess of the maximum point of attachment shall not be eligible to satisfy the Aggregate Point of Attachment. Such amount shall apply for the current Policy Period.

   c. Covered Person per Lifetime Maximum:

   The Individual (Specific) Stop Loss Claims shall not exceed Unlimited per Covered Person per Lifetime. Paid Claims in excess of the Covered Person per Lifetime Maximum shall not be eligible to satisfy the Aggregate Point of Attachment.

   Point of Attachment ☒ Includes Claim Administrator's Provider Access Fee
   ☐ Excludes Claim Administrator's Provider Access Fee

5. Stop Loss Premium (select one):

   ☐ Annual Premium (Due on the first day of the current Policy Period): $_____.

   ☒ Monthly Premium shall be equal to the amounts obtained by multiplying the number of Individual and Family Coverage Units for a particular Month by:

   $296.81 for each Coverage Unit

   $296.81 for each Family Coverage Unit

   Please use the continuous text field directly below for any other structure (leaving the fields above blank). Note: you can use the "return" key to create additional rows, if needed:

   _____

6. The premium is based upon a current membership of 90 Individual Coverage Units and 76 Family Coverage Units.

Additional Provisions:

_____

The undersigned person represents that he/she is authorized and responsible for purchasing stop loss coverage on behalf of the Employer. It is understood that the actual terms and conditions of coverage are those contained in Application the Stop Loss Coverage Policy into which this Application shall be incorporated at the time of acceptance by Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company ("HCSC"). Upon acceptance, HCSC shall issue a Stop Loss Coverage Policy to the Employer. Upon acceptance of this Application and issuance of the Stop Loss Coverage Policy, the Employer shall be referred to as the "Policyholder."

Zac Hammond	
Sales Representative	Signature of Authorized Purchaser
Tammy Cornelison	COUNTY JUDGE
Name of Underwriter	Title of Authorized Purchaser
Signature of Underwriter	Date

INTERNAL USE ONLY	Date Application approved by Underwriting:

Blue Insight Account Authorization Form

Below are the instructions for the completion of this form. Submit the completed form to client_reporting@bcbsil.com or fax to (972) 231-0965. The Blue Insight Administrator listed on the form will receive confirmation of Blue Insight training logistics.

To ensure a timely security and training registration, please follow the steps outlined below. Incomplete forms will be returned. Forms are due 14 days prior to the scheduled training date.

1. **Section One**: Complete general information for Employer/Group.

- The Blue Insight Administrator must be an employee of the account and must be listed as the main contact for the account in BlueStar.

2. **Section Two**: List each user needing access and select the appropriate security role(s) that should be assigned to the user.

- All users must be listed with the specified assigned security role.
- All users must be an authorized representative of the Employer/Group.
- If the account has less than 500 employees, only the broker/producer is allowed to have interactive access to the application.

3. **Section Three**: Complete the signature section.

- The Blue Insight Administrator must initial **EACH** statement indicating that they agree with the statement provided.
- The Blue Insight Administrator signature and date is required.

Blue Insight Account Authorization Form

Please complete the information below and submit the completed form to client_reporting@bcbsil.com or fax to (972) 231-0965.

Section One: General Information for the Account

Account #: 106943	Account Name: COUNTY OF WINKLER	Total Member Count:	
Authorized Blue Insight Administrator *(listed as main contact for the account in BlueStar)*	Name: Jeanna Wilhelm, Auditor Or Charles Wolf, Judge E-mail: jwilhelm@co.winkler.tx.us or charles.wolf@co.winkler.tx.us		Phone: **(432) 586-3161**
Broker / Consultant for the Account	Name: Dal Watson Company Name: Insurance One Management, Inc. dba Don Crawford and Associates E-mail: dalw@doncrawford.com		Phone: 432-687-0213
Would you like to include your account logo on the Blue Insight application and reports?	☐ Yes	☒ No	If yes, please forward logo to client_reporting@bcbsil.com. *(must be GIF format)*

