

T H E C I T Y O F
EDINBURG

REQUEST FOR PROPOSALS

The City of Edinburg is soliciting sealed Request for Proposals; hereinafter referred to as RFP, to be received by the City Secretary's Office located at 415 W. University Drive, Edinburg, Texas 78541. City of Edinburg normal business days are Monday through Friday between the hours of 8:00 a.m. to 5:00 p.m. and shall be closed on recognized holidays.

RFP'S will be received until **3:00 p.m. Central Time**, on **Monday, May 23, 2016**, shortly thereafter all submitted RFP'S will be gathered and taken to the Edinburg City Hall Community Room, 1st Floor, to be publicly opened and read aloud. Any RFP received after the closing time will not be accepted and will be returned to the submitter unopened. It is the responsibility of the submitter to see that any RFP submitted shall have sufficient time to be received by the City Secretary's Office prior to the RFP opening date and time. The receiving time in the City Secretary's Office will be the governing time for acceptability of the RFP's. RFP's will not be accepted by telephone or facsimile machine. All RFP'S must bear original signatures and figures. The RFP shall be for:

RFP #2016-013
GROUP HEALTH INSURANCE COVERAGE

If you have any questions or require additional information regarding this RFP, please contact Ms. Lorena Fuentes, Purchasing Agent, at (956) 388-1895 Ext. 8972 or via email at lfuentes@cityofedinburg.com.

Hand Delivered RFP'S:

415 W. University Drive
C/o City Secretary Department (1st Floor)

If using Land Courier (i.e.FedEx, UPS):

City of Edinburg
C/o City Secretary
415 W. University Drive
Edinburg, Texas 78541

If Mailing Proposals:

City of Edinburg
C/o City Secretary
P.O. Box 1079
Edinburg, Texas 78540-1079

The City of Edinburg reserves the right to refuse and reject any or all RFP's and to waive any or all formalities or technicalities and to accept the RFP deemed most advantageous to the City, and hold the RFP's for a period of **60** days without taking action.

RFP's must be submitted in an envelope sealed with tape and prominently marked on the lower left hand corner of the envelope with corresponding RFP number and title.



Please read your requirements thoroughly and be sure that the RFP offered complies with all requirements/specifications noted. Any variation from the solicitation requirements/specifications must be clearly indicated by letter, on a point by point basis, attached to and made a part of your RFP. If no exceptions are noted, and you are the successful respondent, it will be required that the service(s) be provided as specified.

PURPOSE

(1) The purpose of these solicitation documents is to execute a Professional Services Contract for:

GROUP HEALTH INSURANCE COVERAGE

INTENT

(2) The services to be provided under this RFP shall be in accordance with and shall meet all specifications and/or requirements as shown in this solicitation for RFP. There is no intention to disqualify any respondent who can meet the requirements.

SUBMITTAL OF RFP

(3) RFPs shall be submitted in sealed envelopes as called referenced on the attached solicitation. Three (3) complete sets of the response, One (1) original marked "**ORIGINAL**," and two (2) copies marked "**COPY**". RFPs submitted by facsimile (fax) or electronically shall **NOT** be accepted. Submittal of an RFP in response to this solicitation constitutes an offer by the respondent. Once submitted, RFP's become the property of the City of Edinburg and as such the City reserves the right to use any ideas contained in any RFP regardless of whether that respondent/firm is selected. Submission of a RFP in response to this solicitation, by any respondent, shall indicate that the respondent(s) has/have accepted the conditions contained in the RFP, unless clearly and specifically noted in the RFP submitted and confirmed in the contract between the City and the successful respondent otherwise. RFPs which do not comply with these requirements may be rejected at the option of the City. RFPs must be filed with the City of Edinburg before the deadline day and hour. No late RFPs will be accepted. They will be returned to respondent unopened (if properly identified). Failure to meet RFP requirements may be grounds for disqualification.

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TIME ALLOWED FOR ACTION TAKEN

(4) The City of Edinburg may hold RFP/s 90 days after deadline without taking action. Respondents are required to hold their RFP/s firm for same period of time.

RIGHT TO REJECT/AWARD

(5) The City of Edinburg reserves the right to reject any or all RFPs, to waive any or all formalities or technicalities, and to make such awards of contract as may be deemed to be the best and most advantageous to the City of Edinburg.

ASSIGNMENT

(6) Respondents are advised that the City of Edinburg shall not allow the successful respondent to sell, assign, transfer, or convey any part of any contract resulting from this RFP in whole or in part, to a third party without the written approval of the City of Edinburg.

AWARD

(7) Respondents are advised that the City of Edinburg is soliciting RFPs and award shall be made to the respondent that in the opinion of the City of Edinburg is the best qualified.

NUMBER OF CONTRACTS

(8) THE CITY reserves the right to award one, more than one, or no contract(s) in response to this RFP.

STATUTORY REQUIREMENTS

(9) It shall be the responsibility of the successful respondent to comply with all applicable State & Federal laws, Executive Orders and Municipal Ordinances, and the Rules and Regulations of all authorities having jurisdiction over the work to be performed hereunder and such shall apply to the contract throughout, and that they will be deemed to be included in the contract as though written out in full in the contract documents.

ALTERATIONS/AMENDMENTS TO RFP

(10) RFP **CANNOT** be altered or amended after opening time. Alterations made before opening time must be initiated by respondent guaranteeing authenticity. No RFP may be withdrawn after opening time without acceptable reason in writing and only after approval by the City of Edinburg.

NO RESPONSE TO RFP

(11) If unable to submit a RFP, respondent should return inquiry giving reasons.

LIST OF EXCEPTIONS

(12) The respondent shall attach to his/her RFP a list of any exceptions to the specifications/ requirements.

PAYMENT

(13) The City of Edinburg will execute payment by mail in accordance with the State of Texas Pay Law after SERVICES have been completed, introduced to the City, and found to meet City of Edinburg specifications/requirements. No other method of payment will be considered.

SYNONYM

(14) Where in this solicitation package SERVICES is used, its meaning shall refer to the request for GROUP HEALTH INSURANCE COVERAGE as specified.

RESPONDENT'S EMPLOYEES

(15) Neither the Respondent nor his/her employees engaged in fulfilling the terms and conditions of this Service Contract shall be considered employees of the City. The method and manner of performance of such undertakings shall be under the exclusive control of the vendor on contract. The City shall have the right of

inspection of said undertakings at any time.

INDEMNIFICATION CLAUSE

(16) The Respondent agrees to indemnify and save harmless the City, from all suits and actions of every nature and description brought against them or any of them, for or on account of the use of patented appliances, products or processes, and he shall pay all royalties and charges which are legal and equitable. Evidence of such payment or satisfaction shall be submitted upon request of the Purchasing Agent, as a necessary requirement in connection with the final estimate for payment in which such patented appliance, products or processes are used

INTERPRETATIONS

(17) Any questions concerning the project and/or specifications/requirements with regards to this solicitation for statement(s) of qualifications shall be directed to the designated individuals as outlined in the RFP. Such interpretations, which may affect the eventual outcome of this request for statements of qualifications, shall be furnished in writing to all prospective Respondents via Addendum. No interpretation shall be considered binding unless provided in writing by the City of Edinburg in accordance with paragraph entitled "**Addenda and Modifications**".

VERBAL THREATS

(18) Any threats made to any employee of the City, be it verbal or written, to discontinue the providing of item/material/services for whatever reason and/or reasons shall be considered a breach of contract and the City will immediately sever the contract with the Respondent/Consultant on contract.

CONFIDENTIAL INFORMATION

(19) Any information deemed to be confidential by the respondent should be clearly noted on the pages where confidential information is contained; however, the City cannot guarantee that it will not be compelled to disclose all or part of any public record under Texas Public Information Act, since information deemed to be confidential by the respondent may not be considered confidential under Texas Law, or pursuant to a Court order.

PAST PERFORMANCE

(20) Respondent's past performance shall be taken into consideration in the evaluation of RFP submittal.

JURISDICTION

(21) Contract(s) executed as part of this solicitation shall be subject to and governed under the laws of the State of Texas. Any and all obligations and payments are due and performable and payable in Hidalgo County, Texas.

RIGHT TO AUDIT

(22) The City of Edinburg reserves the right to audit the vendor's books and records relating to the performance of this contract. The City of Edinburg, at its own expense, shall have the right at all reasonable times during normal business hours and upon at least twenty-four (24) hours' advance notice, to audit, to examine, and to make copies of or extracts from the books of account and records maintained by the vendor(s) with respect to the Supply/Service and/or Purchase Contract. If such audit shall disclose overpayment by City to vendor, written notice of such overpayment shall be provided to the vendor and the amount of overpayment shall be promptly reimbursed by vendor to the City. In the event any such overpayment is not paid within ten (10) business days after receipt of such notice, the unpaid amount of such

overpayment shall bear interest at the rate of one percent (1%) per month from the date of such notice until paid.

VENUE

(23) The parties agree that venue for purposes of any and all lawsuits, cause of action, arbitration, and/or any other dispute(s) shall be in Hidalgo County, Texas.

IF YOU HAVE ANY QUESTIONS ABOUT COMPLIANCE, PLEASE CONSULT YOUR OWN LEGAL COUNSEL. COMPLIANCE IS THE INDIVIDUAL RESPONSIBILITY OF EACH PERSON OR AGENT OF A PERSON WHO IS SUBJECT TO THE FILING REQUIREMENT. AN OFFENSE UNDER CHAPTER 176 IS A CLASS "C" MISDEMEANOR.

CONFLICT OF INTEREST

(24) CHAPTER 176 OF THE TEXAS LOCAL GOVERNMENT CODE Effective January 1, 2006, Chapter 176 of the Texas Local Government Code requires that any vendor or person considering doing business with a local government entity disclose in the Questionnaire Form CIQ, the vendor or person's affiliation or business relationship that might cause a conflict of interest with a local government entity. By law, this questionnaire must be filed with the records administrator of the City of Edinburg not later than the 7th business day after the date the person becomes aware of facts that require the statement be filed. See Section 176.006, Local Government Code. A person commits an offense if the person violates Section 176.006, Local Government Code. An offense under this section is a Class C misdemeanor. For more information or to obtain Questionnaire CIQ visit the Texas Ethics Commission web page at www.ethics.state.tx.us/forms/CIQ.pdf.

