

**KLEBERG COUNTY, TEXAS**  
**SPECIFICATIONS AND PROPOSERS' INSTRUCTIONS**  
**EMPLOYEE HEALTH INSURANCE PROPOSAL**

**2013**

The following specifications have been compiled in order to continue to provide Group Health Insurance for employees and retirees of Kleberg County.

Every effort will be made by the County to compare Health Insurance Company's proposals on a fair and equal basis. Kleberg County does not assume responsibility for the accuracy or completeness of the information contained in these specifications, concerning exposure to loss/claims. It is the responsibility of parties submitting proposals to verify exposure to loss/claims.

Please return the complete sealed proposal plainly marked "**EMPLOYEE HEALTH INSURANCE PROPOSAL**" to **County Judge Juan Escobar**

**700 E. Kleberg Kingsville, TX 78363**

The proposal must be received no later than 1:30 p.m. on August 30, 2013. Proposals will be opened in the Judges Office at that time. Facsimile transmittals shall not be accepted. **All proposals received after said time will be returned unopened.** A decision may be made regarding the placement of the coverage at a special called meeting or the next regular meeting of the Commissioners Court which will be announced at a later date.

Kleberg County reserves the right to reject any proposals not responsive and/or reject all proposals. Proposer's will be accorded fair and equal treatment with opportunity for discussion and revision of proposals, and revisions may be permitted after submission and before award for the purpose of obtaining the best and final offers. If awarded, the contract shall be awarded to the responsible proposer whose proposal is determined to be the lowest evaluated offer resulting from negotiation, if any, taking into consideration the relative importance of price and other evaluation factors set forth in this request for proposals.

Any significant deviations from specifications should be noted and explained in the carrier's cover letter. **Please note: There can be no exclusions for pre-existing conditions.**

**KLEBERG COUNTY, TEXAS**  
**SPECIFICATIONS AND PROPOSERS' INSTRUCTIONS**  
**EMPLOYEE HEALTH INSURANCE PROPSAL**

**2013**

**General Information- Primary Insurance Proposal**

Enclosed you will find the current census data, benefit package summary, claim/loss information, Self-Funded Health Insurance information and checklist, and other pertinent data necessary to prepare a proposal.

Plan Anniversary: November 1, 2013

Our current benefit package for group medical is with Texas Association of Counties (Blue Cross Blue Shield) and has been for 2 years.

Prior medical carrier: Entrust

Contribution Basis:

- Employee: County contributes \$552.18 to the employee's monthly premium.
- Dependent: County contributes a monthly premium of \$237.50 for children, \$529.02 for spouse, and \$758.36 for family.
- Retirees: County contributes a monthly premium of \$218.79 for children, \$183.57 for spouse, and \$ 155.61 for family.
- Employees may choose to waive health coverage if they have coverage with another carrier.

Benefit Waiting Period Present Employees:

- New Hires: Group coverage will commence for employees hired between the first and fifteenth of the month on the first day of the month after ninety days. Employees hired between the 16<sup>th</sup> and 30<sup>th</sup> of the month, coverage will begin the first day of the following month after the ninety day period.

Benefits:

- Kleberg County is interested in a Fully Funded Health Insurance PPO Plan while maintaining the current benefits and proposals using a \$250 and \$500 deductible.

\*Kleberg County is also interested in a Self-Funded Health Insurance Plan while maintaining the current benefits and proposals using a \$250 and \$500 deductible.

\*In addition, Kleberg County would be interested in a Self-Funded Health Insurance Plan using a \$250 and \$500 two tier deductible plan and a \$500 and \$1000 two tier deductible plan using a family deductible in both instances if possible.

\*Answer and submit Self-Funded Proposal requirements/checklist.

- Along with the enclosed plan of benefits, we would like the following benefit:

Pre-existing Conditions:

- This will be take-over coverage, so therefore, pre-existing coverage shall be waived as provided by law.

# Census

**Kleberg County Census 2013**

DOB	Policy Type	ZIP Code
3/27/1987	EO	78363
12/19/2011	FAM	78363
2/3/1955	EO	78363
4/3/1958	EO	78363
8/13/1961	EO	78363
10/10/1957	FAM	78363
7/29/1978	ECH	78363
2/26/1965	EO	78363
8/14/1987	EO	78363
7/23/1978	FAM	78363
12/5/1962	EO	78363
10/27/1965	FAM	78363
8/23/1959	ECH	78363
5/28/1969	ECH	78363
12/3/1945	ESP	78379
12/28/1960	EO	78363
2/7/1980	EO	78363
10/24/1971	EO	78363
5/22/1986	ESP	78363
12/10/1953	EO/Retiree	78363
1/21/1973	FAM	78363
1/16/1989	EO	78363
6/29/1960	EO	78363
9/23/1961	EO	78363
5/12/1963	ESP	78363
1/10/1972	FAM	78363
12/20/1941	ESP	78363
12/14/1962	FAM	78363
3/28/1963	ESP	78363
8/1/1981	EO	78363
6/28/1980	ECH	78379
3/2/1936	ESP	78379
5/12/1949	ESP	78363
7/13/1960	ESP	78342
8/30/1960	ECH	78379
11/4/1946	EO	78363
7/9/1963	FAM	78379
7/30/1960	FAM	78363
1/27/1991	EO	78363
10/7/1968	FAM	78363
8/21/1969	ESP	78363
9/28/1960	EO	78363
4/16/1952	EO	78363
4/11/1960	ECH	78363
3/17/1975	EO	78363
1/31/1988	ECH	78363
1/27/1951	ESP	78363
4/25/1974	EO	78363
2/28/1963	EO	78363
3/6/1960	EO	78363
11/28/1974	ECH	78363
3/16/1955	FAM	78363

