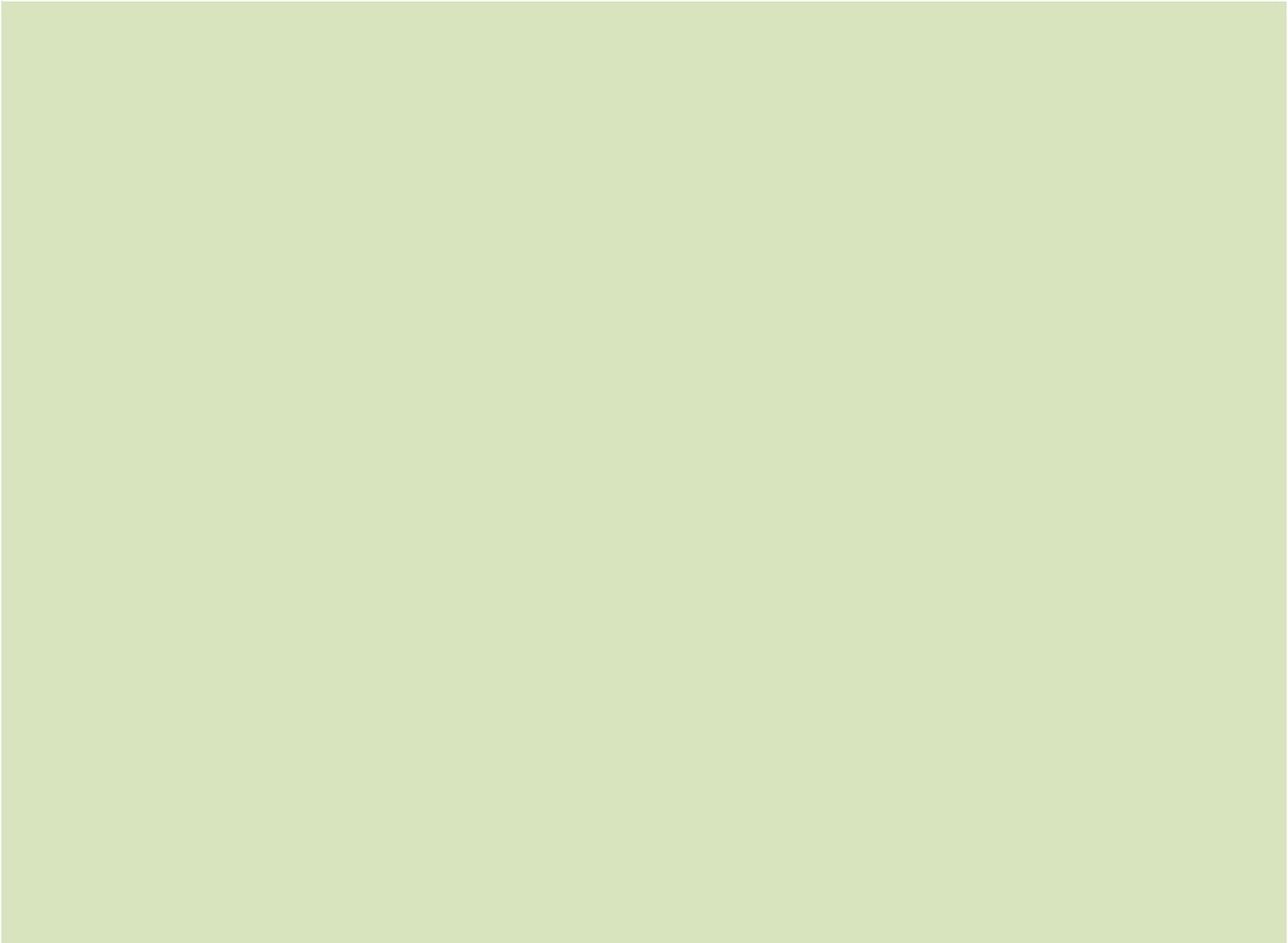


APPENDIX K
EXPERIENCE DATA - INSTRUCTIONS



GROUP BENEFITS PROGRAM

Data Exhibits

The following Exhibits A through K present enrollment, premium and utilization experience information for the Texas Employees Group Benefits Program's (GBP) Dental PPO, Dental HMO, and Dental Discount plans, as well as information on GBP's other plans.

Numerous sources of data have been used in the production of these exhibits which has resulted in some minor discrepancies. ERS believes that these discrepancies do not significantly reduce the quality of the data.

Exhibit A

GROUP BENEFITS PROGRAM

GBP Enrollment and Premium History

This exhibit presents enrollment and premium by fiscal year for the Dental PPO plan, the Dental HMO plan, the Dental Discount Plan, and the GBP health plans.

Exhibit B

GROUP BENEFITS PROGRAM

Total Program Enrollment – January 2018

This exhibit presents January 2018 GBP enrollment by (i) Employment Status (active employee, COBRA, retired employee and nominee) and (ii) Coverage Category (member only, member and spouse, etc.) for each of (a) the Health Plan (includes all health plans combined), (b) the Dental PPO plan, (c) the Dental HMO plan, and (d) the Dental Discount plan. A nominee is the surviving spouse of a retired employee.

Exhibit C

GROUP BENEFITS PROGRAM

Dental Plan Enrollment Demographics – January 2018

This exhibit presents January 2018 Dental PPO plan, Dental HMO plan, and Dental Discount plan enrollment, separated by coverage category (member only, member and spouse, etc.) age, and sex, for each of (i) active employees, (ii) retired employees and (iii) COBRA. The coverage category abbreviations used on the Exhibit are as follows:

MO - Member Only
MS - Member and Spouse
MC - Member and Child(ren)
MF - Member and Family
SO - Spouse Only
CO - Child(ren) Only
SC - Spouse and Child(ren)

Exhibit D

GROUP BENEFITS PROGRAM

Plan Enrollment by County – January 2018

This exhibit presents January 2018 GBP health plan, Dental PPO plan, Dental HMO plan, and Dental Discount plan enrollment by county. The enrollment counts include the number of participants (including active employees, retirees and dependents) residing in each county.

Exhibit E

GROUP BENEFITS PROGRAM

Plan Enrollment by ZIP Code – January 2018

This exhibit presents January 2018, GBP health plan, Dental PPO plan, Dental HMO plan, and Dental Discount plan enrollment by ZIP Code. The enrollment counts include the number of participants (including active employees, retirees and dependents) residing in each ZIP Code.

Exhibit F

GROUP BENEFITS PROGRAM

Dental Plan Rate History

This exhibit presents the monthly premium or contribution rates by coverage category for the Dental PPO Plan, the Dental HMO plan, and the Dental Discount plan for the period fiscal year 2014 (FY2014) through FY2018. The GBP Dental plans are employee pay all. The State makes no contribution to the cost of dental coverage.

Exhibit G

GROUP BENEFITS PROGRAM

Dental PPO Plan Claims Lag Report

This exhibit presents Dental PPO plan monthly claim payments by month of incurral for the experience period September 2013 through November 2017.

Exhibit H

GROUP BENEFITS PROGRAM

Dental PPO Plan Utilization Data

This exhibit presents Dental PPO plan utilization and cost experience by procedure code for FY2016 and FY2017.

Exhibit I

GROUP BENEFITS PROGRAM

Dental PPO Plan Enrollment and Claims by Zip Code – FY 2017

This exhibit presents FY 2017 Dental PPO Plan enrollment and claims experience by three-digit ZIP Code.

Exhibit J

GROUP BENEFITS PROGRAM

Dental PPO Plan Claims Experience for FY 2017

This exhibit presents Dental PPO Plan experience by employment status (active / retiree), dependent status (member/spouse/child), gender and age.

CONFIDENTIAL INFORMATION

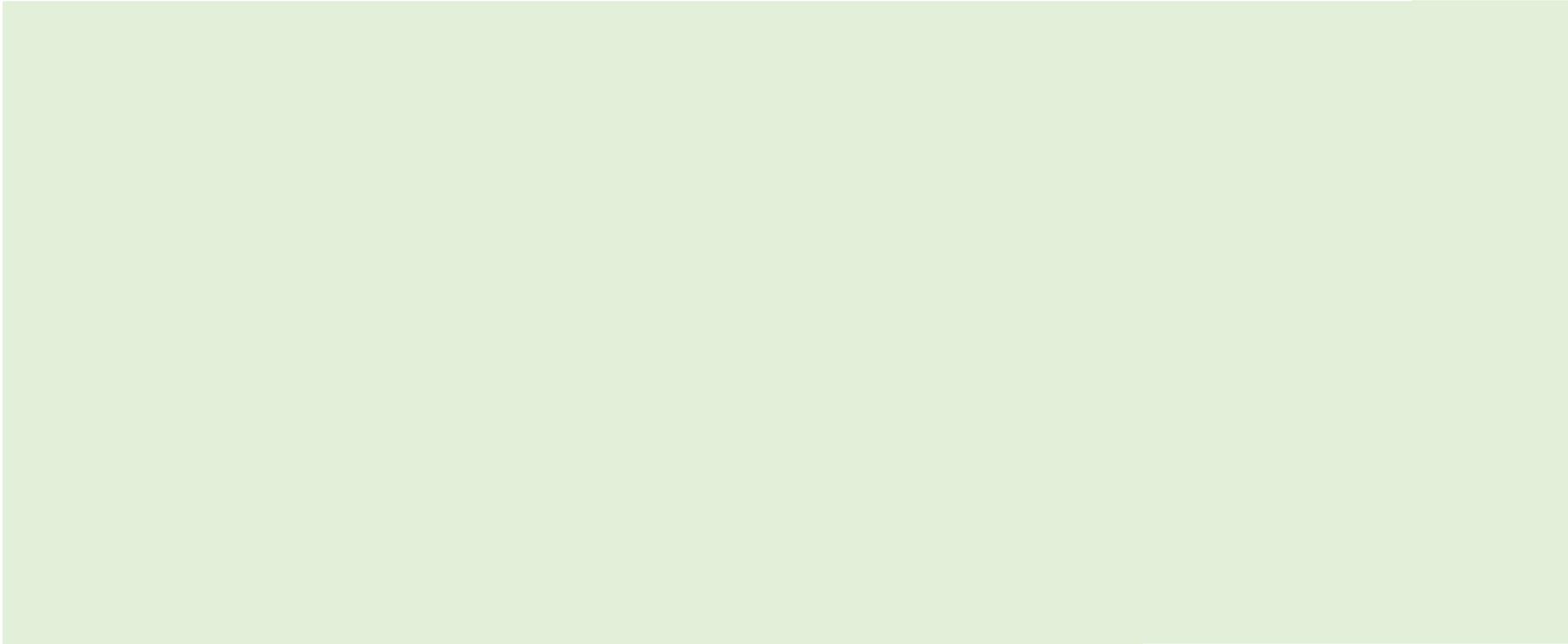
APPENDIX K

EXPERIENCE DATA

**[TO RECEIVE THIS APPENDIX – A NONDISCLOSURE
AGREEMENT WILL NEED TO BE SIGNED]**



**APPENDIX K
EXPERIENCE DATA**



APPENDIX K
Group Benefits Program Exhibit A
GBP Dental Plan Enrollment and Premium History

Month	Dental PPO Plan			Dental HMO Plan			Dental Discount Plan	
	Members	Participants	Premium	Members	Participants	Premium	Members	Participants
FY1993	18,424	34,135	7,301,400	73,945	170,753	9,713,077		
FY1994	20,677	38,059	8,091,399	85,807	196,034	11,178,424		
FY1995	23,288	43,099	7,752,049	99,858	226,707	12,553,556		
FY1996	26,125	48,489	8,135,411	104,780	237,725	13,169,035		
FY1997	28,970	54,185	9,053,488	93,432	219,584	10,227,344		
FY1998	32,598	61,174	10,181,647	97,339	226,186	10,564,541		
FY1999	36,808	69,301	11,503,001	99,465	230,132	10,716,182		
FY2000	41,851	79,061	13,941,493	98,726	224,512	12,397,499		
FY2001	48,822	92,531	16,993,401	96,992	217,834	12,073,290		
FY2002	55,427	105,392	20,634,232	97,524	216,043	11,997,093		
FY2003	61,857	118,136	24,202,343	96,528	211,571	12,144,733		
FY2004	64,834	124,269	27,333,220	93,164	202,172	12,758,623		
FY2005	70,845	135,939	29,890,778	94,110	201,070	12,746,182		
FY2006	76,272	145,948	32,109,354	95,163	200,176	12,748,521		
FY2007	82,911	158,474	34,870,014	95,080	197,132	13,544,637		
FY2008	90,816	173,440	38,155,185	93,947	192,018	13,251,422		
FY2009	100,383	191,561	44,227,623	95,062	191,383	13,267,331		
FY2010	116,658	223,545	54,895,570	90,822	180,236	16,591,215		
FY2011	126,526	241,051	59,189,279	86,676	169,405	15,631,862		
FY2012	132,172	248,555	64,174,001	81,326	154,503	14,326,583		
FY2013	140,832	260,080	67,692,073	81,143	147,572	13,983,025		
FY2014	148,497	271,712	70,895,138	80,259	142,668	14,579,050		
FY2015	155,466	282,396	73,422,127	76,312	133,082	14,982,423	5,139	9,249
FY2016	165,402	299,629	79,866,421	74,666	128,944	13,910,695	6,042	10,355
FY2017	170,389	307,365	90,784,320	71,958	123,511	13,495,137	6,055	10,309
FY2018	175,794	318,130	33,864,552	69,902	119,881	4,611,737	5,782	9,655

* FY2018 includes experience through January 2018 only.

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an	GBP Health Plan	
	Members	Participants
	231,479	438,604
	242,129	464,949
	254,444	491,765
	251,412	495,117
	256,486	505,899
	260,236	512,612
	263,278	517,645
	265,803	521,476
	269,337	521,079
	274,810	526,170
	278,200	527,957
	266,179	502,875
	270,673	504,575
	274,950	505,303
	278,131	506,377
	281,691	509,068
	291,904	523,723
	302,200	541,659
	305,695	544,034
	302,094	522,179
	306,400	513,842
	313,592	518,155
203,213	320,035	523,372
254,379	327,134	532,620
266,810	329,213	534,051
85,371	330,033	536,349

Group Benefits Program
GBP Enrollment - January, 2018

	<u>Health Plan</u>	<u>Dental Choice Plan</u>	<u>Dental HMO</u>	<u>Dental Discount</u>
<u>Actives</u>				
Member Only	131,211	68,537	29,379	3,040
Member & Spouse	17,454	15,629	5,503	533
Member & Children	41,577	22,508	8,139	618
Member & Family	22,903	19,386	6,715	600
Total	213,145	126,060	49,736	4,791
<u>COBRA</u>				
Member Only	556	358	118	6
Member & Spouse	49	59	23	0
Member & Children	34	26	7	0
Member & Family	39	30	6	1
Total	678	473	154	7
<u>Retirees</u>				
Member Only	82,198	27,095	11,234	511
Member & Spouse	23,983	16,731	6,338	376
Member & Children	3,391	1,444	779	28
Member & Family	2,204	1,861	944	50
Spouse Only	3,908	0	0	0
Child(ren) Only	755	0	0	0
Spouse & Children	321	0	0	0
Total	116,760	47,131	19,295	965
<u>Nominees</u>				
Spouse Only	4,311	2,046	686	18
Child(ren) Only	53	34	13	0
Spouse & Children	70	50	18	1
Total	4,434	2,130	717	19
<u>Total</u>				
Member Only	213,965	95,990	40,731	3,557
Member & Spouse	41,486	32,419	11,864	909
Member & Children	45,002	23,978	8,925	646
Member & Family	25,146	21,277	7,665	651
Spouse Only	4,311	2,046	686	18
Child(ren) Only	53	34	13	0
Spouse & Children	70	50	18	1
Total	330,033	175,794	69,902	5,782

Group Benefits Program
Dental PPO Plan Enrollment - January, 2018

Age	Males							Females						
	MO	MS	MC	MF	SO	CO	SC	MO	MS	MC	MF	SO	CO	SC
Active Employees														
15-19	136	4	2	1	0	0	0	92	0	2	0	0	0	0
20-24	1,555	66	45	32	0	0	0	1,824	49	135	15	0	0	0
25-29	3,418	386	231	261	0	0	0	5,192	324	795	181	0	0	0
30-34	3,595	582	568	844	0	0	0	5,559	508	2,036	791	0	0	0
35-39	3,133	512	914	1,528	0	0	0	4,538	427	3,139	1,417	0	0	0
40-44	2,628	447	1,218	1,871	0	0	0	3,774	422	3,363	1,754	0	0	0
45-49	2,729	543	1,341	2,415	0	0	0	4,495	652	3,258	1,924	0	0	0
50-54	2,574	761	980	1,760	0	0	0	5,003	1,106	2,066	1,477	0	0	0
55-59	2,613	1,290	578	1,241	0	0	0	5,544	1,635	1,065	732	0	0	0
60-64	2,034	1,622	258	580	0	0	0	4,211	1,561	357	240	0	0	0
65-69	1,002	1,066	67	198	0	0	0	1,766	704	59	49	0	0	0
70+	443	724	19	70	0	0	0	679	238	12	5	0	0	0
Total	25,860	8,003	6,221	10,801	0	0	0	42,677	7,626	16,287	8,585	0	0	0
COBRA Members														
15-19	1	0	0	0	0	0	0	0	0	0	0	0	0	0
20-24	0	0	0	0	0	0	0	1	0	0	0	0	0	0
25-29	59	0	0	0	0	0	0	46	0	0	0	0	0	0
30-34	14	1	0	0	0	0	0	23	2	2	1	0	0	0
35-39	18	1	0	1	0	0	0	12	4	1	3	0	0	0
40-44	6	1	0	0	0	0	0	15	1	7	3	0	0	0
45-49	8	3	0	2	0	0	0	15	3	5	6	0	0	0
50-54	11	2	0	4	0	0	0	27	5	4	3	0	0	0
55-59	7	0	1	5	0	0	0	17	9	2	0	0	0	0
60-64	14	5	1	2	0	0	0	44	11	3	0	0	0	0
65-69	7	4	0	0	0	0	0	9	4	0	0	0	0	0
70+	1	2	0	0	0	0	0	3	1	0	0	0	0	0
Total	146	19	2	14	0	0	0	212	40	24	16	0	0	0
Retired Employees														
15-19	0	0	0	0	0	9	0	0	0	0	0	0	4	0
20-24	0	0	0	0	0	2	0	0	0	0	0	1	7	0
25-29	0	0	0	0	0	2	0	0	0	0	0	0	4	0
30-34	0	0	0	0	0	1	0	1	0	0	0	1	0	0
35-39	0	0	0	0	1	0	0	1	0	1	0	2	1	2
40-44	5	0	5	2	1	1	0	7	1	9	5	1	0	3
45-49	32	13	24	30	1	0	0	34	9	14	10	4	0	9
50-54	403	151	162	294	1	0	2	539	125	218	111	12	1	5
55-59	844	516	174	373	2	1	2	1,650	523	289	189	23	0	8
60-64	1,417	1,227	127	292	14	0	1	3,424	1,426	168	143	91	0	7
65-69	2,016	2,193	78	186	3	0	0	4,850	2,155	88	56	8	0	0
70+	3,964	5,672	33	140	11	0	0	9,738	2,733	65	30	26	1	0
Total	8,681	9,772	603	1,317	34	16	5	20,244	6,972	852	544	169	18	34

Group Benefits Program
Dental HMO Plan Enrollment - January, 2018

Age	Males							Females						
	MO	MS	MC	MF	SO	CO	SC	MO	MS	MC	MF	SO	CO	SC
Active Employees														
15-19	70	2	1	0	0	0	0	65	0	3	0	0	0	0
20-24	912	61	17	20	0	0	0	1,013	31	96	7	0	0	0
25-29	1,766	205	119	146	0	0	0	2,479	138	393	93	0	0	0
30-34	1,722	307	238	353	0	0	0	2,385	206	689	271	0	0	0
35-39	1,538	295	361	563	0	0	0	1,910	193	915	418	0	0	0
40-44	1,316	217	436	728	0	0	0	1,595	189	1,071	513	0	0	0
45-49	1,445	238	519	836	0	0	0	1,906	271	1,179	610	0	0	0
50-54	1,316	358	406	669	0	0	0	1,952	381	835	469	0	0	0
55-59	1,137	454	223	434	0	0	0	1,849	510	388	232	0	0	0
60-64	750	518	109	204	0	0	0	1,303	390	97	70	0	0	0
65-69	310	256	23	61	0	0	0	416	134	8	3	0	0	0
70+	118	113	5	14	0	0	0	106	36	8	1	0	0	0
Total	12,400	3,024	2,457	4,028	0	0	0	16,979	2,479	5,682	2,687	0	0	0
COBRA Members														
15-19	0	0	0	0	0	0	0	0	0	0	0	0	0	0
20-24	0	0	0	0	0	0	0	1	0	0	0	0	0	0
25-29	14	0	0	0	0	0	0	19	2	0	0	0	0	0
30-34	12	2	0	1	0	0	0	5	1	0	0	0	0	0
35-39	3	0	0	1	0	0	0	3	0	2	1	0	0	0
40-44	5	1	1	1	0	0	0	1	1	0	1	0	0	0
45-49	3	0	0	1	0	0	0	6	3	2	0	0	0	0
50-54	5	0	0	0	0	0	0	9	1	1	0	0	0	0
55-59	6	3	0	0	0	0	0	11	5	1	0	0	0	0
60-64	4	2	0	0	0	0	0	8	1	0	0	0	0	0
65-69	1	1	0	0	0	0	0	1	0	0	0	0	0	0
70+	0	0	0	0	0	0	0	1	0	0	0	0	0	0
Total	53	9	1	4	0	0	0	65	14	6	2	0	0	0
Retired Employees														
15-19	0	0	0	0	0	1	0	0	0	0	0	0	4	0
20-24	0	0	0	0	0	1	0	0	0	0	0	0	2	0
25-29	0	0	0	0	0	1	0	0	0	0	0	0	1	0
30-34	0	0	0	0	0	0	0	0	0	0	0	0	0	0
35-39	0	0	0	0	0	0	0	2	0	0	1	2	0	0
40-44	2	0	1	4	0	1	0	8	0	1	0	1	0	0
45-49	19	6	8	11	0	0	1	17	1	6	3	1	0	2
50-54	274	102	95	131	1	0	0	236	78	109	70	7	1	2
55-59	549	329	103	186	4	0	0	830	299	140	114	9	0	4
60-64	779	544	79	145	12	0	2	1,434	526	105	78	39	1	2
65-69	967	944	44	101	1	0	0	1,882	761	43	24	1	0	0
70+	1,544	1,939	22	67	6	0	0	3,276	814	28	9	12	0	0
Total	4,134	3,864	352	645	24	4	3	7,685	2,479	432	299	72	9	10

Group Benefits Program
Dental Discount Plan Enrollment - January, 2018

Age	Males							Females						
	MO	MS	MC	MF	SO	CO	SC	MO	MS	MC	MF	SO	CO	SC
Active Employees														
15-19	14	0	0	0	0	0	0	12	0	1	0	0	0	0
20-24	192	5	3	1	0	0	0	183	3	8	1	0	0	0
25-29	258	40	8	17	0	0	0	324	17	46	10	0	0	0
30-34	207	36	21	43	0	0	0	243	21	48	30	0	0	0
35-39	151	28	38	53	0	0	0	169	24	67	37	0	0	0
40-44	106	28	30	57	0	0	0	124	11	75	43	0	0	0
45-49	117	32	32	70	0	0	0	172	19	85	61	0	0	0
50-54	95	25	27	60	0	0	0	183	44	53	38	0	0	0
55-59	87	38	13	29	0	0	0	178	43	35	25	0	0	0
60-64	59	38	7	14	0	0	0	104	24	14	6	0	0	0
65-69	22	32	3	4	0	0	0	24	10	3	1	0	0	0
70+	8	11	0	0	0	0	0	8	4	1	0	0	0	0
Total	1,316	313	182	348	0	0	0	1,724	220	436	252	0	0	0
COBRA Members														
15-19	0	0	0	0	0	0	0	0	0	0	0	0	0	0
20-24	0	0	0	0	0	0	0	1	0	0	0	0	0	0
25-29	0	0	0	0	0	0	0	0	0	0	0	0	0	0
30-34	0	0	0	0	0	0	0	2	0	0	0	0	0	0
35-39	0	0	0	0	0	0	0	0	0	0	1	0	0	0
40-44	0	0	0	0	0	0	0	0	0	0	0	0	0	0
45-49	1	0	0	0	0	0	0	0	0	0	0	0	0	0
50-54	0	0	0	0	0	0	0	0	0	0	0	0	0	0
55-59	1	0	0	0	0	0	0	1	0	0	0	0	0	0
60-64	0	0	0	0	0	0	0	0	0	0	0	0	0	0
65-69	0	0	0	0	0	0	0	0	0	0	0	0	0	0
70+	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	2	0	0	0	0	0	0	4	0	0	1	0	0	0
Retired Employees														
15-19	0	0	0	0	0	0	0	0	0	0	0	0	0	0
20-24	0	0	0	0	0	0	0	0	0	0	0	0	0	0
25-29	0	0	0	0	0	0	0	0	0	0	0	0	0	0
30-34	0	0	0	0	0	0	0	0	0	0	0	0	0	0
35-39	0	0	0	0	0	0	0	0	0	0	0	0	0	0
40-44	0	0	0	0	0	0	0	0	0	0	0	0	0	1
45-49	1	0	0	0	0	0	0	1	0	0	0	0	0	0
50-54	5	2	1	7	0	0	0	12	8	5	8	0	0	0
55-59	16	19	5	11	0	0	0	48	24	3	5	0	0	0
60-64	29	27	2	6	0	0	0	89	35	5	2	0	0	0
65-69	47	62	4	6	0	0	0	93	55	1	2	0	0	0
70+	60	97	1	2	0	0	0	127	47	1	1	1	0	0
Total	158	207	13	32	0	0	0	370	169	15	18	1	0	1

Group Benefits Program
GBP Enrollment by County - January, 2018

APPENDIX K
Exhibit D

County	Number of Participants*				County	Number of Participants*				County	Health Plan
	Health Plan	Dental PPO	Dental HMO	Dental Discount		Health Plan	Dental PPO	Dental HMO	Dental Discount		
Anderson	4,749	2,823	840	31	Camp	241	160	43	4	Dickens	73
Andrews	143	92	35	5	Carson	310	133	86	1	Dimmit	200
Angelina	4,315	2,691	442	101	Cass	988	498	198	19	Donley	292
Aransas	520	267	112	15	Castro	97	36	28	0	Duval	255
Archer	260	199	36	4	Chambers	467	299	89	1	Eastland	749
Armstrong	127	42	33	0	Cherokee	3,799	2,030	614	140	Ector	2,257
Atascosa	722	403	134	16	Childress	847	419	100	9	Edwards	65
Austin	765	397	149	4	Clay	384	214	37	8	El Paso	12,496
Bailey	50	31	11	5	Cochran	76	35	16	3	Ellis	1,966
Bandera	358	160	63	11	Coke	113	49	22	1	Erath	522
Bastrop	4,949	2,766	1,346	86	Coleman	242	100	26	5	Falls	759
Baylor	173	108	9	3	Collin	5,515	4,017	961	61	Fannin	973
Bee	2,740	1,756	588	50	Collingsworth	152	78	21	0	Fayette	763
Bell	5,941	3,730	1,858	165	Colorado	427	218	67	5	Fisher	168
Bexar	19,608	10,886	6,096	453	Comal	3,025	1,923	562	59	Floyd	226
Blanco	342	114	54	3	Comanche	268	150	23	6	Foard	104
Borden	27	16	0	6	Concho	84	41	20	1	Fort Bend	11,057
Bosque	517	271	73	2	Cooke	1,302	852	150	20	Franklin	232
Bowie	2,003	1,202	383	36	Coryell	4,258	2,907	983	103	Freestone	1,152
Brazoria	7,312	4,741	1,699	130	Cottle	177	90	21	1	Frio	574
Brazos	3,053	1,962	573	28	Crane	50	24	10	5	Gaines	90
Brewster	982	364	335	15	Crockett	76	19	10	3	Galveston	5,601
Briscoe	120	40	61	0	Crosby	169	109	28	9	Garza	147
Brooks	107	54	18	2	Culberson	94	47	26	0	Gillespie	584
Brown	1,780	959	302	34	Dallam	314	159	112	2	Glasscock	6
Burleson	601	367	114	2	Dallas	16,216	10,134	4,258	266	Goliad	284
Burnet	1,076	496	337	11	Dawson	588	338	107	14	Gonzales	436
Caldwell	1,892	1,103	448	42	DeWitt	568	316	102	3	Gray	739
Calhoun	202	111	37	10	Deaf Smith	242	116	60	2	Grayson	2,075
Callahan	676	303	119	25	Delta	128	52	61	0	Gregg	1,877
Cameron	6,037	2,924	1,106	169	Denton	15,350	9,861	2,955	292	Grimes	1,447

* Participants includes employees, retirees and dependents.

Group Benefits Program
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APPENDIX K
Exhibit D

County	Number of Participants*				County	Number of Participants*				County	Health Plan
	Health Plan	Dental PPO	Dental HMO	Dental Discount		Health Plan	Dental PPO	Dental HMO	Dental Discount		
Guadalupe	1,918	1,293	491	32	Jim Wells	695	390	155	15	Martin	103
Hale	1,322	673	410	44	Johnson	1,968	1,093	509	33	Mason	161
Hall	158	80	22	0	Jones	681	303	109	11	Matagorda	427
Hamilton	349	193	49	11	Karnes	636	350	119	11	Maverick	595
Hansford	67	17	25	0	Kaufman	2,636	1,650	505	54	McCulloch	196
Hardeman	342	232	26	2	Kendall	672	412	74	6	McLennan	6,993
Hardin	1,292	778	197	18	Kenedy	2	1	3	0	McMullen	48
Harris	43,634	26,514	12,138	783	Kent	47	16	11	0	Medina	1,263
Harrison	714	497	65	9	Kerr	1,747	936	221	33	Menard	61
Hartley	36	14	14	0	Kimble	204	68	40	1	Midland	2,228
Haskell	197	97	16	2	King	11	1	0	0	Milam	580
Hays	12,928	8,018	3,211	233	Kinney	104	34	13	1	Mills	205
Hemphill	66	24	23	0	Kleberg	435	262	81	12	Mitchell	629
Henderson	2,228	1,277	496	49	Knox	113	55	17	2	Montague	431
Hidalgo	10,966	5,963	1,821	311	La Salle	259	173	39	5	Montgomery	7,388
Hill	866	481	150	7	Lamar	1,388	697	227	33	Moore	258
Hockley	1,287	773	133	23	Lamb	293	145	67	7	Morris	253
Hood	689	427	109	15	Lampasas	878	450	257	22	Motley	57
Hopkins	677	322	135	20	Lavaca	982	415	133	7	Nacogdoches	4,341
Houston	1,841	1,116	389	16	Lee	1,115	634	200	15	Navarro	1,658
Howard	1,642	787	381	31	Leon	954	543	215	11	Newton	255
Hudspeth	74	25	13	5	Liberty	1,547	1,000	350	26	Nolan	641
Hunt	815	487	156	14	Limestone	2,088	1,118	453	47	Nueces	6,286
Hutchinson	496	241	142	6	Lipscomb	40	27	8	0	Ochiltree	70
Irion	39	17	12	0	Live Oak	243	119	53	4	Oldham	83
Jack	155	82	14	2	Llano	590	298	153	7	Orange	1,322
Jackson	248	123	43	0	Loving	0	0	0	0	Palo Pinto	471
Jasper	1,011	598	154	10	Lubbock	21,782	13,379	3,153	481	Panola	508
Jeff Davis	208	86	59	2	Lynn	198	101	38	8	Parker	1,874
Jefferson	6,516	4,439	1,067	86	Madison	1,095	622	276	18	Parmer	77
Jim Hogg	110	43	43	2	Marion	133	73	14	2	Pecos	739

* Participants includes employees, retirees and dependents.

Group Benefits Program
GBP Enrollment by County - January, 2018

APPENDIX K
Exhibit D

County	Number of Participants*				County	Number of Participants*				County	Health Plan
	Health Plan	Dental PPO	Dental HMO	Dental Discount		Health Plan	Dental PPO	Dental HMO	Dental Discount		
Polk	1,917	1,137	407	15	Sutton	80	50	11	5	Wise	871
Potter	3,119	1,728	574	55	Swisher	409	229	94	4	Wood	908
Presidio	197	71	56	4	Tarrant	16,627	10,083	4,561	288	Yoakum	53
Rains	126	72	25	2	Taylor	6,226	3,283	1,409	151	Young	395
Randall	4,808	2,919	781	48	Terrell	53	8	12	14	Zapata	105
Reagan	30	16	16	1	Terry	367	198	65	7	Zavala	229
Real	113	52	22	2	Throckmorton	72	29	12	1		
Red River	421	228	64	12	Titus	649	440	105	12	Other	9,132
Reeves	232	74	96	0	Tom Green	5,005	2,888	1,026	74		
Refugio	177	91	41	2	Travis	56,484	33,747	15,277	1,066	Total	536,349
Roberts	24	12	11	0	Trinity	1,464	778	499	21		
Robertson	417	259	70	4	Tyler	907	602	110	4		
Rockwall	979	702	150	13	Upshur	431	239	64	7		
Runnels	279	126	81	10	Upton	51	21	2	5		
Rusk	741	426	119	16	Uvalde	1,197	514	216	11		
Sabine	191	82	16	5	Val Verde	691	292	84	9		
San Augustine	191	85	35	6	Van Zandt	1,078	747	128	7		
San Jacinto	811	487	221	7	Victoria	2,227	1,391	451	31		
San Patricio	1,377	786	335	35	Walker	11,088	6,497	3,495	113		
San Saba	297	113	75	4	Waller	490	292	107	6		
Schleicher	44	22	5	0	Ward	219	129	52	0		
Scurry	820	385	175	23	Washington	2,284	1,224	352	43		
Shackelford	136	77	13	3	Webb	3,626	1,959	432	52		
Shelby	396	210	41	0	Wharton	1,236	730	217	1		
Sherman	58	29	30	0	Wheeler	108	44	18	2		
Smith	5,508	3,031	1,127	105	Wichita	6,448	4,334	805	67		
Somervell	145	85	14	1	Wilbarger	2,018	1,367	160	18		
Starr	810	368	83	12	Willacy	455	179	87	9		
Stephens	368	232	40	11	Williamson	23,276	15,060	6,083	393		
Sterling	40	23	13	1	Wilson	977	564	213	18		
Stonewall	63	30	8	0	Winkler	67	37	12	1		

* Participants includes employees, retirees and dependents.

Number of Participants*		
Dental PPO	Dental HMO	Dental Discount
37	10	0
84	45	5
138	47	12
151	45	0
351	132	25
1,251	555	43
24	16	1
7,254	2,803	174
1,191	446	32
235	60	4
491	167	18
646	162	4
383	124	4
98	40	4
108	75	7
55	12	0
6,401	3,166	248
149	21	5
665	271	5
338	101	3
30	17	6
3,856	1,243	85
70	11	4
278	53	8
2	0	0
161	58	8
221	92	19
410	219	6
1,254	308	35
1,092	219	14
837	404	25

Number of Participants*		
Dental PPO	Dental HMO	Dental Discount
32	32	4
71	21	0
237	104	3
221	77	13
101	25	12
3,857	1,566	121
30	11	0
657	302	32
25	24	0
1,592	326	37
321	118	25
89	27	11
336	134	16
255	51	3
4,721	2,024	115
106	137	4
150	56	5
20	2	0
2,570	402	54
1,087	190	23
146	24	4
411	87	6
3,273	1,704	140
24	39	0
35	22	0
829	161	20
230	83	16
336	32	0
1,106	350	45
35	2	5
333	305	11

Number of Participants*		
Dental PPO	Dental HMO	Dental Discount
486	149	21
488	169	13
23	10	0
237	39	3
54	10	3
120	55	1
5,428	482	136
318,130	119,881	9,655

Group Benefits Program
 GBP Enrollment by ZIP Code - January, 2018

APPENDIX K
 Exhibit E

ZIP Code	Number of Participants*				ZIP Code	Number of Participants*				ZIP Code	N
	Health Plan	Dental PPO	Dental HMO	Dental Discount		Health Plan	Dental PPO	Dental HMO	Dental Discount		
75001	86	66	8	2	75058	29	21	3	0	75121	1
75002	476	332	83	1	75060	163	84	67	7	75123	22
75006	268	178	68	2	75061	174	68	71	3	75124	106
75007	396	224	100	12	75062	224	113	70	0	75125	49
75009	112	77	26	3	75063	207	136	51	2	75126	683
75010	179	118	44	3	75065	177	110	34	4	75127	29
75011	21	10	3	0	75067	553	321	163	15	75132	6
75013	190	134	30	3	75068	492	335	104	16	75134	254
75014	4	4	1	0	75069	222	165	23	2	75135	61
75015	3	2	0	0	75070	621	449	132	4	75137	278
75016	11	6	6	0	75071	470	358	74	12	75138	14
75017	6	4	2	0	75074	263	198	46	2	75140	113
75019	281	190	43	11	75075	226	149	58	1	75141	29
75020	322	183	48	8	75076	124	74	17	5	75142	349
75021	109	67	21	2	75077	467	314	105	7	75143	243
75022	182	118	34	7	75078	147	118	26	2	75144	129
75023	286	220	53	2	75080	266	185	32	3	75146	283
75024	144	104	15	6	75081	301	208	62	5	75147	112
75025	279	223	35	2	75082	148	106	15	2	75148	149
75026	14	13	0	0	75083	12	7	0	1	75149	441
75027	12	9	2	0	75085	5	5	0	0	75150	532
75028	327	216	58	8	75086	7	5	3	0	75151	47
75029	7	7	1	0	75087	422	300	66	10	75152	29
75030	12	10	2	0	75088	203	120	56	5	75153	7
75032	308	225	44	1	75089	309	220	55	4	75154	498
75033	137	97	13	4	75090	252	119	51	4	75155	40
75034	282	225	28	1	75091	52	26	14	0	75156	144
75035	332	269	52	3	75092	395	246	66	4	75157	5
75038	110	74	37	0	75093	241	183	19	3	75158	86
75039	79	55	14	1	75094	137	100	15	1	75159	155
75040	339	205	93	4	75097	3	3	0	0	75160	919
75041	127	67	44	3	75098	354	250	67	0	75161	176
75042	97	61	39	0	75101	2	1	1	0	75163	36
75043	585	365	138	15	75102	58	44	4	2	75164	11
75044	285	196	54	4	75103	338	261	26	3	75165	534
75045	8	4	1	0	75104	597	328	229	4	75166	44
75046	5	5	1	0	75105	11	6	0	0	75167	107
75047	3	1	2	0	75106	34	21	6	0	75168	24
75048	186	127	34	1	75109	144	99	12	4	75169	291
75049	18	13	5	0	75110	983	674	115	8	75172	47
75050	216	128	66	10	75114	56	42	6	0	75173	34
75051	148	92	43	3	75115	790	542	229	3	75180	112
75052	900	529	280	21	75116	139	93	33	4	75181	345
75053	16	8	9	0	75117	86	67	8	0	75182	82
75054	136	83	35	1	75118	7	1	0	0	75185	28
75056	310	195	79	4	75119	239	143	33	1	75187	19
75057	95	67	21	0	75120	17	9	2	1	75189	243

Group Benefits Program
 GBP Enrollment by ZIP Code - January, 2018

APPENDIX K
 Exhibit E

ZIP Code	Number of Participants*				ZIP Code	Number of Participants*				ZIP Code	N
	Health Plan	Dental PPO	Dental HMO	Dental Discount		Health Plan	Dental PPO	Dental HMO	Dental Discount		
75201	64	40	13	4	75253	83	38	29	7	75433	30
75202	27	10	12	0	75254	67	31	26	0	75434	2
75203	53	29	20	1	75275	1	3	0	0	75435	24
75204	96	62	23	1	75277	1	0	1	0	75436	81
75205	56	43	3	0	75287	246	174	62	5	75437	34
75206	177	110	38	2	75313	4	3	1	0	75438	44
75207	15	12	1	0	75315	7	4	0	1	75439	32
75208	191	114	53	1	75336	2	1	2	0	75440	110
75209	65	36	12	0	75339	3	3	0	0	75441	5
75210	12	6	3	1	75354	5	2	3	0	75442	112
75211	216	124	68	2	75355	5	0	2	0	75443	2
75212	57	30	25	1	75357	11	9	2	0	75444	8
75214	254	149	50	3	75360	11	10	0	0	75446	96
75215	58	42	11	1	75367	5	5	0	0	75447	37
75216	194	106	74	4	75370	5	2	3	0	75448	28
75217	262	168	68	11	75374	23	12	3	0	75449	23
75218	246	169	30	3	75376	15	12	5	0	75450	6
75219	131	75	29	0	75379	6	5	1	0	75451	16
75220	70	50	10	0	75380	12	12	0	0	75452	45
75221	1	1	0	0	75381	1	1	0	0	75453	56
75222	22	11	10	0	75382	5	3	3	0	75454	98
75223	47	28	12	4	75401	111	69	20	3	75455	555
75224	171	99	52	1	75402	204	124	46	1	75456	68
75225	108	77	6	0	75403	17	13	0	0	75457	189
75226	11	5	5	0	75404	10	6	2	0	75458	9
75227	272	155	93	2	75407	145	93	34	0	75459	77
75228	320	178	101	9	75409	127	87	19	0	75460	465
75229	147	114	22	0	75410	62	29	12	2	75461	37
75230	109	74	11	2	75411	17	7	4	0	75462	449
75231	133	108	28	1	75412	31	14	3	3	75468	24
75232	269	156	85	4	75413	7	2	2	0	75469	4
75233	101	47	34	1	75414	106	84	20	0	75470	17
75234	173	100	54	2	75415	5	3	2	0	75471	15
75235	59	40	17	0	75416	85	41	12	1	75472	16
75236	111	71	24	7	75417	68	34	9	6	75473	108
75237	99	62	36	1	75418	475	353	75	2	75474	156
75238	241	175	23	0	75420	16	6	5	0	75475	10
75240	67	41	13	0	75421	44	27	8	0	75476	33
75241	217	130	93	3	75422	37	12	4	0	75477	26
75243	393	243	86	7	75423	28	19	4	0	75478	25
75244	95	59	9	1	75424	27	17	8	0	75479	63
75246	8	6	2	0	75425	3	2	4	0	75480	19
75247	1	1	0	0	75426	131	63	24	1	75481	15
75248	221	167	22	7	75428	70	36	21	1	75482	489
75249	126	67	49	4	75429	4	3	0	0	75483	21
75251	15	10	2	5	75431	32	15	6	0	75485	3
75252	143	99	14	3	75432	80	35	40	0	75486	87

* Includes active employees, retirees and dependents.

Group Benefits Program
 GBP Enrollment by ZIP Code - January, 2018

APPENDIX K
 Exhibit E

ZIP Code	Number of Participants*				ZIP Code	Number of Participants*				ZIP Code	N
	Health Plan	Dental PPO	Dental HMO	Dental Discount		Health Plan	Dental PPO	Dental HMO	Dental Discount		
75487	24	16	1	0	75631	66	47	1	0	75704	203
75488	58	38	7	0	75633	369	249	17	0	75705	47
75489	17	9	6	0	75636	4	2	1	0	75706	131
75490	29	17	2	0	75637	6	3	1	0	75707	388
75491	96	74	0	4	75638	121	72	28	4	75708	89
75492	19	18	1	0	75639	9	4	2	0	75709	142
75493	3	0	1	0	75640	31	26	3	0	75710	20
75494	223	134	29	5	75641	4	4	0	0	75711	66
75495	117	70	15	2	75642	10	8	0	0	75712	28
75496	52	32	0	3	75643	38	22	2	0	75713	40
75497	48	27	4	0	75644	209	121	14	4	75750	94
75500	1	1	0	0	75645	108	50	23	1	75751	844
75501	625	406	78	11	75647	116	67	26	0	75752	274
75502	1	0	1	0	75650	105	66	8	1	75754	100
75503	530	289	86	12	75651	36	20	2	3	75755	46
75504	14	10	1	0	75652	216	139	41	3	75756	139
75505	26	13	5	0	75653	37	26	1	0	75757	442
75550	24	4	12	0	75654	190	93	27	6	75758	278
75551	463	224	60	3	75656	125	75	39	5	75759	6
75554	86	70	16	0	75657	132	73	14	2	75760	209
75555	34	21	2	0	75659	12	12	0	0	75762	445
75556	31	17	10	0	75660	5	3	0	0	75763	315
75558	23	14	3	0	75661	37	24	7	4	75764	20
75559	188	121	57	0	75662	444	248	43	2	75765	140
75560	33	17	13	2	75663	49	24	5	1	75766	1,458
75561	80	55	6	1	75666	3	3	0	0	75770	115
75563	153	77	30	3	75667	44	25	11	1	75771	436
75564	1	0	0	0	75668	24	17	1	1	75772	38
75565	6	0	0	0	75669	20	11	9	0	75773	241
75566	28	3	24	0	75670	137	81	16	0	75776	1
75567	111	78	12	3	75671	26	19	4	0	75778	123
75568	33	21	9	0	75672	307	235	25	1	75779	38
75569	66	42	16	0	75681	100	56	19	0	75780	8
75570	298	152	101	8	75682	7	1	1	0	75782	19
75571	71	38	17	0	75683	37	23	11	0	75783	186
75572	81	45	9	6	75684	93	52	15	1	75784	70
75573	14	8	0	0	75686	225	153	40	4	75785	1,634
75574	49	27	20	1	75687	2	2	0	0	75788	9
75601	128	62	17	2	75688	9	7	0	0	75789	215
75602	145	91	27	2	75689	4	0	0	0	75790	121
75603	88	52	6	0	75691	45	29	4	5	75791	462
75604	293	184	43	3	75692	27	19	3	0	75792	80
75605	459	273	30	4	75693	80	53	11	0	75801	1,470
75606	16	8	0	0	75694	8	6	0	0	75802	225
75607	23	6	8	0	75701	835	386	186	25	75803	1,607

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APPENDIX K
 Exhibit E

ZIP Code	Number of Participants*				ZIP Code	Number of Participants*				ZIP Code	N
	Health Plan	Dental PPO	Dental HMO	Dental Discount		Health Plan	Dental PPO	Dental HMO	Dental Discount		
75608	27	17	3	0	75702	248	138	77	1	75805	1
75630	34	19	11	0	75703	1,097	585	203	13	75831	240
75832	29	17	1	0	75942	19	13	0	0	76020	246
75833	243	136	60	5	75943	111	71	14	0	76021	329
75835	869	491	182	6	75944	39	22	8	0	76022	111
75838	26	19	5	0	75946	110	63	12	1	76023	69
75839	466	273	78	3	75948	86	41	6	3	76028	840
75840	416	241	83	0	75949	332	206	21	12	76031	137
75844	303	193	55	1	75951	647	415	84	9	76033	372
75845	243	121	70	6	75954	38	27	2	0	76034	173
75846	87	50	14	3	75956	140	80	21	0	76035	24
75847	101	62	10	1	75958	9	4	2	1	76036	377
75848	12	7	1	0	75959	15	12	2	0	76039	193
75849	30	18	5	3	75960	30	16	8	2	76040	141
75850	23	11	3	0	75961	838	522	76	7	76041	3
75851	530	351	134	5	75962	42	38	0	1	76043	130
75852	294	164	72	0	75963	196	106	40	4	76044	47
75853	134	54	25	3	75964	890	524	70	12	76048	217
75855	151	86	39	3	75965	1,830	1,081	145	21	76049	348
75856	27	7	8	0	75966	131	65	9	0	76050	104
75857	3	0	3	0	75968	30	13	3	0	76051	255
75858	8	1	3	0	75969	351	184	49	6	76052	165
75859	103	59	33	0	75972	167	75	31	6	76053	255
75860	407	232	115	4	75973	28	14	6	0	76054	151
75861	463	271	86	2	75974	38	21	4	0	76055	38
75862	1,115	608	395	13	75975	72	35	5	0	76058	159
75865	2	1	0	0	75976	86	38	11	0	76059	24
75867	0	0	4	0	75977	30	19	1	0	76060	88
75880	1	1	0	0	75978	12	6	2	0	76061	2
75901	1,246	844	156	26	75979	430	297	61	2	76063	679
75902	32	17	2	1	75980	60	27	9	0	76064	34
75903	50	29	10	0	76001	304	188	87	4	76065	363
75904	1,761	1,093	126	45	76002	411	220	165	1	76066	65
75915	124	67	14	3	76003	24	17	3	1	76067	274
75925	479	246	76	20	76004	7	4	5	0	76068	28
75926	77	41	22	2	76005	32	20	8	0	76070	3
75928	25	22	1	0	76006	205	121	69	1	76071	28
75929	24	10	4	0	76007	2	2	0	0	76073	68
75930	60	16	5	2	76008	196	122	23	0	76077	12
75931	67	42	15	1	76009	156	78	40	0	76078	109
75932	33	16	8	0	76010	160	78	54	5	76082	165
75933	23	17	5	2	76011	124	84	48	0	76084	72
75934	3	0	3	0	76012	230	144	49	5	76085	160
75935	220	113	24	0	76013	317	178	77	6	76086	465
75936	67	42	6	0	76014	182	127	56	3	76087	523

* Includes active employees, retirees and dependents.

Group Benefits Program
 GBP Enrollment by ZIP Code - January, 2018

APPENDIX K
 Exhibit E

ZIP Code	Number of Participants*				ZIP Code	Number of Participants*				ZIP Code	N
	Health Plan	Dental PPO	Dental HMO	Dental Discount		Health Plan	Dental PPO	Dental HMO	Dental Discount		
75937	46	23	6	0	76015	160	92	60	5	76088	238
75938	151	104	5	2	76016	376	242	83	10	76092	127
75939	174	107	27	0	76017	515	310	166	4	76093	39
75941	359	224	55	8	76018	304	175	101	9	76094	4

* Includes active employees, retirees and dependents.

