

**LEGAL NOTICE
AND
INVITATION FOR SEALED PROPOSALS**

**REQUEST FOR PROPOSALS for
GROUP HEALTH, LIFE, DENTAL, AND VISION INSURANCE**

RFP # INS-HEALTH-08-29-2017

Sealed RFPs will be received by The LAGUNA MADRE WATER DISTRICT for GROUP HEALTH, LIFE, DENTAL, AND VISION INSURANCE by Tuesday August 29, 2017, until 10:00 am, the LMWD, Director of Finance Office; 105 Port Rd. Port Isabel TX 78578

RFPs received after this time will not be considered.

RFPs will be publicly opened and read aloud on **August 29, 2017 at 10:30 am**. Firms are invited to attend the RFPs opening at the LMWD Board Meeting Room.

The RFP package and instructions may be obtained from the Director of Finance during normal business hours at the address above or by accessing our website <http://lagunamadrewater.com/Bids-RFPs-RFQs-RFI>

Two (2) sets of the RFP documents shall be enclosed in a sealed envelope and shall be plainly marked on the outside of the envelope and on any carrier's envelope:

GROUP HEALTH, LIFE, DENTAL, AND VISION INSURANCE
RFP # INS-HEALTH-08-29-2017

This envelope shall be addressed to Director of Finance; Laguna Madre Water District; 105 Port Rd, Port Isabel TX 78578.

The LMWD will not be responsible in the event that the U.S. Postal Service or any other courier system fails to deliver the sealed bids to the Laguna Madre Water District, General Manager Office by the given deadline above. **No bids will be accepted via facsimile or electronic submission.**

The LMWD specifically reserves the right to reject any or all bids, to waive irregularities or informalities in any or all bids and to accept any bid which is deemed to be in the best interest of the LMWD.

Sanjuana Garcia
Director of Finance
105 Port Road
Port Isabel TX 78578

INSTRUCTIONS TO COMPANIES AND AGENTS

Please submit this page upon receipt.

Acknowledgment Form

RFP # INS-HEALTH-08-29-2017

For any clarifications, please contact Sanjuana Garcia at Laguna Madre Water District, Director of Finance at (956) 943-2626 Ext.300 or e-mail: sgarcia@lmwd.org

Please e-mail this page upon receipt of the bid package or legal notice. If you only received the legal notice and you want the bid package mailed, please provide a method of shipment with account number in the space designated below.

Check one:

Yes, I will be able to send a bid; obtained bid package from website.

Yes, I will be able to send a bid; please email the bid package.

Email: _____

Yes, I will be able to send a bid; please mail the bid package using the carrier & account number listed below:

Carrier: _____

Account: _____

No, I will not be able to send a bid for the following reason:

If you are unable to send your bid, kindly indicate your reason for "No bid" above and return this form **via email to sgarcia@lmwd.org**. This will ensure you remain active on our vendor list.

Date _____

Company Name: _____

Authorized Representative _____

CERTIFICATION REGARDING
DEBARMENT, SUSPENSION, AND OTHER RESPONSIBILITY
MATTERS **(Complete and return with bid)**

Name of Entity: _____

The prospective participant certifies to the best of their knowledge and belief that they and their principals:

- a) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency;
- b) Have not within a three year period preceding this bid been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- c) Are not presently indicted for or otherwise criminally or civilly charged by a government entity (Federal, State, Local) with commission of any of the offenses enumerated in paragraph (1) (b) of this certification; and
- d) Have not within a three year period preceding this application/bid had one or more public transactions (Federal, State, and Local) terminated for cause or default.

I understand that a false statement on this certification may be grounds for rejection of this bid or termination of the award. In addition, under 18 USC Section 1001, a false statement may result in a fine up to a \$10,000.00 or imprisonment for up to five (5) years, or both.

Name and Title of Authorized Representative (Typed)

Signature of Authorized Representative

Date

I am unable to certify to the above statements. My explanation is attached.

ETHICS STATEMENT (Complete and return with bid)

The undersigned bidder, by signing and executing this bid, certifies and represents to the Laguna Madre Water District that bidder has not offered, conferred or agreed to confer any pecuniary benefit, as defined by (1.07 (a) (6) of the Texas Penal Code, or any other thing of value as consideration for the receipt of information or any special treatment of advantage relating to this bid; the bidder also certifies and represents that the bidder has not offered, conferred or agreed to confer any pecuniary benefit or other thing of value as consideration for the recipient's decision, opinion, recommendation, vote or other exercise of discretion concerning this bid, the bidder certifies and represents that bidder has neither coerced nor attempted to influence the exercise of discretion by any officer, trustee, agent or employee of the Laguna Madre Water District concerning this bid on the basis of any consideration not authorized by law; the bidder also certifies and represents that bidder has not received any information not available to other bidders so as to give the undersigned a preferential advantage with respect to this bid; the bidder further certifies and represents that bidder has not violated any state, federal, or local law, regulation or ordinance relating to bribery, improper influence, collusion or the like and that bidder will not in the future offer, confer, or agree to confer any pecuniary benefit or other thing of value of any officer, trustee, agent or employee of the Laguna Madre Water District in return for the person having exercised their person's official discretion, power or duty with respect to this bid; the bidder certifies and represents that it has not now and will not in the future offer, confer, or agree to confer a pecuniary benefit or other thing of value to any officer, trustee, agent, or employee of the Laguna Madre Water District in connection with information regarding this bid, the submission of this bid, the award of this bid or the performance, delivery or sale pursuant to this bid.

THE VENDOR SHALL DEFEND, INDEMNIFY, AND HOLD HARMLESS THE LAGUNA MADRE WATER DISTRICT, ALL OF THEIR OFFICERS, AGENTS AND EMPLOYEES FROM AND AGAINST ALL CLAIMS, ACTIONS, SUITS, DEMANDS, PROCEEDING, COSTS, DAMAGES, AND LIABILITIES, ARISING OUT OF, CONNECTED WITH, OR RESULTING FROM ANY ACTS OR OMISSIONS OF CONTRACTOR OR ANY AGENT, EMPLOYEE, SUBCONTRACTOR, OR SUPPLIER OF CONTRACTOR IN THE EXECUTION OR PERFORMANCE OF THIS BID.

I have read all of the specifications and general bid requirements and do hereby certify that all items submitted meet specifications.

COMPANY: _____

AGENT NAME: _____

AGENT SIGNATURE: _____

ADDRESS: _____

ETHICS STATEMENT (Complete and return with bid)

CITY: _____

STATE: _____ ZIP CODE: _____

TELEPHONE: _____ FAX: _____

FEDERAL ID#: _____ AND/OR SOCIAL SECURITY #: _____

DEVIATIONS FROM SPECIFICATIONS IF ANY:

CONFLICT OF INTEREST QUESTIONNAIRE

For vendor or other person doing business with local governmental entity

This questionnaire reflects changes made to the law by H.B. 1491, 80th Leg., Regular Session.

This questionnaire is being filed in accordance with Chapter 176, Local Government Code by a person who has a business relationship as defined by Section 176.001(1-a) with a local governmental entity and the person meets requirements under Section 176.006(a).

By law this questionnaire must be filed with the records administrator of the local governmental entity not later than the 7th business day after the date the person becomes aware of facts that require the statement to be filed. See Section 176.006, Local Government Code.

A person commits an offense if the person knowingly violates Section 176.006, Local Government Code. An offense under this section is a Class C misdemeanor.

OFFICE USE
ONLY

Date
Received

1. Name of person who has a business relationship with local governmental entity.

2. () Check this if you are filing an update to a previously filed questionnaire.

(The law requires that you file an updated completed questionnaire with the appropriate filing authority not later than the 7th business day after the date the originally filed questionnaire becomes incomplete or inaccurate.)

3. Name of local government officer with whom filer has employment or business relationship.

Name of Officer

This section (item 3 including subparts A, B, C & D) must be completed for each officer with whom the filer has an employment or other business relationship as defined by Section 176.001(1-a), Local Government Code. Attach additional pages to this Form CIQ as necessary.

- A. Is the local government officer named in this section receiving or likely to receive taxable income, other than investment income, from the filer of the questionnaire?
Yes No
- B. Is the filer of the questionnaire receiving or likely to receive taxable income, other than investment income, from or at the direction of the local government officer named in this section AND the taxable income is not received from the local governmental entity?
Yes No
- C. Is the filer of this questionnaire employed by a corporation or other business entity with respect to which the local government officer serves as an officer or director, or holds an ownership of 10 percent or more?
Yes No
- D. Describe each employment or business relationship with the local government officer named in this section.

4.

Signature of person doing business with the governmental entity

Date

Special Instructions

Contract Information

- **Interpretation**

Questions concerning terms, conditions, and technical specifications should be directed to:

Sanjuana Garcia
Director of Finance
sgarcia@lmwd.org

- **Tentative Time Line**

1. August 14, 2017 to August 28, 2016 - Companies or Agents will work on RFP.
2. August 29, 2017 at 10:00 am – **Companies or Agents must submit Two (2) sets of RFP's documents sealed in an envelope to:**

Sanjuana Garcia, Director of Finance
105 Port Rd
Port Isabel TX 78578
RFP # INS-HEALTH-08-29-2017

The above noted information must be included on bid envelope and on any carrier's envelope/package. Laguna Madre Water District will not be held responsible for missing, lost or late mail. Laguna Madre Water District, will not accept facsimile or electronic transmission of sealed bids.