Security Roles & Descriptions

- **Non PHI (EXT_NONPHI) – Access to this role does not provide the user access to any PHI.** This role allows the user access to the PDF version of the presentation report and also access to the interactive reporting. This role excludes all identifiers as defined by the Health Insurance Portability & Accountability Act (HIPAA) that could be used alone or in combination with other information to identify an individual who is the subject of the information. This role is available to users within Accounts that do **not** have a valid Business Associates Agreement or Insured Group Certification authorizing release of PHI. Accounts with a valid Business Associate Agreement or Insured Group Certification authorizing release of PHI may also select this role for any user they wish to restrict access to PHI.
- **True PHI (EXT_PHI+) – Access to this role does provide the user access to full PHI.** This role allows the user access to the PDF version of the presentation report and also access to the interactive reporting. This role provides all member level attributes including Name, Social Security Number, Date of Birth, and Identification Numbers. This role is only available to users within Accounts that have a valid Business Associate Agreement or Insured Group Certification authorizing release of PHI. Users who are assigned this role will have the ability to access detailed PHI data via the internet. It is the users' responsibility to appropriately safeguard any PHI that they access via the application. It is the Blue Insight Administrator's responsibility to notify BCBS within 3 business days that access should be removed for a user.

Section Two: Information for Blue Insight Security Setup and Training					
			Please Select One Training Option		
List Each Individual's Name	E-mail Address	Security Role (see page 2 for role descriptions)	Instructor Led	Web-based Classroom	Already Trained
Silvia Corella	silviac@doncrawford.com	True PHI	☐	☐	☒
Karen Dagenhart	karend@doncrawford.com	True PHI	☐	☐	☒
Dal Watson	dalw@doncrawford.com	True PHI	☐	☐	☒
Debbie Brumley	debbieb@doncrawford.com	True PHI	☐	☐	☒
Instructor Led Training (select location)	☐ Albuquerque ☐ Austin ☐ Chicago ☐ Dallas ☐ Downers Grove ☐ Helena ☐ Houston ☐ Tulsa ☐ Oklahoma City				
List any special training needs, training requirements, and/or a training date preference:					

Section Three: Authorization and Signature – The Blue Insight Administrator must initial **EACH** statement indicating that they have read and agree with **EACH** statement.

___ ___ If your Employer/Group is authorized to receive Protected Health Information (PHI), as defined by the Privacy Rule under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), from BCBSIL/BCBSTX/BCBSOK/BCBSNM/BCBSMT and if PHI is accessible through Blue Insight, then, by signing below, you are acting as an authorized representative or Blue Insight Administrator for your Employer/Group. You acknowledge and agree that when you authorize others to review PHI in the Blue Insight reporting application, your Employer/Group is fully responsible for ensuring that each authorized recipient is appropriately trained on the required privacy and security safeguards to protect PHI.

_____ I understand that any user that is assigned the security role of **True PHI (EXT_PHI+)** will have access to detailed PHI data via the internet. My signature below acknowledges that the users listed have full responsibility for the use of their assigned ID. Unauthorized use and/or sharing of the assigned ID(s) is prohibited.

_____ I agree that upon termination of myself as the delegated administrator for the account or upon termination of any user that I have authorized to have access to Blue Insight, I will contact client_reporting@bcbsil.com within three business days to request that the access be removed.

_____ I understand and specifically acknowledge that claim data in the Blue Insight reporting application is not sufficient, by itself, for use in applying for or obtaining Federal funds under programs for Retiree Drug Subsidy, Early Retiree Reinsurance, or other similar programs. Before using data from Blue Insight for purposes of obtaining federal funds, additional data from other sources and other contracts are needed in order to comply with Federal requirements. I agree to contact client_reporting@bcbsil.com to request the required additional information and forms.

_____ _____

Signature of Blue Insight Administrator Date

BlueCross BlueShield of Texas

County Of Winkler #106943

ASO Projection
for the period
October 1, 2020 - September 30, 2021

ASO - Stop Loss Renewal-SOLD

Presented by:

Blue Cross and Blue Shield of Texas

Proprietary and Confidential Information of BCBSTX
Not for use or disclosure outside BCBSTX, Employer, their respective affiliated companies and third-party representatives, except with written permission of BCBSTX.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
an Independent Licensee of the Blue Cross and Blue Shield Association

BlueCross BlueShield of Texas

County Of Winkler #106943

ASO Projection
October 1, 2020 - September 30, 2021
ASO - Stop Loss Renewal-SOLD

Affordable Care Act (ACA) Disclaimer

If your existing group health plan or group health insurance coverage (each "plan") was in effect on March 23, 2010, it may be a "grandfathered health plan" as that term is "defined in the Affordable Care Act and related regulations (currently 75 Fed. Reg. 34538)."

Federal regulations have been published regarding the maintenance and loss of grandfathered health plan status. We encourage you to confer with your own legal counsel to determine what benefit changes or other events may cause the loss of grandfathered health plan status and to evaluate the benefit options that are most suitable for you.