CERTIFICATE OF INTERESTED PARTIES (Form 1295)

(25) In 2015, the Texas Legislature adopted House Bill 1295, which added section 2252.908 of the Government Code. The law states that a governmental entity or state agency may not enter into certain contracts with a business entity unless the business entity submits a disclosure of interested parties to the governmental entity or state agency at the time the business entity submits the signed contract to the governmental entity or state agency. The law applies only to a contract of a governmental entity or state agency that either (1) requires an action or vote by the governing body of the entity or agency before the contract may be signed or (2) has a value of at least \$1 million. The disclosure requirement applies to a contract entered into on or after January 1, 2016. For more information go to the Texas Ethics Commission web page at www.ethics.state.tx.us/forms/CIQ.pdf.

CONSIDERATION OF LOCATION OF BIDDER'S PRINCIPAL PLACE OF BUSINESS

(26) The City may give local vendors, whose principal place of business is located within the City of Edinburg, and whose bid is within five percent (5%) of the lowest bid price preference as allowed by Section 271.9051 of the Local Government Code.

CONFIDENTIALITY OF INFORMATION AND SECURITY

(27) Should the successful respondent become the holder of and have access to confidential information in the process of fulfilling its responsibilities in connection with an awarded contract the successful respondent agrees that it shall keep such information confidential and will comply fully with the laws and regulations of the State of Texas, ordinances and regulations of the City, and any applicable federal laws and regulations relating to confidentiality.

TERMINATION OF CONTRACT

(28) The City of Edinburg reserves the right to terminate the contract if, in the opinion of the City of Edinburg, the successful vendor's performance is not acceptable, no funds are available, or if the City wishes, without cause, to discontinue this contract. Termination will be in written form allowing a 30-day notice.

RESPONSE DEADLINE

(29) Responses to the RFP must be addressed to City Secretary, City of Edinburg, 415 W. University Drive by **Monday, May 23, 2016 until 3:00 p.m.** for consideration. An original and three (3) complete sets of the response must be submitted no later than this date and time in a **sealed envelope** indicating that its contents are in response to the **RFP 2016-013 for "GROUP HEALTH INSURANCE COVERAGE"**. **Respondents are advised that all confidential records must be submitted in a separate sealed envelope and marked accordingly.**

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c/o City Secretary
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Edinburg, Texas 78540-1079

ADDENDA AND MODIFICATIONS

(30) Any changes, additions, or clarifications to the RFP are made by amendments (addenda). Any respondent in doubt as to the true meaning of any part of the RFP or other documents may request an interpretation from the Purchasing Division. At the request of the respondent, or in the event the Purchasing Division deems the interpretation to be substantive, the interpretation will be made by written addendum. Said Addenda shall be mailed, e-mailed, hand delivered and/or faxed, to all prospective respondents. All Addenda issued in respect to this RFP shall be considered official changes to the original documents. Verbal statements in response to inquiries and/or requests for explanations shall not be authoritative or binding. It shall be the respondent's responsibility to ensure that they have received all Addenda in respect to this project. Furthermore, respondents are advised that they must recognize, comply with, and attach a signed copy of each Addendum which shall be made part of their RFP Submittal. Respondent(s) signature on Addenda shall be interpreted as the respondent's "recognition and compliance to" official changes as outlined by the City of Edinburg and as such are made part of the original solicitation documents. Failure of any respondent to receive any such addendum or interpretation shall not relieve such respondent from its terms and requirements. The City may issue a written addendum no later than five calendar days prior to the date bids must be received. Addendums are available online at www.cityofedinburg.com.

RFP PREPARATION COSTS

(31) The City of Edinburg shall not be held liable for any costs incurred by any respondent for work performed in the preparation of and production of a RFP or for any work performed prior to execution of contract.

EQUAL EMPLOYMENT OPPORTUNITY

(32) Respondent agrees that they will not discriminate in hiring, promotion, treatment, or other terms and conditions of employment based on race, sex, national origin, age, disability, or in any way violate Title VII of 1964 Civil Rights Act and amendments, except as permitted by said laws.

AUTHORIZATION TO BIND RESPONDENT TO RFP

(33) RFPs MUST give full firm name and address of respondent, and be manually signed. Failure to do so will disqualify your RFP. Person signing bid must show title or AUTHORITY TO BIND HIS/HER FIRM IN A CONTRACT. Firm name and authorized signature must appear on each page that calls for this information. The legal status of the Respondent whether corporation, partnership, or individual, shall also be stated in the RFP. A corporation shall execute the RFP by its duly authorized officers in accordance with its corporate by-laws and shall also list the state in which it is incorporated. A partnership Respondent shall give full names and addresses of all partners. All partners shall execute the RFP. Partnership and Individual Respondent shall state in the proposal the names and addresses of all persons with a vested interest therein. The place of residence of each Respondent, or the office address in the case of a firm or company, with county and state and telephone number, shall be given after the signature.

Confidential Information Respondents are advised that all confidential records must be submitted in a separate sealed envelope and marked accordingly.



Request for Proposals

Group Health Insurance Coverage

RFP # 2013-013





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REQUEST FOR PROPOSALS

Specifications and Underwriting Information

Group Health Insurance Coverage

1. Proposal may be submitted Monday thru Friday, 8:00 a.m. - 5:00 p.m. to the City Secretary office at address below. Sealed proposals shall be received **by 3:00 p.m., Monday, May 23, 2016** at the office of the City Secretary, at which time all proposals will be publicly opened. Proposals received after the deadline will be returned to sender unopened. The City of Edinburg is not responsible for problems with postal or delivery service.
2. Submit three complete sets, one (1) marked "**ORIGINAL**", and two (2) marked "**COPY**". Sealed proposals shall be received and addressed to:

**CITY OF EDINBURG
c/o City Secretary
415 West University
P. O. Box 1079
Edinburg, Texas 78540-1079**

The envelope shall be clearly identified as follows:

**Group Health Insurance Coverage
RFP # 2016 - 013**

Proposal submitted via facsimile or e-mail **shall not** be accepted. All inquiries can be addressed to Lorena Fuentes, Purchasing Agent at lfuentes@cityofedinburg.com.

3. Due care and diligence has been used in the preparation of this information, and it is believed to be substantially correct. However, the responsibility for determining the full extent of the exposure and verification of all information presented herein shall rest solely upon the proposer.

The City of Edinburg and its representatives will not be responsible for any errors or omissions in these specifications nor for the failure on the part of the proposer to determine the full extent of the exposures.

4. The City of Edinburg reserves the right to renegotiate the term of this coverage. The City of Edinburg shall reserve the right to renew (annually)

the contract with the selected proposer, provided that proof is shown that said insurance carrier is providing the lowest possible rate at time of renewal. **Tentative award date is Tuesday, July 05, 2016.**

5. The City of Edinburg expressly reserves the right to reject any or all proposals, or waive any formalities in any proposal, in its own best interest and also hold the proposals for a period of ninety (90) days after publicly opening the proposal without taking action thereon. The City intends to review all aspects of the proposals to determine the best overall program for the City at this time. Since there are important considerations involved in selecting a carrier in addition to rates, the City will not be required to accept the lowest proposal. Failure to manually **sign** proposal will disqualify it. Person signing proposal should show title or authority to bind their firm to a contract.
6. All rates shall be guaranteed for twelve (12) months, or longer, to be billed beginning October 1, 2016. However, the City of Edinburg reserves the right to accept a guarantee of more than twelve (12) months if it is in the City's interest.
7. The company shall reference its proposal in the same order as provided in the specifications. Any company seeking to provide or underwrite insured programs for the City of Edinburg must respond to appropriate sections of these specifications and must meet all conditions or standards listed in these specifications.
8. The City of Edinburg has named RJG Retirement Services, LLC and Holmes Murphy as agent of record and co-agent respectively.
9. The City of Edinburg, hereafter referred to as the "Planholder", is requesting proposals for Group Health Insurance Coverage.

FIRM and RFP EVALUATION

RFP – EVALUATION

The evaluation system consists of a **100 point system**. The RFP will be ranked after evaluation. The RFP submittal evaluation will be based on the following criteria:

1. **35 points** Health Plan Coverage & Rates
2. **15 points** Provider Network and Utilization Management
3. **15 points** Responses to Proposal & Questions
4. **35 points** Points- Technical & Price Total

PROPOSAL FORMAT

Tab A: Interest Letter

Tab B: Part I – Qualifications of Proposers

Tab C: Part II – Description of the Risk

Tab D: Part III – Administration of Claims

Tab E: Part IV – Census Data Overview

Tab F: Part V – Exhibit of Past Premiums and Losses

Tab G: Part VI – Request for Proposal Form

Tab H: Cost Proposal – Fully Insured [PPO/PPN] Plan

Tab J: 1. Request for Proposal Response Form
2. Certification Statement
3. Non-Collusive Request for Proposal Certificate
4. References
5. Terminations
6. Declaration of Compliance

Part I

QUALIFICATIONS OF PROPOSER

Please read carefully. The Planholder is not required to consider any proposal that does not comply with the criteria set forth herein. All proposers **shall utilize** the “Request for Proposal Form” provided in this specification packet - Part VI (pages 10-36).

1. All companies and agents submitting proposals must be licensed by the State of Texas, have a demonstrated level of good performance with public entities, including municipalities, and be permitted to contract with the State or any of its subdivisions.
2. The agent must have an errors and omissions policy with a minimum limit of \$500,000. **A copy of policy shall be furnished with your proposal.**
3. It is preferred that companies be recommended in the latest editions of “Best’s Insurance Reports” with a general policyholder’s rating of at least an “B+”, or in the case of casualty companies have a rating of at least an “B+” in the latest annual editions of “Best’s Key Rating Guide”. **The agent shall furnish A. M. Best’s Policyholder Rating for each company with which coverage is being quoted.**
4. Any agent or agency submitting a proposal must be licensed by the carrier stipulated therein at the time it is submitted.
5. The company must provide group plans structured to meet Affordable Care Act (ACA) and COBRA guidelines if applicable. All proposals must comply with Federal Health Insurance Portability and Accountability Act (HIPAA). All proposers must comply with federal, state, and local insurance laws and regulations in the preparation and submission of insurance proposals. Specifically, services provided must be in compliance with the Americans Disability Act (ADA) and Texas Insurance Regulations and Laws. All proposals submitted will be presumed to be in compliance with all applicable laws.
6. The company will conduct one initial enrollment and an annual enrollment thereafter, depending on renewal status. Open enrollment is planned for August 2016.
7. Planholder Responsibility: Will provide for payroll deductions of premiums and advise the carrier of additions/deletions from the coverage; will assist in the logistics of the enrollment process and annual enrollment; and, will ensure that enrollment applications are completed and processed

accordingly.