3. August 29, 2017 - Open RFPs at 10:30 am
4. September 5, 2017 Provide Final Recommendations
5. September 13, 2017 - Send to Board of Directors for approval

QUALIFICATION OF COMPANIES AND TPAS SUBMITTING PROPOSALS FOR GROUP HEALTH, LIFE, DENTAL & VISION

STATEMENT OF PURPOSE

LMWD is looking for equal or better current insurance conditions proposals

All companies submitting proposals must be licensed by the state of Texas and have demonstrated level of good performance with municipalities, school district or other public entities in Texas. The company representative must have an Errors and Omissions (E&O) policy with a minimum limit of \$1,000,000.

The company submitting a proposal for the group health, life, dental & vision insurance program should maintain a fully staffed office for the servicing of the program. The company must have been in business for at least five years and must assign a minimum of one qualified account representative to service the LMWD. This representative must have a minimum of five years' experience in group health, life, dental & vision insurance line, or hold the CLU, CEBS and or RHU designation.

DEVIATION FROM SPECIFIED COVERAGE OR SERVICE

Proposals are to be submitted on the basis of the specifications contained herein. Alternative proposals will also be considered, provided the alternatives are clearly explained. **All deviations from the specifications must be clearly identified and explained.**

UNDERWRITING DATA

The LMWD has assembled the underwriting exposure, and loss data included in these specifications. While every effort has been made to ensure the accuracy of this information, it cannot be guaranteed. It shall be the responsibility of the successful proposer to review this information and work with the LMWD on an ongoing basis to ensure all relevant exposures are included in the LMWD's program.

If it becomes necessary to revise any part of this proposal, a written addendum will be provided to all proposers who have returned the acknowledgement form. LMWD is not bound by any oral representation, classifications, or changes made in the written specifications by the LMWD employees, unless such classification or change is provided to proposers in a written addendum from an authorized representative of the LMWD.

COMPLIANCE WITH LAWS

All proposers involved shall observe and comply with all regulations, laws ordinances, etc., of local, state, and federal government as they apply to this proposal process.

TERM OF CONTRACT AND EXTENSION/RENEWAL RIGHTS

The term of the contract for insurances or service shall be for not less than one year, subject to earlier termination as provided by the law and by the terms of the contract. In addition, unless otherwise specified in the proposal, the award of this proposal shall include the right at the option of the LMWD, and contingent upon the agreement by both parties, to any change in premium costs or benefits to renew and extend this contract on a year to year basis as may be permitted by applicable law and Board approval as may be in the best interest of the LMWD; if the maximum term of this contract and all renewals of it shall be not more than three or five years before such contract must again be offered for competitive proposals.

AUTHORIZED SIGNATURE

All proposal forms must be signed by persons who have legal authority to bind the insurer and administrator to the services proposed.

QUALIFICATION OF COMPANIES AND TPAS SUBMITTING PROPOSALS FOR GROUP HEALTH, LIFE, DENTAL & VISION

All companies submitting proposals must be licensed by the state of Texas and have demonstrated level of good performance with municipalities, school district or other public entities in Texas. The company representative must have an Errors and Omissions (E&O) policy with a minimum limit of \$1,000,000.

The company submitting a proposal for the group health, life, dental & vision insurance program should maintain a fully staffed office for the servicing of the program. The company must have been in business for at least five years and must assign a minimum of one qualified account representative to service the LMWD. This representative must have a minimum of five years' experience in group health, life, dental & vision insurance line, or hold the CLU, CEBS and or RHU designation.

DEVIATION FROM SPECIFIED COVERAGE OR SERVICE

Proposals are to be submitted on the basis of the specifications contained herein. Proposer must include the RFP Submission Forms with the proposal.

Alternative proposals will also be considered, provided the alternatives are clearly explained. **All deviations from the specifications must be clearly identified and explained.**

UNDERWRITING DATA

The LMWD has assembled the underwriting exposure, and loss data included in these specifications. While every effort has been made to ensure the accuracy of this information, it cannot be guaranteed. It shall be the responsibility of the successful proposer to review this information and work with the LMWD on an ongoing basis to ensure all relevant exposures are included in the LMWD's program.

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AUTHORIZED SIGNATURE

All proposal forms must be signed by persons who have legal authority to bind the insurer and administrator to the services proposed.

DISQUALIFICATION AND REJECTION OF PROPOSALS

Failure to comply with the requirements or the procedures set forth herein, or to satisfy the insurance and servicing criteria as set forth in the specifications, may result in disqualification. It is not intended that exceptions to the specification will, in and of themselves, result in disqualification.

CONTINUITY OF COVERAGE

All employees, retirees and dependents covered by the current plan are to receive immediate coverage under the new plan. Continuity of coverage for current participants is to be on a “no loss no gain” basis for all insurance coverage. In addition, proposers must waive the actively at-work provisions.

In fulfilling the Continuity of Coverage requirement fair credit must be allowed for all or any part of health insurance deductibles or co-insurance satisfied, and accumulated lifetime maximum amounts before the contract effective date.

RETIREE COVERAGE

For vested employee that retires from the system and is not yet 65 years of age, the Board will defray the monthly insurance premiums and allow the retiree to remain on our group health & dental insurance plan until he reaches age 65. Your proposal should include coverage for all current and future retirees.

The LMWD currently covers 2 retirees for health insurance under the age of 65 under the current group health.

ENROLLMENT

The basis for the “take over” of the group health, life, dental & vision insurance Provider is to be the LMWD’s enrollment records as of September 30, 2017. The selected Provider will be expected to provide a knowledgeable person to explain benefit provisions during enrollment meetings conducted during the period September 14 thru September 15, 2017. The selected Providers will also be responsible for providing enrollment materials before the group health & dental insurance enrollment meetings.

Background Information

The Laguna Madre Water District (hereafter referred to as LMWD) is located in Cameron County. The majority of the 75 for health, life, dental & vision insured employees, retirees and COBRA participants participating in LMWD's self-funded benefit plan use the services of providers located in Cameron County. The following table summarizes current enrollment in the Health Plan:

Health Plan Enrollment Summary				
	Active	Retiree	COBRA	Combined
Employee Only	52	1	1	54
Employee + Family	38	0	0	38
Total	90	1	1	92

Dental Plan Enrollment Summary				
	Active	Retiree	COBRA	Combined
Employee Only	52	0	0	52
Employee + Family	32	0	0	32
Total	84	0	0	84

Life Plan Enrollment Summary				
	Active	Retiree	COBRA	Combined
Employee Only	75	0	0	75
Employee + Family	0	0	0	0
Total	75	0	0	75

Vision Plan Enrollment Summary				
	Active	Retiree	COBRA	Combined
Employee Only	52	0	0	99
Employee + Family	47	0	0	0
Total	99	0	0	99

LMWD desires to receive proposals Your response should comply with all specifications required by the Patient Protection and Affordable Care Act that are applicable. This would include, but not be limited to:

- No lifetime limit on benefits;
- Extension of parents' coverage to your adult children under 26 years old; and
- No coverage exclusion for children with pre-existing conditions.

QUESTIONS:

1. Describe the business entity submitting the proposal:

a. Name of Business Entity: _____

b. Current Business Address: _____

c. Mailing Address: _____

d. Contact Person: _____

e. Telephone Number: _____

f. Type of Business Entity: () Corporation () General Partnership () Sole Proprietorship

() Registered Limited Liability Partnership () Limited Liability Company

g. Please provide jurisdiction for corporation or partnership charter: _____

h. Please provide date corporation or partnership chartered: _____

i. Is the business entity licensed by the State of Texas as a Third Party Administrator? () Yes () No

If yes, attach TPA license.

j. Will you agree to provide a resume for each key employee in your organization upon request? () Yes () No

2. Pending Lawsuits/Claims:

a. Has the business entity been a defendant in any lawsuit in any state or federal court during the preceding five (5) years? () Yes () No

If yes, identify each lawsuit by party, case number, court, subject matter, and disposition:

b. Does the business entity have any claims filed against it which are unresolved and presently pending before any State of Texas Administrative agency? () Yes () No

If yes, attach a full description of the matter:

3. Financial Information:

a. Has the business entity filed a voluntary or involuntary petition in bankruptcy, obtained an order for relief, or received a discharge on any debt under the U.S. Bankruptcy laws during the preceding seven (7) years? () Yes () No

If yes, provide the name of the court and the case number(s):

- b. Has any owner, member, or partner of the business entity filed a petition in bankruptcy, obtained an order for relief, or received a discharge on any debt under the U.S. Bankruptcy laws during the preceding seven (7) years?
 Yes No

If yes, provide the name of the court and the case number(s):

- c. Will you agree to provide an audited financial statement for the preceding fiscal year upon request?
 Yes No

4. Describe Claim Administration experience:

a. Number of Clients: _____

b. Number of Covered Employees: _____

c. Other: _____

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

Name of Client	Contact Person	Telephone Number	Number of Employees

6. Describe insurance coverage (include copy of Insurance Certificate):

- a. The business entity must provide satisfactory evidence of existing insurance coverage in the amount of \$1,000,000.00 for Errors and Omissions or other fiduciary liability. If the business entity is selected to provide services it must provide evidence that such coverage will be in effect for the duration of the agreement.