7/27/1954	FAM	78363
8/4/1957	EO	78363
6/13/1973	ESP	78363
7/18/1954	EO	78351
2/25/1959	EO	78363
9/10/1982	ESP	78379
4/6/1959	ESP	78363
9/19/1983	FAM	78379
6/29/1971	EO	78363
11/16/1953	EO	78363
2/13/1964	FAM	78363
12/27/1954	EO	78363
1/13/1953	EO	78363
7/2/1964	EO	78363
4/14/1976	FAM	78363
4/16/1955	ECH	78363
6/12/1982	EO	78363
5/19/1967	ESP	78363
10/19/1978	EO	78363
8/1/1969	ESP	78363
2/14/1972	ECH	78363
4/16/1985	ESP	78363
9/3/1986	EO	78363
10/17/1982	ECH	78363
5/5/1967	EO	78379
7/12/1971	FAM	78363
4/27/1992	EO	78363
10/3/1986	EO	78363
11/23/1950	EO	78363
5/1/1955	ESP	78363
12/15/1964	FAM	78363
8/31/1962	EO	78363
11/15/1956	FAM	78363
8/20/1954	ESP	78363
8/8/1984	EO	78363
9/3/1937	ESP	78363
10/26/1970	FAM	78363
5/18/1950	EO	78363
8/20/1967	FAM	78379
8/19/1980	EO	78363
10/15/1964	EO	78355
12/4/1970	ECH	78363
2/17/1950	ESP/Retiree	78363
6/19/1950	EO/Retiree	78363
8/1/1953	EO	78363
8/15/1983	EO	78363
12/25/1959	ECH	78363
11/20/1951	EO	78363
9/14/1954	ESP	78363
1/16/1971	ECH	78363
7/7/1982	EO	78363
10/30/1958	ECH	78363
12/15/1955	ECH	78363
7/7/1977	ECH	78410
12/24/1955	FAM	78363

4/30/1980	EO	78363
10/28/1974	FAM	78363
1/20/1972	EO	78363
10/27/1988	EO	78363
11/23/1955	ESP	78379
12/22/1983	EO	78363
11/20/1985	EO	78363
3/15/1964	EO	78363
4/20/1956	EO	78363
3/12/1976	ECH	78363
2/15/1964	EO	78363
12/18/1958	ESP	78363
11/24/1970	ECH	78363
4/14/1955	EO	78363
4/26/1994	EO	78363
10/4/1975	ECH	78363
1/22/1960	FAM	78363
6/5/1969	ECH	78363
1/12/1988	ECH	78363
8/14/1968	EO	78363
5/5/1957	FAM	78379
3/16/1948	EO	78363
2/18/1976	ESP	78363
6/14/1967	EO	78343
1/14/1968	EO	78363
11/11/1976	ECH	78363
3/19/1975	EO	78363
7/4/1962	ECH	78363
7/15/1949	EO	78363
10/3/1953	ESP	78363
11/14/1951	EO/Retiree	78363
3/2/1973	ECH	78363
12/3/1968	EO	78363
8/26/1955	EO	78363
12/12/1952	ESP	78379
6/13/1962	ESP	78363
7/6/1972	EO	78363
10/22/1952	ECH	78363
10/6/1962	ECH	78363
9/9/1956	EO	78363
7/27/1973	ECH	78363
11/2/1949	ESP	78363
5/9/1951	EO/Retiree	78363
10/8/1991	EO	78363
4/22/1964	FAM	78363
8/24/1956	ESP	78363
9/30/1954	EO/Retiree	78363
4/17/1958	ESP	78379
11/21/1977	ECH	78363
2/19/1988	EO	78363
5/1/1976	FAM	78363
11/5/1951	ESP/Retiree	78363
1/30/1975	EO	78380
9/13/1970	EO	78363
9/20/1961	ECH	78363

8/25/1950	FAM	78363
6/13/1985	EO	78379
6/7/1975	ESP	78363
11/3/1961	ESP	78363
7/2/1943	EO	78363
2/4/1977	EO	78363
8/7/1972	EO	78363
8/5/1956	EO	78363
1/27/1958	ESP	78363
10/1/1963	EO	78363
3/16/1976	ECH	78363
8/15/1955	EO	78416
3/13/1983	EO	78363
3/14/1969	ECH	78363
12/16/1953	ESP	78363
EO		83
ESP		35
EC		32
FAM		27
Total Emp:		177



# **Current Plan Summary**



# TEXAS ASSOCIATION of COUNTIES HEALTH AND EMPLOYEE BENEFITS POOL

## BENEFIT HIGHLIGHTS Plan 1200 NG

*BlueChoice Network*

(HCRNon-Grandfathered)