76095	12	12	0	0	76180	352	210	80	1	76268	3
76096	42	24	15	0	76181	1	0	1	0	76270	33
76097	16	17	1	0	76182	291	192	52	3	76271	55
76098	22	15	3	0	76185	12	12	0	0	76272	226
76099	2	0	0	1	76196	4	4	0	0	76273	194
76101	10	4	1	0	76200	1	1	0	0	76287	3
76102	102	62	16	1	76201	1,339	742	255	35	76301	534
76103	122	73	31	0	76202	106	64	19	0	76302	707
76104	100	58	41	0	76203	56	41	6	0	76303	3
76105	71	49	16	1	76204	26	10	13	0	76304	1
76106	125	61	45	0	76205	1,289	825	218	21	76305	254
76107	378	194	103	12	76206	52	35	16	0	76306	543
76108	428	282	116	5	76207	777	488	160	18	76307	37
76109	256	151	48	2	76208	937	598	186	34	76308	1,295
76110	219	125	71	1	76209	1,922	1,159	394	43	76309	604
76111	115	62	41	1	76210	1,923	1,319	324	31	76310	1,264
76112	312	167	101	3	76225	48	28	8	0	76311	33
76114	162	80	36	8	76226	515	387	77	9	76348	2
76115	67	32	24	1	76227	842	548	169	6	76350	0
76116	485	311	116	10	76228	32	22	4	0	76351	104
76117	156	84	46	0	76230	194	101	26	1	76352	6
76118	133	71	42	3	76233	68	39	9	0	76354	375
76119	288	129	128	2	76234	380	217	52	10	76357	24
76120	160	83	69	5	76238	32	24	0	0	76360	155
76121	21	8	11	0	76239	39	29	7	0	76363	1
76123	512	281	177	4	76240	828	517	102	13	76364	8
76124	22	11	6	0	76241	78	59	11	0	76365	272
76126	308	189	85	6	76244	649	414	162	9	76366	96
76130	0	1	0	0	76245	29	11	2	0	76367	629
76131	416	267	89	20	76246	5	2	0	0	76369	12
76132	365	214	70	9	76247	202	122	52	3	76370	12
76133	668	422	175	10	76248	295	206	45	3	76371	63
76134	290	142	98	7	76249	498	323	70	3	76372	16
76135	184	101	64	0	76250	65	41	1	0	76373	24
76136	8	5	1	0	76251	26	12	4	0	76374	66
76137	463	293	115	21	76252	66	46	5	0	76377	50
76140	248	129	101	6	76253	1	0	1	0	76379	17
76147	18	13	4	0	76255	97	58	6	1	76380	173
76148	167	128	39	2	76258	184	134	17	0	76384	1,888
76153	2	3	0	0	76259	173	106	40	0	76385	93
76155	27	23	5	1	76261	5	5	0	0	76388	3

Group Benefits Program
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APPENDIX K
 Exhibit E

ZIP Code	Number of Participants*				ZIP Code	Number of Participants*				ZIP Code	N
	Health Plan	Dental PPO	Dental HMO	Dental Discount		Health Plan	Dental PPO	Dental HMO	Dental Discount		
76161	12	6	2	1	76262	239	191	37	0	76389	31
76162	15	11	3	0	76263	6	4	4	0	76395	0
76163	14	10	2	0	76264	27	15	1	0	76401	387
76164	67	33	25	1	76265	37	27	7	1	76424	352
76177	141	79	49	1	76266	653	412	116	8	76426	109
76179	663	416	171	19	76267	6	1	2	0	76427	26

* Includes active employees, retirees and dependents.

76429	16	9	0	0	76503	30	28	4	0	76574	882
76430	120	73	13	3	76504	329	186	98	15	76576	1
76431	49	22	2	4	76505	1	0	0	0	76577	146
76432	58	34	10	0	76511	40	11	12	2	76578	81
76433	43	22	6	0	76513	710	441	136	14	76579	74
76435	20	8	3	0	76518	29	11	5	1	76582	1
76436	2	1	0	0	76519	12	4	0	0	76596	3
76437	281	148	42	8	76520	175	98	32	8	76597	2
76439	5	2	0	0	76522	1,456	1,094	524	41	76598	0
76442	183	109	15	4	76523	3	0	2	0	76621	55
76443	45	19	6	0	76524	63	33	24	0	76622	34
76444	46	22	6	0	76525	69	23	16	6	76623	9
76445	3	2	0	0	76526	16	9	2	0	76624	115
76446	87	38	13	4	76527	129	61	37	10	76626	59
76448	225	96	48	13	76528	2,441	1,586	412	47	76627	14
76449	39	18	4	4	76530	90	57	15	0	76628	1
76450	288	177	22	1	76531	295	165	44	7	76629	67
76453	24	7	8	0	76533	2	1	0	0	76630	47
76454	56	17	11	0	76534	61	22	15	4	76631	19
76455	22	8	2	2	76537	214	123	75	9	76632	40
76457	49	27	4	4	76538	131	93	13	4	76633	231
76458	118	56	10	2	76539	298	168	92	9	76634	184
76460	14	10	2	0	76540	11	10	1	0	76635	116
76462	43	19	0	2	76541	254	138	73	6	76636	12
76463	5	0	0	0	76542	872	623	375	10	76637	14
76464	16	4	0	0	76543	547	302	229	20	76638	110
76465	5	0	0	0	76544	22	29	12	0	76639	82
76466	9	4	0	0	76545	1	1	0	0	76640	139
76467	2	0	0	0	76547	17	7	7	0	76641	40
76468	2	2	0	0	76548	442	292	155	11	76642	482
76469	6	0	6	0	76549	995	698	424	33	76643	493
76470	120	59	20	4	76550	545	270	152	11	76644	5
76471	35	17	8	0	76554	60	36	4	7	76645	262
76472	48	27	2	6	76556	33	16	10	5	76648	141
76474	15	9	0	0	76557	163	78	27	4	76649	18
76475	30	22	5	0	76558	5	6	0	0	76651	41
76476	55	29	8	0	76559	88	63	25	2	76652	11
76481	11	8	0	0	76561	93	62	7	4	76653	52
76483	46	12	8	0	76564	2	2	0	0	76654	7

Group Benefits Program
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 Exhibit E

ZIP Code	Number of Participants*				ZIP Code	Number of Participants*				ZIP Code	N
	Health Plan	Dental PPO	Dental HMO	Dental Discount		Health Plan	Dental PPO	Dental HMO	Dental Discount		
76484	23	6	6	0	76565	3	0	1	0	76655	340
76485	7	2	5	0	76566	42	31	7	1	76656	86
76486	11	10	2	0	76567	169	95	33	6	76657	241
76487	25	17	2	0	76569	29	16	2	0	76660	13
76490	3	1	0	0	76570	77	41	19	0	76661	533
76491	26	17	4	1	76571	214	102	45	3	76664	217
76501	269	126	61	10	76572	1	1	0	0	76665	98
76502	871	550	164	28	76573	2	0	0	2	76666	5

* Includes active employees, retirees and dependents.

76667	1,282	690	273	31	76837	63	36	12	0	76934	137
76670	17	6	9	0	76841	7	3	6	0	76935	54
76671	20	10	6	2	76842	11	6	0	0	76936	44
76673	64	33	6	2	76844	159	69	17	11	76937	8
76676	27	8	11	0	76845	2	0	0	0	76939	6
76678	11	3	2	0	76848	1	0	0	0	76940	2
76679	39	20	9	0	76849	191	61	40	1	76941	35
76680	23	13	1	5	76852	6	2	0	2	76943	76
76681	19	11	0	0	76853	35	12	13	2	76945	76
76682	111	52	28	2	76854	13	7	0	0	76950	80
76684	5	4	1	0	76856	142	65	21	0	76951	40
76686	52	27	14	0	76857	86	39	13	8	76953	2
76687	93	49	13	5	76858	7	2	0	0	76955	1
76689	158	68	32	0	76859	53	22	18	0	76957	35
76690	9	3	0	0	76861	60	24	22	0	76958	37
76691	271	131	52	2	76862	5	1	5	0	77001	9
76692	181	98	35	1	76864	27	11	6	0	77002	111
76693	185	107	31	1	76865	2	1	0	0	77003	133
76701	20	11	6	1	76866	8	2	3	0	77004	714
76702	43	23	13	0	76869	2	0	0	0	77005	370
76703	33	23	2	0	76870	12	6	0	0	77006	435
76704	92	41	35	0	76871	73	32	8	1	77007	354
76705	1,011	568	213	26	76872	34	20	5	0	77008	437
76706	536	260	139	13	76875	25	11	3	0	77009	432
76707	204	87	62	6	76877	196	70	58	3	77010	4
76708	807	470	219	16	76878	51	28	9	0	77011	110
76710	707	404	174	8	76880	7	3	4	0	77012	64
76711	82	46	25	1	76882	12	4	0	0	77013	72
76712	849	502	176	14	76884	8	2	1	0	77014	350
76714	15	4	4	0	76885	8	6	2	0	77015	368
76715	39	22	6	0	76886	1	0	0	0	77016	261
76716	2	0	0	0	76887	6	6	0	0	77017	238
76801	1,026	549	190	13	76888	2	1	0	0	77018	373
76802	311	191	41	7	76889	1	0	1	0	77019	297
76803	16	5	3	0	76890	68	22	17	2	77020	146
76804	35	17	3	0	76901	1,407	799	315	19	77021	480
76813	1	1	0	0	76902	67	41	11	0	77022	162

Group Benefits Program
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APPENDIX K
 Exhibit E

ZIP Code	Number of Participants*				ZIP Code	Number of Participants*				ZIP Code	N
	Health Plan	Dental PPO	Dental HMO	Dental Discount		Health Plan	Dental PPO	Dental HMO	Dental Discount		
76820	6	0	0	0	76903	883	458	205	17	77023	337
76821	128	55	34	9	76904	1,850	1,161	334	18	77024	214
76823	162	93	21	1	76905	458	246	90	6	77025	487
76824	7	1	1	0	76906	62	44	6	4	77026	171
76825	143	71	20	10	76908	0	2	0	0	77027	160
76827	17	8	3	3	76909	4	2	2	0	77028	196
76828	6	1	1	0	76924	0	2	0	0	77029	110
76831	6	1	3	0	76930	4	1	2	0	77030	235
76832	21	10	8	0	76932	30	16	16	1	77031	165
76834	149	61	12	5	76933	35	17	1	1	77032	62

* Includes active employees, retirees and dependents.

77033	274	174	89	3	77080	150	85	38	2	77240	8
77034	268	134	91	3	77081	198	110	50	7	77241	7
77035	425	242	120	10	77082	594	312	196	31	77242	9
77036	291	118	107	10	77083	1,263	613	417	59	77243	3
77037	44	27	12	1	77084	746	415	258	20	77244	2
77038	147	88	56	1	77085	162	76	80	0	77245	28
77039	114	61	32	1	77086	141	74	56	3	77248	2
77040	365	250	71	4	77087	245	110	87	1	77249	13
77041	237	148	67	0	77088	560	295	212	9	77251	6
77042	331	199	95	9	77089	680	435	206	0	77252	7
77043	163	90	43	3	77090	385	213	143	15	77253	2
77044	512	326	138	7	77091	224	144	63	2	77254	11
77045	344	187	120	4	77092	272	164	86	4	77255	4
77046	22	15	3	0	77093	171	84	70	1	77256	6
77047	550	325	185	12	77094	77	46	16	0	77257	9
77048	272	175	99	12	77095	772	521	192	16	77258	12
77049	371	184	140	3	77096	588	375	123	8	77259	6
77050	33	20	8	0	77098	237	160	43	4	77261	8
77051	209	133	62	2	77099	487	225	149	16	77263	5
77052	10	5	1	0	77110	1	0	0	0	77265	3
77053	387	210	137	3	77204	124	78	22	3	77266	22
77054	357	180	110	16	77205	11	2	11	0	77267	4
77055	200	115	54	1	77206	10	8	1	0	77268	14
77056	159	92	39	0	77207	22	14	8	0	77269	13
77057	237	156	57	5	77209	1	0	0	0	77270	8
77058	311	228	59	5	77210	1	1	0	0	77271	32
77059	461	328	66	16	77213	13	8	5	0	77272	54
77060	78	43	31	1	77215	6	1	2	0	77273	10
77061	198	98	75	0	77217	4	2	2	0	77274	25
77062	668	478	132	15	77219	6	4	2	0	77275	12
77063	194	122	62	1	77220	4	1	2	0	77277	14
77064	352	220	101	2	77221	28	24	3	0	77279	10
77065	319	194	93	3	77222	4	0	4	0	77280	9
77066	314	192	108	8	77223	18	3	9	0	77282	5
77067	234	143	85	5	77224	5	5	0	0	77284	13

APPENDIX K
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Group Benefits Program
GBP Enrollment by ZIP Code - January, 2018

ZIP Code	Number of Participants*				ZIP Code	Number of Participants*				ZIP Code	N
	Health Plan	Dental PPO	Dental HMO	Dental Discount		Health Plan	Dental PPO	Dental HMO	Dental Discount		
77068	95	54	31	1	77225	6	2	1	0	77287	3
77069	154	112	36	1	77226	4	2	2	1	77288	17
77070	489	316	120	10	77227	10	7	1	0	77289	11
77071	467	250	134	13	77228	17	12	3	1	77290	7
77072	361	178	118	16	77229	2	1	0	0	77291	2
77073	422	217	165	16	77230	20	10	9	0	77292	12
77074	217	104	73	5	77231	37	21	10	0	77293	14
77075	349	208	110	4	77233	14	5	8	0	77301	469
77076	98	49	40	3	77234	10	9	1	0	77302	211
77077	491	267	138	16	77235	5	3	0	0	77303	402
77078	135	75	56	4	77236	5	1	4	0	77304	741
77079	215	127	40	1	77238	12	6	5	0	77305	65

* Includes active employees, retirees and dependents.

77306	92	44	25	2	77376	3	2	1	0	77442	26
77316	329	213	90	5	77377	347	244	90	9	77443	16
77318	418	234	134	5	77378	403	241	111	6	77444	12
77320	4,937	2,877	1,583	51	77379	738	466	193	10	77445	353
77325	20	17	0	0	77380	299	201	71	3	77446	49
77326	12	11	1	0	77381	510	401	106	0	77447	165
77327	299	157	87	4	77382	370	293	71	2	77448	33
77328	212	130	79	0	77383	14	8	3	0	77449	864
77331	277	177	67	4	77384	318	213	75	1	77450	523
77332	10	6	1	0	77385	379	254	120	1	77451	31
77333	9	2	3	1	77386	596	406	145	6	77452	11
77334	100	57	27	0	77387	23	21	5	0	77453	3
77335	85	49	14	0	77388	521	321	142	17	77454	3
77336	162	95	39	0	77389	286	222	45	4	77455	35
77338	500	254	188	8	77391	7	2	3	0	77456	10
77339	557	429	120	0	77393	18	12	4	0	77457	7
77340	4,750	2,787	1,476	54	77396	664	427	207	12	77459	1,211
77341	29	19	5	0	77399	119	52	23	0	77460	2
77342	651	381	194	6	77401	215	139	16	5	77461	269
77343	9	7	0	0	77402	20	9	5	0	77463	1
77345	273	232	33	6	77404	25	14	8	0	77464	32
77346	825	586	230	7	77406	701	412	187	17	77465	70
77347	36	19	7	0	77407	1,014	544	342	35	77466	6
77348	0	0	1	0	77410	14	8	3	0	77468	7
77350	24	14	2	0	77411	33	13	6	0	77469	1,249
77351	1,123	670	249	9	77412	2	1	1	0	77470	3
77353	23	13	7	0	77413	2	0	2	0	77471	967
77354	314	202	80	13	77414	245	152	53	3	77473	16
77355	227	160	44	3	77415	8	7	1	0	77474	184
77356	516	343	135	4	77417	49	22	15	1	77475	7
77357	162	92	57	5	77418	329	195	50	2	77476	19
77358	426	250	148	2	77419	16	8	5	0	77477	404
77359	127	84	42	0	77420	66	37	7	0	77478	402

Group Benefits Program
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APPENDIX K
 Exhibit E

ZIP Code	Number of Participants*				ZIP Code	Number of Participants*				ZIP Code	N
	Health Plan	Dental PPO	Dental HMO	Dental Discount		Health Plan	Dental PPO	Dental HMO	Dental Discount		
77360	337	212	79	4	77422	327	190	102	4	77479	1,235
77362	40	15	20	0	77423	82	41	23	3	77480	111
77363	51	28	16	0	77426	92	34	21	4	77481	11
77364	220	109	74	0	77429	854	549	251	14	77482	33
77365	306	183	92	2	77430	64	32	15	0	77483	3
77367	186	119	61	0	77431	2	3	0	0	77484	126
77368	9	5	0	0	77432	2	2	0	0	77485	85
77369	13	11	1	1	77433	812	568	196	23	77486	150
77370	1	0	1	0	77434	98	61	14	0	77487	36
77371	186	117	37	3	77435	180	89	39	0	77488	643
77372	148	103	38	0	77436	9	8	0	0	77489	947
77373	728	473	236	7	77437	246	156	27	0	77491	9
77374	10	7	4	2	77440	3	0	2	0	77492	16
77375	430	279	101	14	77441	129	83	19	2	77493	273

* Includes active employees, retirees and dependents.

77494	675	437	172	5	77562	91	42	36	0	77639	14
77496	28	14	13	0	77563	152	102	43	0	77640	370
77497	24	20	3	0	77564	21	11	0	0	77641	25
77498	595	351	187	17	77565	95	63	18	0	77642	509
77501	1	1	0	0	77566	593	385	93	21	77643	0
77502	183	88	51	2	77567	1	0	3	0	77650	66
77503	170	103	48	1	77568	402	251	106	6	77651	326
77504	186	130	42	7	77571	436	300	119	4	77655	17
77505	275	199	53	1	77572	9	6	0	0	77656	354
77506	127	79	24	1	77573	1,263	942	233	28	77657	529
77507	5	1	4	0	77574	31	14	8	0	77659	114
77508	17	14	2	0	77575	335	248	47	11	77660	57
77510	214	138	40	4	77577	23	12	2	0	77661	17
77511	712	514	143	7	77578	408	237	140	2	77662	357
77512	60	39	12	0	77580	19	14	4	0	77663	56
77514	78	42	8	0	77581	704	489	149	22	77664	105
77515	1,059	640	239	14	77582	18	14	6	0	77665	100
77516	107	66	28	0	77583	685	465	160	13	77670	28
77517	103	69	20	0	77584	1,810	1,185	456	34	77698	1
77518	76	33	30	1	77585	6	4	0	0	77701	250
77519	20	16	6	0	77586	336	244	49	4	77702	105
77520	354	234	75	8	77587	77	44	26	3	77703	279
77521	623	427	144	8	77588	28	21	3	0	77704	12
77522	44	36	2	0	77590	521	350	121	8	77705	644
77523	222	156	48	1	77591	376	261	94	7	77706	1,289
77530	189	96	71	3	77592	29	21	7	2	77707	592
77531	255	170	46	6	77597	11	10	1	0	77708	393
77532	340	207	82	1	77598	293	204	69	5	77710	15
77533	20	7	7	0	77611	169	113	13	4	77713	494
77534	61	39	11	0	77612	133	51	27	0	77720	40
77535	544	362	113	8	77613	46	28	8	0	77723	2

APPENDIX K
Exhibit E

Group Benefits Program
GBP Enrollment by ZIP Code - January, 2018

ZIP Code	Number of Participants*				ZIP Code	Number of Participants*				ZIP Code	N
	Health Plan	Dental PPO	Dental HMO	Dental Discount		Health Plan	Dental PPO	Dental HMO	Dental Discount		
77536	362	265	74	2	77614	13	7	0	2	77725	11
77538	29	20	4	0	77615	24	10	7	0	77726	49
77539	598	403	163	7	77616	30	5	5	0	77801	97
77541	146	86	32	6	77617	3	0	4	0	77802	566
77542	6	2	2	0	77618	1	1	0	0	77803	364
77545	630	356	235	16	77619	408	288	42	3	77805	97
77546	772	566	140	13	77622	31	18	3	0	77806	32
77547	54	39	12	1	77623	11	4	1	0	77807	168
77549	23	13	6	0	77624	48	32	11	0	77808	322
77550	362	240	98	3	77625	200	118	26	0	77830	168
77551	310	210	67	2	77626	21	19	2	0	77831	244
77552	13	12	1	0	77627	591	392	67	5	77833	1,761
77553	33	24	5	0	77629	16	11	2	0	77834	158
77554	147	95	25	4	77630	343	209	45	4	77835	131
77560	20	11	7	0	77631	20	18	1	0	77836	339
77561	47	35	6	2	77632	370	225	36	4	77837	35

* Includes active employees, retirees and dependents.

77838	3	1	0	0	77968	60	33	13	3	78032	1
77840	258	161	67	3	77969	5	4	0	0	78039	49
77841	1	1	0	0	77970	8	3	0	0	78040	394
77842	46	36	5	0	77971	16	6	7	0	78041	732
77843	1	0	0	1	77974	11	5	1	0	78042	21
77845	1,086	695	188	12	77975	35	20	2	2	78043	562
77850	3	0	0	0	77976	5	4	2	0	78044	46
77852	4	4	0	0	77977	1	1	2	0	78045	1,227
77853	70	42	12	2	77979	169	98	25	10	78046	636
77855	12	7	0	0	77982	24	11	9	0	78050	20
77856	164	102	31	1	77983	9	2	3	0	78052	95
77857	13	9	2	0	77984	203	71	34	0	78054	7
77859	139	94	19	2	77986	2	1	0	0	78055	22
77860	0	0	1	0	77987	14	3	0	0	78056	30
77861	72	43	22	2	77988	8	7	1	0	78057	41
77862	0	1	0	0	77990	10	4	0	0	78058	41
77863	31	21	2	0	77991	2	0	0	0	78059	88
77864	693	409	179	17	77993	3	2	0	0	78060	2
77865	48	31	5	0	77994	14	7	2	0	78061	288
77866	12	7	1	0	77995	497	227	72	0	78063	106
77867	1	0	0	0	78001	3	3	0	0	78064	279
77868	770	438	210	10	78002	75	42	18	1	78065	116
77870	5	2	0	0	78003	210	96	37	4	78066	17
77871	147	86	35	0	78004	6	2	1	0	78067	3
77872	108	49	25	1	78005	24	16	3	0	78069	60
77873	111	76	21	1	78006	392	261	42	3	78070	192
77876	31	19	10	0	78007	11	2	4	0	78071	91
77878	20	9	6	0	78008	2	0	0	0	78072	37
77879	204	111	51	1	78009	179	110	37	10	78073	106

Group Benefits Program
 GBP Enrollment by ZIP Code - January, 2018

APPENDIX K
 Exhibit E

ZIP Code	Number of Participants*				ZIP Code	Number of Participants*				ZIP Code	N
	Health Plan	Dental PPO	Dental HMO	Dental Discount		Health Plan	Dental PPO	Dental HMO	Dental Discount		
77880	142	80	22	0	78010	88	31	14	4	78074	5
77881	3	1	1	0	78011	35	23	5	0	78075	1
77882	6	6	0	0	78012	8	3	3	0	78076	98
77901	757	473	187	7	78013	129	58	5	2	78101	126
77902	29	22	3	0	78014	244	155	39	5	78102	2,188
77903	39	25	9	0	78015	139	91	22	1	78104	260
77904	915	566	165	14	78016	221	97	47	4	78107	12
77905	400	255	65	6	78017	221	126	42	0	78108	444
77949	1	0	0	0	78019	5	8	0	0	78109	466
77950	5	0	3	0	78021	7	7	0	0	78112	112
77951	12	5	4	1	78022	149	56	39	4	78113	62
77954	378	222	69	1	78023	364	249	60	10	78114	539
77957	180	88	25	0	78024	41	25	4	2	78115	3
77960	8	7	2	0	78025	140	71	7	3	78116	6
77962	37	22	11	0	78026	167	106	20	5	78117	38
77963	261	146	52	8	78027	1	0	1	0	78118	207
77964	231	93	25	5	78028	1,350	745	184	23	78119	278
77967	1	0	1	0	78029	86	42	10	1	78121	272

* Includes active employees, retirees and dependents.

78122	4	3	0	1	78221	500	223	179	10	78279	11
78123	42	29	13	1	78222	382	230	109	6	78280	2
78124	102	79	24	2	78223	989	481	366	24	78283	11
78125	4	6	0	0	78224	249	112	99	10	78291	3
78130	1,555	1,018	290	41	78225	135	51	59	1	78299	1
78131	37	28	8	0	78226	43	22	21	0	78330	15
78132	749	481	90	7	78227	360	188	144	3	78332	400
78133	278	177	68	7	78228	602	311	168	13	78333	80
78140	38	27	5	1	78229	243	140	67	7	78335	16
78141	32	17	10	0	78230	470	284	91	6	78336	143
78142	7	4	3	0	78231	101	44	18	4	78339	14
78143	1	0	1	0	78232	439	257	105	8	78340	9
78144	7	0	5	0	78233	475	263	166	9	78341	49
78145	10	8	1	0	78234	4	2	4	0	78342	13
78146	52	31	20	0	78235	36	23	12	3	78343	46
78147	60	21	8	3	78236	2	7	0	0	78344	8
78148	221	140	60	12	78237	191	97	61	7	78345	1
78151	38	22	6	0	78238	258	109	86	4	78349	2
78152	39	23	11	0	78239	303	167	109	10	78351	3
78154	493	328	162	8	78240	552	299	176	21	78352	7
78155	701	447	139	11	78242	216	105	86	7	78353	4
78156	27	21	6	0	78244	401	215	183	3	78355	103
78159	11	3	6	0	78245	944	528	351	37	78357	45
78160	91	47	20	4	78246	9	7	2	0	78358	69
78161	14	9	4	0	78247	539	318	184	12	78359	32
78162	41	29	4	3	78248	147	101	23	4	78361	110
78163	119	53	18	0	78249	515	296	162	11	78362	140

Group Benefits Program
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APPENDIX K
 Exhibit E

ZIP Code	Number of Participants*				ZIP Code	Number of Participants*				ZIP Code	N
	Health Plan	Dental PPO	Dental HMO	Dental Discount		Health Plan	Dental PPO	Dental HMO	Dental Discount		
78164	132	65	19	2	78250	697	416	206	13	78363	390
78201	391	208	117	12	78251	713	462	222	15	78364	23
78202	97	63	25	2	78252	110	76	50	0	78365	1
78203	63	29	18	0	78253	614	388	149	14	78368	265
78204	119	60	33	2	78254	587	343	197	6	78370	81
78205	32	24	1	1	78255	137	85	24	0	78372	84
78207	217	85	71	5	78256	75	49	12	3	78373	64
78208	25	11	14	0	78257	39	20	15	1	78374	388
78209	490	286	105	12	78258	277	184	82	0	78375	37
78210	506	223	172	27	78259	258	137	80	6	78376	9
78211	222	90	88	4	78260	239	149	68	7	78377	81
78212	314	173	79	2	78261	210	153	49	0	78379	21
78213	425	228	109	3	78263	68	35	20	3	78380	289
78214	262	114	74	8	78264	122	73	28	4	78381	80
78215	17	21	4	0	78265	14	5	3	2	78382	371
78216	422	241	108	8	78266	58	40	14	0	78383	81
78217	391	202	122	13	78268	15	7	0	0	78384	150
78218	272	161	97	11	78269	9	6	4	0	78385	2
78219	151	73	57	1	78270	17	10	3	0	78387	235
78220	269	114	104	9	78278	13	9	0	0	78389	162

* Includes active employees, retirees and dependents.

78390	70	28	29	0	78538	143	88	11	4	78593	110
78391	16	17	2	0	78539	999	569	147	23	78594	31
78393	72	35	23	2	78540	199	111	28	3	78595	51
78401	31	12	2	1	78541	659	363	128	23	78596	627
78402	7	7	0	0	78542	742	402	136	24	78597	24
78403	7	2	3	0	78543	192	74	25	1	78598	6
78404	302	143	84	9	78545	9	4	0	0	78599	327
78405	183	59	53	9	78547	13	4	2	0	78602	1,450
78406	20	16	7	0	78548	21	6	6	0	78604	6
78407	31	19	12	0	78549	5	4	1	0	78605	183
78408	111	46	29	1	78550	1,299	578	291	35	78606	141
78409	29	7	16	1	78551	36	28	1	0	78607	9
78410	556	306	170	9	78552	871	458	145	15	78608	29
78411	591	296	131	15	78553	73	36	15	0	78609	53
78412	626	336	157	20	78557	116	61	14	1	78610	2,822
78413	805	441	197	16	78558	37	18	9	0	78611	468
78414	934	552	258	27	78559	309	163	45	13	78612	812
78415	716	323	220	12	78560	38	19	9	0	78613	3,298
78416	256	108	87	2	78561	15	11	5	0	78614	22
78417	62	22	18	0	78562	35	22	4	0	78615	111
78418	384	236	126	7	78563	23	14	1	1	78616	265
78422	1	1	0	0	78564	4	0	0	1	78617	818
78426	24	17	5	0	78565	4	3	1	0	78618	7
78427	30	24	2	0	78566	239	142	46	16	78619	241
78460	11	2	5	0	78567	10	12	0	0	78620	882

Group Benefits Program
 GBP Enrollment by ZIP Code - January, 2018

APPENDIX K
 Exhibit E

ZIP Code	Number of Participants*				ZIP Code	Number of Participants*				ZIP Code	N
	Health Plan	Dental PPO	Dental HMO	Dental Discount		Health Plan	Dental PPO	Dental HMO	Dental Discount		
78463	17	8	6	0	78568	10	4	6	0	78621	1,685
78464	3	0	3	0	78569	132	55	20	0	78622	23
78465	11	2	3	0	78570	348	176	67	6	78623	37
78466	30	14	5	0	78572	910	479	144	19	78624	433
78467	32	8	7	0	78573	435	233	63	15	78626	881
78468	16	8	1	0	78574	452	236	88	13	78627	78
78469	20	16	3	0	78575	91	54	11	5	78628	1,389
78480	8	2	5	0	78576	72	39	15	1	78629	282
78501	960	521	170	25	78577	802	403	141	27	78630	71
78502	100	67	12	0	78578	69	37	16	2	78631	110
78503	196	104	37	3	78579	28	5	7	1	78632	35
78504	1,299	758	194	59	78580	267	102	57	9	78633	926
78505	14	4	2	3	78582	566	274	61	10	78634	1,699
78516	283	120	41	14	78583	188	83	53	3	78635	1
78520	632	296	111	20	78584	170	62	8	2	78636	190
78521	688	333	87	28	78586	793	319	135	24	78638	81
78522	4	0	0	0	78587	2	0	4	0	78639	152
78523	48	37	8	0	78588	16	11	6	0	78640	3,165
78526	498	255	101	5	78589	541	304	89	10	78641	2,401
78535	30	19	3	1	78590	4	1	0	0	78642	542
78536	6	4	0	0	78591	9	3	0	0	78643	207
78537	329	191	57	3	78592	13	6	3	0	78644	1,048

* Includes active employees, retirees and dependents.

78645	392	238	97	8	78719	38	22	11	0	78767	29
78646	60	35	17	0	78720	83	52	19	0	78768	40
78648	214	122	56	7	78721	473	247	159	10	78773	2
78650	113	67	27	7	78722	421	258	83	13	78785	1
78651	3	3	0	0	78723	1,813	1,080	440	36	78801	879
78652	438	270	127	5	78724	730	385	270	21	78802	117
78653	1,492	886	492	53	78725	555	312	193	11	78827	16
78654	396	177	126	2	78726	397	266	82	5	78828	4
78655	213	112	46	10	78727	1,753	1,018	505	21	78829	7
78656	102	68	17	1	78728	1,181	691	375	28	78830	6
78657	121	78	23	2	78729	1,610	1,000	437	35	78832	104
78659	195	84	66	6	78730	299	218	43	7	78833	47
78660	6,413	3,807	2,178	132	78731	1,638	1,047	164	18	78834	175
78661	27	11	11	0	78732	360	254	74	4	78835	1
78662	201	89	64	0	78733	434	307	64	13	78836	2
78663	10	4	0	0	78734	623	412	94	11	78837	8
78664	2,576	1,646	810	30	78735	714	457	137	13	78838	24
78665	2,166	1,430	674	32	78736	579	336	175	14	78839	139
78666	3,945	2,398	927	75	78737	930	604	205	8	78840	627
78667	188	124	26	4	78738	429	322	58	27	78841	19
78669	410	253	105	6	78739	1,331	915	283	14	78842	30
78670	25	15	1	0	78741	1,086	557	392	27	78850	78
78671	31	8	4	0	78742	16	9	1	0	78852	515

Group Benefits Program
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 Exhibit E

ZIP Code	Number of Participants*				ZIP Code	Number of Participants*				ZIP Code	N
	Health Plan	Dental PPO	Dental HMO	Dental Discount		Health Plan	Dental PPO	Dental HMO	Dental Discount		
78672	34	13	10	1	78743	1	0	1	0	78853	70
78673	14	13	1	0	78744	1,219	712	457	29	78860	1
78674	8	7	0	0	78745	3,302	1,814	1,028	58	78861	581
78675	3	2	0	0	78746	1,100	723	125	22	78862	1
78676	755	444	128	14	78747	1,137	701	359	33	78870	34
78680	43	30	4	2	78748	3,379	2,030	1,081	54	78871	7
78681	2,663	1,654	757	46	78749	2,580	1,567	741	20	78872	83
78683	71	38	21	0	78750	1,500	985	325	22	78873	60
78691	155	92	40	4	78751	660	386	143	21	78877	9
78701	277	188	41	4	78752	701	396	197	17	78879	6
78702	938	569	248	12	78753	2,156	1,128	723	58	78880	61
78703	957	587	109	11	78754	1,317	766	414	39	78881	91
78704	1,758	994	443	27	78755	54	26	13	0	78883	10
78705	280	176	46	6	78756	588	375	84	9	78884	52
78708	66	35	22	3	78757	1,914	1,170	339	28	78885	10
78709	75	42	19	1	78758	1,849	1,033	571	41	78886	19
78710	2	0	0	0	78759	2,547	1,577	493	27	78931	15
78711	217	128	55	5	78760	75	40	28	0	78932	44
78713	9	3	4	1	78761	71	37	21	2	78933	33
78714	203	133	63	1	78762	23	12	5	0	78934	179
78715	112	62	37	0	78763	38	25	2	2	78935	20
78716	67	37	2	0	78764	8	4	2	0	78938	1
78717	1,269	860	249	22	78765	97	67	14	1	78940	61
78718	3	2	0	0	78766	58	34	14	0	78941	74

* Includes active employees, retirees and dependents.

78942	600	329	117	11	79041	91	30	35	7	79110	693
78944	27	15	1	0	79042	43	30	7	0	79111	146
78945	319	173	49	2	79043	21	11	5	0	79114	87
78946	44	25	12	0	79044	11	7	5	0	79116	19
78947	371	227	54	1	79045	242	116	60	2	79117	10
78948	74	36	17	1	79046	9	11	2	0	79118	799
78949	16	3	5	0	79052	39	15	4	2	79119	670
78950	65	29	5	0	79053	1	1	0	0	79120	44
78951	1	0	0	0	79054	21	14	2	0	79121	270
78952	3	0	0	0	79057	50	26	8	1	79124	386
78953	72	41	13	0	79059	24	12	11	0	79133	1
78954	45	23	1	0	79061	8	1	0	0	79159	56
78956	109	42	18	2	79063	9	6	3	0	79186	2
78957	421	232	91	9	79064	44	15	21	0	79201	847
78959	38	16	5	0	79065	639	356	202	5	79220	4
78960	11	6	0	0	79066	29	14	7	0	79225	98
78961	1	0	1	0	79068	187	80	52	1	79226	253
78962	89	45	18	1	79070	68	22	39	0	79227	104
78963	34	21	3	0	79072	991	511	341	31	79229	24
79001	3	1	1	0	79073	21	15	4	0	79230	1
79003	1	1	0	0	79077	2	2	0	0	79231	4

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APPENDIX K
 Exhibit E

ZIP Code	Number of Participants*				ZIP Code	Number of Participants*				ZIP Code	N
	Health Plan	Dental PPO	Dental HMO	Dental Discount		Health Plan	Dental PPO	Dental HMO	Dental Discount		
79005	15	7	0	0	79078	14	2	10	0	79233	6
79007	279	156	64	5	79079	71	31	15	0	79234	5
79008	24	13	10	0	79080	16	7	3	0	79235	122
79009	35	18	2	1	79081	33	11	10	0	79236	11
79010	13	2	5	0	79082	2	0	1	0	79237	37
79011	2	0	0	0	79083	47	12	20	0	79239	8
79012	34	22	3	0	79084	58	29	30	0	79240	2
79013	13	9	3	0	79086	20	7	13	1	79241	100
79014	66	24	23	0	79087	4	4	3	0	79244	43
79015	605	319	106	2	79088	327	184	83	2	79245	128
79016	3	1	2	0	79091	8	1	2	0	79247	5
79018	25	7	9	0	79092	55	28	10	0	79248	177
79019	126	42	33	0	79094	1	0	0	0	79250	35
79021	3	1	0	0	79095	148	74	19	0	79251	1
79022	310	155	109	2	79096	26	11	3	2	79252	244
79024	12	7	5	0	79097	52	27	17	0	79255	33
79027	67	19	20	0	79098	12	4	6	0	79256	9
79029	225	90	121	3	79101	54	33	12	1	79257	87
79031	12	7	10	2	79102	254	150	53	4	79261	16
79032	1	0	1	0	79103	306	177	65	12	79311	180
79033	2	2	0	0	79104	139	84	37	2	79312	10
79034	4	2	1	0	79105	29	16	2	2	79313	55
79035	27	12	0	4	79106	739	411	126	9	79314	1
79036	132	58	38	1	79107	483	266	98	15	79316	341
79039	55	19	14	0	79108	417	218	85	3	79322	53
79040	34	6	15	0	79109	1,673	1,083	252	12	79323	22

* Includes active employees, retirees and dependents.

79325	14	4	0	0	79409	100	75	4	0	79541	32
79329	291	173	50	1	79410	995	564	135	10	79543	78
79330	13	3	4	0	79411	265	136	40	5	79544	11
79331	578	334	99	14	79412	703	416	149	33	79545	102
79336	1,043	619	88	23	79413	1,925	1,157	288	50	79546	75
79338	6	0	1	0	79414	1,088	695	202	25	79547	11
79339	187	101	32	4	79415	819	502	145	30	79548	19
79342	1	1	0	0	79416	2,885	1,763	441	45	79549	705
79343	54	38	5	0	79417	1	0	0	0	79550	43
79345	20	13	1	0	79423	3,219	2,056	416	82	79553	110
79346	48	29	7	3	79424	4,767	2,966	521	95	79556	516
79347	50	31	11	5	79430	1	0	1	0	79560	7
79350	42	28	7	2	79452	24	14	0	0	79561	24
79351	54	33	23	2	79453	22	16	3	0	79562	263
79355	30	9	6	0	79464	62	34	7	2	79563	46
79356	134	67	7	4	79490	48	18	18	0	79565	35
79357	62	41	16	1	79493	84	67	9	1	79566	7
79358	77	51	17	0	79499	31	20	2	0	79567	57
79359	21	7	7	1	79501	214	111	45	2	79601	763

Group Benefits Program
 GBP Enrollment by ZIP Code - January, 2018

APPENDIX K
 Exhibit E

ZIP Code	Number of Participants*				ZIP Code	Number of Participants*				ZIP Code	N
	Health Plan	Dental PPO	Dental HMO	Dental Discount		Health Plan	Dental PPO	Dental HMO	Dental Discount		
79360	67	22	10	5	79502	58	30	6	0	79602	1,112
79361	1	0	0	0	79503	15	9	0	0	79603	1,028
79363	486	282	54	5	79504	185	70	34	4	79604	53
79364	359	198	79	14	79505	5	2	0	0	79605	1,351
79366	166	113	8	0	79506	13	6	4	0	79606	1,112
79367	60	41	12	0	79508	50	37	10	1	79607	2
79369	2	2	0	0	79510	440	214	73	21	79608	100
79370	45	26	6	0	79511	100	45	18	1	79701	348
79371	36	18	1	0	79512	524	278	110	14	79702	10
79372	37	15	5	0	79517	11	8	2	0	79703	309
79373	106	51	7	6	79518	7	7	0	0	79704	16
79376	1	1	0	0	79519	3	0	0	0	79705	612
79377	10	4	8	0	79520	110	46	13	6	79706	241
79378	6	3	0	2	79521	153	78	16	2	79707	619
79379	27	6	8	0	79525	204	87	37	3	79708	13
79380	9	8	0	0	79526	48	25	15	2	79710	43
79381	30	16	4	0	79527	13	6	2	0	79711	4
79382	598	376	74	7	79528	40	9	11	0	79712	13
79383	8	1	4	0	79529	43	22	11	0	79713	19
79400	1	0	0	0	79530	30	17	6	0	79714	143
79401	236	146	63	10	79532	70	39	15	2	79718	79
79402	2	1	0	0	79533	28	14	2	0	79719	3
79403	652	385	135	26	79534	8	7	0	0	79720	1,443
79404	390	223	86	7	79535	3	2	0	0	79721	91
79405	10	1	5	0	79536	260	141	61	1	79729	0
79406	6	3	0	0	79537	7	5	0	0	79731	50
79407	1,425	908	193	26	79538	9	3	3	0	79733	7
79408	79	43	18	5	79540	5	0	2	0	79734	208

* Includes active employees, retirees and dependents.

79735	660	289	268	11	79789	8	1	2	0	79913	26
79737	1	1	0	0	79821	43	19	12	1	79914	4
79738	27	16	0	6	79830	677	252	248	9	79915	588
79739	6	2	0	0	79831	210	65	64	5	79917	10
79742	11	13	0	0	79832	29	14	10	0	79920	0
79743	5	2	3	0	79835	92	50	22	0	79922	151
79744	33	18	13	0	79836	66	49	12	0	79923	1
79745	59	36	10	1	79837	11	4	0	0	79924	817
79748	1	2	0	0	79838	77	52	12	0	79925	778
79749	7	2	4	0	79839	25	7	3	3	79926	19
79752	39	9	2	5	79840	1	0	0	0	79927	476
79755	4	4	0	0	79842	38	15	6	0	79928	864
79756	189	108	50	0	79843	108	47	28	4	79929	7
79758	44	25	7	2	79845	83	21	28	0	79930	408
79760	47	19	23	0	79846	4	0	0	0	79931	5
79761	443	230	158	13	79847	13	7	2	0	79932	354
79762	686	399	126	5	79848	53	8	12	14	79934	402

Group Benefits Program
 GBP Enrollment by ZIP Code - January, 2018

APPENDIX K
 Exhibit E

ZIP Code	Number of Participants*				ZIP Code	Number of Participants*				ZIP Code	N
	Health Plan	Dental PPO	Dental HMO	Dental Discount		Health Plan	Dental PPO	Dental HMO	Dental Discount		
79763	376	202	102	7	79849	63	42	7	3	79935	306
79764	199	99	59	6	79851	25	7	8	2	79936	2,233
79765	325	195	45	1	79852	27	18	7	1	79937	11
79766	94	50	32	6	79853	17	7	3	1	79938	1,063
79768	24	18	1	3	79854	2	3	0	0	79941	1
79769	18	14	2	0	79855	94	47	26	0	79945	1
79770	2	2	0	0	79859	3	0	3	0	79948	4
79772	144	52	47	0	79901	36	19	6	0	79949	1
79776	1	0	0	0	79902	301	178	46	7	79950	4
79777	6	1	1	0	79903	271	152	59	6	79952	1
79778	8	8	0	0	79904	372	219	111	4	79953	4
79780	5	1	1	0	79905	301	160	60	5	79954	3
79781	40	24	21	0	79906	0	1	0	0	79955	1
79782	69	26	23	1	79907	650	367	162	11	79995	6
79783	8	0	3	3	79908	2	0	0	0	79996	33
79786	2	0	0	0	79911	66	36	19	0	79997	12
79788	10	6	1	0	79912	1543	701	282	10	Other	9,132
										Total	536,349

* Includes active employees, retirees and dependents.

umber of Participants*		
Dental PPO	Dental HMO	Dental Discount
2	0	0
17	4	0
70	21	2
30	10	5
451	161	26
21	3	0
5	1	0
169	83	0
54	6	0
156	95	2
15	1	0
68	8	0
24	3	0
223	67	0
156	31	8
88	2	3
181	86	4
76	13	3
92	19	8
257	128	10
311	154	15
24	8	1
22	6	0
3	0	0
290	141	7
14	8	1
83	46	2
5	0	0
47	13	1
99	37	0
550	183	14
99	31	2
11	16	0
7	3	0
336	95	12
26	18	0
62	26	1
18	3	0
187	44	2
32	5	0
30	3	0
74	38	0
241	81	8
54	11	1
19	7	0
10	8	1
172	39	2

umber of Participants*

<u>Dental</u>	<u>Dental</u>	<u>Dental</u>
<u>PPO</u>	<u>HMO</u>	<u>Discount</u>

16	5	4
0	0	0
9	1	4
43	0	2
19	7	0
29	7	0
15	6	0
58	24	2
3	1	0
57	29	6
2	0	0
6	2	0
46	23	0
24	4	0
4	13	0
16	9	0
5	4	0
7	3	0
30	9	0
25	15	1
74	14	0
384	90	12
42	11	0
126	14	3
6	0	0
51	14	0
216	94	10
26	2	0
224	64	17
11	2	0
2	1	0
15	1	0
6	0	0
14	1	0
59	23	0
88	38	5
8	0	0
15	7	0
17	4	0
6	11	0
33	10	2
7	6	2
0	7	1
246	90	15
8	4	0
1	0	0
43	8	1

Number of Participants*

<u>Dental PPO</u>	<u>Dental HMO</u>	<u>Dental Discount</u>
-----------------------	-----------------------	----------------------------

108	64	3
15	20	0
83	26	0
219	66	11
52	17	2
89	27	0
7	6	0
39	9	0
15	10	1
22	4	0
61	16	0
528	176	14
144	61	17
61	22	2
19	13	2
56	35	3
308	84	14
152	60	1
6	0	0
106	25	7
262	88	7
202	57	3
5	4	2
84	24	0
764	255	46
62	31	2
241	74	3
17	10	2
111	62	6
1	0	0
69	28	0
12	10	0
4	1	2
9	3	0
97	36	0
29	13	1
919	244	67
4	2	0
112	35	11
82	17	0
247	101	9
42	14	5
910	223	12
153	35	2
930	325	6

umber of Participants*		
Dental PPO	Dental HMO	Dental Discount
0	0	0
136	59	0
152	64	2
227	69	6
61	26	2
30	25	1
470	250	18
88	21	1
194	83	5
118	28	0
17	2	3
223	113	5
107	65	10
103	30	1
3	0	0
74	14	1
35	7	4
131	34	2
231	65	8
55	17	0
171	41	4
112	38	1
155	64	4
85	41	1
29	3	4
80	55	3
12	9	1
55	23	0
0	2	0
475	180	17
16	11	0
234	90	5
43	8	0
134	48	6
16	10	0
1	0	0
11	6	0
39	20	2
10	0	0
72	18	0
89	40	9
57	10	0
85	33	1
258	99	17
343	92	10

umber of Participants*		
Dental PPO	Dental HMO	Dental Discount
129	45	8
97	9	1
7	14	1
3	1	0
1	0	0
23	1	0
42	3	2
161	26	7
122	18	4
2	0	0
344	83	5
446	99	2
1	1	0
0	0	0
152	23	5
342	92	10
27	7	0
867	156	8
378	86	8
886	145	8
30	3	1
3	1	0
1	0	0
82	6	4
4	0	2
282	40	5
9	1	2
102	9	4
0	0	0
10	0	0
141	29	2
68	21	0
463	58	11
8	2	0
12	0	0
30	6	2
14	0	0
18	0	0
28	15	2
38	3	2
10	4	0
108	9	3
1,269	158	18
68	2	0
0	0	0

umber of Participants*

<u>Dental PPO</u>	<u>Dental HMO</u>	<u>Dental Discount</u>
25	5	0
2	0	0
175	41	0
223	40	11
64	16	4
16	2	0
471	247	18
1	0	0
88	34	5
48	18	2
46	16	0
0	0	1
3	0	0
0	1	0
0	1	0
32	7	0
17	3	0
3	3	0
72	15	0
40	12	0
4	0	0
0	0	0
39	13	1
33	3	0
14	1	0
22	8	2
118	54	2
95	24	0
71	23	1
6	0	0
13	0	0
68	19	2
47	12	2
52	24	7
17	8	2
258	118	9
286	97	8
4	0	0
157	41	0
74	43	0
8	1	0
18	16	0
14	0	0
20	10	1
2	0	0

Number of Participants*

<u>Dental PPO</u>	<u>Dental HMO</u>	<u>Dental Discount</u>
185	58	3
54	17	3
145	55	4
6	0	0
361	122	8
137	35	2
56	10	0
3	0	0
55	43	5
32	6	2
22	5	0
2	0	1
2	0	0
3	0	0
16	10	0
19	10	3
32	21	0
50	11	5
23	13	1
0	0	0
1	0	0
23	3	0
17	11	3
6	3	0
64	26	4
82	34	0
438	152	13
227	43	4
285	79	5
239	61	5
273	100	3
246	117	5
1	3	0
42	35	0
31	15	3
32	29	0
197	129	2
211	123	6
153	106	2
118	67	3
249	65	2
205	45	5
79	57	2
248	155	11
94	48	0

umber of Participants*

<u>Dental PPO</u>	<u>Dental HMO</u>	<u>Dental Discount</u>
208	80	6
154	21	2
293	91	11
114	60	1
102	30	3
100	86	3
59	40	1
142	36	2
104	49	2
42	17	1
6	1	0
6	0	0
3	3	0
2	0	0
1	1	0
20	4	0
1	1	0
6	2	0
4	2	0
4	2	0
2	0	0
9	1	0
1	3	0
4	2	0
2	4	0
12	0	0
6	0	0
8	0	0
5	0	0
0	3	0
8	12	1
0	4	0
5	6	0
11	2	0
5	1	0
21	7	0
25	15	1
9	1	0
22	6	0
9	2	0
4	4	0
8	1	0
9	1	0
5	1	0
9	4	1

umber of Participants*

<u>Dental PPO</u>	<u>Dental HMO</u>	<u>Dental Discount</u>
1	0	1
14	0	0
9	1	0
2	6	0
0	1	0
8	2	0
11	2	0
237	163	25
103	76	4
227	134	4
455	203	23
53	15	0

11	3	3
7	9	0
4	5	0
227	65	3
22	16	0
93	59	0
13	7	0
467	345	18
312	137	6
14	10	0
1	4	0
0	1	0
0	1	0
35	1	0
10	0	0
3	1	0
794	295	23
2	0	0
127	82	2
0	1	0
16	13	0
20	25	0
2	3	0
3	3	0
640	365	40
0	2	0
474	288	19
11	3	0
82	56	2
1	3	0
13	3	0
236	115	15
272	68	5

umber of Participants*

Dental PPO	Dental HMO	Dental Discount
---------------	---------------	--------------------

785	261	20
82	22	0
5	6	0
19	4	0
1	2	0
77	30	0
35	26	0
84	43	1
21	13	0
383	125	1
551	332	28
7	1	0
4	11	0
166	74	5

