REQUEST FOR PROPOSAL NO. 2017-712
THIRD PARTY MEDICAL & DENTAL CLAIMS ADMINISTRATION SERVICES
UTILIZATION REVIEW / CASE MANAGEMENT
MEDICAL NETWORK
PRESCRIPTION DRUG NETWORK

TO BE EFFECTIVE OCTOBER 01, 2017

GREGG COUNTY, TEXAS

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REQUEST FOR PROPOSALS NO. 2017-712

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Instructions to Proposers

Proposals are solicited for furnishing the services as set forth in this document. **Detailed specifications are provided in RFP Submission Forms.**

Submit one (1) complete ORIGINAL & two (2) copies of your proposal which is typed or legible printed and sealed in a labeled envelope to the Gregg County Purchasing Dept., 101 E. Methvin, Suite 205, Longview, Texas 75601, on or before June 29, 2017 at 2:00 PM, CDT.
LATE BIDS WILL NOT BE ACCEPTED AND WILL BE RETURNED UNOPENED.

Proposals may be withdrawn any time prior to the official opening. Alterations made before proposer-guaranteeing authenticity must be initialed at the time of opening.

The undersigned agrees, if this proposal is accepted, to furnish any/all items upon which prices are offered, at the prices and upon the terms and conditions contained in this document. The period for acceptance of this proposal will be (60) calendar days unless a different period is noted.

Gregg County expressly reserves the right to accept or reject in part or in whole any proposal submitted, and to waive any technicalities or formalities, considered to be in the best interest of Gregg County.

The undersigned affirms that they are duly authorized to execute this proposal; that this company, corporation, firm, partnership or individual has not prepared this proposal in collusion with any other contractor and that the contents of this as to prices, terms or conditions have not been communicated by the undersigned nor by any employee or agent to any other contractor or to any other person(s) engaged in this type of business prior to the official opening. And further, that the manager, secretary or other agent or officer signing this document is not and has not been for the past six months directly or indirectly concerned in any pool or agreement or combination to control the price of services offered, or to influence any person to submit a proposal or not to submit a proposal thereon. **Failure to follow the instructions could result in the rejection of your proposal.**

Acknowledged:

Company _____ Address _____

Contact _____ Phone _____ Fax _____ E-mail _____

Signature _____ Title _____ Date _____

UNSIGNED PROPOSALS WILL BE DISQUALIFIED

Gregg County Texas Standard Terms and Conditions

STANDARD TERMS AND CONDITIONS

By returning this bid with price(s) quoted and forms executed, Respondent's certify and agree to the following:

1. Alternate bids will not be considered unless authorized. If there is any question as to the specifications or any part thereof, Respondent may submit to the Gregg County, Texas Purchasing Agent, a request for clarification. Such requests must be received a minimum of five (5) days prior to scheduled opening date.

2. Non-performance or non-compliance of the Standard Terms & Conditions, or non- performance or non-compliance with the Specifications shall be basis for termination by Gregg County of the bid or final executed contract. Termination in whole, or in part, by the County may be made solely at the County's option and without prejudice to any other remedy to which Gregg County may be entitled by law or in equity, or elsewhere under this Bid or the agreement, by giving thirty (30) days written notice to the vendor with the understanding that all work being performed under this agreement shall cease upon the date specified in such notice. Gregg County shall not pay for work, equipment, services or supplies, which are unsatisfactory. The Respondent may be given reasonable opportunity prior to termination to correct any deficiency. This however shall in no way be construed as negating the basis for termination for non-performance or non-compliance.

3. Respondent shall make all inquiries necessary to be thoroughly informed as to the specifications and all other requirements proposed in the Bid. Any apparent omission or silence of detail in the description concerning any point in the specifications shall be interpreted on the basis of best commercial practices, and best commercial practices shall prevail.

4. The Respondent shall affirmatively demonstrate Respondent's qualifications by meeting or exceeding the following minimum requirements:

   - ✓ Have adequate financial resources, or the ability to obtain such resources as required.
   - ✓ Be able to comply with any required or proposed delivery schedule.
   - ✓ Have a satisfactory record of performance.
   - ✓ Have a satisfactory record of integrity and ethics.
   - ✓ Be otherwise qualified and eligible to receive the award.

5. Invoices shall be sent to the Gregg County Purchasing Department, 101 East Methvin, St. 205, Longview, TX, 75601. Invoices must detail the materials/equipment/services delivered and **must reference the Gregg County Purchase Order Number.** Payments are processed after the Purchasing Department has verified that the material or equipment and/or services have been delivered in good condition and that no unauthorized substitutions have been made according to specifications. Neither a signed receipt nor payments shall be construed as an acceptance of any defective work, improper materials, or release of any claim for damage.

6. Only the Commissioners Court of Gregg County, Texas acting as a body may enter into any type of agreement or contract on behalf of Gregg County. Department heads, other elected or appointed officials, are not authorized to enter into any type of agreement or contract on behalf of Gregg County, or to agree to any type of supplemental agreements or contracts for goods or services. Contracts are subject to review by the County's attorney prior to signature by the authorized County official.

7. The Respondent shall be considered an independent Contractor and not an agent, servant, employee or representative of the County in the performance of the work. No term or provision, hereof, or act of the Respondent shall be construed as changing that status.

8. The Respondent shall defend, indemnify, and shall save whole and harmless the County and all its officers, agents, employees from and against all suits, actions, or claims of the character, name and description brought for or on account of any injuries or damages (including but not restricted to death) received or sustained by any person(s) or property on account of, arising out of, or in connection with the performance of the work, including without limiting the generality of the foregoing, any negligent act or omission of the Respondent on the execution or performance of the Contract.

9. The Respondent agrees, during the performance of the work, to comply with all applicable codes and ordinances of the City of Longview, Gregg County, or State of Texas as they may apply, as these laws may now read or as they may hereafter be changed or amended.

10. The Respondent shall obtain from the appropriate City, Gregg County, or State of Texas the necessary permit(s) required by the ordinances of the City, County, or State, for performance of the work.

11. The Respondent shall not sell, assign, transfer or convey the agreement in whole or in part, without the prior written consent of the County.

12. The parties herein agree that the agreement shall be enforceable in Gregg County, Texas**,** and if legal action is necessary to enforce it, exclusive venue shall lie in Gregg County, Texas.

13. The agreement shall be governed by, and construed in accordance with, the Laws of the State of Texas and all applicable Federal Laws.

14. Funding Clause - Payments required to be made by Gregg County under the terms of the agreement shall be contingent upon and subject to the initial and continuing appropriation of funding for the agreement by and through the Commissioners Court of Gregg County, Texas. In the event appropriations for funding of the agreement are not approved by and through the Commissioners Court, the contract shall terminate. Gregg County shall, submit written notice to Respondent thirty (30) days prior to such termination. Upon notice of termination, as provided in this paragraph, the Respondent may submit a final invoice to the County and coordinate with the Purchasing Agent to remove all property belonging to said Respondent as soon as possible. Payment for final invoice will be subject to verification and approval by the purchasing agent. Thereupon, Gregg County will be released from its obligation to make further payments.

15. Gregg County is exempt from federal excise and sales taxes, ad valorem taxes and personal property taxes; therefore, tax must not be included in proposals tendered. Proposals offered must be complete and all inclusive. Gregg County will not pay additional taxes, surcharges or other fees not included in bid prices.

16. Gregg County expressly reserves the right to accept or reject in part or in whole, any bids submitted, and to waive any technicalities or formalities as to such waiver is determined to be in the best interest of Gregg County.

17. In case any one or more of the provisions contained in the agreement shall for any reason be held to be invalid, illegal, or unenforceable in any respect, such invalidity, illegality, or unenforceability shall not affect any other provision thereof and the agreement shall be considered as if such had never been contained herein.

18. Bids may be withdrawn prior to the official opening. Alterations made before the time of official opening must be initialed by Respondent guaranteeing authenticity. Proposals may not be amended, altered or withdrawn after the official opening, except upon the explicit recommendation of the Purchasing Agent and the formal approval of the Commissioners Court.

19. The agreement embodies the complete agreement of the parties hereto, superseding all oral or written previous and contemporary agreements between the parties and relating to matters herein, and except as otherwise provided herein cannot be modified without written agreement of the parties. A contract will be executed after determination of the award.

20. Respondent must provide a certificate of insurance conforming to the above listed requirements or a statement of Respondent's insurance carrier certifying that the required coverage shall be obtained by Respondent within ten (10) days of formal award of the Contract. In the case where a certification letter from an insurance carrier is attached to the bid in lieu of an insurance certificate, any formal award of a contract shall be contingent upon required coverage being put into force **prior** to any performance required by subject agreement.

21. Gregg County reserves the right to terminate an agreement/contract at any time, without cause, upon thirty (30) days written notice to Respondent. Upon termination, Gregg County shall pay Respondent for those costs directly attributable to work done or supplies obtained in preparation for completion or compliance with the Contract, except no payment shall be made for costs recoverable by Respondent in the normal course of doing business or which can be mitigated through the sale of supplies or materials obtained for use under this Contract. It is further agreed by Respondent that Gregg County shall not be liable for loss or reduction in any anticipated profit.

22. Additional or alternate bonds may be required in accordance with Texas statutes as outlined in the specifications.

23. Gregg County is wholly committed to developing, establishing, maintaining, and enhancing minority business involvement in the total procurement process. The County, its contractors, their suppliers and sub-contractors, vendors of goods, equipment, services, and professional services, shall not discriminate on the basis of race, color, religion, national origin, age, handicap, or sex in the award and/or performance of contracts. However, competition and quality of work remain the ultimate standards in contractor, sub-contractor, vendor service, professional service, and supplier utilization. All vendors, suppliers, professionals and contractors doing business or anticipating doing business with Gregg County shall support, encourage and implement steps toward our common goal of establishing equal opportunity for all citizens of Gregg County.

24. Respondents must agree to provide the following information as part of this proposal:
    - ✓ Form of business. (If a corporation, limited partnership or limited liability company, indicate the state of creation).
    - ✓ Name of contact person (single point of contact with the Respondent).
    - ✓ List of all criminal charges, civil lawsuits or dispute resolutions to which Respondent is a party in the past five (5) years and the nature of the issue. Indicate if and how it was resolved.
    - ✓ List all criminal charges, civil lawsuits, or alternative dispute resolutions to which Respondent becomes a party for the period beginning with the submission of the proposal until the rejection or award of the bid/RFP.

25. Gregg County reserves the right to accept or reject any or all bids, with or without cause, to waive technicalities, or to accept the bid which, in its sole judgment, best serves the interest of the County, or to award a contract to the next most qualified Respondent if a successful Respondent does not execute a contract within 10 business days after approval of the selection by the Gregg County Commissioners Court. Gregg County Reserves the right to award multiple contracts as necessary and in the best interest of the County.

26. Gregg County reserves the right to request clarification of information submitted and to request additional information of one or more Respondents.

27. Costs of preparation of a response to this request for bids are solely those of the Respondent. Gregg County assumes no responsibility for any such costs incurred by the Respondent. The Respondent also agrees that Gregg County assumes no responsibility for any costs associated with any administrative or judicial proceedings resulting from the solicitation process.

28. The awarding Respondent shall maintain adequate records to justify all charges, expenses, and costs incurred in estimating and performing the work for at least two (2) years after completion of the contract resulting from this request for proposal. Gregg County shall have access to all records, documents and information collected and/or maintained by others in the course of the administration of this agreement.

29. Bidder understands and agrees that in returning a response to this proposal/bid that it is neither an "offer" nor an "acceptance" until such time a formal contract is authorized/awarded by the Gregg County Commissioners Court; if any.

30. Bids must be submitted on the forms provided. Bids will not be considered if submitted by telephone, fax or any other means of rapid dispatch, nor will a proposal be considered if submitted to any other person or department other than specifically instructed.

31. Gratuities– Gregg County may, by written notice to the Seller, cancel this contract without liability to Seller if it is determined by Gregg County that gratuities, in the form of entertainment, gifts, or otherwise, were offered or given by the Seller, or any agent or representative of the Seller, to any officer or employee of Gregg County with a view toward securing a contract or securing favorable treatment with respect to the awarding or amending, or the making of any determinations with respect to the performing of such a contract. In the event this contract is canceled by Gregg County pursuant to this provision, Gregg County shall be entitled, in addition to any other rights and remedies, to recover or withhold the amount of the cost incurred by Seller in providing such gratuities.

32. Termination - The performance of work under this order may be terminated in whole or in part by the Buyer in accordance with this provision. Termination of work hereunder shall be effected by the delivery to the Seller of a "Notice of Termination" specifying the extent to which performance of work under the order is terminated and the date upon which such termination becomes effective. Such right of termination is in addition to and not in lieu of rights of Buyer.

33. Force Majeure - If, by reason of Force Majeure, either party hereto shall be rendered unable wholly or in part to carry out its obligations under this Agreement then such party shall give notice and full particulars of such Force Majeure in writing to the other party within a reasonable time after occurrence of the event or cause relied upon, and the obligation of the party giving such notice, so far as it is affected by such Force Majeure, shall be suspended during the continuance of the inability then claimed, except as hereinafter provided, but for no longer period, and such party shall endeavor to remove or overcome such inability with all reasonable dispatch. The term Force Majeure as employed herein, shall mean acts of God, strikes, lockouts, or other industrial disturbances, act of public enemies, orders of any kind of government of the United States or the State of Texas or any civil or military authority, insurrections, riots, epidemics, landslides, lightning, earthquake, fires, hurricanes, storms, floods, washouts, droughts, arrests, restraint of government and people, civil disturbances, explosions, breakage or accidents to machinery, pipelines or canals or other causes not reasonably within the control of the party claiming such inability. It is understood and agreed that the settlement of strikes and lockouts shall be entirely within the discretion of the party having the difficulty, and that the above requirement that any Force Majeure shall be remedied with all reasonable dispatch shall not require the settlement of strikes and lockouts by acceding to the demands of the opposing party or parties when such settlement is unfavorable in the judgment of the party having the difficulty.

34. Assignment Delegation - No right or interest in this contract shall be assigned or delegation of any obligation made by Seller without the written permission of the Buyer. Any attempted assignment or delegation by Seller shall be wholly void and totally ineffective for all purposes unless made in conformity with this paragraph.

35. Waivers - No claim or right arising out of a breach of this contract can be discharged in whole or in part by a waiver or renunciation of the claim or right unless the waiver or renunciation is supported by consideration and is in writing signed by the aggrieved party.

36. Modification - Contract can be modified or rescinded only by a written and signed agreement by both of the parties duly authorized agents.

37. Applicable Law - This agreement shall be governed by the Uniform Commercial Code. Wherever the term "Uniform Commercial Code" is used, it shall be construed as meaning the Uniform Commercial Code as adopted in the State of Texas as effective and in force on the date of this agreement.

38. Advertising - Seller shall not advertise or publish, without Buyer's prior consent, the fact that Buyer has entered into this contract, except to the extent necessary to comply with proper requests for information from an authorized representative of the federal, state, or local government.

39. Right to Assurance - Whenever one party to this contract in good faith has reason to question the other party's intent to perform, he may demand that the other party give written assurance of his intent to perform. In the event a demand is made and no assurance is given within five (5) days, the demanding party may treat this failure as an anticipatory repudiation of the contract.

40. Venue - Both parties agree that venue for any litigation arising from this contract shall be in Longview, Gregg County, Texas.

41. No negotiations, decisions, or actions shall be executed by the vendor as a result of any discussions with any public service official, employee and/or consultant. Only those transactions provided in written form may be considered binding.

42. The contents of each vendor's bid, including specifications shall remain valid for a minimum of 60 calendar days from the Bid due date.

43. All documents submitted as part of the vendor’s offering will be deemed confidential during the evaluation process.

44. Subcontracting: The Vendor must function as the single point of responsibility for the Agency. No vendor shall submit a proposal comprised of separate software packages from multiple subcontractors.

45. Investigation of Conditions: Before submitting a bid, respondent should carefully examine the specifications and fully inform themselves to the conditions of the equipment and limitations.

46. Contract Award:

1) Gregg County reserves the right to reject any or all bids and to waive any minor informality or irregularity in a proposer's response if deemed in the best interests of the County.

2) Award of a contract (if any) resulting from this bid will be made only by written authorization from Gregg County Commissioners Court.

47. Conflict of Interest: No public official shall have interest in this contract except in accordance with Vernon's Texas Codes Annotated, Local Government Code Title 5, Subtitle C, Chapter 171. State Law (CHAPTER 176 of the Local Government Code) requires the filing of a CONFLICT OF INTEREST QUESTIONNAIRE by certain individuals and businesses.

48. Design, Strength, Quality of materials and workmanship must conform to the highest standards of manufacturing and engineering practice.

49. All Hardware of any other item offered in this bid must be new and unused, unless otherwise specified, in first-class condition and of current manufacture.

50. Descriptions: Whenever an article or material is defined or used in the BID specifications by describing a proprietary product or by using the name of a manufacturer, model number, or make, the term "or equal" if not inserted, shall be implied. Any reference to specified article or material shall be understood as descriptive, NOT restrictive, and is used to indicate type and quality level desired for comparison purposes unless otherwise noted. Bids must be submitted on units of quantity specified, extended, and totaled. In the event of discrepancies in extension, the unit prices shall govern.

51. Addendum: Any interpretations, corrections or changes to this Bid and Specifications will be made by addendum, unless otherwise stated. Issuing authority of addendum shall be the Commissioners' Court of Gregg County, Texas. Addendum will be mailed, emailed, or faxed to all that are known to have received a copy of the Bid. Vendors shall acknowledge receipt of all addenda and include receipt and response to addenda with submission.

52. Patents/Copyrights: The successful vendor agrees to protect Gregg County from claims involving infringements of patents and/or copyrights.

53. Contract Administrator: The Contract Administrator will serve as sole liaison between the Gregg County Commissioners Court and affected Gregg County Departments and the successful vendor. Unless directly outlined in this specification the vendor shall consider no one but the Contract Administrator authorized to communicate, by any means, information or suggestions regarding or resembling this bid throughout the proposal process. The Contract Administrator has been designated the responsibility to ensure compliance with contract requirements, such as but not limited to, acceptance, inspection and delivery. The County will not pay for work, equipment or supplies, which it deems unsatisfactory. Vendors will be given a reasonable opportunity to correct deficiencies before termination. This however, shall in no way be construed as negating the basis for termination for non-performance.

54. Packing slips or other suitable shipping documents shall accompany each special order shipment and shall include:

(a)) Name and address of successful vendor;
(b) Name and address of receiving department and/or location;
(c) Gregg County Purchase Order number; and,
(d) Descriptive information of the materials shipped or services rendered, including item numbers, serial numbers, quantities, number of containers and package numbers, address/location of services rendered, as applicable.

55. Unless otherwise indicated, items will be new, unused, and in first class condition in containers suitable for damage-free shipment and storage.

56. Invoices must show all information as stated above, and will be issued for each purchase order.

57. Equipment/Good/Services supplied under this contract shall be subject to the County's approval. Item(s) found defective or not meeting specifications shall be picked up and replaced by the successful vendor within one (1) week after notification at no expense to the County. If item(s) is not picked up within one (1) week after notification, the item(s) will become a donation to the County for disposition.

58. Warranty: Successful vendor shall warrant that all equipment/goods/services shall conform to the proposed specifications and/or all warranties stated in the Uniform Commercial Code and be free from all defects in material, workmanship and title.

59. Remedies: The successful vendor and Gregg County agree that both parties have all rights, duties, and remedies available as stated in the Uniform Commercial Code.

60. Silence of Specification: The apparent silence of these specifications as to any detail or to the apparent omission from it of a detailed description concerning any point, shall be regarded as meaning that only the best commercial practices are to prevail. All interpretations of these specifications shall be made on the basis of this statement.

61. The Contractor shall procure and maintain at its sole cost and expense for the duration of this Agreement insurance against claims for injuries to persons or damages to property that may arise from or in connection with the performance of the work hereunder by the Contractor, its agents, representatives, volunteers, employees or subcontractors. The Contractor's insurance coverage shall be primary insurance with respect to the County, its officials, employees and volunteers. Any insurance or self-insurance maintained by the County, its officials, employees or volunteers shall be considered in excess of the Contractor's insurance and shall not contribute to it. Further, the Contractor shall include all subcontractors as additional insured under its policies or shall furnish separate certificates and endorsements for each subcontractor. All coverage for subcontractors shall be subject to all of the requirements stated herein. **All Certificates of Insurance and endorsements shall be furnished to the County's Purchasing Agent and approved by the County *before* work commences.**

62. *Standard Insurance Policies Required*:

a. Commercial General Liability Policy
b. Automobile Liability Policy
c. Worker's Compensation Policy

General Requirements applicable to all policies:

a. Only insurance carriers licensed and admitted to do business in the State of Texas will be accepted.
b. Deductibles shall be listed on the Certificate of Insurance and are acceptable only on a per occurrence basis for property damage only.
c. "Claims Made" policies will not be accepted.
d. Each insurance policy shall be endorsed to state that coverage shall not be suspended, voided, canceled, reduced in coverage or in limits except after thirty (30) days prior written notice by certified mail, return receipt requested, has been given to Gregg County.
e. All insurance policies shall be furnished to Gregg County upon request.

Commercial General Liability

a. General Liability insurance shall be written by carrier with an A:VIII or better rating in accordance with the current Best Key Rating guide.
b. Minimum Combined Single Limit of $1,000,000.00 per occurrence for bodily Injury and property damage with Gregg County named as an additional insured.
c. No coverage shall be deleted from the standard policy without notification of individual exclusions being attached for review and acceptance.

Automobile Liability

a. General Liability Insurance shall be written by a carrier with an A:VIII or better rating in accordance with the current Best Key Rating Guide.
b. Minimum Combined Single Limit of $600,000.00 per occurrence for bodily injury and property damage.

63. ***Workers Compensation Insurance*** - Pursuant to the requirements set forth in Title 28, Section 110.110 of the Texas compensation insurance policy; either directly through their employer's policy (the Contractor's or subcontractor's policy) or through an executed coverage agreement on an approved TWCC form. Accordingly, if a subcontractor does not have his or her own policy and a coverage agreement is used, Contractors and subcontractors must use that portion of the form whereby the hiring contractor agrees to provide coverage to the employees of the subcontractor. The portion of the form that would otherwise allow them not to provide coverage for the employees of an independent contractor may not be used.

The worker's compensation insurance shall include the following terms:

a. Employer's Liability limits of $500,000.00 for each accident is required.
b. "Texas Waiver of Our Right to Recover from Others Endorsement" shall be included in this policy. (Waiver of Subrogation)

Pursuant to the explicit terms of Title 28, Section 110.110 (c) (7) of the Texas Administrative Code, the Proposal specifications, this Agreement, and all subcontracts on this Project must include the following terms and conditions in the following language, without any additional words or changes, except those required to accommodate the specific document in which they are contained or to impose stricter standards of documentation:

Definitions:

Certificate of coverage ("certificate") - A copy of a certificate of insurance, a certificate of authority to self-insure issued by the Texas Worker's Compensation Commission, or a coverage agreement)TWCC-81), TWCC-83, or TWCC-84), showing statutory worker's compensation insurance coverage for the person's or entity's employees providing services on a project, for the duration of the project.