7. Describe Administration Contract:

- a. Will you allow LMWD to modify your standard Administration Contract? Yes No

Comment: _____

- b. Will you agree to process 98% of all submitted claims within fifteen (15) business days at a minimum of 98% overall accuracy? Yes No

Comment: _____

- c. Will you agree that a failure to uphold the standards in (b) may result in a penalty to be deducted from the administration fee? Yes No

- d. What is your customer service accuracy?

Comment: _____

- e. Will you agree to allow third party to conduct an on-site claims audit? Yes No

Comment: _____

f. Will you agree to hold the LMWD harmless if any of your staff is found to be negligent in the administration of benefits in the Plan? () Yes () No

Comment: _____

8. Will you agree to provide a specimen copy of your administration contract upon request? () Yes () No

9. Describe Claim Payment Services:

a. Location of office where actual settlement of claims will be made? _____

b. Will a specific analyst be assigned to this account? () Yes () No

c. Will a claims analyst be available for on site claims handling on a scheduled basis? () Yes () No

d. Is a toll free telephone number available for checking status of claim? () Yes () No

e. What is the average time on hold? _____

f. What is the abandonment rate? _____

g. Can insured or LMWD's Insurance Department speak directly to claim examiner for questions related to payment of claim? () Yes () No

Comment: _____

h. What is normal processing time? _____

i. Describe process of appeal for contested claim. _____

j. Do you screen for unbundling of provider charges? () Yes () No

Comment: _____

k. Are hospital claims paid utilizing a Medicare plus basis? () Yes () No

Comment: _____

l. Please explain your auditing procedures for in and out-of-network hospital/facility claims.

Comment: _____

m. Will you agree to provide sample EOB and check upon request? () Yes () No

n. Please describe banking arrangements necessary to reimburse claims that are paid.

o. Describe basis and procedure for determining Reasonable and Customary. _____

p. When was the last Third Party Claim Audit? _____

- Will you agree to provide copy of Third Party Claim Audit? () Yes () No
- If SAS 70 Report, please attach

q. Describe procedure used for subrogation investigation and recovery. _____

r. Describe procedures used for checking preexisting condition investigation:

10. Describe Prescription Drug Card Services:

a. Name of Provider used by Administrator: _____

b. Can the LMWD contract directly with this Provider? () Yes () No
 If so, please describe: _____

11. Describe Other Services and list additional costs, if any:

a. (Ex. Large Case Management, Disease Management, Continuation of Coverage, Actuarial Services, Plan Design and Consultation Services): _____

b. Describe experience in coordinating with Preferred Provider organizations (include repricing capabilities):

c. Are On-Line Services available? () Yes () No
 If so, please describe (Ex. Claims Status, Enrollment, Provider Directory, Reports):

d. Are enrollment and education meetings included? () Yes () No
 If yes, how many times per year. If not, what is the additional cost?

Comments: _____

e. Will initial enrollment/communication services as described in RFP Assumptions be provided? () Yes () No

f. Will all materials necessary to effectively communicate and administer the program be prepared and printed by proposer at proposer's expense? (Ex: ID Cards, Employee Benefit Book, Claim Forms, Schedule of Benefits, EOBs, Certificates of Credible Coverage) () Yes () No

Comments: _____

- g. Will employee ID cards, Employee Benefit Book and other related materials be mailed to the employee's home at the proposer's expense? Yes No

Comments: _____

- h. Does your plan comply fully with HIPAA? Yes No

- i. Do you provide all required notices to members at your expense? Yes No

Comment: _____

- j. Do services include Early Retiree Reimbursement Program claim processing services? Yes No

Comment: _____

12. Are the rates quoted in this proposal firm, or will a recalculation be made based on actual enrollment?

13. For what period of time are quoted rates guaranteed? _____

14. Is a longer rate guarantee available? Yes No

Comment: _____

Company Name

Authorized Signature (failure to sign disqualifies proposal)

Company Address

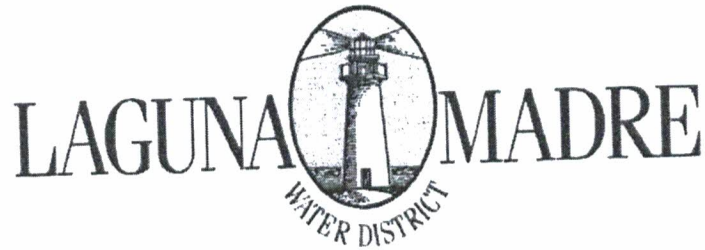
Type Signatory's Name & Title

Telephone Number

Fax Number

Signatory's Email Address

Date

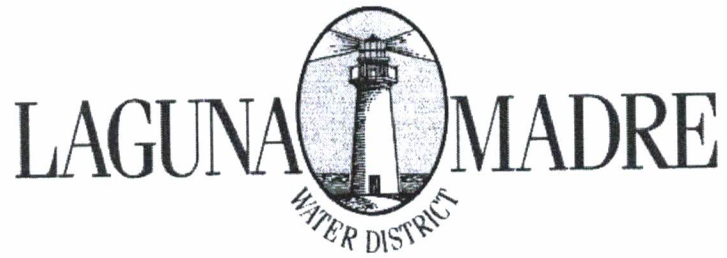


**REQUEST FOR PROPOSAL
HEALTH, LIFE, DENTAL, AND VISION**

**INSURANCE RENEWAL TIMELINE
FY 2017-2018**

RFP # INS-HEALTH-08-29-2017

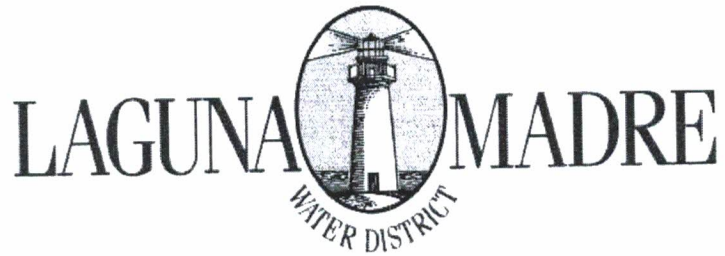
Advertising	August 13, 20, 27, 2017
LMWD web Publication	August 13, 2017
Proposal Due date:	August 29, 2017 at 10:00 am
Bid Opening	August 29, 2017 at 10:30 am
Board Regular Meeting for approved or denied	September 13, 2017 at 5:30 pm
Proposal Acknowledgement	September 14, 2017
Employee Enrollment	September 15, 2017
Premium Payment	September 15, 2017