5	0	0
282	46	2
22	1	0
365	97	8
1	0	0
45	10	0
229	30	7
12	1	0
223	43	2
323	95	6
55	13	6
32	12	0
7	7	0
218	64	8
30	9	2
77	10	0
59	14	0
22	0	0
1	0	0
179	41	3
69	21	0
179	79	1
7	5	0
427	97	15
845	194	17
410	108	4
286	88	5
5	11	0
307	110	14
24	8	2
0	2	0

Number of Participants*

<u>Dental PPO</u>	<u>Dental HMO</u>	<u>Dental Discount</u>
6	2	0
45	4	0
76	6	2
354	112	0
248	84	3
64	13	3
19	14	0
97	34	2
202	48	2
101	45	4
132	79	8
943	268	39
83	26	0
84	15	0
221	55	1
16	7	0
0	0	0
22	11	2
183	29	6
401	68	8
13	3	0
307	82	13
32	7	0
702	156	17
321	82	8
5	3	0
43	32	8
4	0	0
13	6	0
19	6	0
32	4	1
22	2	0
31	35	1
0	0	0
164	52	2
48	14	7
166	44	3
57	27	0
8	8	0
3	0	0
24	31	0
110	60	4
61	14	0
28	7	0
46	33	5

Number of Participants*

Dental PPO	Dental HMO	Dental Discount
---------------	---------------	--------------------

0	3	0
2	0	0
51	10	2
92	25	2
1,399	458	40
164	54	6
6	4	0
315	134	6
307	167	7
51	44	2
34	8	6
332	118	4
1	1	0
4	0	0
18	1	0
105	40	0
167	59	5
155	62	7

4	5	0
1	0	0
8	0	0
2	0	0
0	1	0
7	1	1
237	80	9
44	15	3
8	2	0
72	24	3
10	2	1
6	4	0
30	8	0
7	5	0
25	7	1
0	5	0
0	0	0
3	0	0
3	0	0
7	0	0
1	0	1
53	18	1
36	11	0
36	6	2
19	5	2
43	43	2
75	51	9

Number of Participants*

<u>Dental PPO</u>	<u>Dental HMO</u>	<u>Dental Discount</u>
241	69	12
13	8	0
0	1	0
136	63	8
45	19	3
46	16	1
31	15	0
261	81	8
21	14	0
3	2	0
46	11	0
8	3	0
164	64	8
46	21	1
185	85	12
35	25	2
79	24	0
1	3	0
135	61	2
98	46	1
47	20	1
7	4	0
26	13	0
349	107	15
17	5	1
3	1	0
200	60	17
837	387	31
4	0	0
96	55	5
41	24	2
4	2	0
16	8	2
26	12	0
1,789	756	47
207	148	2
474	230	12
2,295	732	62
17	4	1
68	35	0
107	74	8
432	327	10
3	0	0
157	39	3
500	224	25

Number of Participants*

<u>Dental PPO</u>	<u>Dental HMO</u>	<u>Dental Discount</u>
942	468	21
10	5	0
16	14	0
219	40	3
571	239	12
46	13	0
923	309	14
142	59	16
52	8	1
46	9	5
9	13	0
569	176	13
1,055	542	33
0	0	0
69	30	1
58	11	4
65	50	3
2,002	906	57
1,675	550	36
331	117	13
105	51	1
673	239	16
14	12	1
21	7	0
2	0	0
0	1	0
387	155	5
60	13	0
5	2	5
4	0	0
2	1	0
1	3	0
34	13	1
26	8	1
78	40	0
1	0	0
0	0	0
4	1	0
8	5	0
73	33	0
255	78	7
11	0	2
21	3	0
58	10	0
201	65	11

umber of Participants*

<u>Dental PPO</u>	<u>Dental HMO</u>	<u>Dental Discount</u>
17	12	2
1	0	0
298	145	15
0	0	0
7	5	2
1	2	0
45	21	1
22	13	1
2	0	0
4	1	0
20	16	1
37	26	4
3	0	0
15	12	0
0	6	0
14	3	0
14	0	0
13	11	0
15	4	0
92	22	1
5	4	0
0	0	0
31	7	0
46	16	0
388	161	11
70	42	0
38	17	1
7	1	0
8	1	0
531	137	13
380	80	9
32	2	0
178	24	0
206	41	6
0	0	0
28	4	1
0	2	0
419	100	9
3	0	0
73	9	2
113	44	6
55	12	0
8	4	0
1	0	0
4	0	0

Number of Participants*

<u>Dental PPO</u>	<u>Dental HMO</u>	<u>Dental Discount</u>
2	0	0
4	0	0
48	48	4
1	0	0
23	3	6
5	1	0
2	0	0
56	27	3
14	0	0
66	19	0
2	0	0
90	21	1
18	4	2
1	2	0
159	17	0
14	18	0
2	2	0
26	43	0
7	2	0
98	25	4
2	2	1
39	10	0
0	1	0
182	64	5
30	7	8
13	4	0
17	9	0
47	22	0
8	0	0
63	10	0
40	15	4
5	0	0
6	0	0
331	150	21
15	6	0
36	12	0
335	73	6
4	3	0
13	3	0
144	63	0
26	20	1
19	9	0
0	6	0
35	16	1
403	173	12

Number of Participants*

Dental PPO	Dental HMO	Dental Discount
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590	229	31
494	273	34
33	1	0
718	332	42
599	211	27
5	0	0
46	18	2
255	53	7
3	3	1
239	59	1
13	4	0
444	79	12
164	51	3
425	67	8
8	2	5
27	8	0
3	0	0
11	0	0
4	2	0
92	35	5
19	48	0
1	0	0
695	349	29
41	13	1
1	0	0
24	10	5
4	1	0
86	59	2
21	2	0
3	2	0
342	143	3
6	2	0
0	1	0
58	21	0
1	0	0
462	233	17
525	148	9
6	7	0
256	122	9
510	201	16
7	0	0
273	81	3
1	4	0
193	103	8
279	101	5

umber of Participants*		
Dental PPO	Dental HMO	Dental Discount
194	60	3
1,335	534	31
9	1	0
692	211	21
1	0	0
0	0	0
1	0	1
1	0	0
1	0	0
0	1	0
0	1	0
3	0	0
1	0	0
0	1	0
19	6	0
2	2	0
5,428	482	136
318,130	119,881	9,655

Group Benefits Program
Dental Plan Monthly Premium Rate History

APPENDIX K
Exhibit F

	FY2014		FY2015			FY2016			FY2017		
	Choice Plan	Dental HMO	Choice Plan	Dental HMO	Dental Discount	Choice Plan	Dental HMO	Dental Discount	Choice Plan	Dental HMO	Dental Discount
<u>Actives</u>											
Member Only	\$ 23.58	\$ 9.12	\$ 23.58	\$ 9.96	\$ 2.25	\$ 24.28	\$ 9.59	\$ 2.25	\$ 26.61	\$ 9.59	\$ 2.25
Member & Spouse	47.16	18.24	47.16	19.93	4.50	48.56	19.17	4.50	53.22	19.17	4.50
Member & Children	56.60	21.88	56.60	23.91	5.40	58.28	23.01	5.40	63.86	23.01	5.40
Member & Family	80.18	31.00	80.18	33.88	7.65	82.56	32.59	7.65	90.47	32.59	7.65
<u>COBRA</u>											
Member Only	\$ 24.05	\$ 9.30	\$ 24.05	\$ 10.16	\$ 2.30	\$ 24.77	\$ 9.78	\$ 2.30	\$ 27.14	\$ 9.78	\$ 2.30
Member & Spouse	48.10	18.60	48.10	20.33	4.59	49.53	19.55	4.59	54.28	19.55	4.59
Member & Children	57.73	22.32	57.73	24.39	5.51	59.45	23.47	5.51	65.14	23.47	5.51
Member & Family	81.78	31.62	81.78	34.56	7.80	84.21	33.24	7.80	92.28	33.24	7.80
Spouse Only	24.05	9.30	24.05	10.17	2.29	24.76	9.77	2.29	27.14	9.77	2.29
Children Only	33.68	13.02	33.68	14.23	3.21	34.68	13.69	3.21	38.00	13.69	3.21
Spouse & Children	57.73	22.32	57.73	24.40	5.50	59.44	23.46	5.50	65.14	23.46	5.50
<u>Retirees</u>											
Member Only	\$ 23.58	\$ 9.12	\$ 23.58	\$ 9.96	\$ 2.25	\$ 24.28	\$ 9.59	\$ 2.25	\$ 26.61	\$ 9.59	\$ 2.25
Member & Spouse	47.16	18.24	47.16	19.93	4.50	48.56	19.17	4.50	53.22	19.17	4.50
Member & Children	56.60	21.88	56.60	23.91	5.40	58.28	23.01	5.40	63.86	23.01	5.40
Member & Family	80.18	31.00	80.18	33.88	7.65	82.56	32.59	7.65	90.47	32.59	7.65
<u>Nominees</u>											
Spouse Only	\$ 23.58	\$ 9.12	\$ 23.58	\$ 9.97	\$ 2.25	\$ 24.28	\$ 9.58	\$ 2.25	\$ 26.61	\$ 9.58	\$ 2.25
Spouse & Children	56.60	21.88	56.60	23.92	5.40	58.28	23.00	5.40	63.86	23.00	5.40

FY2018		
Choice Plan	Dental HMO	Dental Discount
\$ 27.41	\$ 9.59	\$ 2.25
54.82	19.17	4.50
65.78	23.01	5.40
93.19	32.59	7.65
\$ 27.96	\$ 9.78	\$ 2.30
55.92	19.55	4.59
67.10	23.47	5.51
95.05	33.24	7.80
27.96	9.77	2.29
39.14	13.69	3.21
67.09	23.46	5.50
\$ 27.41	\$ 9.59	\$ 2.25
54.82	19.17	4.50
65.78	23.01	5.40
93.19	32.59	7.65
\$ 27.41	\$ 9.58	\$ 2.25
65.78	23.00	5.40

Group Benefits Program
Dental PPO Plan Claims Lag Report

Incurral Month	Paid Month													
	Dur 0	Dur 1	Dur 2	Dur 3	Dur 4	Dur 5	Dur 6	Dur 7	Dur 8	Dur 9	Dur 10	Dur 11	Dur 12	Dur 13
201309	3,497,565	1,731,022	162,514	83,190	53,403	27,401	18,990	15,883	7,060	5,437	4,081	3,100	-348	3,639
201310	4,173,421	1,535,119	242,882	121,477	90,979	34,461	16,261	12,613	5,206	2,215	5,431	799	3,330	2,063
201311	3,298,819	1,328,767	198,856	120,606	43,621	27,858	18,816	10,448	6,289	7,474	3,270	1,161	3,602	25
201312	3,254,217	1,482,965	215,968	74,693	48,074	30,790	13,646	12,511	10,664	3,930	7,658	2,071	6,555	818
201401	3,580,560	1,608,123	284,598	106,712	52,491	21,636	22,593	14,031	9,334	5,830	2,355	3,875	2,821	2,327
201402	3,162,307	1,523,655	275,583	69,189	37,680	14,503	13,823	13,798	3,684	1,411	2,094	4,036	657	2,226
201403	3,492,068	1,715,323	222,281	46,963	41,462	21,144	15,396	15,271	2,110	2,701	2,667	6,931	3,556	2,579
201404	3,372,524	1,761,976	171,395	75,327	44,170	20,921	15,198	10,928	7,437	5,793	6,641	2,066	3,554	1,707
201405	3,447,222	1,385,230	173,243	78,221	41,038	27,463	8,789	12,296	8,692	7,242	3,890	5,377	3,158	2,318
201406	3,389,771	1,504,523	195,031	81,115	40,781	24,881	18,419	9,357	7,479	8,001	3,295	4,821	3,428	2,386
201407	3,821,518	1,492,764	286,025	96,111	47,779	30,057	13,720	8,790	8,233	5,138	5,085	5,857	4,759	2,905
201408	3,684,475	1,376,852	282,031	75,125	50,484	23,015	17,555	16,438	1,934	7,420	6,264	3,531	1,744	3,486
201409	4,043,410	1,893,540	326,411	147,558	48,897	39,399	24,326	19,663	12,972	10,317	11,946	6,545	3,408	1,129
201410	4,308,297	1,505,895	598,041	97,490	62,111	34,278	33,324	18,615	9,886	9,200	7,467	5,393	3,912	3,244
201411	3,375,921	1,679,180	165,602	76,941	52,744	33,940	19,661	15,654	7,305	8,987	5,790	2,682	5,063	3,668
201412	4,049,422	1,855,090	280,368	92,400	62,106	40,002	25,604	19,896	14,595	6,131	6,707	7,389	6,473	1,233
201501	3,827,093	1,751,592	261,371	101,686	60,753	36,352	22,801	12,081	13,139	11,176	5,492	6,636	4,592	2,474
201502	3,526,922	1,561,436	325,177	91,341	44,896	27,876	20,220	11,120	14,474	3,319	4,667	2,281	4,823	2,918
201503	3,965,994	2,034,915	330,086	105,018	64,177	32,835	18,213	18,803	13,611	4,628	6,070	4,279	5,258	5,952
201504	3,875,042	1,905,558	235,023	79,914	72,545	33,517	28,295	9,421	10,358	4,114	9,759	4,658	8,173	3,152
201505	3,572,334	1,508,060	221,818	88,079	44,133	28,936	21,381	15,524	6,374	5,995	3,499	6,241	5,723	3,460
201506	4,127,491	1,810,393	278,274	87,213	51,486	19,551	27,419	10,445	11,497	9,118	7,610	2,551	3,555	2,807
201507	4,277,437	2,073,550	198,358	111,444	58,651	38,161	12,611	18,488	6,856	6,302	9,013	6,950	4,153	4,473
201508	4,382,912	1,717,475	277,148	92,833	69,959	43,653	27,938	17,956	11,893	5,070	7,149	6,078	6,263	2,998
201509	4,335,460	2,350,606	258,137	123,116	49,330	34,307	31,546	21,471	14,286	13,105	7,784	7,536	7,978	5,352
201510	4,633,253	1,921,983	243,590	92,292	72,328	31,700	29,541	22,153	13,102	12,371	6,728	6,249	8,162	6,397
201511	3,979,397	1,999,198	160,815	104,988	55,675	36,704	21,003	21,396	8,765	7,267	8,692	6,605	7,414	4,006
201512	4,758,948	1,758,964	308,315	95,150	60,518	43,036	37,171	38,214	19,016	8,977	7,692	11,996	7,545	6,920
201601	3,978,804	2,098,777	221,732	94,113	60,508	48,648	29,634	17,580	10,360	10,685	11,595	3,207	9,479	1,156
201602	4,152,594	1,971,206	252,653	75,672	55,726	45,086	23,666	14,000	13,799	10,702	5,579	8,542	2,463	4,378
201603	4,492,531	2,422,862	243,903	107,301	61,108	43,298	20,833	16,025	9,973	8,388	7,516	3,068	7,878	1,325
201604	3,969,641	1,938,135	243,947	70,870	51,632	17,458	23,413	16,445	6,941	10,282	10,585	4,116	4,507	3,943
201605	4,052,333	2,001,150	216,221	110,722	52,254	30,664	25,027	13,344	14,909	5,693	3,266	1,118	10,112	1,614
201606	4,389,409	2,050,077	355,121	73,281	58,518	50,812	22,905	19,552	10,913	6,803	9,225	5,542	5,665	3,510
201607	4,118,016	2,016,639	241,314	107,795	71,979	37,542	32,114	20,382	10,369	5,220	9,107	4,699	6,953	2,734
201608	5,062,529	1,948,875	383,585	153,318	76,447	45,241	26,808	26,227	12,778	5,521	5,722	7,089	3,531	4,693
201609	4,701,603	2,005,011	561,611	99,170	60,982	41,372	25,089	25,273	14,025	9,381	16,935	7,904	5,742	903

Group Benefits Program
Dental PPO Plan Claims Lag Report

Incurral Month	Dur 14	Dur 15	Dur 16	Dur 17	Dur 18	Dur 19	Dur 20	Dur 21	Dur 22	Dur 23	Total	
											Incurred	Paid
201309	1,058	1,115	370	1,374	1,143	844	19	0	479	0	5,619,338	3,497,565
201310	2,157	1,363	1,532	1,233	402	264	0	100	0	0	6,253,306	5,904,442
201311	1,218	182	1,296	301	1,033	-49	-236	869	0	1,500	5,075,725	4,996,452
201312	561	2,783	2,235	1,177	545	0	-59	37	0	0	5,171,839	4,909,057
201401	1,107	635	2,766	290	323	2,635	18	0	-55	0	5,725,007	5,437,261
201402	1,061	-59	853	1,478	48	637	-14	-97	0	1,442	5,129,996	5,225,384
201403	1,772	2,242	151	4,691	0	0	-158	36	0	0	5,599,188	5,472,088
201404	1,278	1,310	2,056	447	482	36	0	0	-248	0	5,504,998	5,578,218
201405	970	1,824	976	3,000	-24	0	0	0	-409	0	5,210,515	5,622,438
201406	1,851	1,151	913	1,791	622	595	-237	0	0	-1,286	5,298,690	5,087,412
201407	900	2,127	125	70	321	837	64	-89	0	0	5,833,094	5,678,265
201408	4,625	1,298	613	0	461	0	0	0	0	-322	5,557,028	5,570,329
201409	1,949	470	417	184	1,337	1,372	716	0	317	245	6,596,528	5,895,541
201410	733	-354	1,080	3,830	-17	1,265	81	14	112	632	6,704,530	6,703,992
201411	2,062	1,916	665	2,074	473	430	-47	376	87	40	5,461,215	5,390,398
201412	3,184	3,802	3,331	121	503	2,481	-294	87	93	0	6,480,722	6,611,414
201501	2,265	790	83	1,740	1,828	-874	126	62	0	-79	6,123,179	6,068,042
201502	2,905	834	2,224	3,672	112	118	-47	0	0	398	5,651,687	5,798,603
201503	1,803	1,868	1,903	440	1,608	473	-960	1,159	87	-34	6,618,186	6,044,524
201504	1,121	1,648	2,555	1,468	1,071	94	-57	44	502	-165	6,287,809	6,513,207
201505	47	2,546	5,880	494	135	717	-95	1,164	-1,125	0	5,541,319	6,080,487
201506	1,817	1,237	2,910	2,253	-647	-452	826	83	1,071	-194	6,458,313	6,141,326
201507	5,717	2,451	1,050	1,663	872	330	0	-71	546	326	6,839,330	6,568,013
201508	1,564	1,397	1,045	1,762	-34	46	-1,195	0	319	0	6,674,226	7,016,654
201509	1,997	3,237	1,840	98	362	259	-785	66	0	167	7,267,255	6,487,002
201510	3,485	3,273	2,870	737	50	0	66	-226	723	708	7,111,537	7,552,684
201511	1,921	2,110	1,340	2,927	590	718	119	1,038	-72	61	6,432,678	6,404,336
201512	3,781	933	-231	3,114	1,415	123	1,428	-31	987	0	7,173,982	7,314,888
201601	800	84	3,371	935	15	2,077	195	302	310		6,604,367	6,136,062
201602	2,963	3,872	1,356	107	742	495	-454	-316			6,644,832	6,863,739
201603	1,547	2,364	286	-745	1,308	-247	1,011				7,451,532	6,961,355
201604	126	2,825	1,435	3,192	2,239	1,048					6,382,779	6,944,042
201605	1,009	4,172	819	1,581	1,109						6,547,115	6,500,548
201606	2,635	2,485	2,345	3,746							7,072,544	6,960,034
201607	2,736	2,829	3,579								6,694,007	6,682,726
201608	3,545	4,138									7,770,047	7,739,504
201609	2,027										7,577,028	7,131,832

201610	4,474,598	2,121,669	411,561	117,169	55,657	47,363	19,599	18,472	6,895	5,658	13,967	4,316	2,558	2,306
201611	4,439,507	2,057,689	468,035	95,640	63,137	23,975	34,900	25,198	13,941	12,573	6,473	5,884	8,909	8,909
201612	4,608,875	2,226,320	270,554	140,626	52,827	27,838	31,930	27,709	12,634	13,282	6,504	2,568		
201701	4,661,582	2,187,150	365,873	145,500	63,957	38,993	21,340	17,567	6,230	4,647	4,243			
201702	3,891,705	2,111,327	375,726	102,954	58,131	32,218	21,455	11,916	6,741	8,034				
201703	4,699,374	2,400,220	427,613	122,406	55,660	37,737	27,608	26,053	15,862					
201704	4,139,330	1,991,710	308,017	82,818	56,566	22,193	17,600	15,220						
201705	4,699,098	2,155,719	205,624	115,343	62,200	34,160	26,871							
201706	4,849,330	1,930,609	347,843	119,617	70,335	36,602								
201707	4,402,237	2,236,034	210,798	114,005	58,959									
201708	5,638,163	1,808,424	299,476	118,961										
201709	4,790,901	1,972,847	423,402											
201710	4,900,217	2,465,257												
201711	4,683,690													

APPENDIX K
Exhibit G

Group Benefits Program
Dental PPO Plan Utilization and Cost Experience
FY2016 Experience

APPENDIX K
Exhibit H

Procedure Code	Billed Charges	Ineligible Expenses	Member Payments	Claim Amount Paid			Number of Services		
				In-Net	Non Net	Total	In-Net	Non Net	Total
120	8,912,941	344,776	1,643,954	3,589,942	1,665,138	5,255,080	128,076	67,790	195,866
140	2,883,397	95,363	468,417	1,229,908	546,608	1,776,516	27,340	13,980	41,320
145	52,294	13,896	19,297	20,135	5,355	25,490	351	161	512
150	3,527,634	191,230	622,746	1,380,855	505,349	1,886,203	32,666	13,512	46,178
160	69,644	10,295	17,335	21,807	15,405	37,212	302	248	550
170	29,828	5,400	9,037	9,693	5,066	14,758	288	184	472
180	235,258	11,151	146,553	17,469	13,142	30,610	1,660	1,110	2,770
210	2,417,261	425,702	502,344	924,569	497,059	1,421,627	14,549	6,346	20,895
220	2,324,742	85,452	224,243	985,066	492,735	1,477,801	63,915	27,389	91,304
230	1,570,840	81,654	138,926	670,154	302,608	972,762	39,214	13,631	52,845
240	40,847	2,536	3,972	16,937	10,277	27,214	449	260	709
250	2,630	131	210	1,719	306	2,025	44	8	52
251	638	50	53	297	43	340	9	2	11
260	492	464	0	28	0	28	11	2	13
270	88,580	2,463	6,486	41,195	14,895	56,091	2,603	853	3,456
272	945,448	44,573	91,674	438,315	195,639	633,954	17,584	6,912	24,496
273	8,626	239	836	3,675	2,992	6,667	102	75	177
274	6,424,371	191,895	643,736	2,725,777	1,494,896	4,220,674	77,619	35,296	112,915
277	327,074	9,814	37,691	103,482	135,677	239,159	1,931	1,940	3,871
330	2,984,364	538,289	619,971	1,147,904	577,940	1,725,843	20,571	8,894	29,465
340	4,565	2,715	1,416	702	428	1,129	28	27	55
1110	17,044,985	767,085	2,026,507	7,313,641	4,719,714	12,033,356	129,333	75,423	204,756
1120	2,406,863	125,161	209,970	1,216,014	453,033	1,669,047	28,576	9,809	38,385
1206	865,438	364,459	370,755	363,625	83,317	446,943	15,597	5,649	21,246
1208	1,566,931	415,815	446,695	583,396	226,130	809,525	35,135	14,483	49,618
1351	1,365,632	557,431	534,179	597,574	987	598,562	5,989	1,862	7,851
1510	81,832	7,135	6,233	43,194	15,627	58,821	191	65	256
1515	61,685	6,223	6,264	30,443	16,484	46,927	82	46	128
1520	1,413	0	0	1,131	0	1,131	5	0	5
1525	1,099	0	49	389	437	826	1	1	2
1550	2,709	948	511	1,106	360	1,466	30	10	40
2140	1,529,862	26,722	747,592	85,468	623,206	708,673	1,203	6,101	7,304
2150	2,065,965	46,007	970,146	139,311	844,297	983,608	1,513	6,223	7,736
2160	807,997	26,698	368,431	56,533	330,196	386,729	552	2,162	2,714
2161	239,461	6,950	118,930	13,749	95,099	108,848	127	538	665
2330	1,446,309	63,314	419,783	406,303	321,007	727,310	3,914	2,727	6,641
2331	1,738,398	71,593	469,797	532,779	361,400	894,180	4,282	2,738	7,020
2332	1,464,259	79,912	360,754	480,147	287,041	767,188	3,167	1,742	4,909
2335	1,099,615	175,625	261,874	315,700	163,376	479,076	2,159	996	3,155
2390	8,351	4,161	2,445	1,384	951	2,335	11	10	21
2391	4,545,465	226,325	932,553	1,944,712	350,459	2,295,171	15,988	3,021	19,009
2392	7,062,987	373,925	1,345,815	3,314,843	488,606	3,803,449	19,420	3,986	23,406
2393	2,696,899	146,891	482,135	1,218,874	245,318	1,464,192	7,006	1,539	8,545
2394	584,682	39,133	127,568	215,401	93,506	308,907	1,246	375	1,621
2520	1,795	0	897	211	409	620	1	1	2
2530	797	0	592	0	205	205	0	1	1
2542	12,689	1,200	7,589	2,097	2,013	4,110	6	8	14
2610	1,298	-1,092	1,434	0	956	956	1	1	2
2620	16,933	3,750	8,100	3,712	896	4,608	20	5	25
2630	19,225	2,370	11,036	4,551	2,109	6,662	16	8	24

Group Benefits Program
Dental PPO Plan Utilization and Cost Experience
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APPENDIX K
Exhibit H

Procedure Code	Billed Charges	Ineligible Expenses	Member Payments	Claim Amount Paid			Number of Services		
				In-Net	Non Net	Total	In-Net	Non Net	Total
2642	2,842	995	820	720	0	720	3	0	3
2643	13,791	13,791	1,170	0	0	0	6	6	12
2651	0	0	0	0	0	0	0	1	1
2652	900	0	620	0	280	280	0	2	2
2710	2,453	2,173	1,962	89	0	89	1	3	4
2712	1,162	0	197	197	0	197	1	0	1
2721	1,600	800	480	0	320	320	0	1	1
2722	0	0	0	0	0	0	0	0	0
2740	10,338,768	2,114,067	4,660,130	1,885,501	1,136,853	3,022,354	4,558	2,598	7,156
2751	849,709	147,827	397,614	162,115	99,623	261,738	504	300	804
2752	3,067,962	273,359	1,465,164	689,997	356,814	1,046,811	1,723	845	2,568
2782	61,085	298	35,250	10,769	12,267	23,036	22	24	46
2783	53,326	6,166	23,935	9,077	7,952	17,029	18	16	34
2791	1,117,951	15,637	528,924	277,483	137,725	415,208	796	360	1,156
2792	15,757,238	934,209	7,888,216	3,298,408	2,065,311	5,363,719	8,827	4,754	13,581
2794	1,916	0	985	420	376	796	1	1	2
2910	6,964	1,299	4,440	826	512	1,338	34	35	69
2915	1,525	0	1,119	221	136	356	8	6	14
2920	359,142	12,396	230,064	38,354	26,148	64,502	2,141	1,599	3,740
2930	681,610	65,458	320,175	161,487	54,092	215,578	1,084	398	1,482
2931	26,792	25,352	25,308	0	506	506	57	31	88
2932	1,109	250	548	248	0	248	2	1	3
2933	59,076	5,567	31,351	16,085	5,257	21,342	50	19	69
2940	86,625	18,164	47,030	15,090	10,183	25,273	489	323	812
2950	4,412,790	368,487	2,051,298	878,846	431,238	1,310,084	11,171	4,948	16,119
2951	9,793	972	5,835	1,578	1,142	2,720	90	63	153
2952	114,341	13,030	57,568	17,556	16,164	33,720	160	139	299
2953	1,050	0	240	240	0	240	3	0	3
2954	618,531	56,604	287,627	116,670	77,419	194,089	1,185	704	1,889
2955	7,986	7,491	7,099	158	0	158	16	9	25
2971	3,729	1,132	2,001	694	302	995	13	10	23
2980	40,687	1,714	22,938	5,384	8,063	13,447	66	103	169
3220	224,496	14,570	102,130	48,829	18,714	67,543	694	278	972
3221	47,761	3,962	25,671	12,310	2,675	14,985	187	59	246
3222	4,466	308	2,288	264	766	1,030	5	5	10
3230	4,358	298	1,914	1,008	216	1,224	5	3	8
3240	14,473	1,148	7,609	3,888	1,171	5,059	39	12	51
3310	1,288,941	71,165	597,690	259,941	166,655	426,596	1,037	591	1,628
3320	2,423,375	136,656	1,142,257	496,793	321,749	818,542	1,766	1,060	2,826
3330	5,453,607	278,091	2,630,094	1,101,579	814,890	1,916,469	2,945	2,159	5,104
3331	115,735	97,632	83,133	3,080	171	3,251	310	40	350
3332	67,734	17,431	32,789	10,883	7,286	18,168	85	76	161
3333	1,131	816	777	153	0	153	5	2	7
3346	120,889	5,118	61,332	20,934	22,054	42,989	57	63	120
3347	168,320	7,653	82,098	33,767	25,819	59,586	89	66	155
3348	752,185	23,150	375,523	152,444	128,191	280,635	298	278	576
3351	740	250	346	96	0	96	1	1	2
3352	1,472	522	881	0	356	356	0	6	6
3410	54,699	1,300	31,042	5,504	14,581	20,085	15	34	49
3421	36,057	1,114	19,058	4,674	7,142	11,816	14	21	35
3425	67,825	3,245	36,155	6,741	14,553	21,295	19	38	57

Group Benefits Program
Dental PPO Plan Utilization and Cost Experience
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APPENDIX K
Exhibit H

Procedure Code	Billed Charges	Ineligible Expenses	Member Payments	Claim Amount Paid			Number of Services		
				In-Net	Non Net	Total	In-Net	Non Net	Total
3426	8,428	1,084	3,766	968	1,365	2,333	10	11	21
3427	3,137	1,807	2,638	0	499	499	0	4	4
3428	9,419	9,419	8,819	0	0	0	14	8	22
3430	34,558	3,201	15,809	4,130	6,816	10,946	35	64	99
3432	960	960	960	0	0	0	1	3	4
3450	9,072	0	5,781	328	2,116	2,444	3	11	14
3470	1,650	0	1,394	0	256	256	0	1	1
3920	1,590	244	789	241	70	311	3	1	4
4210	25,190	8,444	9,818	2,960	3,547	6,507	12	18	30
4211	85,908	63,280	54,627	1,495	3,947	5,442	151	102	253
4212	43,223	3,659	20,804	9,475	3,908	13,384	114	64	178
4240	26,486	9,555	12,026	2,876	2,800	5,676	11	14	25
4241	59,803	17,640	29,803	2,473	11,394	13,867	31	54	85
4245	1,841	1,841	715	0	0	0	2	1	3
4249	212,694	67,442	116,262	26,418	23,476	49,894	130	98	228
4260	511,141	60,776	223,550	80,175	74,854	155,029	121	101	222
4261	369,916	63,583	177,879	48,062	62,794	110,856	140	173	313
4263	216,287	115,168	101,518	18,010	13,684	31,694	217	186	403
4264	15,870	3,185	8,039	2,294	1,836	4,130	14	14	28
4265	115,926	29,989	56,678	15,457	12,323	27,780	136	132	268
4266	346,151	101,014	179,207	58,802	37,515	96,317	342	239	581
4267	80,246	18,064	44,033	8,985	14,076	23,061	50	103	153
4268	500	0	250	250	0	250	1	0	1
4270	19,220	12,314	6,525	0	2,491	2,491	2	6	8
4273	287,422	44,951	155,190	44,012	43,900	87,912	67	109	176
4274	10,468	3,544	5,599	193	2,055	2,248	4	10	14
4275	78,456	20,740	40,787	5,402	13,068	18,470	15	32	47
4277	79,095	14,327	38,482	7,714	15,109	22,823	22	40	62
4278	21,820	3,325	10,016	2,488	3,820	6,308	10	7	17
4283	71,734	1,915	32,845	14,104	7,693	21,797	21	24	45
4285	27,419	4,083	15,126	801	6,324	7,125	5	11	16
4341	4,354,950	373,688	1,975,989	883,678	428,631	1,312,308	5,324	2,262	7,586
4342	1,013,760	90,060	452,390	193,756	85,237	278,993	2,056	880	2,936
4346	0	0	0	0	0	0	0	0	0
4355	291,841	27,987	180,209	55,994	16,465	72,459	1,313	555	1,868
4381	243,032	185,012	176,242	17,527	2,824	20,351	951	424	1,375
4910	3,790,668	203,328	2,035,187	655,027	361,701	1,016,729	17,809	10,653	28,462
5110	517,359	117,083	261,091	91,411	48,075	139,486	272	134	406
5120	239,962	40,803	120,808	37,287	29,326	66,613	110	68	178
5130	545,147	40,221	260,742	116,312	68,301	184,613	273	160	433
5140	297,715	16,505	147,157	69,659	33,821	103,480	166	77	243
5211	188,475	42,304	83,762	29,409	19,595	49,004	117	81	198
5212	169,654	44,820	73,021	26,228	16,778	43,005	103	63	166
5213	1,454,099	397,880	809,916	217,939	103,365	321,304	524	226	750
5214	1,429,975	361,348	738,544	230,759	104,285	335,044	598	220	818
5221	11,930	2,725	6,106	2,254	1,501	3,755	9	6	15
5222	10,054	0	4,323	3,456	492	3,948	12	1	13
5223	3,024	1,512	418	418	0	418	2	0	2
5224	1,889	500	808	539	0	539	2	0	2
5225	282,234	80,656	115,406	46,778	18,946	65,724	162	61	223
5226	202,409	38,007	78,245	34,750	16,404	51,163	120	44	164

Group Benefits Program
Dental PPO Plan Utilization and Cost Experience
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APPENDIX K
Exhibit H

Procedure Code	Billed Charges	Ineligible Expenses	Member Payments	Claim Amount Paid			Number of Services		
				In-Net	Non Net	Total	In-Net	Non Net	Total
5281	64,186	18,567	31,325	9,874	8,040	17,913	48	30	78
5410	4,892	2,286	3,959	409	156	565	38	16	54
5411	3,965	1,379	3,147	332	188	520	31	16	47
5421	4,189	968	2,735	735	130	865	41	14	55
5422	8,039	1,868	5,171	1,072	314	1,386	68	33	101
5510	13,576	943	8,078	2,213	1,348	3,561	43	44	87
5520	14,993	622	9,452	2,187	1,715	3,902	51	34	85
5610	35,326	8,572	15,934	6,482	1,752	8,234	135	74	209
5620	7,854	4,373	2,733	864	178	1,042	30	12	42
5630	14,656	1,338	7,589	3,443	1,360	4,803	57	21	78
5640	40,825	2,684	24,013	7,322	3,755	11,077	130	103	233
5650	127,892	7,638	62,324	21,547	14,831	36,378	339	199	538
5660	22,261	1,405	10,743	6,100	1,942	8,042	64	26	90
5670	1,142	0	670	210	262	472	1	1	2
5671	3,874	0	1,857	1,344	210	1,554	5	1	6
5710	12,507	7,197	8,871	1,944	370	2,314	15	9	24
5711	6,632	2,838	4,999	991	420	1,411	5	7	12
5720	5,394	835	3,153	1,326	404	1,730	7	4	11
5721	5,266	1,800	3,232	887	372	1,259	4	3	7
5730	25,960	10,262	17,614	3,278	2,097	5,375	48	39	87
5731	12,175	4,708	8,621	1,451	1,172	2,623	21	22	43
5740	4,765	710	2,786	940	453	1,393	10	10	20
5741	6,054	1,092	3,538	551	912	1,463	9	14	23
5750	76,564	21,004	48,341	13,225	6,719	19,944	126	65	191
5751	38,307	10,428	23,493	7,434	3,380	10,814	66	34	100
5760	10,496	2,473	6,097	2,068	1,054	3,121	20	8	28
5761	13,343	1,821	8,692	1,778	2,307	4,085	14	24	38
5850	9,203	4,688	7,449	536	422	958	36	22	58
5851	4,074	1,716	3,146	375	207	582	11	12	23
5875	4,136	698	2,520	1,136	156	1,292	9	1	10
6010	6,726,206	1,208,445	3,306,269	1,225,201	978,184	2,203,384	1,239	1,109	2,348
6011	16,616	5,546	10,199	3,186	497	3,683	25	8	33
6013	44,642	15,528	18,165	5,049	5,232	10,282	8	7	15
6040	0	0	0	0	0	0	0	0	0
6052	10,156	3,756	6,634	298	2,198	2,497	3	7	10
6053	138,197	20,960	71,194	21,933	15,644	37,576	21	21	42
6054	25,836	2,439	13,561	6,698	1,122	7,820	6	2	8
6055	17,690	6,377	15,698	398	1,594	1,992	1	4	5
6056	515,879	80,535	273,788	80,705	75,212	155,917	336	288	624
6057	1,116,016	232,485	566,110	179,405	151,853	331,258	574	517	1,091
6058	1,427,351	236,213	746,658	250,748	213,538	464,286	446	380	826
6059	855,193	142,173	452,628	145,071	140,586	285,657	266	246	512
6060	87,857	30,458	41,068	9,879	12,664	22,543	19	31	50
6061	131,284	31,482	62,772	20,408	18,674	39,082	39	42	81
6062	23,819	5,348	12,854	1,481	5,164	6,645	3	12	15
6063	1,760	0	1,076	0	684	684	0	1	1
6064	5,590	0	2,900	1,101	1,002	2,103	2	2	4
6065	328,654	85,228	175,541	43,092	48,856	91,948	93	100	193
6066	346,808	77,767	169,775	50,834	53,170	104,004	99	94	193
6067	8,149	0	4,177	2,281	1,060	3,341	2	2	4
6068	108,865	39,886	47,969	16,338	9,950	26,288	26	20	46

Group Benefits Program
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APPENDIX K
Exhibit H

Procedure Code	Billed Charges	Ineligible Expenses	Member Payments	Claim Amount Paid			Number of Services		
				In-Net	Non Net	Total	In-Net	Non Net	Total
6069	83,397	26,381	41,585	8,590	13,103	21,693	11	23	34
6070	8,779	4,813	6,220	475	784	1,259	2	3	5
6071	20,239	10,630	8,221	2,990	986	3,976	6	3	9
6072	3,850	1,925	3,172	0	678	678	0	1	1
6073	1,200	0	760	0	440	440	0	1	1
6074	0	0	0	0	0	0	0	0	0
6075	27,308	11,794	10,268	921	3,825	4,746	2	5	7
6076	19,945	2,200	10,674	1,740	5,176	6,916	2	7	9
6077	0	0	0	0	0	0	0	0	0
6078	237,406	19,562	160,131	15,418	38,405	53,822	5	15	20
6079	26,700	3,264	20,849	1,454	238	1,691	1	2	3
6080	15,825	7,682	7,964	509	1,176	1,685	32	86	118
6081	0	0	0	0	0	0	0	0	0
6090	5,208	1,506	3,099	98	848	945	3	19	22
6092	6,610	2,549	3,283	514	510	1,024	22	29	51
6093	370	0	199	70	19	89	1	1	2
6094	0	0	0	0	0	0	0	0	0
6095	1,287	250	599	218	221	438	2	3	5
6100	30,609	12,595	17,875	3,921	2,476	6,397	28	21	49
6101	9,759	3,050	7,012	675	896	1,571	9	10	19
6102	8,773	2,697	5,834	1,414	692	2,106	5	5	10
6103	7,668	1,617	3,414	1,485	440	1,925	10	4	14
6104	210,132	38,679	107,261	45,059	18,904	63,962	233	126	359
6190	33,344	10,824	17,267	3,164	4,090	7,255	33	48	81
6199	43,580	31,528	30,671	2,499	2,401	4,901	40	48	88
6211	94,774	10,990	49,806	21,150	10,569	31,719	70	32	102
6212	571,083	95,230	305,997	123,085	56,943	180,028	383	194	577
6240	150,125	146,138	51,380	875	0	875	81	59	140
6241	210,664	68,777	83,258	30,798	19,408	50,206	130	65	195
6242	660,095	122,724	295,405	104,466	83,920	188,386	334	212	546
6245	605,348	173,968	284,988	113,541	62,680	176,222	296	175	471
6251	1,250	0	882	0	368	368	0	1	1
6252	3,977	1,557	1,698	952	0	952	4	0	4
6545	7,977	1,279	5,401	915	1,283	2,198	3	6	9
6548	21,385	8,510	9,489	2,869	1,116	3,985	12	9	21
6601	2,916	920	1,238	0	758	758	0	2	2
6609	773	773	0	0	0	0	2	1	3
6722	771	0	386	386	0	386	1	0	1
6740	956,850	275,104	425,722	155,650	92,096	247,746	385	208	593
6751	338,963	112,031	139,972	53,135	28,672	81,807	173	81	254
6752	1,011,354	183,641	477,997	194,907	110,553	305,460	501	267	768
6791	152,752	18,664	75,171	38,399	14,278	52,677	106	43	149
6792	872,728	109,375	449,909	188,499	95,466	283,966	551	293	844
6930	45,162	1,617	24,352	5,584	4,085	9,669	180	127	307
6980	7,142	2,800	1,781	757	242	999	12	7	19
6999	11,016	9,150	9,472	0	706	706	22	21	43
7111	86,524	3,798	40,826	11,519	5,732	17,251	350	162	512
7140	2,608,927	144,130	1,265,865	386,649	284,167	670,816	6,013	3,514	9,527
7210	4,928,536	282,936	2,181,175	909,882	464,441	1,374,324	8,533	3,830	12,363
7220	330,406	35,667	138,428	72,057	30,081	102,138	501	195	696
7230	993,281	98,427	414,871	225,000	93,617	318,626	1,000	386	1,386

Group Benefits Program
Dental PPO Plan Utilization and Cost Experience
FY2016 Experience

Procedure Code	Billed Charges	Ineligible Expenses	Member Payments	Claim Amount Paid			Number of Services		
				In-Net	Non Net	Total	In-Net	Non Net	Total
7240	2,345,727	182,138	925,040	580,542	181,409	761,951	1,377	470	1,847
7241	139,271	14,594	57,649	28,386	15,796	44,182	101	54	155
7250	471,327	21,472	191,840	90,399	37,909	128,308	850	291	1,141
7251	5,143	4,468	4,927	0	216	216	8	4	12
7260	5,808	3,883	3,901	703	0	703	2	3	5
7261	5,862	3,896	2,391	925	0	925	7	4	11
7270	13,011	9,351	1,869	1,379	0	1,379	16	1	17
7272	1,280	640	244	244	0	244	2	0	2
7280	138,109	13,919	60,948	31,380	12,359	43,738	123	59	182
7282	4,444	0	2,068	1,318	156	1,473	11	2	13
7283	35,720	2,448	16,855	8,647	3,225	11,872	84	35	119
7285	16,731	7,732	6,361	3,284	452	3,736	15	9	24
7286	67,588	29,329	23,510	6,069	4,917	10,987	93	91	184
7288	1,324	451	480	173	37	209	3	4	7
7290	3,602	2,552	1,105	467	0	467	5	0	5
7291	569	377	423	0	57	57	0	3	3
7310	129,561	37,718	56,199	18,058	9,839	27,896	187	86	273
7311	50,946	11,175	24,431	10,070	4,794	14,864	96	40	136
7320	18,538	2,526	7,832	3,967	1,902	5,870	23	10	33
7321	4,146	578	1,918	1,298	280	1,578	8	3	11
7410	20,188	3,128	9,584	4,499	1,942	6,441	30	23	53
7411	9,082	835	4,071	2,514	704	3,218	10	6	16
7412	2,095	0	1,475	0	620	620	0	2	2
7450	7,826	1,050	3,855	1,375	1,300	2,675	5	10	15
7451	4,088	0	1,915	1,604	0	1,604	4	0	4
7460	9,835	0	6,688	565	2,582	3,147	2	4	6
7461	145	145	0	0	0	0	0	1	1
7465	960	130	509	56	110	166	6	5	11
7471	21,222	1,448	11,238	6,320	1,624	7,944	16	6	22
7472	3,254	1,039	1,329	0	886	886	1	3	4
7473	47,288	6,328	22,523	10,950	4,612	15,562	36	8	44
7510	32,527	13,703	17,265	3,511	2,036	5,547	87	51	138
7511	2,541	1,109	388	288	0	288	6	1	7
7520	6,437	2,217	1,663	199	250	450	4	2	6
7521	0	0	0	0	0	0	0	0	0
7530	3,183	1,214	1,924	254	332	586	6	6	12
7540	629	514	597	33	0	33	3	0	3
7550	11,325	4,569	4,883	1,338	528	1,866	15	9	24
7620	0	0	0	0	0	0	0	0	0
7670	1,860	1,056	325	275	0	275	2	0	2
7910	1,594	983	1,047	234	20	254	8	11	19
7911	781	781	698	0	0	0	2	3	5
7912	3,090	3,090	0	0	0	0	0	2	2
7950	177,584	66,029	96,308	25,757	10,322	36,078	91	45	136
7951	157,044	48,193	92,211	25,562	16,041	41,602	50	41	91
7952	47,253	10,495	24,539	7,596	4,894	12,490	23	22	45
7953	1,187,361	464,673	584,275	150,268	116,355	266,623	1,152	863	2,015
7955	9,724	7,250	3,113	190	238	428	3	9	12
7960	65,194	9,551	29,140	9,841	8,848	18,689	76	71	147
7963	1,602	200	1,089	264	250	514	2	2	4
7970	2,701	352	1,319	531	227	766	7	4	11

Group Benefits Program
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Procedure Code	Billed Charges	Ineligible Expenses	Member Payments	Claim Amount Paid			Number of Services		
				In-Net	Non Net	Total	In-Net	Non Net	Total
7971	12,286	1,647	5,342	1,698	1,876	3,574	19	14	33
7980	0	0	0	0	0	0	0	0	0
7997	636	75	306	256	0	256	3	0	3
8010	2,186	1,200	1,645	192	253	445	2	1	3
8020	11,241	1,900	6,181	1,575	2,706	4,281	12	13	25
8030	20,076	7,770	7,587	1,824	3,873	5,697	11	24	35
8040	74,395	68,751	67,535	1,050	1,555	2,605	17	26	43
8050	9,138	3,070	5,571	1,454	1,217	2,671	5	7	12
8060	243,235	82,271	91,223	24,917	49,831	74,749	122	188	310
8070	103,131	16,895	51,295	8,297	32,969	41,266	25	100	125
8080	3,883,121	1,634,615	1,707,436	304,876	742,392	1,047,268	829	1,543	2,372
8090	1,087,684	732,502	688,976	75,176	84,588	159,764	248	250	498
8660	16,907	4,244	8,608	2,914	2,720	5,634	58	48	106
8670	6,657,449	1,598,533	3,443,144	865,265	1,459,947	2,325,212	13,212	21,475	34,687
8680	50,919	50,085	49,083	167	250	417	76	61	137
8999	220,846	33,827	109,778	41,423	42,803	84,226	376	406	782
9110	133,171	16,524	36,017	33,924	34,038	67,962	735	582	1,317
9120	22,001	21,826	21,931	0	70	70	77	57	134
9220	445,232	132,731	232,061	81,292	21,977	103,269	792	279	1,071
9221	150,395	29,911	61,833	28,755	8,362	37,117	493	116	609
9223	1,231,180	336,262	640,030	234,766	73,550	308,316	1,617	542	2,159
9243	461,595	461,595	449,226	0	0	0	410	457	867
9310	207,499	10,572	21,219	110,498	32,452	142,950	1,165	488	1,653
9430	21,865	9,748	11,760	4,739	3,585	8,325	221	142	363
9440	7,149	2,726	2,545	1,408	1,031	2,439	22	14	36
9610	77,269	30,012	42,377	10,412	1,746	12,159	719	248	967
9612	70,454	25,853	40,418	13,751	1,878	15,630	591	113	704
9930	1,557	1,046	861	127	0	127	10	3	13
9985	1,351	642	565	233	275	508	39	41	80

Group Benefits Program
Dental Choice Plan Utilization and Cost Experience
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APPENDIX K
Exhibit H

Procedure Code	Billed Charges	Ineligible Expenses	Member Payments	Claim Amount Paid			Number of Services		
				In-Net	Non Net	Total	In-Net	Non Net	Total
120	9,777,587	308,669	1,760,132	3,984,229	1,705,576	5,689,805	139,094	68,044	207,138
140	3,064,875	87,288	481,307	1,314,495	553,393	1,867,888	28,774	13,756	42,530
145	60,935	7,988	15,511	23,746	6,204	29,950	370	187	557
150	3,729,637	162,986	660,539	1,429,316	538,328	1,967,643	33,095	13,378	46,473
160	67,836	10,973	16,953	22,521	14,612	37,133	310	209	519
170	29,923	4,864	9,701	9,586	5,206	14,792	265	183	448
180	233,903	13,746	143,668	16,805	12,063	28,868	1,598	1,000	2,598
210	2,536,692	459,320	541,489	958,400	489,346	1,447,746	14,999	5,912	20,911
220	2,671,778	74,487	243,683	1,128,240	563,961	1,692,201	71,361	28,975	100,336
230	1,883,480	75,733	163,477	807,396	356,933	1,164,329	44,932	15,493	60,425
240	43,879	938	3,444	20,486	10,266	30,752	545	216	761
250	745	29	170	196	287	483	9	7	16
251	2,023	35	0	929	0	929	27	0	27
260	110	110	0	0	0	0	1	1	2
270	99,755	2,310	7,475	45,748	16,363	62,111	2,820	903	3,723
272	1,000,520	34,772	83,174	474,188	196,590	670,778	18,504	6,524	25,028
273	8,499	182	813	3,980	2,546	6,527	109	64	173
274	7,169,409	162,408	648,754	3,019,723	1,699,740	4,719,464	84,678	36,911	121,589
277	318,203	5,976	34,571	98,123	132,278	230,400	1,782	1,807	3,589
330	3,232,921	564,327	708,629	1,231,689	609,564	1,841,253	21,749	8,965	30,714
340	3,566	1,484	1,153	701	643	1,344	17	15	32
1110	18,343,372	709,875	2,150,520	7,925,761	4,918,929	12,844,689	137,739	75,860	213,599
1120	2,602,606	102,378	204,127	1,323,943	464,633	1,788,576	30,375	9,446	39,821
1206	1,093,520	439,688	451,029	472,198	110,700	582,898	19,309	6,656	25,965
1208	1,613,472	402,510	439,967	610,652	217,859	828,511	35,725	13,342	49,067
1351	1,403,317	547,374	525,783	612,728	1,108	613,836	6,023	1,759	7,782
1510	85,190	5,980	6,139	45,679	15,857	61,536	187	56	243
1515	55,045	3,058	2,626	29,042	13,956	42,998	70	40	110
1520	1,039	0	67	532	329	861	2	1	3
1525	931	481	526	0	405	405	0	5	5
1550	1,929	237	187	1,286	120	1,406	21	3	24
2140	1,508,090	22,209	748,384	61,991	629,346	691,337	939	5,948	6,887
2150	2,117,595	34,152	1,010,533	115,359	884,912	1,000,271	1,320	6,164	7,484
2160	860,942	11,691	406,837	45,636	371,515	417,152	465	2,208	2,673
2161	257,459	4,902	132,829	11,510	105,124	116,634	107	551	658
2330	1,518,812	57,075	452,614	416,558	334,223	750,780	4,013	2,769	6,782
2331	1,776,476	65,670	487,464	532,355	363,943	896,297	4,413	2,612	7,025
2332	1,546,459	90,597	378,643	498,357	284,316	782,674	3,213	1,683	4,896
2335	1,116,968	163,715	256,717	318,374	166,315	484,689	2,086	965	3,051
2390	8,957	3,626	1,870	2,016	1,257	3,273	7	13	20
2391	4,771,580	189,990	994,740	2,005,485	362,410	2,367,895	16,285	3,028	19,313
2392	7,547,675	300,640	1,411,991	3,520,491	505,407	4,025,899	20,512	3,851	24,363
2393	2,992,461	110,102	532,310	1,354,285	261,628	1,615,912	7,620	1,568	9,188
2394	691,207	22,674	169,117	226,854	138,129	364,983	1,271	441	1,712
2520	0	0	0	0	0	0	0	0	0
2530	2,300	989	820	0	491	491	0	2	2
2542	8,561	223	4,787	1,803	1,022	2,825	4	5	9
2610	555	0	278	278	0	278	1	0	1
2620	16,522	0	9,019	5,891	562	6,453	20	2	22
2630	17,482	4,910	7,864	1,721-63	3,239	4,965	7	7	14