The following proposed benefit programs are not considered "grandfathered health plans".

Proprietary and Confidential Information of BCBSTX
Not for use or disclosure outside BCBSTX, Employer, their respective affiliated companies and third-party representatives, except with written permission of BCBSTX.

BlueCross BlueShield of Texas

County Of Winkler #106943

ASO Projection
for the period
October 1, 2020 - September 30, 2021
ASO - Stop Loss Renewal-SOLD

TOTAL PROJECTED COST

Please refer to the ACA Disclaimer regarding benefits and final pricing.

PPO Plan	90 EO	76 EF	166 Composite	Total Cost
Projected Net Paid Claims				$2,074,110
Individual Stop Loss ($70,000 Level)	$175.96	$439.92	$296.81	$591,246
Aggregate Stop Loss 125% Attachment Point	$12.73	$31.82	$21.47	$42,769
Administration Fee	$37.95	$94.89	$64.02	$127,528
* Prescription Drug Rebate Credit	($31.82)	($79.61)	($53.70)	($106,970)
** Net Administration Fee	$6.13	$15.28	$10.32	
Total Projected Cost				$2,728,683
Run-Off Administration			$15.44	$7,689
Run-Off Claim Liability			$348.32	$173,463

*Traditional Network and Blanced Drug List
** Includes Enable with Behavioral Health, and MDLIVES medical only

Proprietary and Confidential Information of BCBSTX
Not for use or disclosure outside BCBSTX, Employer, their respective affiliated companies and third-party representatives, except with written permission of BCBSTX.
A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

BlueCross BlueShield of Texas

County Of Winkler #106943

ASO Projection
October 1, 2020 - September 30, 2021
ASO - Stop Loss Renewal-SOLD

STOP LOSS

Please refer to the ACA Disclaimer regarding benefits and final pricing.

Paid

	PPO Plan		Customer Total	
	SINGLE	FAMILY	PCPM	TOTAL
Projected Enrollment	90	76	166	1,992
Projected Average Claim Value	$617.31	$1,543.22	$1,041.22	$2,074,110
Aggregate Stop Loss Attachment Point	125%	125%	125%	125%
Aggregate Stop Loss Limit	$771.64	$1,929.03	$1,301.53	$2,592,638
Aggregate Stop Loss Premium	$12.73	$31.82	$21.47	$42,769
Individual Stop Loss Attachment Point	$70,000	$70,000	$70,000	$70,000
Individual Stop Loss Premium	$175.96	$439.92	$296.81	$591,246
Minimum Aggregate Attachment Point				$2,333,374

Proprietary and Confidential Information of BCBSTX
Not for use or disclosure outside BCBSTX, Employer, their respective affiliated companies and third-party representatives, except with written permission of BCBSTX.

Subject to and contingent upon conditions and caveats outlined in attached addendum.
A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
an Independent Licensee of the Blue Cross and Blue Shield Association

BlueCross BlueShield of Texas

County Of Winkler #106943

October 1, 2020 - September 30, 2021
*****Numbers for Illustrative Purposes Only*****
Rx Claims Only
Claims Paid 10/01/2020 Through 09/30/2021

Rx Discount Standard Offer Traditional Pricing			
	Traditional Select	Network Advantage	Preferred
Retail		Discount	
Brand AWP minus	18.50%	19.80%	20.65%
Generic AWP minus	79.00%	80.50%	80.50%
		Dispensing Fee	
Brand	$1.15	$0.85	$0.75
Generic	$1.15	$0.85	$0.75
Mail		Discount	
Brand AWP minus	20.50%	20.50%	20.50%
Generic AWP minus	83.00%	83.00%	83.00%
		Dispensing Fee	
Brand	$0.00	$0.00	$0.00
Generic	$0.00	$0.00	$0.00
ESN		Discount	
Brand AWP minus	19.75%	22.30%	23.00%
Generic AWP minus	80.50%	82.00%	82.00%
		Dispensing Fee	
Brand	$0.00	$0.00	$0.00
Generic	$0.00	$0.00	$0.00
Specialty		Discount	
AWP minus	17.00%	17.00%	17.00%

	Rebate Credits Per Claim	
Drug List	Per Retail Brand Rx	Per Mail Brand Rx
Balanced	$207.00	$459.00
Basic	$183.00	$401.00
Enhanced	$173.00	$383.00
Performance	$196.00	$448.00
Performance Select	$207.00	$459.00