Duration of the project - includes the time from the beginning of the work on the project until the Contractor's/person's work on the project has been completed and accepted by the governmental entity.

Persons providing services on the project ("subcontractors" in section 406.096 {of the Texas Labor Code}) - includes all persons or entities performing all or part of the services the Contractor has undertaken to perform on the project, regardless of whether that person has employees. This includes, without limitation, independent Contractors, subcontractors, leasing companies, motor carriers, owner-operators, employees of any such entity or employees of any entity which furnishes persons to provide services on the project. "Services" include, without limitation, providing, hauling, or delivering equipment or materials, or providing labor, transportation, or other service related to a project. "Services" does not include activities unrelated to the project, such as food/beverage respondents, office supply deliveries, and delivery of portable toilets.

- The Contractor shall provide coverage, based on the proper reporting of classification codes and payroll amounts and filing of any coverage agreements, that meets the statutory requirements of Texas Labor Code, Section 401.011 (44) for all employees of the Contractor providing services on the project, for the duration of the project.

- The Contractor must provide a certificate of coverage to the governmental entity prior to being awarded the contract.

- If the coverage period shown on the Contractor's current certificate of coverage ends during the duration of the project, the Contractor must, prior to the end of the coverage period, file a new certificate of coverage with the governmental entity showing that coverage has been extended.

- The Contractor shall obtain from each person providing services on a project, and provide to the governmental entity:

    (1) a certificate of coverage, prior to that person beginning work on the project, so the governmental entity will have on file providing services on the project, and certificates of coverage showing coverage for all person; and

    (2) no later than seven calendar days after receipt by the Contractor, a new certificate of coverage showing extension of coverage, if the coverage period shown on the current certificate of coverage ends during the duration of the project.

    (3) The Contractor shall retain all required certificates of coverage for the duration of the project and for one year thereafter.

The Contractor shall notify the governmental entity in writing by certified mail or personal delivery, within 10 calendar days after the Contractor knew or should have known, or any change that materially affects the provision of coverage of any person providing services on the project.

The Contractor shall post on each project site a notice, in the text, form and manner prescribed by the Texas Workers' Compensation commission, informing all persons providing services on the project that they are required to be covered, and stating how a person may verify coverage and report lack of coverage.

The Contractor shall contractually require each person with whom it contracts to provide services on a project, to:

(1) provide coverage, based on proper reporting of classification codes and payroll amounts and filing of any coverage agreement, that meets the statutory requirements of Texas Labor Code, Section 401.011 (44) for all of its employees providing services on the project, for the duration of the project;

(2) provide to the Contractor, prior to that person beginning work on the project, a certificate of coverage showing that coverage is being provided for all employees of the person providing services on the project, for the duration of the project;

(3) provide the Contractor, prior to the end of the coverage period, a new certificate of coverage showing extension of coverage, if the coverage period shown on the current certificate of coverage ends during the duration of the project.

(4) obtain from each other person with whom it contracts, and provide to the Contractor:

  (a) a certificate of coverage, prior to the other person beginning work on the project; and

  (b) a new certificate of coverage showing extension of coverage, prior to the end of the coverage period, if the coverage period shown on the current certificate of coverage ends during the duration of the project;

(5) retain all required certificates of coverage on file for the duration of the project and for one year thereafter;

(6) notify the governmental entity in writing by certified mail or personal delivery, within 10 calendar days after the person knew or should have known, of any change that materially affects the provision of coverage of any person providing services on the project; and

(7) Contractually require each person with whom it contracts, to perform as required; with the certificates of coverage to be provided to the person for whom they are providing services.

By signing a contract with Gregg County, or providing, or causing to be provided a certificate of coverage, the Contractor who will provide services on the project will be covered by workers' compensation coverage for the duration of the project, that the coverage will be based on proper reporting of classification codes and payroll amounts, and that all coverage agreements will be filed with the appropriate insurance carrier, or, in the case of a self-insured, with the commission's Division of Self-Insurance regulation. Providing false or misleading information may subject the Contractor to administrative penalties, criminal penalties, civil penalties, or other civil actions.

CERTIFICATES OF INSURANCE shall be prepared and executed by the insurance company or its authorized agent, and shall contain the following provisions and warranties:

a. The company is licensed and admitted to do business in the State of Texas.
b. The insurance policies provided by the insurance company are underwritten on forms that have been provided by the Texas State Board of Insurance or ISO.
c. All endorsements and insurance coverage according to requirements and instructions contained herein.
d. The form of the notice of cancellation, termination, or change in coverage provisions to Gregg County.
e. Original endorsements affecting coverage required by the section shall be furnished with the certificates of insurance.

BONDING REQUIREMENTS

If applicable, a Bid Bond shall be required. Pursuant to the provisions of Section 262.032 (a) of the Texas Local Government Code, if the contract contemplated by this request is a bid for the construction of public works, or will be under a contract exceeding $100,000.00, Gregg County may require the vendor to execute a good and sufficient bid bond in the amount of five percent (5%) of the total contract price. Said bond shall be executed with a surety company authorized to do business in the State of Texas.

If applicable, a Performance Bond shall be required. Pursuant to the provisions of Section

262.032 (b) of the Texas Local Government Code, within thirty (30) days of the date of the signing of a contract or issuance of a purchase order following the acceptance of a bid by Gregg County Commissioners Court and prior to commencement of the actual work, the successful vendor shall furnish a performance bond to Gregg County for the full amount of the contract if the contract exceeds $50,000.00. Said bond shall be for the purpose of insuring the faithful performance of the work in accordance with the plans, specifications and contract documents associated with the contract.

If applicable, a Payment Bond shall be required. Pursuant to the provisions of Section 2253.021, Texas Government Code, if the amount of the contract awarded to the successful vendor exceeds

$25,000.00, the successful vendor shall execute a payment bond in the amount of the contract. Said bond is solely for the protection and use of payment bond beneficiaries who have a direct contractual relationship with the prime contractor or a subcontractor to supply public work labor or material. This bond must be issued to the County within ten (10) days of the award of the contract and before vendor begins the work.

If applicable, a Performance Bond shall be required. Pursuant to the provisions of Section 2253.021, Texas Government Code, if the amount of the contract awarded to the successful vendor exceeds $100,000.00, the successful vendor shall execute a performance bond in the amount of the contract. Said performance bond is solely for the protection of Gregg County and is conditioned on the faithful performance of the work in accordance with the plans, specifications, and contract documents. This bond must be issued to the County within ten (10) days of the award of the contract and before the vendor begins the work.

Certificate of Interested Parties (Form 1295)

In 2015, the Texas Legislature adopted House Bill 1295, which added Section 2252.908 of the Government Code. The law states that a government entity may not enter into certain contracts with a business entity unless the business entity submits a disclosure of interested parties to the government entity. The disclosure of interested parties will be submitted online via Form 1295 and must be submitted to the governmental entity prior to any signed contract and/or vote by the governing authority.

The Filing Process:

1. Prior to award by Commissioners Court, your firm will be required to log in to the Texas Ethics Commission, https://www.ethics.state.tx.us/whatsnew/elf_info_form1295.htm and fill out the Electronic Filing Application.
2. Once submitted, the system will generate an electronic Form 1295 displaying a "Certificate Number." Your firm must print, sign and notarize Form 1295.
3. **Within ten (10) business days** from notification of pending award by the Gregg County Purchasing Agent, the completed Form 1295 **must** be submitted to Gregg County.
4. Your firm will need to repeat this process and obtain a separate Form 1295 each time you enter into a new contract, renew a contract or make modification and/or amendments to a Gregg County contract.

Instructions and information are available at https://www/ethics.state.tx.us/tec/1295-Info.htm or you may call the Texas Ethics Commission at (512) 463-5800.

CERTIFICATION OF ELIGIBILITY

By submitting a bid or Bid in response to this solicitation, the bidder/proposer certifies that at the time of submission, he/she is ***not*** on the Federal Government's list of suspended, ineligible, or debarred contractors.

In the event of placement on the list between the time of bid/Bid submission and time of award, the bidder/proposer will notify the Gregg County Purchasing Agent. Failure to do so may result in terminating this contract for default.

Signature:_____ Date:_____

Printed Name:_____

REQUEST FOR PROPOSAL NO. 2017-712
THIRD PARTY MEDICAL & DENTAL CLAIMS ADMINISTRATION SERVICES
UTILIZATION REVIEW / CASE MANAGEMENT
MEDICAL NETWORK
PRESCRIPTION DRUG NETWORK

GENERAL PROPOSAL INFORMATION

1. These specifications are to obtain competitive proposals pursuant to Chapter 262 of the Texas Local Government Code for Gregg County.

2. Gregg County has appointed Wethe & Associates, Inc. to manage the competitive proposal process. Wethe & Associates is compensated by the County on a fee basis, and is not to be compensated by the service provider.

3. All questions, clarifications, or requests for additional information must be directed to Ken Wethe at Wethe & Associates. Requests or clarifications must be in writing and faxed to 214-350-9570 or e-mailed to Ken Wethe (kenwethe@sbcglobal.net). The deadline for submitting questions, clarifications, and requests for additional information is June 21, 2017 at 5:00 PM CDT. Wethe & Associates will provide all potential individuals or firms submitting a proposal with written answers to questions received, clarifications requested and/or additional information as needed.

4. Gregg County is seeking competitive proposals for Medical & Dental Claims Administration, Utilization Review/Case Management, Medical Network & Prescription Drug Network to be effective on October 01, 2017.

5. Gregg County will only accept competitive proposals from vendors licensed/authorized to do business in the State of Texas.

6. **For a proposal to be considered it must:**

    a. Be received no later than June 29, 2017 at 2:00 PM CDT.
    b. Include (1) original and two (2) copies; Large binders/notebooks are highly discouraged!
    c. Be in a **sealed** envelope that is plainly marked RFP No. 2017-712 - Proposal For Health & Dental Plan Administration;
    d. Be delivered to Purchasing Department, Gregg County Courthouse, 101 E. Methvin St., Suite 205, Longview, Texas 75601;
    e. Faxed or electronically submitted proposals will not be considered.
    f. Be signed by an individual authorized to bind the proposer;
    g. Be submitted on the form provided and in the format requested and include any and all applicable fees;
    h. Have the questionnaire completed, including restating the question if re-typed, in the format provided.

7. Any proposal received after 2:00 P.M. on June 29, 2017 will be returned to the proposer unopened.

8. Proposal forms and specifications are available by email or overnight delivery service on or after June 13, 2017 by contacting:

Ken Wethe, Independent Insurance Consultant
Wethe & Associates, Inc.
2607 Manor Way
Dallas, TX 75235
Tel: 214-350-9570 ~ Fax: 214-350-8745
Email: kenwethe@sbcglobal.net

9. Gregg County accepts no financial responsibility for any costs incurred by any proposer in the course of responding to this request for proposal.

10. Gregg County reserves the right to accept or reject any and all proposals and to waive any informality in the proposal process. Gregg County reserves the right to request post-proposal modifications, including best and final offer.

11. The County **requires** that the resultant contract from this RFP, if any, be performable in Gregg County, Texas.

12. If any of the information submitted in response to this request for proposal is considered to be confidential or a trade secret belonging to the responder and, if released would give advantage to a competitor, that information should be clearly marked: **"CONFIDENTIAL – DO NOT DUPLICATE WITHOUT PERMISSION".**

13. All qualified proposals will be evaluated and rated as follows:

    a. Cost – 50%
    b. Service – 15%
    c. Integration of Services– 15%
    d. Reputation/Financial Stability – 10%
    e. Completeness of Questionnaire – 10%

14. Gregg County **requires** a multiyear contract. Two year rate guarantee will be the minimum accepted and three year rate guarantee is preferred.

15. Proposals are to be submitted directly by service providers net of agent commissions.

GREGG COUNTY, TEXAS

REQUEST FOR PROPOSALS NO. 2017-712
THIRD PARTY MEDICAL & DENTAL CLAIMS ADMINISTRATION SERVICES

RFP SUBMISSION FORM

SPECIFIC INFORMATION

1. Proposal is to be based on current benefits, services& enrollment described in the Exhibits section of the RFP.

2. Gregg County has used the services of HealthFirst TPA since October 1, 2008 for claim administration services. Additional services provided by HealthFirst TPA include COBRA / HIPAA administration, plus record keeping for employee enrollment in various Gregg County insurance plans that include stop loss insurance, basic life / AD&D insurance, supplemental life / AD&D insurance and LTD insurance.

3. Effective date is to be **October 01, 2017**. All participants enrolled in the Health & Dental Benefits Plan as of **September 30, 2017**, are to be covered on a "No Loss/No Gain" basis. All health & dental services incurred on or after **October 01, 2017,** for enrolled participants are to be eligible expenses. Gregg County's enrollment records are to be the basis for "take-over."

4. "No Loss/No Gain" for participants is to include credit for accumulated deductible, coinsurance, and lifetime maximum benefits that will be provided in electronic format by current administrator.

5. First year administration services are for claims incurred and paid/processed during the year. Second and third year administration services are for all claims paid/processed during the respective year. **Current administrator will pay run-off claims**.

6. Gregg County requires the selected service provider to maintain all records on behalf of the County and to transfer the records to the County or their designee at contract termination.

7. Gregg County desires direct contract with claim administration provider. Thus, proposal is not to contain any commission or fee for agent services.

CLAIMS ADMINISTRATION
QUESTIONNAIRE:

1. Describe organization submitting proposal:

   a. Name of firm_____

   b. Address_____

   _____

   c. Contact person_____

   d. Telephone number_____ Fax Number_____

   e. Email Address_____

   f. Year founded_____

2. Attach the following information to determine financial stability:
   a. Most recent financial statement. ☐ Yes ☐ No

   b. Certificate of insurance coverage for Professional Liability, General Liability, Crime, and Fidelity Bond. ☐ Yes ☐ No

   c. Texas license for Third-Party Administration services. ☐ Yes ☐ No

   d. Most recent Report or third party claim audit. ☐ Yes ☐ No

3. Describe claims administration experience:

   a. Number of clients_____

   b. Average employer size_____

   c. Claims staffing levels for every 1,000 members_____

4. Provide three Texas client references, preferably government entities, which have been with your organization for over three (3) years:

Client Name	Contact Person	Telephone #	# Employees

5. Attach the background information for the claims manager, and claims examiner who will be in charge of processing and servicing Gregg County's self-funded health & dental plan.

6. Will services include enrollment and education meetings? ☐ Yes ☐ No

If yes, how many times per year? _____

Comments: _____

7. Describe administration contract:

a. Does your contract provide quality standards for claims turnaround, claims adjudication and accuracy rates (please provide actual percentages)? ☐ Yes ☐ No

If yes, attach specific quality standards to be used.

b. Does your contract provide for payment of run-off claims after contract termination?

☐ Yes ☐ No

Comment: _____

c. Please provide a specimen copy of your administration services contract.

8. Describe claim payment services:

a. Where will claims be paid?

_____

b. Describe the claims payment system(s) that your company would utilize for this group.

_____

c. Does your claims system have the capability of being accessed via a remote terminal for employee inquiry ?

☐ Yes ☐ No

Comment: _____

d. Does your claims payment system have the capability of receiving claims electronically?

☐ Yes ☐ No

e. Is your claim system compliant with HIPAA Privacy requirements? ☐ Yes ☐ No

Comment: _____

f. Is your claims system capable of handling a group with different plan designs?
Please note two levels of In-Network benefits.

☐ Yes ☐ No

Comment: _____

g. Is your medical network repricing seamless? ☐ Yes ☐ No

If no, please explain your medical network repricing procedures.

_____

h. Describe your clinical editing capabilities to detect unbundling, upcoding, duplicate claims payment and other erroneous claims filing practices, including fraud and other abuses.

_____

i. Describe source of reasonable and customary tables and how frequently they are updated.

_____

j. Describe the procedures used for subrogation investigation._____

k. Describe the procedures used for coordination of benefits._____

_____

l. Describe procedure used to screen for duplicate charges: _____

_____

m. Please provide a sample explanation of benefits (EOB).

9. Describe customer service and appeal process:

a. Is a toll-free number available for checking claim status? ☐ Yes ☐ No

Comment: _____

b. What are your customer service hours?

_____

c. Will you provide a local contact for Gregg County? ☐ Yes ☐ No

Comment:_____

d. Will a designated claim examiner process all of the Gregg County claims? ☐ Yes ☐ No

Comment: _____

e. Describe the process of appeal for a contested claim.

_____

10. Describe other services:

a. Will you provide COBRA / HIPAA administration services? ☐ Yes ☐ No

If yes, attach description of services to be provided.

b. Will you provide record keeping services for employee enrollment in various Gregg County insurance plans? ☐ Yes ☐ No

If yes, attach description of services to be provided.

c. Will you provide on-line enrollment services? ☐ Yes ☐ No

If yes, attach description of services to be provided.

d. Are claim reports available on-line? ☐Yes ☐No
Attach sample reports.

e. Will you provide Gregg County with a monthly claim data file in Excel format? ☐Yes ☐No

If yes, attach sample of data to be provided.

f. Will you provide Gregg County, upon request, subscriber eligibility file in Excel format? ☐ Yes ☐ No

If yes, attach sample of data to be provided.

g. Do you offer Health Risk Assessment services? ☐ Yes ☐ No

If so, attach description of services to be provided.

11. Will company agree to hold Gregg County harmless from any legal action resulting from company's services? Yes☐ No☐

12. Attach cost information for the following services for a three year period, assuming enrollment remains constant at 562 medical subscribers and 621 dental subscribers:

a. Medical Claim Administration

b. Dental Claim Administration

c. COBRA / HIPAA Administration

d. Insurance Enrollment Administration

13. Acknowledge Statement – Claims Administration

The undersigned hereby acknowledges that they have reviewed these proposal specifications, have had the opportunity to clarify any question or information in these proposal specifications in the manner provided and that the responses are true and accurate.

The undersigned hereby agrees to furnish all services in complete accordance with the requirements of these proposal specifications and the answers provided in responding to these proposal specifications.

The undersigned affirms that this 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 to the proposer.

The undersigned hereby declares that they have the authority to represent the proposer and to bind this proposal at the rates contained herein and that the contract will reflect the answers provided in this proposal response.

Company Name	Authorized Signature
Address	Type Signatory's Name & Title
	Telephone Number Fax Number
Date	Signatory's Email Address

GREGG COUNTY, TEXAS

REQUEST FOR PROPOSAL NO. 14-010
UTILIZATION REVIEW/CASE MANAGEMENT

RFP SUBMISSION FORM

SPECIFIC INFORMATION

1. Proposal is to be based on current benefits, services& enrollment described in the Exhibits section of the RFP.

2. Gregg County has used the services of MM Solutions since October 1, 2008 for utilization review, large case management and disease management services.

3. The service provider will be expected to coordinate services with the stop loss insurance company and with Gregg County's administrator for their partially self-funded health benefit plan.

4. Effective date is to be October 01, 2017.

5. Gregg County requires the selected service provider to maintain all records on behalf of the County and to transfer the records to the County or their designee at contract termination.

UTILIZATION REVIEW / CASE MANAGEMENT QUESTIONNAIRE:

1. Describe organization submitting proposal.
   a. Company Name: _____
   b. Address: _____
      _____
   c. Contact Person: _____
   d. Telephone Number: _____ Fax Number: _____
   e. Email Address: _____
   f. Year Founded: _____
2. Attach the following information to determine financial stability:
   a. Most recent financial statement Yes☐ No☐
   b. Certificate of Insurance Coverage for Professional Liability and General Liability insurance. Yes☐ No☐
3. Provide three Texas client references (preferably government entities):

Name of Client	Contact Person	Telephone Number	Number of Employees

4. Provide the date services first began for:
   a. Utilization Review
   b. Large Case management
   c. Disease Management
5. Provide complete description of services proposed to include the following:
   a. Professional staff
   b. Pre-Certification procedures & reports
   c. Large Case Management procedures & reports.
   d. Disease Management procedures & reports.

6. Will company agree to hold Gregg County harmless from any legal action resulting from company's services?
Yes☐ No☐

Comment: _____

7. Attach cost information for the following services for a three year period, assuming enrollment remains constant at 562 medical subscribers:

   a. Utilization Review

   b. Large Case Management

   c. Disease Management

   d. High Risk Pregnancy

8. Acknowledge Statement – Utilization Review/Case Management:

The undersigned hereby acknowledges that they have reviewed these proposal specifications, have had the opportunity to clarify any question or information in these proposal specifications in the manner provided and that the responses are true and accurate.

The undersigned hereby agrees to furnish all services in complete accordance with the requirements of these proposal specifications and the answers provided in responding to these proposal specifications.

The undersigned affirms that this 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 to the proposer.

The undersigned hereby declares that they have the authority to represent the proposer and to bind this proposal at the rates contained herein and that the contract will reflect the answers provided in this proposal response.

Company Name	Authorized Signature
Address	Type Signatory's Name & Title
	Telephone Number Fax Number
Date	Signatory's Email Address

GREGG COUNTY, TEXAS

REQUEST FOR PROPOSALS NO. 2017-712
MEDICAL NETWORK SERVICES

RFP SUBMISSION FORM

SPECIFIC INFORMATION

1. Proposal is to be based on current benefits, services & enrollment as described in the Exhibit section of the RFP.

2. Gregg County has used two medical networks, Access Direct Platinum (ADP) and Verity with client specific contracts with Good Shepard Medical Center, Longview Regional Medical Center & other Gregg County providers. The wrap network for medical providers outside of Gregg County & ADP Counties has been PHCS Health Directions.

3. Effective date is to be October 1, 2017.

MEDICAL NETWORK QUESTIONNAIRE:

1. Describe organization submitting proposal.
   a. Company Name: _____
   b. Address: _____
   _____
   c. Contact Person: _____
   e. Telephone Number: _____ Fax Number: _____
   d. Email Address: _____
   f. Year Founded: _____

2. Attach the following information to determine financial stability:
   a. Most recent financial statement Yes☐ No☐
   b. Certificate of Insurance Coverage for Professional Liability and General Liability insurance. Yes☐ No☐
   c. Copy of Texas license for Medical Network services. Yes☐ No☐

3. Provide three Texas client references (preferably government entities):

Name of Client	Contact Person	Telephone Number	Number of Employees

4. How long has proposer been providing a Medical Network in Texas? _____

5. Assuming Gregg County makes their selection and notifies the selected Medical Network on August 4, 2017 can the proposer complete all steps necessary to provide both a hospital and physician Medical Network on October 1, 2017?