Group Benefits Program
Dental Choice Plan Utilization and Cost Experience
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APPENDIX K
Exhibit H

Procedure Code	Billed Charges	Ineligible Expenses	Member Payments	Claim Amount Paid			Number of Services		
				In-Net	Non Net	Total	In-Net	Non Net	Total
2642	5,039	0	1,845	1,791	0	1,791	6	0	6
2643	15,224	14,024	2,166	381	0	381	4	5	9
2651	806	0	484	0	322	322	0	3	3
2652	3,234	931	1,601	541	0	541	2	1	3
2710	4,850	450	2,514	2,106	0	2,106	4	1	5
2712	0	0	0	0	0	0	0	0	0
2721	0	0	0	0	0	0	0	0	0
2722	4,397	2,161	2,750	753	74	827	2	1	3
2740	11,143,636	2,118,139	5,135,328	2,048,315	1,226,288	3,274,603	5,035	2,640	7,675
2751	695,528	118,789	314,301	137,341	77,324	214,665	432	225	657
2752	2,728,404	253,705	1,293,537	563,442	345,821	909,264	1,427	816	2,243
2782	71,961	2,465	43,488	10,925	13,888	24,813	23	29	52
2783	40,407	12,565	20,045	4,921	6,317	11,237	10	16	26
2791	897,646	22,642	423,607	219,373	109,741	329,115	636	293	929
2792	17,263,906	1,075,099	8,538,713	3,604,563	2,147,598	5,752,161	9,581	4,864	14,445
2794	2,925	0	1,368	1,109	0	1,109	3	0	3
2910	6,551	3,291	4,433	262	271	533	23	34	57
2915	744	0	431	224	30	254	6	2	8
2920	377,769	15,563	237,761	39,532	23,552	63,084	2,256	1,488	3,744
2930	660,399	48,707	304,890	161,189	51,185	212,374	1,050	352	1,402
2931	30,823	30,823	29,867	0	0	0	60	24	84
2932	2,615	1,024	1,398	599	0	599	7	1	8
2933	51,492	3,974	26,408	11,758	6,284	18,041	37	20	57
2940	81,168	16,668	42,260	15,550	9,532	25,082	478	269	747
2950	4,764,767	370,780	2,196,818	950,140	443,285	1,393,424	11,874	4,954	16,828
2951	8,340	1,944	5,438	1,187	677	1,865	74	51	125
2952	119,172	9,512	58,781	18,886	15,836	34,722	177	124	301
2953	160	0	132	0	28	28	0	1	1
2954	606,659	52,466	277,692	113,318	75,819	189,137	1,123	675	1,798
2955	6,020	5,003	3,673	139	140	279	11	9	20
2971	3,552	1,093	2,210	513	242	755	17	6	23
2980	31,884	1,674	18,360	4,799	6,080	10,879	50	77	127
3220	230,473	13,351	96,047	50,487	17,070	67,556	700	229	929
3221	53,909	6,568	26,840	12,570	2,946	15,516	194	58	252
3222	817	0	544	40	46	86	1	2	3
3230	5,461	1,130	2,808	1,070	448	1,517	7	6	13
3240	16,440	1,022	7,554	4,433	1,140	5,573	37	16	53
3310	1,323,340	67,607	619,544	248,590	178,081	426,671	988	590	1,578
3320	2,337,015	107,091	1,092,260	501,459	292,276	793,735	1,746	946	2,692
3330	5,441,646	198,633	2,608,638	1,149,522	768,359	1,917,881	2,988	1,977	4,965
3331	129,915	105,678	90,264	4,916	685	5,600	328	57	385
3332	71,642	18,468	31,691	13,864	5,519	19,384	106	64	170
3333	5,107	3,572	1,733	216	0	216	10	5	15
3346	132,501	4,511	62,447	24,426	20,290	44,716	65	51	116
3347	213,246	17,461	98,419	44,343	28,162	72,505	114	88	202
3348	854,620	50,839	406,884	190,275	121,149	311,424	355	274	629
3351	1,345	262	765	62	147	208	1	2	3
3352	1,207	377	519	0	276	276	1	4	5
3410	47,856	3,087	24,779	5,655	9,890	15,545	21	27	48
3421	35,024	5,138	17,878	5,511	5,133	10,644	17	17	34
3425	37,006	0	18,440	7,151	5,979	13,132	19	16	35

Group Benefits Program
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APPENDIX K
Exhibit H

Procedure Code	Billed Charges	Ineligible Expenses	Member Payments	Claim Amount Paid			Number of Services		
				In-Net	Non Net	Total	In-Net	Non Net	Total
3426	3,388	928	1,833	719	91	810	7	1	8
3427	1,845	1,845	1,845	0	0	0	1	2	3
3428	8,349	7,469	7,565	186	106	292	11	10	21
3430	23,330	2,814	10,343	4,153	3,266	7,420	45	37	82
3432	2,082	1,762	1,954	0	128	128	3	2	5
3450	8,782	-95	5,903	395	2,368	2,764	2	10	12
3470	950	0	290	290	0	290	1	0	1
3920	785	0	253	253	0	253	2	0	2
4210	16,812	5,068	5,852	2,863	1,039	3,901	16	5	21
4211	60,139	51,513	41,392	732	1,000	1,731	129	85	214
4212	54,854	3,216	28,569	10,706	7,836	18,541	159	109	268
4240	37,425	5,472	13,807	4,523	3,703	8,225	14	16	30
4241	56,322	14,436	25,477	4,112	8,331	12,443	28	50	78
4245	1,705	0	894	646	165	811	3	1	4
4249	218,568	64,060	110,263	31,568	20,538	52,106	174	88	262
4260	423,987	46,160	177,229	71,393	57,992	129,385	113	90	203
4261	361,271	38,682	168,611	46,385	64,405	110,791	124	164	288
4263	207,093	68,103	93,748	20,028	18,552	38,580	171	142	313
4264	25,874	4,797	13,666	5,301	1,606	6,907	33	12	45
4265	135,737	35,133	62,644	17,840	12,569	30,409	153	133	286
4266	430,763	92,312	218,287	87,017	42,346	129,363	395	254	649
4267	83,870	11,879	41,618	14,435	11,867	26,302	71	90	161
4268	1,236	350	679	269	40	309	2	1	3
4270	36,475	18,751	13,526	3,308	3,286	6,594	4	14	18
4273	253,601	51,840	119,278	36,399	35,864	72,262	71	86	157
4274	13,097	6,007	7,962	918	1,732	2,649	7	8	15
4275	124,464	17,441	61,878	10,990	19,261	30,250	29	33	62
4277	68,445	13,127	29,684	5,600	12,864	18,464	17	35	52
4278	21,087	3,912	8,215	3,396	2,818	6,214	8	11	19
4283	79,472	5,205	42,400	14,655	11,544	26,199	28	32	60
4285	67,336	19,168	27,225	8,789	4,720	13,509	22	15	37
4341	4,651,224	341,010	2,081,197	961,800	436,248	1,398,048	5,795	2,189	7,984
4342	1,073,929	76,043	480,542	204,493	91,013	295,506	2,221	858	3,079
4346	61,368	45,580	38,860	3,224	802	4,027	317	93	410
4355	264,879	18,624	164,885	51,929	14,583	66,511	1,139	492	1,631
4381	260,923	210,102	200,411	14,770	2,422	17,192	1,002	379	1,381
4910	4,172,294	194,069	2,182,760	730,846	381,288	1,112,134	19,701	10,662	30,363
5110	625,056	163,129	305,818	99,529	57,350	156,880	295	154	449
5120	227,886	55,186	110,631	43,580	18,071	61,651	134	50	184
5130	598,869	63,087	267,919	126,836	60,275	187,111	289	150	439
5140	358,740	47,557	159,012	77,169	30,166	107,335	194	82	276
5211	199,037	54,767	91,351	28,361	20,333	48,694	111	82	193
5212	164,565	38,837	80,264	25,706	16,783	42,489	91	55	146
5213	1,651,930	411,918	936,817	234,146	120,146	354,291	555	225	780
5214	1,319,945	296,038	667,054	220,153	98,571	318,724	533	197	730
5221	23,803	1,559	11,197	6,332	2,000	8,332	21	7	28
5222	26,041	1,038	10,366	6,339	2,202	8,540	20	8	28
5223	7,107	1,478	3,852	1,037	792	1,829	3	2	5
5224	4,989	1,500	1,622	892	348	1,239	3	1	4
5225	317,885	61,562	133,091	46,915	31,151	78,066	168	72	240
5226	268,713	71,893	111,846	42,749	20,740	63,489	144	58	202

Group Benefits Program
Dental Choice Plan Utilization and Cost Experience
FY2017 Experience

APPENDIX K
Exhibit H

Procedure Code	Billed Charges	Ineligible Expenses	Member Payments	Claim Amount Paid			Number of Services		
				In-Net	Non Net	Total	In-Net	Non Net	Total
5281	55,692	12,070	30,727	9,404	7,425	16,829	38	32	70
5410	4,263	1,433	3,025	499	45	543	39	8	47
5411	3,392	794	2,423	474	123	596	28	13	41
5421	6,055	1,559	4,579	607	225	832	50	23	73
5422	7,811	2,219	5,607	1,066	354	1,420	67	27	94
5510	21,149	1,559	13,618	3,095	1,992	5,088	62	55	117
5520	22,482	613	13,271	4,417	1,779	6,196	67	45	112
5610	36,266	6,089	19,065	7,159	2,458	9,617	132	71	203
5620	7,295	5,170	1,468	660	36	696	23	10	33
5630	13,665	1,343	6,501	2,721	1,529	4,250	36	23	59
5640	46,530	2,554	25,490	9,064	4,622	13,686	139	88	227
5650	147,233	9,077	68,486	25,977	15,929	41,906	377	217	594
5660	19,620	2,360	10,050	4,516	2,108	6,623	57	32	89
5670	0	0	0	0	0	0	0	0	0
5671	600	600	0	0	0	0	1	0	1
5710	12,197	2,408	6,836	859	2,250	3,109	6	14	20
5711	10,191	2,630	6,315	542	2,069	2,611	6	9	15
5720	4,227	1,361	2,645	526	646	1,171	7	3	10
5721	3,143	615	1,947	669	396	1,065	3	3	6
5730	31,068	11,563	21,104	5,235	1,885	7,121	69	32	101
5731	17,659	6,560	12,664	2,593	1,213	3,806	33	22	55
5740	6,883	168	4,251	869	1,219	2,088	10	14	24
5741	3,631	930	1,945	780	182	961	10	7	17
5750	85,008	21,748	54,354	14,595	8,210	22,805	127	86	213
5751	36,441	9,825	23,858	6,318	3,572	9,890	53	40	93
5760	10,348	1,169	6,440	1,986	1,469	3,455	17	12	29
5761	13,558	1,659	8,728	3,036	1,269	4,306	26	12	38
5850	10,872	5,527	8,199	1,060	448	1,508	42	24	66
5851	3,606	1,757	2,636	329	284	613	9	15	24
5875	5,030	150	2,316	452	586	1,038	2	4	6
6010	7,220,541	1,276,150	3,586,955	1,277,080	1,051,701	2,328,781	1,240	1,137	2,377
6011	20,536	8,886	13,439	2,523	736	3,259	32	14	46
6013	42,162	19,466	15,485	4,125	3,937	8,063	9	12	21
6040	3,700	0	2,300	0	1,400	1,400	0	2	2
6052	56,175	27,631	31,185	3,367	1,076	4,443	19	6	25
6053	96,919	17,134	55,270	16,148	15,104	31,252	25	18	43
6054	18,698	2,176	13,722	1,024	3,322	4,346	2	7	9
6055	27,545	19,804	18,067	0	0	0	2	4	6
6056	543,271	121,401	273,149	72,277	74,623	146,900	307	292	599
6057	1,329,329	235,707	651,281	244,009	160,269	404,278	754	532	1,286
6058	1,842,066	303,784	934,590	359,152	238,109	597,262	655	438	1,093
6059	847,778	126,667	450,651	156,244	129,087	285,331	278	245	523
6060	78,297	17,152	43,096	13,746	10,465	24,211	33	23	56
6061	86,915	11,826	47,792	10,817	17,654	28,471	22	38	60
6062	23,780	5,790	9,674	3,379	3,010	6,389	10	8	18
6063	2,728	0	1,592	1,136	0	1,136	2	0	2
6064	0	0	0	0	0	0	0	0	0
6065	338,802	119,449	170,059	30,093	50,066	80,159	67	113	180
6066	261,675	64,493	127,643	33,536	40,569	74,105	68	74	142
6067	6,788	1,070	4,495	807	1,412	2,219	2	5	7
6068	175,852	32,337	95,285	29,561	25,979	55,542	40	28	68

Group Benefits Program
Dental Choice Plan Utilization and Cost Experience
FY2017 Experience

APPENDIX K
Exhibit H

Procedure Code	Billed Charges	Ineligible Expenses	Member Payments	Claim Amount Paid			Number of Services		
				In-Net	Non Net	Total	In-Net	Non Net	Total
6069	76,346	19,378	42,048	6,289	15,500	21,789	9	19	28
6070	12,605	1,750	7,722	3,465	1,058	4,523	4	2	6
6071	12,777	581	7,817	266	4,113	4,379	2	5	7
6072	3,956	1,978	1,187	0	791	791	0	2	2
6073	0	0	0	0	0	0	0	0	0
6074	6,854	2,178	2,677	786	999	1,785	2	1	3
6075	17,966	1,532	7,823	4,130	2,680	6,810	6	5	11
6076	10,008	1,155	5,019	1,944	1,576	3,520	4	2	6
6077	4,872	0	2,813	993	1,066	2,059	1	2	3
6078	272,109	55,439	150,619	17,586	40,248	57,834	8	20	28
6079	10,210	1,890	8,870	0	1,340	1,340	0	3	3
6080	20,193	7,107	12,390	1,349	1,724	3,073	39	90	129
6081	1,068	885	396	40	0	40	4	2	6
6090	7,436	4,135	2,810	340	394	734	6	13	19
6092	6,510	1,742	3,597	688	523	1,211	27	27	54
6093	543	354	247	0	60	60	3	1	4
6094	2,400	0	1,440	0	960	960	0	1	1
6095	1,715	925	732	334	0	334	3	1	4
6100	41,711	31,291	22,810	2,306	1,527	3,833	29	24	53
6101	10,762	827	7,222	504	2,105	2,609	3	14	17
6102	16,478	7,876	9,029	1,892	1,564	3,456	7	12	19
6103	21,074	6,349	9,560	3,714	2,370	6,084	19	16	35
6104	263,542	53,130	137,982	55,072	21,815	76,886	274	153	427
6190	40,224	4,433	21,566	5,865	5,891	11,756	46	56	102
6199	33,323	30,160	24,207	580	619	1,199	44	35	79
6211	72,351	16,758	33,805	14,675	5,788	20,463	52	23	75
6212	647,406	133,082	343,354	126,001	61,166	187,167	412	188	600
6240	95,046	94,504	15,043	0	0	0	60	32	92
6241	136,781	41,056	61,878	18,550	15,238	33,788	82	42	124
6242	605,406	132,204	294,475	99,921	63,909	163,831	333	170	503
6245	849,024	214,428	405,797	173,149	88,411	261,560	392	213	605
6251	1,350	0	918	0	432	432	0	1	1
6252	7,581	338	4,205	1,309	862	2,172	1	2	3
6545	7,919	1,685	5,045	654	1,036	1,690	3	6	9
6548	21,079	7,995	9,093	1,493	2,278	3,770	5	8	13
6601	1,237	1,237	1,237	0	0	0	0	1	1
6609	1,095	0	669	0	426	426	0	2	2
6722	3,804	654	2,206	0	1,086	1,086	1	2	3
6740	1,336,924	372,722	601,559	238,055	110,681	348,736	551	224	775
6751	253,179	86,387	126,189	32,620	25,275	57,895	117	66	183
6752	937,684	215,534	465,250	164,184	98,241	262,425	437	230	667
6791	124,354	21,936	58,721	24,695	12,991	37,686	80	45	125
6792	968,994	173,972	483,646	201,260	90,459	291,718	618	270	888
6930	42,014	566	22,540	5,254	3,843	9,097	158	111	269
6980	3,318	2,046	720	380	44	424	5	4	9
6999	10,571	10,571	10,571	0	0	0	21	16	37
7111	78,542	3,082	37,357	9,978	6,446	16,424	316	132	448
7140	2,466,087	121,693	1,178,484	375,050	257,509	632,559	5,685	3,204	8,889
7210	5,371,454	283,161	2,359,392	999,958	488,103	1,488,061	9,002	3,636	12,638
7220	349,435	44,555	143,472	78,829	27,628	106,457	534	194	728
7230	1,062,315	142,976	418,840	237,741	91,887	329,630	1,076	404	1,480

Group Benefits Program
Dental Choice Plan Utilization and Cost Experience
FY2017 Experience

Procedure Code	Billed Charges	Ineligible Expenses	Member Payments	Claim Amount Paid			Number of Services		
				In-Net	Non Net	Total	In-Net	Non Net	Total
7240	2,450,154	246,687	929,828	588,661	178,214	766,874	1,440	458	1,898
7241	159,806	22,164	59,253	36,110	12,025	48,135	132	44	176
7250	472,950	20,193	185,783	94,029	33,090	127,120	840	257	1,097
7251	7,879	7,879	7,879	0	0	0	6	10	16
7260	8,525	3,368	2,875	981	525	1,506	3	4	7
7261	9,914	4,095	5,954	1,268	825	2,093	12	3	15
7270	3,310	2,220	640	340	0	340	4	5	9
7272	0	0	0	0	0	0	0	0	0
7280	116,419	21,122	57,681	20,922	12,474	33,396	88	65	153
7282	4,739	638	1,582	746	278	1,024	9	3	12
7283	40,713	6,985	16,684	6,930	4,062	10,992	61	44	105
7285	23,633	12,628	7,923	2,892	627	3,520	16	10	26
7286	65,220	27,695	24,486	5,542	5,234	10,775	96	69	165
7288	513	310	140	0	63	63	0	3	3
7290	550	0	275	275	0	275	2	0	2
7291	1,786	709	717	150	142	292	1	4	5
7310	134,062	21,392	51,409	20,306	12,129	32,435	168	84	252
7311	46,000	13,884	20,355	9,458	2,716	12,173	111	32	143
7320	35,877	5,141	16,709	7,694	4,168	11,862	26	16	42
7321	9,034	1,516	4,718	1,901	1,019	2,920	13	7	20
7410	26,223	2,955	13,756	4,661	3,255	7,917	30	35	65
7411	4,838	1,075	1,464	1,364	0	1,364	6	2	8
7412	2,750	0	403	403	0	403	1	0	1
7450	14,040	2,055	6,901	2,446	1,578	4,024	9	6	15
7451	6,602	0	2,920	2,144	451	2,595	5	2	7
7460	6,489	1,385	3,347	675	1,082	1,757	3	7	10
7461	5,555	105	946	922	0	922	5	0	5
7465	5,332	75	2,802	1,850	227	2,077	7	5	12
7471	28,214	5,850	13,503	3,323	4,202	7,525	9	13	22
7472	1,469	0	760	710	0	710	2	0	2
7473	59,456	7,632	22,204	13,796	3,654	17,450	34	13	47
7510	32,755	14,432	18,153	3,405	2,135	5,540	95	48	143
7511	1,961	886	1,315	248	116	364	2	3	5
7520	1,481	225	991	55	210	265	1	5	6
7521	3,106	256	246	246	0	246	1	1	2
7530	2,491	1,129	1,170	405	105	509	8	2	10
7540	1,884	1,884	1,884	0	0	0	1	0	1
7550	7,667	3,717	1,925	1,400	0	1,400	13	6	19
7620	475	0	238	238	0	238	1	0	1
7670	675	675	0	0	0	0	1	0	1
7910	1,825	1,825	1,034	0	0	0	9	3	12
7911	1,575	1,450	1,050	63	0	63	2	4	6
7912	596	250	208	0	138	138	0	2	2
7950	173,065	31,573	72,440	28,543	15,689	44,232	79	41	120
7951	223,527	44,669	103,044	33,555	31,867	65,422	56	69	125
7952	69,116	11,546	31,770	10,243	7,199	17,442	26	23	49
7953	1,334,515	414,554	693,013	214,596	132,706	347,302	1,339	863	2,202
7955	18,709	10,032	5,737	945	0	945	5	7	12
7960	74,074	13,047	34,021	11,281	9,286	20,567	94	69	163
7963	1,571	1,571	0	0	0	0	1	2	3
7970	6,254	1,086	1,765	1,158	99	1,256	10	2	12

Group Benefits Program
Dental Choice Plan Utilization and Cost Experience
FY2017 Experience

Procedure Code	Billed Charges	Ineligible Expenses	Member Payments	Claim Amount Paid			Number of Services		
				In-Net	Non Net	Total	In-Net	Non Net	Total
7971	9,823	1,427	5,167	1,679	1,166	2,845	23	14	37
7980	2,425	0	1,674	376	375	751	1	1	2
7997	2,591	780	1,245	608	0	608	7	4	11
8010	7,415	6,757	4,245	162	126	288	3	2	5
8020	24,621	7,340	11,165	2,527	5,628	8,155	16	29	45
8030	31,229	13,465	12,891	2,884	5,362	8,246	13	23	36
8040	66749	63302	61870.2	621.2	947	1,568	11	17	28
8050	14711	3280	4764.5	2754.4	2272.5	5,027	13	9	22
8060	225200.54	80015.1	97159.84	24184.67	43182.5	67,367	107	166	273
8070	170663	52434.5	64312.46	9918.32	46821.12	56,739	33	128	161
8080	3361300.75	1202561.86	1563947.59	271329.26	740501.24	1,011,831	705	1446	2,151
8090	1100124.58	773308.96	819045.12	65526.81	82355.61	147,882	231	262	493
8660	17737	5316	8572.45	2411.95	3221.5	5,633	67	62	129
8670	6521594.5	1529029.34	3329352.15	807213.72	1495962.99	2,303,177	12304	21718	34,022
8680	55287	55224.5	48771.5	25	0	25	73	53	126
8999	224238	34145	109689.04	39390.61	46528.75	85,919	339	419	758
9110	161521.71	18403.73	52000.93	38397.4	41258.69	79,656	804	618	1,422
9120	26507.7	26507.7	26245.9	0	0	0	87	65	152
9220	3258	3258	0	0	0	0	2	4	6
9221	3058	3058	0	0	0	0	3	3	6
9223	1918371.5	549825.11	963779.07	352080.41	96097.88	448,178	2403	769	3,172
9243	756524.79	755324.79	737707.54	984	0	984	670	701	1,371
9310	249742.67	9920	20244.87	140551.61	33243.93	173,796	1356	456	1,812
9430	24860	16448	17204.2	3088	3016.8	6,105	219	161	380
9440	4958	1757	2172.1	1020	1332.79	2,353	18	20	38
9610	88075.7	33497.7	46587.52	10919.88	2161.2	13,081	787	242	1,029
9612	88811	28797	46369.1	18564.46	2012.8	20,577	714	135	849
9930	2174	1151	930.1	44.5	110.4	155	6	7	13
9985	1234.76	184.58	446.81	156.64	329.9	487	21	37	58

Group Benefits Program
FY2017 Dental PPO Plan Enrollment and Claims by Zip Code

APPENDIX K
Exhibit J

Zipcode	Members			Participants			Incurred and Paid Claims (1)		
	Active	Retiree	Total	Active	Retiree	Total	Actives	Retirees	Total
750	4,226	1,394	5,620	8,181	2,107	10,288	2,766,609	858,259	3,624,868
751	2,854	928	3,782	5,631	1,395	7,026	1,600,977	450,407	2,051,384
752	1,787	634	2,421	2,836	901	3,737	908,696	387,491	1,296,187
753	42	10	52	61	16	77	17,892	3,935	21,827
754	1,266	573	1,839	2,686	891	3,577	695,005	276,887	971,892
755	660	221	881	1,408	352	1,760	292,376	121,303	413,679
756	1,018	502	1,520	2,142	772	2,914	519,571	231,560	751,131
757	2,376	1,023	3,399	4,879	1,541	6,420	1,145,779	501,985	1,647,764
758	2,115	908	3,023	4,014	1,399	5,413	736,815	373,802	1,110,618
759	2,897	888	3,785	5,631	1,331	6,962	1,156,831	330,723	1,487,553
760	2,658	1,135	3,793	5,376	1,688	7,064	1,715,893	623,674	2,339,567
761	2,169	808	2,977	3,940	1,143	5,083	1,229,525	458,217	1,687,742
762	3,824	1,269	5,093	7,331	1,872	9,203	2,493,723	774,420	3,268,144
763	2,657	798	3,455	4,937	1,165	6,102	1,365,497	421,519	1,787,016
764	553	284	837	1,129	460	1,589	238,899	124,217	363,117
765	3,008	1,383	4,391	6,151	2,091	8,242	1,447,127	634,618	2,081,745
766	1,536	642	2,178	2,843	924	3,767	641,892	261,932	903,824
767	978	393	1,371	1,869	566	2,435	500,588	175,265	675,852
768	534	283	817	1,155	424	1,579	232,057	100,217	332,274
769	1,300	425	1,725	2,433	614	3,047	539,964	186,668	726,632
770	8,036	1,999	10,035	13,444	2,903	16,347	4,118,768	1,063,226	5,181,994
771	0	0	0	0	0	0	0	0	0
772	248	79	327	408	118	526	147,461	37,118	184,578
773	6,541	2,317	8,858	12,819	3,588	16,407	3,479,558	1,185,766	4,665,325
774	3,912	1,208	5,120	7,976	1,839	9,815	2,340,218	695,560	3,035,779
775	4,776	1,673	6,449	9,401	2,485	11,886	2,477,077	765,735	3,242,811
776	1,378	607	1,985	2,666	915	3,581	560,353	236,635	796,988
777	1,184	412	1,596	2,123	583	2,706	454,587	162,441	617,029
778	1,859	904	2,763	3,698	1,392	5,090	873,761	386,452	1,260,213
779	850	379	1,229	1,764	593	2,357	352,598	146,698	499,295
780	1,877	831	2,708	3,861	1,319	5,180	797,962	337,766	1,135,728
781	2,170	856	3,026	4,752	1,377	6,129	1,124,600	456,602	1,581,202
782	3,932	1,622	5,554	7,136	2,346	9,482	1,798,694	790,824	2,589,518
783	850	349	1,199	1,773	549	2,322	346,398	130,008	476,406
784	1,198	428	1,626	2,303	613	2,916	489,096	150,941	640,036
785	3,834	886	4,720	7,684	1,384	9,068	1,668,185	375,463	2,043,647
786	10,792	4,800	15,592	22,399	7,275	29,674	6,917,885	2,641,482	9,559,367
787	12,982	5,148	18,130	22,160	7,250	29,410	7,329,342	3,125,618	10,454,960
788	636	249	885	1,314	392	1,706	247,118	90,404	337,522
789	454	289	743	985	438	1,423	265,486	130,602	396,088
790	1,010	303	1,313	2,129	465	2,594	428,726	108,606	537,332
791	1,711	610	2,321	3,372	869	4,241	777,041	256,484	1,033,525
792	459	155	614	945	240	1,185	175,415	68,526	243,941
793	1,153	274	1,427	2,557	439	2,996	583,835	105,217	689,052
794	5,101	1,213	6,314	9,971	1,769	11,740	2,626,826	548,165	3,174,991
795	905	336	1,241	1,848	534	2,382	417,937	125,763	543,700
796	1,231	355	1,586	2,175	550	2,725	504,363	136,232	640,595

Group Benefits Program
 FY2017 Dental PPO Plan Enrollment and Claims by Zip Code

APPENDIX K
 Exhibit J

Zipcode	Members			Participants			Incurred and Paid Claims (1)		
	Active	Retiree	Total	Active	Retiree	Total	Actives	Retirees	Total
797	1,789	540	2,329	3,488	796	4,284	780,579	212,970	993,549
798	259	102	361	530	159	689	105,550	35,135	140,685
799	3,034	742	3,776	5,784	1,069	6,853	1,321,245	276,761	1,598,005
Texas	122,619	44,167	166,786	236,098	65,901	301,999	63,756,383	22,080,295	85,836,678
Other	707	2,896	3,603	1,257	4,109	5,366	312,433	1,530,911	1,843,345
Total	123,326	47,063	170,389	237,355	70,010	307,365	64,068,816	23,611,206	87,680,022

Footnotes:

(1) Claims incurred in FY2017 and paid through 11/30/2017.

Group Benefits Program
Dental PPO Plan Claims Experience for FY2017

<u>Age</u>	<u>Number Contracts</u>	<u>Incurred and Paid Claims</u>	<u>Amount per Emp</u>
Male Active Employees			
<30	6,237	1,075,337	172.41
30-34	5,481	1,141,087	208.19
35-39	5,870	1,227,113	209.05
40-44	5,974	1,224,428	204.96
45-49	6,797	1,464,153	215.41
50-54	5,979	1,517,484	253.80
55-59	5,627	1,649,827	293.20
60-64	4,504	1,489,058	330.61
65-69	2,240	894,146	399.17
70+	1,201	500,729	416.93
All	49,910	12,183,363	244.11
Female Active Employees			
<30	8,418	2,259,744	268.44
30-34	8,715	2,363,663	271.22
35-39	9,149	2,347,451	256.58
40-44	9,029	2,324,144	257.41
45-49	10,063	2,773,201	275.58
50-54	9,530	2,758,391	289.44
55-59	8,786	2,861,141	325.65
60-64	6,297	2,215,804	351.88
65-69	2,538	931,903	367.18
70+	891	297,943	334.39
All	73,416	21,133,386	287.86
All Active Employees			
<30	14,655	3,335,082	227.57
30-34	14,196	3,504,750	246.88
35-39	15,019	3,574,564	238.00
40-44	15,003	3,548,572	236.52
45-49	16,860	4,237,354	251.33
50-54	15,509	4,275,875	275.70
55-59	14,413	4,510,969	312.98
60-64	10,801	3,704,862	343.01
65-69	4,778	1,826,050	382.18
70+	2,092	798,672	381.77
All	123,326	33,316,749	270.15

Group Benefits Program
Dental PPO Plan Claims Experience for FY2017

<u>Age</u>	<u>Number Contracts</u>	<u>Incurred and Paid Claims</u>	<u>Amount per Emp</u>
Spouses of Female Active Employees			
<30	524	142,001	270.99
30-34	1,253	297,010	237.04
35-39	1,790	398,860	222.83
40-44	2,063	455,784	220.93
45-49	2,498	558,808	223.70
50-54	2,536	614,394	242.27
55-59	2,349	682,331	290.48
60-64	1,757	547,287	311.49
65-69	762	287,341	377.09
70+	235	85,327	363.10
All	15,767	4,069,143	258.08
Spouses of Male Active Employees			
<30	704	161,684	229.66
30-34	1,381	343,142	248.47
35-39	1,933	510,049	263.86
40-44	2,281	588,351	257.94
45-49	2,879	706,353	245.35
50-54	2,481	678,942	273.66
55-59	2,470	722,149	292.37
60-64	2,212	736,150	332.80
65-69	1,224	461,818	377.30
70+	761	292,268	384.06
All	18,326	5,200,905	283.80
Spouses of All Active Employees			
<30	1,228	303,685	247.30
30-34	2,634	640,152	243.03
35-39	3,723	908,909	244.13
40-44	4,344	1,044,135	240.36
45-49	5,377	1,265,160	235.29
50-54	5,017	1,293,336	257.79
55-59	4,819	1,404,479	291.45
60-64	3,969	1,283,437	323.37
65-69	1,986	749,159	377.22
70+	996	377,595	379.11
All	34,093	9,270,048	271.90

Group Benefits Program
Dental PPO Plan Claims Experience for FY2017

<u>Age</u>	<u>Number Contracts</u>	<u>Incurred and Paid Claims</u>	<u>Amount per Emp</u>
Children of Male Active Employees			
<30	916	171,483	187.21
30-34	2,708	606,468	223.95
35-39	5,075	1,384,362	272.78
40-44	6,961	1,971,440	283.21
45-49	8,154	2,284,344	280.15
50-54	5,587	1,439,443	257.64
55-59	3,253	855,696	263.05
60-64	1,376	325,157	236.31
65-69	393	100,299	255.21
70+	112	28,059	250.53
All	34,535	9,166,751	265.43
Children of Female Active Employees			
<30	1,633	378,563	231.82
30-34	5,047	1,404,098	278.20
35-39	8,988	2,580,062	287.06
40-44	10,487	2,880,997	274.72
45-49	9,769	2,667,120	273.02
50-54	5,888	1,513,980	257.13
55-59	2,635	661,995	251.23
60-64	794	189,383	238.52
65-69	132	31,925	241.86
70+	28	7,145	255.19
All	45,401	12,315,269	271.26
Children of All Active Employees			
<30	2,549	550,045	215.79
30-34	7,755	2,010,567	259.26
35-39	14,063	3,964,423	281.90
40-44	17,448	4,852,437	278.11
45-49	17,923	4,951,464	276.26
50-54	11,475	2,953,423	257.38
55-59	5,888	1,517,691	257.76
60-64	2,170	514,540	237.12
65-69	525	132,224	251.85
70+	140	35,205	251.46
All	79,936	21,482,020	268.74

Group Benefits Program
Dental PPO Plan Claims Experience for FY2017

<u>Age</u>	<u>Number Contracts</u>	<u>Incurred and Paid Claims</u>	<u>Amount per Emp</u>
Male Active Employees, Spouses and Children			
<30	6,237	1,408,504	225.83
30-34	5,481	2,090,697	381.44
35-39	5,870	3,121,523	531.78
40-44	5,974	3,784,220	633.45
45-49	6,797	4,454,850	655.41
50-54	5,979	3,635,869	608.11
55-59	5,627	3,227,672	573.60
60-64	4,504	2,550,364	566.24
65-69	2,240	1,456,263	650.12
70+	1,201	821,057	683.64
All	49,910	26,551,018	531.98
Female Active Employees, Spouses and Children			
<30	8,418	2,780,308	330.28
30-34	8,715	4,064,771	466.41
35-39	9,149	5,326,373	582.18
40-44	9,029	5,660,925	626.97
45-49	10,063	5,999,129	596.16
50-54	9,530	4,886,765	512.78
55-59	8,786	4,205,467	478.66
60-64	6,297	2,952,474	468.87
65-69	2,538	1,251,169	492.97
70+	891	390,415	438.18
All	73,416	37,517,798	511.03
All Active Employees, Spouses and Children			
<30	14,655	4,188,812	285.83
30-34	14,196	6,155,468	433.61
35-39	15,019	8,447,896	562.48
40-44	15,003	9,445,145	629.55
45-49	16,860	10,453,979	620.05
50-54	15,509	8,522,634	549.53
55-59	14,413	7,433,139	515.72
60-64	10,801	5,502,838	509.47
65-69	4,778	2,707,432	566.65
70+	2,092	1,211,472	579.10
All	123,326	64,068,816	519.51

Group Benefits Program
Dental PPO Plan Claims Experience for FY2017

<u>Age</u>	<u>Number Contracts</u>	<u>Incurred and Paid Claims</u>	<u>Amount per Emp</u>
Male Retirees			
<30	9	1,682	186.87
30-34	1	234	234.14
35-39	2	221	110.57
40-44	14	1,691	120.76
45-49	87	15,262	175.43
50-54	986	224,783	227.97
55-59	1,875	490,112	261.39
60-64	2,917	928,904	318.44
65-69	4,358	1,584,118	363.50
70+	9,302	3,538,116	380.36
All	19,551	6,785,122	347.05
Female Retirees			
<30	14	2,207	157.66
30-34	3	941	313.59
35-39	10	3,062	306.15
40-44	23	5,665	246.29
45-49	73	18,676	255.83
50-54	967	280,085	289.64
55-59	2,637	879,786	333.63
60-64	5,076	1,720,403	338.93
65-69	6,857	2,465,990	359.63
70+	11,852	4,132,568	348.68
All	27,512	9,509,382	345.64
All Retirees			
<30	23	3,889	169.09
30-34	4	1,175	293.73
35-39	12	3,283	273.56
40-44	37	7,355	198.79
45-49	160	33,938	212.11
50-54	1,953	504,868	258.51
55-59	4,512	1,369,897	303.61
60-64	7,993	2,649,307	331.45
65-69	11,215	4,050,107	361.13
70+	21,154	7,670,684	362.61
All	47,063	16,294,504	346.23

Group Benefits Program
Dental PPO Plan Claims Experience for FY2017

<u>Age</u>	<u>Number Contracts</u>	<u>Incurred and Paid Claims</u>	<u>Amount per Emp</u>
Spouses of Female Retirees			
<30	0	0	
30-34	0	0	
35-39	1	69	69.04
40-44	6	353	58.75
45-49	19	4,423	232.79
50-54	234	53,263	227.62
55-59	719	253,716	352.87
60-64	1,531	531,441	347.12
65-69	2,094	736,336	351.64
70+	2,580	862,804	334.42
All	7,184	2,442,403	339.98
Spouses of Male Retirees			
<30	0	0	
30-34	0	0	
35-39	0	0	
40-44	3	262	87.39
45-49	38	7,508	197.59
50-54	416	115,301	277.17
55-59	874	233,769	267.47
60-64	1,430	425,068	297.25
65-69	2,337	892,364	381.84
70+	5,509	1,961,333	356.02
All	10,607	3,635,605	342.76
Spouses of All Retirees			
<30	0	0	
30-34	0	0	
35-39	1	69	69.04
40-44	9	615	68.30
45-49	57	11,931	209.32
50-54	650	168,564	259.33
55-59	1,593	487,484	306.02
60-64	2,961	956,509	323.04
65-69	4,431	1,628,701	367.57
70+	8,089	2,824,136	349.13
All	17,791	6,078,009	341.63

Group Benefits Program
Dental PPO Plan Claims Experience for FY2017

<u>Age</u>	<u>Number Contracts</u>	<u>Incurred and Paid Claims</u>	<u>Amount per Emp</u>
Children of Male Retirees			
<30	12	1,555	129.61
30-34	0	0	
35-39	0	0	
40-44	12	2,704	225.33
45-49	116	27,026	232.98
50-54	899	217,086	241.47
55-59	931	209,786	225.33
60-64	643	153,988	239.48
65-69	365	95,156	260.70
70+	220	54,699	248.63
All	3,198	762,000	238.27
Children of Female Retirees			
<30	5	478	95.64
30-34	0	0	
35-39	9	5,087	565.17
40-44	28	12,305	439.48
45-49	55	10,965	199.36
50-54	510	113,664	222.87
55-59	677	167,002	246.68
60-64	382	95,037	248.79
65-69	173	44,126	255.06
70+	120	28,030	233.58
All	1,959	476,694	243.34
Children of All Retirees			
<30	17	2,034	119.62
30-34	0	0	
35-39	9	5,087	565.17
40-44	40	15,009	375.23
45-49	171	37,991	222.17
50-54	1,409	330,750	234.74
55-59	1,608	376,788	234.32
60-64	1,025	249,025	242.95
65-69	538	139,282	258.89
70+	340	82,730	243.32
All	5,157	1,238,694	240.20

Group Benefits Program
Dental PPO Plan Claims Experience for FY2017

<u>Age</u>	<u>Number Contracts</u>	<u>Incurred and Paid Claims</u>	<u>Amount per Emp</u>
Male Retirees, Spouses and Children			
<30	9	3,237	359.68
30-34	1	234	234.14
35-39	2	221	110.57
40-44	14	4,657	332.62
45-49	87	49,797	572.38
50-54	986	557,169	565.08
55-59	1,875	933,666	497.96
60-64	2,917	1,507,960	516.96
65-69	4,358	2,571,637	590.10
70+	9,302	5,554,148	597.09
All	19,551	11,182,727	571.98
Female Retirees, Spouses and Children			
<30	14	2,685	191.82
30-34	3	941	313.59
35-39	10	8,217	821.71
40-44	23	18,323	796.64
45-49	73	34,063	466.62
50-54	967	447,012	462.27
55-59	2,637	1,300,504	493.18
60-64	5,076	2,346,881	462.35
65-69	6,857	3,246,452	473.45
70+	11,852	5,023,402	423.84
All	27,512	12,428,479	451.75
All Retirees, Spouses and Children			
<30	23	5,923	257.50
30-34	4	1,175	293.73
35-39	12	8,438	703.19
40-44	37	22,979	621.06
45-49	160	83,860	524.13
50-54	1,953	1,004,181	514.17
55-59	4,512	2,234,170	495.16
60-64	7,993	3,854,841	482.28
65-69	11,215	5,818,090	518.78
70+	21,154	10,577,550	500.03
All	47,063	23,611,206	501.69

Group Benefits Program
Dental PPO Plan Claims Experience for FY2017

<u>Age</u>	<u>Number Contracts</u>	<u>Incurred and Paid Claims</u>	<u>Amount per Emp</u>
Male Employees and Retirees			
<30	6,246	1,077,019	172.43
30-34	5,482	1,141,321	208.19
35-39	5,872	1,227,334	209.01
40-44	5,988	1,226,119	204.76
45-49	6,884	1,479,415	214.91
50-54	6,965	1,742,266	250.15
55-59	7,502	2,139,939	285.25
60-64	7,421	2,417,962	325.83
65-69	6,598	2,478,264	375.61
70+	10,503	4,038,846	384.54
All	69,461	18,968,485	273.08
Female Employees and Retirees			
<30	8,432	2,261,951	268.26
30-34	8,718	2,364,604	271.23
35-39	9,159	2,350,512	256.63
40-44	9,052	2,329,809	257.38
45-49	10,136	2,791,877	275.44
50-54	10,497	3,038,476	289.46
55-59	11,423	3,740,927	327.49
60-64	11,373	3,936,207	346.10
65-69	9,395	3,397,893	361.67
70+	12,743	4,430,510	347.68
All	100,928	30,642,768	303.61
All Employees and Retirees			
<30	14,678	3,338,971	227.48
30-34	14,200	3,505,925	246.90
35-39	15,031	3,577,846	238.03
40-44	15,040	3,555,928	236.43
45-49	17,020	4,271,293	250.96
50-54	17,462	4,780,743	273.78
55-59	18,925	5,880,866	310.75
60-64	18,794	6,354,169	338.10
65-69	15,993	5,876,157	367.42
70+	23,246	8,469,356	364.34
All	170,389	49,611,252	291.16

Group Benefits Program
Dental PPO Plan Claims Experience for FY2017

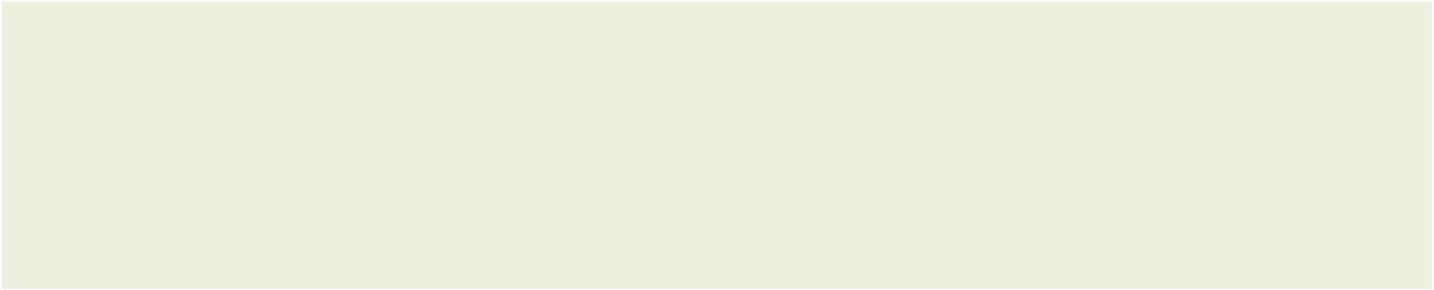
<u>Age</u>	<u>Number Contracts</u>	<u>Incurred and Paid Claims</u>	<u>Amount per Emp</u>
Spouses of Female Employees and Retirees			
<30	524	142,001	270.99
30-34	1,253	297,010	237.04
35-39	1,791	398,929	222.74
40-44	2,069	456,136	220.46
45-49	2,517	563,231	223.77
50-54	2,770	667,657	241.03
55-59	3,068	936,046	305.10
60-64	3,288	1,078,728	328.08
65-69	2,856	1,023,677	358.43
70+	2,815	948,131	336.81
All	22,951	6,511,546	283.72
Spouses of Male Employees and Retirees			
<30	704	161,684	229.66
30-34	1,381	343,142	248.47
35-39	1,933	510,049	263.86
40-44	2,284	588,614	257.71
45-49	2,917	713,861	244.72
50-54	2,897	794,243	274.16
55-59	3,344	955,917	285.86
60-64	3,642	1,161,218	318.84
65-69	3,561	1,354,182	380.28
70+	6,270	2,253,601	359.43
All	28,933	8,836,510	305.41
Spouses of All Employees and Retirees			
<30	1,228	303,685	247.30
30-34	2,634	640,152	243.03
35-39	3,724	908,978	244.09
40-44	4,353	1,044,750	240.01
45-49	5,434	1,277,092	235.02
50-54	5,667	1,461,900	257.97
55-59	6,412	1,891,964	295.07
60-64	6,930	2,239,945	323.22
65-69	6,417	2,377,859	370.56
70+	9,085	3,201,732	352.42
All	51,884	15,348,056	295.81

Group Benefits Program
Dental PPO Plan Claims Experience for FY2017

<u>Age</u>	<u>Number Contracts</u>	<u>Incurred and Paid Claims</u>	<u>Amount per Emp</u>
Children of Male Employees and Retirees			
<30	928	173,038	186.46
30-34	2,708	606,468	223.95
35-39	5,075	1,384,362	272.78
40-44	6,973	1,974,144	283.11
45-49	8,270	2,311,370	279.49
50-54	6,486	1,656,529	255.40
55-59	4,184	1,065,481	254.66
60-64	2,019	479,144	237.32
65-69	758	195,455	257.86
70+	332	82,759	249.27
All	37,733	9,928,750	263.13
Children of Female Employees and Retirees			
<30	1,638	379,041	231.40
30-34	5,047	1,404,098	278.20
35-39	8,997	2,585,148	287.33
40-44	10,515	2,893,302	275.16
45-49	9,824	2,678,085	272.61
50-54	6,398	1,627,644	254.40
55-59	3,312	828,998	250.30
60-64	1,176	284,421	241.85
65-69	305	76,051	249.35
70+	148	35,176	237.67
All	47,360	12,791,964	270.10
Children of All Employees and Retirees			
<30	2,566	552,079	215.15
30-34	7,755	2,010,567	259.26
35-39	14,072	3,969,510	282.09
40-44	17,488	4,867,447	278.33
45-49	18,094	4,989,455	275.75
50-54	12,884	3,284,173	254.90
55-59	7,496	1,894,479	252.73
60-64	3,195	763,565	238.99
65-69	1,063	271,505	255.41
70+	480	117,934	245.70
All	85,093	22,720,714	267.01

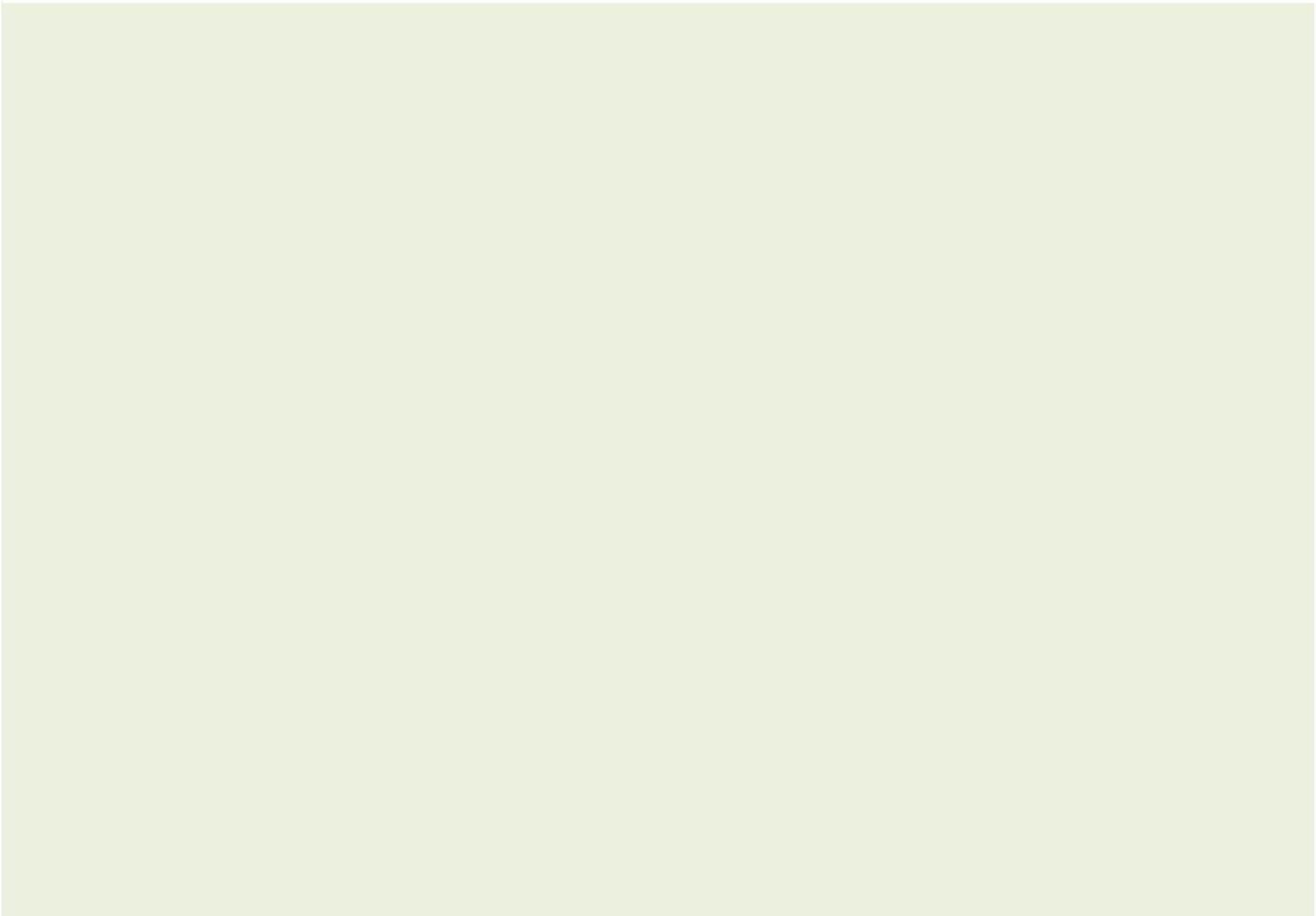
Group Benefits Program
Dental PPO Plan Claims Experience for FY2017

<u>Age</u>	<u>Number Contracts</u>	<u>Incurred and Paid Claims</u>	<u>Amount per Emp</u>
Male Employees and Retirees, Spouses and Children			
<30	6,246	1,392,058	222.87
30-34	5,482	2,044,799	373.00
35-39	5,872	3,010,625	512.71
40-44	5,988	3,656,399	610.62
45-49	6,884	4,354,016	632.48
50-54	6,965	4,066,452	583.84
55-59	7,502	4,141,467	552.05
60-64	7,421	3,975,834	535.75
65-69	6,598	3,697,396	560.38
70+	10,503	5,069,735	482.69
All	69,461	35,408,781	509.76
Female Employees and Retirees, Spouses and Children			
<30	8,432	2,802,676	332.39
30-34	8,718	4,111,844	471.65
35-39	9,159	5,445,710	594.57
40-44	9,052	5,811,725	642.04
45-49	10,136	6,183,823	610.09
50-54	10,497	5,460,364	520.18
55-59	11,423	5,525,842	483.75
60-64	11,373	5,381,845	473.21
65-69	9,395	4,828,126	513.90
70+	12,743	6,719,287	527.29
All	100,928	52,271,241	517.91
All Employees and Retirees, Spouses and Children			
<30	14,678	4,194,734	285.78
30-34	14,200	6,156,643	433.57
35-39	15,031	8,456,334	562.59
40-44	15,040	9,468,124	629.53
45-49	17,020	10,537,839	619.14
50-54	17,462	9,526,815	545.57
55-59	18,925	9,667,309	510.82
60-64	18,794	9,357,679	497.91
65-69	15,993	8,525,522	533.08
70+	23,246	11,789,022	507.14
All	170,389	87,680,022	514.59



APPENDIX L

CONFIDENTIALITY AND NONDISCLOSURE AGREEMENT



STATE OF TEXAS §
 §
COUNTY OF TRAVIS §

**CONFIDENTIALITY AND
NONDISCLOSURE AGREEMENT**

[DENTAL PROVIDER], with its principal place of business at _____ (**Dental Provider**), desires to work with the Employees Retirement System of Texas, whose place of business is located at 200 E. 18th Street, Austin, Texas 78701 (**ERS**), for the purpose of responding to ERS' Request for Proposal to Provide a Dental Preferred Provider Organization and/or Dental Health Maintenance Organization Plan(s) under the Texas Employees Group Benefits Plan (**the RFP**). As part of the RFP, ERS may provide Dental Provider with certain documentation, including, but not limited to, documentation pertaining to participants in the Texas Employees Group Benefits Plan (**GBP**), which information may also include personal and dental health information (**GBP Dental Health Information**).