Caveats

- *Per Script Rebates above are for Illustrative purposes only. The per script rebates will be converted into a monthly PEPM credit to be applied to the monthly billing statement.*
- *Members will pay the lower of the contracted rate, U&C, or their applicable copayment. Zero balance logic is not employed.*
- *Discounts are based on the actual NDC-11 dispensed.*
- *Discounts provided do not include savings from DUR or other clinical programs.*
- *Assumes client does not have 340B pricing.*
- *Rebates will be paid on all eligible claims incurred during the life of the contract.*
- *Rebates are earned on all eligible claims, regardless of days supply and member contribution percentages.*
- *Compound claims and OTC claims are excluded from rebates.*
- *Discount rates exclude compounds, foreign claims and specialty (as defined by the Prime Specialty Fee Schedule).*
- *If changes occur within the PBM marketplace which lead to a significant deviation from the current economic environment, both parties agree to proactively amend the contract to make all parties commercially reasonably economically neutral.*
- *"Brand" products include "Brand Drugs" as defined in the PBM Exhibit and also include generic products that are available from no greater than three (3) generic manufacturers.*
- *For purposes of AWP discount calculations generic products are all products not defined as brand name products.*
- *Assumes Exclusive Specialty through Prime Specialty Pharmacy.*
- *Dispensing fee will be $0.00 for those drugs dispensed through Prime Specialty Pharmacy.*
- *The above AWP's, Dispensing fees and per script Rebates reflects HCSC's RX standard product for the Networks and Drug Lists offered. Group's estimated pricing will be based on the Network and Drug List selected.*
- *Drug list options above do not apply to plans with Bluescript Rx.*

Proprietary and Confidential Information of BCBSTX
Not for use or disclosure outside BCBSTX, Employer, their respective affiliated companies and third-party representatives, except with written permission of BCBSTX.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
an Independent Licensee of the Blue Cross and Blue Shield Association

BlueCross BlueShield of Texas

County Of Winkler #106943

ASO Projection
for the period
October 1, 2020 - September 30, 2021
ASO - Stop Loss Renewal-SOLD

CONVENTIONAL EQUIVALENT RATE DEVELOPMENT

Please refer to the ACA Disclaimer regarding benefits and final pricing.

	PPO Plan
Requested Premium at Renewal Rates	$2,741,755

	Lives	Renewal
HCSC Primary		
Single	90	$838.15
Single + Spouse	21	$1,843.93
Single + Child(ren)	26	$1,592.48
Family	29	$2,514.45
TOTAL	166	

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Wellbeing Management Detail

Please refer to the ACA Disclaimer regarding benefits and final pricing.

	Total
Projected Enrollment	166
WBM Package Included in Administration Fee	Enable BH
Foundational Package Components	
Foundational Package Components	
Total Foundational and Configurable	$4.95
Total WBM Fee Included in Administration Fee	$4.95

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CONDITIONS AND CAVEATS

Please refer to the ACA Disclaimer regarding benefits and final pricing.

Notwithstanding anything in the renewal or Proposal to the contrary, BCBSTX reserves the right to revise or withdraw our offer, or to change our administrative fees (and/or pass-through amounts) at any time before or during the contract period (all of which may be estimates, allocated or pro-rated amounts) if any local, state or federal legislation, regulation, rule or guidance (or amendments or clarifications thereto) is enacted or becomes effective/implemented, which would increase projected claim costs or BCBSTX's expenses or cost of plan administration, or would otherwise require BCBSTX to pay, submit or forward, on its own behalf or on the Employer Group's behalf, any additional tax, surcharge, fee, or other amount.

NOTICE: ACA provided for the establishment of a temporary reinsurance program(s) for a three (3) year period (2014-2016), which is funded by reinsurance contributions ("Reinsurance Fees") collected from health insurance issuers and self-funded group health plans, beginning in 2014. Information as to how these fees are calculated is provided by federal and state governments. Federal regulations establish a flat, per member, per month fee.

ACA also provides that self-funded plan sponsors are responsible for the Reinsurance Fee. BCBSTX will not assist in the remittance of those fees to the federal government; however, upon request, we can make available to our self-funded/ASO customers, existing data and information that may be helpful in determining, reporting on, and remitting their Reinsurance Fee amounts.

The total annual Stop Loss premiums and ACV factors are based upon the total projected enrollment and contract distribution as indicated on this exhibit.
Significant changes in the above stated enrollment and contract distribution will require a review and adjustment of the fees and factors.