*This is a general summary of your benefits. Please refer to your benefit booklet for additional details and a description of the plan requirements and benefit design. This plan does not cover all health care expenses. Upon receipt of your benefit booklet, carefully review the plan's limitations and exclusions.*

### Overall Payment Provisions

	<i>In-Network Benefits</i>	<i>Out-of-Network Benefits</i>
<b>Deductibles</b>		
Per-admission Deductible Deductible <i>Applies to all Eligible Expenses except Inpatient Hospital Expenses (unless otherwise indicated)</i>	\$0 \$1,000 Individual / \$3,000 Family	\$0 \$3,000 Individual / \$9,000 Family
Three-month Deductible carryover applies	Yes	Yes
Deductible credit from prior carrier (Applied on initial group enrollment only)	Yes	Yes
<b>CoShare Stoploss Maximum</b>		
Deductibles are not applied to the CoShare Stoploss Maximum. Copayment Amounts are applied but will continue to be required after the benefit percentages increase to 100%. Your benefit booklet will provide more details.	\$3,000 Individual / \$9,000 Family  <i>Network Deductible &amp; CoShare Stoploss Maximum will only apply toward Network Deductible &amp; CoShare Stoploss Maximum</i>	\$6,000 Individual / \$18,000 Family  <i>Out-of-Network Deductible &amp; CoShare Stoploss Maximum will also apply toward Network Deductible &amp; CoShare Stoploss Maximum</i>
Credit for Coshare Stoploss Maximum from prior carrier (Applied on initial group enrollment only)	Yes	Yes
<b>Copayment Amounts Required</b>		
Physician office visit/consultation <i>Refer to Medical/Surgical Expenses section for more information</i>	\$30 Copayment Amount	N/A-Refer to Medical/Surgical Expense section for benefits
Outpatient Hospital Emergency Room/Treatment Room <i>Refer to Emergency Room/Treatment Room section for more information</i>	\$100 Copayment Amount	\$100 Copayment Amount
<b>Maximum Lifetime Benefits</b>		
Per Participant	Unlimited	
<b>Inpatient Hospital Expenses</b>		
<b>Inpatient Hospital Expenses</b>		
All services must be preauthorized <i>All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units</i>	80% of Allowable Amount	60% of Allowable Amount
Penalty for failure to preauthorize services	None	\$250



**BlueCross BlueShield  
of Texas**

Initials gmb Date 09/19/2012



# TEXAS ASSOCIATION of COUNTIES HEALTH AND EMPLOYEE BENEFITS POOL

## Medical/Surgical Expenses

### Medical / Surgical Expenses

Services performed during the Physician's office visit/consultation, including lab & x-ray (does not include Certain Diagnostic Procedures and surgical services)

### In-Network Benefits

### Out-of-Network Benefits

100% of Allowable Amount after \$30 Copayment

70% of Allowable Amount after Calendar Year Deductible

Lab & x-ray in other outpatient facilities (excluding Certain Diagnostic Procedures)

100% of Allowable Amount

70% of Allowable Amount after Calendar Year Deductible

Allergy Injections

100% of Allowable Amount

70% of Allowable Amount after Calendar Year Deductible

Colonoscopy (All places of treatment and diagnoses)

100% of Allowable Amount

70% of Allowable Amount after Calendar Year Deductible

Physician surgical services performed in any setting

80% of Allowable Amount after Calendar Year Deductible

60% of Allowable Amount after Calendar Year Deductible

Certain Diagnostic Procedures; such as Bone Scan, Cardiac Stress Test, CT -Scan (with or without contrast), Ultrasound, MRI, Myelogram, PET Scan.

80% of Allowable Amount after Calendar Year Deductible

60% of Allowable Amount after Calendar Year Deductible

Home Infusion Therapy (Services must be preauthorized)

80% of Allowable Amount after Calendar Year Deductible

60% of Allowable Amount after Calendar Year Deductible

Organ Transplants

80% of Allowable Amount after Calendar Year Deductible

60% of Allowable Amount after Calendar Year Deductible

All other outpatient services and supplies

80% of Allowable Amount after Calendar Year Deductible

60% of Allowable Amount after Calendar Year Deductible

In Vitro Fertilization Services

Declined

## Extended Care Expenses

### Extended Care Expenses

All services must be preauthorized

100% of Allowable Amount

70% of Allowable Amount after Calendar Year Deductible

Skilled Nursing Facility  
Home Health Care  
Hospice Care

25 day maximum each Calendar Year\*  
60 visit maximum each Calendar Year\*

Unlimited

## Special Provisions Expenses

### Serious Mental Illness

All services must be preauthorized

#### Inpatient Services

-Hospital services (facility)

80% of Allowable Amount

60% of Allowable Amount

-Physician services

80% of Allowable Amount after Calendar Year Deductible

60% of Allowable Amount after Calendar Year Deductible

#### Outpatient Services

-Services performed during Physician office visit/consultation (does not include psychological testing)