6. Attach a copy of the proposer's Medical Network Directory for the Gregg County area in Excel format.

7. Does the proposer have a Web Site that includes the Medical Network Directory? Yes☐ No☐

8. Which hospital, Longview Regional or Good Shepherd Medical Center, is included in your Network? _____

9. If both hospitals are not currently in your Network, how is discount for each hospital affected if both hospitals are included in Network? _____

10. If your Network is only regional, which Network are you proposing to use as a wrap-around?

    _____

    a. Is this cost included in your proposed fee? Yes☐ No☐

11. Will the proposer provide, at no additional cost, to Gregg County or their designee, a quarterly report in either Microsoft Excel or Microsoft Access that lists for all claims: the provider, provider TIN, date of service, procedure code, procedure description, charged amount and discount? Yes☐ No☐

12. Does the proposer allow the County's claims administrator to audit a bill from Network providers?

13. If the proposer's Network is determined to not have sufficient providers in the geographic area or in a specialty:

    a. Does the proposer provide the County with the assistance to negotiate and secure additional provider contracts on a single case basis, direct and/or comprehensive basis? Yes☐ No☐

    b. Does the proposer allow for multiple Networks? Yes☐ No☐

14. Will the proposer provide specific payment information for selected providers to determine specific payment arrangements/discounts for selected providers? Yes☐ No☐

    If yes, please attach confidentiality agreement with proposal.

15. Will company agree to hold Gregg County harmless from any legal action resulting from company's services? Yes☐ No☐

    Comment: _____

16. Attach cost information for the following services for a three year period, assuming enrollment remains constant at 562 medical subscribers:

    a. Medical Network - Primary

    b. Medical Network - Wrap

17. Acknowledge Statement – Medical Network

The undersigned hereby acknowledges that they have reviewed these proposal specifications, have had the opportunity to clarify any question or information in these proposal specifications in the manner provided and that the responses are true and accurate.

The undersigned hereby agrees to furnish all services in complete accordance with the requirements of these proposal specifications and the answers provided in responding to these proposal specifications.

The undersigned affirms that this 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 to the proposer.

The undersigned hereby declares that they have the authority to represent the proposer and to bind this proposal at the rates contained herein and that the contract will reflect the answers provided in this proposal response.

Company Name	Authorized Signature
Address	Type Signatory's Name & Title
	Telephone Number Fax Number
Date	Signatory's Email Address

GREGG COUNTY, TEXAS

REQUEST FOR PROPOSAL NO. 2017-712
PRESCRIPTION DRUG NETWORK SERVICES

RFP SUBMISSION FORM

SPECIFIC INFORMATION

1. Proposal is to be based on current benefits, services & enrollment as described in the Exhibit section of the RFP.

2. Gregg County has used the services of MEDTRAK since October 1, 2014 for PBM services.

3. Gregg County has used the services of TRIA Health since January 12, 2016 for Medication Therapy Management Services.

4. Effective date is to be October 1, 2017.

PRESCRIPTION DRUG QUESTIONNAIRE:

1. Describe organization submitting proposal:

   a. Name of Firm: _____

   b. Address: _____

   c. Contact Person: _____

   d. Telephone Number: _____ Fax Number: _____

   e. Email Address: _____

   f. Year Founded: _____

2. Attach the following information to determine financial stability:

   a. Most recent financial statement Yes☐ No☐

   b. Certificate of Insurance Coverage for Professional Liability and General Liability insurance. Yes☐ No☐

   c. Most recent _____ Report or third party operations audit. Yes☐ No☐

3. Describe Prescription Drug experience:

   a. Number of Texas Clients: _____

   b. Number of Texas Pharmacies: _____

   c. Other: _____

4. Provide three (3) Texas client references (preferably government entities):

Name of Client	Contact Person	Telephone Number	Number of Employees

5. Describe Pharmacy network:

   a. Please provide list of pharmacists currently in pharmacy network in Gregg County in electronic spreadsheet format.

b. Describe relationship with pharmacists including degree of automation and reimbursement procedures:

_____

6. Will you be willing to provide a sample identification card upon request? ☐ Yes ☐ No

   a. Can identification card be mailed to employee's home? ☐ Yes ☐ No

   b. Can identification card be combined with medical card? ☐ Yes ☐ No

7. Prescription Drug Costs

   a. Please provide the following cost information for the proposed network:

Retail	Non Preferred Brand	Preferred Brand	Generic
• Filling Fee			
• AWP Discount			
• Other			
Mail Order			
• Filling Fee			
• AWP Discount			
• Other			

8. Other Services:

   a. Generic Drug Substitution: _____

   _____

   b. Maintenance Drugs: _____

   _____

   c. Mail Order Prescriptions: _____

   _____

   d. Medication Therapy Management Services: _____

   _____

9. Manufacturer Refunds:
   Please provide complete description for allocation of manufacturers' refunds; including allocation formula for sharing refund with Gregg County:_____

10. Reports:
    a. Are reports provided in electronic spreadsheet format? ☐ Yes ☐ No

    Comment: _____

    b. Please provide sample of reports that will be provided and the frequency of the reports.

11. Will company agree to hold Gregg County harmless from any legal action resulting from company's services? ☐ Yes ☐ No

    Comment: _____

12. Attach cost information for the following services for a three year period, assuming enrollment remains constant at 562 prescription drug subscribers:

    a. Retail Pharmacy Services

    b. Mail-Order Pharmacy Services

    c. Medication Therapy Management Services

13. Acknowledge Statement – Prescription Drug Network

The undersigned hereby acknowledges that they have reviewed these proposal specifications, have had the opportunity to clarify any question or information in these proposal specifications in the manner provided and that the responses are true and accurate.

The undersigned hereby agrees to furnish all services in complete accordance with the requirements of these proposal specifications and the answers provided in responding to these proposal specifications.

The undersigned affirms that this 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 to the proposer.

The undersigned hereby declares that they have the authority to represent the proposer and to bind this proposal at the rates contained herein and that the contract will reflect the answers provided in this proposal response.

Company Name	Authorized Signature
Address	Type Signatory's Name & Title
	Telephone Number Fax Number
Date	Signatory's Email Address

ADMINISTRATIVE SERVICES AGREEMENT

FOR

GREGG COUNTY

ADMINISTRATIVE SERVICES AGREEMENT

THIS Service Agreement (this "Agreement") is made and entered into as of the 1st day of October 2014, by and between Gregg County, a political subdivision of the State of Texas and a body politic duly organized and existing under the laws of the state of Texas with its principal place of business at 101 East Methvin, Suite 109 Longview, Texas 75601 (hereinafter referred to as the "Plan Administrator"), and HealthFirst TPA, Inc. (hereinafter referred to as the "TPA"), a corporation duly organized and existing under the laws of the state of Texas with its principal place of business at 821 ESE Loop 323, Suite 200, Tyler, Texas 75701.

WHEREAS, the Plan Administrator is the plan sponsor of a self-funded employee welfare benefit plan within the meaning of the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, known as the Gregg County Employee Benefit Health Plan (hereinafter referred to as the Plan and as defined by the Department of Labor under section 29 CFR 2510.3-1); and

WHEREAS, the Plan Administrator wishes to contract with an independent third party to perform certain services with respect to the Plan as enumerated below; and

WHEREAS, TPA desires to contract with the Plan Administrator to perform certain services with respect to the Plan as enumerated below; and

Whereas, Plan Administrator desires that TPA provide claims administration and other services to the Plan Administrator in connection with the Plan, and TPA has agreed that it will provide such services to the Plan Administrator in accordance with the terms and conditions of this Agreement and the terms of the applicable plan document(s); and,

The parties intend that TPA shall not be deemed a "fiduciary" for the Plan within the meaning of the Employee Retirement Income Security Act of 1974 ("ERISA"). TPA shall have no discretionary authority or final determinative capability.

Accordingly, the services to be performed by TPA shall be limited to those set forth in this Agreement and the performance by TPA of such services shall be subject in all respects to review by the Plan Administrator within the framework of policies, interpretations, rules, practices and procedures made or established by the Plan Administrator.

Plan Administrator and TPA agree as follows:

2.5. **COBRA** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

2.6. **Covered Services** means the care, treatments, services, or supplies described in the Plan Document as eligible for payment or reimbursement from the Plan.

2.7. **ERISA** means the Employee Retirement Income Security Act of 1974, as amended.

2.8. **Fee Schedule** means the listing of fees or charges for services provided under this Agreement. This Fee Schedule may be modified from time to time in writing by the mutual agreement of the parties. It is set forth in Exhibit "A" and is a part of this Agreement.

2.9. **Health Care Providers** means a physician, dentist, hospitals, or other medical practitioner or medical care facility that is duly licensed and authorized to receive payment or reimbursement for Covered Services provided under the terms of the Plan.

2.10. **Individual** means "individual" as defined in 45 CFR § 164.501, and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).

2.11. **Plan** means the Gregg County Employee Welfare Benefit Plan established by the Plan Administrator pursuant to the Plan Document.

2.12. **Plan Administrator** means Gregg County and any successor organization or affiliate of such Plan Administrator, which assumes the obligations of the Plan and this Agreement.

2.13. **Plan Document and Summary Plan Description** means the instrument or instruments that set forth, govern the duties of the Plan Administrator as the plan sponsor, Plan Administrator of the Plan and eligibility, and benefit provisions of the Plan, which provide for the payment or reimbursement of Covered Services. In the event of a conflict between the Plan Document and the Summary Plan Description, the Plan Document shall control.

2.14. **Plan Participant** is any person who is properly enrolled and entitled to benefits from the Plan.

2.15. **Plan Year** means the period of time specified as such in the Plan Document.

2.16. **Privacy Rule** means the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E.

2.17. **Protected Health Information** means, "Protected health information" as defined in 45 CFR § 164.501, but limited to the information created or received by the TPA from or on behalf of the Plan Administrator or the Plan.

2.18. **"Electronic Protected Health Information"** as defined in 45 C.F.R. § 160.103, as amended from time to time, and generally means protected health information that is transmitted or maintained in any electronic media.

2.19. **"Security Incidents"** as defined in 45 C.F.R. § 164.304, as amended from time to time, generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

2.20. **Required by Law** means, "required by law" as defined in 45 CFR § 164.501.

3.7 The TPA agrees to be duly licensed as a Third Party Administrator to the extent required under applicable law and agrees to maintain such licensure throughout the term of this Agreement. The TPA will possess throughout the term of this Agreement, an in-force fidelity bond or other insurance as may be required by state and federal laws for the protection of its Plan Administrators. Additionally, the TPA agrees to comply with any state or federal statutes or regulations regarding its operations and to obtain any additional licenses or registrations, which may apply in the future.

3.8 The TPA will indemnify, defend, save, and hold the Plan and the Plan Administrator harmless from and against any and all claims, suits, actions, liabilities, losses, fines, penalties, damages, and expenses of any kind including, but not limited to, direct, indirect, consequential, or punitive expenses or fees, including court costs and attorney's fees, with respect to the Plan which directly results from or arise out of the dishonest, fraudulent, negligent, or criminal acts of the TPA or its employees, except for acts taken at the specific direction of the Plan Administrator.

3.9 The TPA shall be entitled to rely, without investigation or inquiry, upon any written or oral information or communication of the Plan Administrator or agents of the Plan Administrator.

3.10 The Plan Administrator will indemnify, defend, save, and hold the TPA harmless from and against any and all claims, suits, actions, liabilities, losses, fines, penalties, damages, and expenses of any kind including, but not limited to, direct, indirect, consequential, or punitive expenses or fees, including court costs and attorney's fees, to the extent that such claims, losses, liabilities, damages, and expenses that arise out of or are based upon the Plan Administrator's negligence in the performance of its duties under this Agreement, a release of claims data by the TPA to the Plan Administrator, an interpretation of the Plan or this Agreement by the Plan Administrator, or any other written or oral communication by the Plan Administrator or any of its authorized representatives upon which the TPA relies or any breach of this Agreement by the Plan Administrator, including, but not limited to, failure to fund the Claims Payment Account.

ARTICLE IV.
THE TPA'S RESPONSIBILITIES

The TPA will provide the following Plan administrative services for the Plan Administrator:

4.1 Maintain Plan records based on eligibility information submitted by the Plan Administrator as to the dates on which a Plan Participant's coverage commences and terminates.

a) Maintain Plan records of Plan coverage applicable to each Plan Participant based on information submitted by the Plan Administrator.

b) Maintain Plan records regarding payments of claims, denials of claims, and claims pended.

4.2 Verify Plan Participant eligibility and coverage upon request by a Plan Participant, an authorized member of a Plan Participant's family unit, or an authorized Health Care Provider treating a Plan Participant.

a) The TPA will only release this information for certificate of need reviews; for medical necessity determinations; to set uniform data standards; to update relative values scales; to use in claims analysis; to further cost containment programs; to verify eligibility; to comply with federal, state or local laws; for coordination of benefits; for subrogation; in response to a civil or criminal action upon issuance of a subpoena; or with the written consent of the Plan Participant or his or her legal representative.

4.10 The TPA will arrange for claims appeal services for individuals who request a review of an Adverse Benefit Determination on medical claims, in accordance with the Department of Labor regulations. It is understood that the TPA will provide appeal services for covered participants in accordance with the Plan Administrator's Plan Document / Summary Plan Description. Any fees associated with this review will be the sole expense of the Plan Administrator.

The TPA will not provide any external review services (as defined in the Patient Protection and Affordable Care Act of 2010 and its implementing regulations ("PPACA")), but will facilitate the provision of external review services through third party Independent Review Organization (IROs) (as such term is defined in PPACA), for the fees set forth on Exhibit "A" below (if applicable). The TPA will be responsible for facilitating all such reviews (and the IROs will be responsible for providing all such reviews in accordance with PPACA and all other applicable federal and state laws), and the Plan Administrator hereby acknowledges and agrees that:

The IROs, and not the TPA, will be providing external review services; the IROs are third parties with which the TPA has no direct contractual relationship; the TPA does not in any way control or direct the IROs with respect to facilitation or performance of external review services provided by the IROs; and to the extent not prohibited by law, the Plan Administrator will indemnify, defend and hold the TPA harmless from and against any and all losses, damages, injuries, causes of action, claims, demands and expenses (including reasonable attorney's fees, costs and expenses), arising out of, resulting from, or related to any act, omission or default by the IROs in their performance of the external reviews.

4.11 Upon request the TPA will prepare a draft Plan Document and Summary Plan Description for review and final approval by Plan Administrator and the Plan Administrator's legal counsel. It is understood that the TPA will make reasonable efforts to update this draft as needed to maintain compliance with federal regulations, however compliance with applicable laws and regulations is the responsibility of the Plan Administrator. The Plan Administrator is responsible for insuring that any changes it makes to TPA's draft will be in compliance with federal and other applicable laws. Plan Administrator is solely responsible for the final content of the Plan Document / Summary Plan Description. TPA shall not have the power or authority to alter, modify, or waive any terms of the Plan.

If the Plan Administrator's Plan Document / Summary Plan Description is not finalized and approved before TPA begins administering the Plan(s) TPA is not responsible for any conflicts that may occur if charges are made by the Plan Administrator. This does not apply to amendments that the Plan Administrator may make at a later date to the extent those changes become effective after the TPA has been notified of the change.

a) Provide forms and handle correspondence for claims administration, including procedures for filing claims, claim forms, request forms for obtaining additional information, and claims payment explanation of benefits.

b) Process all claims presented for benefits under the plan, audit claims, prepare and distribute benefit checks to employees, Plan Administrators, and/or service providers, and provide an explanation of claim settlements to the Plan Participants.

c) Verify and handle inquiries, from the Plan Administrator, Plan Participants, hospitals, doctors, and other service providers concerning requirements, procedures, or benefits of the plan.

d) Maintain all the claim data.

e) Request funds from the Plan Administrator on a scheduled basis from which checks are issued to cover expenses of the plan.

f) Complete and submit all premium reports, statements, claim reports, and other reports required to all insurers and reinsurers of the plan.

g) File the necessary 1099 Forms with the Internal Revenue Service in the required format with respect to the checks printed by the TPA which are payable to persons who provide medical services to covered persons under the Plan.

4.17 Disclosure of Third Party Revenue: HealthFirst may receive direct or indirect compensation from third parties in the course of administering Plan Administrator's employee benefit Plan. Sources of third party compensation may include commissions paid for the placement of stop loss policies. All third party compensation received is taken into account when HealthFirst prices the administrative fees that are charged to Plan Administrator for services under this Agreement to the extent reasonably possible, it being understood that certain compensation relates to HealthFirst's total book of business rather than to any single customer. HealthFirst agrees to use commercially reasonable efforts to disclose to Plan Administrator any third party revenue directly related to Plan Administrator's Plan received during the prior twelve (12) month period.

4.18 Under the terms of this Agreement, the TPA may choose to outsource the printing of Checks and Explanation of Benefits. This function is achieved with an electronic interface.

a) Checks will be drawn on the Plan Administrator's bank account. Checks/Explanations of Benefits are outsourced for printing and distribution. A copy of the check/Explanation of Benefits is provided to the employee and, if applicable, the provider of service. Reproduction of the Explanation of Benefits is available on the TPA's website at no charge.

4.19 During the existence of the Agreement remaining active, the TPA will maintain all records for this Plan Administrator for seven (7) years. After the expiration of this period, the TPA reserves the right to destroy these records. The TPA will contact the Plan Administrator prior to the destruction of the records as notification of this procedure. The Plan Administrator may choose for the records to be shipped to an address of their choice at the Plan Administrator's expense.

and will be treated as part of the cost of the claim. If unsuccessful in achieving a discount on any submitted claim, there will be no charge for this service. (See Exhibit "A")

4.26 The Plan Administrator may elect to enter into an agreement with an outside vendor to handle Subrogation (claims determined to be the fault of a third party) for the TPA and the Plan Administrator. The decision to litigate a particular case will be made by the Plan Administrator and/or the TPA. The TPA and/or the Plan Administrator will use good faith to decide whether to pursue such litigation and disburse reasonable related expenses upon settlement. This vendor will seek the TPA's and/or the Plan Administrator's authority to file suit if it is deemed necessary to collect the recovery or the outside vendor deems a case in need of adjudication by trial or appeal. The related expenses associated with filing and service will be billed to the Plan Administrator.

4.27 The Plan Administrator may elect loss control services that reduce health care cost on a shared savings basis. This will include prepayment detection, prevention and investigation services that assist in identifying potential health care claims overpayments from potentially abusive or fraudulent billing practices and prepayment claims coding compliance.

4.28 The TPA will take commercially reasonable steps to prevent and recover from disruptive events that are beyond its control and represents that it has backup systems in place in case of emergencies or natural disasters.

ARTICLE V.
THE PLAN ADMINISTRATOR'S RESPONSIBILITIES

The Plan Administrator will:

5.1 Maintain current and accurate Plan eligibility and coverage records and submit this information to the TPA.

a) This information shall be provided in a format reasonably acceptable to the TPA and include the following for each Plan Participant: name and address, Social Security number, date of birth, type of coverage, sex, relationship to employee, changes in coverage, date coverage begins or ends, and any other information necessary to determine eligibility and coverage levels under the Plan. Such information must be provided by the Plan Administrator in a timely manner that will allow TPA to provide services in accordance with this agreement. The Plan Administrator shall submit enrollment data to TPA electronically via the FTP File Transfer with PGP Encryption method, or by using the Web Based File Exchange Method, Internet, or other mutually agreed upon method.

b) The Plan Administrator assumes the responsibility for the erroneous disbursement of benefits by the TPA in the event of error or neglect on the Plan Administrator's part of providing eligibility and coverage information to the TPA, including but not limited to, failure to give timely notification of ineligibility of a former Plan Participant.

5.11 Maintain any fidelity bond or other insurance as may be required by state or federal law for the protection of the Plan and Plan Participants, and promptly notify the TPA of any termination, expiration, lapse, or modification of this insurance.

5.12 The Plan Administrator agrees to provide TPA with the names and titles of employees who are designated as individuals who are permitted to access Protected Health Information, and to notify TPA as soon as reasonably possible when this list of designated employees changes. It is understood that the TPA will not release Protected Health Information to any employee of the Plan Administrator who is not on the list of designated employees for Protected Health Information.

5.13 The Plan Administrator shall establish, maintain and appropriately fund a checking account in the name of the Plan Administrator. The Plan Administrator shall be responsible for all claim checks issued against the account. TPA shall be given the necessary nonexclusive authority to utilize any funds in said account for payment of Covered Services under the Plan. TPA shall provide the Plan Administrator with a check register and also provide a monthly report for reconciliation purposes.

5.14 The Plan Administrator shall establish, maintain and appropriately fund the Plan and shall be solely responsible for the operation and administration of the Plan, except as expressly delegated to TPA in this agreement.

5.15 It is understood that the Plan Administrator is solely responsible for handling issues related to un-cashed checks, including any record keeping, reporting or payment responsibilities set forth under any state's unclaimed property law, to the extent such laws apply.

ARTICLE VI.
DURATION OF AGREEMENT

6.1 The initial term of this Agreement shall commence on October 1, 2014 and end on September 30, 2017. Thereafter, this Agreement shall automatically renew each year for a one-year period unless modified or terminated as described herein.

6.2 Any amendment or change to this Agreement must be agreed upon in advance in writing by both the Plan Administrator and the TPA. If any such amendment increases the anticipated claims experience under the Plan or the TPA's cost of administering the Plan, the Plan Administrator agrees to pay any increase in claims expenses, as well as increases in administrative fees or other costs, which the TPA reasonably expects to incur as a result of such modification.

6.3 Change to Service Fee: TPA reserves the right to change the service fees applicable to this Agreement every twelve (12) months following the effective date of this Agreement unless otherwise stated on the attached Fee Schedule, subject to Plan Administrator receiving renewal information from TPA at least ninety (90) calendar days prior to the effective date. The 90-day notice of fee change does not apply to network access fees. TPA also reserves the right to change the service fees sooner if additional services are being purchased by the Employer, or if one of the following conditions occur:

7.4 This Agreement may be executed in two or more counterparts, each, all of which shall be deemed an original, and all of which together shall constitute but one and the same instrument.

7.5 In the event any provision of this Agreement is held to be invalid, illegal, or unenforceable for any reason and in any respect, such invalidity, illegality, or unenforceability shall in no event affect, prejudice, or disturb the validity of the remainder of this Agreement, which shall be in full force and effect, enforceable in accordance with its terms.

7.6 In the event that either party is unable to perform any of its obligations under this Agreement because of natural disaster, labor unrest, civil disobedience, acts of war (declared or undeclared), or actions or decrees of governmental bodies (any one of these events which is referred to as a Force Majeure Event), the party who has been so affected shall immediately notify the other party and shall do everything possible to resume performance.

a) Upon receipt of such notice, all obligations under this Agreement shall be immediately suspended. If the period of non-performance exceeds ten (10) working days from the receipt of notice of the Force Majeure Event, the party whose ability to perform has not been so affected may, by giving written notice, terminate this Agreement.

7.7 All notices required to be given to either party by this Agreement shall, unless otherwise specified in writing, be deemed to have been given three (3) days after deposit in the U.S. Mail, first class postage prepaid, certified mail, return receipt requested.