EMPLOYEE CENSUS FOR HEALTH, DENTAL, LIFE AND VISION

INSURANCE RENEWAL INFORMATION

FY 2017-2018



EMPLOYEE CENSUS

EMPLOYEE CENSUS FOR HEALTH, DENTAL, LIFE AND VISION

INSURANCE RENEWAL INFORMATION

FY 2017-2018

LAGUNA MADRE WATER DISTRICT
EMPLOYEE CENSUS FOR HEALTH, DENTAL, LIFE AND VISION INSURANCE

FY 2017-2018

D.O.B	AS OF	AGE	SEX	DESCRIPTION	COVERAGE	EMP #	CITY	STATE	ZIP
05/07/1977	9/30/2017	40	M	CLERICAL OFFICE EMPLOYEES NOC	HEALTH+LIFE+DENTAL-VISION	236	HARLINGEN	TX	78550
07/24/1951	9/30/2017	66	F	CLERICAL OFFICE EMPLOYEES NOC	HEALTH+LIFE+DENTAL-VISION	297	PORT ISABEL	TX	-78578
02/20/1966	9/30/2017	51	F	CLERICAL OFFICE EMPLOYEES NOC	HEALTH+LIFE+DENTAL-VISION	249	PORT ISABEL	TX	-78578
01/31/1980	9/30/2017	37	F	CLERICAL OFFICE EMPLOYEES NOC	HEALTH+LIFE+DENTAL-VISION	333	LAGUNA VISTA	TX	78578
06/22/1960	9/30/2017	57	M	CLERICAL OFFICE EMPLOYEES NOC	HEALTH+LIFE+DENTAL-VISION	803	PORT ISABEL	TX	78578
01/08/1971	9/30/2017	46	F	CLERICAL OFFICE EMPLOYEES NOC	HEALTH+LIFE+DENTAL-VISION	327	PORT ISABEL	TX	78578
09/10/1956	9/30/2017	61	M	CLERICAL OFFICE EMPLOYEES NOC	HEALTH+LIFE+DENTAL-VISION	296	RANCHO VIEJO	TX	78575
07/28/1967	9/30/2017	50	F	CLERICAL OFFICE EMPLOYEES NOC	HEALTH+LIFE+DENTAL-VISION	814	BROWNSVILLE	TX	78526
08/08/1946	9/30/2017	71	M	CLERICAL OFFICE EMPLOYEES NOC	HEALTH+LIFE+DENTAL-VISION	335	BROWNSVILLE	TX	78520
08/22/1985	9/30/2017	32	M	CLERICAL OFFICE EMPLOYEES NOC	HEALTH+LIFE+DENTAL-VISION	310	LAGUNA VISTA	TX	78578
12/03/1970	9/30/2017	46	F	CLERICAL OFFICE EMPLOYEES NOC	HEALTH+LIFE+DENTAL-VISION	153	LAGUNA VISTA	TX	-78578
06/11/1986	9/30/2017	31	M	CLERICAL OFFICE EMPLOYEES NOC	HEALTH+LIFE+DENTAL-VISION	246	LOS FRESNOS	TX	78566
01/16/1961	9/30/2017	56	F	CLERICAL OFFICE EMPLOYEES NOC	HEALTH+LIFE+DENTAL-VISION	804	PORT ISABEL	TX	-78578
07/18/1974	9/30/2017	43	M	CLERICAL OFFICE EMPLOYEES NOC	HEALTH+LIFE+DENTAL-VISION	811	BROWNSVILLE	TX	78520
07/22/1991	9/30/2017	26	F	CLERICAL OFFICE EMPLOYEES NOC	HEALTH+LIFE+DENTAL-VISION	287	PORT ISABEL	TX	-78578
06/19/1982	9/30/2017	35	M	CLERICAL OFFICE EMPLOYEES NOC	HEALTH+LIFE+DENTAL-VISION	332	BROWNSVILLE	TX	78521
05/04/1990	9/30/2017	27	F	CLERICAL OFFICE EMPLOYEES NOC	HEALTH+LIFE+DENTAL-VISION	295	PORT ISABEL	TX	78578
12/30/1982	9/30/2017	34	F	CLERICAL OFFICE EMPLOYEES NOC	HEALTH+LIFE+DENTAL-VISION	195	PORT ISABEL	TX	-78578
04/03/1981	9/30/2017	36	M	SEWAGE DISPOSAL PLANT OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	280	BROWNSVILLE	TX	78521
11/11/1989	9/30/2017	27	M	SEWAGE DISPOSAL PLANT OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	289	PORT ISABEL	TX	78578
02/06/1985	9/30/2017	32	M	SEWAGE DISPOSAL PLANT OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	271	PORT ISABEL	TX	-78578
02/15/1990	9/30/2017	27	M	SEWAGE DISPOSAL PLANT OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	336	LOS FRESNOS	TX	78566
08/27/1987	9/30/2017	30	M	SEWAGE DISPOSAL PLANT OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	231	PORT ISABEL	TX	78578
07/12/1967	9/30/2017	50	M	SEWAGE DISPOSAL PLANT OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	69	PORT ISABEL	TX	78578
03/07/1994	9/30/2017	23	M	SEWAGE DISPOSAL PLANT OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	275	LAGUNA VISTA	TX	78578
01/10/1996	9/30/2017	21	M	SEWAGE DISPOSAL PLANT OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	284	LAGUNA VISTA	TX	78578
12/19/1973	9/30/2017	43	M	SEWAGE DISPOSAL PLANT OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	121	LAGUNA VISTA	TX	78578
05/31/1985	9/30/2017	32	M	SEWAGE DISPOSAL PLANT OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	254	LAGUNA VISTA	TX	78578
12/26/1979	9/30/2017	37	M	SEWAGE DISPOSAL PLANT OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	251	LAGUNA VISTA	TX	78578
11/16/1988	9/30/2017	28	M	SEWAGE DISPOSAL PLANT OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	277	LAGUNA VISTA	TX	78578
01/11/1980	9/30/2017	37	M	SEWAGE DISPOSAL PLANT OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	253	PORT ISABEL	TX	-78578
02/02/1981	9/30/2017	36	M	SEWAGE DISPOSAL PLANT OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	234	SAN BENITO	TX	78586
07/25/1990	9/30/2017	27	M	SEWAGE DISPOSAL PLANT OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	238	LOS FRESNOS	TX	78566
03/01/1993	9/30/2017	24	M	SEWAGE DISPOSAL PLANT OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	270	PORT ISABEL	TX	-78578
02/08/1972	9/30/2017	45	M	SEWAGE DISPOSAL PLANT OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	127	LAGUNA VISTA	TX	78578
10/17/1985	9/30/2017	31	M	SEWAGE DISPOSAL PLANT OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	206	PORT ISABEL	TX	78566
12/05/1983	9/30/2017	33	M	SEWAGE DISPOSAL PLANT OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	218	LOS FRESNOS	TX	78578
06/21/1981	9/30/2017	36	M	SEWAGE DISPOSAL PLANT OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	260	PORT ISABEL	TX	-78578
08/19/1964	9/30/2017	53	M	SEWAGE DISPOSAL PLANT OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	244	LOS FRESNOS	TX	78566
10/30/1978	9/30/2017	38	M	SEWAGE DISPOSAL PLANT OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	164	PORT ISABEL	TX	-78578
06/09/1985	9/30/2017	32	M	SEWAGE DISPOSAL PLANT OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	285	PORT ISABEL	TX	78578
10/25/1965	9/30/2017	51	M	SEWAGE DISPOSAL PLANT OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	136	LAGUNA VISTA	TX	78578

09/18/1990	9/30/2017	27	M	SEWAGE DISPOSAL PLANT OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	274	PORT ISABEL	TX	-78578
06/24/1972	9/30/2017	45	M	WATERWORKS OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	181	PORT ISABEL	TX	-78578
06/24/1972	9/30/2017	45	M	WATERWORKS OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	179	PORT ISABEL	TX	-78578
06/03/1983	9/30/2017	34	M	WATERWORKS OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	264	PORT ISABEL	TX	78578
02/07/1981	9/30/2017	36	M	WATERWORKS OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	226	PORT ISABEL	TX	-78578
10/04/1983	9/30/2017	33	M	WATERWORKS OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	201	PORT ISABEL	TX	-78578
08/07/1991	9/30/2017	26	M	WATERWORKS OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	293	PORT ISABEL	TX	78578
08/25/1988	9/30/2017	29	M	WATERWORKS OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	291	PORT ISABEL	TX	78578
09/04/1965	9/30/2017	52	M	WATERWORKS OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	161	PORT ISABEL	TX	-78578
07/01/1982	9/30/2017	35	M	WATERWORKS OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	328	LAGUNA VISTA	TX	78578
05/03/1993	9/30/2017	24	M	WATERWORKS OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	298	LAGUNA VISTA	TX	78578
07/27/1983	9/30/2017	34	M	WATERWORKS OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	247	PORT ISABEL	TX	78578
07/21/1980	9/30/2017	37	M	WATERWORKS OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	219	LOS FRESNOS	TX	78566
05/15/1983	9/30/2017	34	M	WATERWORKS OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	255	PORT ISABEL	TX	-78578
11/26/1978	9/30/2017	38	M	WATERWORKS OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	329	PORT ISABEL	TX	78578
01/11/1966	9/30/2017	51	M	WATERWORKS OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	115	PORT ISABEL	TX	-78578
11/08/1980	9/30/2017	36	M	WATERWORKS OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	208	PORT ISABEL	TX	-78578
01/26/1980	9/30/2017	37	M	WATERWORKS OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	176	PORT ISABEL	TX	78578
08/25/1971	9/30/2017	46	M	WATERWORKS OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	98	PORT ISABEL	TX	-78578
10/07/1985	9/30/2017	31	M	WATERWORKS OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	233	PORT ISABEL	TX	78578
03/25/1966	9/30/2017	51	M	WATERWORKS OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	228	PORT ISABEL	TX	78578
03/18/1983	9/30/2017	34	M	WATERWORKS OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	240	PORT ISABEL	TX	78578
07/02/1979	9/30/2017	38	M	WATERWORKS OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	185	LOS FRESNOS	TX	78566
02/26/1972	9/30/2017	45	M	WATERWORKS OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	82	PORT ISABEL	TX	-78578
08/12/1979	9/30/2017	38	M	WATERWORKS OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	163	PORT ISABEL	TX	78578
03/29/1982	9/30/2017	35	M	WATERWORKS OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	191	PORT ISABEL	TX	78559
11/03/1992	9/30/2017	24	M	WATERWORKS OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	331	LA FERRIA	TX	78559
03/07/1974	9/30/2017	43	F	WATERWORKS OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	183	PORT ISABEL	TX	-78578
08/13/1973	9/30/2017	44	M	WATERWORKS OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	261	PORT ISABEL	TX	-78578
05/13/1985	9/30/2017	32	M	WATERWORKS OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	257	PORT ISABEL	TX	-78578
10/05/1982	9/30/2017	34	M	WATERWORKS OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	209	PORT ISABEL	TX	-78578
06/28/1969	9/30/2017	48	M	WATERWORKS OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	126	PORT ISABEL	TX	-78578
02/09/1987	9/30/2017	30	M	WATERWORKS OPERATION & DRIVERS	HEALTH+LIFE+DENTAL-VISION	330	LA FERRIA	TX	78559