8. Selected Carriers Responsibility: The carrier will provide employee booklets outlining the benefits and instructions on filing a claim, identification cards, enrollment and orientation materials, and other appropriate communication materials deemed necessary by the Planholder each plan year. Selected carrier is liable for all claims incurred as of the effective date through the termination date. The carrier will provide the following quarterly claim reports:

- a. Summary of Paid Medical and Prescription Claims,
 - b. Variance of Current Benefits with Submitted Benefits,
 - c. And upon request of the Planholder, furnish a Summary of Claims in excess of \$10,000, including diagnoses and prognosis,
 - d. Average claim turn around time,
 - e. Telephone abandonment rate,
 - f. Telephone average on hold time,
 - g. Customer Service Accuracy for Benefit Eligibility and Verification,
 - h. Claims Financial Accuracy,
 - i. Claims Procedural Accuracy,
 - j. Average Network Discounts for the most current twelve (12) months,
 - k. Formula for Calculating Discounts, and,
 - a) Billed Charges,
 - b) Eligible Plan Charges, and
 - c) Discount includes discount calculation after stop loss provision.
 - l. Provider Network Directory.
9. The Selected Carrier will describe their Medical Management Services including:
- a. Utilization Review,
 - b. Concurrent Review,
 - c. Large Case Management,
 - d. Transplant Management,
 - e. Discharge Planning, and,
 - f. Disease Management.

10. The company will be responsible for providing the Planholder with a monthly itemized billing statement, which should include the following:
- a. Full name of covered individual,
 - b. Type of coverage elected by each individual,

- c. Total premium (by individual),
- d. Invoice total (by department),
- e. Planholder total (total premiums for all covered individuals), and,
- f. Number of enrollees (include in each invoice and sort by the type of coverage).

- 11.** All proposed policies must be non-assessable.
- 12.** The Planholder prefers a wellness program for its covered members. Please provide details of the program to be provided.
- 13.** Flu Shots are currently being provided to City employees, retirees, elected official, Chamber of Commerce, EEDC and Boys & Girls Club during the Fall Season. The Planholder would like to continue this service, confirm available through your plan.

Part II

DESCRIPTION OF THE RISK

1. NAME OF INSURED:

City of Edinburg, Texas

2. EFFECTIVE DATE:

October 1, 2016

3. TERMS:

October 1, 2016 through September 30, 2017

For a period of two (2) year contract with option to extend for two (2) additional one (1) year term.

4. It is the intent of these specifications to establish a Fully Insured (PPO) Plan contract with proposer for the following employee and dependent(s) benefits:

a. Hospital

b. Medical

5. The Planholder pays 100% of health coverage for full-time equivalent employees, as outlined by the Affordable Care Act, retirees (through age 65), as well as elected officials. In addition, a percentage of dependent health coverage is paid by the Planholder, as approved by the Mayor and City Council. Employees, retirees, and elected official pay the difference of the dependent health coverage. In addition, Planholder also provided group insurance coverage to employees of intergovernmental agencies currently the Boys & Girls Club, Economic Development Corporation and Edinburg Chamber of Commerce.

6. MEDICAL AND PRESCRIPITON DRUG BENEFITS AND SERVICES: Refer to Exhibit E.

Part III

ADMINISTRATION OF CLAIMS

1. Proposer will act as a third party claims administrator or contractual claims administrator, for the express purpose of administering the Planholders Benefit Plan.

The proposer will be responsible for, but not limited to the following:

- a. Consulting and Installation of the Plan. Reviewing carrier policies to assure they meet specifications.
- b. Drafting of the Plan Document or Master Contract and announcement material.
- c. Printing and mailing of ID Cards and Employee Booklets directly to each employees mailing address. Employee plan booklets must be available no later than October 1, 2016.
- d. Coordination with other plans for benefits. The Proposer will be responsible for coordination of benefits with all employed spouses' group insurance plans or other collectible insurance and will furnish an annual list of those claims put aside awaiting coordination of benefits.
- e. The proposer will analyze all statistical data for future cost projections. Periodic meetings will be held to advise Planholder staff on these projections.
- f. Original contracts for all carriers will be filed with the City of Edinburg.
- g. Processing and payment of all claims within ten (10) days of receipt from employees, hospital, or doctor.
- h. Proposals must include an agreement to furnish monthly reports of all paid claims showing plan year to date amount paid, lag report that indicates incurred date and payments for claims of \$10,000 or more, nature summary, etc. These reports must be furnished within fifteen (15) days of the end of each previous quarterly period.
- h. The proposer will honor and assist in administering any discount plan, which the Planholder has arranged with the Rio Grande Valley Area.

j. Processing and payment of administrative fees and premiums will be done on a monthly basis.

k. Necessary Government Filings.

Part IV

CENSUS DATA OVERVIEW

Number of full-time employees employed as of March 2016 is seven hundred twelve (712), sixty three (63) retirees, zero (0) COBRA, five (5) elected officials, four (4) Chamber of Commerce, six (6) EEDC, and eleven (11) Boys & Girls Club (included in employee census). There are seven hundred seventy six (776) authorized full-time permanent City positions for Fiscal Year 2015-2016. See exhibit A–City of Edinburg Group Census.

a. Age Distribution (5 year brackets):

AGE GROUP	FULL-TIME EMPLOYEES	RETIREEES	COBRA	ELECTED OFFICIALS/ CHAMBER
18 – 23	18			
24 – 29	107			
30 – 35	139			2
36 – 41	115	1		2
42 – 47	123	1		1
48 – 53	100	14		3
54 – 59	73	19		
60 – 65	42	28		
Over 65	12	0		1
Totals	729	63	0	9

b. Gender:

	FULL-TIME EMPLOYEES	RETIREEES	COBRA	ELECTED OFFICIALS/ CHAMBER
Male	544	53		7
Female	185	13		2
Totals	729	63	0	9

Part V

EXHIBIT OF PAST PREMIUMS AND LOSSES

The current plan year is October 1 - September 30, in order to coincide with the Planholders fiscal year. Humana is currently providing the Planholder with Group Health Benefits.

CURRENT AND PRIOR HEALTH INSURANCE CARRIERS/PROVIDERS

10/2013 – Present	Humana
10/2012 – 09/2013	Valley Baptist Health Plans
10/2008 – 09/2012	BlueCross BlueShield
09/1999 – 09/2008	Texas Municipal League - IEBP
10/1998 – 08/1999	Certus HealthCare, L.L.C.

a. History of Health Insurance Premium Rates (Employee/Elected Officials & COBRA participants)

NO. OF EMPLOYEES	EFFECTIVE DATE	EMPLOYEE ONLY RATE	EMPLOYEE & CHILD(REN)	EMPLOYEE & SPOUSE	EMPLOYEE & FAMILY
716	10/01/2011	\$297.95	\$505.43	\$787.48	\$902.03
726	10/01/2012	\$340.35	\$577.35	\$899.53	\$1,030.38
721	10/01/2013	\$364.53	\$618.36	\$961.93	\$1,103.59
748	10/01/2014	\$364.53	\$618.36	\$961.93	\$1,103.59
738	10/01/2015	\$382.54	\$648.90	\$1,009.45	\$1,158.14

b. History of Health Insurance Premium Rates (Retirees)

NO. OF RETIREES	EFFECTIVE DATE	RETIREE ONLY RATE	RETIREE & CHILD(REN)	RETIREE & SPOUSE	RETIREE & FAMILY
54	10/01/2011	\$551.21	\$935.02	\$1,453.32	\$1,668.76
54	10/01/2012	\$629.64	\$1,068.06	\$1,660.10	\$1,906.20
59	10/01/2013	\$674.38	\$1,143.95	\$1,779.55	\$2,041.61
57	10/01/2014	\$674.38	\$1,143.95	\$1,779.55	\$2,041.61
63	10/01/2015	\$707.69	\$1,200.45	\$1,867.45	\$2,142.53

c. Distribution by Type of Coverage

Health Insurance Coverage

F/T Employees, Chamber of Commerce
EEDC, Boys and Girls Club, Elected
Officials, COBRA, and Retirees

Employee Only	461
Employee & Child(ren)	153
Employee & Spouse	46
Employee & Family	<u>69</u>
Total	729

SUMMARY TOTALS

(Above summary totals include the following:)

Total COBRA	0
Total Retirees	63
Total Elected Officials	5
Chamber of Commerce	<u>4</u>
	72

Total Health **801**

Part VI

REQUEST FOR PROPOSAL FORM

ONLY THOSE PROPOSALS SUBMITTED ON THIS FORM AND IN DUPLICATE WILL BE CONSIDERED. ALL OTHERS WILL BE REJECTED AND DISQUALIFIED.

This form must include **ALL COSTS OF THE PROGRAM**. This should include fixed costs, prescription plan, cost containment options, and all printing expenses and miscellaneous expenses. The costs should be quoted per monthly charge.

All costs must be shown at the time of the proposal. We reserve the right to get written clarification of any benefits you propose.

The Planholder is interested in determining the cost or savings related to various changes in plan coverage. After quoting rates to duplicate proposed benefits, please provide the cost or savings related to changes in coverage as a rate change to the base monthly rates.

Program Information

1. What is your company's most current "A M Best Policyholder Rating"?

2. What is your customer quality service statistics for the most recent twelve (12) month period?

3. On the provided form, for reference purposes, a list of at least three (3) governmental entities or clients served in Texas by your company shall be completed along with proposal. List shall include, but not be limited to, name of contact person, telephone number, number of employees, and how long the entity/client was/is contracted by the company.

4. (a) How many open complaints are on file against your company with the Texas Department of Insurance?

(b) How many complaints were filed with the Texas Department of Insurance during the past two (2) years?

5. Is your company currently involved in any litigation as a defendant over any benefits or services being proposed in response to this Proposal? _____ if yes, please provide a brief description of each suit and the amount involved.