7.8 This Agreement shall be interpreted and construed in accordance with the laws of the state of Texas except to the extent superseded by federal law.

7.9 No forbearance or neglect on the part of either party to enforce or insist upon any of the provisions of this Agreement shall be construed as a waiver, alteration, or modification of the Agreement.

ARTICLE VIII.
LIMITATION OF LIABILITY

8.1 Plan Administrator agrees to defend, indemnify and hold harmless TPA and its employees from any and all loss, damage, liability, judgments, claims and expenses arising out of the Plan Administrator's performance, or lack thereof, of its duties and obligations under the Plan or this Agreement, the good faith performance by TPA of its duties to the Plan Administrator under this Agreement or actions taken by TPA at the direction of the Plan Administrator.

8.2 TPA shall be responsible to the Plan Administrator for loss of money resulting directly from the fraudulent or dishonest acts by its employees. The remedy for payments made in error will be to seek recovery from the employee or the provider of services.

8.3 TPA shall have no responsibility, risk, liability or obligation for the funding of the Benefit Program or for any extended liabilities of the Benefit Program whether resulting from the termination of the Benefit Program or from a change to fully or partially insured

ARTICLE IX.
STOP-LOSS NEGOTIATION & ADMINISTRATION

9.1 Procure excess loss or stop loss (specific and aggregate) insurance proposals and policies for the Plan Administrator's consideration and selection, which excess loss or stop loss insurance will be an asset of the Plan Administrator and not of the Plan (if applicable).

9.2 Notify the excess loss insurance company of any potential large claims which may become a claim under the excess loss coverage. On behalf of the Plan, the claims Administrator will file in a timely manner any claims for benefits under the excess loss policies.

9.3 Promptly pay on behalf of the Plan Administrator any premium and other notices received from the excess loss insurance company concerning the policy.

9.4 Responsibilities of TPA. To the extent specified below, TPA shall provide the services for, and shall assist the Plan Administrator in the analysis of their stop-loss coverage, if any, as follows:

a) Annually market the coverage's Plan Administrator requests to a select number of insurance and reinsurance carriers in order to obtain alternate quotes for comparison.

b) Prepare and deliver renewal proposal prior to renewal date.

c) Provide supporting claims documentation to support renewal action.

d) Interpret and analyze claim information in order to make suggestions for possible plan design changes.

e) Upon renewal, complete all applications, forms and amendments for Plan Administrator's signature.

f) Communicate renewal decisions to Claims Administrator departments and all appropriate carrier(s) and/or vendor(s).

ARTICLE X.
CONFIDENTIALITY

10.1 Business Associate Agreement. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended, requires that the TPA and the Plan enter into a Business Associate Agreement to ensure that "protected health information" (as defined in HIPAA) remains private and is only used or disclosed to the extent provided by HIPAA. The Business Associate Agreement is hereby incorporated by reference as Exhibit "F". Any release of confidential records or information by TPA to Plan Sponsor or its designee shall be made only as required to satisfy its obligations under this Agreement, or as permitted or required by law, and as set forth in the attached Business Associate Agreement.

10.2 Confidentiality of this Agreement. Except as required by law, the parties shall keep this Agreement confidential and shall not disclose this Agreement or any of its terms, without the other party's written consent.

EXHIBIT "A"
FEE SCHEDULE

The following fees shall apply during the term of this agreement. In the event of a termination of this agreement, the payment of fees shall be governed by the applicable provisions of the agreement or the insurance policy.

Services	Fees 10/1/2014 to 9/30/2017
HealthFirst Services:	
▪ Medical Administration Fee	$15.25 PEPM
▪ Dental Administration Fee	$3.00 PEPM
▪ Plan Document Fee	$1750 Per Document
▪ Plan Document Amendments (HealthFirst)	$150.00 Per Document
▪ Plan Document Amendments (External)	$325.00 Per Hour
▪ Summary of Benefits & Coverage (SBC)	$500.00 Per Plan
▪ Pre-Certification	$3.00 PEPM
▪ Consulting Fee	$75.00 Per Hour
▪ Large Case Management	$150.00 Per Hour; $40.00 Per Hour travel time & mileage (IRS standard reimbursement rate)
▪ Non Network Claims Negotiations	25% of Realized Savings
COBRA/HIPAA - CONEXIS	$2.00 PEPM
Subrogation - The Phia Group	30% of Recovered Savings
Prescription Drug Program - MedTrak	See Exhibit "B"
PPO Network Access	
▪ Verity Helath Network (Gregg County)	$5.00 PEPM
▪ Good Shepherd Hospital Direct Contracts (Gregg County)	Included in Verity Fee
▪ Access Direct Platinum (ADP Counties)	Included in Verity Fee
▪ PHCS Healthy Directions (Outside Verity, Good Shephered & ADP Counties. Inside Texas)	Included in Verity Fee
▪ PHCS Healthy Directions (Outside Texas)	20% of Savings

Employee Benefit Plan Disclosure

The Department of Labor and the Internal Revenue Service require certain disclosure to be made to the Plan Administrator, Plan Administrator, or other fiduciary of the employee benefit plan before any transaction occurs with respect to the plan purchase of any insurance policies or contracts. This notice serves to satisfy the disclosure requirements of PTE 84-24.

The following entity is not a trustee of the plan, Plan Administrator, named fiduciary of the plan, or a fiduciary who is expressly authorized in writing to manage, acquire, or dispose of the assets of the above plan on a discretionary basis. HealthFirst TPA, Inc. is a licensed third party administrator (TPA) providing services to the Gregg County Employee Welfare Benefit Plan.

EXHIBIT "B" – PHARMACY BENEFIT SCHEDULE OF SERVICES

B.1 If elected the TPA will arrange for and coordinate Pharmacy Benefit Management (PBM) services as needed. In the course of implementation the TPA will contract with a third party Pharmacy Benefit Management Associate.

B.2 TPA will direct its Pharmacy Benefit Management Associate to accept and process claims submitted by network pharmacies in the HIPAA designated standard format, or any other designated standard as required by law or as otherwise permitted under the network provider agreement.

B.3 HealthFirst shall arrange for its Pharmacy Benefit Management Associate to accept and process claims electronically submitted by a participating pharmacy directly to HealthFirst or to TPA's Pharmacy Benefit Management Associate when such claims are submitted properly on a completed paper claim form or through industry standard electronic claim submission, together with proper proof of payment.

B.4 TPA and its Pharmacy Benefit Management Associate will determine preferred status for prescription medication, determine preferred status of prescription medication therapeutic classes and set criteria for preferred exceptions.

B.5 TPA will direct its Pharmacy Benefit Management Associate to receive and review requests for exceptions on quantity limits and clinical necessity based on objective and consistent criteria.

B.6 TPA and its Pharmacy Benefit Management Associate will provide customer service assistance to plan participants. Such assistance will include assistance to healthcare providers and pharmacies concerning questions regarding the pharmacy benefit program.

B.7 TPA will provide the Plan Administrator with a standard quarterly report package summarizing drug utilization.

B.8 Retroactive termination or disenrollment of a group, Eligible Employee, or Covered Individual shall not release the Plan Sponsor of its obligation to pay claims incurred, at any time, on behalf of such Covered Individual, or Administrative Fees due to TPA for such Covered Individual during any period for which services were renderable hereunder based on the then current eligibility.

B.9 TPA will arrange for claims appeal services, at a cost determined by the TPA based upon the level of appeal, for individuals who request a review of an Adverse Benefit Determination on pharmacy claims, in accordance with the Department of Labor regulations. TPA's Pharmacy Benefit Management Associate will allow a five (5) calendar day mail time in addition to the maximum appeal timelines listed in this ASA. It is understood that TPA's Pharmacy Benefit Management Associate will provide appeal services for covered participants in accordance with the Plan Administrators Plan Document or Summary Plan Description.

B.10 TPA's Pharmacy Benefit Management Associate uses commercially reasonable efforts to not reimburse covered participants for prescription drugs purchased outside the United States, with the exception of prescription drugs purchased for emergency purposes. An exception may also be made for covered participants who are covered by a United States health plan while living abroad.

Pharmacy Services (or its assignee) shall remain responsible for the proper performance of its obligations in accordance with the terms of this Agreement. This Agreement shall inure to the benefit of the parties' successors and assigns.

B.16 Plan Administrator further agrees and acknowledges that TPA is not responsible for and shall have no liability for the professional errors of any Participating Pharmacies (including without limitation errors in compounding, dispensing, labeling and advising Participants of potential interactions of prescription drugs), or the failure of Participating Pharmacies (each an independent contractor), collectively or individually, to provide pharmacy benefit services to Plan Administrator or Participants.

B.17 Plan Administrator acknowledges and agrees that TPA is receiving compensation from drug manufacturers and pharmacy benefit managers associated with this contract as payment for administrative duties and responsibilities associated with this contract. If required the amount of this compensation will be reported annually to the Plan Administrator according to state and federal requirements.

B.18 Pricing and discount rates are outlined below in Attachment "A" for brand and generic drugs. Specialty Drugs will be priced at MedTrak cost plus 1% administrative fee.

ATTACHMENT "A" – PBM Cost Summary

	Type		Amended Pricing
Ingredient Costs	**Retail**		
		Brand	AWP - 13.5%
		Generic	AWP - 74%
	Mail Order		
		Brand	AWP - 20%
		Generic	AWP - 74%

	Type		Amended Pricing
Dispensing Fees	**Retail**		
		Brand	$1.75 per Rx
		Generic	$2.50 per Rx
	Mail Order		
		Brand	$2.00 per Rx
		Generic	$2.00 per Rx

	Type		Amended Pricing
Administrative Fee			$2.25 per Rx
Additional Fees		Start Up	N/A
		Security Deposits	N/A
		Paper Claims	$2.50

Manufacturer Rebates	100% Share

EXHIBIT "D"
POST-TERMINATION PROVIDER-AUDIT

WHEREAS, TPA on behalf of Plan Administrator entered or may enter into agreements with Healthcare Networks and/or Preferred Provider Organization Networks (the "Networks"), which enable Plan Administrators' plans and/or participants to receive contracted rates for medical services from Preferred Providers that are less than the Preferred Providers' normal billed charges for such medical services;

WHEREAS, the Networks have entered into contracts with the Preferred Providers (generally, "Hospital Services Agreements") that set forth the contract rates for the medical services provided for Plan participants that are less than the Preferred Providers' normal billed charges;

WHEREAS, some or all of the Hospital Services Agreements may contain contractual provisions that require the Plan to pay the contract rate amount due on or before the [30th day (or 45th, as applicable)] after a clean claim is received by the Administrator (the "Prompt Payment Deadline");

WHEREAS, some or all of the Hospital Services Agreements further provide that, if the contract rate amount is not paid on or before the Prompt Payment Deadline, then the Plan may owe the Preferred Provider the normal billed charges for such medical services, which in all cases is substantially greater than the contract rate; and

THEREFORE, with respect to such Preferred Providers, Plan Administrator agrees as follows:

Plan Administrator authorizes TPA to enter into agreements with Networks that adopt, assume or otherwise make Plan Administrator a party to, or bound by, the terms of the Hospital Services Agreements, including, but not limited to, the Prompt Payment Deadline, if any.

Plan Administrator understands that paying for medical services on or before the Prompt Payment Deadline may result in the Plan paying for medical services that are not "covered services" as that term is defined in the Plan, in order to avoid prompt payment penalties.

To the extent that the Plan fails or refuses to pay for Covered Services prior to the Prompt Payment Deadline and the Preferred Provider seeks the difference between the contract amount and normal billed charges, Plan Administrator will indemnify and hold TPA harmless from any and all indirect, special, consequential, penalty or incidental damages in connection with or arising out of the Plan's failure and/or refusal to pay for such Covered Services prior to the Prompt Payment Deadline, including, but not limited to, any and all liabilities, obligations, costs, claims, judgments, attorney fees, and attachments related to same.

EXHIBIT "E"
TERMINATION OF CONTRACT PROVISIONS

The TPA may, at its option, terminate this Agreement effective upon the occurrence of any one or more of the following events on written notice to the Plan Administrator:

E.1 The TPA, or the bank selected by the Plan Administrator, on which benefit payment checks are drawn in satisfaction of a claim for Plan benefits ("Bank"), makes a request of the Plan Administrator to provide funds to the Bank for the payment of claims or other payments approved and recorded by the TPA, with such request being transmitted to the Plan Administrator by mail, facsimile or other means of communication (including electronic mail), and either (a) the Plan Administrator fails to provide the requested funds within five (5) business days of the receipt of such request from the TPA, or (b) the TPA reasonably and in good faith determines that the Plan Administrator will not meet its obligation to provide such funds within such five (5) business days;

E.2 The Plan Administrator fails to pay administration fees or other fees for the TPA's services upon presentation for payment and in accordance with the Fee Schedule within ten (10) business days of receipt of notice of such unpaid fees, or the TPA reasonably and in good faith determines that the Plan Administrator will not meet its obligation to pay such fees within such ten (10) business days; or

E.3 The TPA gives the Plan Administrator ninety (90) days advance written notice of its intent to terminate this Agreement.

The Plan Administrator may, at its option, terminate this Agreement effective upon ninety (90) days advance written notice of its intent to terminate this Agreement.

Run-Out Claims

If the Plan Administrator so elects, and if the Plan Administrator is not in default on any obligations for benefit claims, administration fees or other fees, the TPA agrees to administer claims run-out, with the following terms:

Run-Out Claim Fee:	Current administration fee multiplied by the number of employees multiplied by three (3) months
Run-Out Claim End Date:	Last day of the month following 180 days after the termination date.
Extended Run-Out Fee:	$18 per claim for an additional 185 days after the Run-Out Claim End Date.
Run out Reports and Fees:	$0 Initial eligibility/census report $500 Initial accumulator report
Additional Reports:	Time and materials ($500 minimum)

EXHIBIT "F"
BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement is entered into as of the 1st day of October, 2014 by and between Gregg County ("Covered Entity") and HealthFirst TPA, Inc. ("Business Associate").

RECITALS

WHEREAS, the parties have entered into an Administrative Services Agreement, Appendixes and Exhibits attached thereto, heretofore collectively referred to as the "Agreement", with Effective Date of October 1, 2014 under which Business Associate provides certain services to Covered Entity;

WHEREAS, the Agreement requires that Covered Entity provide Business Associate with access to certain Protected Health Information, as defined herein;

WHEREAS, the parties acknowledge that Covered Entity is considered a "covered entity" subject to the Privacy Rule;

WHEREAS, the parties agree that the terms of this Business Associate Agreement are intended to coordinate with and be interpreted to apply in addition to the terms of the aforementioned Agreement and, in the event of any conflict or inconsistency with such other provisions, the provisions of this Business Associate Agreement must control;

NOW, THEREFORE, in consideration of the mutual promises set forth in this Business Associate Agreement and for other good and valuable consideration, the parties hereby agree as follows:

F.1 Definitions

a) The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA Rules: **Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information,** and **Use**.

b) **Administrative Services Agreement**. "Administrative Services Agreement" shall mean the agreement between Business Associate and Covered Entity under which Business Associate provides certain services to Covered Entity and Covered Entity provides PHI to Business Associate, to which this Agreement is an Appendix.

c) **Agreement**. "Agreement" shall mean the Administrative Services Agreement, Appendixes and Exhibits attached thereto, with Effective Date of October 1, 2014.

d) **Business Associate**. "Business Associate" shall mean an individual or entity that creates, receives, maintains or transmits protected health information to perform a function or activity on behalf of a Covered Entity, or provides a service that involves the creation, use or disclosure of PHI. It shall also have the meaning given

b) Business Associate agrees to use safeguards appropriate to its size and complexity to prevent use or disclosure of the Protected Health Information other than as provided for by this Business Associate Agreement.

c) Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Business Associate Agreement.

d) Business Associate agrees to report to Covered Entity any use or disclosure of Protected Health Information not provided for by this Business Associate Agreement within fifteen (15) days after Business Associate becomes aware of such use or disclosure. Business Associate will provide any and all information reasonably requested by Covered Entity with regard to any such use or disclosure.

e) Business Associate agrees to include in any written agreement with any agent, including a subcontractor, to whom it provides Protected Health Information, a requirement that such agent agrees to restrictions and conditions with respect to such information that are at least as restrictive as those that apply through this Business Associate Agreement to Business Associate, and to enforce those restrictions and conditions against such agent or subcontractor.

f) Business Associate agrees to provide access, at the request of an Individual or Covered Entity, and in the time and manner specified by the Individual or Covered Entity, to Protected Health Information to the Individual or Covered Entity, in accordance with 45 CFR § 164.524.

g) Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set at the request of an Individual or Covered Entity, in accordance with 45 CFR § 164.526.

h) Business Associate agrees to respond to a request from an Individual or Covered Entity for an Accounting of Disclosures of an Individual's Protected Health Information, in accordance with 45 CFR § 164.528. Additionally, notwithstanding any provision in this Business Associate Agreement to the contrary, Business Associate agrees to retain all PHI throughout the term of this Business Associate Agreement and shall continue to maintain all information required to provide an Accounting of Disclosures for a period of three years after termination of this Business Associate Agreement.

i) Upon reasonable notice, Business Associate agrees to make Protected Health Information and books and records relating to the use and disclosure of Protected Health Information available to Covered Entity or to the Secretary of the Department of Health and Human Services, or his designee, (the "Secretary") at Covered Entity's reasonable expense in the time and manner specified by Covered

confidentiality of such PHI was breached; and (3) transmitting or sharing any PHI to any recipient Offshore without first obtaining written consent from Covered Entity as to such Offshore transmission.

h) Business Associate is permitted to disclose PHI, as defined in the HIPAA privacy rules, to the extent that such PHI is necessary for Business Associate to carry out its administrative functions and to provide services.

i) Business Associate shall not use or further disclose PHI other than as permitted or required by applicable plan documents or as required by all applicable law, including but not limited to the HIPAA privacy rules or the HITECH Act. When using or disclosing PHI or when requesting PHI, Business Associate shall make reasonable efforts to limit the PHI retained, obtained, and/or utilized to the minimum amount necessary to accomplish the intended purpose of the use, disclosure or request.

j) Business Associate shall promptly report any improper use or disclosure of PHI of which it becomes aware.

k) Business Associate shall provide adequate protection of PHI by ensuring that: (i) only those employees who work on issues related to healthcare will have access to the PHI provided by Covered Entity; (ii) restricting access to and use of PHI to only the employees identified in clause (i) above and only for the functions performed by Business Associate on behalf of Covered Entity; (iii) requiring any who receive PHI to abide by the applicable privacy rules and laws; and (iv) using established disciplinary procedures to resolve issues of noncompliance by the employees identified above.

l) Business Associate will abide by requirements not to disclose data to insurers and other health plans if the Individual pays for the pertinent service in full and requests confidentiality. If applicable, the Covered Entity shall notify the Business Associate that the Individual has requested such secrecy.

m) Subject to the appropriate Statute of Limitations, if feasible, Business Associate shall return or destroy all PHI received, and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If such return or destruction is not feasible, Business Associate shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

n) Business Associate shall provide plan participants with the following rights: (i) the right to access to their PHI in accordance with 45 C.F.R. §164.524; (ii) the right to amend their PHI upon request and incorporate any such amendment into a participant's PHI in accordance with 45 C.F.R. §164.526; and (iii) the right to an accounting of all disclosures of their PHI in accordance with 45 C.F.R. §164.528.

Business Associate Agreement and the Agreement if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity; or (2) immediately terminate this Business Associate Agreement and the Agreement.

c) Termination for HIPAA Breach. Business Associate may terminate this Agreement in the event that the Covered Entity fails to meet any obligations imposed upon it by the HIPAA Rules or the HITECH Act.

F.6 Effect of Termination.

a) Except as provided in paragraph (2) of this section, upon termination of this Business Associate Agreement, Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

b) In the event that Business Associate determines that returning or destroying Protected Health Information is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon the mutual agreement of Covered Entity and Business Associate that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Business Associate Agreement to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

F.7 Electronic Data Interchange

To the extent that Business Associate performs any standard transaction electronically on behalf of the Covered Entity, Business Associate will do so in accordance with the requirements of HIPAA and the standards for Electronic Transactions at 45 CFR § 162 (the "Transactions Rule"). In particular, Business Associate will:

a) Conduct, as a standard transaction, using electronic media, a transaction which must be conducted as a standard transaction by Covered Entity;

b) Comply with the applicable requirements of the Transactions Rule; and

c) Require its subcontractors and agents to comply with the applicable requirements of the Transactions Rule.

F.8 Security Standards for the Protection of ePHI

Effective April 20, 2006, Business Associate agrees to comply with the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR §§ 160 and 164 (the "Security Rules"). Electronic Protected Health Information ("EPHI") for this purpose, shall have the same meaning as that term is defined in 45 CFR § 160.103. In particular, Business Associate will:

a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that

g) This Business Associate Agreement constitutes the entire Agreement between the parties concerning the subject herein, and supersedes all prior oral or written agreements between the parties on same.

h) A reference in this Business Associate Agreement to a section in the Privacy Rule means the section as in effect or as amended.

i) The parties agree to take such action as is necessary to amend this Business Associate Agreement from time to time as is necessary for Covered Entity to comply with the Privacy Rule and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.

j) The respective rights and obligations of Business Associate under Article VI(C) of this Business Associate Agreement shall survive the termination of this Business Associate Agreement.

k) Any ambiguity in this Business Associate Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule.

l) Nothing in this Business Associate Agreement shall be construed to create any third party beneficiary rights in any person, including any participant or beneficiary of Covered Entity.

ADDENDUM 01
TO THE ADMINISTRATIVE SERVICE AGREEMENT
GREGG COUNTY

This Addendum to the Service Agreement (the "Agreement") is made and entered into effect this 1st day of January, 2016.

Article IV. is hereby updated to include the following:

4.29 The Plan Administrator has elected to participate in the following Tria Medical Management Therapy Program as outlined below;

a) Medication Therapy Management. (Tria will implement and provide its proprietary Medication Therapy Management (CDTM) services to and on behalf of Client, by providing pharmacy guidance services to Enrollees, in accordance with the implementation plan mutually developed by Tria and TPA on behalf of Gregg County and otherwise in accordance with Tria's overall Medication Therapy Management design. See Exhibit "A" for fee associated with this service.

EXHIBIT "A" FEE SCHEDULE is hereby updated as follows:

Services	Fees
Pharmacy Advocate Program -	
• Medical Therapy Program Fee	$5.80 PEPM

Compensation Schedules for the TPA:

- $.80 PEPM from **Tria** for electronic reporting and billing

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed on their behalf by their duly authorized representatives' signatures, effective on this 1st day of January, 2016.

GREGG COUNTY

BY: Rita D. Fyffe

PRINTED NAME: Rita D Fyffe

TITLE: Human Resource Director

DATE: 5-18-2016

HEALTHFIRST TPA, INC.