100% of Allowable Amount after \$30 Copayment

60% of Allowable Amount after Calendar Year Deductible

-All outpatient services and psychological testing

80% of Allowable Amount after Calendar Year Deductible

60% of Allowable Amount after Calendar Year Deductible

\* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, Calendar Year, Plan Year, Annual Maximum, series of treatments benefits indicated

Initials *DE* Date *09/19/2012*



# TEXAS ASSOCIATION of COUNTIES HEALTH AND EMPLOYEE BENEFITS POOL

## Special Provisions Expenses, cont.

### In-Network Benefits

### Out-of-network Benefits

#### Mental Health Care/Chemical Dependency

All services must be preauthorized

##### Inpatient Services

-Hospital services (facility)

80% of Allowable Amount

60% of Allowable Amount

-Physician services

80% of Allowable Amount after  
Calendar Year Deductible

60% of Allowable Amount after  
Calendar Year Deductible

##### Calendar Year Maximum

30 inpatient days/30 inpatient Physician  
visits each Calendar Year\*

30 inpatient days/30 inpatient  
Physician visits each Calendar Year\*

##### Outpatient Services

-Services performed during Physician office visit/consultation  
(does not include psychological testing)

100% of Allowable Amount after \$30  
Copayment Amount

70% of Allowable Amount after  
Calendar Year Deductible

-Emergency Room/Treatment Room

80% of Allowable Amount after  
\$100 Copayment Amount  
  
(Copayment Amount waived if admitted,  
Inpatient Hospital Expenses will apply)

60% of Allowable Amount after \$100  
Copayment Amount & Calendar Year  
Deductible  
  
(Copayment Amount waived if  
admitted, Inpatient Hospital Expenses  
will apply)

-Other Outpatient Services and psychological testing

80% of Allowable Amount after  
Calendar Year Deductible

60% of Allowable Amount after  
Calendar Year Deductible

##### Calendar Year Maximum

30 outpatient visits each Calendar Year\*

##### Chemical Dependency Maximum

(Inpatient treatment must be provided in a Chemical Dependency  
Treatment Center)

Limited to three separate series of treatments for each covered individual per  
lifetime \*

#### Emergency Room/Treatment Room

##### Accidental Injury & Emergency Care

-Facility charges (outpatient Hospital emergency treatment room  
charges)

80% of Allowable Amount after \$100 Copayment Amount  
(Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)

-Physician charges

80% of Allowable Amount after Calendar Year Deductible

##### Non-Emergency Care

-Facility charges (outpatient Hospital emergency treatment room  
charges)

80% of Allowable Amount after \$100  
Copayment Amount  
(Copayment Amount waived if admitted,  
Inpatient Hospital Expenses will apply)

60% of Allowable Amount after \$100  
Copayment Amount & Calendar Year  
Deductible  
(Copayment Amount waived if  
admitted, Inpatient Hospital Expenses  
will apply)

-Physician charges

80% of Allowable Amount after  
Calendar Year Deductible

60% of Allowable Amount after  
Calendar Year Deductible

#### Ground and Air Ambulance Services

80% of Allowable Amount after Calendar Year Deductible

\* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, Calendar Year, Plan Year, Annual Maximum, series of treatments benefits indicated

Initials *JK* Date *09/19/2012*



# TEXAS ASSOCIATION *of* COUNTIES HEALTH AND EMPLOYEE BENEFITS POOL

## Special Provisions Expenses, cont.

	<i>In-Network Benefits</i>	<i>Out-of-network Benefits</i>
<b>Preventive Care</b>		
Routine annual physical examinations, well-baby care exams, immunizations 6 years of age & over, vision exams, hearing exams, and any other preventive health services as determined by USPSTF	100% of Allowable Amount	70% of Allowable Amount after Calendar Year Deductible
Immunizations for Dependent children through the date of the child's 6 <sup>th</sup> birthday	100% of Allowable Amount	100% of Allowable Amount
<b>Speech and Hearing Services</b>		
Services to restore loss of or correct an impaired speech or hearing function without hearing aids	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
<b>Physical Medicine Services</b>		
Chiropractic Care-Office Services	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
<b>Calendar Year Maximum</b>	35 visit maximum each Calendar Year*	
	<i>All other Physical Medicine Services rendered by any other eligible Provider will be allowed on the same basis as any other sickness.</i>	

\* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, Calendar Year, Plan Year, Annual Maximum, series of treatments benefits indicated

## EMPLOYEE INFORMATION

This is a general Summary of your benefit design. Please refer to your benefit booklet for other details and for limitations and exclusions.

### The following benefits apply to dependent coverage:

- Dependent children are covered to age 26.
- Automatic coverage for newborns for the first 31 days following birth. Infants not enrolled for coverage within the first 31 days after birth will not be eligible for coverage until the following open enrollment period or special enrollment event.

**Payments:** Network providers agree to accept amounts negotiated with BCBSTX and are paid according to this BCBSTX-determined Allowable Amount. Covered individuals are responsible for any required Deductibles, Coinsurance Amounts, and Copayments. Plan benefits paid to Out-of-Network providers are based on the BCBSTX-determined Allowable Amount, except in the event of Emergency Care received in an outpatient hospital emergency treatment room within 48 hours of the incident. For all other services received by an Out-of-Network Provider, the covered individual will be responsible for charges in excess of the Allowable Amount in addition to any applicable Deductibles, Coinsurance Amounts, and Copayments. For cost savings information, refer to the section on ParPlan Providers and the definition of Allowable Amount in the benefit booklet.