6. Do you have a toll free telephone number for handling inquiries from staff and employees? If so, is there an additional charge? Is there an assigned claims representative for the Planholder?

7. What procedures have you implemented to become compliant with HIPAA, Title H Privacy/ Confidentiality and Security requirements?

8. Define process to transition from social security numbers to unique identification numbers.

9. What are the pre-certification requirements?

10. Will you honor deductibles that have been satisfied for the current calendar year and what evidence would employees need to furnish?

11. Will you provide the administration of Continuation of

Coverage?

12. Please explain if there are any additional fees for Continuation of Coverage administration do you offer direct billing to the Continuation of Coverage?

13. Will all new full-time employees qualify for full coverage automatically or will they be subject to underwriting conditions?

14. Will the initial enrollment period for new employees be effective immediately after or within 30 - 60 days? The city does not currently have a waiting period for new employees.

15. Will your company provide on-site enrollment assistance? If yes, is there a charge?

16. Does your company provide on-line enrollment? Is there a cost? Does your company provide run-in and run-out claims payment services?

17. Do you provide, to the employer and to the employee, an explanation of benefits? If so, in what form and how often?

18. Is the cost of providing employee booklets and identification

cards included in the quoted rate? If no, what is the additional charge?

19. Is self-billing an option? If so, will there be a billing contact person assigned to the city? Explain how the discrepancies are handled or corrected?

20. How do you establish "usual and customary" or "reasonable and customary"? What provider services are limited to reasonable and customary charges?

21. Do you have a preferred lab program? How are lab benefits paid?

22. Please attach your Preferred Provider Directory.

23. Please list your participating hospitals surrounding the City of Edinburg.

24. What are the average negotiated discounts for hospital and outpatient services in this metropolitan area? Please ensure the average percentage of discount does not include savings due to no payment for non-eligible benefits and claims in excess of reasonable & customary. Please define your formula for discount calculation regarding: billed charges, eligible plan charges, out of pocket, or other insurance charges; and do the discounts reflect payment made after provider stop loss provision met?

25. Do you agree to a no-loss/no-gain takeover on all benefits for all employees (continuation of coverage to retirees, council, or governing body) and dependents?

26. What benefits do you offer for preventive wellness?

27. Do you have a wellness program? How do you encourage members to take advantage of your preventive wellness benefit(s)? Please describe program and how do you encourage participation?

28. Is Medical Management, including on-site wellness programs, Health Risk Assessment, Utilization Review, Concurrent Review, Discharge Planning, Disease Management, and Large Case Management included in your proposal? If yes, briefly describe the process, including who has the authority to deny an admission.

a) What is the procedure to provide Health Risk Assessments to covered individuals?

b) Do you provide Medical Management Services? If so, please describe.

c) Do you provide Disease Management Services? If so, please describe.

d) Do you provide Large Case Management Services? If so, please describe.

29. Describe the integration of the previously mentioned Medical Management information.

30. Do your plans cover morbid obesity treatment benefits?

31. Do you have a schedule of mandatory second opinions? If yes, please include your schedule.

32. Does your plan cover any over-the-counter medications? If so, which and at what cost?

33. Identify how many non over-the-counter prescriptions are on the maximum allowable charge list.

34. Identify any prescriptions that require prior authorization. Identify any prescriptions that have a monthly or calendar year cap.

35. Identify if the pharmacy benefit manager requires step therapy intervention.

36. Are injectable prescriptions available through the pharmacy benefit manager?

37. Identify any prescriptions that have an age cap.

38. Identify prescriptions that are excluded from plan.

39. Does the mail order program substitute prescriptions if provider does not document "dispense as written"? If so, how is employee notified?

40. Are rebate programs available through the Pharmacy Benefit Manager? If so, explain.

41. Please describe how your organization will assist with GASB requirements over the next three (3) years.

42. Will your company direct bill retirees for department coverage and Continuation of Coverage participants? _____ if yes, is there an additional charge?

43. Do you require a claim form to be completed by the employee, doctor, and/or hospital? (If applicable, please provide a sample of form.)

44. Who will process the claims and where are your claims paying service located?

45. Describe claim payment system.

46. Describe your procedures for handling appeals of denied or disputed claims?

47. How do you define turn around time? Provide claim turnaround time statistics for the most recent twelve (12) month period

48. Is the claim system integrated with Medical Management, Billing, Eligibility, Customer Service, Disease Management, and Flex?

49. How promptly are referrals processed after you receive requests from primary care providers? (hrs./days)

50. Does your company provide professional negotiation services for non-network providers?

51. Does your company use usual and customary for physician, ancillary, and facility claims? For out-of- network claims?

52. Does your company access a supplemental network for out of

network claims?

53. Does your plan coordinate benefits? Specify.

54. Specify what guidelines your processors are required to follow to identify potential coordination for benefits cases, and describe your procedures for handling these claims.

55. Do you provide an on-line customer service and claim status look up program?

56. How promptly are payments made after you receive requests for payment of bills?

57. Do you provide a monthly statement of all payments? How is the statement provided?

58. What kind of reports regarding loss ratio or claims paid vs. premiums may we expect and in what time period?

59. What is your company process for collecting provider overpayments?

60. Do the health rates include IBNR (Incurred but not reported) reserves? _____ If no, what are your company's procedures for developing IBNR reserves for the renewal?

61. Will your carrier provide a service representative for the group? What services are included?

62. Are there additional administrative fee(s), and if so how much? How long are administrative fee(s) guaranteed? (Include a sample of administrative document.)

63. What is your time frame for providing renewal rates to the Planholder?

64. What percent of revenue is your company's operating expense?

65. Provide abandonment rate statistics for the most recent twelve (12) month period.

66. If your contract is terminated at the end of the contract year, how long will you continue to pay claims incurred prior to the termination date?

67. Upon termination, will you release last twelve (12) months of Claims History and Benefits Accumulator information?

68. Upon termination, will you release a list of paid claims, diagnosis, and prognosis in excess of \$10,000 for last twelve (12) months claims history?

69. Does your company offer a flexible spending account (FSA) benefit? If so, please define the program and include covered benefits. Is the flexible spending account paper or debit?

70. Does your quote include a waiver of premium, if applicable?

71. Are your rates guaranteed or subject to final enrollment?

72. Are the rates your company quoted guaranteed for twelve (12) months?

73. What are your average increases for groups over 500 for the last one (1) year, three (3) years, and five (5) years?

FULLY INSURED (PPO/PPN) PLAN

ONLY THOSE PROPOSALS SUBMITTED ON THIS FORM AND IN DUPLICATE WILL BE CONSIDERED. ALL OTHERS WILL BE REJECTED AND DISQUALIFIED.

1. ADMINISTRATION COSTS:

	<u>Per Participant</u>	<u>Per Month</u>
1. Claims Administration	_____	_____
2. Plan Document or Master Contract	_____	_____
3. Printing (Booklets, ID Cards, Forms)	_____	_____
4. Set-up costs	_____	_____
5. Consulting & Claims Liaison	_____	_____
6. Broker Fee or Commission	_____	_____
7. Taxes	_____	_____
8. COBRA Administration	_____	_____
9. Pre-certification/Pre-admission	_____	_____
10. Second Surgical Opinion	_____	_____
11. Discount program with hospitals and pharmacies	_____	_____

12. Total Costs ===== =====

13. Other Costs (Explain below.)

14. Are set up fees a one time cost?
Explain:

15. What is the cost to administer run-in claims (Incurred during past carrier's coverage)?

2. HEALTH PLAN COSTS:

Current Out-of-Pocket limits \$6,000 deductible at \$2,000 per individual

HEALTH INSURANCE BENEFITS

EMPLOYEE, EEDC, BOYS & GIRLS CLUB HEALTH INSURANCE BENEFITS

Health Only	Rate	No. of Emp.	Monthly Cost	(x12)	Annual Cost
Employee Only	_____	X 461 =	_____	X 12 =	_____
Employee & Child(ren)	_____	X 153 =	_____	X 12 =	_____
Employee & Spouse	_____	X 46 =	_____	X 12 =	_____
Employee & Family	_____	X 69 =	_____	X 12 =	_____
TOTAL					_____

RETIREE HEALTH INSURANCE BENEFITS

Health Only	Rate	No. of Emp.	Monthly Cost	(x12)	Annual Cost
Retiree Only	_____	X 62 =	_____	X 12 =	_____
Retiree & Child(ren)	_____	X 1 =	_____	X 12 =	_____
Retiree & Spouse	_____	X 0 =	_____	X 12 =	_____
Retiree & Family	_____	X 0 =	_____	X 12 =	_____
TOTAL					_____

CHAMBER/ELECTED/COBRA OFFICIAL HEALTH INSURANCE BENEFITS

Health Only	Rate	No. of Emp.	Monthly Cost	(x12)	Annual Cost
Participant Only	_____	X 3 =	_____	X 12 =	_____
Participant & Child(ren)	_____	X 1 =	_____	X 12 =	_____
Participant & Spouse	_____	X 0 =	_____	X 12 =	_____
Participant & Family	_____	X 5 =	_____	X 12 =	_____
TOTAL					_____

Name of Excess Insurance Carrier: _____

Rating: _____

Any Contingency? _____

DEVIATIONS:

Indicate any deviations or qualifications of the proposed plan.

Show example of rates and plan design and minimum participation requirements. Attach additional documentation if necessary.