32 WATERWORKS OPERATION & DRIVERS
25 SEWAGE DISPOSAL PLANT OPERATION & DRIVERS
18 CLERICAL OFFICE EMPLOYEES NOC
75 TOTAL EMPLOYEES

EMPLOYEE DEPENDENTS

RELATED TO EMP #	RELATIONSHIP	GENDER	DATE OF BIRTH	AGE AS OF 09/30/2017	AGE	COVERAGE TYPE
136	SPOUSE	F	04/14/1968	09/30/2017	49	VISION
136	CHILD	F	08/09/1996	09/30/2017	21	VISION
153	SPOUSE	M	11/18/1961	09/30/2017	55	HEALTH
164	SPOUSE	F	01/04/1980	09/30/2017	37	VISION
164	CHILD	M	05/13/2011	09/30/2017	6	VISION
164	CHILD	F	3/24/2000	09/30/2017	17	VISION
183	CHILD	F	09/03/1997	09/30/2017	20	DENTAL
183	CHILD	M	11/03/1999	09/30/2017	17	DENTAL
240	CHILD	F	06/10/2006	09/30/2017	11	DENTAL
247	SPOUSE	F	09/19/1985	09/30/2017	32	DENTAL
247	CHILD	M	10/01/2015	09/30/2017	1	DENTAL
247	CHILD	M	10/01/2015	09/30/2017	1	HEALTH
247	CHILD	M	09/07/2006	09/30/2017	11	DENTAL
247	CHILD	M	09/07/2006	09/30/2017	11	HEALTH
247	CHILD	M	09/07/2006	09/30/2017	11	DENTAL
247	CHILD	M	09/07/2006	09/30/2017	11	HEALTH
247	CHILD	F	12/31/2000	09/30/2017	16	DENTAL
247	CHILD	F	12/31/2000	09/30/2017	16	HEALTH
254	CHILD	F	09/12/2002	09/30/2017	15	DENTAL
254	CHILD	F	09/12/2002	09/30/2017	15	VISION
254	CHILD	M	10/05/2004	09/30/2017	12	DENTAL
254	CHILD	M	10/05/2004	09/30/2017	12	VISION
255	SPOUSE	F	06/25/1987	09/30/2017	30	VISION
261	SPOUSE	F	06/29/1977	09/30/2017	40	VISION
277	SPOUSE	M	11/16/1988	09/30/2017	28	VISION
277	CHILD	F	08/27/2007	09/30/2017	10	VISION
277	CHILD	M	11/22/2005	09/30/2017	11	VISION
296	SPOUSE	F	09/26/1961	09/30/2017	56	VISION
296	CHILD	M	04/07/1998	09/30/2017	19	DENTAL
296	CHILD	F	06/22/1994	09/30/2017	23	VISION
298	SPOUSE	F	03/08/1974	09/30/2017	43	VISION
327	CHILD	M	06/03/1992	09/30/2017	25	DENTAL
327	CHILD	M	06/03/1992	09/30/2017	25	VISION
327	CHILD	M	06/03/1996	09/30/2017	21	DENTAL
327	CHILD	M	06/03/1996	09/30/2017	21	VISION
327	CHILD	F	08/12/2000	09/30/2017	17	DENTAL
327	CHILD	F	08/12/2000	09/30/2017	17	VISION
335	SPOUSE	F	07/07/1948	09/30/2017	69	VISION
803	SPOUSE	F	02/19/1962	09/30/2017	55	DENTAL
803	SPOUSE	F	02/19/1962	09/30/2017	55	HEALTH
811	CHILD	F	05/15/2002	09/30/2017	15	DENTAL
811	CHILD	F	05/15/2002	09/30/2017	15	HEALTH
811	CHILD	F	05/15/2002	09/30/2017	15	VISION
811	CHILD	F	11/26/2007	09/30/2017	9	DENTAL
811	CHILD	F	11/26/2007	09/30/2017	9	HEALTH
811	CHILD	F	11/26/2007	09/30/2017	9	VISION
811	CHILD	F	11/16/2004	09/30/2017	12	DENTAL
811	CHILD	F	11/16/2004	09/30/2017	12	HEALTH
811	CHILD	F	11/16/2004	09/30/2017	12	VISION
814	CHILD	M	04/07/1998	09/30/2017	19	HEALTH
814	CHILD	M	04/07/1998	09/30/2017	19	VISION
161	CHILD	M	03/03/1998	09/30/2017	19	DENTAL
161	CHILD	M	03/03/1998	09/30/2017	19	HEALTH
236	CHILD	M	01/26/2007	09/30/2017	10	HEALTH
236	CHILD	F	10/7/2011	09/30/2017	5	HEALTH

249	SPOUSE	M	06/10/1962	09/30/2017	55	VISION
328	CHILD	M	01/15/2007	09/30/2017	10	HEALTH
	RETIREE	F	9/7/1953	09/30/2017	64	HEALTH
	RETIREE	M	11/15/1973	09/30/2018	44	HEALTH



ACTUAL INSURANCE COVERAGE

EMPLOYEE CENSUS FOR HEALTH, DENTAL, LIFE AND VISION

INSURANCE RENEWAL INFORMATION

FY 2017-2018

LAGUNA MADRE WATER DISTRICT

Health insurance	Monthly Payment	
Employee	\$	526.36
Employee & Spouse	\$	842.17
Employee & Children	\$	889.55
Employee & Family	\$	1,394.86
Co Pay	\$	20.00
Specialist	\$	40.00
Urgente care	\$	75.00
Prescriptions		\$10/\$ 30/\$50
Mail Order 90 day Supply		\$25/\$ 75/\$125
Deductible Network	\$	250.00
Deductible Network Family	\$	500.00
Out of Pocket max	\$	1,750.00
Out of Pocket max Family	\$	3,500.00
Annual physical examination		100%
Dental		
Employee	\$	22.19
Employee & Spouse	\$	44.39
Employee & Children	\$	54.92
Employee & Family	\$	81.48
Preventive		100%
Basic		80%
Major		50%
Deductible	\$	50.00
Deductible Family	\$	150.00
Annual Max	\$	1,500.00
Orthodontics		50%
Lifetime max		Up to age of 19
Vision		
Employee	\$	8.01
Employee & Spouse	\$	15.18
Employee & Children	\$	17.81
Employee & Family	\$	25.05
Vision Exam Co pay	\$	10.00
Materials Co pay	\$	25.00
Exam, lenses & Frames		Once Every 12 months
Retail frame Allowance	\$	130.00
Life		
Employee	\$	0.50
AD&D	\$	3.75
\$25,000.00 LIFE	\$	3.75



2015-2016 MEDICAL LOSSES REPORT

EMPLOYEE CENSUS FOR HEALTH, DENTAL, LIFE AND VISION

INSURANCE RENEWAL INFORMATION

FY 2017-2018

TEXAS - MANDATED REPORTING FOR INSURED BUSINESS

Section I, II: Hospital Pre-Certification, Premium, Claims, Enrollment

Customer Name: LAGUNAMADREWATERDISTRICT
 Policy Number: 0001U6814
 Reporting Period:
 Processed (paid) Dates: 10/01/2014-04/30/2017
 Service (incurred) Dates: ALL

Date of Information Request:	5/25/17
Receipt Date of Information Request:	5/25/17
Receipt Date of HIPAA Certification:	1/1/00
Date of Report Production:	5/30/17

Section I:

For claims that are not part of this report, the number of pre-certification requests for hospital stays of 5 days or longer that were made during the 30-day period preceding the Reporting Period last Processed (paid) Date	0
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Section II:

Bill / Book Year / Month	Restated Billed Premium	Total Payments	Single Subscribers	Subscribers plus Spouse	Subscribers plus Child/Children	Subscribers plus Family	Total Subscribers	Positively Enrolled Dependents	Total Members
201410	\$ 46,744	\$ 5,460	69	2	8	1	80	25	105
201411	\$ 45,692	\$ 12,133	67	2	8	1	78	24	102
201412	\$ 45,714	\$ 16,828	67	2	8	1	78	24	102
201501	\$ 45,166	\$ 16,042	66	2	8	1	77	24	101
201502	\$ 44,864	\$ 21,910	67	1	8	1	77	25	102
201503	\$ 44,333	\$ 15,991	66	1	8	1	76	25	101
201504	\$ 44,316	\$ 17,846	66	1	8	1	76	25	101
201505	\$ 44,338	\$ 13,268	66	1	8	1	76	25	101
201506	\$ 41,810	\$ 12,347	63	1	7	1	72	18	90
201507	\$ 40,894	\$ 14,951	62	1	8	0	71	17	88
201508	\$ 43,863	\$ 19,678	68	1	8	0	77	17	94
201509	\$ 44,769	\$ 9,616	68	1	9	0	78	18	96
201510	\$ 43,359	\$ 20,404	67	1	8	0	76	17	93
201511	\$ 42,833	\$ 19,754	66	1	8	0	75	18	93
201512	\$ 43,505	\$ 17,423	69	1	7	0	77	16	93
201601	\$ 42,979	\$ 68,307	68	1	7	0	76	16	92
201602	\$ 44,030	\$ 14,575	70	1	7	0	78	16	94
201603	\$ 43,505	\$ 7,936	69	1	7	0	77	16	93
201604	\$ 44,030	\$ 12,744	70	1	7	0	78	16	94
201605	\$ 44,030	\$ 51,947	70	1	7	0	78	16	94
201606	\$ 44,691	\$ 51,014	70	1	8	0	79	19	98
201607	\$ 44,063	\$ 59,570	70	1	7	0	78	16	94
201608	\$ 43,537	\$ 21,989	69	1	7	0	77	15	92
201609	\$ 43,537	\$ 12,778	69	1	7	0	77	15	92
201610	\$ 45,784	\$ 13,891	68	1	8	0	77	16	93
201611	\$ 46,445	\$ 17,547	69	1	8	0	78	16	94
201612	\$ 47,131	\$ 1,956	69	2	8	0	79	17	96
201701	\$ 47,219	\$ 2,188	69	2	8	0	79	17	96
201702	\$ 47,879	\$ 9,548	69	3	8	0	80	18	98
201703	\$ 48,502	\$ 19,771	68	4	8	0	80	19	99
201704	\$ 48,866	\$ 16,057	70	4	8	0	82	19	101
TOTAL	\$ 1,388,430	\$ 615,471	2104	45	239	9	2397	585	2982