BY: [signature]

PRINTED NAME: Kirk V. Hopkins

TITLE: COO

DATE: 4/5/16

GREGG COUNTY

Self-Funded Health & Dental Plan

Enrollment Summary

HEALTH PLAN - May 31, 2017					
Benefit Description	**Active Units**	**COBRA Units**	**Retiree Units**	**Total Units**	**Total Members**
Employee Only	417	1	2	420	420
Employee + Spouse	33			33	66
Employee + 1 Child	54			54	108
Employee + 2 Children	21			21	63
Employee + More Than 2 Children	6			6	22
Employee + Spouse + 1 Child	10			10	30
Employee + Spouse + Children	14			14	54
Child Only-COBRA		3		3	3
2 Children-COBRA		1		1	2
	555	5	2	562	768
DENTAL PLAN - May 31, 2017					
Benefit Description	**Active Units**	**COBRA Units**	**Retiree Units**	**Total Units**	**Total Members**
Employee Only	369	2	44	415	415
Employee + Spouse	69		14	83	166
Employee + Children	64			64	192
Employee + Family	55		1	56	210
Child Only COBRA		3		3	3
	557	5	59	621	986

GREGG COUNTY

Drug Rebates Received

Period: January 1, 2012 Thru June 30, 2016

Period	Amount	Cumulative
1st Quarter 2012	$ 22,982	$ 22,982
2nd Quarter 2012	$ 22,933	$ 45,915
3rd Quarter 2012	$ 20,137	$ 66,052
4th Quarter 2012	$ 20,691	$ 86,743
1st Quarter 2013	$ 20,109	$ 106,853
2nd Quarter 2013	$ 16,956	$ 123,808
3rd Quarter 2013	$ 18,987	$ 142,795
4th Quarter 2013	$ 23,205	$ 166,001
1st Quarter 2014	$ 35,422	$ 201,423
2nd Quarter 2014	$ 41,807	$ 243,229
3rd Quarter 2014	$ 38,224	$ 281,453
4th Quarter 2014	$ 38,963	$ 320,417
1st Quarter 2015	$ 38,406	$ 358,822
2nd Quarter 2015	$ 45,079	$ 403,901
3rd Quarter 2015	$ 51,016	$ 454,917
4th Quarter 2015	$ 50,833	$ 505,750
1st Quarter 2016	$ 42,565	$ 548,315
2nd Quarter 2016	$ 48,415	$ 596,729
	$ 596,729	

Comments:

1. Source is Gregg County insurance records.

GREGG COUNTY

Medical & Drug Provider Payments Greater Than $5,000

Period: May 1, 2016 Thru April 30, 2017

Nbr.	Benefits Paid	Number Claims	Tax ID	Provider Name	City/State	PPO Code
1	$ 1,287,666	396	62-1762420 -133	LONGVIEW REG MED CTR	DALLAS TX	VERI
2	$ 671,152	444	75-1041154 -001	GOOD SHEPHERD MED CTR	DALLAS TX	GSH
3	$ 190,870	46	74-6001118 -013	MD ANDERSON CANCER CENTER	HOUSTON TX	PHDT
4	$ 184,502	2	46-0862033 -001	AMBULATORY SURGICAL INSTITUTE	DALLAS TX	MLP
5	$ 133,514	4	72-0400933 -078	WILLIS KNIGHTON SOUTH HLTH	SHREVEPORT LA	PHHD
6	$ 117,806	15	75-2951355 -003	TEXAS SPINE & JOINT HOSPITAL	DALLAS TX	ADP
7	$ 96,456	277	75-2131429 -472	MATEI SOCOTEANU MD	DALLAS TX	VERI
8	$ 94,943	15	23-2791135 -015	LONGVIEW DIALYSIS CENTER	ATLANTA GA	PHDT
9	$ 89,326	115	75-2131429 -210	BERNARD W TAYLOR MD	DALLAS TX	VERI
10	$ 77,264	164	75-2131429 -659	JOSEPH C HODGES MD	DALLAS TX	VERI
11	$ 60,259	25	47-3923087 -001	LONGVIEW ER OPERATIONS	HOUSTON TX	MLP
12	$ 54,199	44	90-0259782 -001	GOOD SHEPHERD AMBULATORY SURGI	DALLAS TX	GSH
13	$ 45,114	305	75-2131429 -205	LARRY L FRASE MD	DALLAS TX	VERI
14	$ 31,676	1	75-1047527 -095	TX HEALTH DALLAS	DALLAS TX	PHDT
15	$ 27,451	3	75-0818167 -001	MOTHER FRANCES HOSPITAL	DALLAS TX	HFD
16	$ 27,022	164	75-1707737 -120	DOUGLAS A HOLDER MD	PARIS TX	VERI
17	$ 24,849	564	75-1041154 -372	ACUITY DIAGNOSTICS	DALLAS TX	GSH
18	$ 23,854	35	75-1506393 -043	BABAJIDE A OGUNSEINDE MD	LONGVIEW TX	GSH
19	$ 23,118	32	75-1803325 -001	EAST TEXAS MEDICAL CENTER	TYLER TX	ADP
20	$ 15,755	365	75-2724479 -001	SITA M DEVULAPALLI MD	LONGVIEW TX	GSH
21	$ 15,002	142	27-1167113 -001	YASSER F ZEID MD	LONGVIEW TX	VERI
22	$ 14,927	5	76-0273984 -04B	MICHAEL KUPFERMAN MD	HOUSTON TX	PHDT
23	$ 14,641	150	20-4791426 -396	MARISA GUILLORY MD	DALLAS TX	VERI
25	$ 14,144	41	20-4791426 -407	ANDREI GASIC MD	DALLAS TX	VERI
26	$ 14,110	22	75-2747708 -003	CHAMPION EMS	DALLAS TX	
27	$ 14,032	3	76-0273984 -06B	MARGARET ROUBAUD MD	HOUSTON TX	PHDT
28	$ 13,241	82	46-4078404 -004	BARBARA SIGAL MD	BELFAST ME	MLP
29	$ 13,220	253	75-2863868 -008	LARRY HUFFMAN MD	LONGVIEW TX	GSH
30	$ 12,785	93	75-2131429 -204	LEWIS A DUNCAN MD	DALLAS TX	VERI
33	$ 12,190	123	86-1090156 -019	RODNEY VAN ANDEL MD	TEXARKANA TX	PHDT
34	$ 12,189	1	75-1837454 -005	BAYLOR UNIVERSITY MED CTR	DALLAS TX	PHDT
35	$ 12,100	4	04-3504115 -002	THE PHIA GROUP LLC	BRAINTREE MA	
36	$ 11,885	7	01-0894487 -003	NATERA INC	PASADENA CA	PHHD
37	$ 11,831	46	75-2762417 -506	PAUL R BRADLEY MD	DALLAS TX	GSH
38	$ 11,666	77	20-4791426 -301	JANET KELLEY MD	LONGVIEW TX	VERI
39	$ 11,631	9	45-3131686 -003	ROBERT BULGER MD	DALLAS TX	MLP
40	$ 11,367	14	20-0937057 -001	HARSHIVINDERJIT S BAINS MD	TYLER TX	ADP
41	$ 11,320	64	71-0882255 -003	RITESH R PRASAD MD	TYLER TX	ADP
42	$ 11,014	18	47-5326463 -00Q	KRISTEN WALKER MD	DALLAS TX	
44	$ 10,858	1	20-1508140 -002	NORTH CENTRAL SURGERY CENTER	DALLAS TX	PHDT
45	$ 10,575	11	75-2562784 -01H	HAROLD R TAYLOR MD	CINCINNATI OH	PHDT
47	$ 10,401	35	11-3678481 -010	RICHARD R YATES MD	TYLER TX	ADP
48	$ 10,250	31	76-0273984 -04K	JACK PHAN MD PHD	HOUSTON TX	PHDT
49	$ 10,247	13	87-0514323 -001	MYRIAD GENETIC LABORATORIES	SALT LAKE CITY UT	PHHD
50	$ 10,208	1	75-6004221 -003	DALLAS COUNTY HOSPITAL	DALLAS TX	MLP
51	$ 10,062	27	72-0423660 -044	SHREVEPORT VAMC	SMYRNA TN	
52	$ 10,060	292	75-2762417 -396	JOHN A ADIET MD	DALLAS TX	GSH
53	$ 10,014	618	38-2084239 -050	QUEST DIAGNOSTIC	PHILADELPHIA PA	PHDT
54	$ 9,990	95	45-4041922 -010	ALYN HATTER DO	LONGVIEW TX	VERI
55	$ 9,475	249	75-2762417 -395	SIDNEY L REDELS DO	DALLAS TX	GSH
56	$ 9,451	19	20-4791426 -446	DAVID JAYAKAR MD	DALLAS TX	VERI

GREGG COUNTY

Medical & Drug Provider Payments Greater Than $5,000

Period: May 1, 2016 Thru April 30, 2017

Nbr.	Benefits Paid	Number Claims	Tax ID	Provider Name	City/State	PPO Code
57	$ 9,174	79	20-4791426 -439	ANITA CHIN MD	DALLAS TX	VERI
59	$ 8,834	7	74-2152396 -00A	KCI USA INC	DALLAS TX	PHDT
60	$ 8,735	656	76-0360550 -039	MELTON HARWELL FISH DO	HOUSTON TX	GSH
61	$ 8,734	19	20-4791426 -232	PAVAN R SARIDENA MD	LONGVIEW TX	VERI
62	$ 8,509	28	20-4791426 -357	FRANCIS TIBILETTI MD	DALLAS TX	VERI
63	$ 8,508	69	20-4791426 -324	JONATHAN GREIFENKAMP MD	LONGVIEW TX	VERI
64	$ 8,255	12	75-2762417 -435	TODD J WALTRIP MD	DALLAS TX	GSH
65	$ 8,194	31	75-2564858 -104	RAJASHEKAR R LAKKADI MD	LONGVIEW TX	GSH
68	$ 7,861	3	47-3155409 -001	NEC TYLER EMERGENCY CENTER LP	HOUSTON TX	
69	$ 7,635	58	20-4791426 -457	M LISS A HUDSON MD	DALLAS TX	VERI
70	$ 7,555	20	75-2762417 -385	OLUSOLA OLOFINLADE MD	DALLAS TX	GSH
71	$ 7,537	16	75-2241871 -002	RANDY L MORTON MD	LONGVIEW TX	GSH
72	$ 7,464	91	75-2307763 -001	MARK A LITTLE OD	LONGVIEW TX	VERI
73	$ 7,451	31	75-2825011 -003	MARK J WILLIAMS MD	LONGVIEW TX	GSH
74	$ 7,418	13	75-0974351 -146	GSMC MARSHALL	DALLAS TX	PHDT
76	$ 7,304	35	75-2762417 -480	CHARLES L SECREST MD	DALLAS TX	GSH
77	$ 7,166	84	75-2307763 -005	JUSTIN C WARD OD	LONGVIEW TX	VERI
78	$ 7,091	25	76-0273984 -A36	MICHELLE D WILLIAMS MD	HOUSTON TX	PHDT
79	$ 7,057	110	20-4791426 -411	JASON SUITS MD	DALLAS TX	VERI
80	$ 7,053	20	75-6000588 -003	CITY OF LONGVIEW	LONGVIEW TX	
81	$ 7,003	128	75-2946793 -002	HONG I SHEN MD	LONGVIEW TX	GSH
82	$ 6,821	17	75-2762417 -443	DUSTIN M MCDERMOTT MD	DALLAS TX	GSH
83	$ 6,771	4	75-3175630 -003	UT SOUTHWESTERN UNIVERSITY	DALLAS TX	PHDT
84	$ 6,613	7	75-2562784 -02M	MICHAEL KYRELLOS MD	CINCINNATI OH	
86	$ 6,484	9	47-5326463 -00B	JACQUELINE BUTLER MD	DALLAS TX	
87	$ 6,466	1,135	20-4791426 -382	MOYNE KORNMAN MD	DALLAS TX	VERI
89	$ 6,371	3	75-2715084 -001	ETMC JACKSONVILLE	JACKSONVILLE TX	ADP
90	$ 6,344	14	75-2616977 -355	GEORGE KARIAMPUZHA MD	TYLER TX	
93	$ 6,321	24	20-4791426 -403	DAVID JENKINS MD	DALLAS TX	VERI
94	$ 6,229	9	75-2562784 -02C	JERRY H JENKINS MD	CINCINNATI OH	PHDT
95	$ 6,156	150	20-4791426 -356	DAVID WITT MD	DALLAS TX	VERI
96	$ 6,143	64	75-2307763 -006	SARAH E WARD OD	LONGVIEW TX	VERI
98	$ 6,036	109	75-2961826 -048	WALTER K HOWARD MD	PEORIA IL	GSH
99	$ 6,023	39	20-4791426 -351	RYAN GUILLORY MD	DALLAS TX	VERI
100	$ 5,994	67	75-2961826 -052	JOHN C CAMPBELL MD	PEORIA IL	GSH
101	$ 5,950	158	20-4791426 -428	MICHAEL MORRIS MD	DALLAS TX	VERI
102	$ 5,926	27	75-1506393 -038	STEPHEN G LITTLEJOHN MD	LONGVIEW TX	GSH
103	$ 5,909	80	47-4690841 -001	GREGORY K WACASEY OD	LONGVIEW TX	VERI
104	$ 5,908	113	75-2961826 -047	KIANNE A HARDEE MD	PEORIA IL	GSH
106	$ 5,776	58	20-4791426 -363	SAMIR GERMANWALA DO	DALLAS TX	VERI
107	$ 5,749	6	47-5326463 -017	TODD STEWART MD	DALLAS TX	
108	$ 5,710	8	47-5326463 -00Y	NICOLE SNEED MD	DALLAS TX	
109	$ 5,671	2	32-0503438 -001	HIGHLAND PINES	LONGVIEW TX	
110	$ 5,652	120	20-4791426 -410	HENRY GOR MD	DALLAS TX	VERI
111	$ 5,637	43	20-4791426 -406	MARTIN HILTON MD	DALLAS TX	VERI
112	$ 5,597	132	20-4791426 -401	JOHN L WRIGHT DO	DALLAS TX	VERI
113	$ 5,583	53	75-2794485 -001	BAHER M ELHALWAGI MD	LONGVIEW TX	GSH
114	$ 5,547	3	46-3550503 -003	HOANG NGUYEN MD	DALLAS TX	MLP
115	$ 5,534	7	47-4133502 -001	THOMAS MITCHELL MD	DALLAS TX	
116	$ 5,519	13	75-2562784 -01I	GENE P KELLY MD	CINCINNATI OH	PHDT
117	$ 5,428	38	75-1841922 -001	MICHAEL B GUILLORY MD	LONGVIEW TX	VERI

GREGG COUNTY

Medical & Drug Provider Payments Greater Than $5,000

Period: May 1, 2016 Thru April 30, 2017

Nbr.	Benefits Paid	Number Claims	Tax ID	Provider Name	City/State	PPO Code
118	$ 5,399	1	47-4187773 -001	TYLER ER OPERATIONS	HOUSTON TX	
119	$ 5,385	134	20-4791426 -371	SARITHA KORTIKERE MD	DALLAS TX	VERI
120	$ 5,342	7	47-5326463 -00C	BRADLEY EFUNE MD	DALLAS TX	
121	$ 5,334	72	45-4041922 -001	MARK S WALLIS MD	LONGVIEW TX	VERI
122	$ 5,232	58	33-1080544 -004	KAYVAN KAMALI MD	LONGVIEW TX	GSH
123	$ 5,222	9	47-5326463 -003	MATTHEW PORTER MD	DALLAS TX	
124	$ 5,155	82	46-2470632 -001	KRISTI B BAGNELL MD	LONGVIEW TX	GSH
126	$ 5,132	72	20-1084404 -009	CHRISTOPHER E IHIONKHAN MD	LONGVIEW TX	GSH
127	$ 5,122	10	27-3577229 -001	JULIE A DOLLISON CCP	TEMPE AZ	MLP
128	$ 5,107	1	47-3923087 -001	LONGVIEW ER OPERATIONS	HOUSTON TX	
129	$ 5,065	39	27-1167113 -023	VANESSA R NEIMAN MD	LONGVIEW TX	VERI
130	$ 5,001	3	75-0800628 -015	CHILDRENS MEDICAL CENTER OF DA	DALLAS TX	PHDT
Total	$ 4,048,582	10,097				

Comments:

1. Source is Health First claim data file.
2. PPO Codes are the following:
   - GSH is Good Shepherd Hospital Direct Contracts
   - VERI is Verity Healthnet
   - ADP is Access Direct Platinum
   - PHDT is PHCS Health Directions

Prescription Management Reports

Prepared for:

GREGG COUNTY, TEXAS - 10001621

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6/1/16 through 5/31/17

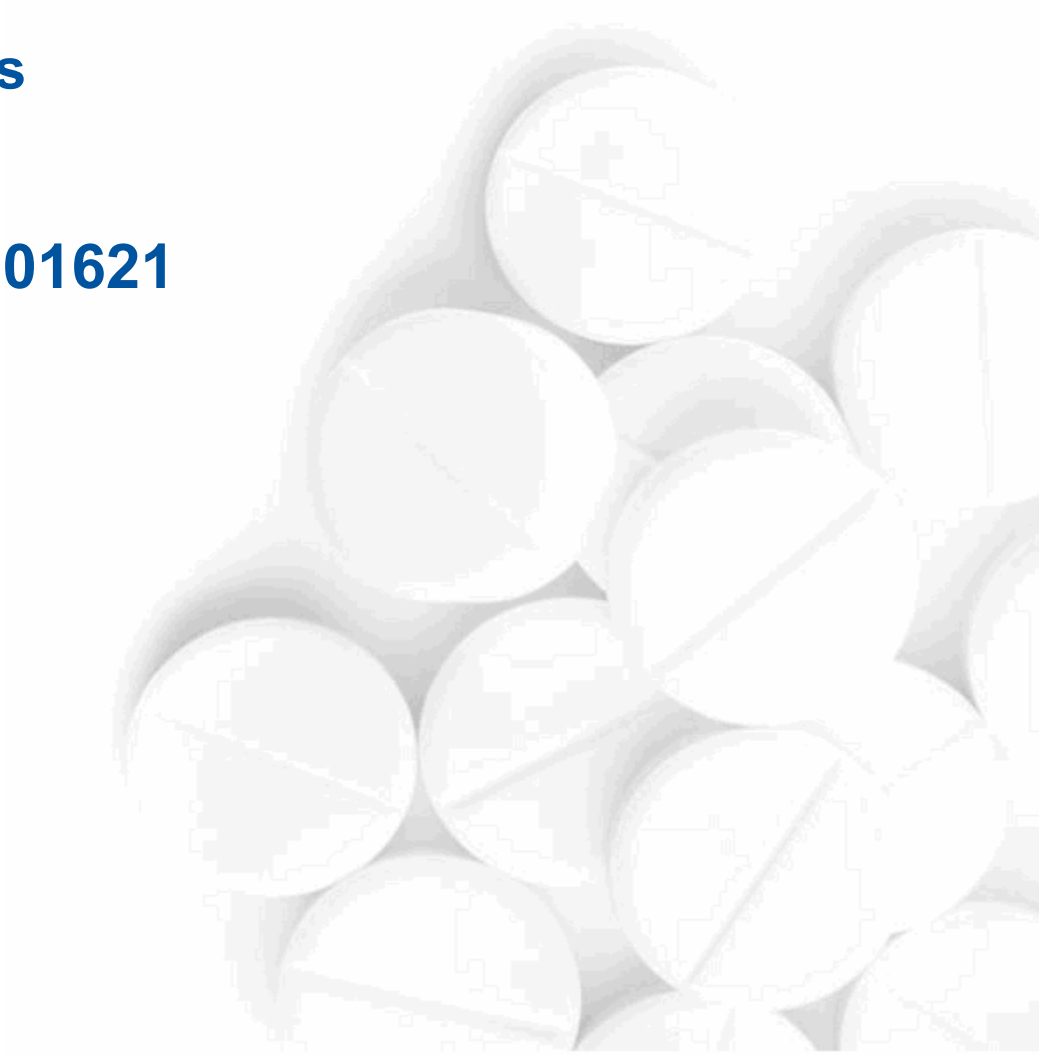


Table of Contents

GREGG COUNTY, TEXAS
10001621

Within this package you will find the below reports:

Key Performance Indicators

GREGG COUNTY, TEXAS
10001621

	Current Year 6/1/16 through 5/31/17	Previous Year 6/1/15 through 5/31/16	Current QTR 3/1/17 through 5/31/17	Previous QTR 3/1/16 through 5/31/16	Benchmarks: MedTrakRx* Current QTR 3/1/17 through 5/31/17	Benchmarks: NAICS** Current QTR 3/1/17 through 5/31/17
Average Approved Price	$94.48	$90.28	$88.16	$93.60	$105.24	$87.93
Average Patient Pay	$8.27	$8.74	$7.98	$8.76	$15.47	$11.67
Per Member/Per Month Client Pay	$156.32	$147.10	$149.44	$150.50	$65.00	$26.70
Rx Per Member/Per Month	1.81	1.80	1.86	1.77	0.72	0.35
% Generic of all Rxs	85%	82%	86%	83%	86%	86%

* MedTrakRx Book of Business (BOB)
** MedTrakRx BOB for clients with same North American Industry Classification System (NAICS) code

Utilization Summary: All Prescriptions

GREGG COUNTY, TEXAS
10001621

	Current Year 6/1/16 to 5/31/17	Previous Year 6/1/15 to 5/31/16	Current QTR 3/1/17 to 5/31/17	Previous QTR 3/1/16 to 5/31/16
Average Number of Eligible Members	779	758	787	773
Average Number of Utilizing Members	425	407	432	417
Percent of Members Utilizing Service	55%	54%	55%	54%
All Dispenses:				
Total Number of Rxs	16,945	16,408	4,402	4,112
Total Usual and Customary	$3,017,864.40	$2,716,647.78	$763,390.80	$700,865.73
Total Approved Price	$1,600,946.31	$1,481,263.40	$388,077.14	$384,899.43
Total Patient Pay	$140,113.43	$143,406.54	$35,111.33	$36,030.00
Total Client Pay	$1,460,832.88	$1,337,856.86	$352,965.81	$348,869.43
Average Approved Price	**$94.48**	**$90.28**	**$88.16**	**$93.60**
Average Patient Pay	**$8.27**	**$8.74**	**$7.98**	**$8.76**
Average Days Supply	26	27	26	27
Per Member/Per Month Client Pay	**$156.32**	**$147.10**	**$149.44**	**$150.50**
Per Member/Per Month Patient Pay	$14.99	$15.77	$14.87	$15.54
Rx Per Member/Per Month	**1.81**	**1.80**	**1.86**	**1.77**
Brand Dispenses:				
Total Number of Rxs	2,609	2,876	618	692
Average Approved Price	$472.06	$387.92	$490.37	$406.54
Average Patient Pay	$28.23	$26.70	$28.48	$28.89
Average Days Supply	28	29	28	28
% Brand of all Rxs	15%	18%	14%	17%
Generic Dispenses:				
Total Number of Rxs	14,336	13,532	3,784	3,420
Average Approved Price	$25.76	$27.02	$22.47	$30.28
Average Patient Pay	$4.64	$4.92	$4.63	$4.69
Average Days Supply	26	27	26	27
% Generic of all Rxs	**85%**	**82%**	**86%**	**83%**
Savings:				
Savings from Usual and Customary	$1,416,918.09	$1,235,384.38	$375,313.66	$315,966.30