RECOMMENDED CHANGES TO HEALTH INSURANCE PLAN:

**RECOMMENDED CHANGES TO LAB CARD PROGRAM
(Simplify/clarify present program):**

RECOMMENDATION REGARDING COVERAGE FOR RETIREES AND THEIR DEPENDENTS:

HEALTH INSURANCE ALTERNATE PROPOSAL #1

This alternate proposal should include the following benefit change:
 Out of pocket limits _____ with contract year deductible of _____
 (currently have limit of 2,000 per individual)

EMPLOYEE, EEDC, AND BOYS & GRILS CLUB HEALTH INSURANCE BENEFITS

Health Only	Rate	No. of Emp.	Monthly Cost	(x12)	Annual Cost
Employee Only	_____	X 461 =	_____	X 12 =	_____
Employee & Child(ren)	_____	X 153 =	_____	X 12 =	_____
Employee & Spouse	_____	X 46 =	_____	X 12 =	_____
Employee & Family	_____	X 69 =	_____	X 12 =	_____
TOTAL					_____

RETIREE HEALTH INSURANCE BENEFITS

Health Only	Rate	No. of Emp.	Monthly Cost	(x12)	Annual Cost
Retiree Only	_____	X 62 =	_____	X 12 =	_____
Retiree & Child(ren)	_____	X 1 =	_____	X 12 =	_____
Retiree & Spouse	_____	X 0 =	_____	X 12 =	_____
Retiree & Family	_____	X 0 =	_____	X 12 =	_____
TOTAL					_____

CHAMBER/ELECTED/COBRA OFFICIAL HEALTH INSURANCE BENEFITS

Health Only	Rate	No. of Emp.	Monthly Cost	(x12)	Annual Cost
Participant Only	_____	X 3 =	_____	X 12 =	_____
Participant & Child(ren)	_____	X 1 =	_____	X 12 =	_____
Participant & Spouse	_____	X 0 =	_____	X 12 =	_____
Participant & Family	_____	X 5 =	_____	X 12 =	_____
TOTAL					_____

HEALTH INSURANCE ALTERNATE PROPOSAL #2

This alternate proposal should include the following benefit change:
 Out-of-Pocket Limits _____ with contract year deductible of _____.

EMPLOYEE, EEDC, BOYS & GIRLS CLUB HEALTH INSURANCE BENEFITS

Health Only	Rate	No. of Emp.	Monthly Cost	(x12)	Annual Cost
Employee Only	_____	X 461 =	_____	X 12 =	_____
Employee & Child(ren)	_____	X 153 =	_____	X 12 =	_____
Employee & Spouse	_____	X 46 =	_____	X 12 =	_____
Employee & Family	_____	X 69 =	_____	X 12 =	_____
TOTAL					_____

RETIREE HEALTH INSURANCE BENEFITS

Health Only	Rate	No. of Emp.	Monthly Cost	(x12)	Annual Cost
Retiree Only	_____	X 62 =	_____	X 12 =	_____
Retiree & Child(ren)	_____	X 1 =	_____	X 12 =	_____
Retiree & Spouse	_____	X 0 =	_____	X 12 =	_____
Retiree & Family	_____	X 0 =	_____	X 12 =	_____
TOTAL					_____

CHAMBER/ELECTED/COBRA OFFICIAL HEALTH INSURANCE BENEFITS

Health Only	Rate	No. of Emp.	Monthly Cost	(x12)	Annual Cost
Participant Only	_____	X 3 =	_____	X 12 =	_____
Participant & Child(ren)	_____	X 1 =	_____	X 12 =	_____
Participant & Spouse	_____	X 0 =	_____	X 12 =	_____
Participant & Family	_____	X 5 =	_____	X 12 =	_____
TOTAL					_____

HEALTH INSURANCE ALTERNATE PROPOSAL #3 TIER PROPOSAL

This alternate proposal should include the following benefit change:
 Out-of-Pocket Limits _____ with contract year deductible of _____.

3. FEATURES TO PROPOSED PLAN(S):

4. COST/SAVINGS RECOMMENDATIONS:

The Planholder is interested in determining the cost or savings related to various changes in plan coverage. After quoting rates to duplicate proposed benefits, please provide the cost or savings related to changes in coverage as a rate change to the base monthly rates.

5. FEATURES TO PROPOSED PLAN(S):

**REQUEST FOR PROPOSAL RESPONSE FORM
GROUP HEALTH INSURANCE COVERAGE**

Name of Company/Organization: _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Person: _____

Telephone#: _____ Facsimile#: _____

Current "A.M. Best" Rating: _____

*(Shall furnish copy of policyholder rating for each company
with which coverage is being quoted)*

Name of Agent: _____

Address: _____

City: _____ State: _____ Zip: _____

Agency Name: _____

Telephone #: _____ Facsimile#: _____

Number of Years in Business: _____

(Must enclose E & O Certificate of Insurance)

IMPORTANT:

In order for your proposal to receive consideration, you must complete the certification statement below acknowledging that you have full knowledge of the requirements for providing insurance programs to the City of Edinburg.

CERTIFICATION STATEMENT

The undersigned does hereby declare that they have read the specifications for the Group Health Insurance Coverage and with full knowledge for the requirements, does hereby agree to furnish the coverage in full accordance with the specifications and requirements.

I certify that _____ and its response
(Name of Company/Organization)
complies with these specifications.

Authorized Signature

Type/Print Name

Title

Date

NON-COLLUSIVE REQUEST FOR PROPOSAL CERTIFICATE

By submission of this proposal, the PROPOSER certifies that:

- (a) This proposal has been independently arrived at without collusion with any other proposer, or with any competitor;
- (b) This proposal has not been knowingly disclosed and will not be knowingly disclosed, prior to the opening of the proposals for this project, to any other proposer, competitor, or potential competitor;
- (c) No attempt has been or will be made to induce any other person, partnership or corporation to submit or not to submit a proposal; and
- (d) The person signing this proposal certifies that he/she has fully informed himself/herself regarding the accuracy of the statements contained in this certification, and under the penalties being applicable to the proposer as well as to the person signing in its behalf.

Authorized Signature

Type/Print Name

Title

Name of Company/Organization

Date

REFERENCES

Please provide the Planholder with three (3) municipality references that have been insured with your company for at least three (3) years and are similar in size as City of Edinburg.

Company Name: _____

Name of Proposer: _____

Contact Person: _____ Title: _____

Address: _____

City, State, Zip: _____

Telephone Number: _____ # of Employees: _____

Company Name: _____

Name of Proposer: _____

Contact Person: _____ Title: _____

Address: _____

City, State, Zip: _____

Telephone Number: _____ # of Employees: _____

Company Name: _____

Name of Proposer: _____

Contact Person: _____ Title: _____

Address: _____

City, State, Zip: _____

Telephone Number: _____ # of Employees: _____

TERMINATIONS

Please provide the Planholder with three (3) references that have terminated with your company in the past year.

Company Name: _____
Name of Proposer: _____
Contact Person: _____ Title: _____
Address: _____
City, State, Zip: _____
Telephone Number: _____ # of Employees: _____

Company Name: _____
Name of Proposer: _____
Contact Person: _____ Title: _____
Address: _____
City, State, Zip: _____
Telephone Number: _____ # of Employees: _____

Company Name: _____
Name of Proposer: _____
Contact Person: _____ Title: _____
Address: _____
City, State, Zip: _____
Telephone Number: _____ # of Employees: _____

DECLARATION OF COMPLIANCE

The undersigned does hereby declare that they have read the Request for Proposal on which they are submitting a proposal with full knowledge of the requirements, and does hereby agree to furnish all services in full accordance with the requirements outlined in the Request for Proposal.

The proposer affirms that, to the best of their knowledge, the proposal has been arrived at independently and is submitted without collusion to obtain information or gain any favoritism that would in any way limit competition or give unfair advantage over other proposers.

The undersigned hereby declares that they have the authority to represent the proposer in submitting this proposal at the unit prices and level of services herein after notice of proposal award.

Company Name: _____
Address: _____
City, State, Zip Code: _____
Contact Person/Agent: _____
Area Code & Phone Number: _____
Authorized Signature: _____
Typed Name of Signatory: _____
Title of Signatory: _____
Date: _____

EXHIBIT A

City of Edinburg Group Census

CITY OF EDINBURG
Employee Census (March 2016)

Gender	Birth Year	Medical Coverage	# of Dependents
M	1993	E	0
M	1961	E	0
M	1975	E	0
M	1963	E	0
M	1995	E	0
F	1974	E	0
M	1974	E	0
M	1983	E	0
M	1982	E	0
M	1960	E	0
M	1984	E	0
F	1985	E	0
M	1982	E	0
M	1978	E	0
M	1980	E	0
F	1986	E	0
F	1987	E	0
F	1971	E	0
F	1973	E	0
M	1980	E	0
M	1981	E	0
F	1982	E	0
M	1987	E	0
M	1983	E	0
M	1968	E	0
F	1969	E	0
M	1970	E	0
F	1979	E	0
M	1986	E	0
M	1961	E	0
F	1985	E	0
M	1953	E	0
F	1986	E	0

CITY OF EDINBURG
Employee Census (March 2016)

Gender	Birth Year	Medical Coverage	# of Dependents
M	1983	E	0
M	1956	E	0
M	1981	E	0
M	1975	E	0
F	1975	E	0
M	1989	E	0
F	1983	E	0
M	1975	E	0
M	1990	E	0
M	1959	E	0
F	1994	E	0
F	1980	E	0
M	1972	E	0
M	1956	E	0
M	1961	E	0
M	1983	E	0
M	1985	E	0
M	1996	E	0
M	1980	E	0
M	1981	E	0
M	1981	E	0
F	1978	E	0
M	1973	E	0
M	1990	E	0
M	1995	E	0
M	1961	E	0
F	1986	E	0
M	1953	E	0
F	1992	E	0
M	1963	E	0
M	1970	E	0
M	1972	E	0
M	1958	E	0

CITY OF EDINBURG
Employee Census (March 2016)

Gender	Birth Year	Medical Coverage	# of Dependents
F	1977	E	0
F	1972	E	0
M	1957	E	0
M	1981	E	0
M	1966	E	0
F	1971	E	0
F	1986	E	0
M	1960	E	0
M	1971	E	0
F	1971	E	0
F	1983	E	0
M	1997	E	0
F	1970	E	0
M	1983	E	0
M	1989	E	0
M	1991	E	0
M	1990	E	0
M	1983	E	0
M	1987	E	0
M	1981	E	0
M	1967	E	0
F	1992	E	0
M	1995	E	0
F	1989	E	0
F	1992	E	0
M	1991	E	0
M	1989	E	0
M	1968	E	0
M	1979	E	0
M	1971	E	0
M	1961	E	0
M	1957	E	0
F	1970	E	0

CITY OF EDINBURG
Employee Census (March 2016)