**Preexisting conditions Provision:** Benefits for Eligible Expenses incurred for treatment of a Preexisting Condition will not be available during the twelve-month period following the individual's initial Effective Date, or if a Waiting Period applies, the first day of the Waiting Period. In accordance with state and federal law, certain conditions will not be considered Preexisting Conditions and the Preexisting Condition exclusion will not apply to certain individuals. Details are provided in the benefit booklet.

**Replacement of Medical Coverage:** In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the following provisions apply to each eligible participant who has health coverage under the employer's plan immediately prior to the effective date of the health contract between the employer and BCBSTX (the contract date):

- Benefits for eligible expenses incurred for any service or supplies prior to the contract date, are not covered under the contract.
- Eligible expenses for services or supplies incurred on or after the effective date will be considered for benefits subject to all applicable contract provisions.

Initials *QWB* Date *09/19/2012*

COBRA ADMINISTRATION

Please indicate how your group manages COBRA administration:

- Self Administration on OASys       BCBS       Other

If "Other", please indicate COBRA Administrator: \_\_\_\_\_

PE Initial to confirm COBRA Administration.

PLAN INFORMATION

Please indicate your broker / agent's name, if applicable Phil Esquivel

- Retirees pay the same premium as active employees regardless of age for medical and dental.
- Rates based upon current benefits and enrollment. A substantial change in enrollment (10% over 30 days or 30% over 90 days) may result in a change in rates.
- Form must be received by **09/19/2012** in order to avoid additional administrative fees.
- Signature on the following page is required to confirm and accept your group's renewal.

RETIREE

Please circle one for each benefit that applies.

Your group allows retiree coverage for:

Medical

Pre 65

Post 65

**Both**

QNE Initial to confirm.

WAITING PERIOD

Waiting period applies to all benefits.

**Employees**

**Elected Officials**

90 days - 1st of the month following date of  
hire but first of the month

Date of hire

QNE Initial to confirm.

# Claims History





TEXAS ASSOCIATION of COUNTIES  
HEALTH AND EMPLOYEE BENEFITS POOL

# Large Claimant Summary

**Report Elements**

**Claimant Number** Claimant number assigned to member

**Status** Active, Retired, or COBRA

**Medical Claims** Paid Medical Claims - (May include out-of-state network access fees.)

**Rx Claims** Paid Rx Claims

**Total Paid Claims** Total Paid for Large Claimant

Claimants Over: \$10,000

Group Number: Kleberg County - 94681

Claims Paid: 5/1/2011 - 4/30/2012

Run Date: May 18, 2012

**CONFIDENTIAL**



TEXAS ASSOCIATION of COUNTIES  
HEALTH AND EMPLOYEE BENEFITS POOL

## Large Claimant Summary

Claimants Over: \$10,000

Group Number: Kleberg County - 94681

Claims Paid: 5/1/2011 - 4/30/2012

Product Type: PPO

Claimant Number	Status	Medical Claims	Rx Claims	Total Paid Claims
854602G	Retired	\$135,445.47	\$149.54	\$135,595.01
857638G	Active	\$104,877.07	\$715.72	\$105,592.79
857343G	Active	\$16,569.94	\$38,474.58	\$55,044.52
851971G	Active	\$35,927.57	\$696.81	\$36,624.38
849928G	Active	\$21,291.29	\$1,258.62	\$22,549.91
896530G	Retired	\$21,640.87	\$356.64	\$21,997.51
874711G	Active	\$16,235.76	\$651.85	\$16,887.61
869353G	Active	\$15,829.76	\$0.00	\$15,829.76
874710G	Active	\$11,087.19	\$3,591.17	\$14,678.36
922427G	Active	\$13,031.72	\$182.96	\$13,214.68
905366G	Active	\$10,760.89	\$1,107.93	\$11,868.82
864744G	Active	\$7,085.03	\$4,621.88	\$11,706.91
920136G	Active	\$11,511.44	\$0.00	\$11,511.44
857948G	Active	\$10,546.32	\$850.57	\$11,396.89
869333G	Active	\$925.15	\$10,321.81	\$11,246.96
873478G	Active	\$8,437.01	\$2,013.56	\$10,450.57
<b>PPO Group Total for Large Claimants</b>		<b>\$441,202.48</b>	<b>\$64,993.64</b>	<b>\$506,196.12</b>
<b>Grand Total for Large Claimants</b>		<b>\$441,202.48</b>	<b>\$64,993.64</b>	<b>\$506,196.12</b>