Utilization Summary: Retail Prescriptions 1-83 Days Supply

GREGG COUNTY, TEXAS
10001621

	Current Year 6/1/16 to 5/31/17	Previous Year 6/1/15 to 5/31/16	Current QTR 3/1/17 to 5/31/17	Previous QTR 3/1/16 to 5/31/16
Average Number of Eligible Members	779	758	787	773
Average Number of Utilizing Members	422	404	429	415
Percent of Members Utilizing Service	54%	53%	55%	54%
All Dispenses:				
Total Number of Rxs	16,748	16,177	4,361	4,060
Total Usual and Customary	$2,499,438.63	$2,352,830.17	$645,701.75	$610,151.99
Total Approved Price	$1,180,223.14	$1,192,600.65	$292,752.46	$312,185.65
Total Patient Pay	$134,896.86	$138,170.96	$33,991.33	$34,855.36
Total Client Pay	$1,045,326.28	$1,054,429.69	$258,761.13	$277,330.29
Average Approved Price	**$70.47**	**$73.72**	**$67.13**	**$76.89**
Average Patient Pay	**$8.05**	**$8.54**	**$7.79**	**$8.59**
Average Days Supply	26	26	26	26
Per Member/Per Month Client Pay	**$111.86**	**$115.94**	**$109.55**	**$119.64**
Per Member/Per Month Patient Pay	$14.44	$15.19	$14.39	$15.04
Rx Per Member/Per Month	**1.79**	**1.78**	**1.85**	**1.75**
Brand Dispenses:				
Total Number of Rxs	2,527	2,791	599	673
Average Approved Price	$325.80	$301.34	$351.52	$314.93
Average Patient Pay	$27.72	$26.36	$28.05	$28.59
Average Days Supply	28	28	28	28
% Brand of all Rxs	15%	17%	14%	17%
Generic Dispenses:				
Total Number of Rxs	14,221	13,386	3,762	3,387
Average Approved Price	$25.10	$26.26	$21.85	$29.59
Average Patient Pay	$4.56	$4.83	$4.57	$4.61
Average Days Supply	26	26	26	26
% Generic of all Rxs	**85%**	**83%**	**86%**	**83%**
Savings:				
Savings from Usual and Customary	$1,319,215.49	$1,160,229.52	$352,949.29	$297,966.34

Utilization Summary: Retail Prescriptions 84+ Days Supply

GREGG COUNTY, TEXAS
10001621

	Current Year 6/1/16 to 5/31/17	Previous Year 6/1/15 to 5/31/16	Current QTR 3/1/17 to 5/31/17	Previous QTR 3/1/16 to 5/31/16
Average Number of Eligible Members	779	758	787	773
Average Number of Utilizing Members	2	2	2	2
Percent of Members Utilizing Service	0%	0%	0%	0%
All Dispenses:				
Total Number of Rxs	27	24	6	5
Total Usual and Customary	$4,114.33	$3,227.67	$1,146.37	$624.53
Total Approved Price	$3,032.77	$2,209.42	$892.52	$485.84
Total Patient Pay	$510.00	$350.00	$195.00	$75.00
Total Client Pay	$2,522.77	$1,859.42	$697.52	$410.84
Average Approved Price	**$112.32**	**$92.06**	**$148.75**	**$97.17**
Average Patient Pay	**$18.89**	**$14.58**	**$32.50**	**$15.00**
Average Days Supply	93	89	96	89
Per Member/Per Month Client Pay	**$0.27**	**$0.20**	**$0.30**	**$0.18**
Per Member/Per Month Patient Pay	$0.05	$0.04	$0.08	$0.03
Rx Per Member/Per Month	**0.00**	**0.00**	**0.00**	**0.00**
Brand Dispenses:				
Total Number of Rxs	1	0	1	0
Average Approved Price	$375.43	$0.00	$375.43	$0.00
Average Patient Pay	$120.00	$0.00	$120.00	$0.00
Average Days Supply	84	0	84	0
% Brand of all Rxs	4%	0%	17%	0%
Generic Dispenses:				
Total Number of Rxs	26	24	5	5
Average Approved Price	$102.21	$92.06	$103.42	$97.17
Average Patient Pay	$15.00	$14.58	$15.00	$15.00
Average Days Supply	93	89	98	89
% Generic of all Rxs	**96%**	**100%**	**83%**	**100%**
Savings:				
Savings from Usual and Customary	$1,081.56	$1,018.25	$253.85	$138.69

Utilization Summary: Mail Prescriptions

GREGG COUNTY, TEXAS
10001621

	Current Year 6/1/16 to 5/31/17	Previous Year 6/1/15 to 5/31/16	Current QTR 3/1/17 to 5/31/17	Previous QTR 3/1/16 to 5/31/16
Average Number of Eligible Members	779	758	787	773
Average Number of Utilizing Members	4	5	5	3
Percent of Members Utilizing Service	1%	1%	1%	0%
All Dispenses:				
Total Number of Rxs	107	146	19	30
Total Usual and Customary	$50,761.47	$62,652.90	$8,098.69	$11,629.90
Total Approved Price	$24,697.17	$30,771.07	$2,702.48	$4,644.35
Total Patient Pay	$2,676.57	$3,175.58	$415.00	$549.64
Total Client Pay	$22,020.60	$27,595.49	$2,287.48	$4,094.71
Average Approved Price	**$230.81**	**$210.76**	**$142.24**	**$154.81**
Average Patient Pay	**$25.01**	**$21.75**	**$21.84**	**$18.32**
Average Days Supply	85	88	83	90
Per Member/Per Month Client Pay	**$2.36**	**$3.03**	**$0.97**	**$1.77**
Per Member/Per Month Patient Pay	$0.29	$0.35	$0.18	$0.24
Rx Per Member/Per Month	**0.01**	**0.02**	**0.01**	**0.01**
Brand Dispenses:				
Total Number of Rxs	18	24	2	2
Average Approved Price	$829.86	$789.86	$191.90	$896.61
Average Patient Pay	$80.82	$62.50	$85.00	$100.00
Average Days Supply	90	90	90	90
% Brand of all Rxs	17%	16%	11%	7%
Generic Dispenses:				
Total Number of Rxs	89	122	17	28
Average Approved Price	$109.66	$96.84	$136.39	$101.83
Average Patient Pay	$13.73	$13.73	$14.41	$12.49
Average Days Supply	84	88	82	90
% Generic of all Rxs	**83%**	**84%**	**89%**	**93%**
Savings:				
Savings from Usual and Customary	$26,064.30	$31,881.83	$5,396.21	$6,985.55

Utilization Summary: Specialty Prescriptions

GREGG COUNTY, TEXAS
10001621

	Current Year 6/1/16 to 5/31/17	Previous Year 6/1/15 to 5/31/16	Current QTR 3/1/17 to 5/31/17	Previous QTR 3/1/16 to 5/31/16
Average Number of Eligible Members	779	758	787	773
Average Number of Utilizing Members	4	4	3	4
Percent of Members Utilizing Service	0%	1%	0%	1%
All Dispenses:				
Total Number of Rxs	63	61	16	17
Total Usual and Customary	$463,549.97	$297,937.04	$108,443.99	$78,459.31
Total Approved Price	$392,993.23	$255,682.26	$91,729.68	$67,583.59
Total Patient Pay	$2,030.00	$1,710.00	$510.00	$550.00
Total Client Pay	$390,963.23	$253,972.26	$91,219.68	$67,033.59
Average Approved Price	**$6,237.99**	**$4,191.51**	**$5,733.11**	**$3,975.51**
Average Patient Pay	**$32.22**	**$28.03**	**$31.88**	**$32.35**
Average Days Supply	31	34	29	38
Per Member/Per Month Client Pay	**$41.84**	**$27.92**	**$38.62**	**$28.92**
Per Member/Per Month Patient Pay	$0.22	$0.19	$0.22	$0.24
Rx Per Member/Per Month	**0.01**	**0.01**	**0.01**	**0.01**
Brand Dispenses:				
Total Number of Rxs	63	61	16	17
Average Approved Price	$6,237.99	$4,191.51	$5,733.11	$3,975.51
Average Patient Pay	$32.22	$28.03	$31.88	$32.35
Average Days Supply	31	34	29	38
% Brand of all Rxs	100%	100%	100%	100%
Generic Dispenses:				
Total Number of Rxs	0	0	0	0
Average Approved Price	$0.00	$0.00	$0.00	$0.00
Average Patient Pay	$0.00	$0.00	$0.00	$0.00
Average Days Supply	0	0	0	0
% Generic of all Rxs	**0%**	**0%**	**0%**	**0%**
Savings:				
Savings from Usual and Customary	$70,556.74	$42,254.78	$16,714.31	$10,875.72

Brand/Generic Utilization Summary

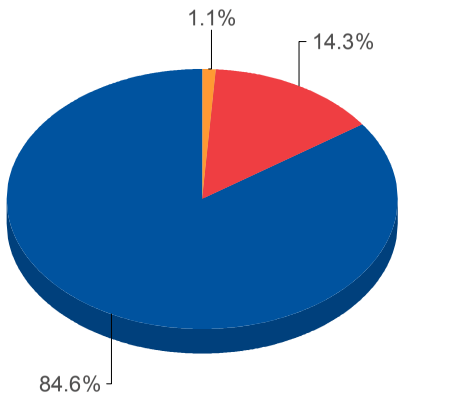
GREGG COUNTY, TEXAS

10001621

6/1/16 - 5/31/17

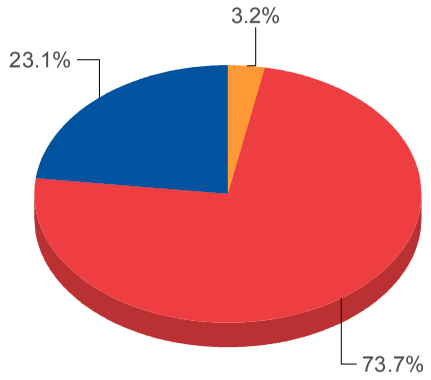
	Total RXs	DAW1 (Dr)	DAW2 (Mem)	DAW3 (Pha)	Total Ingr Cost	Total Disp Fee	Total Tax	Total Approved Price	Total Patient Pay	Total Client Pay	Avg Patient Pay	Avg Client Pay
BRAND DRUGS (No Generics Available)	2,430	14	15	0	$1,176,512.11	$4,089.00	$0.00	$1,180,601.11	$67,492.28	$1,113,108.83	$27.77	$458.07
BRAND DRUGS (Generics Available)	179	51	111	0	$50,697.55	$313.25	$0.00	$51,010.80	$6,162.34	$44,848.46	$34.43	$250.55
GENERICS	14,336	65	24	0	$336,282.40	$33,052.00	$0.00	$369,334.40	$66,458.81	$302,875.59	$4.64	$21.13
TOTALS:	**16,945**	**130**	**150**	**0**	**$1,563,492.06**	**$37,454.25**	**$0.00**	**$1,600,946.31**	**$140,113.43**	**$1,460,832.88**	**$8.27**	**$86.21**

Prescription Count



BRAND DRUGS (Generics Available)	1.1%
BRAND DRUGS (No Generics Available)	14.3%
GENERICS	84.6%
Total:	100.0%

Approved Price



BRAND DRUGS (Generics Available)	3.2%
BRAND DRUGS (No Generics Available)	73.7%
GENERICS	23.1%
Total:	100.0%

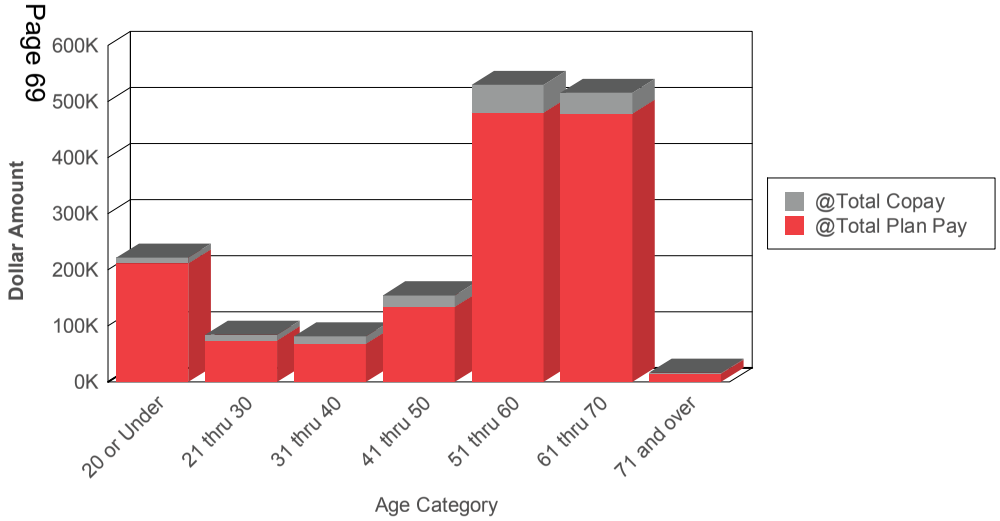
Utilization by Age Category

GREGG COUNTY, TEXAS

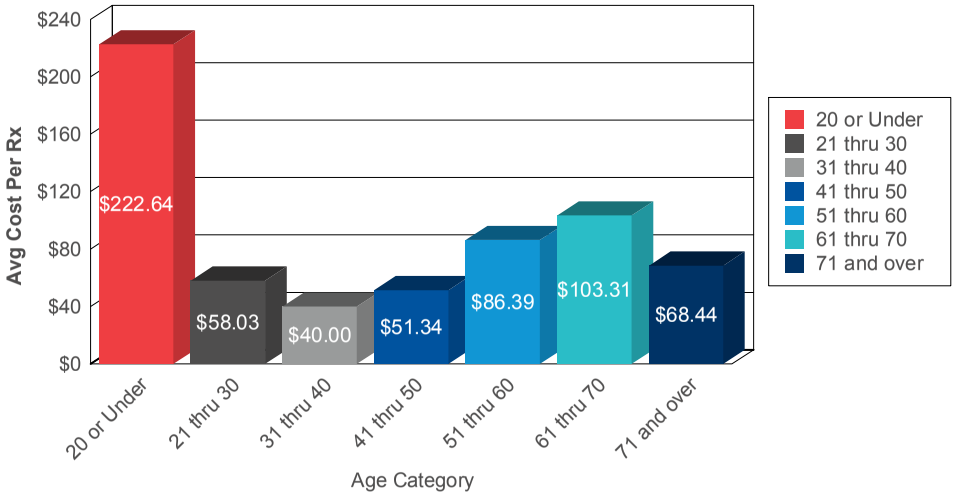
10001621 **6/1/16 - 5/31/17**

Age	Total Rxs	Utilizing Members	Cost Per Utilizing Member	Generic Percentage	Avg Cost Per Rx	Total Patient Pay	Total Client Pay	Total Approved Price
20 or Under	950	131	$1,614.59	77%	$222.64	$9,848.97	$211,511.83	$221,360.80
21 thru 30	1,277	113	$655.75	88%	$58.03	$9,908.17	$74,099.47	$84,007.64
31 thru 40	1,707	127	$537.68	89%	$40.00	$12,753.60	$68,285.15	$81,038.75
41 thru 50	2,613	116	$1,156.50	88%	$51.34	$20,040.24	$134,153.81	$154,194.05
51 thru 60	5,557	179	$2,681.86	82%	$86.39	$49,088.44	$480,053.37	$529,141.81
61 thru 70	4,629	110	$4,347.45	84%	$103.31	$36,798.08	$478,219.84	$515,017.92
71 and over	212	8	$1,813.68	87%	$68.44	$1,675.93	$14,509.41	$16,185.34
Total:	16,945	736	$1,984.83	85%	$86.21	$140,113.43	$1,460,832.88	$1,600,946.31

Total Plan Pay vs. Total Copay by Age Category



Avg Cost Per Rx by Age Category



Top 10 Therapeutic Classes: Non-Specialty

GREGG COUNTY, TEXAS

10001621

6/1/16 - 5/31/17

Rank	Therapeutic Class	Total Ingr Cost	Total Rxs	Avg Qty	Avg Ingr Cost	Avg Days	Avg Cost/Day	% Gen Disp
1	ANTIDIABETICS	$248,501.96	1,097	48	$226.53	30	$7.56	55.42%
2	DERMATOLOGICALS	$131,945.29	331	86	$398.63	21	$19.12	78.55%
3	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	$67,717.97	293	41	$231.12	32	$7.31	52.56%
4	ANTICONVULSANTS	$63,595.34	543	75	$117.12	30	$3.92	77.90%
5	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	$57,501.63	586	36	$98.13	28	$3.53	59.22%
6	ANTIHYPERLIPIDEMICS	$55,838.32	1,204	34	$46.38	31	$1.51	89.12%
7	ULCER DRUGS	$52,723.89	864	40	$61.02	29	$2.07	84.84%
8	ANTIDEPRESSANTS	$46,106.78	1,332	35	$34.61	30	$1.16	94.07%
9	ANTIHYPERTENSIVES	$43,165.11	1,592	34	$27.11	30	$0.89	93.28%
10	GASTROINTESTINAL AGENTS - MISC.	$33,903.20	70	94	$484.33	29	$16.55	32.86%
Totals for Top 10 Therapeutic Classes:		**$800,999.49**	**7,912**		**101.24**			

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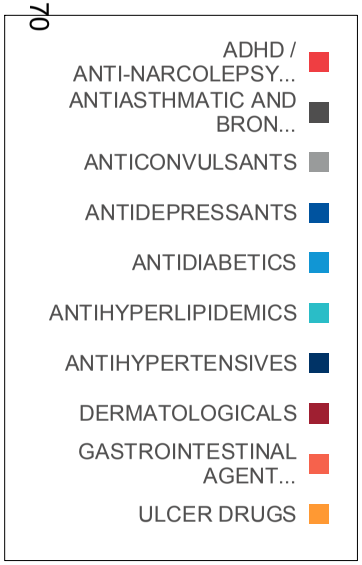
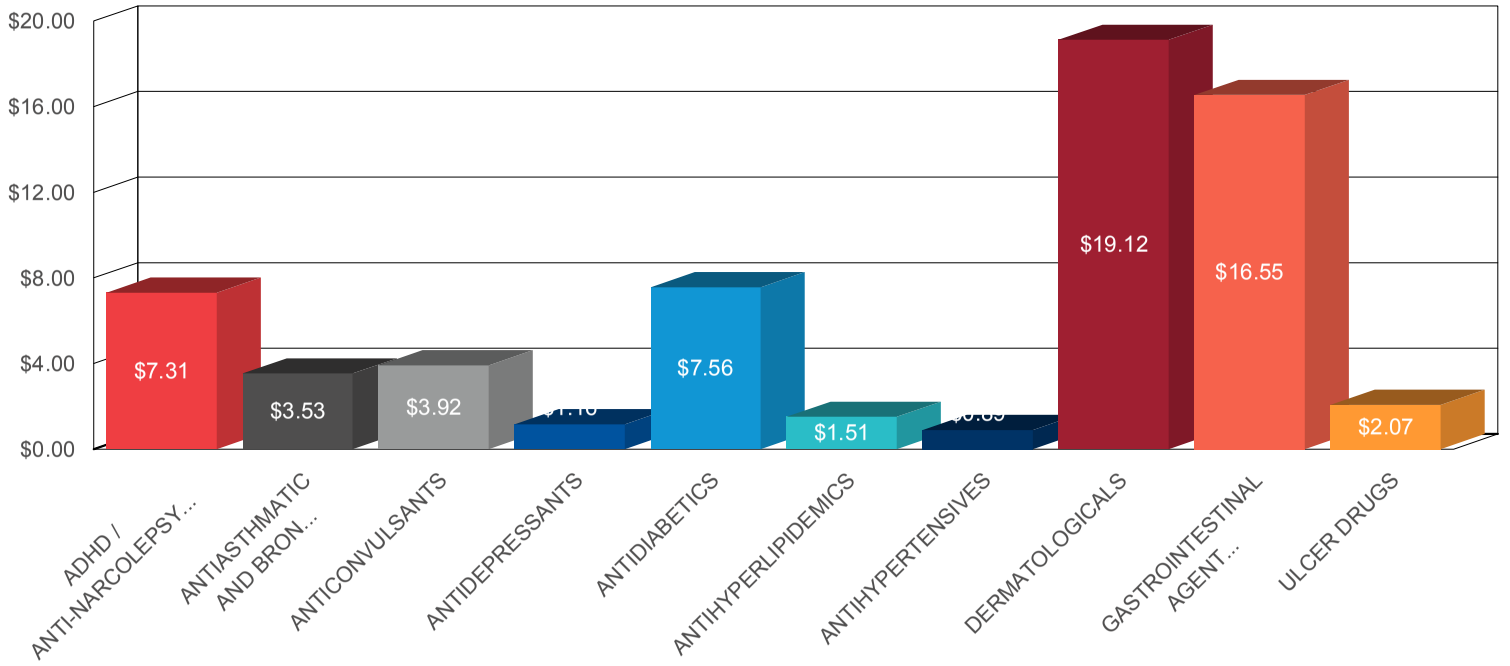