Gender	Birth Year	Medical Coverage	# of Dependents
M	1962	E	0
M	1963	E	0
M	1974	E	0
M	1966	E	0
F	1986	E	0
M	1984	E	0
M	1968	E	0
F	1966	E	0
M	1983	E	0
M	1959	E	0
M	1977	E	0
M	1974	E	0
F	1987	E	0
F	1988	E	0
M	1964	E	0
M	1979	E	0
M	1989	E	0
M	1971	E	0
F	1961	E	0
M	1954	E	0
M	1989	E	0
F	1990	E	0
F	1991	E	0
F	1991	E	0
F	1992	E	0
M	1977	E	0
F	1983	E	0
M	1992	E	0
F	1963	E	0
F	1991	E	0
F	1959	E	0
M	1988	E	0
F	1972	E	0

CITY OF EDINBURG
Employee Census (March 2016)

Gender	Birth Year	Medical Coverage	# of Dependents
M	1972	E	0
M	1955	E	0
M	1958	E	0
M	1968	E	0
F	1982	E	0
M	1976	E	0
M	1976	E	0
M	1972	E	0
M	1960	E	0
M	1972	E	0
M	1962	E	0
F	1959	E	0
M	1981	E	0
M	1961	E	0
M	1991	E	0
M	1957	E	0
M	1961	E	0
M	1981	E	0
M	1983	E	0
F	1980	E	0
F	1981	E	0
M	1975	E	0
M	1980	E	0
M	1985	E	0
M	1946	E	0
M	1977	E	0
F	1984	E	0
M	1981	E	0
F	1963	E	0
F	1992	E	0
M	1972	E	0
M	1986	E	0
F	1960	E	0

CITY OF EDINBURG
Employee Census (March 2016)

Gender	Birth Year	Medical Coverage	# of Dependents
F	1992	E	0
F	1959	E	0
F	1982	E	0
F	1983	E	0
F	1965	E	0
M	1986	E	0
M	1963	E	0
M	1991	E	0
M	1988	E	0
M	1967	E	0
M	1953	E	0
M	1986	E	0
M	1986	E	0
M	1954	E	0
F	1985	E	0
M	1956	E	0
F	1965	E	0
M	1940	E	0
F	1979	E	0
M	1975	E	0
M	1995	E	0
M	1995	E	0
F	1979	E	0
M	1954	E	0
M	1990	E	0
M	1963	E	0
M	1960	E	0
M	1970	E	0
F	1988	E	0
F	1954	E	0
M	1981	E	0
M	1974	E	0
M	1985	E	0

CITY OF EDINBURG
Employee Census (March 2016)

Gender	Birth Year	Medical Coverage	# of Dependents
M	1965	E	0
F	1989	E	0
M	1991	E	0
M	1979	E	0
M	1990	E	0
M	1990	E	0
F	1968	E	0
M	1964	E	0
F	1963	E	0
M	1988	E	0
M	1953	E	0
M	1987	E	0
M	1969	E	0
F	1968	E	0
F	1983	E	0
M	1974	E	0
M	1961	E	0
M	1990	E	0
M	1960	E	0
M	1989	E	0
M	1973	E	0
F	1975	E	0
M	1983	E	0
M	1983	E	0
F	1965	E	0
M	1972	E	0
M	1992	E	0
F	1979	E	0
M	1964	E	0
M	1971	E	0
F	1981	E	0
M	1969	E	0
M	1993	E	0

CITY OF EDINBURG
Employee Census (March 2016)

Gender	Birth Year	Medical Coverage	# of Dependents
F	1968	E	0
M	1948	E	0
M	1957	E	0
F	1971	E	0
M	1970	E	0
M	1991	E	0
F	1986	E	0
M	1995	E	0
M	1965	E	0
M	1984	E	0
M	1983	E	0
F	1971	E	0
M	1971	E	0
M	1992	E	0
M	1970	E	0
M	1953	E	0
M	1967	E	0
M	1989	E	0
M	1968	E	0
M	1966	E	0
M	1971	E	0
F	1994	E	0
M	1990	E	0
M	1992	E	0
F	1959	E	0
M	1950	E	0
M	1949	E	0
F	1980	E	0
M	1983	E	0
M	1984	E	0
M	1979	E	0
M	1973	E	0
M	1950	E	0

CITY OF EDINBURG
Employee Census (March 2016)

Gender	Birth Year	Medical Coverage	# of Dependents
M	1985	E	0
M	1985	E	0
M	1958	E	0
F	1978	E	0
M	1976	E	0
M	1987	E	0
M	1987	E	0
M	1973	E	0
F	1990	E	0
M	1955	E	0
M	1969	E	0
M	1977	E	0
F	1979	E	0
F	1986	E	0
F	1964	E	0
M	1988	E	0
F	1973	E	0
M	1995	E	0
M	1995	E	0
M	1986	E	0
F	1971	E	0
M	1986	E	0
M	1974	E	0
M	1941	E	0
M	1962	E	0
M	1992	E	0
M	1960	E	0
M	1987	E	0
M	1982	E	0
F	1969	E	0
M	1979	E	0
M	1976	E	0
M	1984	E	0

CITY OF EDINBURG
Employee Census (March 2016)

Gender	Birth Year	Medical Coverage	# of Dependents
M	1989	E	0
M	1989	E	0
M	1992	E	0
F	1977	E	0
F	1962	E	0
M	1983	E	0
M	1956	E	0
F	1985	E	0
M	1961	E	0
M	1988	E	0
F	1990	E	0
F	1978	E	0
M	1977	E	0
M	1938	E	0
M	1957	E	0
M	1986	E	0
F	1957	E	0
M	1961	E	0
M	1989	E	0
M	1991	E	0
F	1974	E	0
F	1972	E	0
M	1950	E	0
M	1978	E	0
M	1976	E	0
M	1986	E	0
F	1991	E	0
M	1969	E	0
F	1974	E	0
F	1980	E	0
M	1959	E	0
M	1991	E	0
M	1976	E	0

CITY OF EDINBURG
Employee Census (March 2016)

Gender	Birth Year	Medical Coverage	# of Dependents
F	1982	E	0
F	1982	E	0
M	1993	E	0
M	1963	E	0
M	1958	E	0
M	1984	E	0
F	1985	E	0
M	1964	E	0
M	1969	E	0
M	1986	E	0
M	1989	E	0
M	1956	E	0
M	1993	E	0
M	1967	E	0
M	1965	E	0
M	1983	E	0
F	1960	E	0
F	1984	E	0
M	1993	E	0
F	1987	E	0
F	1967	E	0
F	1952	E	0
M	1984	E	0
M	1960	E	0
M	1987	E	0
M	1975	E	0
F	1986	E	0
M	1989	E	0
M	1979	E	0
M	1991	E	0
M	1954	E	0
F	1988	E	0
F	1981	E	0

CITY OF EDINBURG
Employee Census (March 2016)

Gender	Birth Year	Medical Coverage	# of Dependents
F	1990	E	0
M	1950	E	0
M	1968	E	0
F	1991	E	0
F	1985	E	0
M	1988	E	0
M	1974	E	0
M	1992	E	0
M	1978	E	0
M	1992	E	0
F	1983	E	0
F	1955	E	0
M	1959	E	0
F	1967	E	0
M	1988	E	0
M	1991	E	0
M	1965	E	0
M	1992	E	0
M	1989	E	0
F	1969	E	0
M	1985	E	0
M	1969	E	0
M	1981	E	0
M	1981	E	0
M	1992	E	0
M	1986	E	0
M	1964	E	0
M	1985	E	0
F	1970	E	0
M	1967	E	0
M	1977	E	0
M	1945	E	0
M	1953	E	0

CITY OF EDINBURG
Employee Census (March 2016)

Gender	Birth Year	Medical Coverage	# of Dependents
M	1977	E	0
M	1956	E	0
M	1964	E	0
M	1958	E	0
M	1975	E	0
M	1981	E	0
M	1988	E	0
F	1972	E	0
M	1991	E	0
F	1984	E	0
M	1967	E	0
F	1959	E	0
F	1978	E	0
F	1951	E	0
M	1980	E	0
M	1953	E	0
M	1989	E	0
M	1964	E	0
M	1985	E	0
M	1983	E	0
M	1977	E	0
F	1973	E	0
M	1985	E	0
M	1981	E	0
M	1965	E	0
M	1963	E	0
M	1992	E	0
M	1962	E	0
F	1988	E	0
M	1966	E	0
M	1987	E	0
M	1976	E	0
F	1969	E	0

CITY OF EDINBURG
Employee Census (March 2016)

Gender	Birth Year	Medical Coverage	# of Dependents
M	1956	E	0
M	1968	E	0
M	1981	E	0
M	1981	E	0
F	1975	E	0
F	1986	E	0
F	1964	E	0
F	1991	E	0
M	1981	E	0
M	1954	E	0
M	1977	E	0
M	1989	E	0
F	1985	E	0
M	1976	E	0
M	1971	E	0
M	1961	E	0
M	1978	E	0
F	1982	E	0
M	1978	E	0
M	1951	E	0
M	1985	E	0
M	1989	E	0
F	1987	E	0
M	1957	E	0
M	1986	E	0
M	1962	E	0
M	1978	E	0
M	1961	E	0
M	1957	E	0
M	1970	E	0
F	1986	E	0
M	1973	E	0
M	1974	EC	3

CITY OF EDINBURG
Employee Census (March 2016)

Gender	Birth Year	Medical Coverage	# of Dependents
F	1975	EC	3
M	1969	EC	2
F	1966	EC	3
F	1956	EC	1
M	1973	EC	2
F	1963	EC	1
M	1982	EC	2
M	1983	EC	2
M	1964	EC	2
M	1960	EC	2
M	1965	EC	2
M	1964	EC	3
M	1966	EC	6
M	1965	EC	3
M	1961	EC	2
M	1968	EC	2
M	1968	EC	4
M	1969	EC	4
M	1971	EC	3
M	1972	EC	2
M	1974	EC	4
M	1974	EC	2
M	1966	EC	3
M	1970	EC	2
M	1974	EC	3
M	1976	EC	5
F	1974	EC	1
F	1969	EC	2
M	1974	EC	2
M	1964	EC	2
F	1967	EC	3
M	1977	EC	3
F	1973	EC	3

CITY OF EDINBURG
Employee Census (March 2016)