TEXAS - MANDATED REPORTING FOR INSURED BUSINESS

Section III: Individual Claimants - Paid Claims >\$15,000

Customer Name: LAGUNAMADREWATERDISTRICT
 Policy Number: 0001U6814
 Reporting Period:
 Processed (paid) Dates: 05/01/2016-04/30/2017
 Service (incurred) Dates: ALL

Notification of Withheld Information and Confidentiality Statement

The Texas Insurance Code section 1215.003(d) provides that protected health information may be withheld from this claims report if subject to privacy restrictions more stringent than HIPAA. This constitutes notice that the following categories of claims information for specified individuals is withheld from this report:

- Utilization review related records including individual medical records, personal information, or other confidential information about a patient obtained in the performance of utilization review per Texas Insurance Code section 4201-552.
- Records related to the diagnosis, evaluation, or treatment of a mental or emotional disorder, including alcoholism or drug addiction, per Chapter 611 of the Texas Health & Safety Code.
- Records related to AIDS and HIV test results per Texas Health & Safety Code Section 81.101 et seq.
- Genetic information, if any, per Texas Insurance Code Section 546.102.

Information included in this document is considered to be UnitedHealthcare's confidential and/or proprietary business information. Consequently, this information may be used only by the person or entity to which it is addressed by UnitedHealthcare. Such recipient shall be liable for using and protecting UnitedHealthcare's proprietary business information from further disclosure or misuse, consistent with recipient's contractual obligations under any applicable administrative services agreement, group policy contract, non-disclosure agreement or other applicable contract or law, including but not limited to, Exemption 4 of the U.S. Freedom of Information Act and state freedom of information law exemptions for "trade secrets". The report you have received may contain protected health information (PHI) and must be handled according to applicable state and federal law, including, but not limited to HIPAA. Individuals who misuse information may be subject to both civil and criminal penalties.

Claimant ID	1	Amount Paid \$	30,422
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One or more of the following Diagnosis, Procedure, and Service Dates were indicated for this claimant during the reporting period. Diagnosis and Procedure information is listed in ascending order based on Code. Service Date information is listed chronologically.

Diagnosis		Procedure		Service Date
Code	Description	Code	Description	
A41.2	SEPSIS D/T UNSPEC STAPHYLOCOCCUS	36415	ROUTINE VENIPUNCTURE	05/02/2016
A41.50	GRAM-NEGATIVE SEPSIS UNSPECIFIED	47000	NEEDLE BIOPSY OF LIVER	05/09/2016
C25.9	MALIGNANT NEOPLASM OF PANCREAS UNS	71010	CHEST X-RAY 1 VIEW FRONTAL	05/13/2016
C78.7	SEC MAL NEO LIVER & INTRAHEPATIC BD	74176	CT ABD & PELVIS W/O CONTRAST	05/18/2016
D72.829	ELEVATED WHITE BLOOD CELL COUNT UNS	74178	CT ABD & PELV 1/> REGNS	05/19/2016
K76.9	LIVER DISEASE UNSPECIFIED	76700	US EXAM, ABDOM, COMPLETE	05/20/2016
K80.20	CALCU GB W/O CHOLECYST W/O OBST	76705	ECHO EXAM OF ABDOMEN	05/25/2016
K83.1	OBSTRUCTION OF BILE DUCT	77012	CT SCAN FOR NEEDLE BIOPSY	05/26/2016
K92.2	GASTROINTESTINAL HEMORRHAGE UNS	80050	GENERAL HEALTH PANEL	05/27/2016
M79.662	PAIN IN LEFT LOWER LEG	80053	COMPREHEN METABOLIC PANEL	06/03/2016
R10.84	GENERALIZED ABDOMINAL PAIN	80061	LIPID PANEL	06/10/2016
R10.9	UNSPECIFIED ABDOMINAL PAIN	80074	ACUTE HEPATITIS PANEL	06/11/2016
R16.0	HEPATOMEGALY NEC	81003	URINALYSIS, AUTO, W/O SCOPE	06/12/2016
R79.89	OTH SPEC ABNORMAL FINDINGS BLD CHEM	83036	GLYCOSYLATED HEMOGLOBIN TEST	06/13/2016
Z00.00	ENC GEN ADULT EXAM W/O ABNORM FIND	84153	ASSAY OF PSA, TOTAL	06/14/2016
Z45.2	ENC ADJUSTMENT & MANAGEMENT VAD	85007	BL SMEAR W/DIFF WBC COUNT	06/15/2016
		85025	COMPLETE CBC W/AUTO DIFF WBC	06/16/2016

Claimant ID	1	Amount Paid \$	30,422
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One or more of the following Diagnosis, Procedure, and Service Dates were indicated for this claimant during the reporting period. Diagnosis and Procedure information is listed in ascending order based on Code. Service Date information is listed chronologically.

Diagnosis		Procedure		Service Date
Code	Description	Code	Description	
		85027	COMPLETE CBC, AUTOMATED	
		85610	PROTHROMBIN TIME	
		88307	TISSUE EXAM BY PATHOLOGIST	
		88341	IMMUNOHISTO ANTIBODY SLIDE	
		88342	IMMUNOHISTO ANTB 1ST STAIN	
		96367	TX/PROPH/DG ADDL SEQ IV INF	
		96413	CHEMO, IV INFUSION, 1 HR	
		96417	CHEMO IV INFUS EACH ADDL SEQ	
		99203	OFFICE/OUTPATIENT VISIT, NEW	
		99214	OFFICE/OUTPATIENT VISIT, EST	
		99223	INITIAL HOSPITAL CARE	
		99232	SUBSEQUENT HOSPITAL CARE	
		99233	SUBSEQUENT HOSPITAL CARE	
		99238	HOSPITAL DISCHARGE DAY	
		99254	INPATIENT CONSULTATION	
		99255	INPATIENT CONSULTATION	
		99285	EMERGENCY DEPT VISIT	
		J1100	INJ DEXMETHOSON SODIM PHOSHATE 1 MG	
		J1626	INJ GRANISETRN HYDROCHLORID 100 MCG	
		J7050	INFUS NORMAL SALINE SOLUTION 250 CC	
		J9201	INJECTION GEMCITABINE HCL 200 MG	
		J9264	INJ PACLITAXEL PROTBNB PARTICL 1 MG	

TEXAS - MANDATED REPORTING FOR INSURED BUSINESS
Section III: Individual Claimants - Paid Claims >\$15,000

Customer Name: LAGUNAMADREWATERDISTRICT
 Policy Number: 0001U6814
 Reporting Period:
 Processed (paid) Dates: 05/01/2016-04/30/2017
 Service (incurred) Dates: ALL

Notification of Withheld Information and Confidentiality Statement

The Texas Insurance Code section 1215.003(d) provides that protected health information may be withheld from this claims report if subject to privacy restrictions more stringent than HIPAA. This constitutes notice that the following categories of claims information for specified individuals is withheld from this report:

- Utilization review related records including individual medical records, personal information, or other confidential information about a patient obtained in the performance of utilization review per Texas Insurance Code section 4201-552.
- Records related to the diagnosis, evaluation, or treatment of a mental or emotional disorder, including alcoholism or drug addiction, per Chapter 611 of the Texas Health & Safety Code.
- Records related to AIDS and HIV test results per Texas Health & Safety Code Section 81.101 et seq.
- Genetic information, if any, per Texas Insurance Code Section 546.102.

Information included in this document is considered to be UnitedHealthcare's confidential and/or proprietary business information. Consequently, this information may be used only by the person or entity to which it is addressed by UnitedHealthcare. Such recipient shall be liable for using and protecting UnitedHealthcare's proprietary business information from further disclosure or misuse, consistent with recipient's contractual obligations under any applicable administrative services agreement, group policy contract, non-disclosure agreement or other applicable contract or law, including but not limited to, Exemption 4 of the U.S. Freedom of Information Act and state freedom of information law exemptions for "trade secrets". The report you have received may contain protected health information (PHI) and must be handled according to applicable state and federal law, including, but not limited to HIPAA. Individuals who misuse information may be subject to both civil and criminal penalties.