Average Cost per Day



Top 100 Drugs: Non-Specialty

GREGG COUNTY, TEXAS

10001621 **6/1/16 - 5/31/17**

Rank	Drug Name	Therapeutic Class	Brand/ Generic	Maint	Rx Count	Avg Cost Per Rx	Total Ingredient Cost
1	LIDOCAINE	DERMATOLOGICALS	Generic	No	44	$1,062.04	$46,729.57
2	LYRICA	ANTICONVULSANTS	Brand	Yes	96	$467.89	$44,917.57
3	DEXILANT	ULCER DRUGS	Brand	Yes	116	$248.15	$28,785.81
4	PENNSAID	DERMATOLOGICALS	Brand	No	12	$2,085.62	$25,027.46
5	VYVANSE	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	Brand	Yes	94	$258.92	$24,338.26
6	LANTUS SOLOSTAR	ANTIDIABETICS	Brand	Yes	42	$554.95	$23,308.06
7	INVOKANA	ANTIDIABETICS	Brand	Yes	52	$407.58	$21,194.35
8	RENAGEL	GASTROINTESTINAL AGENTS - MISC.	Brand	Yes	9	$1,907.67	$17,168.99
9	SYMBICORT	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	Brand	Yes	57	$299.27	$17,058.53
10	JANUVIA	ANTIDIABETICS	Brand	Yes	42	$384.35	$16,142.72
11	PRISTIQ	ANTIDEPRESSANTS	Brand	Yes	50	$304.00	$15,200.09
12	ADVAIR DISKUS	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	Brand	Yes	36	$392.09	$14,115.33
13	METHYLPHENIDATE HCL ER	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	Brand	Yes	55	$252.82	$13,905.14
14	RELPAX	MIGRAINE PRODUCTS	Brand	No	32	$418.63	$13,396.13
15	CRESTOR	ANTIHYPERLIPIDEMICS	Brand	Yes	52	$255.23	$13,271.85
16	NOVOLOG MIX 70/30 PREFILL	ANTIDIABETICS	Brand	Yes	13	$1,009.75	$13,126.74
17	XARELTO	ANTICOAGULANTS	Brand	Yes	36	$358.80	$12,916.79
18	NOVOLOG FLEXPEN	ANTIDIABETICS	Brand	Yes	14	$904.54	$12,663.55
19	LEVEMIR	ANTIDIABETICS	Brand	Yes	14	$858.83	$12,023.63
20	WELLBUTRIN XL	ANTIDEPRESSANTS	Brand	Yes	8	$1,499.29	$11,994.32
21	VICTOZA	ANTIDIABETICS	Brand	Yes	17	$664.98	$11,304.73
22	STRATTERA	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	Brand	Yes	20	$559.98	$11,199.67
23	ONGLYZA	ANTIDIABETICS	Brand	Yes	26	$425.55	$11,064.27
24	ESOMEPRAZOLE MAGNESIUM	ULCER DRUGS	Generic	Yes	113	$97.59	$11,027.24
25	PREMARIN	ESTROGENS	Brand	Yes	66	$155.48	$10,261.61
26	TOUJEO SOLOSTAR	ANTIDIABETICS	Brand	Yes	18	$565.94	$10,186.95
27	LINZESS	GASTROINTESTINAL AGENTS - MISC.	Brand	Yes	30	$338.58	$10,157.51
28	HUMALOG	ANTIDIABETICS	Brand	Yes	6	$1,656.63	$9,939.77
29	VIMPAT	ANTICONVULSANTS	Brand	Yes	13	$717.09	$9,322.12
30	ULORIC	GOUT AGENTS	Brand	Yes	32	$290.42	$9,293.46
31	LANTUS	ANTIDIABETICS	Brand	Yes	24	$355.06	$8,521.54
32	VYTORIN	ANTIHYPERLIPIDEMICS	Brand	Yes	29	$293.49	$8,511.34

Top 100 Drugs: Non-Specialty

GREGG COUNTY, TEXAS

10001621 **6/1/16 - 5/31/17**

Rank	Drug Name	Therapeutic Class	Brand/ Generic	Maint	Rx Count	Avg Cost Per Rx	Total Ingredient Cost
33	UCERIS	CORTICOSTEROIDS	Brand	No	5	$1,631.97	$8,159.87
34	LEVEMIR FLEXTOUCH	ANTIDIABETICS	Brand	Yes	13	$595.62	$7,743.11
35	SOLODYN	TETRACYCLINES	Brand	No	7	$1,090.72	$7,635.05
36	BYDUREON PEN	ANTIDIABETICS	Brand	Yes	12	$603.75	$7,244.94
37	BYDUREON	ANTIDIABETICS	Brand	Yes	12	$598.93	$7,187.20
38	JANUMET XR	ANTIDIABETICS	Brand	Yes	24	$289.38	$6,945.01
39	MULTAQ	ANTIARRHYTHMICS	Brand	Yes	12	$577.10	$6,925.14
40	BYSTOLIC	BETA BLOCKERS	Brand	Yes	53	$128.28	$6,798.78
41	NOVOLOG	ANTIDIABETICS	Brand	Yes	16	$424.19	$6,786.97
42	ANDROGEL PUMP	ANDROGENS-ANABOLIC	Brand	Yes	13	$517.84	$6,731.95
43	SPIRIVA HANDIHALER	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	Brand	Yes	19	$350.21	$6,653.95
44	FARXIGA	ANTIDIABETICS	Brand	Yes	16	$400.08	$6,401.27
45	AXIRON	ANDROGENS-ANABOLIC	Brand	Yes	11	$577.42	$6,351.67
46	KOMBIGLYZE XR	ANTIDIABETICS	Brand	Yes	14	$447.32	$6,262.43
47	NAPROXEN SODIUM	ANALGESICS - ANTI-INFLAMMATORY	Generic	Yes	13	$474.27	$6,165.57
48	BENICAR	ANTIHYPERTENSIVES	Brand	Yes	29	$209.93	$6,088.11
49	HUMALOG KWIKPEN	ANTIDIABETICS	Brand	Yes	9	$657.06	$5,913.53
50	TRULICITY	ANTIDIABETICS	Brand	Yes	9	$629.35	$5,664.14
51	ZENPEP	DIGESTIVE AIDS	Brand	Yes	2	$2,746.56	$5,493.12
52	XIGDUO XR	ANTIDIABETICS	Brand	Yes	13	$418.23	$5,437.05
53	JUBLIA	DERMATOLOGICALS	Brand	No	5	$1,083.80	$5,419.01
54	MODAFINIL	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	Generic	Yes	26	$204.78	$5,324.15
55	FLUOCINONIDE	DERMATOLOGICALS	Generic	No	9	$584.48	$5,260.33
56	GLYXAMBI	ANTIDIABETICS	Brand	Yes	10	$525.39	$5,253.92
57	ELIQUIS	ANTICOAGULANTS	Brand	Yes	14	$370.99	$5,193.89
58	EFFIENT	HEMATOLOGICAL AGENTS - MISC.	Brand	Yes	13	$399.03	$5,187.43
59	CELEBREX	ANALGESICS - ANTI-INFLAMMATORY	Brand	Yes	13	$392.22	$5,098.91
60	TRESIBA FLEXTOUCH	ANTIDIABETICS	Brand	Yes	10	$505.35	$5,053.47
61	ZETIA	ANTIHYPERLIPIDEMICS	Brand	Yes	17	$292.55	$4,973.31
62	RALOXIFENE HYDROCHLORIDE	ENDOCRINE AND METABOLIC AGENTS - MISC.	Generic	Yes	44	$111.76	$4,917.44
63	INVOKAMET	ANTIDIABETICS	Brand	Yes	23	$210.88	$4,850.21
64	RISEDRONATE SODIUM	ENDOCRINE AND METABOLIC AGENTS - MISC.	Generic	Yes	36	$133.50	$4,805.93
65	ABSORICA	DERMATOLOGICALS	Brand	No	5	$952.70	$4,763.48

Top 100 Drugs: Non-Specialty

GREGG COUNTY, TEXAS

10001621 **6/1/16 - 5/31/17**

Rank	Drug Name	Therapeutic Class	Brand/ Generic	Maint	Rx Count	Avg Cost Per Rx	Total Ingredient Cost
66	BUPROPION HCL XL	ANTIDEPRESSANTS	Generic	Yes	178	$26.01	$4,629.36
67	LIVALO	ANTIHYPERLIPIDEMICS	Brand	Yes	19	$230.75	$4,384.24
68	PURAMINO DHA/ARA	DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS	Brand	No	6	$717.64	$4,305.82
69	FREESTYLE LITE TEST STRIP	DIAGNOSTIC PRODUCTS	Brand	No	29	$148.27	$4,299.76
70	LEVOTHYROXINE SODIUM	THYROID AGENTS	Generic	Yes	374	$11.25	$4,207.11
71	OMEGA-3-ACID ETHYL ESTERS	ANTIHYPERLIPIDEMICS	Generic	Yes	24	$174.13	$4,179.08
72	ROSUVASTATIN CALCIUM	ANTIHYPERLIPIDEMICS	Generic	Yes	96	$43.04	$4,131.61
73	CIPRODEX	OTIC AGENTS	Brand	No	18	$220.90	$3,976.13
74	DOXEPIN HYDROCHLORIDE	DERMATOLOGICALS	Brand	No	2	$1,930.93	$3,861.85
75	EPIPEN 2-PAK	VASOPRESSORS	Brand	No	6	$617.98	$3,707.89
76	ACCU-CHEK AVIVA PLUS	DIAGNOSTIC PRODUCTS	Brand	No	10	$369.48	$3,694.82
77	ACZONE	DERMATOLOGICALS	Brand	No	7	$526.58	$3,686.07
78	AMPHETAMINE/DEXTROAMPHETA	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	Generic	Yes	32	$113.80	$3,641.49
79	OLMESARTAN MEDOXOMIL/HYDR	ANTIHYPERTENSIVES	Generic	Yes	25	$145.33	$3,633.31
80	JARDIANCE	ANTIDIABETICS	Brand	Yes	9	$402.12	$3,619.09
81	AZOR	ANTIHYPERTENSIVES	Brand	Yes	14	$249.90	$3,498.56
82	ALINIA	ANTI-INFECTIVE AGENTS - MISC.	Brand	No	3	$1,149.60	$3,448.80
83	JANUMET	ANTIDIABETICS	Brand	Yes	11	$313.18	$3,445.00
84	TRIBENZOR	ANTIHYPERTENSIVES	Brand	Yes	12	$285.59	$3,427.03
85	DYMISTA	NASAL AGENTS - SYSTEMIC AND TOPICAL	Brand	No	19	$178.29	$3,387.57
86	FENOFIBRATE	ANTIHYPERLIPIDEMICS	Generic	Yes	82	$40.33	$3,307.41
87	LO LOESTRIN FE	CONTRACEPTIVES	Brand	Yes	29	$111.99	$3,247.67
88	BENICAR HCT	ANTIHYPERTENSIVES	Brand	Yes	16	$202.92	$3,246.79
89	CANASA	GASTROINTESTINAL AGENTS - MISC.	Brand	No	4	$805.56	$3,222.22
90	RESTASIS	OPHTHALMIC AGENTS	Brand	Yes	7	$453.22	$3,172.56
91	CELECOXIB	ANALGESICS - ANTI-INFLAMMATORY	Generic	Yes	66	$47.94	$3,163.80
92	MONTELUKAST SODIUM	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	Generic	Yes	311	$9.82	$3,054.29
93	HYDROCODONE/ACETAMINOPHEN	ANALGESICS - OPIOID	Generic	No	179	$17.04	$3,050.91
94	VESICARE	URINARY ANTISPASMODICS	Brand	Yes	10	$302.29	$3,022.90
95	TOLTERODINE TARTRATE ER	URINARY ANTISPASMODICS	Generic	Yes	11	$274.69	$3,021.64
96	CONTRAVE	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	Brand	No	14	$215.69	$3,019.61
97	OLMESARTAN MEDOXOMIL	ANTIHYPERTENSIVES	Generic	Yes	23	$131.27	$3,019.21
98	COREG CR	BETA BLOCKERS	Brand	Yes	11	$270.56	$2,976.20

Top 100 Drugs: Non-Specialty

GREGG COUNTY, TEXAS

10001621 **6/1/16 - 5/31/17**

Rank	Drug Name	Therapeutic Class	Brand/ Generic	Maint	Rx Count	Avg Cost Per Rx	Total Ingredient Cost
99	PROAIR HFA	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	Brand	Yes	54	$55.08	$2,974.56
100	REGRANEX	DERMATOLOGICALS	Brand	No	3	$989.55	$2,968.64

Specialty Therapeutic Classes by Ingredient Cost

GREGG COUNTY, TEXAS

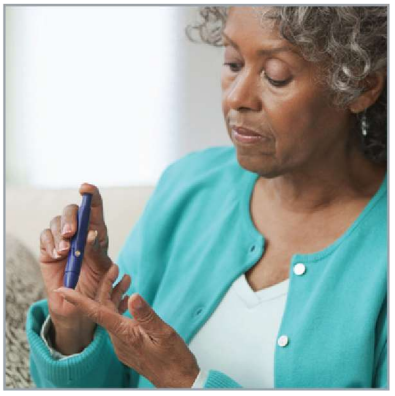
10001621 **6/1/16 - 5/31/17**

Rank	Therapeutic Class		Drug Name	Brand/Generic	Maint	Rx Count	Avg Ingr Cost	Total Ingredient Cost	Unique Members
1	MULTIPLE SCLEROSIS AGENTS								
		1	GILENYA	Brand	Y	13	$7,017.74	$91,230.66	1
		2	AVONEX PEN	Brand	Y	13	$6,207.00	$80,691.05	1
		3	AMPYRA	Brand	Y	13	$2,103.94	$27,351.16	1
					Total:	**39**	**$5,109.56**	**$199,272.87**	**2**
2	CYSTIC FIBROSIS AGENTS								
		1	ORKAMBI	Brand	Y	6	$20,114.34	$120,686.05	1
		2	PULMOZYME	Brand	Y	1	$3,284.06	$3,284.06	1
					Total:	**7**	**$17,710.02**	**$123,970.11**	**1**
3	INFLAMMATORY BOWEL AGENTS								
		1	CIMZIA	Brand	Y	13	$3,516.46	$45,714.00	1
					Total:	**13**	**$3,516.46**	**$45,714.00**	**1**
4	ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES								
		1	HUMIRA PEN-CROHNS DISEASE	Brand	Y	1	$11,810.54	$11,810.54	1
		2	HUMIRA PEN	Brand	Y	1	$8,495.68	$8,495.68	1
					Total:	**2**	**$10,153.11**	**$20,306.22**	**1**
5	BONE DENSITY REGULATORS								
		1	FORTEO	Brand	Y	1	$2,664.04	$2,664.04	1
		2	PROLIA	Brand	N	1	$1,003.99	$1,003.99	1
					Total:	**2**	**$1,834.02**	**$3,668.03**	**2**
				Totals for All Specialty Therapeutic Classes:		**63**	**$6,237.00**	**$392,931.23**	**7**

Tria Health Summary Report

GREGG COUNTY

Report Period: June 01, 2016 - May 31, 2017



tria HEALTH

Report Contents:

Patient Success Stories

Patient #1 - Follow Up Consultation - 12/21/2016

Problem(s) Identified:
Unnecessary drug therapy - duplicate therapy

Intervention:
A 52 year old patient with asthma and high blood pressure had a follow up consultation with Tria Health in December 2016. The patient reported that they were taking Spiriva and Symbicort inhalers for asthma. Upon questioning, Tria Pharmacist discovered that the patient had very good control of asthma symptoms for the past 12 months and had not had an exacerbation or symptoms of shortness of breath. Due to excellent control of asthma, Tria Pharmacist recommended to simplify their asthma inhaler regimen. The patient's physician agreed with our recommendation and discontinued Symbicort.

Impact/Benefit:
RX drug discontinuation
Symbicort - 12 month supply - $2929.92

Patient #2 - Follow Up Consultation - 12/29/2016

Problem(s) Identified:
Compliance - more affordable product available

Intervention:
A 65 year old patient with generalized anxiety disorder, heartburn, high blood pressure, and high cholesterol had an appointment with Tria Health in December 2016. The patient reported excellent control of anxiety symptoms with use of Pristiq 50mg once daily. The patient was unaware that a generic formulation was available and Tria Pharmacist recommended to switch from brand name Pristiq to generic desvenlafaxine. Upon followup, the patient was taking the generic medication and their anxiety continued to be well controlled

Impact/Benefit:
Generic substitution
Pristiq 50mg - 30 day supply: $318.22
Desvenlafaxine 50mg - 30 day supply: $86.50
Annual savings: $2780.64

Patient #3 - Follow Up Consultation - 3/17/2017

Problem(s) Identified:
Unnecessary drug therapy - duplicate therapy

Intervention:
A 60 year old patient with high blood pressure, heartburn, and chronic pain had a consultation with Tria Health in March 2017. The patient recently had shoulder surgery and reported that they were taking meloxicam and naproxen on a daily basis. The patient was unaware that these were both in the same class of medications and should not be taken together. Inappropriate use of these medications increases the risk for bleeding stomch ulcers by 50%. Tria Pharmacist educated the patient regarding these concerns and the patient agreed to stop taking naproxen and only use meloxicam.

Impact/Benefit:
Specialist visit avoided
Decreased risk of adverse drug reaction

Investment & Savings Summary

Total Amount Invested: **$33,225**

Total Annualized Savings: **$176,184**

Financial outcomes: Rx Savings

Category of Health Care Savings	Estimated Cost	Occurrences	Cost Savings
PA: Generic Substitutions	$1,800 per Switch	7	$12,600
PA: Less Expensive Substitutions	$240 per Switch	1	$240
PA: Discontinued Medications	$1,000 per Discontinuation	9	$9,000
Affordable Med Program Switches	$1,800 per Switch	1	$1,800
Non-Statin Cholesterol Discontinuation	$1,000 per Discontinuation	3	$3,000
PPI Drug Discontinuation	$1,000 per Discontinuation	23	$23,000
		Total Net Rx Savings:	$49,640

Financial outcomes: Health Care Savings [1]

Category of Health Care Savings	Estimated Cost	Occurrences	Cost Savings
ER Visits Avoided	$821 per visit	0	$0
Outpatient Clinic Visits Avoided	$182 per visit	80	$14,560
Specialists' Visit Avoided	$564 per visit	8	$4,512
Lab Monitoring Services Avoided	$50 per service	2	$100
Urgent Care Visits	$182 per visit	22	$4,004
Hospital Admission Visits Avoided	$29,046 per visit	0	$0
		Total Estimated Health Care Savings:	$23,176

Financial outcomes: Compliance Saving [2]

Chronic Disease Category	Estimated Cost	Occurrences	Cost Savings
Diabetes	$3,756.00	9	$33,804
Heart Disease	$7,823.00	2	$15,646
High Blood Pressure	$3,908.00	10	$39,080
High Cholesterol	$1,258.00	11	$13,838
Respiratory	$3,000.00		$0
Osteoporosis	$1,000.00	1	$1,000
		Total Compliance Savings	$103,368

[1] AHRQ-Agency for Healthcare Research and Quality, Rockville, MD 20850, MEPS-Medical Expenditure Panel Survey, 2008 http://www.meps.ahrq.gov/mepsweb/ and http://www.ahrq.gov/browse/hospital.htm

[2] M. Christopher Roebuck, Joshua N. Liberman, Marin Gemmill-Toyama and Troyen A. Brennan. Medical Adherence Leads to Lower Health Care Use and Costs Despite Increased Drug Spending. Health Affairs, 30, no.1(2011):9199. Doi:10.1377/hlthaff.2009.1087 .http:://content.healthaffairs.org/content/30/1/91.full.html.

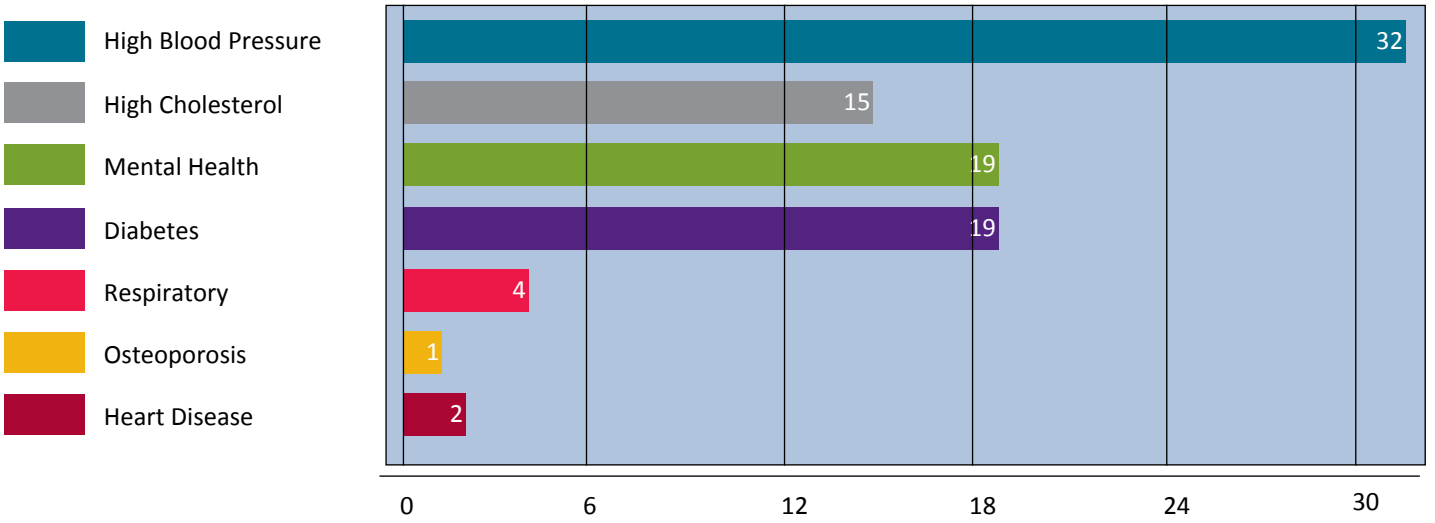
Pharmacy Advocate Program Overview

Number of Engaged Members: 47

Patient Demographics	%	Count
Female:	60%	28
Male:	40%	19
Average Age:	54	

Patient Data	
Total Number of Identified Drug Therapy Problems:	76
Total Number of Drugs Reviewed:	777
Total Number of Conditions Reviewed:	548

Number of Engaged Members by Targeted Conditions

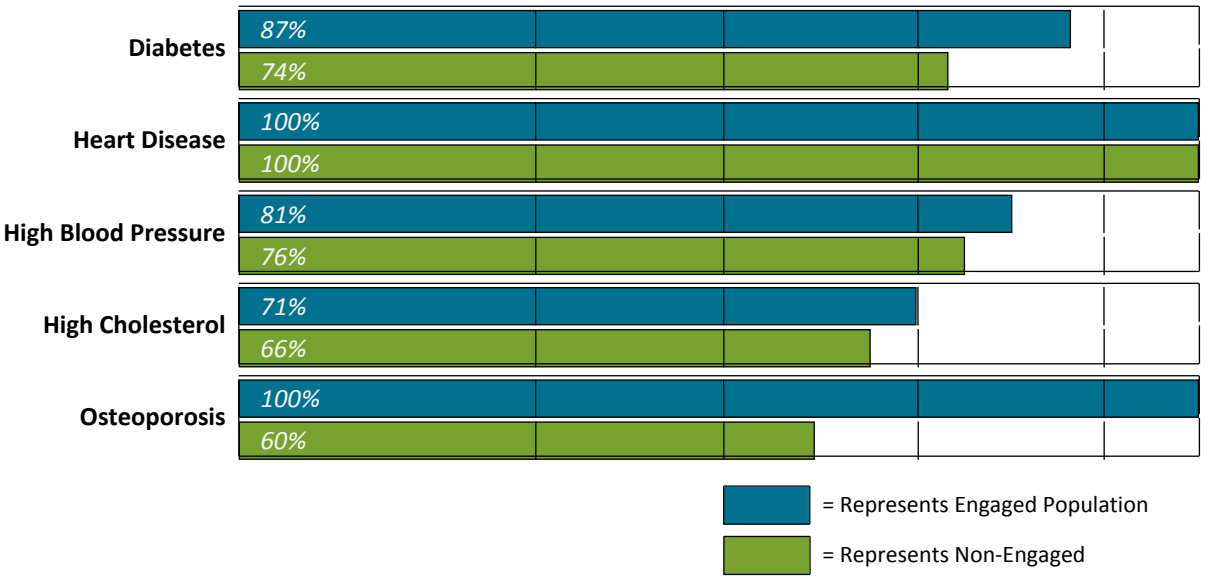


Drug Therapy Problems Identified

Category of Drug Therapy Problem	Total Occurences
Compliance	13
Different Drug Needed	5
Dosage Too High	3
Unnecessary Drug Therapy	3
Needs Additional Therapy	34
Adverse Drug Reaction	8
Dosage Too low	10
Total Drug Therapy Problems	76

Member Compliance Report

Reflects compliance in the Pharmacy Advocate participants as compared to all non-engaged members on your plan.