Rates are projected to be effective for the 12-month period beginning on the effective date indicated.
Final rates may vary based on actual enrollment results.

This renewal offer assumes BCBSTX will remain the exclusive carrier.

The total annual premiums are based upon the total current enrollment and contract distribution as indicated.

If the enrollment or contract distribution varies by more than 10% in total or in each coverage independently, we reserve the right to re-rate.

The minimum participation requirement is 75% without waivers and 65% with valid waivers in order for coverages to be issued.

The employer maintaining the current contribution schedule.

Annual open enrollment.

Upon inquiry from employer groups, BCBSTX will provide information to the employer group regarding commissions and other compensation paid to the employer's agent by BCBSTX in connection with the employer's policy or contract with BCBSTX.

The Individual Stop Loss quote is being offered on a Paid basis during the policy period indicated above.

The Aggregate Stop Loss quote is being offered on a Paid basis during the policy period indicated above.

Health Paid Claims subject to Individual Stop Loss are paid claims from the following line(s) of coverage: Medical and Drug

Health Paid Claims subject to Aggregate Stop Loss are paid claims from the following line(s) of coverage: Medical and Drug

BCBSTX reserves the right to adjust the Average Claim Value if one or more of the following occurs within the coverage period:

The minimum Aggregate Attachment Point was calculated as 90% of the ASL Limit per contract per month multiplied by the projected cumulative contracts for the period.

Individual Health Stop Loss and Aggregate Health Stop Loss premiums are payable on the first day of each month.

Any amount in excess of the Individual Health Stop Loss limit will not be included in the Aggregate Health Stop Loss Settlement.

The Aggregate Stop Loss benefit payment is unlimited per policy year.

Premium Equivalent Rates reflect expected benefit cost only and do not include an adjustment for a change in needed reserves.
Premium Equivalent Rates should fund expected paid claims (EPC), administration, stoploss charges and estimated reserves; if claims exceed EPC, the Employer will be required to make additional funds available up to the Maximum Claim Liability.

Commissions $26.51 pepm in ISL

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Upon Termination, the run-off factors above will be multiplied times the total of all certificates actually exposed during each of the three months immediately preceding contract termination and the result will be the obligation of the Employer. The Run-off Administration amount is due and payable whether or not BCBSTX processes the run-off claims.

HCSC's pharmacy benefit manager, PRIME Therapeutics (PBM), holds rebate contracts with pharmaceutical manufacturers. HCSC may, in some circumstances, provide the Employer with a Rebate Credit, but such Rebate Credit may not equal the entire amount of the rebates provided to HCSC by the PBM.

Employers that do not use Prime Therapeutics as their pharmacy benefit manager are NOT eligible for a Rebate Credit.

HCSC's current estimate of the rebates it will receive from the PBM, for drugs covered under the pharmacy benefit, for the employer's covered members, is approximately $30.61 per script.

HCSC's current estimate of the rebates it will receive from the PBM, for drugs covered under the medical benefit on an aggregate basis for the policy period, is approximately $1.00 per employee per month.

The Administrative charge includes a network access fee for employees residing in HCSC service areas (IL, MT, OK, NM, TX). Claims incurred outside HCSC service areas through the BlueCard program may be assessed a BlueCard access fee of no more than 3.97% of the discount applied, not to exceed $2,000 per claim. An estimate of this access fee is included in our projected claim figures.

Costs associated with special services or custom materials provided by BCBSTX will be billed separate and apart from the Administrative Charges outlined on this exhibit. The employer is responsible for any administrative services taxes due for benefits paid under this agreement.

This quote is contingent upon the account signing new contract documents in a timely manner. If not signed, then HCSC may withdraw and/or revise the quote.

Pharmacy Rebate Credit includes estimate of rebates for all categories of drugs, including specialty drugs, based on our book of business.

If the prescription drug program is not administered by Prime today but is awarded the administration of the prescription drug program, the medical claim cost will be reduced due to the integration of the medical and prescription drug program.

Wellbeing Management (Health Management & Advocacy program) is included in the quoted administration fee.

If a non-preferred vendor is selected for automated eligibility processing, an additional charge will apply.

If a third party pharmacy benefit manager is selected, additional charges will apply.

Lock-In requirements for all stop loss proposals and renewals as follows:

-Stop Loss quotes/renewals released 10 or more months prior to effective date:
-All such offers are illustrative and cannot be locked in. See note below.