Claimant ID	2	Amount Paid \$	28,097
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One or more of the following Diagnosis, Procedure, and Service Dates were indicated for this claimant during the reporting period. Diagnosis and Procedure information is listed in ascending order based on Code. Service Date information is listed chronologically.

Diagnosis		Procedure		Service Date
Code	Description	Code	Description	
E11.65	TYPE 2 DM W/HYPERGLYCEMIA	00790	ANESTH, SURG UPPER ABDOMEN	04/19/2016
K80.20	CALCU GB W/O CHOLECYST W/O OBST	74300	X-RAY BILE DUCTS/PANCREAS	04/21/2016
K82.8	OTHER SPEC DISEASES GALLBLADDER	80053	COMPREHEN METABOLIC PANEL	06/14/2016
Z23	ENCOUNTER FOR IMMUNIZATION	80061	LIPID PANEL	07/12/2016
		81002	URINALYSIS NONAUTO W/O SCOPE	09/03/2016
		82044	MICROALBUMIN, SEMIQUANT	10/21/2016
		83036	GLYCOSYLATED HEMOGLOBIN TEST	10/25/2016
		85025	COMPLETE CBC W/AUTO DIFF WBC	12/08/2016
		88304	TISSUE EXAM BY PATHOLOGIST	02/27/2017
		90656	IIV3 VACC NO PRSV 0.5 ML IM	02/28/2017
		99213	OFFICE/OUTPATIENT VISIT, EST	04/26/2017
		99214	OFFICE/OUTPATIENT VISIT, EST	

TEXAS - MANDATED REPORTING FOR INSURED BUSINESS

Section III: Individual Claimants - Paid Claims >\$15,000

Customer Name: LAGUNAMADREWATERDISTRICT
 Policy Number: 0001U6814
Reporting Period
 Processed (paid) Dates: 05/01/2016-04/30/2017
 Service (incurred) Dates: ALL

Notification of Withheld Information and Confidentiality Statement

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- Records related to AIDS and HIV test results per Texas Health & Safety Code Section 81.101 et seq.
- Genetic information, if any, per Texas Insurance Code Section 546.102.

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Claimant ID	3	Amount Paid \$	19,571
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One or more of the following Diagnosis, Procedure, and Service Dates were indicated for this claimant during the reporting period. Diagnosis and Procedure information is listed in ascending order based on Code. Service Date information is listed chronologically.

Diagnosis		Procedure		Service Date
Code	Description	Code	Description	
999.99	OTHER DIAGNOSES	36415	ROUTINE VENIPUNCTURE	05/09/2016
E03.9	HYPOTHYROIDISM UNSPECIFIED	70450	CT HEAD/BRAIN W/O DYE	05/19/2016
150.30	UNSPECIFIED DIASTOLIC HEART FAILURE	70498	CT ANGIOGRAPHY, NECK	05/28/2016
163.8	OTHER CEREBRAL INFARCTION	70540	MRI ORBIT/FACE/NECK W/O DYE	05/29/2016
163.9	CEREBRAL INFARCTION UNSPECIFIED	70551	MRI BRAIN STEM W/O DYE	06/01/2016
165.22	OCCCLUSION & STENOSIS LT CAROTID ART	71010	CHEST X-RAY 1 VIEW FRONTAL	06/06/2016
M79.671	PAIN IN RIGHT FOOT	73620	X-RAY EXAM OF FOOT	07/11/2016
M84.374D	STRESS FX RT FOOT SUB ENC RTN HEAL	73630	X-RAY EXAM OF FOOT	07/15/2016
M84.379D	STRESS FX UNS TOES SUB ENC RTN HEAL	80061	LIPID PANEL	
R20.2	PARESTHESIA OF SKIN	81225	CYP2C19 GENE COM VARIANTS	
R40.0	SOMNOLENCE	81226	CYP2D6 GENE COM VARIANTS	
R55	SYNCOPE AND COLLAPSE	81227	CYP2C9 GENE COM VARIANTS	
		81240	F2 GENE	
		81241	F5 GENE	
		81291	MTHFR GENE	
		81355	VKORC1 GENE	
		81401	MOPATH PROCEDURE LEVEL 2	
		81479	UNLISTED MOLECULAR PATHOLOGY	
		82306	VITAMIN D, 25 HYDROXY	
		84443	ASSAY THYROID STIM HORMONE	
		84481	FREE ASSAY (FT-3)	
		84550	ASSAY OF BLOOD/URIC ACID	

Claimant ID	3	Amount Paid \$	19,571
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One or more of the following Diagnosis, Procedure, and Service Dates were indicated for this claimant during the reporting period. Diagnosis and Procedure information is listed in ascending order based on Code. Service Date information is listed chronologically.

Diagnosis		Procedure		Service Date
Code	Description	Code	Description	
		85025	COMPLETE CBC W/AUTO DIFF WBC	
		93010	ELECTROCARDIOGRAM REPORT	
		93306	TTE W/DOPPLER, COMPLETE	
		96360	HYDRATION IV INFUSION, INIT	
		99202	OFFICE/OUTPATIENT VISIT, NEW	
		99203	OFFICE/OUTPATIENT VISIT, NEW	
		99214	OFFICE/OUTPATIENT VISIT, EST	
		99221	INITIAL HOSPITAL CARE	
		99239	HOSPITAL DISCHARGE DAY	
		99245	OFFICE CONSULTATION	
		99285	EMERGENCY DEPT VISIT	

TEXAS - MANDATED REPORTING FOR INSURED BUSINESS
Section III: Individual Claimants - Paid Claims >\$15,000

Customer Name: LAGUNAMADREWATERDISTRICT
 Policy Number: 0001U6814
 Reporting Period:
 Processed (paid) Dates: 05/01/2016-04/30/2017
 Service (incurred) Dates: ALL

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- Records related to the diagnosis, evaluation, or treatment of a mental or emotional disorder, including alcoholism or drug addiction, per Chapter 611 of the Texas Health & Safety Code.
- Records related to AIDS and HIV test results per Texas Health & Safety Code Section 81.101 et seq.
- Genetic information, if any, per Texas Insurance Code Section 546.102.

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Claimant ID	4	Amount Paid \$	15,080
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One or more of the following Diagnosis, Procedure, and Service Dates were indicated for this claimant during the reporting period. Diagnosis and Procedure information is listed in ascending order based on Code. Service Date information is listed chronologically.

Diagnosis		Procedure		Service Date
Code	Description	Code	Description	
724.2	LUMBAGO	00810	ANESTH, LOW INTESTINE SCOPE	02/03/2015
724.3	SCIATICA	36415	ROUTINE VENIPUNCTURE	02/24/2015
724.4	THOR/LUMBOSACRL NURIT/RADICULIT UNS	43239	EGD BIOPSY SINGLE/MULTIPLE	05/20/2015
847.2	LUMBAR SPRAIN AND STRAIN	43251	EGD REMOVE LESION SNARE	06/10/2015
D12.0	BENIGN NEOPLASM OF CECUM	45380	COLONOSCOPY AND BIOPSY	06/18/2015
E11.3293	TYPE 2 DM MILD NPDR W/O MAC ED BIL	71020	CHEST X-RAY 2VW FRONTAL&LATL	08/24/2015
E11.9	TYPE 2 DM WITHOUT COMPLICATIONS	72148	MRI LUMBAR SPINE W/O DYE	04/15/2016
I10	ESSENTIAL PRIMARY HYPERTENSION	74176	CT ABD & PELVIS W/O CONTRAST	04/18/2016
J01.90	ACUTE SINUSITIS UNSPECIFIED	76700	US EXAM, ABDOM, COMPLETE	04/27/2016
J03.90	ACUTE TONSILLITIS UNSPECIFIED	76770	US EXAM ABDO BACK WALL, COMP	04/30/2016
K76.0	FATTY CHANGE LIVER NEC	76775	US EXAM ABDO BACK WALL, LIM	05/03/2016
N13.2	HYDRONPHROS RENL&URETRL CALCUL OBST	80048	METABOLIC PANEL TOTAL CA	05/19/2016
N20.0	CALCULUS OF KIDNEY	80050	GENERAL HEALTH PANEL	05/23/2016
N20.1	CALCULUS OF URETER	80053	COMPREHEN METABOLIC PANEL	06/07/2016
N28.1	CYST OF KIDNEY ACQUIRED	80061	LIPID PANEL	06/14/2016
N28.9	DISORDER KIDNEY AND URETER UNS	81000	URINALYSIS, NONAUTO W/SCOPE	09/03/2016
N39.0	UTI SITE NOT SPECIFIED	81003	URINALYSIS, AUTO, W/O SCOPE	09/07/2016
R04.0	EPISTAXIS	82043	MICROALBUMIN, QUANTITATIVE	09/19/2016
R10.13	EPIGASTRIC PAIN	82570	ASSAY OF URINE CREATININE	10/03/2016
R19.7	DIARRHEA UNSPECIFIED	82784	ASSAY, IGA/IGD/IGG/IGM EACH	12/27/2016

Claimant ID	4	Amount Paid \$	15,080
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One or more of the following Diagnosis, Procedure, and Service Dates were indicated for this claimant during the reporting period. Diagnosis and Procedure information is listed in ascending order based on Code. Service Date information is listed chronologically.