Rx Plan Protection Suite

Affordable Med Switches: 1

Affordable Med Letters Sent: 79

Members receive access to education about generic medications and co-pay waiver programs, informing them about lower cost alternative drugs and potential health care savings. Our Tria Pharmacists offer comprehensive guidance and assistance in helping members switch from high cost brands to lower cost generic alternatives.

Med Safety Alerts: 1

Tria Health Clinical Pharmacists educate members and physicians about potential drug-to-drug interactions, adverse drug reactions and duplicate therapies.

Clinical Alerts: 94

Tria Pharmacists evaluate prescription profiles of all individuals and identify gaps in care based on current treatment guidelines. These individuals receive education regarding the condition and the opportunity to speak with a pharmacist for additional information.

Compliance Alerts: 110

Targeted communication is provided for individuals who are identified as being non-compliant with their chronic medications based on their prescription profiles.

Help Desk Calls: 17

All members have access to the toll-free Tria Help Desk, which allows them to contact one of our Clinical Pharmacists directly to seek answers for questions regarding medications.

Categories of Drug Therapy Problems

Adverse Drug Reaction:
A response to a drug that is harmful and unintended that occurs at doses normally used for prevention, diagnosis, or treatment of disease. ADRs can be caused by one or more of the following: drug-drug or drug-food interactions, improper administration, or inappropriate medication choices.

Compliance:
The extent to which a patient takes their medications as prescribed by their health care provider. Reasons patients are unable to take their medications as directed include: inability to afford or obtain drug products, unable to correctly administer, poor understanding of instructions, and intentionally choosing to omit or forgetting to take a medication.

Different Drug Needed:
Current medication use is not meeting the desired goals of therapy and a recognized change is indicated. Reasons to consider changing to an alternative medication include: inappropriate dosage form, condition is resistant to current treatment, drug is not indicated for condition, a more effective medication is available, or a more cost-effective medication is available.

Dosage too High:
Medication is improperly prescribed, taken too often or via the wrong route, duration is too long, or it interacts with another drug resulting in an increased risk for undesirable outcomes without added benefit.

Dosage too Low:
Medication is improperly prescribed, taken too infrequently or via the wrong route, duration is too short, or it interacts with another drug resulting in less effective treatment of a patient's medical condition and higher occurrence of signs and symptoms of disease.

Need Additional Drug Therapy:
Another medication is needed in combination with the current regimen to optimize treatment or prevention of a patient's medical condition.

Unnecessary Drug Therapy:
Medication is determined to treat a condition that is no longer active, it is treated with another similar medication, or therapy with a non-drug approach may be more effective.

Gregg County
Employee Benefit Health & Dental Plan

Plan Document and Summary Plan Description
Effective: October 01, 2010
Restated: October 01, 2016

SCHEDULE OF MEDICAL BENEFITS – ACTIVE & RETIREE

Calendar Year Maximum Benefit

The following Calendar Year maximums apply to each Participant.

BENEFIT MAXIMUMS Once a Maximum Benefit for a specified service is met, no additional benefits for that service are available for the remainder of the time period specified. The Maximum Benefits specified below are per Covered Person. All Maximums are for Gregg County Preferred Network, Network, and Non-Network benefits combined.	
Chiropractic Care	16 visits per Calendar Year
Extended Care Facility	30 days per Calendar Year
Hearing Exams and Hearing Aids	Hearing exams are limited to 1 exam every 3 years. Hearing aids are limited to a Maximum Benefit of $1,000 every 3 years.
Home Health Care	30 visits per Calendar Year. A "visit" is defined as up to four hours of care per day.
Wigs/ wig maintenance following chemotherapy	1 per Lifetime

CALENDAR YEAR DEDUCTIBLE Except as specified otherwise, Covered Expenses are subject to a Calendar Year Deductible that must be met before benefits are payable. The Individual Deductible is satisfied once a Covered Person has paid the Individual Deductible amount. The Family Deductible is satisfied once amounts credited towards the Individual Deductibles of a family total the Family Deductible amount. Once the Family Deductible is satisfied, all Individual Deductibles for that family are considered to be satisfied for the remainder of that Calendar Year. Amounts incurred with Network providers are credited toward Network Deductibles only. Amounts incurred with Non-Network providers are credited toward the Non-Network Deductibles only.			
Deductible Amounts	Gregg County Preferred Network	Network	Non-Network
• Individual	N/A	$350	$1,200
• Family	N/A	$700	$2,400

CALENDAR YEAR OUT-OF-POCKET MAXIMUMS

Most Covered Expenses are paid by the Plan at less than one hundred percent. The remaining percentage of the expense, known as "co-insurance", must be paid by the Covered Person. Except as specified below, co-insurances paid by a Covered Person are credited towards that person's Out-of-Pocket Maximum. The Individual Out-of-Pocket Maximum is satisfied once a Covered Person has paid the Individual Out-of-Pocket Maximum amount. The Family Out-of-Pocket Maximum is satisfied once amounts credited towards the Individual Out-of-Pocket Maximums of a family total the Family Out-of-Pocket. Once the Family Out-of-Pocket Maximum is satisfied, all Individual Out-of-Pocket Maximums for that family are considered to be satisfied for the remainder of that Calendar Year.

Amounts incurred with Gregg County Preferred Network providers and Network providers are credited toward both the Gregg County Preferred Network providers and Network providers Out-of-Pocket Maximums. Amounts incurred with Non-Network providers are credited toward the Non-Network Out-of-Pocket Maximum only.

Once an Out-of-Pocket Maximum has been satisfied, all remaining Covered Expenses for that Covered Person incurred during that same Calendar Year will be payable by the Plan at one hundred percent, except as specified below.

Out-of-Pocket Maximums	Gregg County Preferred Network	Network	Non-Network
• Individual	$1,700	$2,500	$18,000
• Family	$3,400	$5,000	$36,000
Expenses Not Credited Toward the Out-of-Pocket Maximum:	• Deductibles; • Co-pays; • Penalties for failure to comply with the Utilization Management Program, including any portion of a hospital stay that is not certified by the Utilization Management Program as being Medically Necessary; • Non-Covered Expenses; and • Expenses in excess of any Maximum Benefit		

ELIGIBLE MEDICAL EXPENSES

This schedule shows the percentage payable by the Plan for a Covered Expense after any Deductible, in applicable, has been satisfied. The percentages shown are applied to the "Reasonable and Appropriate" amount for an expense. For Network providers, that amount is based on negotiated rates. After finding the percentage payable for an expense in this schedule, please refer to the section **Eligible Medical Expenses** for any terms or conditions that apply to that expense.

Covered Medical Expense	Gregg County Preferred Network	Network	Non-Network
Allergy Care • Office visit	100% after $25 co-pay	100% after $30 co-pay, Deductible waived	60% after Deductible
• Testing, Serum and Injections	90% after Deductible	80% after Deductible	60% after Deductible
Ambulance	90% after $25 co-pay	80% after $30 co-pay; Deductible applies	60% after Deductible
Chiropractic Care Limited to 16 visits per Calendar Year	100% after $25 co-pay	100% after $30 co-pay, Deductible waived	60% after Deductible
Diagnostic Lab & X-ray • Inpatient Hospital	90% after Deductible	80% after Deductible	60% after Deductible
• Outpatient Hospital	90% after $100 co-pay	80% after $200 co-pay; Deductible applies	60% after Deductible
• Independent Lab	90% after $25 co-pay	80% after Deductible	60% after Deductible
• Office Visit	100% after $25 co-pay	100% after $30 co-pay	60% after Deductible
• Office Visit Major Diagnostic Test MRI, CT, PET Scan, etc.	90% after $25 co-pay	80% after Deductible	60% after Deductible
Durable Medical Equipment	90%	80% after Deductible	60% after Deductible
Extended Care Facility Limited to 30 days per Calendar Year	90%	80% after Deductible	60% after Deductible
Hearing Aid and Exams Exams are limited to one every three years. Hearing aids are limited to a Maximum Benefit of $1,000 every 3 years.	100%	100% Deductible waived	60% after Deductible
Home Health Care Limited to 30 visits per Calendar Year. A "visit" is defined as up to four hours of care per day.	90%	80% after Deductible	60% after Deductible
Hospice Care Includes bereavement care.	100%	100% Deductible waived	100% Deductible waived

Covered Medical Expense	Gregg County Preferred Network	Network	Non-Network
Hospital Services • Inpatient Care Room & Board is limited to the semi-private room rate	90% after $200 co-pay	80% after $300 co-pay; Deductible applies	60% after $500 co-pay; Deductible applies
• Emergency Room Co-pay waived if visit results in admission	90% after $85 co-pay	80% after $120 co-pay; Deductible applies	60% after $250 co-pay; Deductible applies
• All Other Outpatient Services	90% after $100 co-pay	80% after $200 co-pay; Deductible applies	60% after $300 co-pay; Deductible applies
Infertility Testing and Treatment Limited to diagnostic testing and treatment of blocked fallopian tubes. Drugs and impregnation are not covered.	90% after Deductible	80% after Deductible	60% after Deductible
Mental/Nervous Disorders • Inpatient Care	90% after $200 co-pay	80% after $300 co-pay; Deductible applies	60% after $500 co-pay; Deductible applies
• Partial Hospitalization	90% after Deductible	80% after Deductible	60% after Deductible
• Outpatient Care	90% after $25 co-pay	80% after $30 co-pay; Deductible applies	60% after Deductible
Occupational, Physical and Speech Therapy	90% after $25 co-pay	80% after $30 co-pay; Deductible applies	60% after Deductible
Orthotics/Prosthetics	90%	80% after Deductible	60% after Deductible
Physician Services • Inpatient Services	90%	80% after Deductible	60% after Deductible
• Office Services Includes office visit and all services performed in and/or billed by the Physician's office, such as surgery, injections and supplies. Does <u>not</u> include lab, x-rays and Major Diagnostic Testing (see separate entry).	100% after $25 co-pay	100% after $30 co-pay, Deductible waived	60% after Deductible

Covered Medical Expense	Gregg County Preferred Network	Network	Non-Network
Preventive Care - per calendar year • Routine Well Care and Child Well Care: Physicals, Immunizations, Lab & X-ray; Pap Smear; Mammograms; PSA - first test with or without a diagnosis; CA 125 blood test and Fecal occult blood test - with or without diagnosis; Eye exam - including refraction & contact lens fitting fee;	100% Deductible waived	100% Deductible waived	60% after Deductible
• Colonoscopy-with or without diagnosis: Limited to once every 3 years age 45+	100% Deductible waived	100% Deductible waived	60% after Deductible
Private Duty Nursing	90% after Deductible	80% after Deductible	60% after Deductible
Serious Mental Illness Please refer to **Medical Benefits** for a definition of "Serious Mental Illness." • Inpatient Care	90% after $200 co-pay	80% after $300 co-pay Deductible applies	60% after $500 co-pay; Deductible applies
• Outpatient Hospital Care	90% after $100 co-pay	80% after Deductible	60% after Deductible
• Outpatient Physician Services Evaluation, psychotherapy, med/mgmt.	100% after $25 co-pay	100% after $30 co-pay, Deductible waived	60% after Deductible
Substance Abuse • Inpatient Care	90% after $200 co-pay	80% after $300 co-pay; Deductible applies	60% after $500 co-pay; Deductible applies
• Partial Hospitalization	90% after Deductible	80% after Deductible	60% after Deductible
• Outpatient Care	90% after $25 co-pay	80% after $30 co-pay; Deductible applies	60% after Deductible
TMJ/Jaw Joint	90% after Deductible	80% after Deductible	60% after Deductible
Transplants	90% after Deductible	80% after Deductible	N/A
Wig/maintenance-following chemotherapy Limited to 1 per Lifetime	90% after Deductible	80% after Deductible	60% after Deductible

SCHEDULE OF REDUCED MEDICAL BENEFITS OPTION – RETIREE

BENEFIT MAXIMUMS
REDUCED BENEFIT OPTION

The Reduced Benefit Plan is offered only to under age 65 Retirees and under age 65 Dependents of Retirees. This Reduced Benefit Option is offered pursuant to Section 175.003 (d) of the Texas Local Government Rule.

Once a Maximum Benefit for a specified service is met, no additional benefits for that service are available for the remainder of the time period specified. The Maximum Benefits specified below are per Covered Person. All Benefit Maximums are for Network and Non-Network benefits, combined.

Chiropractic Care	16 visits per Calendar Year
Extended Care Facility	30 days per Calendar Year
Hearing Exams and Hearing Aids	Hearing exams are limited to 1 exam every 3 years. Hearing aids are limited to a Maximum Benefit of $1,000 every 3 years.
Home Health Care	30 visits per Calendar year. A "visit" is defined as up to four hours of care per day.
Wigs/wig maintenance following chemotherapy	1 per Lifetime

CALENDAR YEAR DEDUCTIBLE

Except as specified otherwise, Covered Expenses are subject to a Calendar Year Deductible that must be met before benefits are payable. The Individual Deductible is satisfied once a Covered Person has paid the Individual Deductible amount. The Family Deductible is satisfied once amounts credited towards the Individual Deductibles of a family total the Family Deductible amount. Once the Family Deductible is satisfied, all Individual Deductibles for that family are considered to be satisfied for the remainder of that Calendar Year.

Amounts incurred with Network providers are credited toward Network Deductibles only.
Amounts incurred with Non-Network providers are credited toward the Non-Network Deductibles only.

Deductible Amounts	**Network**	**Non-Network**
• Individual • Family	$2,000 $4,000	$4,000 $8,000
Expenses Not Credited Toward the Out-of-Pocket Maximum:	• **Deductibles;** • **Co-pays;** • **Penalties for failure to comply with the Utilization Management Program, including any portion of a hospital stay that is not certified by the Utilization Management Program as being Medically Necessary;** • **Non-Covered Expenses; and** • **Expenses in excess of any Maximum Benefit**	

CALENDAR YEAR OUT-OF-POCKET MAXIMUMS

The Reduced Benefit Plan is offered only to under age 65 Retirees and under age 65 Dependents of Retirees. This Reduced Benefit Option is offered pursuant to Section 175.003 (d) of the Texas Local Government Rule.

Most Covered Expenses are paid by the Plan at less than one hundred percent. The remaining percentage of the expense, known as "co-insurance", must be paid by the Covered Person. Except as specified below, co-insurances paid by a Covered Person are credited towards that person's Out-of-Pocket Maximum.

The Individual Out-of-Pocket Maximum is satisfied once a Covered Person has paid the Individual Out-of-Pocket Maximum amount. The Family Out-of-Pocket Maximum is satisfied once amounts credited towards the Individual Out-of-Pocket Maximums of a family total the Family Out-of-Pocket. Once the Family Out-of-Pocket Maximum is satisfied, all Individual Out-of-Pocket Maximums for that family are considered to be satisfied for the remainder of that Calendar Year.

Amounts incurred with Network providers are credited toward the Network providers Out-of-Pocket Maximums. Amounts incurred with Non-Network providers are credited toward the Non-Network Out-of-Pocket Maximum only.

Once an Out-of-Pocket Maximum has been satisfied, all remaining Covered Expenses for that Covered Person incurred during that same Calendar Year will be payable by the Plan at one hundred percent, except as specified below.

Out-of-Pocket Maximums	**Network**	**Non-Network**
• **Individual** • **Family**	**$2,000** **$4,000**	**$15,000** **$30,000**
Expenses Not Credited Toward the Out-of-Pocket Maximum:	• **Deductibles;** • **Co-pays;** • **Penalties for failure to comply with the Utilization Management Program, including any portion of a hospital stay that is not certified by the Utilization Management Program as being Medically Necessary;** • **Non-Covered Expenses; and** • **Expenses in excess of any Maximum Benefit**	

ELIGIBILE MEDICAL EXPENSES

This schedule shows the percentage payable by the Plan for a Covered Expense after any Deductible, in applicable, has been satisfied. The percentages shown are applied to the "Reasonable and Customary" amount for an expense. For Network providers, that amount is based on negotiated rates. After finding the percentage payable for an expense in this schedule, please refer to the section Eligible Medical Expenses for any terms or conditions that apply to that expense.

Covered Medical Expense	Network	Non-Network
Allergy Care • Office Visit Testing, Serum and Injections	80% after Deductible	80% after Deductible
Chiropractic Care Limited to 16 visits per Calendar Year	80% after Deductible	50% after Deductible
Diagnostic Lab & X-ray – Independent Lab • Major Diagnostic Testing • Lab and X-ray	 80% after Deductible 80% after Deductible	 50% after Deductible 50% after Deductible
Durable Medical Equipment	80% after Deductible	50% after Deductible
Extended Care Facility Limited to 30 days per Calendar Year	80% after Deductible	50% after Deductible
Hearing Aids and Exams Exams limited to one every three years. Hearing aids are limited to a max benefit of $1,000 every 3 years.	80% after Deductible	50% after Deductible
Home Health Care	80% after Deductible	50% after Deductible
Hospice Care Includes Bereavement Care	100% Deductible waived	100% Deductible waived
Hospital Services • Inpatient Care Room & Board limited to semi-private rate. • Emergency Room Co-pay waived if visit results in an admission All Other Outpatient Services	 80% after $300 co-pay; Deductible applies 80% after $75 co-pay; Deductible applies 80% after $150 co-pay; Deductible waived	 50% after $500 co-pay; Deductible applies 50% after $100 co-pay; Deductible applies 80% after $300 co-pay; Deductible waived
Infertility Testing and Treatment Limited to diagnostic testing and treatment of blocked fallopian tubes. Drugs and impregnation not covered.	80% after Deductible	50% after Deductible
Mental/Nervous Disorders "Serious Mental Illness" is not subject to the Maximums listed here. Please see separate entry. • Inpatient Care • Partial Hospitalization • Outpatient Care	 80% after $300 co-pay; Deductible applies 80% after Deductible 80% after Deductible	 50% after $500 co-pay; Deductible applies 50% after Deductible 50% after Deductible

ELIGIBILE MEDICAL EXPENSES

This schedule shows the percentage payable by the Plan for a Covered Expense after any Deductible, in applicable, has been satisfied. The percentages shown are applied to the "Reasonable and Customary" amount for an expense. For Network providers, that amount is based on negotiated rates. After finding the percentage payable for an expense in this schedule, please refer to the section Eligible Medical Expenses for any terms or conditions that apply to that expense.

Covered Medical Expense	Network	Non-Network
Occupational, Physical and Speech Therapy	80% after Deductible	50% after Deductible
Orthotics/Prosthetics	80% after Deductible	50% after Deductible
Physician Services • Inpatient Services	80% after Deductible	50% after Deductible
• Office Services Includes office visits and all services performed in and/or billed by the Physician's office, such as surgery, injections and supplies. Does not include Major Diagnostic Testing (see separate entry.)	80% after Deductible	50% after Deductible
Preventive Care - per calendar year • Routine Well Care and Child Well Care: Physicals, Immunizations, Lab & X-ray; Pap Smear; Mammograms; PSA - first test with or without a diagnosis; CA 125 blood test and Fecal occult blood test - with or without diagnosis; Eye exam - including refraction & contact lens fitting fee;	80% after Deductible	50% after Deductible
• Colonoscopy-with or without diagnosis: Limited to once every 3 years age 45+	80% after Deductible	50% after Deductible
Private Duty Nursing	80% after Deductible	50% after Deductible
Serious Mental Illness Please refer to Medical Benefits for a definition of "Serious Mental Illness." • Inpatient Care	80% after $300 co-pay; Deductible applies	50% after $500 co-pay; Deductible applies
• Outpatient Hospital Care	80% after $150 co-pay; Deductible applies	50% after $300 co-pay; Deductible applies
• Outpatient Physician Services Evaluation, psychotherapy & med/mgmt	80% after Deductible	50% after Deductible
Substance Abuse • Inpatient Care	80% after $300 co-pay; Deductible applies	50% after $500 co-pay; Deductible applies
• Partial Hospitalization	80% after Deductible	50% after Deductible
• Outpatient Care	80% after Deductible	50% after Deductible
TMJ / Jaw Joint	80% after Deductible	50% after Deductible
Transplants	80% after Deductible	N/A
Wigs/maintenance- 1 per lifetime Following chemotherapy treatment	80% after Deductible	50% after Deductible

DENTAL BENEFITS – ACTIVE & RETIREE

Schedule of Dental Care Benefits

Benefits for Eligible Dental Care Expenses, including for the Reduced Benefit Option, are provided based on the schedule presented below.	
Deductible	
• Individual • Family	$50 $150
Benefits for Eligible Expenses	
• Preventive Services	100% of eligible expenses; the calendar year deductible does not apply.
• Basic Services	80% of eligible expenses incurred, after the calendar year deductible is satisfied.
• Major Restorative Services	50% of eligible expenses incurred, after the calendar year deductible is satisfied.
Maximum Benefit	
Preventive, Basic and Major Services	$1,500 per person per calendar year

The Deductible amount, if any, which is listed above, is the amount each Participant must pay each Calendar Year toward Covered Expenses. Once the Deductible is satisfied, additional Covered Expenses will be reimbursed according to the percentages set forth above, subject to the limitations and exclusions set forth in this section. Dental expense benefits are separate from and in addition to the Medical Benefits of this Plan. These benefits are available only if elected by an Employee for himself/herself and eligible Dependents.

Covered Expenses

The following is a brief description of the types of expenses that will be considered for coverage under the Plan, subject to the limitations contained in the Summary of Benefits. Charges must be for services and supplies customarily employed for treatment of the dental condition, and rendered in accordance with ADA accepted standards of practice. Coverage will be limited to Usual and Customary fees.

Alternate Treatment

Many dental conditions can be treated in more than one way. This Plan has an “alternate treatment” clause which governs the amount of benefits the Plan will pay for treatments covered under the Plan. If a Participant chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost effective level.

For example, if a regular amalgam filling is sufficient to restore a tooth to health, and the Participant and the Dentist decide to use a gold filling, the Plan will base its reimbursement on the Usual and Customary and Reasonable charge for an amalgam filling. The patient will pay the difference in cost