Although ERS is subject to the Texas Public Information Act, Tex. Gov't Code Ann., ch. 552 (West 2012 and Supp. 2014), ERS maintains documents and information that are considered confidential by ERS and/or by law (**ERS Confidential Information**). The ERS Confidential Information includes, but is not limited to, any and all discussions and communications with ERS and any and all information and documentation provided by ERS, including, but not limited to, information provided by ERS employees, GBP Participants, and current dental vendors. The Confidential Information may also include employees' personal information and information pertaining to ERS' members, retirees, and participants (**Participants**) in any program or retirement system administered by ERS. Further, the Confidential Information also includes, but is not limited to, records and confidential or protected health information (**PHI**), as PHI is defined by the privacy regulations adopted pursuant to the Health Insurance Portability and Accountability Act of 1996 (**HIPAA**) of any or all Participants ("**Participant Confidential Information**"). The GBP Dental Health Information, ERS Confidential Information, Participant Confidential Information, and all discussions and communications with ERS will hereinafter be referred to as "**Confidential Information**."

Dental Provider agrees that all Confidential Information provided and made available to Dental Provider and/or its Related Parties (as hereinafter defined) by ERS must remain confidential and subject to release or disclosure only by prior written consent of ERS, except as provided in this Confidentiality and Nondisclosure Agreement (**Nondisclosure Agreement**). Dental Provider additionally acknowledges and agrees that ERS will require execution of this Nondisclosure Agreement prior to Dental Provider and/or its Related Parties being given access to any Confidential Information.

In consideration of the receipt of information, promises and covenants herein contained, and other good and valuable consideration, the receipt of which is hereby acknowledged by Dental Provider, Dental Provider agrees as follows:

1. The Confidential Information is the exclusive property of ERS and shall be properly safeguarded and kept confidential as required by this Nondisclosure Agreement and any and all other applicable Texas and federal laws and regulations including, but not limited to, Tex. Gov't Code Ann. §§ 552.0038, 552.110, 552.143, 615.045, 803.402, 815.503 and 840.402 (West 2012) and 2054.077 (West Supp. 2014); Tex. Ins. Code, § 1551.063 (West Supp. 2014); HIPAA, the HIPAA Privacy Rule, the HIPAA Security Rule and the Health Information Technology for Economic and Clinical Health Act (**HITECH**).
2. Dental Provider warrants and represents that (a) it has systems, measures and procedures in place to safeguard and maintain, and to cause its employees, temporary workers, officers, directors, principals, affiliates, agents, assigns, independent contractors, subcontractors, successors or any other related person or entity (**Related Parties**) to safeguard and maintain the confidentiality of the Confidential Information at all times; and (b) Dental Provider and the Related Parties shall

safeguard and maintain the confidentiality of the Confidential Information at all times in accordance with this Nondisclosure Agreement and applicable law.

3. The Confidential Information may be used by Dental Provider and/or its Related Parties only as necessary to prepare Dental Provider's response to the RFP. Dental Provider may not assign or subcontract any of its obligations under this Nondisclosure Agreement.
4. Dental Provider and the Related Parties shall not copy, reproduce, distribute, disseminate, sell, assign, release, convey, provide, give away or otherwise provide the Confidential Information to any person or entity without ERS' prior written consent and except as is absolutely necessary for the RFP. This entire paragraph shall survive any termination, expiration, renewal, extension or amendment of this Nondisclosure Agreement.
5. Dental Provider warrants and represents that any Confidential Information transmitted by it or the Related Parties shall be disseminated in an encrypted fashion readable to ERS.
6. Dental Provider and the Related Parties warrant and represent that they shall not in any manner contact ERS' employees or make use of the Confidential Information to contact ERS' employees unless directed to do so by ERS.
7. Dental Provider and the Related Parties may not retain any copies, electronic or otherwise, of the Confidential Information.
8. This Nondisclosure Agreement and the parties' performance of same and all matters in connection with the relationship of the parties shall be governed by and construed and performed in accordance and conformity with the laws of the state of Texas without regard to conflicts of law provisions. Subject to and without waiving ERS' or the state of Texas' sovereign or official immunity, ERS and Dental Provider agree and consent to Austin, Travis County, Texas as the proper venue for any court proceedings between the parties, and that a Texas state court sitting in Austin, Travis County, Texas shall have jurisdiction in connection with any action or proceeding arising out of, in connection with or related to the Nondisclosure Agreement or the parties' relationship. Dental Provider and/or its Related Parties shall not, at any time, use the Confidential Information in any fashion, form or manner except in Dental Provider's capacity as independent contractor to ERS and as described herein. This entire paragraph shall survive any termination, expiration, renewal, extension or amendment of this Nondisclosure Agreement.
9. In addition to any other rights and remedies available to ERS under this Nondisclosure Agreement, at equity or pursuant to applicable statutory, regulatory and common law, the breach of this Nondisclosure Agreement by Dental Provider and/or its Related Parties shall entitle ERS to immediately terminate the Contract and Dental Provider's and/or its Related Parties' right of access to and possession of the Confidential Information pursuant to the terms of this Nondisclosure Agreement. In the event that ERS terminates Dental Provider's and/or its Related Parties' right of access to the Confidential Information, ERS shall provide written notice to Dental Provider that all Confidential Information made available to Dental Provider and/or its Related Parties pursuant to this Nondisclosure Agreement, or to which Dental Provider and/or its Related Parties have been provided access pursuant to this Nondisclosure Agreement, including in each event all copies thereof, must be returned to ERS as soon as reasonably possible after Dental Provider's receipt of such notice from ERS. This entire paragraph shall survive any termination, expiration, renewal, extension or amendment of this Nondisclosure Agreement.
10. **Due to the sensitive nature of the Confidential Information that ERS is providing to Dental Provider, Dental Provider agrees to defend, indemnify, save and hold harmless the state of Texas, its past, present and future officers, departments, employees and agencies, ERS, its past, present and future officers, directors, trustees, employees, attorneys, and agents, from and against any and all damages and claims of contribution and indemnity, any other**

claims, lawsuits, settlements, liability, judgments, costs, penalties, losses and expenses of whatever nature, kind or description, of any person or entity whomsoever, including, without limitation, interest, court costs, attorney fees, and any measure or type of damages (collectively "Claims, Liability and/or Damages"), resulting from, alleged to result from, in connection with, arising out of, or related to:

- A. Any intentional or negligent failure, refusal or inability of Dental Provider or the Related Parties to meet or comply with any of their obligations under this Nondisclosure Agreement.
- B. Any other malfeasance, misfeasance, omission or act of negligence on the part of Dental Provider and the Related Parties in meeting such obligations, including improperly disclosing to any person or entity the Confidential Information or for any intentional or malicious act in violation of such obligations.

This indemnification includes, but is not limited to, any and all Claims, Liability and/or Damages resulting from, alleged to result from, arising out of or in connection with alleged negligence or intentional wrongdoing by Dental Provider or the Related Parties and all Claims, Liability and/or Damages resulting from, alleged to result from, arising out of or in connection with Dental Provider's or the Related Parties' failure or inability to comply with applicable Texas and federal laws and regulations. This provision shall not be construed to eliminate or reduce any other indemnification or right which ERS has in law, contract or equity. This obligation to indemnify shall survive any termination, renewal or amendment of the Nondisclosure Agreement.

- 11. Dental Provider warrants and represents that it has full power and authority to enter into this Nondisclosure Agreement, and that the Nondisclosure Agreement has been duly authorized, executed and delivered by Dental Provider's authorized officer on behalf of Dental Provider and constitutes a valid, binding, and legally enforceable agreement of Dental Provider.
- 12. **Dental Provider warrants and represents that it will give immediate notice to ERS of any breach of this Nondisclosure Agreement.**
- 13. Any notices required pursuant to this Nondisclosure Agreement shall be given by hand-delivery, facsimile or email to:

A. **Dental Provider at:**

[name]
[address]
[city, state, zip]
Attn:
Telephone:
Fax:
Email:

B. **ERS at:**

Employees Retirement System of Texas
P.O. Box 13207
Austin, Texas 78711-3207
Attn: Porter Wilson, Executive Director
Email: porter.wilson@ers.texas.gov

cc: Paula A. Jones, Deputy Executive Director and General Counsel
Fax: (512) 867-3480
Email: paula.jones@ers.texas.gov

14. This Nondisclosure Agreement shall become effective as of the date Confidential Information is first made available to Dental Provider and/or its Related Parties, and shall survive so long as Dental Provider has any Confidential Information in its possession, including originals, copies or otherwise.
15. Without limiting the obligations of Dental Provider and/or its Related Parties to comply with the terms of this Nondisclosure Agreement, Dental Provider agrees that Confidentiality Acknowledgements in the form attached to this Nondisclosure Agreement shall be executed by any person that works on the RFP and/or that has access to Confidential Information.
16. Dental Provider agrees to monitor the performance of all persons having access to the Confidential Information on its behalf, and to be liable for the actions of all such persons.
17. This Nondisclosure Agreement may be executed and delivered by email; such email delivery shall constitute the final Nondisclosure Agreement of the parties and conclusive proof of such Nondisclosure Agreement.

The authorized representative of Dental Provider hereby executes this Nondisclosure Agreement to be fully effective immediately upon execution and by doing so evidences its intent to be legally bound by the terms set out above.

DENTAL PROVIDER

By: _____
Printed Name: _____
Title: _____
Legal Name of Dental Provider: _____

Date: _____

CONFIDENTIALITY ACKNOWLEDGMENT

I, _____, hereby acknowledge that I received a copy of the Confidentiality and Nondisclosure Agreement (**Nondisclosure Agreement**) relating to the agreement between the Employees Retirement System of Texas (**ERS**) and _____ (**Dental Provider**) with regard to the RFP and Dental Provider's access to ERS' Confidential Information, as Confidential Information is defined in the Nondisclosure Agreement. I acknowledge and agree that I may have access to ERS' Confidential Information as defined in the Nondisclosure Agreement, and I agree not to copy, reproduce, distribute, disseminate, sell, assign, release, convey, provide, give away or otherwise provide, give away or otherwise provide any Confidential Information without the express written permission of ERS and except as absolutely necessary to prepare Dental Provider's response to the RFP.

Signature

Printed Name

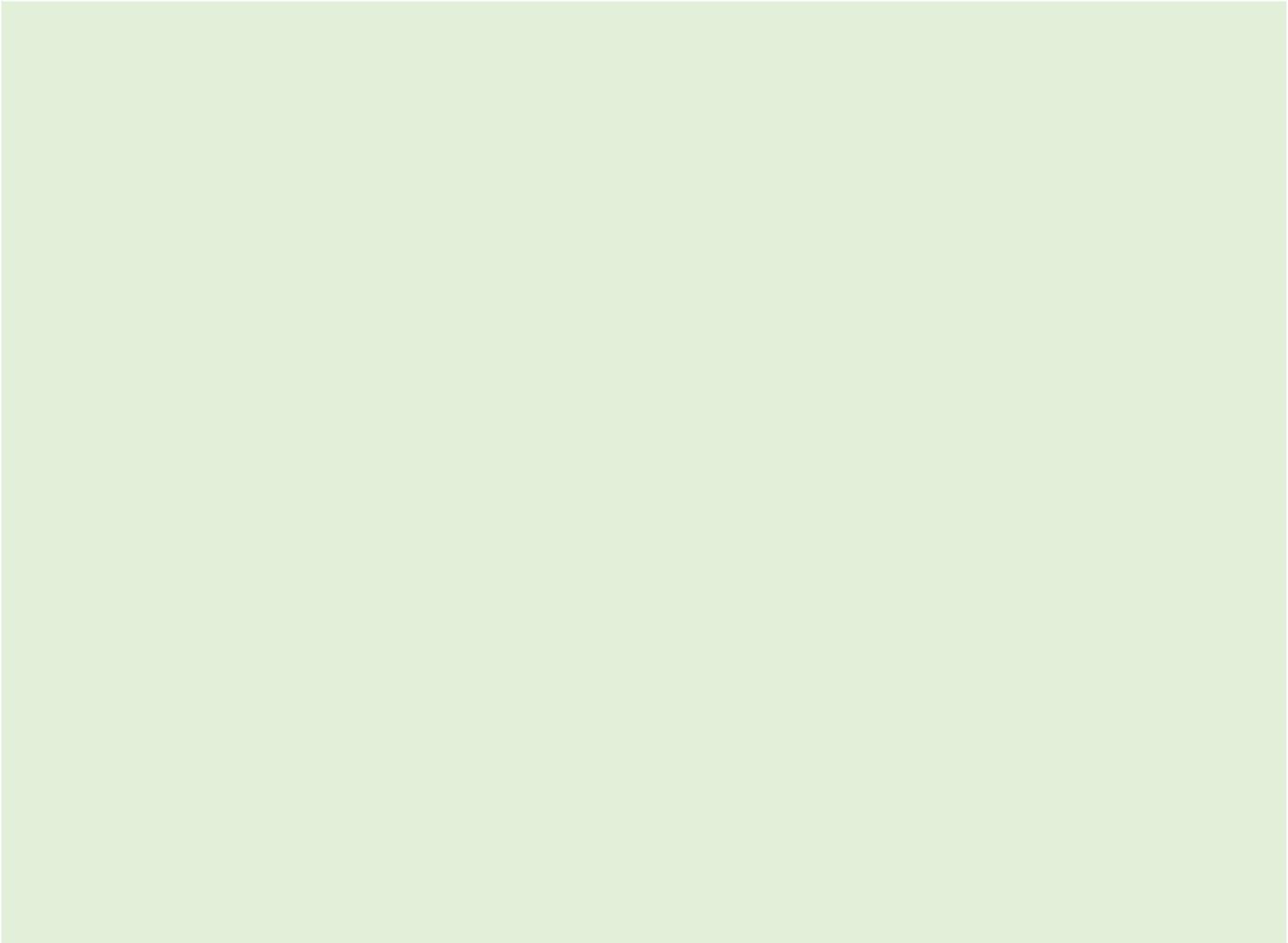
Title

Date



APPENDIX M

MINIMUM REQUIREMENTS



MINIMUM REQUIREMENTS

Respondents must meet all of the Minimum Requirements listed below. Failure to satisfy the Minimum Requirements shall result in the disqualification of Respondent's Proposal. ERS will not accept deviations to the Minimum Requirements.

A. Licenses and Certifications

A.1. Respondent shall confirm that it holds, and will continue to hold, all required business and professional licenses and/or certifications necessary to provide the Dental services during the Contract Term, as applicable. Confirm

A.1.a. If applicable, please provide a copy of each business or professional license and/or certification with Respondent's Proposal, including Respondent's current Texas license.

B. Experience

B.1. Respondent shall confirm that it has been providing Dental PPO or DHMO (or both Dental PPO and DHMO if bidding on both) services to group benefit plans for a period of no less than three (3) years to at least one client, public sector and/or private organization, with no less than 50,000 eligible covered employees. Confirm

B.2. Provide the date that Dental PPO and/or DHMO third-party administrative services were first underwritten and/or administered by Respondent.

B.3. Provide the number of participants managed by Respondent as of:

	January 1, 2016	January 1, 2017	January 1, 2018
Number of eligible covered employees			

C. Provider Network

C.1. Respondent shall confirm it has a dental provider network as of Proposal submission date and throughout the entire State as follows:

- **For the PPO:** Respondent shall provide access to dental care for at least 310,000 Participants with a minimum of 3,500 dentists, dental practice facilities or clinics.

Confirm

- **For the PPO:** Respondent does not use leased networks to meet the requirements of the RFP, and further confirms contractual arrangements relied upon to meet the requirements of the RFP are directly between Respondent and contracting dentist, specialist, group practice, DSO and/or facility. Confirm

- **For the DHMO:** Respondent shall provide access to dental care for at least 128,000 Participants with a minimum of 500 dental facilities and/or DSOs. Confirm

- **For the DHMO:** Respondent does not use leased networks to meet the requirements of the RFP, and further confirms contractual arrangements relied upon to meet the requirements of the RFP are directly between Respondent and contracting dentist, specialist, group practice, DSO and/or facility.

Confirm

D. Net Worth

D.1. If Respondent is bidding on the **PPO Plan only:**

Respondent shall confirm that it has a current net worth of \$50 million, with a minimum of at least \$20 million, in cash and cash equivalents available (on average) as demonstrated by an audited or reviewed financial statement at the close of Respondent's most recent Fiscal or Calendar Year. Confirm

D.1.a. Respondent shall complete the following table to show its current net worth as demonstrated by an audited or reviewed financial statement at the close of Respondent's most recent Fiscal or Calendar Year for the most recent two (2) years. Respondent shall disclose if the information provided is Respondent's or its sponsors, or parent organization/entity's financial information by checking the appropriate box below. Doing so implies Respondent's ability to rely on the financials of the identified organization.

Respondent's Financial Information:

Sponsor or parent organization/entity's financial information:

	FY/CY _____	FY/CY _____
Current Assets		
Total Assets		
Current Liabilities		
Total Liabilities		
Total Equity		
Cash Flow from Operations		
Cash and Cash Equivalent		

D.2. If Respondent is bidding on the **DHMO Plan only:**

Respondent shall confirm is has a current net worth of \$30 million, with a minimum of at least \$10 million, in cash and cash equivalents available (on average) as demonstrated by an audited or reviewed financial statement at the close of Respondent's most recent Fiscal or Calendar Year. Confirm

D.2.a. Respondent shall complete the following table to show its current net worth as demonstrated by an audited or reviewed financial statement at the close of Respondent's most recent Fiscal or Calendar Year for the most recent two (2) years. Respondent shall disclose if the information provided is Respondent's or its sponsors or parent organization/entity's financial information by checking the appropriate box below. Doing so implies Respondent's ability to rely on the financials of the identified organization.

Respondent's Financial Information:

Sponsor or parent organization/entity's financial information:

	FY/CY _____	FY/CY _____
Current Assets		
Total Assets		
Current Liabilities		
Total Liabilities		
Total Equity		
Cash Flow from Operations		
Cash and Cash Equivalent		

D.3. If Respondent is bidding on **both the PPO and DHMO:**

Respondent shall confirm it has a current net worth of \$50 million, with a minimum of at least \$20 million, in cash and cash equivalents available (on average) as demonstrated by an audited or reviewed financial statement at the close of Respondent's most recent Fiscal or Calendar Year. Confirm

D.3.a. Respondent shall complete the following table to show its current net worth as demonstrated by an audited or reviewed financial statement at of the close of Respondent's most recent Fiscal or Calendar Year for the most recent two (2) years. Respondent shall disclose if the information provided is Respondent's, its sponsors or parent organization/entity's financial information by checking the appropriate box below. Doing so implies Respondent's ability to rely on the financials of the identified organization.

Respondent's Financial Information:

Sponsor or parent organization/entity's financial information:

	FY/CY _____	FY/CY _____
Current Assets		
Total Assets		
Current Liabilities		
Total Liabilities		
Total Equity		
Cash Flow from Operations		
Cash and Cash Equivalent		

APPENDIX N

LEGAL REQUIREMENTS AND REGULATORY COMPLIANCE DEVIATIONS AND INTERROGATORIES

Legal Requirements and Regulatory Compliance Deviations and Interrogatories

Respondent shall review the Deviation and Interrogatory instructions referenced at RFP Sections I.D.2. and I.D.3. Respondent shall review and complete the Interrogatories listed below by providing Respondent's answer following each question. **Respondent shall complete both PPO and DHMO sections if Respondent will be providing both plans. If Respondent is not providing services for both plans, then Respondent only needs to provide its Responses to either the PPO or DHMO sections.**

PPO RESPONSES

A. Deviations – Contractual Matters - PPO

Review the Deviation instructions referenced below.

- A.1. Respondent shall provide its Deviations to the Contractual Agreement, BAA, and DSBNA by providing redlined changes within the forms provided in **Appendices B, C, and D** and in accordance with the specifications provided within the RFP Section VI.A.3.
- A.2. Respondent shall provide its Deviations to the Performance Guarantees by providing redlined changes within **Appendix G** and in accordance with the specifications provided within RFP Sections VI.A.8. – VI.A.8.c.

B. Interrogatories - Legal Services and Litigation - PPO

Deviations to this Section are not permitted.

- B.1. Respondent shall provide legal services and litigation support. Legal services and litigation support include, but are not limited to, Respondent assisting and supporting ERS in administrative hearings, appeals, and court proceedings by providing records, affidavits, and may include witness testimony. Respondent shall provide its own legal representation in administrative hearings, lawsuits, and subrogation-related suits when appropriate. Respondent shall coordinate its legal services and legal support with ERS' Office of General Counsel. Confirm
- B.1.a. For the past five (5) years, describe:

Any completed and/or pending state or federal litigation, whether civil or criminal, including all suits, actions, or prosecutions, and any state or federal regulatory or other proceedings, investigations, disciplinary actions, violations of the rules of any self-regulatory organization, license revocations and/or governmental inquiries against Respondent that resulted in a felony conviction and/or included any allegations of criminal conduct, fraud, corrupt practices, violations of fiduciary duties, and/or intentional torts involving any allegations of moral turpitude by providing the information requested below, as applicable, for each such matter.
- B.1.a.i. Any completed and/or pending state or federal litigation, whether civil or criminal, including all suits, actions, or prosecutions, and any state or federal regulatory or other proceedings, investigations, disciplinary actions, violations of the rules of any self-regulatory organization, license revocations and/or governmental inquiries against Respondent's officers, directors, parent companies, affiliates, subcontractors and any persons identified by Respondent who will be performing any services required under the RFP and Contract that resulted in a felony conviction and/or included any allegations of criminal conduct, fraud, corrupt practices, violations of fiduciary duties, and/or intentional torts involving any allegations of moral turpitude by providing the information requested below, as applicable, for each such matter.

Provide the following information for each matter identified in interrogatory B.1.a. and B.1.a.i. above:

Case number:
Date filed:
Full style of matter:
Court:
County, District and State:
State or Federal Regulatory Body, Attorney General or other law enforcement or applicable governmental body:
Brief summary of the dispute:
Current status:
Resolution:



Respondent shall not refer ERS to any third-party websites or other sources in order for ERS to obtain this information.

B.1.b. If Respondent did not provide any information for the preceding question, confirm that Respondent (including its officers, directors, parent companies, affiliates, subcontractors and any persons identified by Respondent who will be performing any services required under the RFP and Contract) has not been the subject of any completed and/or pending or threatened state or federal litigation, whether civil or criminal, including any suit, action, or prosecution, or any state or federal regulatory or other proceeding, investigation, disciplinary action, violations of the rules of any self-regulatory organization, license revocations and/or governmental inquiry) that resulted in a felony conviction and/or included any allegations of criminal conduct, fraud, corrupt practices, violations of fiduciary duties, and/or intentional torts involving any allegations of moral turpitude for the past five (5) years. Confirm

B.1.c. Confirm that Respondent shall notify ERS whenever Respondent is involved in litigation that directly involves the plans and/or services associated with the Dental PPO plan and/or Participants. Confirm

B.1.d. Provide a schedule and describe in detail previous contract implementation breakdowns, performance assessments, contract disputes resulting in suit or settlement and/or contract breaches for the **past five (5) years** (if any) by Respondent and discuss all measures Respondent took to rectify the situation or remedy the breach. Please separate by governmental and non-governmental clients indicating the reason for the assessment and the amount paid. **List in most recent chronological order.**

Governmental:
Non-governmental:
Action taken to resolve issue:
Assessment amount paid:



B.1.e. If the Respondent did not provide a schedule of contract implementation breakdowns, performance assessments or contract disputes as outlined in interrogatory B.1.d. above, confirm that Respondent has not been involved in any contract implementation breakdowns, performance assessments or contract disputes described in interrogatory B.1.d. above. Confirm

B.1.f. Provide a schedule and describe in detail successfully completed agreements, negotiations, mergers, acquisitions or sale of Respondent's organization from the **past five (5) years** (if applicable). This should include any joint ventures or other financial arrangements regarding a change in ownership of Respondent's organization. 

B.1.g. Does Respondent have any pending agreements, negotiations, and/or offers to merge or sell Respondent’s organization? This should include any joint ventures or other financial arrangements regarding a pending change in ownership of Respondent’s organization that could affect the services described in Respondent’s Proposal or affect Respondent’s organizational financial liability to meet its obligations under a Contract with ERS.
 Yes No

If the answer to this question is “Yes,” describe. [Redacted]

B.1.h. Does Respondent have any obligation or arrangement to purchase another entity that would involve substantial commitment of assets or capital? Yes No

If the answer to this question is “Yes,” describe, including an outline of the anticipated timelines. [Redacted]

C. Interrogatories - Regulatory Compliance - PPO

Deviations to this Section are not permitted.

C.1. As a business associate of ERS, Respondent shall comply with all privacy and security protections as provided in Tex. Health & Safety Code Ann. Chapter 181 (West Supp. 2015) and in HIPAA. Confirm

C.2. Respondent is and shall stay in compliance with the requirements of all state and federal privacy rules and regulations. Confirm

C.3. Respondent is not presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded from contracting with any federal, state or local department or agency. Confirm

C.4. Describe in detail Respondent’s policies, procedures and/or systems used to ensure compliance with HIPAA and state privacy laws. [Redacted]

C.4.a. Provide a full description of any HIPAA violations (such as unauthorized disclosures) alleged against Respondent during the past five (5) years. For each HIPAA violation, Respondent’s description shall include, but not be limited to:

The identity of the entity that made the complaint:	[Redacted]
The date the complaint was made:	[Redacted]
A description of the complaint:	[Redacted]
The date the complaint was resolved:	[Redacted]
Any fines or penalties assessed against Respondent:	[Redacted]
The regulatory body that assessed any such claim:	[Redacted]
How the complaint was resolved:	[Redacted]

C.4.b. Provide a description of any HIPAA breach involving notification to the affected individual during the past five (5) years. These may be summarized, but should give ERS a clear understanding of the number of breaches, the number or affected Participants per breach, the types of actions that led to the breaches, and any mitigation completed by Respondent to prevent such breaches in the future. [Redacted]

- C.4.c. For the five (5) year period preceding the Proposal, provide a brief description of any violations alleged against Respondent with regard to any state or federal privacy laws and/or regulations (for example, Tex. Bus. and Com. Code Chapter 521). [REDACTED]
- C.4.d. Describe and confirm the validity of any license(s) that Respondent or its employees, independent contractors, or subcontractors are required to maintain.
- C.4.e. Provide the following information for the organization(s) that will be contracting with ERS. This must include the entity holding any license required to provide the services.
1. Provide a copy of each entity's Certificate of Formation (including any amendments).
 2. If not formed in Texas, provide a corporate charter or other equivalent formation document (including any amendments) from the jurisdiction of formation.
 3. Provide a copy of any assumed name certificates filed in Texas.

Organization full legal name:	
Physical address of principal place of business:	
Mailing address (if different):	
Telephone number:	
Website Address:	

- C.4.f. **Authorized Representatives.** Provide the following information for Respondent's Authorized Representatives. This shall include, at a minimum, the individuals listed on the Incumbency Certificate discussed at RFP Section VI.A.2.

Name:	
Title:	
Mailing address:	
Email address:	
Telephone number:	

- C.4.g. Provide Respondent's evidence of good standing in its jurisdiction of incorporation or formation. (For example, a Certificate of Good Standing from the State of Delaware.) [REDACTED]
- C.4.h. Respondent must be authorized to do business in Texas and be in good standing in the state in which it was incorporated or formed. Confirm
- C.4.i. If Respondent was not formed in Texas, provide evidence of Respondent's Certificate of Authority to conduct business in Texas.
- C.4.j. Provide Respondent's Texas Franchise Tax Account Status Report.
- C.4.k. Respondent will provide the following information:

State in which Respondent incorporated or formed:	[REDACTED]
Year in which Respondent incorporated or formed:	[REDACTED]
Year in which Respondent became authorized to do business in Texas, if Texas is not its jurisdiction of incorporation or formation:	[REDACTED]
Federal Identification Number:	[REDACTED]
Texas Identification Number:	[REDACTED]

Respondent will be required to submit an application for Texas Identification Number should it be awarded the Contract if it does not already have one. That application may be obtained at:

<https://comptroller.texas.gov/taxes/permits>

C.4.l. Has Respondent ever had its authority to conduct business in any state revoked, cancelled, suspended or forfeited? Yes No

If yes, explain.

C.4.m. As stated at RFP Section VI.A.6., ERS retains the right to have its data excluded from any type of data sharing arrangement. In order for ERS to better understand Respondent's background and business structure, Respondent shall provide the following information if it sells or reports any data from its current clients to others, either specifically or in aggregate:

The arrangements for the data sharing;	
The details of what data was shared, including how it is masked; and	
The measures taken to ensure the information is not identifiable.	

C.4.m.i. Respondent shall confirm, unless specifically authorized in writing by ERS, it shall not share ERS data or include ERS data in any data sharing arrangement. Confirm

C.4.n. **Ratings.** Provide copies of ratings and reports on Respondent issued by independent rating organizations or similar entities, such as those issued by A.M. Best's, Moody's, Standard and Poor's. If any such reports are not provided, please explain why not.

C.4.o **Previous State Employment.** Pursuant to Tex. Gov't Code Sec. 572.069, if any of the individuals who will perform the services specified in the RFP or in the Contract have been employed by ERS at any time during the two (2) years preceding Proposal submission date or, in the case of a former Executive Director of ERS during the preceding four (4) years of the Proposal submission date, state the following:

Name of individual:	
Nature of previous employment:	
Date of termination:	

DHMO RESPONSES

D. Deviations – Contractual Matters - DHMO

Review the Deviation instructions referenced below.

D.1. Respondent shall provide its Deviations to the Contractual Agreement, BAA, and DSBNA by providing redlined changes within the forms provided in **Appendices B, C, and D** and in accordance with the specifications provided within the RFP Section VI.A.3.

D.2. Respondent shall provide its Deviations to the Performance Guarantees by providing redlined changes within **Appendix G** and in accordance with the specifications provided within RFP Sections VI.A.8. – VI.A.8.c.

E. Interrogatories - Legal Services and Litigation - DHMO

Deviations to this Section are not permitted.

E.1. Respondent shall provide legal services and litigation support. Legal services and litigation support include, but are not limited to, Respondent assisting and supporting ERS in court proceedings by providing records, affidavits, and witness testimony. Upon the request of ERS, Respondent may have to provide its own legal representation in lawsuits when appropriate. Respondent shall coordinate its legal services and legal support with ERS' Office of General Counsel. Confirm

E.1.a. For the past five (5) years, describe:

Any completed and/or pending state or federal litigation, whether civil or criminal, including all suits, actions, or prosecutions, and any state or federal regulatory or other proceedings, investigations, disciplinary actions, violations of the rules of any self-regulatory organization, license revocations and/or governmental inquiries against Respondent that resulted in a felony conviction and/or included any allegations of criminal conduct, fraud, corrupt practices, violations of fiduciary duties, and/or intentional torts involving any allegations of moral turpitude by providing the information requested below, as applicable, for each such matter.

E.1.a.i. Any completed and/or pending state or federal litigation, whether civil or criminal, including all suits, actions, or prosecutions, and any state or federal regulatory or other proceedings, investigations, disciplinary actions, violations of the rules of any self-regulatory organization, license revocations and/or governmental inquiries against Respondent's officers, directors, parent companies, affiliates, subcontractors and any persons identified by Respondent who will be performing any services required under the RFP and Contract that resulted in a felony conviction and/or included any allegations of criminal conduct, fraud, corrupt practices, violations of fiduciary duties, and/or intentional torts involving any allegations of moral turpitude by providing the information requested below, as applicable, for each such matter.

Provide the following information for each matter identified in interrogatory E.1.a. and E.1.a.i. above:

- Case number:
- Date filed:
- Full style of matter:
- Court:
- County, District and State:
- State or Federal Regulatory Body, Attorney General or other law enforcement or applicable governmental body:
- Brief summary of the dispute:
- Current status:
- Resolution:



Respondent shall not refer ERS to any third-party websites or other sources in order for ERS to obtain this information.

E.1.b. If Respondent did not provide any information for the preceding question, confirm that Respondent (including its officers, directors, parent companies, affiliates, subcontractors and any persons identified by Respondent who will be performing any services required under the RFP and Contract) has not been the subject of any completed and/or pending state or federal litigation, whether civil or criminal, including any suit, action, or prosecution, or any state or federal regulatory or other proceeding, investigation, disciplinary action, violations of the rules of any self-regulatory organization, license revocations and/or governmental inquiry) that

resulted in a felony conviction and/or included any allegations of criminal conduct, fraud, corrupt practices, violations of fiduciary duties, and/or intentional torts involving any allegations of moral turpitude for the past five (5) years. Confirm

E.1.c. Confirm that Respondent shall notify ERS whenever Respondent is involved in litigation that directly involves the plans and/or services associated with the DHMO plan and/or Participants. Confirm

E.1.d. Provide a schedule and describe in detail previous contract implementation breakdowns, performance assessments, contract disputes resulting in suit or settlement and/or contract breaches for the **past five (5) years** (if any) by Respondent and discuss all measures Respondent took to rectify the situation or remedy the breach. Please separate by governmental and non-governmental clients indicating the reason for the assessment and the amount paid. **List in most recent chronological order.**

Governmental:

Non-governmental:

Action taken to resolve issue:

Assessment amount paid:

E.1.e. If the Respondent did not provide a schedule of contract implementation breakdowns, performance assessments or contract disputes as outlined in interrogatory E.1.d. above, confirm that Respondent has not been involved in any contract implementation breakdowns, performance assessments or contract disputes described in interrogatory E.1.d. above. Confirm

E.1.f. Provide a schedule and describe in detail successfully completed agreements, negotiations, mergers, acquisitions or sale of Respondent's organization from the **past five (5) years** (if applicable). This should include any joint ventures or other financial arrangements regarding a change in ownership of Respondent's organization.

E.1.g. Does Respondent have any pending agreements, negotiations, and/or offers to merge or sell Respondent's organization? This should include any joint ventures or other financial arrangements regarding a pending change in ownership of Respondent's organization that could affect the services described in Respondent's Proposal or affect Respondent's organizational financial liability to meet its obligations under a Contract with ERS. Yes No

If the answer to this question is "Yes," describe.

E.1.h. Does Respondent have any obligation or arrangement to purchase another entity that would involve substantial commitment of assets or capital? Yes No

If the answer to this question is "Yes," describe, including an outline of the anticipated timelines.

F. Interrogatories - Regulatory Compliance - DHMO

Deviations to this Section are not permitted.

F.1. As a business associate of ERS, Respondent shall comply with all privacy and security protections as provided in Tex. Health & Safety Code Ann. Chapter 181 (West Supp. 2015) and in HIPAA. Confirm

F.2. Respondent is and shall stay in compliance with the requirements of all state and federal privacy rules and regulations. Confirm

F.3. Respondent is not presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded from contracting with any federal, state or local department or agency. Confirm

F.4. Describe in detail Respondent's policies, procedures and/or systems used to ensure compliance with HIPAA and state privacy laws. [REDACTED]

F.4.a. Provide a full description of any HIPAA violations (such as unauthorized disclosures) alleged against Respondent during the past five (5) years. For each HIPAA violation, Respondent's description shall include, but not be limited to:

The identity of the entity that made the complaint:	[REDACTED]
The date the complaint was made:	[REDACTED]
A description of the complaint:	[REDACTED]
The date the complaint was resolved:	[REDACTED]
Any fines or penalties assessed against Respondent:	[REDACTED]
The regulatory body that assessed any such claim:	[REDACTED]
How the complaint was resolved:	[REDACTED]

F.4.b. Provide a description of any HIPAA breach involving notification to the affected individual during the past five (5) years. These may be summarized, but should give ERS a clear understanding of the number of breaches, the number or affected Participants per breach, the types of actions that led to the breaches, and any mitigation completed by Respondent to prevent such breaches in the future. [REDACTED]

F.4.c. For the five (5) year period preceding the Proposal, provide a brief description of any violations alleged against Respondent with regard to any state or federal privacy laws and/or regulations (for example, Tex. Bus. and Com. Code Chapter 521). [REDACTED]

F.4.d. Describe and confirm the validity of any license(s) that Respondent or its employees, independent contractors, or subcontractors are required to maintain.

F.4.e. Provide the following information for the organization(s) that will be contracting with ERS. This must include the entity holding any license required to provide the services.

1. Provide a copy of each entity's Certificate of Formation (including any amendments).
2. If not formed in Texas, provide a corporate charter or other equivalent formation document (including any amendments) from the jurisdiction of formation.
3. Provide a copy of any assumed name certificates filed in Texas.

Organization full legal name:	
Physical address of principal place of business:	
Mailing address (if different):	
Telephone number:	
Website Address:	

F.4.f. **Authorized Representatives.** Provide the following information for Respondent's Authorized Representatives. This shall include, at a minimum, the individuals listed on the Incumbency Certificate discussed at RFP Section VI.A.2.

Name:	
Title:	
Mailing address:	
Email address:	
Telephone number:	

F.4.g. Provide Respondent's evidence of good standing in its jurisdiction of incorporation or formation. (For example, a Certificate of Good Standing from the State of Delaware.) [REDACTED]

F.4.h. Respondent must be authorized to do business in Texas and be in good standing in the state in which it was incorporated or formed. Confirm

F.4.i. If Respondent was not formed in Texas, provide evidence of Respondent's Certificate of Authority to conduct business in Texas.

F.4.j. Provide Respondent's Texas Franchise Tax Account Status Report.

F.4.k. Respondent will provide the following information:

State in which Respondent incorporated or formed:	[REDACTED]
Year in which Respondent incorporated or formed:	[REDACTED]
Year in which Respondent became authorized to do business in Texas, if Texas is not its jurisdiction of incorporation or formation:	[REDACTED]
Federal Identification Number:	[REDACTED]
Texas Identification Number:	[REDACTED]

Respondent will be required to submit an application for Texas Identification Number should it be awarded the Contract if it does not already have one. That application may be obtained at:

<https://comptroller.texas.gov/taxes/permits>

F.4.l. Has Respondent ever had its authority to conduct business in any state revoked, cancelled, suspended or forfeited? Yes No

If yes, explain. [REDACTED]

F.4.m. As stated at RFP Section VI.A.6., ERS retains the right to have its data excluded from any type of data sharing arrangement. In order for ERS to better understand Respondent's background and business structure, Respondent shall provide the following information if it sells or reports any data from its current clients to others, either specifically or in aggregate:

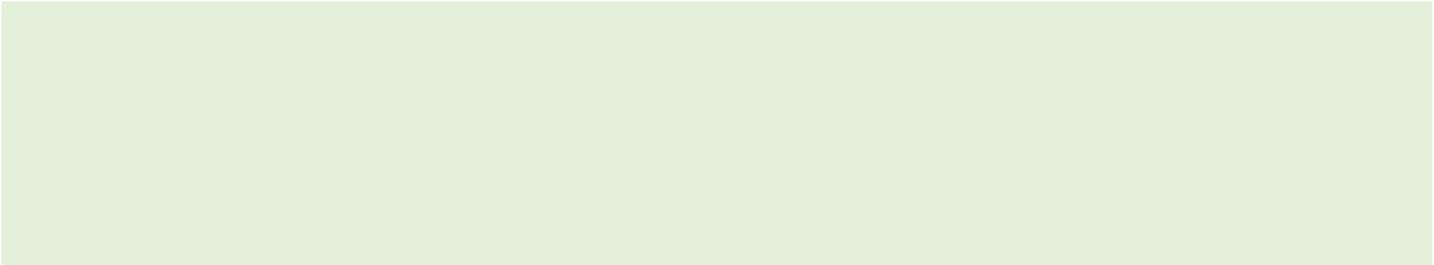
The arrangements for the data sharing;	
The details of what data was shared, including how it is masked; and	
The measures taken to ensure the information is not identifiable.	

F.4.m.i. Respondent shall confirm, unless specifically authorized in writing by ERS, it shall not share ERS data or include ERS data in any data sharing arrangement. Confirm

F.4.n. **Ratings.** Provide copies of ratings and reports on Respondent issued by independent rating organizations or similar entities, such as those issued by A.M. Best's, Moody's, Standard and Poor's. If any such reports are not provided, please explain why not. [REDACTED]

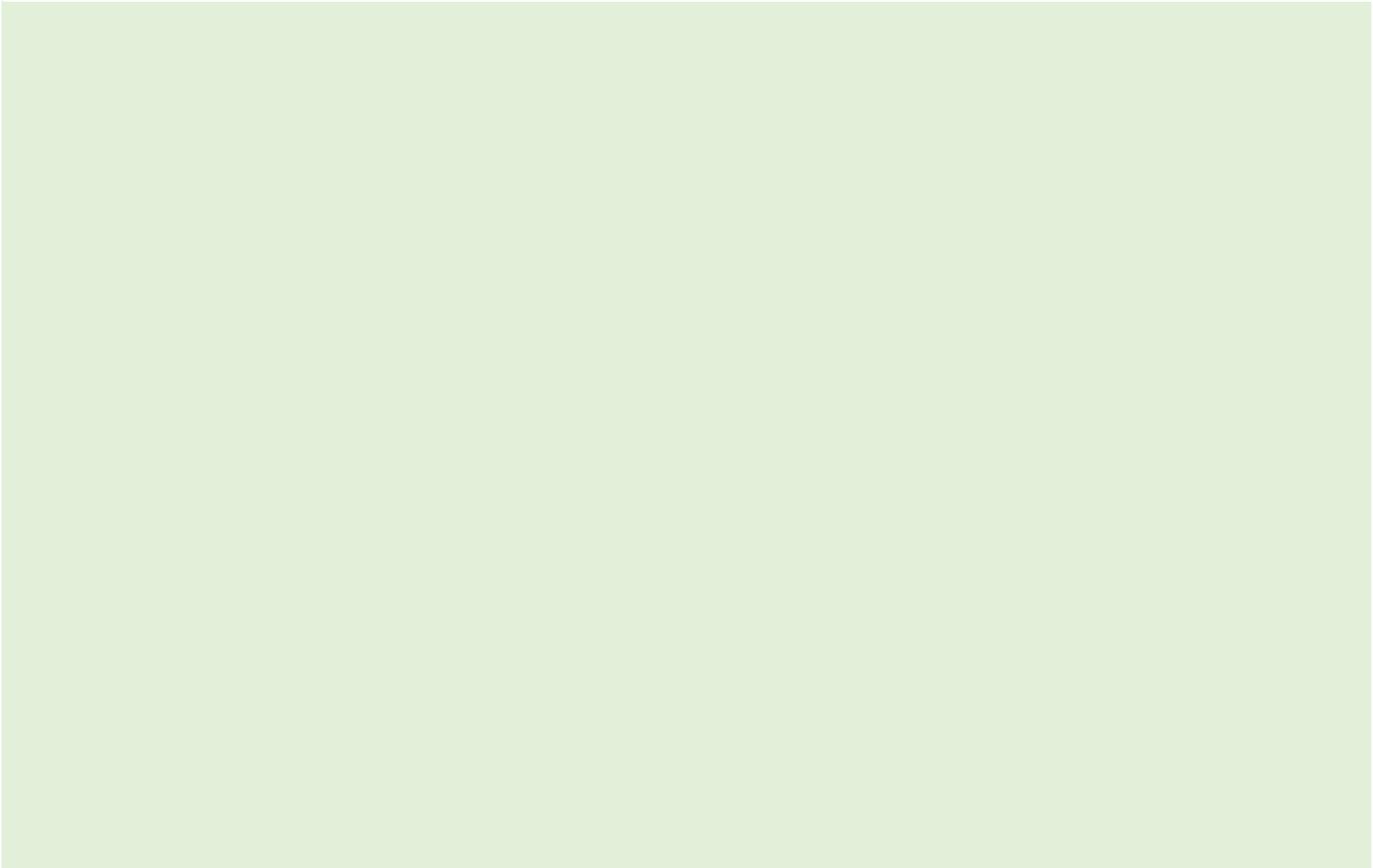
F.4.o **Previous State Employment.** Pursuant to Tex. Gov't Code Sec. 572.069, if any of the individuals who will perform the services specified in the RFP or in the Contract have been employed by ERS at any time during the two (2) years preceding Proposal submission date or, in the case of a former Executive Director of ERS during the preceding four (4) years of the Proposal submission date, state the following:

Name of individual:	[REDACTED]
Nature of previous employment:	[REDACTED]
Date of termination:	[REDACTED]



APPENDIX O

RESPONDENT'S ORGANIZATIONAL AND REFERENCE INFORMATION INTERROGATORIES



Respondent's Organizational and Reference Information Interrogatories

Respondent shall review the Interrogatory instructions referenced at RFP Section I.D.3. Respondent shall review and complete the Interrogatories listed below by providing Respondent's answer following each question. Deviations to this Article are not permissible and will not be considered by ERS. **Respondent shall complete both PPO and DHMO sections if Respondent will be providing both plans. If Respondent is not providing services for both plans, then Respondent only needs to provide its Responses to either the PPO or DHMO sections.**

PPO RESPONSES

A. Organizational Information - PPO

A.1. **Authorized Representatives.** Provide the following information for Respondent's Authorized Representatives. This shall include, at a minimum, the individuals listed on the Incumbency Certificate discussed at RFP Section VI.A.2.

Name:	
Title:	
Mailing address:	
Email address:	
Telephone number:	

A.2. **Organizational Contacts.** Provide the following information, in full, for each of Respondent's personnel listed below:

- Primary contact for purposes of the RFP (including the individual responsible for preparing Respondent's Clarifications);
- Person responsible for the preparation of the Price Proposal;
- Account Management Team Lead;
- Chief Security Officer;
- Privacy Officer; and
- Legal Counsel for purposes of the RFP, for general Contract performance, and for representing Respondent in appeals, administrative hearings, litigation and subrogation.

Name:	
Title:	
Mailing address:	
Email address:	
Telephone number	

A.3. **Site Visit Information.** In the event that Respondent is selected as a Finalist, ERS may request a site visit to Respondent's operational facilities, call center/customer service, and/or information systems data center facilities, as applicable. To better assist ERS with future travel arrangements, Respondent shall provide the following information for the applicable facilities:

Physical address of the operational headquarters facility:	■
Physical addresses of the call center and/or customer service facilities:	■
Physical address of the information systems data center facility (the facility where ERS' data will be housed; this location must not be a disaster recovery location):	■
Physical address of the security operations center:	■

A.3.a. To maximize the effectiveness of the site visits, Respondent shall state if a Nondisclosure Agreement will need to be executed by ERS prior to ERS' site visits to its call center and customer service facilities and/or its data center facility. [REDACTED]

Respondent shall provide a copy of its Nondisclosure Agreement in its Proposal.