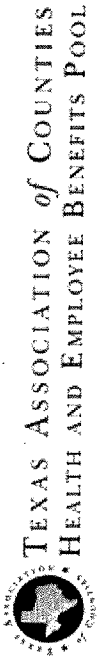
TEXAS ASSOCIATION OF COUNTIES  
HEALTH AND EMPLOYEE BENEFITS POOL

# 12 Month Report - Medical

Group Number: Kleberg County - 94681

Claims Paid Through: 4/30/2012

Month / Year	Total EEs	Total Members	Contribution	Paid Medical	Paid RX	Total Paid
Apr-2012	174	388	\$176,644.46	\$89,054.69	\$36,758.21	\$125,812.90
Mar-2012	173	382	\$178,892.64	\$111,476.83	\$35,975.38	\$147,452.21
Feb-2012	180	391	\$184,730.06	\$125,181.07	\$32,169.59	\$157,350.66
Jan-2012	181	390	\$183,470.62	\$212,416.87	\$23,273.32	\$235,690.19
Dec-2011	184	398	\$187,316.26	\$50,382.06	\$32,386.60	\$82,768.66
Nov-2011	179	389	\$185,270.64	\$73,576.38	\$26,751.66	\$100,328.04
Oct-2011	180	389	\$185,900.34	\$46,928.07	\$18,018.16	\$64,946.23
Sep-2011	0	0	\$0.00	\$0.00	\$0.00	\$0.00
Aug-2011	0	0	\$0.00	\$0.00	\$0.00	\$0.00
Jul-2011	0	0	\$0.00	\$0.00	\$0.00	\$0.00
Jun-2011	0	0	\$0.00	\$0.00	\$0.00	\$0.00
May-2011	0	0	\$0.00	\$0.00	\$0.00	\$0.00
Total for 12 months			\$1,282,225.02	\$709,015.97	\$205,332.92	\$914,348.89



**TEXAS ASSOCIATION OF COUNTIES  
HEALTH AND EMPLOYEE BENEFITS POOL**

# 12 Month Report - Medical

Group Number: Kieberg County - 094681

Claims Paid Through: 5/31/2013

Month / Year	Total EEs	Total Members	Contribution	Paid Medical	Paid RX	Total Paid
May-2013	184	385	\$170,328.68	\$167,428.04	\$23,185.26	\$190,613.30
Apr-2013	182	380	\$170,001.94	\$258,832.11	\$24,068.24	\$282,900.35
Mar-2013	179	376	\$167,235.92	\$119,814.00	\$22,632.32	\$142,446.32
Feb-2013	179	376	\$167,819.96	\$153,502.98	\$21,211.93	\$174,714.91
Jan-2013	179	375	\$169,331.62	\$73,798.70	\$20,640.33	\$94,439.03
Dec-2012	175	372	\$166,265.16	\$178,160.78	\$25,483.66	\$203,644.44
Nov-2012	172	361	\$163,284.98	\$134,833.22	\$15,754.28	\$150,587.50
Oct-2012	169	356	\$171,166.10	\$114,293.75	\$42,027.17	\$156,320.92
Sep-2012	165	357	\$167,895.12	\$143,154.64	\$30,310.68	\$173,465.32
Aug-2012	167	368	\$172,980.38	\$156,640.20	\$32,196.35	\$188,836.55
Jul-2012	167	368	\$172,032.44	\$195,690.41	\$28,283.24	\$223,973.65
Jun-2012	171	381	\$178,458.76	\$131,880.45	\$29,041.67	\$160,922.12
Total for 12 months			\$2,036,801.06	\$1,828,029.28	\$314,835.13	\$2,142,864.41

# **Self-Funded Health Insurance Checklist**

**Self-Funded Health Plan Checklist**  
(Please return with your proposal)

Name of Submitting Firm: \_\_\_\_\_

Please check

- \_\_\_ Third Party Administrator / Insurance Carrier Services
- \_\_\_ Stop Loss Coverage (include carriers full proposal)
- \_\_\_ Prescription Card Services
- \_\_\_ UR / Large Case Management Service
- \_\_\_ PPO Network Services
- \_\_\_ COBRA / HIPAA Services
- \_\_\_ Disease Management
- \_\_\_ Self-funded questionnaire, proposal forms and other attachments
- \_\_\_ Litigation for past 5 years
- \_\_\_ PPO Provider Interruption Report
- \_\_\_ Pharmacy Provider Interruption Report
- \_\_\_ Sample Reports
- \_\_\_ Sample EOB
- \_\_\_ Stop Loss Quote
- \_\_\_ Insurance Certificates
- \_\_\_ Client References
- \_\_\_ Company's Recent Audited Financial Statement
- \_\_\_ Anti Collusion Certification Form
- \_\_\_ Errors & Omissions Certifications
- \_\_\_ Enclosed & Signed Bid Certification and Declaration of
- \_\_\_ Conflict of Interest Form

Compliance Form

**KLEBERG COUNTY**  
**HEALTH BENEFIT PLAN**  
**REQUEST FOR PROPOSALS**

**SELF-INSURED MEDICAL WITH STOP LOSS COVERAGE**  
**AND ADMINISTRATION SERVICES**

**Bid Certification**  
**and**  
**Declaration of Compliance**

The undersigned, as Proposing Insurance Company and / or Third Party Administrator does hereby declare that they have read the specifications for KLEBERG COUNTY Request for Self-Insured Medical Stop Loss Coverage and Administration Services, and with full knowledge of the requirements, does hereby agree to furnish all services and afford all provisions of coverage in full accordance with the specifications and requirements.