-Stop Loss quotes/renewals released 4 to 9 months prior to effective date:
-Can be locked in (via written acceptance) up to 45 calendar days after quote is released.
-After 45 calendar days without written acceptance, those offers become illustrative. See note below.

-Stop Loss quotes/renewals released within 3 months prior to effective date:
-Can be locked in at any time prior to effective date. (Stop Loss cannot be purchased after the policy period begins.)

Note: For quotes/renewals that are illustrative or otherwise not locked in, HCSC will require/review updated claim data which is within 120 days of the quoted effective date. A revised and final stop loss quote/renewal will be issued at that time.

Projected Net Paid Claims for non-HMO Medical coverages on these exhibits include Estimated Value Based Care Payments and Savings.

Value Based Care payments apply to Stop Loss Coverage.

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BCBSTX retains the right to recoup monetary credits provided, any remaining implementation costs, shared savings or PG incentive fees from the plan sponsor in the event of early termination of the proposed coverage or contract, either in its entirety or with respect to certain custom services or programs included in this offer.

If a third party stop loss carrier is selected, a Third-Party Stop Loss Carrier fee will apply.

If an HMO network product is selected, mental health capitation charges may apply and be billed separate and apart from the Administrative Charges outlined on this exhibit.

Offer is contingent upon proposed Wellbeing Management package design. Any modifications to the proposed package will impact the Wellbeing Management fee and Administrative Fee.

Administration Fee assumes Weekly claim funding.

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OTIS

Made to move you

Otis Service and Repair Order

DATE: 09/10/2020

TO:
Winkler County Courthouse
C/O County Auditor
P.O. Drawer 0
Kermit, TX 79745

FROM:
Otis Elevator Company
1308 S Midkiff, #221, Box #9
Midland, TX 79701

Jace White
469-315-2822

EQUIPMENT LOCATION:
WINKLER CO COURTHOUSE
100 East Winkler
Kermit, TX 79745

PROPOSAL NUMBER: JZW200910150129

MACHINE NUMBER(S) : 150256

CUSTOMER DESIGNATION(S) : ONLY ELV

We will provide labor and material to furnish and install on the above referenced machine(s) the following:

Brake Coil Repair

We will furnish the necessary labor and material to replace the brake coil and to adjust.

The scope proposed herein represents the entire scope that Otis is contracted for, if additional work is required by others to allow for completion of this work and/or for the inspection to occur, that work is not included.

The price quoted below does not include sales tax and is valid for 30 days from the date specified above.

The price quoted below assumes the work will be scheduled based on the availability of material and manpower to complete the job efficiently. A local representative will contact you to schedule the work.

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PRICE: **$ 6,375.48**
Six thousand three hundred seventy-five dollars and forty-eight cents

This price is based on a one hundred percent (100 %) downpayment in the amount of $ 6,375.48.

PAYMENT TERMS:

- The base proposal price is contingent upon receiving a pre-payment of 100% of the base contract amount.
- The pre-payment amount is due in full prior to ordering material and/or mobilizing.
- If you choose the alternative down-payment amount listed below, the corresponding Add shall be applied to the base contract amount.

Down Payment Amount	Price Adjustment Percentage	Authorization (Initial)
50%	+10%	

In the event 100% of the contract price is not paid up front, we must be paid the remaining balance no later than the completion of work. Final invoice will be submitted once work is scheduled

This proposal, including the provisions printed on the last page(s), and the specifications and other provisions attached hereto shall, when accepted by you below and approved by our authorized representative, constitute the entire contract between us, and all prior representations or agreements not incorporated herein are superseded.

Submitted by: Jace White
Title: Sales Representative
E-mail: jace.white@otis.com

Accepted in Duplicate

CUSTOMER
Approved by Authorized Representative

Date: 9-11-2020
Signed: C M Wolf
Print Name: Charles M Wolf
Title: Judge
E-mail: Charles.wolf@co.winkler.tx.us
Name of Company: Winkler County

☑ Principal, Owner or Authorized Representative of Principal or Owner

☐ Agent: _____
(Name of Principal or Owner)

Otis Elevator Company
Approved by Authorized Representative

Date: _____
Signed: _____
Print Name: Corey von Merveldt
Title: General Manager

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TERMS AND CONDITIONS

1. The work shall be performed for the agreed price plus any applicable sales, excise or similar taxes as required by law.

2. In addition to the agreed price, you shall pay to us any future applicable tax imposed on us, our suppliers or you in connection with the performance of the work described.