Diagnosis		Procedure		Service Date
Code	Description	Code	Description	
Z01.818	ENCOUNTER OTHER PREPROCEDURAL EXAM	82947	ASSAY, GLUCOSE, BLOOD QUANT	02/07/2017
Z23	ENCOUNTER FOR IMMUNIZATION	83036	GLYCOSYLATED HEMOGLOBIN TEST	02/16/2017
		84155	ASSAY OF PROTEIN, SERUM	02/28/2017
		84165	PROTEIN E-PHORESIS, SERUM	
		85018	HEMOGLOBIN	
		86334	IMMUNOFIX E-PHORESIS, SERUM	
		87086	URINE CULTURE/COLONY COUNT	
		88305	TISSUE EXAM BY PATHOLOGIST	
		88313	SPECIAL STAINS GROUP 2	
		90471	IMMUNIZATION ADMIN	
		90656	IIV3 VACC NO PRSV 0.5 ML IM	
		92004	EYE EXAM, NEW PATIENT	
		93000	ELECTROCARDIOGRAM, COMPLETE	
		95831	LIMB MUSCLE TESTING, MANUAL	
		95832	HAND MUSCLE TESTING, MANUAL	
		96361	HYDRATE IV INFUSION, ADD-ON	
		99212	OFFICE/OUTPATIENT VISIT, EST	
		99213	OFFICE/OUTPATIENT VISIT, EST	
		99214	OFFICE/OUTPATIENT VISIT, EST	
		99244	OFFICE CONSULTATION	
		99285	EMERGENCY DEPT VISIT	
		J0696	INJ CEFTRIAXONE SODIUM PER 250 MG	
		Q0092	SET-UP PORTABLE X-RAY EQUIPMENT	
		R0070	TRANS PRTBL XRAY EQP&PERS-TRIP 1 PT	

TEXAS HOUSE BILL 2015 DATA DICTIONARY

This is the report provided to fulfill the Texas House Bill 2015 state mandate regarding Texas group health plan claim information. It contains hospital precert info for the most current 30 days (Section I), a premiums and claims history with a membership by month summary for up to 36 months (Section II), and a large loss report at the \$15,000 threshold for the most current 12 months (Section III). This is only upon completion of the HIPAA certificate, without a signed HIPAA cert the customer is not eligible to receive the large loss report, although they still get all other reporting mentioned above.

Filter Data Dictionary

Data Element	Definition
Policy Number	This is the policy number(s) included in this report. Reporting has been limited based on this policy number(s). Identifies the claimant population for the entity that purchased products and/or services from UnitedHealth Group.
Reporting Period Process (Paid) Dates	These are the paid months that are included in this report. This option limits the report to claims for which a payment was processed into the financial accounting system within the time period you select. Events processed before or after the dates listed will not be included in this report.
Reporting Period Service Dates	These are the service months that are included in this report. This option limits the report to services rendered (claims incurred) within the time period you select. Events incurred before or after the dates listed will not be included in this report.
Date of Information Request:	This is the date that the ad hoc request form was submitted.
Receipt Date of Information Request:	This is the date that we triaged the ad hoc form and assigned it out for production.
Receipt Date of HIPAA Certification:	This is the date that the Data Resources team received the HIPAA cert for this customer.
Date of Report Production:	This is the first date that the Data Resources team began producing this customers report.

Report Data Dictionary

Data Element	Definition
Section I	
For claims that are not part of this report, the number of pre-certification requests for hospital stays of 5 days or longer that were made during the 30-day period preceding the Reporting Period last Processed (paid) date.	This is number of precertification requests for hospital stays of five days or longer that were made during the 30-day period preceding the date of the report. This number only contains individuals with a stay of 5+ days that are not already included in the claimant tabs of the report. The 30 day period preceding the date of the report has been defined as the 30 days preceding the last Processed (paid) date included in the report.
Section II	
Bill/Book Year/Month	The year and month in which an invoice was sent to a customer for payment of an insurance premium, and/or payment for a claim is entered into the financial accounting system.
Restated Billed Premium	The contracted amount sought by UnitedHealth Group for providing coverage. Data is updated monthly; therefore, the premium amount for a fixed point in time may change from month-to-month.
Total Payments	The total amount paid for claims derived from a premium product — including capitation payments. = Capitation Payments + Managed Pharmacy Payments + HMO In-Network Claim Payments + Other Claim Payments.
Single Subscribers	The number of employees who are enrolled in a plan but have no dependents enrolled in the plan. Subscribers include eligible retirees and surviving spouses.
Subscribers plus Spouse	The count of families consisting of an employee plus his/her married partner.
Subscribers plus Child/Children	The count of families consisting of an employee plus 1 or more dependents (excluding the employee's spouse), just the employee's spouse and children, or the children alone.
Subscribers plus Family	The count of families consisting of an employee plus his/her spouse and child/children, or some variant of that composition.
Total Subscribers	The number of people (typically employees) who are the primary policy-holder of a benefit. Subscribers include eligible retirees and surviving spouses.
Positively Enrolled Dependents	The number of spouses, children, and other individuals related to the subscriber who are registered for coverage.
Total Members	The count of all people enrolled for coverage under a benefit. = Total Subscribers + [Positively Enrolled Dependents + Non-Positively Enrolled Dependents].
Section III (Without a HIPAA Cert for the specified customer, these definitions will not apply as "Individual Claimants" detail will not be provided)	
Claimant ID	Unique claimants are denoted by using a 1, 2, 3, etc next to the word Claimant. No identifying information will be released such as Social Security Numbers, Gender, Age, employee v/s dependent, etc.
Amount Paid	Total Paid Claims for Claimant in this experience period.
Diagnosis Code	ICD-9/10 (International Classification of Disease, 9th/10th Revision, Clinical Modification) Code as entered on the claim (without decimal point). ICD-9/10-CM is designed for the classification of morbidity and mortality information for statistical purposes and for the indexing of hospital records by disease and operations, for data storage retrieval. ICD-9/10-CM is an accepted national standard for coding diagnostic and disease information. This code represents the diagnosis with the highest cumulative paid amount for this experience period. Claims with HIV-related diagnosis and claims with Mental Health Substance Abuse (MHSA) diagnosis are protected by existing federal regulations and must not be disclosed. The diagnosis provided in these cases must be indicated as "99999."

Diagnosis Description	Describes the International Classification of Disease, 9th/10th Revision, Clinical Modification (ICD-9/10-CM) code. ICD-9/10-CM is designed for the classification of morbidity and mortality information for statistical purposes and for the indexing of hospital records by disease and operations, for data storage retrieval. ICD-9/10-CM is an accepted national standard for coding diagnostic and disease information. Claims with HIV-related diagnosis and claims with Mental Health Substance Abuse (MHS) diagnosis are protected by existing federal regulations and must not be disclosed. The diagnosis provided in these cases must be indicated as "Other Diagnosis."
Procedure Code	Procedure Code describes the type of procedure performed or service provided. This procedure code is usually a CPT-4 OR HCPCS Code. Claims with HIV-related diagnosis and claims with Mental Health Substance Abuse (MHS) diagnosis are protected by existing federal regulations and must not be disclosed.
Procedure Description	Describes a specific procedure performed or service provided. A procedure code can be an ICD9, CPT4, or HCPCS code. Claims with HIV-related diagnosis and claims with Mental Health Substance Abuse (MHS) diagnosis are protected by existing federal regulations and must not be disclosed.
Service Date	These are the dates of service associated with the respective procedure and diagnosis codes for each individual claimant's history processed within the Reporting Period.



RECENT PAID BILL

EMPLOYEE CENSUS FOR HEALTH, DENTAL, LIFE AND VISION

INSURANCE RENEWAL INFORMATION

FY 2017-2018

UnitedHealthcare
Dept. CH 10151
600550151C0009
Palatine IL 60055-0151



Page: 1 of 14

0476473PBN0115401

LAGUNAMADREWATERDISTRICT
SANJUANA GARCIA/MARIA GAMBOA
105 PORT ROAD
PORT ISABEL TX 78578

Invoice No: C0042880028
Invoice Date: Feb 16, 2017
Customer No: 665153
Bill Group: 1

Account Summary

Previous Balance	\$46,598.18
Payments (-)	\$-46,583.00
Bill Group Adjustments (+/-)	\$0.00
Late Payment Charge (+)	\$0.00
Current Charges (+)	\$48,150.91
0042890034	
Current Adjustments (+/-)	\$1,411.29
0042890086	
Total Balance Due	\$49,577.38

Please Detach and Return the Portion Below with Remittance

Customer Name LAGUNAMADREWATERDISTRICT	Customer Number 665153	Payment Due Date Mar 01, 2017	INV # C0042880028
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Return payment stub to:

UnitedHealthcare Insurance Company
Dept. CH 10151
Palatine IL 60055-0151



AMOUNT DUE

\$49,577.38

AMOUNT PAID

\$ 49,577.38