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 an unfair advantage over other proposers in the award of this insurance.

Company: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Signature of Authorized Agent: \_\_\_\_\_

Typed Name: \_\_\_\_\_

Title: \_\_\_\_\_

**KLEBERG COUNTY  
HEALTH BENEFIT PLAN  
REQUEST FOR PROPOSALS**

**SELF-INSURED MEDICAL WITH STOP LOSS COVERAGE  
AND ADMINISTRATION SERVICES**

**ANTI-COLLUSION CERTIFICATION**

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By submission of this proposal, the Proposer certifies that:

- (1) This proposal has been independently arrived at without collusion with any other Proposer or with any competitor;
- (2) This proposal has not been knowingly disclosed and will not be knowingly disclosed, prior to the opening of proposals for this project, to any other proposer competitor or potential competitor;
- (3) No attempt has been or will be made to induce any other person, partnership or corporation to submit or not to submit a proposal;
- (4) The person signing this proposal certifies that the has fully informed himself 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.

\_\_\_\_\_  
Company Name

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Address

\_\_\_\_\_  
Type Signatory's Name & Title

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Agent Name

\_\_\_\_\_  
Fax Number

\_\_\_\_\_  
Agent Address



## 1. ADMINISTRATION AND CUSTOMER SERVICE

Administrator / Insurance Company Name: \_\_\_\_\_

1. Where is your claims office located?
2. Please comment on where customer service will be provided.
3. Who will be the account executive / representative assigned to the COUNTY's account during the implementation stage and during the operational stage and available for County committee meetings and campus presentations?
4. Have you provided all the managed healthcare administration services requested in this RFP? Please list all the vendors or sub contractors selected and their respective services.
5. Will you provide enrollment materials, Rx information, plan documents, benefit booklets, network directories, ID cards, claim forms, and all appropriate employee communication? Detail all costs associated with this material and illustrate on the enclosed forms.
6. Would you be willing to provide a representative to assist in the enrollment of the medical plan? If so, is there any additional fee for this service?
7. Does your company have bi-lingual (Spanish speaking) customer service representatives servicing incoming phone calls?
8. Are all fee schedules of facility and individual provider contracts loaded on the claim adjudication software?
9. Briefly explain your electronic claims processing capability. What percentage of hospital claims and physician claims are processed electronically?

10. Can the COUNTY utilize a local banking arrangement for claims disbursements? Will you provide bank reconciliation services and what are those fees?
11. Will you provide a Master Plan Document and Single Plan Document? How long does it take to create the initial document after implementation?
12. The administrator must provide an acceptable contract for execution within 45 days of the effective date.
13. Provide 2011 and 2012 processing accuracy data.
14. Will you provide necessary 1099's to providers?
15. The administrator must have a Letter of Authority from the Texas State Board of Insurance. A copy of this authority must be included in the proposal. The administrator must show proof of being bonded in the amount of no less than \$1,000,000. The administrator must show proof of Errors and Omissions coverage with a minimum per cause coverage of \$1,000,000 and an aggregate per policyholder of \$1,000,000. A copy of this coverage should be submitted with the proposal.
16. Disclosure of litigation history for the past 5 years is required by proposing company.
17. Please provide a copy of your employee and provider EOB's in your responses.
18. How are your financial and statistical reports managed and supported? Do you operate a separate data warehouse or use your software vendor's standard and reporting process?
19. Are you willing to meet quarterly with KLEBERG COUNTY staff to discuss administrative (financial reports), service, provider relations issues, and provide prompt response / resolution to problems?

20. What are the days and hours (Central Standard Time) of your customer service unit? How do you handle after hours calls? How do you handle incoming after hour calls from providers?
21. Will your company operate on “real time” for claims and eligibility?
22. Will ID cards be mailed to covered members to their home address?
23. Will your company provide a dedicated toll free line for our accounts?
24. Will your company auto adjudicate claims or will there be adjuster intervention? What percentage?
25. What is your procedure for notifying / terminating over age dependents? What is your procedure for file maintenance and employee terminations?
26. Do you offer online enrollment services? If so, please describe your enrollment capabilities? Is there an additional cost for these services?
27. Will you provide electronic information necessary to KLEBERG COUNTY to populate their summary of benefits on the COUNTY’s home page?
28. Explain your pre-existing investigation process.
29. Please discuss your procedures and processes for handling the following during the transition period.
  - a. Transfer of claim and benefit history.
  - b. Employees / dependents in active treatment
  - c. Pregnancy (2<sup>nd</sup> and 3<sup>rd</sup> trimesters)
  - d. Members undergoing chemotherapy or radiation
  - e. Members confined in hospital at changeover dates
  - f. Members under case management