3. This quotation is subject to change or withdrawal by us prior to acceptance.

4. We warrant to you that the work performed by us hereunder shall be free from defects, not inherent in the quality required or permitted, in material and workmanship for one (1) year from the date of substantial completion. We used commercially reasonable efforts to ensure that the EMS Panorama 2.0 software provided to you is free from viruses and vulnerabilities that may be exploited by third parties. Our duty and your remedy under this warranty are limited to our correcting any such defect you report to us within the warranty period by, at our opinion, repair or replacement, provided all payments due under the terms of this contract have been made in full. All parts used for repair or replacement under this warranty shall be good quality and furnished on an exchange basis. Printed circuit boards used for replacement parts under this warranty may be refurbished boards. Exchanged parts become our property. This warranty shall be voided if said defect is caused by your breach or negligence or unauthorized access or manipulation of the system.

5. We shall perform the work during our regular working hours of our regular working days unless otherwise agreed in writing. You shall be responsible for providing suitable storage space at the site for our material.

6. You shall obtain title to all the equipment, excluding the software, furnished hereunder when final payment for such material is received by us.

7. Any drawings, illustrations or descriptive matter furnished with the proposal are submitted only to show the general style, arrangement and dimensions of the equipment.

8. Payments shall be made as follows: A down payment of hundred percent (100%) of the price shall be paid after we have completed processing your equipment requirements, and orders are placed; the balance shall be paid on completion if the work is completed within a thirty day period. If the work is not completed within a thirty day period, monthly progress payments shall be made based on the value of any equipment ready or delivered, if any, and labor performed through the end of the month less a five percent (5%) retainage and the aggregate of previous payments. The retainage shall be paid when the work is completed. We reserve the right to discontinue our work at any time until payments shall have been made as agreed and we have assurance satisfactory to us that subsequent payments will be made when due. Payments not received within thirty (30) days of the date of invoice shall be subject to interest accrued at the rate of eighteen percent (18%) per annum or at the maximum rate allowed by applicable law, whichever is less. We shall also be entitled to reimbursement from you of the expenses, including attorney's fees, incurred in collecting any overdue payments.

9. Any material removed by us in the performance of the work shall become our property.

10. Our performance is conditioned upon your securing any required governmental approvals for the installation of any equipment provided hereunder and your providing our workmen with adequate electrical power at no cost to us with a safe place in which to work, and we reserve the right to discontinue our work in the building whenever in our opinion working conditions are unsafe. If overtime work is mutually agreed upon and performed, an additional charge thereof, at our usual rates for such work, shall be added to the contract price. The performance of our work hereunder is conditioned on your performing the preparatory work and supplying the necessary data specified on the front of this proposal or in the attached specification, if any. Should we be required to make an unscheduled return to your site to begin or complete the work due to your request, acts or omissions, then such return visits shall be subject to additional charges at our current labor rates.

11. We shall retain a security interest in all material furnished hereunder and not paid for in full. You agree that a copy of this Agreement may be used as a financing statement for the purpose of placing upon public record our interest in any material furnished hereunder, and you agree to execute a UCC-1 form or any other document reasonably requested by us for that purpose.

12. Except insofar as your equipment may be covered by an Otis maintenance or service contract, it is agreed that we will make no examination of your equipment other than that necessary to do the work described in this contract and assume no responsibility for any part of your equipment except that upon which work has been done under this contract.

13. Neither you nor we shall be liable to the other party hereto for any loss, damage or delay due to any cause beyond your or our reasonable control, including, but not limited to, acts of government, strikes, lockouts, fire, explosion, theft, floods, riot, civil commotion, war, malicious mischief or actors, or act of God; provided, however, that, should loss of or damage to our material or work occur at the site, you shall compensate us therefor unless such loss or damage results from our acts or omissions.

14. We do not agree under our warranty to bear the cost of repairs or replacements due to vandalism, abuse, misuse, neglect, normal wear and tear, modifications not performed by us, improper or insufficient maintenance by others, or any cause beyond our control.