Gender	Birth Year	Medical Coverage	# of Dependents
M	1971	EC	4
M	1976	EC	2
F	1978	EC	3
F	1968	EC	4
M	1970	EC	1
M	1973	EC	4
M	1963	EC	2
M	1975	EC	4
M	1980	EC	1
M	1978	EC	3
M	1975	EC	2
M	1982	EC	2
M	1976	EC	1
M	1984	EC	2
M	1983	EC	1
M	1982	EC	3
M	1985	EC	2
M	1986	EC	3
M	1987	EC	1
M	1964	EC	1
M	1966	EC	2
F	1983	EC	2
M	1985	EC	1
M	1979	EC	4
M	1975	EC	2
F	1969	EC	3
F	1973	EC	3
M	1955	EC	1
M	1976	EC	3
M	1960	EC	4
M	1965	EC	1
M	1965	EC	2
M	1967	EC	1

CITY OF EDINBURG
Employee Census (March 2016)

Gender	Birth Year	Medical Coverage	# of Dependents
F	1963	EC	3
F	1969	EC	1
F	1970	EC	1
F	1964	EC	1
F	1986	EC	1
F	1984	EC	1
M	1960	EC	3
M	1957	EC	3
M	1967	EC	2
M	1981	EC	2
M	1976	EC	3
M	1973	EC	1
M	1947	EC	1
F	1974	EC	2
F	1971	EC	4
F	1971	EC	2
F	1972	EC	1
F	1971	EC	5
F	1978	EC	2
M	1974	EC	1
F	1978	EC	2
F	1974	EC	3
F	1970	EC	1
F	1974	EC	3
M	1979	EC	3
M	1976	EC	1
F	1979	EC	2
F	1982	EC	3
F	1983	EC	1
M	1963	EC	1
M	1973	EC	3
M	1972	EC	3
M	1953	EC	1

CITY OF EDINBURG
Employee Census (March 2016)

Gender	Birth Year	Medical Coverage	# of Dependents
M	1961	EC	2
M	1984	EC	3
M	1980	EC	3
M	1958	EC	1
F	1969	EC	1
F	1974	EC	2
M	1962	EC	2
M	1968	EC	5
M	1972	EC	5
M	1979	EC	3
M	1967	EC	2
F	1983	EC	4
M	1988	EC	2
M	1988	EC	1
M	1968	EC	1
M	1969	EC	2
M	1967	EC	2
M	1966	EC	3
M	1990	EC	2
F	1981	EC	2
M	1975	EC	3
F	1982	EC	1
M	1984	EC	3
M	1979	EC	2
F	1986	EC	1
F	1988	EC	2
F	1971	EC	1
M	1978	EC	1
M	1980	EC	4
M	1986	EC	2
M	1984	EC	4
M	1963	EC	1
M	1979	EC	3

CITY OF EDINBURG
Employee Census (March 2016)

Gender	Birth Year	Medical Coverage	# of Dependents
M	1952	EC	2
M	1965	EC	2
F	1969	EC	2
F	1984	EC	2
M	1971	EC	4
M	1964	EC	1
M	1988	EC	1
F	1980	EC	4
M	1959	EC	1
M	1970	EC	2
M	1980	EC	1
M	1979	EC	1
M	1971	EC	1
M	1989	EC	1
F	1995	EC	1
M	1961	EC	1
M	1980	EC	3
M	1980	EC	3
M	1990	EC	2
M	1985	EC	2
M	1957	EF	2
F	1974	EF	4
M	1969	EF	4
M	1968	EF	5
M	1968	EF	3
M	1975	EF	2
M	1966	EF	4
M	1965	EF	4
M	1969	EF	2
M	1966	EF	3
M	1974	EF	4
M	1969	EF	5
M	1976	EF	3

CITY OF EDINBURG
Employee Census (March 2016)

Gender	Birth Year	Medical Coverage	# of Dependents
M	1968	EF	4
M	1975	EF	5
M	1977	EF	3
M	1968	EF	3
M	1977	EF	5
M	1979	EF	2
M	1982	EF	4
M	1968	EF	2
M	1984	EF	4
M	1970	EF	3
F	1983	EF	4
M	1975	EF	4
M	1975	EF	4
M	1981	EF	5
M	1984	EF	4
M	1972	EF	4
M	1974	EF	2
F	1971	EF	3
M	1988	EF	2
M	1970	EF	6
M	1981	EF	4
M	1967	EF	3
M	1981	EF	4
M	1959	EF	3
M	1966	EF	5
M	1970	EF	4
M	1972	EF	3
M	1963	EF	4
M	1962	EF	2
M	1962	EF	2
M	1979	EF	3
M	1961	EF	2
M	1973	EF	3

CITY OF EDINBURG
Employee Census (March 2016)

Gender	Birth Year	Medical Coverage	# of Dependents
M	1983	EF	5
M	1983	EF	2
M	1973	EF	4
M	1988	EF	3
M	1966	EF	6
M	1977	EF	4
M	1989	EF	4
M	1978	EF	2
M	1988	EF	2
M	1980	EF	3
M	1977	EF	4
M	1987	EF	4
M	1975	EF	3
M	1988	EF	2
M	1975	EF	3
M	1984	EF	3
M	1978	EF	5
F	1991	EF	2
F	1980	EF	3
M	1978	EF	2
M	1977	EF	2
M	1982	EF	6
M	1977	EF	4
F	1967	ES	1
M	1970	ES	1
M	1978	ES	1
M	1982	ES	1
M	1956	ES	1
M	1951	ES	1
M	1973	ES	1
M	1953	ES	1
M	1956	ES	1
M	1975	ES	1

CITY OF EDINBURG
Employee Census (March 2016)

Gender	Birth Year	Medical Coverage	# of Dependents
M	1959	ES	1
M	1956	ES	1
M	1961	ES	1
M	1953	ES	1
M	1967	ES	1
M	1951	ES	1
M	1954	ES	1
M	1954	ES	1
M	1970	ES	1
M	1965	ES	1
M	1967	ES	1
M	1954	ES	1
M	1953	ES	1
M	1966	ES	1
M	1978	ES	1
M	1972	ES	1
M	1959	ES	1
M	1965	ES	1
M	1961	ES	1
M	1964	ES	1
M	1960	ES	1
F	1985	ES	1
M	1986	ES	1
M	1962	ES	1
M	1974	ES	1
M	1992	ES	1
M	1973	ES	1
M	1990	ES	1
M	1992	ES	1
F	1975	ES	1
M	1957	ES	1
M	1952	ES	1
M	1984	ES	1

CITY OF EDINBURG
Employee Census (March 2016)

Gender	Birth Year	Medical Coverage	# of Dependents
F	1989	ES	1
M	1980	ES	1
M	1962	ES	1
Notation:			
E = EMPLOYEE ONLY			
EC = EMPLOYEE & CHILD(REN)			
EF = EMPLOYEE & FAMILY			
ES = EMPLOYEE & SPOUSE			

EXHIBIT B

City of Edinburg Yearly Participation

CITY OF EDINBURG YEARLY PARTICIPATION

FISCAL YEAR	SINGLE	FAMILY	TOTAL
2011-2012	474	252	726
2012-2013	464	257	721
2013-2014	483	265	748
2014-2015	476	282	758
2015-2016	460	269	729

EXHIBIT C

City of Edinburg
Retiree, Elected Official,
Chamber of Commerce, and COBRA Census

CITY OF EDINBURG			
Retiree, Elected Officials, Chamber of Commerce			
and COBRA Census (March 2016)			
Gender	Birth Year	Medical Coverage	# of Dependents
M	1985	E	0
M	1982	E	0
M	1978	E	0
F	1975	E	0
F	1969	E	0
M	1968	E	0
M	1968	E	0
M	1967	E	0
M	1967	E	0
M	1967	E	0
M	1966	E	0
M	1965	E	0
M	1964	E	0
M	1964	E	0
M	1964	E	0
F	1963	E	0
M	1963	E	0
M	1963	E	0
M	1963	E	0
F	1962	E	0
F	1960	E	0
M	1960	E	0
M	1960	E	0
M	1960	E	0
M	1960	E	0
F	1959	E	0
M	1959	E	0
M	1959	E	0
M	1959	E	0
M	1959	E	0

CITY OF EDINBURG			
Retiree, Elected Officials, Chamber of Commerce			
and COBRA Census (March 2016)			
Gender	Birth Year	Medical Coverage	# of Dependents
M	1959	E	0
F	1958	E	0
M	1958	E	0
M	1958	E	0
M	1958	E	0
F	1957	E	0
M	1957	E	0
M	1957	E	0
F	1956	E	0
M	1956	E	0
M	1956	E	0
M	1956	E	0
M	1956	E	0
F	1955	E	0
F	1955	E	0
M	1955	E	0
M	1955	E	0
F	1954	E	0
F	1954	E	0
M	1954	E	0
M	1954	E	0
M	1953	E	0
M	1953	E	0
M	1953	E	0
M	1953	E	0
M	1952	E	0
M	1952	E	0
M	1952	E	0
M	1952	E	0
M	1952	E	0
M	1952	E	0

CITY OF EDINBURG			
Retiree, Elected Officials, Chamber of Commerce			
and COBRA Census (March 2016)			
Gender	Birth Year	Medical Coverage	# of Dependents
M	1952	E	0
M	1952	E	0
M	1951	E	0
M	1951	E	0
M	1951	E	0
F	1963	EC	1
M	1978	EF	3
M	1972	EF	4
M	1967	EF	5
F	1966	EF	2
M	1954	EF	1
M	1946	EF	1
E = EMPLOYEE ONLY			
EC = EMPLOYEE & CHILDREN			
EF = EMPLOYEE & FAMILY			
ES = EMPLOYEE & SPOUSE			

EXHIBIT D

City of Edinburg Health Insurance
Premiums/Claims History



EDW Underwriting Reporting

Premium & Claims Summary Report – Incurred Basis

Parameter Name	Parameter Values	Parameter Description
Customer	665082	CITY OF EDINBURG
Platform	EM	METAVANCE
Type of Customer	ENTERPRISE	CUSTOMER AND PLATFORM ABOVE ARE ENTERPRISE-LEVEL FIELDS
Auto Cross-Reference	YES	SELECT ALL SOURCE CUSTOMERS IN THE ENTERPRISE CUSTOMER
Division	BLANK	ALL SOURCE DIVISION IDS
Benefit ID	BLANK	ALL SOURCE CUSTOMER BENEFIT IDS
From Date	01-01-2014	
To Date	12-31-2015	
As of Date	02-29-2016	
Reporting Level	ENT CUST	ENTERPRISE CUSTOMER
Product Line Codes	MEDICAL (Only product line code of Medical)	
Financial Product Codes	Display all Separately	

EXHIBIT

E

Humana Benefit Highlights

Coverage Period: 10/01/2015 - 09/30/2016
 Plan Type: PPO Copay F

Notice:

There will be a federally mandated maximum out-of-pocket (MOOP) limit that health insurance plans cannot exceed. All health insurance plans with non-grandfathered self-funded and self-funded must have the MOOP include all member cost sharing for medical and pharmacy (excluding premiums, balance billing amounts for non-network providers, non-covered services). Cost-sharing includes all copayments, deductibles, and coinsurance amounts for medical, behavioral health and pharmacy amounts. The inclusion of the MOOP will likely be a change to your plan.