- g. Services that have been pre-certified but not completed as of the non-effective date
30. Please discuss your process in handling patients that are currently receiving care in a non-network hospital as well as those currently receiving outpatient services.
  31. Provide a plan for continuation of current treatment during transition.
  32. Will your firm pay the run-off claims and facilitate the preferred provider network pricing? If yes, what is the cost?
  33. Can your claims system administer a family monthly deductible and a family annual out of pocket? If yes, please propose options.
  34. Can your claims system administer a two tier deductible plan? If yes, please propose options.
  35. Disclose if you have any ownership interest in any companies you are proposing. Please indicate yes or no. Provider Network: \_\_\_\_\_. Prescription Benefit Manager: \_\_\_\_\_. Stop Loss Carrier: \_\_\_\_\_. UR Case Management Companies: \_\_\_\_\_. Cobra/HIPPA: \_\_\_\_\_. Administration Company: \_\_\_\_\_. Disease Management Company: \_\_\_\_\_.
  36. Please provide complete information about your Company's website site capabilities and answer the following questions:

**Customer Self Service**

- Can members access PPO provider information?
- Can members access benefit plan summaries?
- Can members check eligibility?
- Can members order replacement ID cards?
- Can members file a claim?
- Can members download a printable claim form?
- Can members check claim status?
- Can members submit appeals?
- Can members submit inquiries to customer service via email?
- Can members access personal disease management information?
- Can members check RX orders online?
- Can members make refill orders of mail order RX?

YES	NO

**Provider Support**

- Can providers verify in “real-time”, the eligibility status of members?
- Can providers access drug and medical history for their patients?
- Can providers access lab values or other encounter data?
- Can providers submit claims?
- Can providers submit precertification information?
- Can providers initiate appeals, see performance profiles, access protocols, policies, and procedures?

YES	NO

**Plan Sponsor / Enrollment**

- Can plan sponsor access health care information reports specific to their population?
- Can plan sponsor view employee eligibility records?
- Can plan sponsor change employee eligibility records?
- Can plan participants enroll online?

YES	NO

## 2. AGGREGATE AND SPECIFIC STOP LOSS COVERAGES

Name of Firm Submitting Proposal: \_\_\_\_\_

Stop Loss Carrier Name: \_\_\_\_\_

1. Best Rating and class of Stop Loss Carrier and /or Insurance Company.
2. What benefits accumulate to Stop Loss Coverage?
3. Describe Stop Loss settlement procedures for both specific and aggregate and documentation needed. Who is responsible for the process?
4. Do you laser or exclude individuals under the Stop Loss? If yes, please explain.
5. Do you laser or exclude individuals under the Stop Loss at renewal? If yes, explain.
6. Are there any qualifications to stop your Stop Loss Quotes? Please Explain. Include the Stop Loss quotation with your quote?
7. Do you require a particular Transplant Network? If yes, please name.
8. What trend factors have been used for your proposal?
9. What formula is used to calculate minimum annual attachment factor?
10. Describe your renewal rating formula.
11. Please state any variations from bidding assumptions.
12. Does your stop loss carrier contract allow credit to the aggregate for run-off claims paid by the current Third Party Administrator?

### 3. PROVIDER NETWORK

Name of Firm Submitting Proposal: \_\_\_\_\_

Name of Provider Network: \_\_\_\_\_

1. Do you publish network directories? If so how often? At what cost?
2. Are network directories available online?
3. Do you notify the client in writing when major changes in the provider networks are anticipated?
4. Will you provide notification of physician's loss of license? Dropping from the network?
5. What percent of the physician panel in the Kingsville/Corpus Christi, Texas area is closed to new patients?
6. Will you provide quarterly / annual Provider Savings Reports? Will there be an additional cost?
7. Include a copy of the directory of the Provider Network you are proposing.
8. What are the average hospital discounts, inpatient and outpatient, in the Kingsville/Corpus Christi, Texas area?
9. What are your average discounts for physicians in the Kingsville/Corpus Christi, Texas area?
10. Do you utilize a wrap around network in Texas, for services rendered outside Kingsville/Corpus Christi, Texas? If so, what network do you use? What is the cost of utilizing the wrap around network?
11. Describe the procedures that employees would follow when inquiring about network providers.
12. Provide background information on your network including ownership.

#### 4. PHARMACY

Name of Firm Submitting Proposal: \_\_\_\_\_

Name of Prescription Drug Management Company:  
\_\_\_\_\_

1. How often is the preferred drug list (formulary) revised?
2. Under what circumstances are drugs removed from the list?
3. How does your company inform participants of changes to the formulary?
4. Indicate the formulary options included in your quotation.
5. What percent of your total prescriptions filled in 2012 used formulary drugs?
6. How many drugs (brand name and generic) are included in the formulary?
7. Are physicians required to obtain prior authorization for prescribing certain drugs that are on the formulary? If so, what drugs require pre-authorization?
8. Does your plan have a formalized drug utilization review program? If yes, please describe.
9. Describe your formulary rebate program. Will rebates be reimbursed directly to Kleberg County?
10. Do you have any recommendations for plan design to maximize the benefit / cost ratio?
11. Include samples of the various formulary listings that would be distributed to employees.
12. List the Kingsville/ Corpus Christi, Texas area pharmacies included in your network.
13. Do you have Rx Performance Guarantee refunds? Will those be sent to the County?
14. Will your PBM support specific OTC meds (Claritin, Prilosec) at no cost to covered member?
15. Will your PBM provide utilization reports? What type and how often? Is there a charge?