A.4. **Previous State Employment.** Pursuant to Tex. Gov't Code Sec. 572.069, if any of the individuals who will perform the services specified in the RFP or in the Contract have been employed by ERS at any time during the two (2) years preceding Proposal submission date or, in the case of a former Executive Director of ERS during the preceding four (4) years of the Proposal submission date, state the following:

Name of individual:	[REDACTED]
Nature of previous employment:	[REDACTED]
Date of termination:	[REDACTED]

A.5. **Organizational Charts.** Provide the following organizational charts:

- An organizational chart that identifies any parent company, affiliate, subsidiary, or other related entity that will be involved in providing Dental services (including any entity to which fees will be sent and any entity for which financial statements are provided) and describes the services provided by each entity;
- A company organizational chart that identifies any internal department(s) that will have responsibility for providing the dental services and explains each department's role in providing the services; and
- An organizational chart for the Information Technology department. If Respondent outsources its information technology functionality to third-party vendors, state the name and address of all such vendors and specify the exact functions outsourced; and
- An organizational chart containing the titles of all staff members and independent contractors performing any function related to the dental services.

B. References - PPO

B.1. ERS reserves the right to contact any of the entities provided in response to this section when evaluating a Finalist's Past Performance, as discussed at RFP Sections II.D.3.a. – II.D.3.b.

B.1.a. A response to the RFP officially authorizes ERS to contact all persons or entities provided by Respondent as client references to discuss the services and other considerations that Respondent has provided for such persons or entities, authorizes the entities to provide such information to ERS, and acknowledges that Respondent agrees that neither ERS, nor any entity contacted by ERS, shall be liable to Respondent in any respect in connection with such contact. Therefore, in consideration of ERS' review of response to provide services for ERS, Respondent shall hold harmless, defend, indemnify, and release ERS, its officers, agents, employees, actuaries, the State, and any person or entity contacted by ERS from any and all claims, damages, liability, and causes of action in connection with any communication, written or verbal, related to Respondent.

B.2. **Top Clients.** Provide a list of Respondent's top five (5) dental clients with at least one client with an enrollment of 310,000 for PPO covered employees. Respondent must have performed services for each of these clients for at least five (5) years. For each client, include the information requested below in full:

Company Name:	
Account Primary Contact:	
Title:	
Email Address:	
Telephone Number:	
Number of Participants enrolled in the plans:	
Services Provided:	

- B.3. **Public Clients.** List all public entity clients for whom Respondent has provided dental services within the past five (5) years. For each client, include the information requested below in full:

Company Name:	
Account Primary Contact:	
Title:	
Email Address:	
Telephone Number:	
Number of Participants enrolled in the plans:	
Services Performed for Client:	

- B.4. **Client Due Diligence.** Provide the information below for the five (5) most recent client contracts that were terminated before the anticipated end of term date for any reason. For each client, include the information requested below in full:

Company Name:	
Account Primary Contact:	
Title:	
Email Address:	
Telephone Number:	
Services Respondent Performed for Client:	
Date contract terminated:	
Reason contract terminated:	

- B.5. **ERS Comparable Clients.** Provide a list of five (5) clients for whom Respondent provides dental services at organizations similar to ERS with regard to program size and complexity. Respondent must have performed services for each of these clients for at least three (3) years. For each client, include the information requested below in full:

Company Name:	
Account Primary Contact:	
Title:	
Email Address:	
Telephone Number:	
Number of Participants enrolled in the plans:	
Services Provided:	

DHMO RESPONSES

C. Organizational Information - DHMO

- C.1. **Authorized Representatives.** Provide the following information for Respondent's Authorized Representatives. This shall include, at a minimum, the individuals listed on the Incumbency Certificate discussed at RFP Section VI.A.2.

Name:	
Title:	
Mailing address:	
Email address:	
Telephone number:	

- C.2. **Organizational Contacts.** Provide the following information, in full, for each of Respondent's personnel listed below:

- Primary contact for purposes of the RFP (including the individual responsible for preparing Respondent's Clarifications);
- Person responsible for the preparation of the Price Proposal;
- Account Management Team Lead;

- Chief Security Officer;
- Privacy Officer; and
- Legal Counsel for purposes of the RFP, for general Contract performance, and for representing Respondent in litigation matters involving ERS and Respondent.

Name:	
Title:	
Mailing address:	
Email address:	
Telephone number	

C.3. **Site Visit Information.** In the event that Respondent is selected as a Finalist, ERS may request a site visit to Respondent's operational facilities, call center/customer service, and/or information systems data center facilities, as applicable. To better assist ERS with future travel arrangements, Respondent shall provide the following information for the applicable facilities:

Physical address of the operational headquarters facility:	
Physical addresses of the call center and/or customer service facilities:	
Physical address of the information systems data center facility (the facility where ERS' data will be housed; this location must not be a disaster recovery location):	
Physical address of the security operations center:	

C.3.a. To maximize the effectiveness of the site visits, Respondent shall state if a Nondisclosure Agreement will need to be executed by ERS prior to ERS' site visits to its call center and customer service facilities and/or its data center facility.

Respondent shall provide a copy of its Nondisclosure Agreement in its Proposal.

C.4. **Previous State Employment.** Pursuant to Tex. Gov't Code Sec. 572.069, if any of the individuals who will perform the services specified in the RFP or in the Contract have been employed by ERS at any time during the two (2) years preceding Proposal submission date or, in the case of a former Executive Director of ERS during the preceding four (4) years of the Proposal submission date, state the following:

Name of individual:	
Nature of previous employment:	
Date of termination:	

C.5. **Organizational Charts.** Provide the following organizational charts:

- An organizational chart that identifies any parent company, affiliate, subsidiary, or other related entity that will be involved in providing Dental services (including any entity to which fees will be sent and any entity for which financial statements are provided) and describes the services provided by each entity;
- A company organizational chart that identifies any internal department(s) that will have responsibility for providing the dental services and explains each department's role in providing the services; and
- An organizational chart for the Information Technology department. If Respondent outsources its information technology functionality to third-party vendors, state the name and address of all such vendors and specify the exact functions outsourced; and
- An organizational chart containing the titles of all staff members and independent contractors performing any function related to the dental services.

D. References - DHMO

D.1. ERS reserves the right to contact any of the entities provided in response to this section when evaluating a Finalist's Past Performance, as discussed at RFP Sections II.D.3.a. – II.D.3.b.

D.1.a. A response to the RFP officially authorizes ERS to contact all persons or entities provided by Respondent as client references to discuss the services and other considerations that Respondent has provided for such persons or entities, authorizes the entities to provide such information to ERS, and acknowledges that Respondent agrees that neither ERS, nor any entity contacted by ERS, shall be liable to Respondent in any respect in connection with such contact. Therefore, in consideration of ERS' review of response to provide services for ERS, Respondent shall hold harmless, defend, indemnify, and release ERS, its officers, agents, employees, actuaries, the State, and any person or entity contacted by ERS from any and all claims, damages, liability, and causes of action in connection with any communication, written or verbal, related to Respondent.

D.2. **Top Clients.** Provide a list of Respondent's top five (5) dental clients with at least one client with an enrollment of 128,000 for DHMO covered employees. Respondent must have performed services for each of these clients for at least five (5) years. For each client, include the information requested below in full:

Company Name:	
Account Primary Contact:	
Title:	
Email Address:	
Telephone Number:	
Number of Participants enrolled in the plans:	
Services Provided:	

D.3. **Public Clients.** List all public entity clients for whom Respondent has provided dental services within the past five (5) years. For each client, include the information requested below in full:

Company Name:	
Account Primary Contact:	
Title:	
Email Address:	
Telephone Number:	
Number of Participants enrolled in the plans:	
Services Performed for Client:	

D.4. **Client Due Diligence.** Provide the information below for the five (5) most recent client contracts that were terminated before the anticipated end of term date for any reason. For each client, include the information requested below in full:

Company Name:	
Account Primary Contact:	
Title:	
Email Address:	
Telephone Number:	
Services Respondent Performed for Client:	
Date contract terminated:	
Reason contract terminated:	

D.5. **ERS Comparable Clients.** Provide a list of five (5) clients for whom Respondent provides dental services at organizations similar to ERS with regard to program size and complexity. Respondent must have performed services for each of these clients for at least three (3) years. For each client, include the information requested below in full:

Company Name:	
Account Primary Contact:	
Title:	
Email Address:	
Telephone Number:	
Number of Participants enrolled in the plans:	
Services Provided:	

APPENDIX P

DENTAL PPO AND DHMO
STRUCTURE AND
ADMINISTRATION
REQUIREMENTS
DEVIATIONS AND
INTERROGATORIES

Dental PPO and DHMO Structure and Administration Requirements Deviations and Interrogatories

Respondent shall review the Deviation and Interrogatory instructions referenced at RFP Sections I.D.2. and I.D.3. Respondent shall complete the Interrogatories listed below by providing Respondent's answer following each question. **Respondent shall complete both PPO and DHMO sections if Respondent will be providing both plans. If Respondent is not providing services for both plans, then Respondent only needs to provide its Responses to either the PPO or DHMO sections.**

A. Deviations – Dental PPO Plan Benefits Requirements

A.1. Affirm that Respondent shall comply with all of the **Dental PPO Plan Benefits Requirements** described in RFP Section VII.A.

Affirm Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each Deviation between Respondent's response and these requirements:

Respondent's Requested Deviation Detail:

B. Interrogatories – Dental PPO Plan Benefits Requirements

B.1. In response to the RFP, the Dental PPO Respondent shall submit its self-funded Proposal in accordance with the Dental PPO plan benefit package as outlined in the current Dental PPO Schedule _____ of _____ Benefits _____ referenced at: <http://apps.humana.com/marketing/documents.asp?file=1384422>, with expected changes effective September 1, 2018, see **Appendix H**.

C. Deviations – DHMO Plan Benefits Requirements

C.1. Affirm that Respondent shall comply with all of the **DHMO Benefits Requirements** described in RFP Section VII.B.

Affirm Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each Deviation between Respondent's response and these requirements:

Respondent's Requested Deviation Detail:

D. Interrogatories – DHMO Plan Benefits Requirements

D.1. In response to the RFP, the DHMO Respondent shall submit rates in accordance with the DHMO _____ Schedule _____ of _____ Benefits _____ located _____ at: <http://apps.humana.com/marketing/documents.asp?file=1384318>.

E. Deviations – COBRA Administration Requirements – PPO

E.1. Affirm that Respondent shall comply with all of the **COBRA Administration Requirements** described in RFP Section VII.C.

Affirm Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each Deviation between Respondent's response and these requirements:

Respondent's Requested Deviation Detail:

F. Deviations – COBRA Administration Requirements - DHMO

F.1. Affirm that Respondent shall comply with all of the **COBRA Administration Requirements** described in RFP Section VII.C.

Affirm Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each Deviation between Respondent's response and these requirements:

Respondent's Requested Deviation Detail:

G. Deviations – Coordination with Other GBP Contracted Vendors Requirements - PPO

G.1. Affirm that Respondent shall comply with all of the **Coordination with Other GBP Contracted Vendors Requirements** described in RFP Section VII.D.

Affirm Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each Deviation between Respondent's response and these requirements:

Respondent's Requested Deviation Detail:

H. Deviations – Coordination with Other GBP Contracted Vendors Requirements - DHMO

H.1. Affirm that Respondent shall comply with all of the **Coordination with Other GBP Contracted Vendors Requirements** described in RFP Section VII.D.

Affirm Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each Deviation between Respondent's response and these requirements:

Respondent's Requested Deviation Detail:

APPENDIX Q

PROVIDER NETWORK AND SERVICE AREA REQUIREMENTS DEVIATIONS AND INTERROGATORIES

Provider Network and Service Area Requirements Deviations and Interrogatories

Respondent shall review the Deviation and Interrogatory instructions referenced at RFP Sections I.D.2. and I.D.3. Respondent shall complete the Interrogatories listed below by providing Respondent's answer following each question. **Respondent shall complete both PPO and DHMO sections if Respondent will be providing both plans. If Respondent is not providing services for both plans, then Respondent only needs to provide its Responses to either the PPO or DHMO sections.**

A. Deviations – DHMO Provider Network Requirements

A.1. Affirm that Respondent shall comply with all of the **Provider Network and Service Area Requirements – DHMO Provider Network Requirements** described in RFP Sections VIII.A.1. – VIII.A.7.c.

Affirm Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each deviation between Respondent's response and these requirements:

Respondent's Requested Deviation Detail:

B. Deviations – Dental PPO Provider Network Requirements

B.1. Affirm that Respondent shall comply with all of the **Provider Network and Service Area Requirements – Dental PPO Provider Network Requirements** described in RFP Sections VIII.B.1. – VIII.B.8.b.

Affirm Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each Deviation between Respondent's response and these requirements:

Respondent's Requested Deviation Detail:

C. Deviations – Network Management Requirements - PPO

C.1. Affirm that Respondent shall comply with all of the **Provider Network and Service Area Requirements – Network Management Requirements** described in RFP Sections VIII.C.1. – VIII.C.5.

Affirm Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each Deviation between Respondent's response and these requirements:

Respondent's Requested Deviation Detail:

D. Interrogatories – Network Management Requirements – PPO

D.1. Does Respondent own all of its contracts with participating providers, groups and DSO's?
 Yes No

D.1.a. If no, what percentage of state of Texas network is through leased networks?

D.1.b. In what areas are the leased networks located? Please identify the contract owner for each area.

- D.2. Does Respondent have more than one provider network available? Yes No
- If Respondent marked yes, what are the different network options and how do the network options impact the proposed rates? [REDACTED]
- D.3. If Respondent provides more than one provider network, identify the network(s) that Respondent proposes be used by GBP Participants. [REDACTED]
- D.3.a. How long has each network been in place? [REDACTED]
- D.3.b. Describe Respondent's network arrangements for national dental PPO coverage outside the State. [REDACTED]
- D.4. If Respondent contracts with a management company, Respondent shall describe the details of the arrangement. [REDACTED]
- D.5. Does Respondent have contracts with PCD groups, which require that specialty care referrals be made to a specified subset of the network's specialists, if applicable? Yes No
- If yes, provide details. [REDACTED]
- D.6. Does Respondent's organization operate provider networks in other areas of the United States that would be available to GBP Participants working, living (retired), or visiting out-of-state? Yes No
- If yes, list all areas served by the out-of-state network(s). [REDACTED]
- D.6.a. Is Respondent licensed in other states for reciprocity arrangements? Yes No
- If yes, where? [REDACTED]
- D.6.b. Respondent shall describe its specific reciprocity arrangements. [REDACTED]
- D.6.c. Is there a limit to the number of Participants living outside of the State that Respondent would be able to cover in a reciprocity arrangement? Yes No
- D.7. Discuss the network's methodology in evaluating patient access to dental care providers? [REDACTED]
- D.8. What is the availability of appointments for scheduling office visits within the dental networks? [REDACTED]
- D.9. What are the professional liability coverage requirements for each type of dental care provider in Respondent network, if applicable? [REDACTED]
- D.10. How often does Respondent add dental care providers to its network, if applicable? Provide a detailed explanation for the need to add dental care providers, the timeframe and frequency of the updates to Respondent's dental care provider network. [REDACTED]
- D.11. What is the most frequent reason that a dental care provider leaves Respondent's network, if applicable? [REDACTED]
- D.12. What is Respondent's credentialing and re-credentialing process for all dental care providers? [REDACTED]
- D.12.a. How often does Respondent conduct the re-credentialing process? [REDACTED]
- D.13. What is the fee and risk sharing arrangements that Respondent has with dental care providers in each network for which Respondent is submitting a Proposal response? To assist in communication of this information, complete GBP Utilization of CDT Codes located in **Appendix I**. The fee schedules information needs to be by Texas three (3) digit zips.

- D.13.a. Is any provider compensation for providers related to utilization levels? Yes No
If so, explain the methodology. [REDACTED]
- D.14. What minimum periods are included in Respondent's dental care provider contracts concerning the following:
- D.14.a. Provider's notice to not accept new patients; [REDACTED]
- D.14.b. Provider's intent to terminate; [REDACTED]
- D.14.c. Respondent's intent to terminate; and [REDACTED]
- D.14.d. Provider's required continuation of care to existing network Participants following provider's termination from the network, if applicable. [REDACTED]
- D.15. Respondent shall provide a detailed explanation of how it is in compliance with continuation of coverage and conversion policies. [REDACTED]
- D.16. What does Respondent offer, an individual conversion policy or a group conversion policy?
 Individual Conversion Policy Group Conversion Policy
Describe the policy offered. [REDACTED]
If a policy is not offered, Respondent shall provide reasoning as to why it is not offered. [REDACTED]
- D.17. What percentage of each network's dentists are Board certified, if applicable? [REDACTED]
- D.18. What is the training/orientation process for Respondent's network providers, if applicable? [REDACTED]. Address the specific training/orientation items below and provide a specific explanation to:
- D.18.a. Participant eligibility; [REDACTED]
- D.18.b. Utilization review procedures; [REDACTED]
- D.18.c. Billing; and [REDACTED]
- D.18.d. Quality improvement responsibilities. [REDACTED]
- D.19. What was the turnover rate of dentists and Respondent's network, in 2014, 2015, 2016, and 2017 year-to-date, if applicable? Respondent shall differentiate between voluntary and involuntary turnover. [REDACTED]
- D.20. Describe Respondent's financial arrangements with contracted dentists. If Respondent's financial arrangements include different reimbursement methodologies, specify these arrangements, if applicable. (i.e., fixed fee schedules, percentage of usual and customary, variable by provider, area, specialty, etc.) [REDACTED]
- D.20.a. Texas statute does not allow a benefit differentiation in payment between contracted and non-contracted providers for PPO plans. Respondent shall describe what method Respondent uses to encourage in-network usage, if applicable. [REDACTED]
- D.20.b. Please describe Respondent's calculation of usual and customary as applicable to out-of-network charges? Does ERS have the flexibility to establish usual and customary? [REDACTED]
- D.21. Describe the growth (or reduction) of Respondent's network in 2014, 2015, 2016, and 2017 year-to-date and if there are plans for future development of the network, if applicable. [REDACTED]
- D.22. In the event lab work is needed for dental care, can Respondent's providers use any lab or their own lab, or are patients directed to network labs? [REDACTED]
- D.22.a. Please explain how Respondent's system adjudicates lab services. [REDACTED]

- D.23. Please describe how Respondent transitions orthodontic treatment in process. [REDACTED]
- D.24. Disclose any dental group, facility or DSO in which Respondent's organization owns an interest (majority or otherwise). [REDACTED]
- D.25. When considering the total number of providers in Respondent's network, please disclose the percentage of each shown below.

Provider contract type	Percentage of provider network
Individual provider contract	
Group practice contract	
DSO contracts	

- D.26. Is Respondent's organization NCQA accredited or certified? Yes No

If so, provide proof of such certification.

E. Deviations – Network Management Requirements - DHMO

- E.1. Affirm that Respondent shall comply with all of the **Provider Network and Service Area Requirements – Network Management Requirements** described in RFP Sections VIII.C.1. – VIII.C.5.

- Affirm Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each Deviation between Respondent's response and these requirements:

Respondent's Requested Deviation Detail: [REDACTED]

F. Interrogatories – Network Management Requirements - DHMO

- F.1. Does Respondent own all of its contracts with participating providers, groups and DSO's?
 Yes No
- F.1.a. If no, what percentage of state of Texas network is through leased networks? [REDACTED]
- F.1.b. In what areas are the leased networks located? Please identify the contract owner for each area. [REDACTED]
- F.2. Does Respondent have more than one provider network available? Yes No
- If Respondent marked yes, what are the different network options and how do the network options impact the proposed rates? [REDACTED]
- F.3. If Respondent provides more than one provider network, identify the network(s) that Respondent proposes be used by GBP Participants. [REDACTED]
- F.3.a. How long has each network been in place? [REDACTED]
State. [REDACTED]
- F.4. If Respondent contracts with a management company, Respondent shall describe the details of the arrangement. [REDACTED]
- F.5. Does Respondent have contracts with PCD groups, which require that specialty care referrals be made to a specified subset of the network's specialists, if applicable? Yes No
- If yes, provide details. [REDACTED]
- F.6. Discuss the network's methodology in evaluating patient access to dental care providers?
[REDACTED]

- F.7. What is the availability of appointments for scheduling office visits within the dental networks? [REDACTED]
- F.8. What are the professional liability coverage requirements for each type of dental care provider in Respondent network, if applicable? [REDACTED]
- F.9. How often does Respondent add dental care providers to its network, if applicable? Provide a detailed explanation for the need to add dental care providers, the timeframe and frequency of the updates to Respondent's dental care provider network. [REDACTED]
- F.10. What is the most frequent reason that a dental care provider leaves Respondent's network, if applicable? [REDACTED]
- F.11. What is Respondent's credentialing and re-credentialing process for all dental care providers? [REDACTED]
- F.11.a. How often does Respondent conduct the re-credentialing process? [REDACTED]
- F.12. What is the fee and risk sharing arrangements that Respondent has with dental care providers in each network for which Respondent is submitting a Proposal response? To assist in communication of this information, complete GBP Utilization of CDT Codes located in **Appendix I**. The fee schedules information needs to be by Texas three (3) digit zips.
- F.12.a. Is any provider compensation for providers related to utilization levels? Yes No
If so, explain the methodology. [REDACTED]
- F.13. What minimum periods are included in Respondent's dental care provider contracts concerning the following:
- F.13.a. Provider's notice to not accept new patients; [REDACTED]
- F.13.b. Provider's intent to terminate; [REDACTED]
- F.13.c. Respondent's intent to terminate; and [REDACTED]
- F.13.d. Provider's required continuation of care to existing network Participants following provider's termination from the network, if applicable. [REDACTED]
- F.14. Respondent shall provide a detailed explanation of how it is in compliance with continuation of coverage and conversion policies. [REDACTED]
- F.15. What does Respondent offer, an individual conversion policy or a group conversion policy?
 Individual Conversion Policy Group Conversion Policy
Describe the policy offered. [REDACTED]
If a policy is not offered, Respondent shall provide reasoning as to why it is not offered. [REDACTED]
- F.16. What percentage of each network's dentists are Board certified, if applicable? [REDACTED]
- F.17. What is the training/orientation process for Respondent's network providers, if applicable? [REDACTED]. Address the specific training/orientation items below and provide a specific explanation to:
- F.17.a. Participant eligibility; [REDACTED]
- F.17.b. Utilization review procedures; [REDACTED]
- F.17.c. Billing; and [REDACTED]
- F.17.d. Quality improvement responsibilities. [REDACTED]

- F.18. What was the turnover rate of dentists and Respondent's network, in 2014, 2015, 2016, and 2017 year-to-date, if applicable? Respondent shall differentiate between voluntary and involuntary turnover. [REDACTED]
- F.19. Describe Respondent's financial arrangements with contracted dentists. If Respondent's financial arrangements include different reimbursement methodologies, specify these arrangements, if applicable. (i.e., fixed fee schedules, percentage of usual and customary, variable by provider, area, specialty, etc.) [REDACTED]
- F.20. Describe the growth (or reduction) of Respondent's network in 2014, 2015, 2016, and 2017 year-to-date and if there are plans for future development of the network, if applicable. [REDACTED]
- F.21. In the event lab work is needed for dental care, can Respondent's providers use any lab or their own lab, or are patients directed to network labs? [REDACTED]
- F.21.a. Please explain how Respondent's system adjudicates lab services. [REDACTED]
- F.22. Please describe how Respondent transitions orthodontic treatment in process. [REDACTED]
- F.23. Disclose any dental group, facility or DSO in which Respondent's organization owns an interest (majority or otherwise). [REDACTED]
- F.24. When considering the total number of providers in Respondent's network, please disclose the percentage of each shown below.

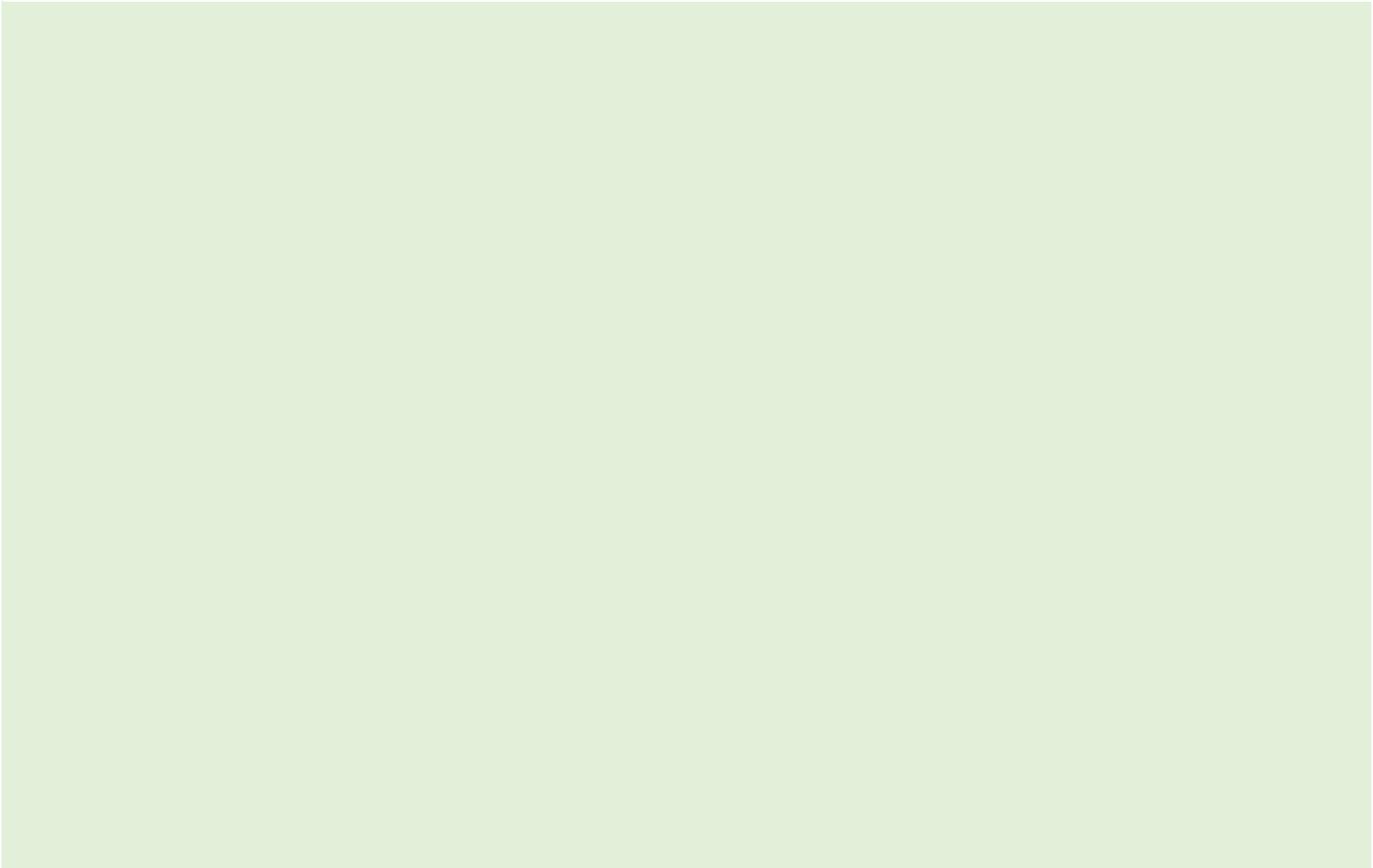
Provider contract type	Percentage of provider network
Individual provider contract	
Group practice contract	
DSO contracts	

- F.25. Is Respondent's organization NCQA accredited or certified? Yes No
 If so, provide proof of such certification.



APPENDIX R

COMMUNICATION REQUIREMENTS DEVIATIONS AND INTERROGATORIES



Communication Requirements Deviations and Interrogatories

Respondent shall review the Deviation and Interrogatory instructions referenced at RFP Sections I.D.2. and I.D.3. Respondent shall complete the Interrogatories listed below by providing Respondent's answer following each question. **Respondent shall complete both PPO and DHMO sections if Respondent will be providing both plans. If Respondent is not providing services for both plans, then Respondent only needs to provide its Responses to either the PPO or DHMO sections.**

PPO RESPONSES

A. Deviations – Program Specific Overview Requirements - PPO

A.1. Affirm that Respondent shall comply with all of the **Scope of Work – Communication Requirements – Program Specific Overview Requirements** described in RFP Sections IX.A.1.a. – IX.A.20.

Affirm Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each deviation between Respondent's response and these requirements:

Respondent's Requested Deviation Detail:

B. Interrogatories – Program Specific Overview Requirements- PPO

B.1. Respondent shall provide samples and/or copies of the enrollment marketing packets it will provide to Participants. This response should include, but not be limited to, the items discussed at RFP Section IX.A.17., which are as follows:

- An enrollment presentation to be recorded and posted on the ERS website and delivered upon request at enrollment events;
- Targeted enrollment communication brochures;
- Welcome Letter to new Participants;
- Brochures explaining Plan changes and updates;
- Explanation of Benefits – Fact Sheet;
- General Plan information; and
- Enrollment information on Respondent's website.

B.2. Describe Respondent's ability to produce Participant-specific communications.

B.3. How does the Participant-specific customizations impact the cost or quality of communications for ERS?

B.4. Describe Respondent's capabilities for staffing benefit fairs, wellness fairs, and other presentation and events.

B.5. Respondent shall confirm that it will assign a dedicated communications specialist(s) to meet and work with ERS staff to produce the communication materials. Confirm

B.5.a. If Respondent cannot confirm the above interrogatory B.5., Respondent shall enumerate and provide a detailed description as to why not.

B.6. Respondent shall describe its methods for a Participant to access information about the Plans, (i.e., mobile application, innovative methods, etc.).

- B.7. Respondent shall provide copies of its generic communications used for plans similar to the Plans. Respondent's response should include, but not be limited to, enrollment marketing packets.

C. Deviations – Ongoing Member Communications Requirements – PPO

- C.1. Affirm that Respondent shall comply with all of the **Scope of Work – Communication Requirements – Ongoing Member Communication Requirements** described in RFP Sections IX.B.1. – IX.B.12.

Affirm Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each deviation between Respondent's response and these requirements:

Respondent's Requested Deviation Detail:

D. Interrogatories – Ongoing Member Communications Requirements - PPO

- D.1. Respondent shall refer to RFP Section IX.B.9 for ERS' requirements regarding Fact Sheets. Respondent shall provide its sample Fact Sheets.
- D.2. Respondent shall provide with its Proposal the Master Benefit Plan Document (MBPD) for FY20. Provided
- D.3. Respondent shall provide with its Proposal a draft of the Member Handbook. Provided
- D.4. Respondent shall submit with its Proposal a proposed MBPD on a separate CD-ROM or USB Thumb Drive for ERS' review and approval. Provided
- D.5. Respondent shall provide with its Dental PPO Proposal a sample of a Dental PPO packet used to identify the Dental PPO to the GBP Dental Program Participants.
- D.6. Respondent shall submit with its Proposal an electronic mock-up of a proposed GBP-specific ID card. Provided

E. Deviations – Website Specifications Requirements - PPO

- E.1. Affirm that Respondent shall comply with all of the **Scope of Work – Communication Requirements – Website Specifications Requirements** described in RFP Sections IX.D.1. – IX.D.8.c.

Affirm Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each Deviation between Respondent's response and these requirements:

Respondent's Requested Deviation Detail:

F. Interrogatories – Website Specifications Requirements - PPO

- F.1. If Respondent currently maintains an internet website, provide the URL address.

- F.2. Respondent shall provide a report from an independent provider evidencing its organization's Section 508 compliance. Provided
- F.3. Is Respondent currently using the WCAG 2.0 or does Respondent have plans to use these guidelines in the future? Yes No
- F.3.a. If not currently using WCAG 2.0, provide a date when Respondent would be able to implement the WCAG standards in the future.
- F.4. Respondent shall confirm that its customizable plan website will be functioning in accordance with the implementation schedule. Confirm
- F.4.a. If Respondent cannot confirm the above interrogatory F.4., Respondent shall enumerate and provide a detailed description as to why not.
- F.5. Respondent shall confirm that its configurable claims website will be functioning in accordance with the implementation schedule. Confirm
- F.5.a. If Respondent cannot confirm the above interrogatory F.5., Respondent shall enumerate and provide a detailed description as to why not.

G. Deviations – Respondent Website Content Requirements - PPO

- G.1. Affirm that Respondent shall comply with all of the **Scope of Work – Communication Requirements – Respondent Website Content Requirements** described in RFP Sections IX.E.1. – IX.E.8.b.
- Affirm Affirm with the proposed Deviation
- If applicable, enumerate and provide a detailed description of each Deviation between Respondent's response and these requirements:
- Respondent's Requested Deviation Detail:

DHMO RESPONSES

H. Deviations – Program Specific Overview Requirements - DHMO

- H.1. Affirm that Respondent shall comply with all of the **Scope of Work – Communication Requirements – Program Specific Overview Requirements** described in RFP Sections IX.A.1.a. – IX.A.20.
- Affirm Affirm with the proposed Deviation
- If applicable, enumerate and provide a detailed description of each deviation between Respondent's response and these requirements:
- Respondent's Requested Deviation Detail:

I. Interrogatories – Program Specific Overview Requirements- DHMO

- I.1. Respondent shall provide samples and/or copies of the enrollment marketing packets it will provide to Participants. This response should include, but not be limited to, the items discussed at RFP Section IX.A.17., which are as follows:
- An enrollment presentation to be recorded and posted on the ERS website and delivered upon request at enrollment events;
 - Targeted enrollment communication brochures;
 - Welcome Letter to new Participants;
 - Brochures explaining Plan changes and updates;
 - Explanation of Benefits – Fact Sheet;
 - General Plan information; and
 - Enrollment information on Respondent’s website.
- I.2. Describe Respondent’s ability to produce Participant-specific communications. [REDACTED]
- I.3. How does the Participant-specific customizations impact the cost or quality of communications for ERS? [REDACTED]
- I.4. Describe Respondent’s capabilities for staffing benefit fairs, wellness fairs, and other presentation and events. [REDACTED]
- I.5. Respondent shall confirm that it will assign a dedicated communications specialist(s) to meet and work with ERS staff to produce the communication materials. Confirm
- I.5.a. If Respondent cannot confirm the above interrogatory I.5., Respondent shall enumerate and provide a detailed description as to why not. [REDACTED]
- I.6. Respondent shall describe its methods for a Participant to access information about the Plans, (i.e., mobile application, innovative methods, etc.). [REDACTED]
- I.7. Respondent shall provide copies of its generic communications used for plans similar to the Plans. Respondent’s response should include, but not be limited to, enrollment marketing packets.

J. Deviations – Ongoing Member Communications Requirements - DHMO

- J.1. Affirm that Respondent shall comply with all of the **Scope of Work – Communication Requirements – Ongoing Member Communication Requirements** described in RFP Sections IX.C.1. – IX.C.12.
- Affirm Affirm with the proposed Deviation
- If applicable, enumerate and provide a detailed description of each deviation between Respondent’s response and these requirements:
- Respondent’s Requested Deviation Detail: [REDACTED]

K. Interrogatories – Ongoing Member Communication Requirements - DHMO

- K.1. Respondent shall refer to RFP Section IX.C.9 for ERS’ requirements regarding Fact Sheets. Respondent shall provide its sample Fact Sheets.

- K.2. Respondent shall provide with its DHMO Proposal a proposed EOC on a separate CD-ROM or USB Thumb Drive (in Word or Excel document, no PDF documents will be accepted) and a sample ID card. Provided
- K.3. Respondent shall provide to the Assistant Director of Benefit Contracts or designee a draft of the Member Handbook with its DHMO Proposal. Provided
- K.4. Respondent shall submit with its DHMO Proposal an electronic mock-up of a proposed GBP-specific ID card. Provided

L. Deviations – Website Specifications Requirements - DHMO

- L.1. Affirm that Respondent shall comply with all of the **Scope of Work – Communication Requirements – Website Specifications Requirements** described in RFP Sections IX.D.1. – IX.D.8.c.

Affirm Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each Deviation between Respondent's response and these requirements:

Respondent's Requested Deviation Detail:

M. Interrogatories – Website Specifications Requirements - DHMO

- M.1. If Respondent currently maintains an internet website, provide the URL address.
- M.2. Respondent shall provide a report from an independent provider evidencing its organization's Section 508 compliance. Provided
- M.3. Is Respondent currently using the WCAG 2.0 or does Respondent have plans to use these guidelines in the future? Yes No
- M.3.a. If not currently using WCAG 2.0, provide a date when Respondent would be able to implement the WCAG standards in the future.
- M.4. Respondent shall confirm that its customizable plan website will be functioning in accordance with the implementation schedule. Confirm
- M.4.a. If Respondent cannot confirm the above interrogatory M.4., Respondent shall enumerate and provide a detailed description as to why not.
- M.5. Respondent shall confirm that its configurable claims website will be functioning in accordance with the implementation schedule. Confirm
- M.5.a. If Respondent cannot confirm the above interrogatory M.5., Respondent shall enumerate and provide a detailed description as to why not.

N. Deviations – Respondent Website Content Requirements - DHMO

N.1. Affirm that Respondent shall comply with all of the **Scope of Work – Communication Requirements – Respondent Website Content Requirements** described in RFP Sections IX.E.1. – IX.E.8.b.

Affirm Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each Deviation between Respondent's response and these requirements:

Respondent's Requested Deviation Detail:

APPENDIX S

TEXAS INSURANCE CODE CHAPTER 1551. TEXAS EMPLOYEES GROUP BENEFITS ACT

INSURANCE CODE

TITLE 8. HEALTH INSURANCE AND OTHER HEALTH COVERAGES

SUBTITLE H. HEALTH BENEFITS AND OTHER COVERAGES FOR GOVERNMENTAL EMPLOYEES

CHAPTER 1551. TEXAS EMPLOYEES GROUP BENEFITS ACT

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1551.001. SHORT TITLE. This chapter may be cited as the Texas Employees Group Benefits Act.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.002. PURPOSES. The purposes of this chapter are to:

(1) provide uniformity in life, accident, and health benefit coverages for all state officers and employees and their dependents;

(2) enable the state to attract and retain competent and able employees by providing employees and their dependents with life, accident, and health benefit coverages at least equal to those commonly provided in private industry;

(3) foster, promote, and encourage employment by and service to the state as a career profession for individuals of high standards of competence and ability;

(4) recognize and protect the state's investment in each permanent employee by promoting and preserving economic security and good health among employees and their dependents;

(5) foster and develop high standards of employer-employee relationships between the state and its employees;

(6) recognize the long and faithful service and dedication of state officers and employees and encourage them to remain in state service until eligible for retirement by providing health benefits for them and their dependents; and

(7) recognize the service to the state by employees and retired employees of community supervision and corrections departments by extending to them and their dependents the same life, accident, and health benefit coverages as those provided under this chapter to state employees, retired state employees, and their dependents.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003. Amended by Acts 2003, 78th Leg., ch. 1030, Sec. 1.01, eff. Sept. 1, 2003.

Sec. 1551.003. GENERAL DEFINITIONS. In this chapter:

(1) "Administering firm" means a firm designated by the board of trustees to administer coverages, services, benefits, or requirements in accordance with this chapter and the rules adopted by the board of trustees under this chapter.

(2) "Annuitant" means an individual eligible to participate in the group benefits program under Section [1551.102](#).

(3) "Basic coverage" means the group coverage plans determined by the board of trustees in which each eligible full-time employee and annuitant participates automatically unless participation is specifically waived.

(4) "Board of trustees" means the board of trustees established under Chapter [815](#), Government Code, to administer the Employees Retirement System of Texas.

(5) "Cafeteria plan" means a plan defined and authorized by Section 125, Internal Revenue Code of 1986.

(6) "Employee" means an individual eligible to participate in the group benefits program under Section [1551.101](#).

(7) "Employer" means this state and its agencies.

(8) "Executive director" means the executive director of the Employees Retirement System of Texas.

(9) "Full-time employee" means an employee designated as a full-time employee under Section [1551.319](#)(c) or (d) or an employee designated by the employer as working 30 or more hours a week.

(9-a) "Good cause" means that a person's failure to act was not because of a lack of due diligence the exercise of which would have caused a reasonable person to take prompt and timely action. A failure to act based on ignorance of the law or facts reasonably discoverable through the exercise of due diligence does not constitute good cause.

(10) "Group benefits program" means the state employees group benefits program provided by this chapter.

(10-a) "Participant" means an eligible individual who participates in the group benefits program.

(11) "Part-time employee" means an employee designated by the employer as working less than 30 hours a week. For purposes of this chapter, an individual described by Section [1551.101\(e\)\(2\)](#) is considered a part-time employee.

(12) "Serious mental illness" has the meaning assigned by Section [1355.001](#).

(13) "Service" means personal service to the state creditable in accordance with rules adopted by the board of trustees.

(14) "State agency" means a commission, board, department, division, institution of higher education, or other agency of this state created by the constitution or statutes of this state. The term also includes the Texas Municipal Retirement System and the Texas County and District Retirement System.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003. Amended by Acts 2003, 78th Leg., ch. 366, Sec. 2.01, eff. Sept. 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 347 (S.B. [1176](#)), Sec. 24, eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2G.018, eff. April 1, 2009.

Acts 2009, 81st Leg., R.S., Ch. 1308 (H.B. [2559](#)), Sec. 31, eff. September 1, 2009.

Acts 2013, 83rd Leg., R.S., Ch. 618 (S.B. [1459](#)), Sec. 21, eff. September 1, 2013.

Sec. 1551.004. DEFINITION OF DEPENDENT. (a) In this chapter, "dependent" with respect to an individual eligible to participate in the group benefits program means the individual's:

(1) spouse;

(2) unmarried child younger than 26 years of age;

(3) child of any age who the board of trustees determines lives with or has the child's care provided by the individual on a regular basis if the child is mentally or physically incapacitated to the extent that the child is dependent on the individual for care or support, as determined by the board of trustees;

(4) child of any age who is unmarried, for purposes of health benefit coverage under this chapter, on expiration of the child's continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. No. 99-272) and its subsequent amendments; and

(5) ward, as that term is defined by Section 601, Texas Probate Code, who is 26 years of age or younger.

(b) In this section, "child" includes:

(1) a natural child, adopted child, stepchild, foster child, or child in the possession of a participant who is designated as managing conservator of the child under an irrevocable or unrevoked affidavit of relinquishment under Chapter 161, Family Code; or

(2) a child who is related by blood or marriage and was claimed as a dependent on the federal income tax return of an individual who is eligible to participate in the group benefits program under Section 1551.101 or 1551.102 for the calendar year preceding the plan year in which the child is first enrolled as a dependent under Subchapter D, and for each subsequent year in which the child is enrolled as a dependent.

(c) The requirement in Subsection (b)(2) that a child must be claimed as a dependent on a federal income tax return in the calendar year preceding the child's enrollment does not apply if:

(1) the child is born in the year in which the child is first enrolled; or

(2) the participant can demonstrate good cause for not claiming the child as a dependent in the preceding calendar year.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003. Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.401(a), eff. Sept. 1, 2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1308 (H.B. 2559), Sec. 32, eff. September 1, 2009.

Acts 2011, 82nd Leg., R.S., Ch. 109 (H.B. 755), Sec. 1, eff. September 1, 2011.

Acts 2011, 82nd Leg., R.S., Ch. 1249 (S.B. 1664), Sec. 17, eff. September 1, 2011.

Acts 2013, 83rd Leg., R.S., Ch. 618 (S.B. 1459), Sec. 22, eff. September 1, 2013.

Acts 2013, 83rd Leg., R.S., Ch. 1285 (H.B. 2155), Sec. 1, eff. June 14, 2013.

Sec. 1551.005. DEFINITION OF HEALTH BENEFIT PLAN. (a) In this chapter, "health benefit plan" means a plan that provides, pays for, or reimburses expenses for health care services, including comparable health care services for participants who rely solely on spiritual means through prayer for healing in accordance with the teaching of a well-recognized church or denomination.

(b) A health benefit plan shall be provided on a group basis through:

(1) a policy or contract;

- (2) a medical, dental, or hospital service agreement;
- (3) a membership or subscription contract;
- (4) a salary continuation plan;
- (5) a health maintenance organization agreement;
- (6) a preferred provider arrangement; or
- (7) any other similar group arrangement or a combination of policies, plans, contracts, agreements, or arrangements described by this subsection.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.006. DEFINITION OF INSTITUTION OF HIGHER EDUCATION. (a) In this chapter, except as provided by Subsection (b), "institution of higher education" means a public junior college, a senior college or university, or any other agency of higher education within the meaning and jurisdiction of Chapter 61, Education Code.

(b) In this chapter, "institution of higher education" does not include:

(1) an entity in The University of Texas System, as described by Section 65.02, Education Code; and

(2) an entity in The Texas A&M University System, as described by Subtitle D, Title 3, Education Code, including the Texas Veterinary Medical Diagnostic Laboratory.

(c) Notwithstanding Subsection (b), The Texas A&M University System, including the Texas Veterinary Medical Diagnostic Laboratory, participates in the group benefits program if, not later than November 1, 2004, the system notifies the board of trustees of the system's election to participate. If notice is provided as required by this subsection, the employees and annuitants of the system, including the veterinary medical laboratory, and the dependents of those employees and annuitants, participate in the group benefits program effective not later than September 1, 2005.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003. Amended by Acts 2003, 78th Leg., ch. 366, Sec. 2.02, eff. Sept. 1, 2003.

Sec. 1551.007. DEFINITION OF CARRIER. In this chapter, "carrier" means:

(1) an insurance company that is authorized by the department under this code or another insurance law of this state to provide any of the types of insurance coverages, benefits, or services provided for in this chapter and that:

(A) has a surplus of \$1 million;

(B) has a successful operating history; and
(C) has had successful experience, as determined by the department, in providing and servicing any of the types of group coverage provided for in this chapter;

(2) a corporation operating under Chapter [842](#) or [843](#) that provides any of the types of coverage, benefits, or services provided for in this chapter and that:

(A) has a successful operating history; and
(B) has had successful experience, as determined by the department, in providing and servicing any of the types of group coverage provided for in this chapter; or

(3) any combination of carriers described by Subdivisions (1) and (2) on terms the board of trustees prescribes.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003. Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.402, eff. Sept. 1, 2003.

Sec. 1551.008. APPLICABILITY OF DEFINITIONS. The definition of a term defined by this subchapter and the use of the terms "employee" and "annuitant" to refer to individuals eligible to participate in the group benefits program under Sections [1551.101](#) and [1551.102](#) apply to this chapter unless a different meaning is plainly required by the context in which the term appears.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.009. BOARD OF TRUSTEES MAY DEFINE OTHER WORDS. The board of trustees may define by rule a word in terms necessary in the administration of this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.010. BOARD OF TRUSTEES APPROVAL FOR PAYROLL DEDUCTIONS OR REDUCTIONS. A state agency may not establish, continue, or authorize payroll deductions or reductions for any benefit or coverage as provided by this chapter without the express approval of the board of trustees.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.011. EXEMPTION FROM EXECUTION. All benefit payments, contributions of employees and annuitants, and optional benefit payments, any rights, benefits, or payments accruing to a person under this chapter, and all money in a fund created by this chapter:

(1) are exempt from execution, attachment, garnishment, or any other process; and

(2) may not be assigned, except:

(A) for direct payment that a participant may assign to a provider of health care services; and

(B) as specifically provided by this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.012. EXEMPTION FROM STATE TAXES AND FEES. Any coverage established under this chapter, including a policy, an insurance contract, a certificate of coverage, an evidence of coverage, and an agreement with a health maintenance organization or a plan administrator, is not subject to any state tax, regulatory fee, or surcharge, including a premium or maintenance tax or fee.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.013. COMBINING OF CARRIERS NOT RESTRAINT OF TRADE. Carriers combining to bid, underwrite, or both bid and underwrite for the group benefits program are not in violation of Chapter 15, Business & Commerce Code.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.014. EXCLUSIVE REMEDIES. The remedies provided under this chapter are the exclusive remedies available to an employee, participant, annuitant, or dependent.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.403(a), eff. Sept. 1, 2003.

SUBCHAPTER B. ADMINISTRATION AND IMPLEMENTATION

Sec. 1551.051. ADMINISTRATION AND IMPLEMENTATION. The administration and implementation of this chapter are vested solely in the board of trustees.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.052. AUTHORITY FOR RULES, PLANS, PROCEDURES, AND ORDERS. (a) The board of trustees may adopt rules consistent with this chapter as it considers necessary to implement this chapter and its purposes, including rules that provide standards for determining eligibility for participation in the group benefits program, including standards for determining disability.

(b) The board of trustees may adopt a plan, procedure, or order reasonably necessary to implement this chapter and its purposes.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.053. AUTHORITY TO HIRE EMPLOYEES. (a) The board of trustees may hire employees as the board considers necessary to ensure the proper administration of this chapter and the coverages, services, and benefits provided for or authorized by this chapter.

(b) The board of trustees shall determine and assign the compensation and duties of the employees.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.055. GENERAL POWERS OF BOARD OF TRUSTEES REGARDING COVERAGE PLANS. The board of trustees may:

- (1) prepare specifications for a coverage provided under this chapter;
- (2) prescribe the time and conditions under which an employee, annuitant, or dependent is eligible for a coverage provided under this chapter;
- (3) determine the methods and procedures of claims administration;
- (4) determine the amount of payroll deductions and reductions applicable to employees and annuitants and establish procedures to implement those deductions and reductions;
- (5) establish procedures for the board of trustees to decide contested cases arising from a coverage provided under this chapter;

(6) study, on an ongoing basis, the operation of all coverages provided under this chapter, including gross and net costs, administration costs, benefits, utilization of benefits, and claims administration;

(7) administer the employees life, accident, and health insurance and benefits fund;

(8) provide the beginning and ending dates of coverages of participants under all benefit plans;

(9) develop basic group coverage plans applicable to all individuals eligible to participate in the group benefits program under Sections [1551.101](#) and [1551.102](#);

(10) provide for optional group coverage plans in addition to the basic group coverage plans;

(11) provide, as the board of trustees determines is appropriate, either additional statewide optional coverage plans or individual agency coverage plans;

(12) develop health benefit plans that permit access to high-quality, cost-effective health care;

(13) design, implement, and monitor health benefit plan features intended to discourage excessive utilization, promote efficiency, and contain costs;

(14) develop and refine, on an ongoing basis, a health benefit strategy consistent with evolving benefit delivery systems;

(15) develop a funding strategy that efficiently uses employer contributions to achieve the purposes of this chapter and that is reasonable and ensures participants a fair choice among health benefit plans as provided by Section [1551.302](#); and

(16) appoint an advisory committee for the group benefits program under the terms provided by Section [815.509](#), Government Code.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003. Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.406(a), eff. Sept. 1, 2003.