14 your in-network medical and pharmacy out-of-pocket maximums combine and cannot exceed the total plan maximum out-of-pocket.

es your plan's maximum out-of-pocket limits for in-network services:

Individual Medical Maximum Out-of-Pocket: \$ 6,000
 Individual Pharmacy Maximum Out-of-Pocket: \$ 2,500

Family Medical Maximum Out-of-Pocket: \$ 12,000
 Family Pharmacy Maximum Out-of-Pocket: \$ 5,000

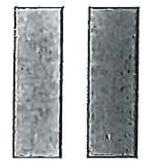
Medical
 Maximum Out-of-Pocket

Pharmacy expenses out of your pocket that accumulate to this limit:
 - Copays
 - Deductible
 - Coinsurance



Pharmacy
 Maximum Out-of-Pocket

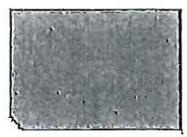
Pharmacy expenses out of your pocket that accumulate to this limit:
 - Copays
 - Deductible
 - Coinsurance



Total Plan
Maximum Out-of-Pocket

Individual Maximum - \$ 6,250
 Family Maximum - \$ 12,500

Humana members with individual plans won't exceed \$6,250, whereas members with family plans won't exceed \$12,500



HUMANA HEALTH PLAN OF TX, INC/HUMANA INSURANCE

CO: TX LG NPOS 14

Coverage Period: Beginning on or after 10/01/2015
Coverage For: Individual + Family | Plan Type: NPOS

Summary of Benefits and Coverage: What this Plan Covers & What it Costs



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.humana.com or by calling 1-866-4ASSIST (427-7478).

Important Questions	Answers	Why this Matters
What is the overall deductible?	<p>Network: \$2,000 Individual / \$4,000 Family</p> <p>Non-Network: \$6,000 Individual / \$12,000 Family</p> <p>Doesn't apply to prescription drugs and preventative services. Co-insurance and co-payments don't count toward the deductible</p>	<p>You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u>.</p>
Are there other deductibles for specific services?	<p>Prescription drug coverage Network: \$0 Individual / \$0 Family</p> <p>Non-Network: \$0 Individual / \$0 Family</p>	<p>You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.</p>
Is there an <u>out-of-pocket limit</u> on my expenses?	<p>Yes. For Network providers \$6,250 Individual / \$12,500 Family</p> <p>For Non-Network providers \$18,000 Individual / \$36,000 Family</p>	<p>The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</p>
What is not included in the <u>out-of-pocket limit</u> ?	<p>Premiums, Balance-billed charges, Health care this plan doesn't cover, Penalties, Non-network transplant, Out-of-network Co-Insurance, prescription drugs, specialty drugs</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>
Is there an overall annual limit on what the plan pays?	<p>No.</p>	<p>The chart starting on page 2 describes any limits on what the plan will pay for <u>specific</u> covered services, such as office visits.</p>

Questions: Call 1-866-4ASSIST (427-7478) or visit us at www.humana.com

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view

the Glossary at www.humana.com

Does this plan use a network of providers?	Yes. See www.humana.com or call 1-866-4ASSIST (427-7478) for a list of Network providers.	If you are an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers. You can see the specialist you choose without permission from this plan.
Do I need a referral to see a specialist?	No.	
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <u>excluded services</u> .

- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network provider charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network providers by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness Specialist visit Other practitioner office visit	\$30 copay/visit \$45 copay/visit Chiropractor Exam: \$45 copay/visit No charge	50% coinsurance 50% coinsurance Chiropractor Exam: 50% coinsurance 50% coinsurance	none none none limited coverage for preventive care
If you have a test	Diagnostic test (x-ray, blood work) Imaging (CT/PET scans, MRIs)	No charge after deductible 20% coinsurance	50% coinsurance 50% coinsurance	Cost share may vary based on where service is performed Cost share may vary based on where service is performed. Preauthorization may be required - if not obtained, penalty will be 50%

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
<p>If you need drugs to treat your illness or condition</p> <p>More information about <u>prescription drug coverage</u> is available at www.humana.com.</p>	<p>Level 1 - Lowest cost generic and brand-name drugs</p>	<p>\$15 copay (Retail) \$37.5 copay (Mail Order)</p>	<p>30% coinsurance, after Network copay (Retail) 30% coinsurance, after Network copay (Mail Order)</p>	<p>30 day supply Preauthorization may be required - if not obtained, penalty will be 100% for certain prescription drugs (Retail) 90 day supply Preauthorization may be required - if not obtained, penalty will be 100% for certain prescription drugs (Mail Order)</p>
	<p>Level 2 - Higher cost generic and brand-name drugs</p>	<p>\$35 copay (Retail) \$87.5 copay (Mail Order)</p>	<p>30% coinsurance, after Network copay (Retail) 30% coinsurance, after Network copay (Mail Order)</p>	
	<p>Level 3 - Generic and brand-name drugs with higher cost than Level 2</p>	<p>\$55 copay (Retail) \$137.5 copay (Mail Order)</p>	<p>30% coinsurance, after Network copay (Retail) 30% coinsurance, after Network copay (Mail Order)</p>	
	<p>Level 4 - Highest cost drugs</p>	<p>25% coinsurance (Retail) 25% coinsurance (Mail Order)</p>	<p>30% coinsurance, after Network copay (Retail) 30% coinsurance, after Network copay (Mail Order)</p>	
	<p>Specialty drugs</p>	<p>35% coinsurance</p>	<p>50% coinsurance</p>	<p>25% coinsurance when filled via a preferred network specialty pharmacy Preauthorization may be required - if not obtained, penalty will be 100% for certain prescription drugs</p>
<p>If you have outpatient surgery</p>	<p>Facility fee (e.g., ambulatory surgery center) Physician/surgeon fees</p>	<p>20% coinsurance 20% coinsurance</p>	<p>50% coinsurance 50% coinsurance</p>	<p>Preauthorization may be required - if not obtained, penalty will be 50%</p> <p>_____none_____</p>

Common Medical-Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services Emergency medical transportation	\$250 copay/visit 20% coinsurance	\$250 copay/visit 20% coinsurance	Copayment waived if admitted none
If you have a hospital stay	Urgent care Facility fee (e.g., hospital room)	\$100 copay/visit 20% coinsurance	50% coinsurance 50% coinsurance	none Preauthorization may be required - if not obtained, penalty will be 50%
If you have mental health, behavioral health, or substance abuse needs	Physician/surgeon fee Mental/Behavioral health outpatient services Mental/Behavioral health inpatient services	20% coinsurance \$30 copay/visit 20% coinsurance	50% coinsurance 50% coinsurance 50% coinsurance	none none Preauthorization may be required - if not obtained, penalty will be 50%
If you are pregnant	Substance use disorder outpatient services Substance use disorder inpatient services	\$30 copay/visit 20% coinsurance	50% coinsurance 50% coinsurance	none Preauthorization may be required - if not obtained, penalty will be 50%
If you need help recovering or have other special health needs	Prenatal and postnatal care Delivery and all inpatient services Home health care	20% coinsurance 20% coinsurance 20% coinsurance	50% coinsurance 50% coinsurance 50% coinsurance	none Preauthorization may be required - if not obtained, penalty will be 50% Preauthorization may be required - if not obtained, penalty will be 50%
	Rehabilitation services	\$45 copay/visit	50% coinsurance	Therapies: Preauthorization may be required - if not obtained, penalty will be 50% Manipulations and Therapies: 30 PT,OT,ST,CT,AT visit limit per year includes manips & adjustments For non-network, 10 PT,OT,CT,ST,AT visits per year includes manips & adjustments
	Habilitation services Skilled nursing care	\$45 copay/visit 20% coinsurance	50% coinsurance 50% coinsurance	60 day limit per cal yr/plan yr Preauthorization may be required - if not obtained, penalty will be 50%

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
	Durable medical equipment	20% coinsurance	50% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50% for durable medical equipment \$750 and over
	Hospice service	20% coinsurance	50% coinsurance	Preauthorization may be required - if not obtained, penalty will be 50%
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	_____none
	Glasses	Not Covered	Not Covered	_____none
	Dental check-up	Not Covered	Not Covered	_____none

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery, unless to correct a functional impairment
- Dental care (Adult), unless for dental injury of a sound natural tooth
- Infertility treatment
- Long-term care
- Non Emergent Care received from foreign providers
- Private Duty Nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care - spinal manipulations are covered
- Hearing aids, 1 per ear every 36 months

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-4ASSIST (427-7478). You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.ccoio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact:

Humana, Inc.: www.humana.com or 1-866-4ASSIST (427-7478)

Department of Labor Employee Benefits Security Administration: 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
Texas Department of Insurance, PO Box 149104, Austin, TX 78714-9104, Phone: 512-463-6169 or 800-252-3439, Website: <http://www.tdi.texas.gov/index.html>

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide **minimum essential coverage**.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does provide **minimum essential coverage for the benefits it provides**.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-4ASSIST (427-7478)

_____ To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$4,590
- Patient pays \$2,950

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$2,000
Copays	\$50
Coinsurance	\$900
Limits or exclusions	\$0
Total	\$2,950

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$3,680
- Patient pays \$1,720

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$0
Copays	\$1,700
Coinsurance	\$0
Limits or exclusions	\$20
Total	\$1,720

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from network providers. If the patient had received care from non-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✖ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✖ No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✔ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✔ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-866-4ASSIST (427-7478) or visit us at www.humana.com

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.humana.com