15. We shall conduct, at our own expense, the entire defense of any claim, suit or action alleging that, without further combination, the use by you of any equipment provided hereunder directly infringes any patent, but only on the conditions that (a) we receive prompt written notice of such claim, suit or action and full opportunity to assume the sole defense thereof, including settlement and appeals, and all information available to you for such defense; (b) said equipment is made according to a specification or design furnished by us; and (c) the claim, suit or action is brought against you. Provided all of the foregoing conditions have been met, we shall, at our own expense, either settle said claim, suit or action or shall pay all damages, excluding special, consequential damages (INCLUDING DAMAGES FOR LOSS OF PROFITS, DAMAGES TO ANY COMPUTER, DEVICE, OR SYSTEM, LOSS OF DATA, GOODWILL, USE OR OTHER LOSSES), indirect damages, punitive damages, and costs awarded by the court therein and, if the use or resale of such equipment is finally enjoined, we shall at our option, (i) procure for you the right use of the equipment, (ii) replace the equipment with equivalent noninfringing equipment, (iii) modify the equipment so it becomes noninfringing but equivalent, or (iv) remove the equipment and refund the purchase price (if any) less a reasonable allowance for use, damage or obsolescence.

16. THE EXPRESS WARRANTIES SET FORTH IN THIS AGREEMENT ARE THE EXCLUSIVE WARRANTIES GIVEN: WE MAKE NO OTHER WARRANTIES EXPRESS OR IMPLIED, AND SPECIFICALLY MAKE NO WARRANTY OF MERCHANTABILITY, OF FITNESS FOR ANY PARTICULAR PURPOSE, OR THAT THE SOFTWARE IS FREE FROM VIRUSES OR VULNERABILITIES WHICH MAY BE EXPLOITED BY A THIRD PARTY; AND THE EXPRESS WARRANTIES SET FORTH IN THIS AGREEMENT ARE IN LIEU OF ANY SUCH WARRANTIES AND ANY OTHER OBLIGATION OR LIABILITY ON OUR PART.

17. Your remedies set forth herein are exclusive and our liability with respect to any contract, or anything done in connection therewith such as performance or breach thereof, or from the manufacture, sale, delivery, installation, repair or use of any equipment furnished under this contract, whether in contract, in tort, in warranty or otherwise, shall not exceed the price for the equipment or services rendered.

18. It is agreed that after completion of our work, you shall be responsible for ensuring that the operation of any equipment furnished hereunder is periodically inspected. The interval between such inspections shall not be longer than what may be required by the applicable governing safety code.
By accepting delivery of parts incorporating software you agree that the transaction is not a sale of such software but merely a license to use such software solely for operating the unit(s) for which the part was provided, not to copy or let others copy such software for any purpose whatsoever, to keep such software in confidence as a trade secret, and not to transfer possession of such part to others except as a part of a transfer of ownership of the equipment in which such part is installed, provided that you inform us in writing about such ownership transfer and the transferee agrees in writing to abide by the above license terms prior to any such transfer.

19. Our work shall not include the identification, detection, abatement, encapsulation or removal of asbestos, polychlorinated biphenyl (PCB), or products or materials containing asbestos, PCB's or other hazardous substances. In the event we encounter any such product or materials in the course of performing work, we shall have the right to discontinue our work and remove our employees from the project until you have taken the appropriate action to abate, encapsulate or remove such products or materials, and any hazards connected therewith, or until it is determined that no hazard exists (as the case may require). We shall receive an extension of time to complete the work hereunder and compensation for delays encountered as a result of such situation.

20. This Agreement constitutes the entire understanding between the parties regarding the subject matter hereof and may not be modified by any terms on your order form or any other document, and supersedes any prior written or oral communication relating to the same subject. Any amendment or modifications to this Agreement shall not be binding upon either party unless agreed to in writing by an authorized representative of each party. Both parties agree that any form issued by you that contains any terms that are inconsistent with those contained herein shall not modify this Agreement, nor shall it constitute an acceptance of any additional terms.

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KERMIT MOTOR CO., INC.

201 S. Poplar • 432.586.2551 voice • 432.586.5012 fax

Kermit, Texas 79745

INVOICE

Date : 09/14/2020

Winkler County
PO Drawer Y
Kermit , TX 79745

2020 Ford F350 Supercab XL LWB
VIN 1FTX3ATLEE22162
6.7 Diesel, Auto trans, Cloth seat, Power Pkg,
XL Value Pkg, Cruise, Tilt, Running board, Gooseneck Pkg,
Grille Guard, Headache rack, Tool Box

		$42,464.52
	VIT	78.73
	State Inspection	16.75
	Total	$ 42,560.00
Trades:	2005 F150 Reg Cab	-2,300.00
	2005 Chev 3500	-5,700.00
	NET TOTAL	$34,560.00

_____ _____
Date