Sec. 1551.056. INDEPENDENT ADMINISTRATOR. (a) The board of trustees may, on a competitive bid basis, contract with an entity to act for the board as an independent administrator or manager of the coverages, services, and benefits authorized under this chapter.

(b) The entity must be a qualified, experienced firm of group insurance specialists or an administering firm and shall assist the board of trustees in ensuring the proper

administration of this chapter and the coverages, services, and benefits provided for or authorized by this chapter.

(c) The board of trustees shall pay an independent administrator selected under this section.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.057. COMPENSATION OF PERSON EMPLOYED BY BOARD OF TRUSTEES. The board of trustees shall pay the compensation and expenses of a person employed by the board at the rate or in the amount approved by the board. The rate or amount may not exceed the rate or amount paid for similar services.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.058. ELECTRONIC AUTHORIZATIONS. (a) The board of trustees may develop a system for a participant to electronically authorize:

- (1) enrollment in a coverage or benefit;
- (2) contributions to a coverage or benefit; and
- (3) deductions or reductions to the participant's compensation or annuity for participation in a coverage or benefit.

(b) Notwithstanding any other law, the board of trustees may permit or require an authorization covered by Subsection (a) to be made electronically.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.059. CERTIFICATE OF COVERAGE. The board of trustees shall provide for issuance to each employee or annuitant participating in the group benefits program a certificate of coverage that states:

- (1) the benefits to which the participant is entitled;
- (2) to whom the benefits are payable;
- (3) to whom a claim must be submitted; and
- (4) the provisions of the plan document, in summary form, that principally affect the participant.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.060. IDENTIFICATION CARDS. (a) The board of trustees may issue a single identification card to a participant in a health benefit plan and separately administered coverage under this chapter that offers pharmacy benefits.

(b) The card may contain information regarding both health and pharmacy benefits.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.061. ANNUAL REPORT. The board of trustees shall submit a written report not later than January 1 of each year to the governor, lieutenant governor, speaker of the house of representatives, and Legislative Budget Board concerning the coverages provided and the benefits and services being received by all participants under this chapter. The report must include information about the effectiveness and efficiency of:

- (1) managed care cost containment practices; and
- (2) fraud detection and prevention procedures.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.062. INFORMATION ON OPERATION AND ADMINISTRATION OF CHAPTER. (a) The board of trustees shall:

(1) conduct a continuing study of the operation and administration of this chapter, including:

(A) conducting surveys and preparing reports on group coverages and benefits available to participants; and

(B) studying experience relating to group coverages and benefits available to participants; and

(2) maintain statistics on the number, type, and disposition of fraudulent claims for benefits under this chapter.

(b) A contract entered into under this chapter must require a carrier to:

(1) furnish any reasonable report the board of trustees determines is necessary to enable the board to perform its functions under this chapter; and

(2) permit the board and a representative of the state auditor to examine records of the carrier as necessary to accomplish the purposes of this chapter.

(c) Each state agency shall keep records, make certifications, and furnish the board of trustees with information and reports necessary to enable the board to perform its functions under this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.063. CONFIDENTIALITY OF CERTAIN RECORDS. (a) The records of a participant in the group benefits program in the custody of the Employees Retirement System of Texas, or of an administering firm, carrier, or another governmental entity acting on behalf of the retirement system, are confidential and not subject to disclosure, and the retirement system, administering firm, carrier, or governmental entity is not required to accept or comply with a request for a record or information about a record or to seek an opinion from the attorney general, because the records are exempt from the provisions of Chapter 552, Government Code, except as provided by this section.

(b) The records may be released to a participant or to an authorized attorney, family member, or representative acting on behalf of the participant.

(c) To accomplish the purposes of this chapter, the board of trustees may release the records to:

(1) an administering firm, carrier, agent, or attorney acting on behalf of the board;

(2) another governmental entity having a legitimate need for the information to perform a function of the board of trustees;

(3) an authorized medical provider of the participant; or

(4) a party in response to a subpoena issued under applicable law.

(d) The records of a participant remain confidential after release to a person as authorized by this section.

(d-1) A record released or received by the Employees Retirement System of Texas under this section may be transmitted electronically, including through the use of an electronic signature or certification in a form acceptable to the retirement system. An unintentional disclosure to, or unauthorized access by, a third party related to the transmission or receipt of information under this section is not a violation by the retirement system of any law, including a law or rule relating to the protection of confidential information.

(e) The records of a participant may become part of the public record of an administrative or judicial proceeding related to a contested case under this chapter unless the records are closed to public access by a protective order issued under applicable law. If a participant's records have become part of the public record of a proceeding and the records are not the subject of a protective order, the participant is considered to have waived the privacy of the participant's records.

(f) The Employees Retirement System of Texas has sole discretion in determining if a record is subject to this section. For purposes of this section, a record includes any identifying information about a person, living or deceased, who is or was an employee, annuitant, dependent, or participant in the group benefits program.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003. Amended by Acts 2003, 78th Leg., ch. 1111, Sec. 33, eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 1276, Sec. 10A.404(a), eff. Sept. 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 347 (S.B. [1176](#)), Sec. 25, eff. September 1, 2005.

Acts 2009, 81st Leg., R.S., Ch. 1308 (H.B. [2559](#)), Sec. 33, eff. September 1, 2009.

Sec. 1551.064. CERTAIN GROUP HEALTH AND ACCIDENT POLICIES OR CONTRACTS. (a) This section applies only to a group policy or contract described by Section [1251.301](#). A policy or contract executed under this chapter must provide that:

(1) premium payments must be:

(A) paid directly to the Employees Retirement System of Texas;

and

(B) postmarked or received not later than the 10th day of the month for which the premium is due;

(2) the premium for group continuation coverage under Subchapter G, Chapter [1251](#), may not exceed the level established for other surviving dependents of deceased employees and annuitants;

(3) at the time the group policy or contract is delivered, issued for delivery, renewed, amended, or extended, the Employees Retirement System of Texas shall give notice of the continuation option to each state agency covered by the group benefits program; and

(4) each state agency shall give written notice of the continuation option to each employee and dependent of an employee who is covered by the group benefits program.

(b) A group policy or contract executed under this chapter must provide that, not later than the 15th day after the date of any severance of the family relationship that might activate the continuation option under Subchapter G, Chapter [1251](#), the group member shall give written notice of the severance to the employing state agency.

(c) On receipt of notice under Subsection (b) or on the death of an employee, the employing state agency shall give written notice of the continuation option to each affected dependent. The notice must state the amount of the premium to be charged and must be accompanied by any necessary enrollment forms.

(d) A covered dependent must exercise the continuation option not later than the 45th day after the date of:

- (1) the severance of the family relationship; or
- (2) the retirement or death of the group member.

(e) A covered dependent must provide written notice of the exercise of the continuation option to the employing state agency within the time prescribed by Subsection (d). Coverage under the policy or contract remains in effect during the period prescribed by Subsection (d) if the premiums are paid.

(f) Any period of previous coverage under the policy or contract must be used in full or partial satisfaction of any required probationary or waiting periods provided in the policy or contract for dependent coverage.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. [2636](#)), Sec. 2G.019, eff. April 1, 2009.

Sec. 1551.065. DISCLOSURE OF SOCIAL SECURITY NUMBER. The board of trustees may require an individual to disclose the individual's social security number as the board considers necessary to properly administer this chapter and any coverage, service, or benefit authorized by this chapter or as otherwise required by state or federal law.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.404(b), eff. Sept. 1, 2003.

Sec. 1551.066. INFORMATION RELATING TO MISCONDUCT. (a) This section applies to:

- (1) the Employees Retirement System of Texas;
- (2) a carrier or other insurance company or health maintenance organization;
- (3) an administering firm or other insurance support organization that provides information or services to the group benefits program or the Employees Retirement System of Texas;

(4) an agent or third-party administrator authorized under this chapter or licensed under this code;

(5) a regulatory authority or department; and

(6) a board member, executive director, employee, auditor, or actuary of an entity described by this section.

(b) A person may collect from, furnish to, or exchange with another person information, including medical records or other confidential information, to the extent the person considers necessary to detect or to impose a sanction for a criminal act, a misrepresentation, or nondisclosure that is related to an attempt to obtain coverage, payment, reimbursement, or a benefit under this chapter.

(c) A person who acts under Subsection (b) is immune from suit and criminal or civil liability unless the person acts with malice or intent to defraud.

Added by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.405(a), eff. Sept. 1, 2003.

Sec. 1551.067. PHARMACY BENEFIT MANAGER CONTRACTS. (a) In awarding a contract to provide pharmacy benefit manager services under this chapter, the board of trustees is not required to select the lowest bid but must select a contract that meets the criteria established by this section.

(b) The contract must state that:

(1) the board of trustees is entitled to audit the pharmacy benefit manager to verify costs and discounts associated with drug claims, pharmacy benefit manager compliance with contract requirements, and services provided by subcontractors;

(2) the audit must be conducted by an independent auditor in accordance with established auditing standards; and

(3) to conduct the audit, the board of trustees and the independent auditor are entitled access to information related to the services and the costs associated with the services performed under the contract, including access to the pharmacy benefit manager's facilities, records, contracts, medical records, and agreements with subcontractors.

(c) The contract must define the information that the pharmacy benefit manager is required to provide to the board of trustees concerning the audit of the retail, independent, and mail order pharmacies performing services under the contract and describe how the results of these audits must be reported to the board of trustees, including how often the results must be reported. The contract must state whether the

pharmacy benefit manager is required to return recovered overpayments to the board of trustees.

(d) The contract must state that any audit of a mail order pharmacy owned by the pharmacy benefit manager must be conducted by an independent auditor selected by the board of trustees in accordance with established auditing standards.

Added by Acts 2009, 81st Leg., R.S., Ch. 1207 (S.B. [704](#)), Sec. 3, eff. September 1, 2009.

Sec. 1551.068. QUALIFICATION OF GROUP BENEFITS PROGRAM. Notwithstanding any provision of this chapter or any other law, it is intended that the provisions of this chapter be construed and administered in a manner that coverages under the group benefits program will be considered in compliance with applicable federal law. The board of trustees may adopt rules that modify the coverage provided under the program by adding, deleting, or changing a provision of the program, including rules that modify eligibility and enrollment requirements and the benefits available under the program.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1249 (S.B. [1664](#)), Sec. 18, eff. September 1, 2011.

SUBCHAPTER C. COVERAGE AND PARTICIPATION

Sec. 1551.101. PARTICIPATION ELIGIBILITY: STATE OFFICERS AND EMPLOYEES. (a) An elected or appointed officer or employee who performs service, other than as an independent contractor, for this state, including an institution of higher education, and who is described by this section is eligible to participate in the group benefits program as an employee on the date specified by Section [1551.1055](#).

(b) An individual is eligible to participate in the group benefits program as provided by Subsection (a) if the individual receives compensation for service performed for this state pursuant to a payroll certified by a state agency, other than an institution of higher education, or by an elected or appointed officer of this state, including a payment made from:

- (1) an amount appropriated by the legislature from a state fund;
- (2) a trust fund held by the comptroller; or
- (3) money paid under the official budget of a state agency, other than money appropriated under a general appropriations act.

(c), (d) Repealed by Acts 2003, 78th Leg., ch. 366, Sec. 2.14.

(e) An individual is eligible to participate in the group benefits program as provided by Subsection (a) if the individual receives compensation for service performed for an institution of higher education pursuant to a payroll certified by an institution of higher education or by an elected or appointed officer of this state and either:

(1) is eligible to become a member of the Teacher Retirement System of Texas after any waiting period provided by law before membership in that retirement system; or

(2) is employed at least 20 hours a week and is not permitted to be a member of the Teacher Retirement System of Texas because the individual is employed by an institution of higher education only in a position that as a condition of employment requires the individual to be enrolled as a student in the institution in graduate-level courses.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003. Amended by Acts 2003, 78th Leg., ch. 366, Sec. 2.03, 2.14, eff. Sept. 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 347 (S.B. [1176](#)), Sec. 26, eff. September 1, 2005.

Sec. 1551.102. PARTICIPATION ELIGIBILITY: ANNUITANTS. (a) An individual who has at least 10 years of service credit, as determined by the board of trustees, for which the individual was eligible to participate in the group benefits program under Section [1551.101](#) or who has at least five years of membership and five years of military service credited in the Employees Retirement System of Texas and who retires in a manner described by this section is eligible, subject to Section [1551.1055](#), to participate as an annuitant in the group benefits program.

(b) An individual is eligible to participate in the group benefits program as provided by Subsection (a) if:

(1) the individual retires under the jurisdiction of the Employees Retirement System of Texas; and

(2) the individual:

(A) receives or is eligible to receive an annuity under Section [814.104\(a\)\(2\)](#), Government Code, and has at least 10 years of eligible service credit;

(B) receives or is eligible to receive an annuity under Chapter [803](#) or Section [814.104\(a\)\(1\)](#), Government Code, has at least 10 years of eligible service credit, and is at least 65 years of age; or

(C) receives or is eligible to receive an annuity that is based on eligibility under Section [814.002](#), [814.102](#), [814.104\(b\)](#), [814.107\(a\)](#), [834.101](#), or [839.101](#), Government Code.

(c) An individual is eligible to participate in the group benefits program as provided by Subsection (a) if:

(1) the individual retires under the jurisdiction of the Teacher Retirement System of Texas and has at least 10 years of eligible service credit, including not more than five years of military service credited in the Employees Retirement System of Texas, or has five years of eligible service credit and is the sole surviving spouse of military personnel who was killed in action;

(2) the individual:

(A) has accumulated eligible service credit in an amount so that the sum of the person's age and amount of service credit, including months of age and credit, equals or exceeds the number 80; or

(B) is at least 65 years of age; and

(3) the individual was employed, as the last state employment before retirement, including employment by a public junior college, by a state agency whose employees are authorized to participate in the group benefits program.

(d) An individual is eligible to participate in the group benefits program as provided by Subsection (a) if:

(1) the individual retires under the optional retirement program established by Chapter [830](#), Government Code;

(2) the individual has at least 10 years of eligible service credit; and

(3) the individual:

(A) is at least 65 years of age, or would have been eligible to retire and receive a service or disability retirement annuity from the Teacher Retirement System of Texas or the Employees Retirement System of Texas in an amount such that the sum of the person's age and amount of service credit, including months of age and credit, equals or exceeds the number 80 or would have been eligible to retire and receive a disability retirement annuity from the Teacher Retirement System of Texas or the Employees Retirement System of Texas, if the individual had not elected to participate in the optional retirement program, and is eligible to receive an annuity or periodic distribution of funds from an account under the optional retirement program; or

(B) is disabled as determined by the Employees Retirement System of Texas based on at least 10 years of eligible service credit, and is receiving an

annuity or periodic distribution of funds from an account under the optional retirement program.

(e) An individual is eligible to participate in the group benefits program as provided by Subsection (a) if the individual retired under Subtitle C, Title 8, Government Code, before September 1, 1991, with at least five and less than 10 years of service credit.

(f) An individual is eligible to participate in the group benefits program if the individual is certified and qualified as disabled and receives or is eligible to receive an annuity under Section 814.202, 814.207, 824.302, only as to higher education, 834.201, or 839.201, Government Code.

(g) An individual is eligible to participate in the group benefits program as provided by Subsection (a) if the individual is at least 65 years of age and retires under a federal or state statutory retirement program not described by another provision of this section, to which an institution of higher education has made employer contributions, and the individual has met service requirements, age requirements, and other applicable requirements comparable to the requirements for retirement under the Teacher Retirement System of Texas, based on at least 10 years of service credit.

(h) A person eligible to participate and participating in the group benefits program as an annuitant on September 1, 2003, may continue to participate in the program as an annuitant if a lapse in coverage has not occurred.

(i) Subject to Section [1551.323](#), an individual and the individual's dependents are eligible to participate in the group benefits program as an annuitant and the dependents of an annuitant if the individual:

(1) served in a position for which the individual was eligible to participate in the group benefits program under Section [1551.101](#) on or before August 31, 2003; and

(2) at the time of retirement meets the requirements for eligibility for participation in the program as an annuitant as those requirements existed on August 31, 2003.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003. Amended by Acts 2003, 78th Leg., ch. 366, Sec. 2.04, 2.05, eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 1111, Sec. 34, eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 1276, Sec. 10A.401(b), eff. Sept. 1, 2003; Acts 2003, 78th Leg., 3rd C.S., ch. 3, Sec. 16.01, eff. Jan. 11, 2004.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1308 (H.B. [2559](#)), Sec. 34, eff. September 1, 2009.

Sec. 1551.1021. PARTICIPATION ELIGIBILITY: CERTAIN FACULTY OF INSTITUTIONS OF HIGHER EDUCATION. (a) An adjunct faculty member at a public institution of higher education is eligible to participate in the group benefits program as an employee if the faculty member:

(1) receives compensation for services rendered to a public institution of higher education as an adjunct faculty member;

(2) was employed as a faculty member by the same public institution of higher education and taught at least one course in the regular fall and spring semester at the public institution of higher education in the preceding academic year; and

(3) is under contract or is scheduled to teach at least 12 semester credit hours in the academic year of coverage or, if the person is also employed by the public institution of higher education to perform nonteaching duties, is under contract or is scheduled to teach at least six semester credit hours in the academic year of coverage and has been approved by the public institution of higher education to participate in the group benefits program.

(a-1) Notwithstanding Subsection (a)(3), an adjunct faculty member at a public institution of higher education who is a professional librarian is eligible to participate in the group benefits program as an employee if the faculty member receives compensation for services rendered to a public institution of higher education as an adjunct faculty member.

(b) From money appropriated from a fund other than the general revenue fund or from money available from local sources, a public institution of higher education may, for an adjunct faculty member eligible to receive benefits under this section, contribute:

(1) not more than 50 percent of the cost of basic coverage for the employee; and

(2) not more than 25 percent of the cost of dependent coverage.

(c) Subsection (b) does not prohibit a public institution of higher education from contributing, from money other than money appropriated from the general revenue fund, amounts that exceed the amount specified in Subsection (b) to provide coverage for a person employed by a public institution of higher education who meets the criteria for eligibility under Subsection (a).

Added by Acts 2003, 78th Leg., ch. 366, Sec. 4.04, eff. Sept. 1, 2003.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 343 (H.B. [2127](#)), Sec. 1, eff. September 1, 2013.

Sec. 1551.1022. PARTICIPATION ELIGIBILITY: CERTAIN POSTDOCTORAL FELLOWS AND GRADUATE STUDENTS. (a) An individual who is not eligible to participate in the group benefits program under Section 1551.101 is eligible to participate in the group benefits program under this section if the individual, at an institution of higher education:

(1) holds:

(A) a postdoctoral fellowship; or

(B) one or more graduate student fellowships awarded to the individual on a competitive basis that, either singly or in combination, are valued at not less than \$10,000 per year; and

(2) is currently receiving a stipend from an applicable fellowship.

(b) An individual who is eligible to participate in the group benefits program under this section shall pay all contributions required under this chapter for the coverage selected by the individual, except that an institution of higher education may make contributions for the individual from available funds other than money appropriated to the institution from the general revenue fund.

(c) An institution of higher education shall determine which individuals are eligible to participate in the group benefits program under this section and, at the time of initial eligibility, shall notify each individual of the individual's eligibility to participate in the program.

(d) An individual who participates in the group benefits program under this section is not considered an employee of an institution of higher education solely as a result of the individual's participation in the program.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1198 (S.B. 29), Sec. 1, eff. September 1, 2011.

Sec. 1551.103. RIGHT TO COVERAGE. Subject to Section 1551.351, an individual eligible to participate in the group benefits program under Section 1551.101 or 1551.102 may not be denied any group coverage under this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.104. AUTOMATIC COVERAGE. (a) Subject to Sections 1551.101 and 1551.102, each full-time employee is covered automatically by the basic coverage

plan for employees and each annuitant is covered by the basic coverage plan for annuitants unless:

- (1) participation is specifically waived as provided by Section [1551.1045](#);
- (2) the employee or annuitant is expelled from the program under Section [1551.351](#); or
- (3) eligibility is otherwise limited by this chapter.

(b) This section does not apply to an employee described by Section [1551.101\(e\)\(2\)](#).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003. Amended by Acts 2003, 78th Leg., ch. 366, Sec. 2.06, eff. Sept. 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 899 (S.B. [1863](#)), Sec. 4.01, eff. August 29, 2005.

Sec. 1551.1045. WAIVER. (a) Subject to Subsections (b) and (c), an employee or annuitant may waive in writing any coverage provided under this chapter.

(b) To waive coverage under the basic coverage plan for employees, a full-time employee must demonstrate, in the manner required by the board of trustees, that the employee is:

- (1) covered by another health benefit plan that provides substantially equivalent coverage, as determined by the board of trustees, to the coverage provided to employees by the basic coverage plan; or
- (2) eligible for benefits under the TRICARE Military Health System.

(c) To waive coverage under the basic coverage plan for annuitants for the purpose of eligibility for an incentive payment under Section [1551.222](#), an annuitant must demonstrate, in the manner required by the board of trustees, that the annuitant is:

- (1) covered by another health benefit plan that provides substantially equivalent coverage, as determined by the board of trustees, to the coverage provided to annuitants by the basic coverage plan; or
- (2) eligible for benefits under the TRICARE Military Health System.

Added by Acts 2005, 79th Leg., Ch. 899 (S.B. [1863](#)), Sec. 4.02, eff. August 29, 2005.

Sec. 1551.105. DATE AUTOMATIC COVERAGE BEGINS. Automatic coverage under this subchapter begins on the date an employee or annuitant becomes eligible for coverage.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.1055. DATE ELIGIBILITY BEGINS; WAITING PERIOD. (a) Except as provided by Subsection (c), (d), or (e), eligibility under Section [1551.101](#) begins not later than the 90th day after the date the employee performs services for a state agency or is qualified for and begins to hold elected or appointed office.

(b) Except as provided by Subsection (c), eligibility under Section [1551.102](#), for an individual who does not retire at the end of the last month for which the individual is on the payroll of a state agency before retirement, begins not later than the 90th day after the date the individual retires.

(c) The waiting period established by Subsections (a) and (b) applies only to the determination of initial eligibility to participate in the group benefits program and does not apply to the determination of initial eligibility to participate in optional and voluntary insurance coverages under the group benefits program.

(d) This subsection applies only to an employee of an institution of higher education or a dependent of the employee. Notwithstanding Subsection (a), eligibility under Section [1551.101](#) may not begin earlier than the first day that an employee performs services for an institution of higher education if any amount paid for premium incurred before the date specified under Subsection (a) for the employee and any dependents of the employee is paid from money not appropriated from the general revenue fund, in accordance with policies and procedures established by the governing body of the institution of higher education.

(e) Eligibility under Section [1551.101](#) for an employee reemployed under Chapter [613](#), Government Code, begins on the first day of reemployment on which the employee performs services for a state agency.

Added by Acts 2003, 78th Leg., ch. 366, Sec. 2.07, eff. Sept. 1, 2003.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 618 (S.B. [1459](#)), Sec. 23, eff. September 1, 2014.

Acts 2015, 84th Leg., R.S., Ch. 150 (H.B. [437](#)), Sec. 1, eff. September 1, 2015.

Sec. 1551.106. GROUP COVERAGE PLAN PURCHASED TO PROVIDE FOR AUTOMATIC COVERAGE. A group coverage plan purchased by the board of trustees must provide for the automatic coverage described by this subchapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.107. CONTINGENT COVERAGE. (a) Each part-time employee or employee eligible to participate in the group benefits program under Section 1551.101(e)(2) may participate in the program on execution of an appropriate application for coverage unless the employee is:

- (1) ineligible for the group benefits program under Section 1551.110; or
- (2) expelled from the group benefits program under Section 1551.351.

(b) An institution of higher education shall, at the time of employment, notify each of the institution's employees eligible to participate in the group benefits program under Section 1551.101(e)(2) of the employee's eligibility to participate.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.108. CONTINUING ELIGIBILITY OF CERTAIN PERSONS WITH LEGISLATIVE SERVICE OR EMPLOYMENT. Subject to Section 1551.351, on application to the board of trustees and on arrangement for payment of contributions and postage:

(1) an individual who has at least eight years of service credit in the Employees Retirement System of Texas for service as a member of the legislature, on ending the individual's service in the legislature, remains eligible for participation in the group benefits program; and

(2) an individual who has at least 10 years of service credit in the Employees Retirement System of Texas as an employee of the legislature, on ending the individual's service for the legislature, remains eligible for participation in the group benefits program.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.109. CONTINUING ELIGIBILITY OF CERTAIN MEMBERS OF BOARDS, COMMISSIONS, AND INSTITUTIONS OF HIGHER EDUCATION. (a) Subject to Section 1551.351, on application to the board of trustees and arrangement for payment of contributions, an individual participating in the group benefits program on August 31, 2003, as a current or former member of a governing body with administrative responsibility over a state agency created under a statute of this state that has statewide

jurisdiction and whose employees are covered by this chapter or as a current or former member of the State Board of Education or the governing body of an institution of higher education remains eligible for participation in a health benefit plan offered under this chapter if a lapse in coverage has not occurred.

(b) A participant described by this section may not receive a state contribution for premiums. The governing body of an institution of higher education may pay from local funds part or all of the contributions the state would pay for similar coverage of other participants in the group benefits program.

(c) The participant's contribution for coverage under a health benefit plan may not be greater than the contribution for continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. No. 99-272).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003. Amended by Acts 2003, 78th Leg., ch. 366, Sec. 2.09, eff. Sept. 1, 2003.

Sec. 1551.110. INELIGIBILITY OF CERTAIN JUNIOR COLLEGE EMPLOYEES.

(a) Except as provided by Subsections (c) and (d), an employee of a public junior college who is employed to perform services outside this state is not eligible to participate in the group benefits program unless the college elects, under procedures adopted by the board of trustees, to permit the employee to participate in the group benefits program.

(b) For purposes of this section, an employee is employed to perform services outside this state if 75 percent or more of the services performed by the employee are performed outside this state.

(c) This section does not apply to an individual employed by a public junior college on August 31, 1999. That individual remains eligible to participate in the group benefits program in the same manner as other employees of the college even if the individual's employment by the college is not continuous.

(d) An employee of a public junior college who is employed to perform services outside this state and who is employed after June 18, 1999, is eligible to participate in a group coverage provided under this chapter if the coverage is provided under an insurance policy, contract, or other agreement that:

(1) is in effect on June 18, 1999; and

(2) requires that the employee be eligible to participate in the coverage provided under the agreement.

(e) Eligibility to participate in a coverage under Subsection (d) ends on the date the insurance policy, contract, or other agreement is terminated or renewed.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.111. PARTICIPATION BY CERTAIN RETIREMENT SYSTEMS. (a) The Texas Municipal Retirement System and the Texas County and District Retirement System shall participate in the group benefits program in the manner described by this section.

(b) Participation is limited to:

(1) an officer or employee of either system who has been an officer or employee of either system following completion of the waiting period described by Section [1551.1055](#);

(2) an eligible dependent of an officer or employee of either system described by Subdivision (1);

(3) an individual who:

(A) was an officer or employee of either system;

(B) has retired from either system, subject to Section [1551.1055](#);

(C) receives or is eligible to receive an annuity from either system or under Chapter [803](#), Government Code, based on at least 10 years of service credit and is at least 65 years of age; and

(D) has at least 10 years of service credit with a state agency whose employees are authorized to participate in the group benefits program; and

(4) an eligible dependent of a retired officer or employee described by Subdivision (3).

(c) Except as provided by Section [1551.114](#), participation in the group benefits program does not extend to:

(1) the governing body of either system;

(2) a municipality or subdivision participating in either system; or

(3) a trustee, officer, or employee, or a dependent of a trustee, officer, or employee, of a participating municipality or subdivision.

(d) A participant described by this section may not receive a state contribution for premiums.

(e) Subject to Section [1551.323](#), an individual and the individual's dependents are eligible to participate in the group benefits program as an annuitant and the dependents of an annuitant as described under this section if the individual:

(1) served as an officer or employee as described by Subsection (b)(1) on or before August 31, 2003; and

(2) at the time of retirement meets the requirements for eligibility for participation in the program as an annuitant as those requirements existed on August 31, 2003.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003. Amended by Acts 2003, 78th Leg., ch. 366, Sec. 2.10, eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 1030, Sec. 1.02, eff. Sept. 1, 2003; Acts 2003, 78th Leg., 3rd C.S., ch. 3, Sec. 16.02, eff. Jan. 11, 2004.

Sec. 1551.112. PARTICIPATION BY TEXAS TURNPIKE AUTHORITY. (a) An individual may participate in the group benefits program as an annuitant, subject to Section [1551.1055](#), and may obtain coverage for the individual's dependents as any other participating annuitant if the individual:

(1) began employment with, or became an officer of, the Texas Turnpike Authority within the three-year period preceding August 31, 1997;

(2) was an officer or employee of the Texas Turnpike Authority on August 31, 1997;

(3) became an officer or employee of the North Texas Tollway Authority on September 1, 1997; and

(4) retires or is eligible to retire with at least 10 years of service credit under the proportionate retirement program established by Chapter [803](#), Government Code, or under a public retirement system to which Chapter [803](#) applies and is at least 65 years of age.

(b) The North Texas Tollway Authority is responsible for payment of the contributions the state would make if the annuitant were a state employee.

(c) Subject to Section [1551.323](#), an individual and the individual's dependents are eligible to participate in the group benefits program as an annuitant and the dependents of an annuitant as described under this section if the individual:

(1) served in a position described by Subsection (a) on or before August 31, 2003; and

(2) at the time of retirement meets the requirements for eligibility for participation in the program as an annuitant as those requirements existed on August 31, 2003.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003. Amended by Acts 2003, 78th Leg., ch. 366, Sec. 2.11, eff. Sept. 1, 2003; Acts 2003, 78th Leg., 3rd C.S., ch. 3, Sec. 16.03, eff. Jan. 11, 2004.

Sec. 1551.113. PARTICIPATION BY CERTAIN EMPLOYEES WHOSE POSITIONS ARE PRIVATIZED OR ELIMINATED. (a) An individual described by Subsection (b) is entitled to receive state contributions required to provide health benefit plan coverage under the group benefits program for two months after the effective date of the individual's separation from state service.

(b) This section applies only to an individual who separates from state service and receives a cash payment under an incentive program implemented by the Texas Department of Human Services or the Texas Department of Health for certain employees whose positions are eliminated as a result of privatization or other reductions in services provided by those agencies.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.114. PARTICIPATION BY COMMUNITY SUPERVISION AND CORRECTIONS DEPARTMENTS. (a) In this section, "employee of a community supervision and corrections department" means an employee of a department established under Chapter [76](#), Government Code.

(b) An employee or retired employee of a community supervision and corrections department shall be treated as an employee or annuitant, as applicable, for purposes of this chapter only as provided by this section.

(c) A community supervision and corrections department of this state participates in the group benefits program administered by the board of trustees under this chapter. Participation under this section is limited to:

(1) active employees of a community supervision and corrections department;

(2) retired employees of a community supervision and corrections department who retire on or after September 1, 2004, and who:

(A) have been employed by one or more community supervision and corrections departments for a total of at least 10 years of creditable service; and

(B) meet all the requirements for retirement benefits prescribed by the Texas County and District Retirement System; and

(3) eligible dependents of the active employees and retired employees described by Subdivisions (1) and (2).

(d) Each full-time active employee of a community supervision and corrections department is automatically covered by the basic coverage for employees unless the employee specifically waives coverage or unless the employee is expelled from the program. Each part-time active employee of a community supervision and corrections department is eligible to participate in the group benefits program on application in the manner provided by the board of trustees, unless the employee has been expelled from the program. Each community supervision and corrections department shall notify each of its part-time employees of the employee's eligibility for participation.

(e) An active employee described by Subsection (d) is not eligible to receive a state contribution under Subchapter G for premiums. The community justice assistance division of the Texas Department of Criminal Justice is responsible for payment of the contributions for each of a department's participating active employees and the employees' dependents that the state would make under Subchapter G if the employees were state employees. Each covered active employee shall pay that portion of the cost of group coverages selected by the employee that exceeds the amount of division contributions.

(f) A retired employee is eligible to participate in the group benefits program on application to the board of trustees. On application, a retired employee is automatically covered by the basic coverage for annuitants unless the retired employee specifically waives coverage or unless the retired employee is expelled from the program. A retired employee is not eligible to receive a state contribution under Subchapter G for premiums. The community justice assistance division of the Texas Department of Criminal Justice is responsible for payment of the contributions for each of a department's retired employees and the retired employees' participating dependents that the state would make under Subchapter G if the retired employees were retired state employees. Each participating retired employee shall pay that portion of the cost of group coverage selected by the retired employee that exceeds the amount of division contributions. The retired employee shall pay contributions required from the retired employee in the manner prescribed by the board of trustees. Each community supervision and corrections department shall notify each of its retired employees of the eligibility for participation and the costs associated with participation.

(g) All contributions received under this section from the community justice assistance division of the Texas Department of Criminal Justice, active employees of community supervision and corrections departments, and retired employees of

community supervision and corrections departments for basic, optional, and voluntary coverages under the group benefits program shall be paid into the employees life, accident, and health insurance and benefits fund and shall be used by the board of trustees to provide those coverages as provided by this chapter.

Added by Acts 2003, 78th Leg., ch. 1030, Sec. 1.03, eff. Sept. 1, 2003.

Sec. 1551.115. PARTICIPATION BY WRONGFULLY IMPRISONED PERSONS. Subject to Section 103.001, Civil Practice and Remedies Code, a person who is entitled to compensation under Chapter 103, Civil Practice and Remedies Code, is eligible to obtain health benefit plan coverage under the group benefits program in the manner and to the extent that an employee of the Texas Department of Criminal Justice would be entitled to coverage, except that this section does not entitle the person's spouse or other dependent or family member to coverage.

Added by Acts 2011, 82nd Leg., R.S., Ch. 698 (H.B. 417), Sec. 9, eff. June 17, 2011.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1107 (S.B. 1686), Sec. 4, eff. September 1, 2011.

SUBCHAPTER D. COVERAGE FOR DEPENDENTS

Sec. 1551.151. ENTITLEMENT TO COVERAGE. An individual who is eligible to participate in the group benefits program under Section 1551.101, 1551.102, or 1551.1022 is entitled to secure for a dependent of the individual any group coverages provided under this chapter, as determined by the board of trustees and subject to the exceptions provided by this subchapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1198 (S.B. 29), Sec. 2, eff. September 1, 2011.

Sec. 1551.152. ELIGIBILITY OF FOSTER CHILD. A foster child is eligible for health benefit plan coverage only if the child is not covered by another governmental health program.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.153. PARTICIPANT RESIDING OUTSIDE OF SERVICE AREA. An individual who is eligible to participate in the group benefits program under Section [1551.101](#) or [1551.102](#) and who resides outside of a health maintenance organization service area is entitled to group coverages for a dependent of the individual without evidence of insurability if the individual applies for the coverage for the dependent during the annual enrollment period.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.154. EMPLOYEE PAYMENTS. In the manner and form the board of trustees determines, payments required of an employee in excess of employer contributions shall be made by:

- (1) a deduction from the employee's monthly pay or retirement benefits;
- or
- (2) a reduction of the employee's salary.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.155. COVERAGE OPTIONS FOR SURVIVING SPOUSE. (a) A surviving spouse of an individual who is eligible to participate in the group benefits program under Section [1551.101](#) or [1551.102](#) and who is entitled to monthly benefits paid by a retirement system named in this chapter may, following the death of the individual, elect to retain:

- (1) the spouse's authorized coverages; and
 - (2) authorized coverages for any dependent of the spouse.
- (b) The coverage is at the group rate for other participants if:
- (1) the coverage was previously secured by the deceased participant for the surviving spouse or dependent; and
 - (2) the surviving spouse directs the applicable retirement system to deduct required contributions from the monthly benefits paid to the spouse by the retirement system.
- (c) A person who is the surviving spouse of an individual described by Subsection (a) may secure group health coverage without evidence of the person's insurability if the individual was eligible to participate in the group benefits program under Section [1551.101](#) or [1551.102](#) but was not participating at the time of the individual's death.

(d) A surviving spouse seeking group coverage under Subsection (c):

(1) must apply for the coverage not later than the 30th day after the date on which the individual who was eligible to participate in the group benefits program dies; and

(2) shall pay for the coverage at the group rate as provided by Subsection (b).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1308 (H.B. [2559](#)), Sec. 35, eff. September 1, 2009.

Sec. 1551.156. COVERAGE OPTIONS FOR SURVIVING DEPENDENT. (a) A surviving dependent of an annuitant who was receiving monthly benefits paid by a retirement system named in this chapter may, following the death of the annuitant if there is not a surviving spouse, elect to retain any coverage previously secured by the annuitant until the dependent becomes ineligible for coverage for a reason other than the death of the member of the group.

(b) The coverage is at the group rate for other participants.

(c) A dependent who elects to retain coverage under this section and who is entitled to monthly benefits from a retirement system named in this chapter based on the service of the deceased annuitant must direct the retirement system to deduct required contributions for the coverage from the monthly benefits paid the surviving dependent by the retirement system.

(d) A person who is a surviving dependent of an annuitant may secure group health coverage after the death of the annuitant without evidence of the person's insurability if the annuitant was eligible to participate in the group benefits program of a retirement system named in this chapter but was not participating at the time of the individual's death.

(e) A surviving dependent seeking group coverage under Subsection (d):

(1) must apply for the coverage not later than the 30th day after the date on which the individual who was eligible to participate in the group benefits program dies; and

(2) shall pay for the coverage at the group rate as provided by Subsection (b).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1308 (H.B. [2559](#)), Sec. 36, eff. September 1, 2009.

Acts 2009, 81st Leg., R.S., Ch. 1308 (H.B. [2559](#)), Sec. 37, eff. September 1, 2009.

Sec. 1551.157. COVERAGE OPTIONS AFTER EXPIRATION OF ANNUITY OPTION. The surviving spouse or dependent of an employee or annuitant may retain authorized coverages after expiration of a time-certain annuity option selected by the employee or annuitant. To retain the coverages, the surviving spouse or dependent must make advance payment of contributions to the Employees Retirement System of Texas under rules adopted by the board of trustees.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.158. REINSTATEMENT OF HEALTH BENEFIT PLAN COVERAGE BY CERTAIN DEPENDENTS. (a) A dependent child who is unmarried and whose coverage under this chapter ends when the child becomes 26 years of age may, on expiration of continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. No. 99-272), reinstate health benefit plan coverage under this chapter if the child, or the child's participating parent, pays the full cost of the health benefit plan coverage.

(b) A state contribution is not payable for coverage under this section.

(c) Coverage under this section terminates at the end of the month in which the child marries.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 618 (S.B. [1459](#)), Sec. 24, eff. September 1, 2013.

SUBCHAPTER E. GROUP COVERAGES

Sec. 1551.201. ESTABLISHMENT. (a) The board of trustees by rule shall establish group coverage plans for individuals eligible to participate in the group benefits program.

(b) The group coverage plans may, in the board of trustees' discretion, include:

- (1) life coverage;
- (2) accidental death and dismemberment coverage;
- (3) health benefit coverage, including coverage for:
 - (A) hospital care and benefits;
 - (B) surgical care and treatment;
 - (C) medical care and treatment;
 - (D) dental care;
 - (E) obstetrical benefits;
 - (F) prescribed drugs, medicines, and prosthetic devices; and
 - (G) supplemental benefits, supplies, and services in accordance

with this chapter;

(4) coverage providing protection against either long-term or short-term loss of salary; and

(5) any other group coverage that the board of trustees, in consultation with the advisory committee, considers advisable.

(c) The group coverage plans for annuitants may, at the discretion of the board of trustees, be separate or a part of the group coverage plans for employees. If the trustee establishes separate group coverage plans for annuitants, the separate group coverage plans must include both full benefits and supplemental coverage options.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003. Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.412(b), eff. Sept. 1, 2003.

Sec. 1551.2011. EMPLOYEE AWARENESS AND EDUCATION. (a) The board of trustees by rule shall ensure that employees receive information about life coverage, accidental death and dismemberment coverage, and long-term and short-term loss of salary coverage, if those coverages are included in a group coverage plan established under Section [1551.201](#).

(b) The information must contain descriptions of:

- (1) probabilities of death and disability; and
- (2) policy exclusions and limitations, including:
 - (A) limitations based on multiple sources of benefits;
 - (B) preexisting condition exclusions; and
 - (C) required waiting periods for benefits.

(c) The board of trustees by rule may provide the information described by Subsections (a) and (b) in printed materials for new employees distributed on the first day of employment. The board of trustees may consider using printed materials, online presentations, and educational presentations to ensure the information described by Subsections (a) and (b) is provided to employees.

(d) If applicable, the board of trustees shall annually review the materials and presentations described by Subsection (c) to determine if changes to the contents of the materials or presentations are necessary. If applicable, the department shall adopt rules necessary for considering and making changes to the materials or presentations.

(e) The board of trustees shall publish the information described by Subsections (a) and (b) on the Employees Retirement System of Texas website.

Added by Acts 2013, 83rd Leg., R.S., Ch. 296 (H.B. [1265](#)), Sec. 1, eff. June 14, 2013.

Sec. 1551.202. AUTHORITY TO DEFINE BASIC COVERAGES. (a) The board of trustees may define the basic coverage applicable to each individual for whom coverage is automatic unless participation is specifically waived.

(b) The board of trustees may define different basic coverage plans for individuals eligible to participate in the uniform program under Section [1551.101](#) and for individuals eligible to participate in the group benefits program under Section [1551.102](#).

(c) Basic coverage must include basic health coverage. The coverage may be offered through any health benefit plan.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.203. AUTHORITY TO DEFINE OPTIONAL COVERAGES. The board of trustees may define optional coverages for which the board may make available employer contributions under Section [1551.303](#).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.204. AUTHORITY TO DEFINE VOLUNTARY COVERAGES. Subject to Section [1551.304](#), the board of trustees may define voluntary coverages.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.205. LIMITATIONS. The board of trustees may not contract for or provide a coverage plan that:

(1) excludes or limits coverage or services for acquired immune deficiency syndrome, as defined by the Centers for Disease Control and Prevention of the United States Public Health Service, or human immunodeficiency virus infection;

(2) provides coverage for serious mental illness that is less extensive than the coverage provided for any physical illness; or

(3) may provide coverage for prescription drugs to assist in stopping smoking at a lower benefit level than is provided for other prescription drugs.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003. Amended by Acts 2003, 78th Leg., ch. 213, Sec. 1, eff. Sept. 1, 2003.

Sec. 1551.206. CAFETERIA PLAN. (a) The board of trustees may develop, implement, and administer a cafeteria plan if the board determines that establishment of the plan:

(1) is feasible;

(2) would be beneficial to the state and to employees who would be eligible to participate in the plan; and

(3) would not adversely affect the coverage plans provided under the group benefits program.

(b) The board of trustees may include in the cafeteria plan any benefit that may be included in a cafeteria plan under federal law.

(c) The board of trustees may enter into a contract or agreement with an independent and qualified agency, individual, or entity to:

(1) develop, implement, or administer a cafeteria plan; or

(2) assist in those activities.

(d) The board of trustees may adopt an order terminating the cafeteria plan and providing a procedure for the orderly withdrawal of the state and its employees from the plan if the board determines that a cafeteria plan established under this section is no longer advantageous to the state or its employees.

(e) The board of trustees may adopt rules for the use of a debit card or other similar technology for claims administration under this section.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003. Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.408(a), eff. Sept. 1, 2003.

Sec. 1551.207. PREMIUM CONVERSION BENEFIT PORTION OF CAFETERIA PLAN. Each employee must be enrolled in the premium conversion benefit portion of a cafeteria plan established under Section [1551.206](#).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.208. DETERMINATION TO SELF-FUND. (a) The board of trustees, in the board's sole discretion, shall determine those coverage plans that the board does not intend to purchase but intends to provide directly from the employees life, accident, and health insurance and benefits fund.

(b) The board of trustees, in the board's sole discretion and under conditions the board approves, may reinsure any coverage the board determines will be provided directly from the employees life, accident, and health insurance and benefits fund under Subsection (a).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.209. COVERAGE EXEMPT FROM INSURANCE LAW. A coverage plan provided under this chapter is exempt from any other insurance law, including common law, that does not expressly apply to the plan or this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003. Amended by Acts 2003, 78th Leg., ch. 1111, Sec. 35, eff. Sept. 1, 2003.

Sec. 1551.210. ACTUARIAL ADVICE FOR SELF-FUNDED COVERAGE. A qualified actuary selected by the board of trustees shall advise the board regarding an actuarially sound level of contributions required to provide coverage directly from the employees life, accident, and health insurance and benefits fund.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.211. CONTINGENCY RESERVE FUND FOR SELF-FUNDED COVERAGE. (a) Before the first day of each state fiscal biennium, the board of trustees shall estimate for an average 60-day period during the biennium the expenditures from the employees life, accident, and health insurance and benefits fund anticipated for self-

funded coverage plans, considering projected claims and administrative expenses for those plans.

(b) The board of trustees shall place the estimated amount in a contingency reserve fund to provide for adverse fluctuations in claims or administrative expenses.

(c) The board of trustees shall include in each request for legislative appropriations to the group benefits program the amount the board determines to be necessary to maintain the contingency reserve fund at the level required by this section.

(d) The board of trustees may invest and reinvest any portion of the contingency reserve fund under the standard of care provided by Section 815.307, Government Code, considering the functional need to provide for adverse fluctuations in claims or administrative expenses.

(e) The interest on, earnings of, and proceeds from the sale of investments of assets in the contingency reserve fund shall be credited to the fund.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.212. FIRMS TO ADMINISTER SELF-FUNDED COVERAGE. (a) For those coverage plans that the board of trustees funds from the employees life, accident, and health insurance and benefits fund, the board may contract with one or more qualified and experienced administering firms to administer the plans in the best interest of the participants in the group benefits program.

(b) The contract may be awarded only after a competitive bid process. The board of trustees is not required to select the lowest bid but shall take into consideration other relevant criteria, including ability to service large group programs and past experience.

(c) If the board of trustees selects a firm whose bid was not the lowest or whose bid differs from that specified, the board shall fully justify and explain the reasons for the action in the minutes of the next meeting of the board.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.213. BIDS FOR PURCHASED COVERAGE. (a) For those coverage plans for which the board of trustees determines to purchase coverage, the board shall notify eligible carriers:

- (1) that competitive bidding will be conducted; and
- (2) of the date by which an eligible carrier must submit a bid on the contract to the board.

(b) The board of trustees shall submit the group coverages provided by the group benefits program for competitive bidding at least every six years.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.214. SELECTION OF BIDS FOR PURCHASED COVERAGE. (a) An actuary selected by the board of trustees shall advise the board as to the actuarial soundness of the bids received under Section [1551.213](#).

(b) The board of trustees:

(1) shall select carriers to provide services that will be in the best interest of participants; and

(2) is not required to select the lowest bid but shall take into consideration other relevant criteria, including ability to service contracts, past experience, and financial ability.

(c) If the board of trustees selects a carrier whose bid differs from that advertised, the board shall record the deviation and shall fully justify and explain the reasons for the deviation in the minutes of the next meeting of the board.

(d) The board of trustees shall notify the carriers that submitted bids of the results of the bidding.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.215. ACCOUNTING BY CARRIER PROVIDING PURCHASED COVERAGE. (a) A carrier providing a coverage purchased under this chapter shall provide an accounting to the board of trustees not later than the 90th day after the end of each plan year.

(b) The accounting must be in a form approved by the board of trustees.

(c) The accounting must state for the period from the coverage's date of issue to the end of the plan year:

(1) the amounts of contributions accrued under the coverage;

(2) the total of mortality and other claims, charges, losses, and expenses incurred; and

(3) the amounts of the carrier's allowance for a reasonable profit and contingencies.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.216. SPECIAL CONTINGENCY RESERVE. (a) A carrier issuing a group coverage plan under this chapter shall hold as a special contingency reserve an amount that equals the amount by which the amount described by Section 1551.215(c)(1) exceeds the sum of the amounts described by Sections 1551.215(c)(2) and (3).

(b) The carrier may use the special contingency reserve only for charges, claims, and expenses under the plan.

(c) The special contingency reserve earns interest at a rate determined before each plan year by the carrier and approved by the board of trustees as consistent with the rates generally used by the carrier for similar funds held under other group coverage plans.

(d) On a determination by the board of trustees that the special contingency reserve has attained an amount estimated by the board to make satisfactory provision for adverse fluctuations in future charges, claims, or expenses under the plan, any further excess shall be deposited to the credit of the employees life, accident, and health insurance and benefits fund.

(e) On discontinuation of a plan, any balance remaining in the special contingency reserve after all charges have been made shall be deposited to the credit of the employees life, accident, and health insurance and benefits fund. The carrier may make the deposit in equal monthly installments over a period of not more than two years.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.217. USE OF EMPLOYEE'S SALARY IN COMPUTATION OF PREMIUM OR COVERAGE. (a) If the board of trustees establishes a group coverage plan that protects against either long-term or short-term loss of salary, the board may use an employee's annual salary in computing the amount of the employee's premium or coverage, or both, under the plan.

(b) In this section, an employee's annual salary includes benefit replacement pay under Subchapter H, Chapter 659, Government Code, as added by Chapter 417, Acts of the 74th Legislature, Regular Session, 1995.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.218. PRIOR AUTHORIZATION FOR CERTAIN DRUGS. (a) In this section, "drug formulary" means a list of drugs preferred for use and eligible for coverage under a health benefit plan.

(b) A health benefit plan provided under this chapter that uses a drug formulary in providing a prescription drug benefit must require prior authorization for coverage of the following categories of prescribed drugs if the specific drug prescribed is not included in the formulary:

- (1) a gastrointestinal drug;
- (2) a cholesterol-lowering drug;
- (3) an anti-inflammatory drug;
- (4) an antihistamine drug; and
- (5) an antidepressant drug.

(c) Repealed by Acts 2009, 81st Leg., R.S., Ch. 1308, Sec. 41(8), eff. September 1, 2009.

Added by Acts 2003, 78th Leg., ch. 213, Sec. 2, eff. Sept. 1, 2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1308 (H.B. [2559](#)), Sec. 41(8), eff. September 1, 2009.

Sec. 1551.219. DISEASE MANAGEMENT SERVICES. (a) In this section, "disease management services" means services to assist an individual manage a disease or other chronic health condition, such as heart disease, diabetes, respiratory illness, end-stage renal disease, HIV infection, or AIDS, and with respect to which the board of trustees identifies populations requiring disease management.

(b) A group health benefit plan offered under the group benefits program must provide disease management services or coverage for disease management services in the manner required by the board of trustees, including:

- (1) patient self-management education;
- (2) provider education;
- (3) evidence-based models and minimum standards of care;
- (4) standardized protocols and participation criteria; and
- (5) physician-directed or physician-supervised care.

Added by Acts 2003, 78th Leg., ch. 589, Sec. 3, eff. June 20, 2003.

Sec. 1551.220. BENEFICIARY CAUSING DEATH OF PARTICIPANT OR BENEFICIARY OF PARTICIPANT. (a) Any benefits, funds, or account balances payable on the death of a participant or the beneficiary of a participant in the group benefits program may not be paid to a person convicted of or adjudicated as having caused that death but instead are payable as if the convicted person had predeceased the decedent.

(b) The Employees Retirement System of Texas is not required to change the recipient of any benefits, funds, or account balances under this section unless it receives actual notice of the conviction or adjudication of a beneficiary. However, the retirement system may delay payment of any benefits, funds, or account balances payable on the death of a participant or beneficiary of a participant pending the results of a criminal investigation or civil proceeding and other legal proceedings relating to the cause of death.

(c) For the purposes of this section, a person has been convicted of or adjudicated as having caused the death of a participant or beneficiary of a participant if the person:

(1) pleads guilty or nolo contendere to, or is found guilty by a court or jury in a criminal proceeding of, causing the death of the participant or beneficiary of a participant, regardless of whether sentence is imposed or probated, and no appeal of the conviction is pending and the time provided for appeal has expired; or

(2) is found liable by a court or jury in a civil proceeding for causing the death of the member or annuitant and no appeal of the judgment is pending and the time provided for appeal has expired.

Added by Acts 2005, 79th Leg., Ch. 347 (S.B. [1176](#)), Sec. 27, eff. September 1, 2005.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1249 (S.B. [1664](#)), Sec. 19, eff. September 1, 2011.

Sec. 1551.222. INCENTIVE PAYMENTS. (a) The board of trustees may allow an incentive payment under this section to an employee or annuitant who elects to waive coverage under the basic coverage plan for employees or annuitants as provided by Section [1551.1045](#)(b) or (c).

(b) The incentive payment authorized by this section is in the amount authorized by the General Appropriations Act and may be used by the employee or annuitant, in the manner prescribed by the board of trustees, only to pay for other group coverage plans

provided under the group benefits program, including the supplemental health coverage offered under Section 1551.221.

(c) The board of trustees, at the time of initial enrollment in the group benefits program and during subsequent open-enrollment periods, shall inform employees and annuitants that they may make an election described by Subsection (a), if eligible, and receive any authorized incentive payment.

Added by Acts 2005, 79th Leg., Ch. 899 (S.B. 1863), Sec. 4.03, eff. August 29, 2005.

Sec. 1551.224. MAIL ORDER REQUIREMENT FOR PRESCRIPTION DRUG COVERAGE PROHIBITED. (a) The board of trustees or a health benefit plan under this chapter that provides benefits for prescription drugs may not require a participant in the group benefits program to purchase a prescription drug through a mail order program.

(b) Except as provided by Subsection (c), the board of trustees or a health benefit plan shall require that a participant who chooses to obtain a prescription drug through a retail pharmacy or other method other than by mail order pay a deductible, copayment, coinsurance, or other cost-sharing obligation to cover the additional cost of obtaining a prescription drug through that method rather than by mail order.

(c) The board of trustees or a health benefit plan may not require a participant who obtains a multiple-month supply of a prescription drug from a retail pharmacy under Section 1560.003 to pay a deductible, copayment, coinsurance, or other cost-sharing obligation that differs from the amount the participant pays for a multiple-month supply of that drug through a mail order program.

Added by Acts 2003, 78th Leg., ch. 213, Sec. 2, eff. Sept. 1, 2003.

Renumbered from Insurance Code, Section 1551.219 by Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 17.001(52), eff. September 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1207 (S.B. 704), Sec. 4, eff. September 1, 2009.

Sec. 1551.225. BARIATRIC SURGERY COVERAGE. (a) The board of trustees shall develop a cost-neutral or cost-positive plan for providing under the group benefits program bariatric surgery coverage for employees eligible to participate in the program under Section 1551.101.

(b) The board of trustees may adopt rules as necessary to implement this section.

Added by Acts 2009, 81st Leg., R.S., Ch. 1270 (H.B. [1290](#)), Sec. 2, eff. September 1, 2009.

Added by Acts 2009, 81st Leg., R.S., Ch. 1399 (S.B. [2577](#)), Sec. 1, eff. September 1, 2009.

Sec. 1551.226. TOBACCO CESSATION COVERAGE. (a) The board of trustees shall develop a plan for providing under any health benefit plan provided under the group benefits program tobacco cessation coverage for participants.

(b) The plan developed under Subsection (a) must include coverage for prescription drugs that aid participants in ceasing the use of tobacco products.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1249 (S.B. [1664](#)), Sec. 20, eff. September 1, 2011.

Sec. 1551.227. TRICARE MILITARY HEALTH SYSTEM SUPPLEMENTAL PLAN. (a) The board of trustees shall make available a TRICARE Military Health System supplemental plan to an employee or annuitant who waives coverage under the basic coverage plan under Section [1551.1045](#) and is eligible for benefits under the TRICARE Military Health System. The board of trustees may not contribute to the cost of the supplemental plan, including the premium cost.

(b) A plan offered under this section must be considered a permissible offering to TRICARE participants and beneficiaries under 10 U.S.C. Section 1097c.

(c) The board of trustees may adopt rules necessary to implement this section, including rules regarding eligibility for the plan, available insurance products, and enrollment in the plan.

Added by Acts 2015, 84th Leg., R.S., Ch. 807 (H.B. [3307](#)), Sec. 1, eff. June 17, 2015.

SUBCHAPTER F. GROUP LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE COVERAGE PLAN

Sec. 1551.251. GROUP LIFE INSURANCE COVERAGE PLAN. (a) The board of trustees shall administer a group life insurance coverage plan to provide each individual eligible to participate in the group benefits program under Section [1551.101](#) or [1551.102](#) group life coverages that provide payments and benefits in an amount and manner the board determines.

(b) The group life insurance coverage plan is subject to the conditions and limitations of:

- (1) this chapter and rules adopted under this chapter; and
- (2) the policy or policies purchased by the board of trustees.

(c) The board of trustees may include the dependents of individuals eligible to participate in the group benefits program under Section [1551.101](#) or [1551.102](#) in the group life insurance coverage plan.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.252. **ADDITIONAL TERM LIFE INSURANCE.** Notwithstanding any other provision of this code, the board of trustees may authorize:

- (1) dependent term life insurance in an amount equal to the term life insurance provided under the basic coverage; and
- (2) optional term life insurance in an amount equal to four times the employee's annual salary plus the amount of term life insurance provided under the basic coverage.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.253. **DETERMINATION OF ANNUAL SALARY.** (a) To implement this subchapter, the board of trustees shall:

- (1) adopt rules for the conversion of other than annual rates of salary; and
- (2) specify the types of pay included in annual salary and any other matter necessary to implement this subchapter.

(b) For the purpose of determining the amount of an employee's optional term life insurance coverage, an employee's annual salary includes benefit replacement pay under Subchapter H, Chapter [659](#), Government Code, as added by Chapter 417, Acts of the 74th Legislature, Regular Session, 1995.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.254. **ACCELERATED LIFE INSURANCE BENEFITS.** (a) In addition to exercising the authority granted under Subchapter B, Chapter [1111](#), the board of trustees may adopt rules to provide for payment of accelerated life insurance benefits to a terminally ill, terminally injured, or permanently disabled participant, including an

annuitant participating in optional term life insurance coverage, in amounts that benefit the participant without increasing the cost of providing the benefits.

(b) The amount of any payment of an accelerated benefit under a rule adopted under this section must be deducted from the amount that would otherwise be payable as a death benefit.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.255. INCLUSION OF PROVISIONS FOR VIATICAL SETTLEMENTS.

(a) In this section, "viatical settlement" has the meaning assigned to "life settlement contract" by Section [1111A.002](#).

(b) The board of trustees shall adopt rules that require a group life insurance coverage plan established under this chapter to allow a participant in the plan to make, in conjunction with receipt of a viatical settlement, an irrevocable designation of beneficiary for part or all of the group life coverage benefits.

(c) A viatical settlement is not valid for any coverage under the group benefits program unless the participant has a terminal illness or terminal injury, as defined by rules adopted by the board of trustees, at the time application for benefits is made.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1156 (H.B. [2277](#)), Sec. 16, eff. September 1, 2011.

Sec. 1551.256. OPTIONAL TERM LIFE INSURANCE COVERAGE AFTER RETIREMENT. (a) A participant in the optional group term life insurance coverage plan may maintain optional term life insurance coverage after retirement in addition to basic term life insurance coverage after retirement.

(b) The board of trustees may adopt rules to implement and administer Subsection (a).

(c) Under Subsection (a), the participant may maintain an amount of optional term life insurance coverage on the participant's life on the date of retirement, not to exceed two times the participant's annual salary on the last September 1 before retirement and subject to benefit reduction factors based on age as determined by the board of trustees.

(d) The board of trustees shall determine the premium rate for optional term life insurance coverage for annuitants under Subsection (a). The rate must be comparable to the premium rate for optional term life insurance coverage for employees of the same age.

(e) As an alternative to the optional term life insurance coverage plan, an annuitant may choose a minimum optional term life insurance coverage amount not subject to benefit reduction factors based on age, with a coverage amount and premium rate determined by the board of trustees.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.257. ELIGIBILITY OF ANNUITANT FOR EXTENDED INSURANCE BENEFITS. An annuitant participating in optional term life insurance coverage is not eligible for premium-waived extended insurance benefits if the total disability begins after the date of retirement.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.258. TERMINATION OF ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE COVERAGE ON RETIREMENT. Without regard to the employee's age, accidental death and dismemberment insurance coverage ends on the employee's date of retirement.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.259. ORDER OF PRECEDENCE OF PAYMENT TO SURVIVORS.
(a) The amount of group life coverage and group accidental death and dismemberment coverage in force for a participant on the date the participant dies shall be paid, on the establishment of a valid claim, to a person surviving the death in the following order of precedence:

(1) to the beneficiary designated by the participant in a signed and witnessed document mailed before the death of the participant;

(2) if a beneficiary is not designated, to the spouse of the participant;

(3) if Subdivisions (1) and (2) do not apply, to the children of the participant and descendants of the deceased children by representation;

(4) if Subdivisions (1)-(3) do not apply, to the parents of the participant or the survivor of the parents;

(5) if Subdivisions (1)-(4) do not apply, to the executor or administrator of the estate of the participant; or

(6) if Subdivisions (1)-(5) do not apply, to other relatives of the participant entitled under applicable laws of the participant's domicile on the date of the participant's death.

(b) If before the first anniversary of the date of death of the participant a claim for payment has not been filed by a person entitled under the order of precedence in Subsection (a), or if payment to the person within that period is prohibited by any statute or rule, payment may be made in the order of precedence as if the person had predeceased the participant.

(c) If before the second anniversary of the date of death of the participant a claim for payment has not been filed by a person entitled under the order of precedence in Subsection (a), and neither the board of trustees nor the office established by the administering carrier has received notice that the claim will be made, payment may be to a claimant equitably entitled to the payment as determined by the board.

(d) If before the fourth anniversary of the date of death of the participant payment has not been made under this section and a claim for payment by a person entitled under this section is not pending, the amount payable escheats to the credit of the employees life, accident, and health insurance and benefits fund.

(e) The board of trustees shall give effect to a full or partial disclaimer of benefits executed in accordance with Chapter [240](#), Property Code.

(f) Payment under Subsection (b) or (c) bars recovery by any other person.

(g) For purposes of Subsection (a)(1), a designation, change, or cancellation of a beneficiary in a document, including a will, that is not executed and filed in the manner described by that subsection is not valid.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 347 (S.B. [1176](#)), Sec. 28, eff. September 1, 2005.

Acts 2015, 84th Leg., R.S., Ch. 562 (H.B. [2428](#)), Sec. 12, eff. September 1, 2015.

SUBCHAPTER G. CONTRIBUTIONS AND COSTS

Sec. 1551.301. FUNDING OF BASIC COVERAGE. The board of trustees shall use the amount appropriated for employer contributions in the manner provided by this subchapter to fund the basic coverage.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.3015. COST ASSESSMENT FOR CERTAIN PARTICIPANTS. Notwithstanding any other provision of law, the board of trustees may impose against an employer whose employees are not paid salaries from amounts appropriated by the General Appropriations Act and whose participation in the group benefits program begins after August 31, 2003, as a condition for participation in the program, a one-time assessment of administrative costs for participation of the employees and annuitants in the program, which may include the actuarial costs of including the group in the program and a participation premium determined by the board. The board of trustees shall deposit all amounts recovered under this section in the employees life, accident, and health insurance and benefits fund.

Added by Acts 2003, 78th Leg., ch. 366, Sec. 2.08, eff. Sept. 1, 2003.

Sec. 1551.302. ALLOCATION OF EMPLOYER CONTRIBUTIONS. (a) The board of trustees may equitably allocate to each health benefit plan the employer contributions that would be required to fund basic health coverage for participants in the plans to the extent funds are available.

(b) In allocating the employer contributions among plans, the board of trustees shall consider the relevant risk characteristics of each plan's enrollment, including:

- (1) demographic variations in the use and cost of health care; and
- (2) prevailing cost patterns in the area in which the plan operates.

(c) The allocation must be reasonable and set in a manner that ensures participants a fair choice among health benefit plans providing a basic plan.

(d) The contribution set for each participant must be within the total amount appropriated in the General Appropriations Act.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.303. FUNDING OF OPTIONAL COVERAGES. The board of trustees may allocate any employer contributions remaining after the basic coverage has been funded to fund optional coverages in any manner the board determines is appropriate.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.304. FUNDING OF VOLUNTARY COVERAGES. The board of trustees may not allocate any employer contributions to fund voluntary coverages. Voluntary coverages may be funded only by participant contributions.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.305. COST OF BASIC COVERAGE EXCEEDING EMPLOYER CONTRIBUTIONS. If the cost of the basic coverage for an individual eligible to participate in the group benefits program under Section [1551.101](#) or [1551.102](#) exceeds the amount of employer contributions allocated to fund the basic coverage, the state shall deduct from or reduce the monthly compensation of the participant or deduct from the retirement benefits of the participant, as applicable, an amount sufficient to pay the cost of the basic coverage.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.306. PAYMENT OF EXCESS COST OVER BASIC COVERAGE CONTRIBUTION. (a) The board of trustees shall apply the amount of any employer contribution for optional coverages to the excess of the cost of the basic and optional coverages for which an individual eligible to participate in the group benefits program under Section [1551.101](#) or [1551.102](#) applies over the basic coverage contribution.

(b) Except as provided by Section [1551.309](#), if a participant applies for basic and optional coverages for which the cost exceeds the employer contributions for those coverages under this chapter, the participant shall authorize in a form and manner satisfactory to the board of trustees a deduction from the participant's monthly compensation or monthly annuity equal to the difference between:

(1) the cost of basic and optional coverages for which the participant applies; and

(2) the employer contributions for basic and optional coverages.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.307. PAYMENT FOR VOLUNTARY COVERAGES. Except as provided by Section [1551.309](#), if an individual eligible to participate in the group benefits program under Section [1551.101](#) or [1551.102](#) applies for voluntary coverages, the participant shall authorize in a form and manner satisfactory to the board of trustees a deduction from the participant's monthly compensation or monthly annuity equal to the cost of the voluntary coverages.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.3075. TOBACCO USER PREMIUM DIFFERENTIAL. (a) The board of trustees shall assess each participant in a health benefit plan provided under the group benefits program who uses one or more tobacco products a tobacco user premium differential, to be paid in monthly installments. Except as provided by Subsection (b), the board of trustees shall determine the amount of the monthly installments of the premium differential.

(b) If the General Appropriations Act for a state fiscal biennium sets the amount of the monthly installments of the tobacco user premium differential for that biennium, the board of trustees shall assess the premium differential during that biennium in the amount prescribed by the General Appropriations Act.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1249 (S.B. [1664](#)), Sec. 21, eff. September 1, 2011.

Sec. 1551.3076. EMPLOYER ENROLLMENT FEE. (a) The board of trustees shall assess each employer whose employees participate in the group benefits program an employer enrollment fee in an amount not to exceed a percentage of the employer's total payroll, as determined by the General Appropriations Act.

(b) The board of trustees shall deposit the enrollment fees to the credit of the employees life, accident, and health insurance and benefits fund to be used for the purposes specified by Section [1551.401](#).

Added by Acts 2011, 82nd Leg., R.S., Ch. 1249 (S.B. [1664](#)), Sec. 22, eff. September 1, 2011.

Sec. 1551.308. NO CONTRIBUTION ON REFUSAL OF COVERAGE. The state and a state agency may not make any contribution to the cost of any coverages or benefits provided under this chapter for an individual who refuses the coverages or benefits in a form and manner satisfactory to the board of trustees.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.309. EMPLOYEE PAYMENTS FOR PARTICIPATION IN CAFETERIA PLAN. (a) If an employee elects to participate in the cafeteria plan, the employee must execute a salary reduction agreement under which the employee's monthly compensation will be reduced in an amount equal to the difference between:

- (1) the employer contributions for basic and optional coverages; and
- (2) the cost of the cafeteria plan coverages the board of trustees identifies as comparable to the basic and optional coverages for which the employee is eligible.

(b) The salary reduction agreement must also provide for an additional reduction in the employee's compensation equal to the cost of voluntary coverages for which the employee has applied.

(c) An employee who executes a salary reduction agreement for a group coverage plan included in the cafeteria plan elects to participate in the cafeteria plan and agrees to a salary reduction for the coverages for subsequent plan years unless the employee, during an annual enrollment period specified by the board of trustees, elects in a form and manner satisfactory to the board not to participate for the next plan year in the coverages.

(d) An employee who elects not to participate in the cafeteria plan group coverage plans may reenroll by executing a new salary reduction agreement during a subsequent annual enrollment period.

(e) A salary reduction agreement for cafeteria plan benefits, other than a group coverage plan, must be executed annually during the annual enrollment period.

(f) The employee shall pay any remaining portion of the cost of benefits that is not covered by the contributions for basic and optional coverages and the salary reduction under the cafeteria plan by executing a payroll deduction agreement.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.310. STATE CONTRIBUTION REQUIRED. The state shall contribute to the cost of each participant's group coverages, including dependents' group coverages, the amounts appropriated for the coverages in the General Appropriations Act.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.311. AMOUNT OF STATE CONTRIBUTION. (a) Not later than November 1 preceding each regular session of the legislature, the board of trustees, in coordination with the Legislative Budget Board, shall certify to the budget division of the governor's office for information and review the amount necessary to pay the contributions of the state to the board for the coverages provided under this chapter during the following biennium.

(b) The governor shall include the amount in the budget that the governor submits to the legislature.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 812 (S.B. [1812](#)), Sec. 4, eff. June 14, 2013.

Sec. 1551.3111. AMOUNT OF STATE CONTRIBUTION FOR CERTAIN JUNIOR COLLEGE EMPLOYEES. (a) In computing the amount to be certified under Section [1551.311](#), for participants who are employed by public junior colleges or public junior college districts, the board of trustees shall include:

(1) 50 percent of the cost associated with eligible employees who:

(A) otherwise are eligible to participate in the group benefits program; and

(B) are instructional or administrative employees whose salaries may be fully paid from funds appropriated under the General Appropriations Act, regardless of whether such salaries are actually paid from appropriated funds; and

(2) none of the cost associated with employees who:

(A) do not meet the requirements of Subdivision (1)(B) but are otherwise eligible to participate in the group benefits program; or

(B) cannot be included as a qualifying employee under Subdivision (1) by application of Subsection (c).

(b) For qualifying employees under Subsection (a)(1), the board of trustees shall include only the amount payable by the state under Subsection (a)(1) in determining the amount to be certified under Section [1551.311](#).

(c) In determining the amount described by Subsection (b), the number of qualifying employees under Subsection (a)(1) whose group benefits program costs may be included for each public junior college or public junior college district in each biennium may not be adjusted in a proportion greater than the change in student enrollment at each college during the reporting period except that a college that experiences a decline in student enrollment may petition the Legislative Budget Board to maintain the number of eligible employees up to 98 percent of the level of the prior biennium.

Added by Acts 2013, 83rd Leg., R.S., Ch. 812 (S.B. [1812](#)), Sec. 5, eff. June 14, 2013.

Sec. 1551.313. AMOUNT OF STATE CONTRIBUTION FOR CERTAIN SURVIVING DEPENDENTS. If funds are specifically appropriated for the purpose, this state shall pay the same portion of the cost of the required contributions for a deceased annuitant's surviving spouse or other surviving dependent who elects to retain coverage under Section [1551.156](#) as this state pays for similar dependent coverage for an employee or annuitant participating in the program.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.314. CERTAIN STATE CONTRIBUTIONS PROHIBITED. A state contribution may not be:

(1) made for coverages under this chapter selected by an individual who receives a state contribution for coverages under a group benefits program provided by another state health plan or by an institution of higher education, as defined by Section [61.003](#), Education Code; or

(2) made for or used to pay a tobacco user premium differential assessed under Section [1551.3075](#).

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by:

Acts 2011, 82nd Leg., R.S., Ch. 1249 (S.B. [1664](#)), Sec. 23, eff. September 1, 2011.

Sec. 1551.315. REQUIRED CONTRIBUTIONS BY STATE AGENCIES. (a) The governing board of each state agency participating in the group benefits program shall pay to the board of trustees an amount equal to the amount appropriated by the legislature for each employee's individual group coverages or dependents' group coverages for the agency's employees who are, and annuitants who were, compensated from funds not appropriated in the General Appropriations Act.

(b) The state agency shall:

(1) include the required contributions from funds not appropriated in the General Appropriations Act in its annual operating budget;

(2) ensure current participant coverages based on the records of the board of trustees;

(3) make timely payments of amounts due the board of trustees from all fund sources under the state agency's control; and

(4) each month reconcile board of trustees and state agency records of coverages and payments.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.316. ALLOCATION TO BOARD OF TRUSTEES OF EMPLOYER CONTRIBUTIONS. From the several funds from which employees receive their respective salaries, all employer contributions computed in accordance with this chapter and rules adopted under this chapter are allocated to the board of trustees as provided by this chapter.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.317. PAYMENT OF EMPLOYER CONTRIBUTIONS ALLOCATED BY THE STATE. (a) All money allocated by this state, including by institutions of higher education, to the board of trustees under this chapter shall be paid to the board in monthly installments based on the annual estimate by the board of the contributions to be received for all employees during the year.

(b) At the end of each fiscal year, the board of trustees shall make any adjustments required to cover the difference between:

(1) the annual estimate; and

(2) the actual amount of the employer contributions during the year.

(c) Each monthly installment shall be paid to the appropriate fund created by this chapter in the amount certified by the board of trustees.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.318. PAYMENT OF EMPLOYER CONTRIBUTIONS NOT ALLOCATED BY THE STATE. (a) The board of trustees shall certify to the governing board of each state agency participating in the group benefits program that provides contributions for its employees' group coverages and dependents' group coverages from operating budgets provided from sources other than the General Appropriations Act the proportionate amounts required to pay its contributions.

(b) The board of trustees shall make the certification not later than the 30th day before the date of the meeting at which the governing board of the state agency adopts its operating budget.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.319. AMOUNT OF CONTRIBUTION FOR FULL-TIME AND PART-TIME EMPLOYEES. (a) A full-time employee receives the benefits of a full state contribution for coverage under this chapter.

(b) A part-time employee receives the benefits of one-half of the amount of the state contribution received by a full-time employee.

(c) The superintendent of the Texas School for the Deaf and the superintendent of the Texas School for the Blind and Visually Impaired shall determine whether an educational professional employee under contract with the school under Section [30.024](#) or [30.055](#), Education Code, as applicable, is a full-time employee for purposes of this chapter.

(d) The executive head of the Windham School District shall determine whether an educational professional employee of the school is a full-time employee for purposes of this chapter.

(e) This section does not prohibit an institution of higher education from contributing, from money not appropriated from the general revenue fund, amounts in excess of the state contribution for a part-time employee described by Section [1551.101\(e\)\(2\)](#).

(f) Notwithstanding any other provision of this section, if the board of trustees establishes a supplemental health coverage program under Section 1551.221, the

amount of the contribution made for an individual who elects to receive supplemental health coverage under the program may be reduced, as provided in the General Appropriations Act, to reflect the reduced cost of the supplemental health coverage.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003. Amended by Acts 2003, 78th Leg., ch. 366, Sec. 2.12, eff. Sept. 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 178 (H.B. 417), Sec. 2, eff. May 27, 2005.

Sec. 1551.3195. AMOUNT OF CONTRIBUTION FOR ANNUITANTS WHO WERE PART-TIME EMPLOYEES. An annuitant who as an employee received the benefits of a state contribution under Section 1551.319(b) for coverage during any portion of the annuitant's last employment by a state agency is not eligible to receive more than the state contribution provided under Section 1551.319(b) unless the annuitant was designated by the annuitant's employer as a full-time employee during the three-consecutive-month period before retirement.

Added by Acts 2005, 79th Leg., Ch. 347 (S.B. 1176), Sec. 29, eff. January 1, 2006.

Sec. 1551.3196. AMOUNT OF CONTRIBUTION FOR CERTAIN ANNUITANTS.

(a) An annuitant receives the benefits of a state contribution for coverage under this chapter based on the annuitant's eligible service credit, as follows:

(1) for an annuitant with 20 years or more of eligible service credit, a full state contribution;

(2) for an annuitant with at least 15 years but less than 20 years of eligible service credit, 75 percent of a full state contribution; and

(3) for an annuitant with less than 15 years of eligible service credit, 50 percent of a full state contribution.

(b) An annuitant receiving a reduced state contribution under Subsection (a) shall have any state contribution for dependent coverage reduced in an amount proportional to the reduction under Subsection (a).

(c) This section does not apply to an individual who:

(1) receives or is eligible to receive an annuity that is based on eligibility under Section 814.002, 814.102, 834.101, or 839.101, Government Code; or

(2) is eligible to participate in the group benefits program under:

(A) Section 1551.102(d) because of a disability; or

(B) Section [1551.102\(f\)](#).

Added by Acts 2013, 83rd Leg., R.S., Ch. 618 (S.B. [1459](#)), Sec. 25, eff. September 1, 2014.

Sec. 1551.320. CERTAIN COSTS. The Texas Higher Education Coordinating Board shall pay all costs incurred in determining whether an individual is disabled if:

(1) the individual is an annuitant under the optional retirement program established by Chapter [830](#), Government Code; and

(2) the individual's last state employment was as an officer or employee of the coordinating board.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.322. REQUIRED CONTRIBUTIONS BY TEXAS DEPARTMENT OF CRIMINAL JUSTICE. (a) Not later than August 1 of each year, the board of trustees shall notify the community justice assistance division of the Texas Department of Criminal Justice of:

(1) the estimated number of community supervision and corrections department active employees, retired employees, and dependents of active or retired employees to be covered under the group benefits program for the following fiscal year; and

(2) administrative costs incurred by the board of trustees that are specifically attributable to processing this population.

(b) The community justice assistance division of the Texas Department of Criminal Justice, on receipt of the notification described by Subsection (a), shall:

(1) make timely payments of amounts due the board of trustees, including the administrative costs incurred by the board of trustees; and

(2) reconcile, each month, the board of trustees records and the division records of coverage and payments.

Added by Acts 2003, 78th Leg., ch. 1030, Sec. 1.04, eff. Sept. 1, 2003.

Sec. 1551.323. COST OF CERTAIN ANNUITANTS. (a) An annuitant eligible to participate under Section [1551.102\(i\)](#), [1551.111\(e\)](#), or [1551.112\(c\)](#) is, except as provided by this subsection, required to pay the total cost, as determined by the board, attributable

to the participation of that individual and the dependents of that individual until the date the individual is 65 years of age. If the General Appropriations Act or other similar legislation addresses the payment of those costs, those costs shall be paid in the manner specified by that legislation.

(b) This section applies only to an individual who is eligible to participate as an annuitant under Section [1551.102\(i\)](#), [1551.111\(e\)](#), or [1551.112\(c\)](#) and who is not eligible to participate under another provision of Section [1551.102](#), [1551.111](#), or [1551.112](#).

Added by Acts 2003, 78th Leg., 3rd C.S., ch. 3, Sec. 16.04, eff. Jan. 11, 2004.

Sec. 1551.324. REDUCTION IN CONTRIBUTION FOR CERTAIN ACTIVE EMPLOYEES AND ANNUITANTS; INCENTIVE PAYMENTS. (a) Notwithstanding any other provision of this subchapter, the state contribution for an employee's coverage or an annuitant's coverage under this chapter may be reduced, as provided in the General Appropriations Act, to reflect the reduced cost of coverage for an employee or annuitant who elects to waive basic coverage as provided by Section [1551.1045\(b\)](#) or (c).

(b) Instead of the full state contribution for an employee or annuitant who makes an election described by Subsection (a), the state may contribute, as specified by the General Appropriations Act, an amount for the incentive payment authorized by Section [1551.222](#).

Added by Acts 2005, 79th Leg., Ch. 899 (S.B. [1863](#)), Sec. 4.04, eff. August 29, 2005.

SUBCHAPTER H. SANCTIONS AND ADJUDICATION OF CLAIMS

Sec. 1551.351. ADMINISTRATIVE PROCESS AND SANCTIONS FOR PROGRAM VIOLATIONS. (a) The Employees Retirement System of Texas may impose one or more sanctions described by this section against any employee, participant, annuitant, or dependent who:

(1) submits a materially false claim or application for coverage under a group coverage plan offered under the group benefits program;

(2) defrauds or attempts to defraud a group coverage plan offered under the group benefits program;

(3) obtains or induces the extension of coverage under any program provided under this chapter by a materially negligent or intentional misrepresentation, a failure to disclose material information, or fraud; or

(4) induces the extension of coverage under any program provided under this chapter by supplying false information on an application for coverage or in related documentation or in any communication.

(b) On receipt of a complaint or on its own motion, if the Employees Retirement System of Texas determines that an employee, participant, annuitant, or dependent has engaged in conduct described by Subsection (a), the retirement system may:

(1) expel from the program the employee, participant, annuitant, or dependent;

(2) impose limitations on the person's participation in the program;

(3) rescind any coverage obtained or extended as a result of the conduct under Subsection (a);

(4) deny a claim arising from coverage; or

(5) require the person to reimburse the employees life, accident, and health insurance and benefits fund for any benefit obtained as a result of the conduct.

(c) An expulsion under Subsection (b) may be permanent or for a specified period. A rescission of coverage under Subsection (b) may be from the date of inception of the coverage or from the date of the prohibited conduct.

(d) A person may appeal a determination made under Subsection (a) or (b) or Section 1551.352 only to the board of trustees. A proceeding under this subsection is a contested case under Chapter 2001, Government Code. This subchapter applies to an appeal to the board of trustees under this subsection. The appellant has the burden of proof on all issues, including issues in the nature of an affirmative defense. Any sanction imposed is not stayed during an appeal under this subsection. An appeal of a decision of the board of trustees under this subsection is under the substantial evidence rule.

(e) An employee, participant, annuitant, or dependent expelled from the group benefits program may not participate in a coverage plan offered by the program for the period determined by the Employees Retirement System of Texas.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003. Amended by Acts 2003, 78th Leg., ch. 1111, Sec. 36, eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 1276, Sec. 10A.409(b), eff. Sept. 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 347 (S.B. 1176), Sec. 30, eff. September 1, 2005.

Sec. 1551.352. EXECUTIVE DIRECTOR DETERMINES QUESTIONS RELATING TO ENROLLMENT OR PAYMENT OF CLAIMS. The executive director has

exclusive authority to determine all questions relating to enrollment in or payment of a claim arising from group coverages or benefits provided under this chapter other than questions relating to payment of a claim by a health maintenance organization.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.354. DOUBLE OR MULTIPLE LIABILITY. (a) The executive director may determine that a claim arising under any group coverage plan administered by the board of trustees may expose the plan to double or multiple liability.

(b) The executive director may cause the filing of an action for interpleader concerning the claim in a district court in Travis County on behalf of the Employees Retirement System of Texas to protect the group coverage plan from double or multiple liability.

(c) A person may not pursue a counterclaim or other cause of action against the Employees Retirement System of Texas, a trustee, officer, or employee of the retirement system, or a carrier or administering firm for the retirement system in connection with a transaction or occurrence related to the interpleader action.

(d) A person who violates Subsection (c) is liable for the costs and attorney's fees incurred by the Employees Retirement System of Texas, a trustee, officer, or employee of the retirement system, or a carrier or administering firm for the retirement system as a result of the violation.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1308 (H.B. [2559](#)), Sec. 38, eff. September 1, 2009.

Sec. 1551.355. APPEAL OF EXECUTIVE DIRECTOR'S DETERMINATION. (a) Subject to Subsection (b), an appeal of a determination of the executive director under this subchapter is only to the board of trustees.

(b) On behalf of the board of trustees and notwithstanding any other law, including Section [2003.021](#), Government Code, the executive director may:

(1) refer an appeal to the State Office of Administrative Hearings for a hearing; or

(2) employ, select, or contract for the services of an administrative law judge or other hearing examiner not affiliated with the State Office of Administrative Hearings to conduct the hearing of an appeal.

(c) The appeal is a contested case under Chapter [2001](#), Government Code.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003. Amended by Acts 2003, 78th Leg., ch. 1111, Sec. 37, eff. Sept. 1, 2003.

Sec. 1551.356. STANDING. (a) A person has standing to appeal a determination of the executive director under this subchapter only if the person is:

(1) an employee, participant, annuitant, or covered dependent participating in the group benefits program; or

(2) after the death of an employee, participant, annuitant, or covered dependent, the person's estate, personal representative, heir at law, or designated beneficiary.

(b) A person has no standing to appeal a determination of the executive director under this subchapter or to pursue a private cause of action against the state, the board of trustees, the retirement system, the executive director, an administering firm, or an employee of any of those persons based on a determination or the implementation by the board or executive director of the type or scope of plan design features under the group benefits program.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003. Amended by Acts 2003, 78th Leg., ch. 1111, Sec. 38, eff. Sept. 1, 2003; Acts 2003, 78th Leg., ch. 1276, Sec. 10A.411(a), eff. Sept. 1, 2003.

Sec. 1551.357. DETERMINATION OF APPEAL BY BOARD OF TRUSTEES.

(a) Notwithstanding any other law, in a proceeding considered to be a contested case under Chapter [2001](#), Government Code, the board of trustees in its sole discretion may modify, refuse to accept, or delete any proposed finding of fact or conclusion of law contained in a proposal for decision submitted by an administrative law judge or other hearing examiner, or make alternative findings of fact and conclusions of law.

(b) The board of trustees shall state in writing the specific reason for the board's determination.

(c) The board of trustees may adopt rules to implement this section.

(d) The appellant in a contested case under this subchapter has the burden of proof on all issues, including issues in the nature of an affirmative defense.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003. Amended by Acts 2003, 78th Leg., ch. 1111, Sec. 39, eff. Sept. 1, 2003.

Sec. 1551.358. NEGOTIATION. (a) Notwithstanding any other provision of this subchapter, the board of trustees and a person who has standing to pursue an administrative appeal under this subchapter may at any time informally negotiate an award of benefits.

(b) Negotiated benefits may not exceed the maximum benefits otherwise available or required by law.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.359. JUDICIAL REVIEW. A person aggrieved by a final decision of the Employees Retirement System of Texas in a contested case under this subchapter is entitled to judicial review of the decision. Venue of an appeal under this subchapter is only in a district court in Travis County. The standard of review for the appeal of a determination made by the board of trustees under this subchapter is by substantial evidence.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003. Amended by Acts 2003, 78th Leg., ch. 1111, Sec. 40, eff. Sept. 1, 2003.

Sec. 1551.360. DELEGATION. (a) The board of trustees may delegate its duty to hear an appeal to the executive director.

(b) The executive director may delegate the director's duty under this subchapter to another employee of the Employees Retirement System of Texas.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.361. DILIGENT PROSECUTION OF SUIT. The plaintiff shall prosecute with reasonable diligence any suit brought under Section [1551.359](#). If the plaintiff does not secure proper service of process or does not prosecute the suit within one year after it is filed, the court shall presume that the suit has been abandoned. The

court shall dismiss the suit on a motion for dismissal made on or behalf of the Employees Retirement System of Texas, unless the plaintiff, after receiving appropriate notice, shows good cause for the delay.

Added by Acts 2005, 79th Leg., Ch. 347 (S.B. [1176](#)), Sec. 31, eff. September 1, 2005.

Sec. 1551.362. SUBPOENA. Notwithstanding any other law, the Employees Retirement System of Texas may issue a subpoena that conforms to Rule 176, Texas Rules of Civil Procedure, including a preappeal investigative subpoena or any subpoena otherwise authorized by the Texas Rules of Civil Procedure, that the retirement system determines necessary to protect the interests of a program or system administered by the retirement system.

Added by Acts 2009, 81st Leg., R.S., Ch. 1308 (H.B. [2559](#)), Sec. 39, eff. September 1, 2009.

SUBCHAPTER I. FUNDS

Sec. 1551.401. EMPLOYEES LIFE, ACCIDENT, AND HEALTH INSURANCE AND BENEFITS FUND. (a) The employees life, accident, and health insurance and benefits fund is in the state treasury.

(b) The board of trustees shall administer the fund.

(c) Contributions of participants and the state provided for under this chapter shall be credited to the fund.

(d) The fund is available:

(1) without fiscal year limitation for all payments for any coverages provided for under this chapter; and

(2) for payment of expenses of administering this chapter within the limitations that may be specified annually by the legislature.

(e) The board of trustees shall regularly set aside in the fund an amount equal to a percentage of the contributions made by participants and the state that the board determines is reasonably adequate to pay the expenses of administering this chapter.

(f) The board of trustees, from time to time and in amounts it considers appropriate, may transfer unused funds for administrative expenses to the contingency reserves to be used by the board only for charges, claims, and expenses under the group benefits program.

(g) Except as provided by Section 1551.259(d), the retirement system may deposit to the credit of the fund any unclaimed money on a finding that a good faith effort has been made to locate the person entitled to the money.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1308 (H.B. 2559), Sec. 40, eff. September 1, 2009.

Sec. 1551.402. STATE EMPLOYEES CAFETERIA PLAN TRUST FUND. (a) The state employees cafeteria plan trust fund is in the state treasury.

(b) The board of trustees shall administer the fund.

(c) The following shall be credited to the fund:

(1) salary reduction payments for benefits included in a cafeteria plan other than group coverage plans under the group benefits program; and

(2) appropriations by the state for the administration of a cafeteria plan.

(d) The trust fund is available without fiscal year limitation:

(1) for all payments for any benefits included in a cafeteria plan other than group coverage plans under the group benefits program; and

(2) for payment of expenses of administering a cafeteria plan.

(e) The board of trustees may establish accounts for money in the fund as the board considers necessary, including accounts for the administration of a cafeteria plan.

The board of trustees may transfer assets from one account to another:

(1) to pay benefits if:

(A) the transfer is necessary for financial management purposes;

and

(B) adequate arrangements are made to reimburse the account from which the transfer was made; and

(2) to pay administrative expenses.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.403. FEES FOR STATE EMPLOYEES CAFETERIA PLAN TRUST FUND. (a) Subject to Subsection (e), the board of trustees may establish a monthly fee to be paid by each employee who elects to participate in a cafeteria plan for the purpose of paying the expenses of administering the cafeteria plan.

(b) The board of trustees shall establish the amount of the monthly fee and may establish a separate fee for each benefit included in a cafeteria plan.

(c) If the board of trustees establishes a monthly fee, each employee who participates in the cafeteria plan must authorize payment of the fee by executing a separate payroll deduction agreement or as part of the salary reduction agreement, as determined by the board.

(d) The monthly fee shall be paid into the state employees cafeteria plan trust fund.

(e) The board of trustees may not establish a fee for administering the premium conversion benefit portion of a cafeteria plan.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.404. INSUFFICIENT EARNINGS FOR EMPLOYEE TO PARTICIPATE IN CAFETERIA FUND. (a) If the earnings of an employee who elects to participate in a cafeteria plan are insufficient to pay the cost of the coverages and benefits selected by the employee, the employee is liable to the board of trustees for an amount equal to the difference between:

- (1) the amount received by the board; and
- (2) the cost of the coverages and benefits.

(b) If the employee does not pay the difference within the time specified by the board of trustees, the board may:

- (1) cancel the coverages and benefits retroactive to the last month for which full payment was made; or
- (2) pursue any other available legal remedy.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.405. EMPLOYEES' HEALTH CARE STABILIZATION TRUST FUND.

(a) The employees' health care stabilization trust fund is a fund in the state treasury.

(b) The board of trustees shall administer the fund.

(c) The following shall be credited to the fund:

- (1) money transferred to the fund at the direction of the legislature; and
- (2) gifts and grants contributed to the fund.

(d) In administering the fund, the board of trustees shall make investments in a manner that preserves the purchasing power of the fund's assets.

(e) Money in the fund may not be spent for any purpose, except that the interest and investment returns of the fund may be appropriated only to stabilize the cost of state and participant contributions for health benefit coverage under this chapter by minimizing to the greatest extent possible increases in those contributions.

(f) The fund is exempt from the application of Section 403.095, Government Code.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.406. INVESTMENT OF FUNDS. (a) Under the standard of care provided by Section 815.307, Government Code, the board of trustees may manage and has full power to invest and reinvest the money in:

- (1) the employees life, accident, and health insurance and benefits fund;
- (2) the state employees cafeteria plan trust fund; and
- (3) the employees' health care stabilization trust fund.

(b) The earnings, including interest on money in the fund and proceeds from the sale of any investments, become a part of the fund.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

Sec. 1551.407. MANAGEMENT OF ASSETS. The board of trustees may commingle for investment purposes the assets of a fund created under this chapter with another fund created under this chapter or any other trust fund administered by the board if the board maintains and credits proportionate ownership records.

Added by Acts 2001, 77th Leg., ch. 1419, Sec. 3, eff. June 1, 2003.

SUBCHAPTER J. STATE CONSUMER-DIRECTED HEALTH PLAN

Sec. 1551.451. DEFINITIONS. In this subchapter:

(1) "High deductible health plan" means a health benefit plan that complies with Section 223(c), Internal Revenue Code of 1986, and other federal law.

(2) "Plan enrollee" means an employee or annuitant who is enrolled in the plan established under this subchapter.

(3) "Qualified medical expense" means an expense paid by a plan enrollee for medical care, as defined by Section 213(d), Internal Revenue Code of 1986, for the

plan enrollee or the enrollee's dependents as defined by Section 152, Internal Revenue Code of 1986.

Added by Acts 2015, 84th Leg., R.S., Ch. 1015 (H.B. 966), Sec. 1, eff. September 1, 2015.

Sec. 1551.452. ESTABLISHMENT OF STATE CONSUMER-DIRECTED HEALTH PLAN. (a) The state consumer-directed health plan is established for the benefit of individuals eligible to participate in the group benefits program and those individuals' eligible dependents.

(b) The board of trustees may adopt rules necessary to administer this subchapter. In implementing this subchapter the board shall:

(1) establish health savings accounts under this subchapter and administer or select an administrator in accordance with Section 1551.453 for the accounts;

(2) finance a self-funded high deductible health plan that:

(A) is an integral part of the state consumer-directed health plan;

and

(B) provides health benefit coverage, including preventive health care, to a plan enrollee in the state consumer-directed health plan and to the dependents of a plan enrollee in accordance with Section 1551.455; and

(3) provide to individuals eligible to participate in the group benefits program information regarding the operation of and option to participate in the state consumer-directed health plan established under this subchapter.

(c) In adopting rules and administering health savings accounts or selecting administrators for health savings accounts under this subchapter, the board of trustees shall ensure that the health savings accounts are qualified for appropriate federal tax exemptions.

Added by Acts 2015, 84th Leg., R.S., Ch. 1015 (H.B. 966), Sec. 1, eff. September 1, 2015.

Sec. 1551.453. ACCOUNT ADMINISTRATOR. (a) The account administrator selected to administer a health savings account established under this subchapter must be a person:

(1) qualified to serve as trustee under Section 223(d)(1)(B), Internal Revenue Code of 1986, and the rules adopted under that section; and

(2) experienced in administering health savings accounts or other similar trust accounts.

(b) An account administrator is the fiduciary of a plan enrollee who has a health savings account established under this subchapter.

Added by Acts 2015, 84th Leg., R.S., Ch. 1015 (H.B. 966), Sec. 1, eff. September 1, 2015.

Sec. 1551.454. PARTICIPATION IN PROGRAM. (a) Each individual eligible to participate in the basic coverage may choose instead to participate in the state consumer-directed health plan if the plan enrollee is an eligible individual under Section 223(c)(1), Internal Revenue Code of 1986. The dependents of a plan enrollee may participate in the state consumer-directed health plan in accordance with Section 1551.455.

(b) Participation in the state consumer-directed health plan qualifies a plan enrollee to receive a contribution to a health savings account under Section 1551.456. An individual who elects not to participate in the plan is not eligible to receive a contribution under that section.

(c) Under this section, the board of trustees has exclusive authority to determine an individual's eligibility to participate in the state consumer-directed health plan and may adopt rules regarding eligibility to participate in the plan.

Added by Acts 2015, 84th Leg., R.S., Ch. 1015 (H.B. 966), Sec. 1, eff. September 1, 2015.

Sec. 1551.455. COVERAGE FOR DEPENDENTS; REQUIRED CONTRIBUTIONS. (a) A plan enrollee may obtain for the enrollee's dependents coverage in the state consumer-directed health plan in the manner determined by the board of trustees.

(b) If the plan enrollee elects to obtain dependent coverage under Subsection (a), the plan enrollee shall pay any required contribution for the dependent coverage in the state consumer-directed health plan in the manner prescribed by the board of trustees.

(c) Amounts contributed by a plan enrollee under this section may be:

(1) used to pay the cost of coverage in the high deductible health plan not paid by the state under Section [1551.456\(b\)](#); or

(2) allocated by the board of trustees to an enrollee's health savings account in the manner described by Section [1551.456\(c\)](#).

Added by Acts 2015, 84th Leg., R.S., Ch. 1015 (H.B. [966](#)), Sec. 1, eff. September 1, 2015.

Sec. 1551.456. STATE CONTRIBUTION. (a) For each plan enrollee, from the state contribution that would otherwise be made for basic coverage for the enrollee, the state shall contribute annually to a high deductible health plan under this subchapter the amount that is necessary to pay the cost of coverage under the high deductible health plan and does not exceed the amount the state annually contributes for a full-time or part-time employee, as applicable, who is covered by the basic coverage.

(b) For each plan enrollee's dependent covered under this subchapter, from the state contribution that would otherwise be made for basic coverage for the dependent, the state shall contribute annually to the high deductible health plan under this subchapter the same percentage of the cost of coverage under the high deductible health plan as the state annually contributes for dependent coverage in the basic coverage.

(c) Before each plan year, the board of trustees may determine the amount of allocation of the state's contribution, if any, to an enrollee's health savings account that would otherwise be made for basic coverage for the enrollee and that remains after payment for coverage under Subsection (a) or (b).

(d) For a calendar year, the amount of any allocations made under Subsection (c) and Section [1551.455\(c\)\(2\)](#), in the aggregate, may not exceed the sum of the monthly limitations imposed by federal law for health savings accounts.

Added by Acts 2015, 84th Leg., R.S., Ch. 1015 (H.B. [966](#)), Sec. 1, eff. September 1, 2015.

Sec. 1551.457. PLAN ENROLLEE CONTRIBUTIONS. (a) Each plan enrollee, in accordance with Section [1551.305](#), shall contribute any amount required to cover the selected participation in the high deductible health plan that exceeds the state contribution amount under Section [1551.456](#).

(b) A plan enrollee may contribute any amount allowed under federal law to the enrollee's health savings account in addition to the state contribution under Section [1551.456](#).

(c) A plan enrollee shall make contributions under this section in the manner prescribed by the board of trustees.

Added by Acts 2015, 84th Leg., R.S., Ch. 1015 (H.B. [966](#)), Sec. 1, eff. September 1, 2015.

Sec. 1551.458. COORDINATION WITH CAFETERIA PLAN. (a) The board of trustees has exclusive authority to determine the eligibility of a plan enrollee to participate in any flexible spending account that is part of a cafeteria plan offered under this chapter.

(b) The board of trustees may adopt rules regarding the eligibility of a plan enrollee to participate in any flexible spending account that is part of a cafeteria plan offered under this chapter.

(c) A plan enrollee may not participate in any flexible spending account that would disqualify the enrollee's health savings account from favorable tax treatment under federal law.

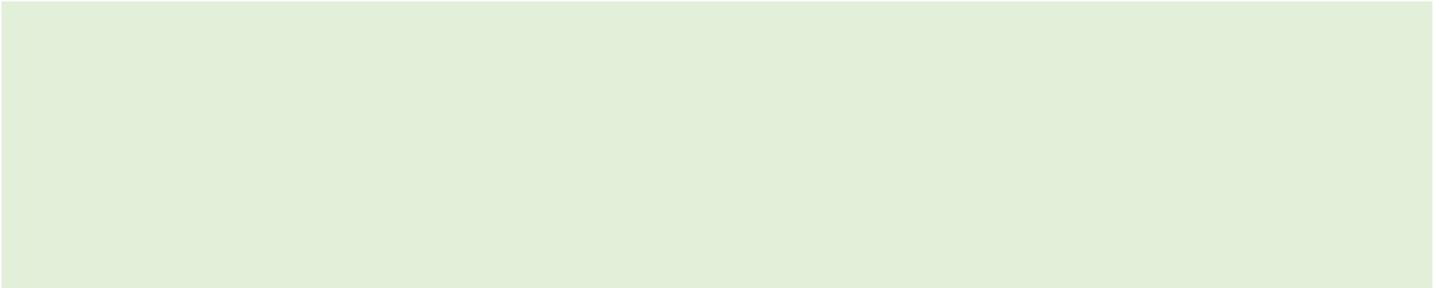
Added by Acts 2015, 84th Leg., R.S., Ch. 1015 (H.B. [966](#)), Sec. 1, eff. September 1, 2015.

Sec. 1551.459. EXEMPTION FROM EXECUTION; UNASSIGNABILITY. A state contribution to a health savings account or a high deductible health plan is exempt from execution and is unassignable in the same manner and to the same extent as an amount described by Section [1551.011](#).

Added by Acts 2015, 84th Leg., R.S., Ch. 1015 (H.B. [966](#)), Sec. 1, eff. September 1, 2015.

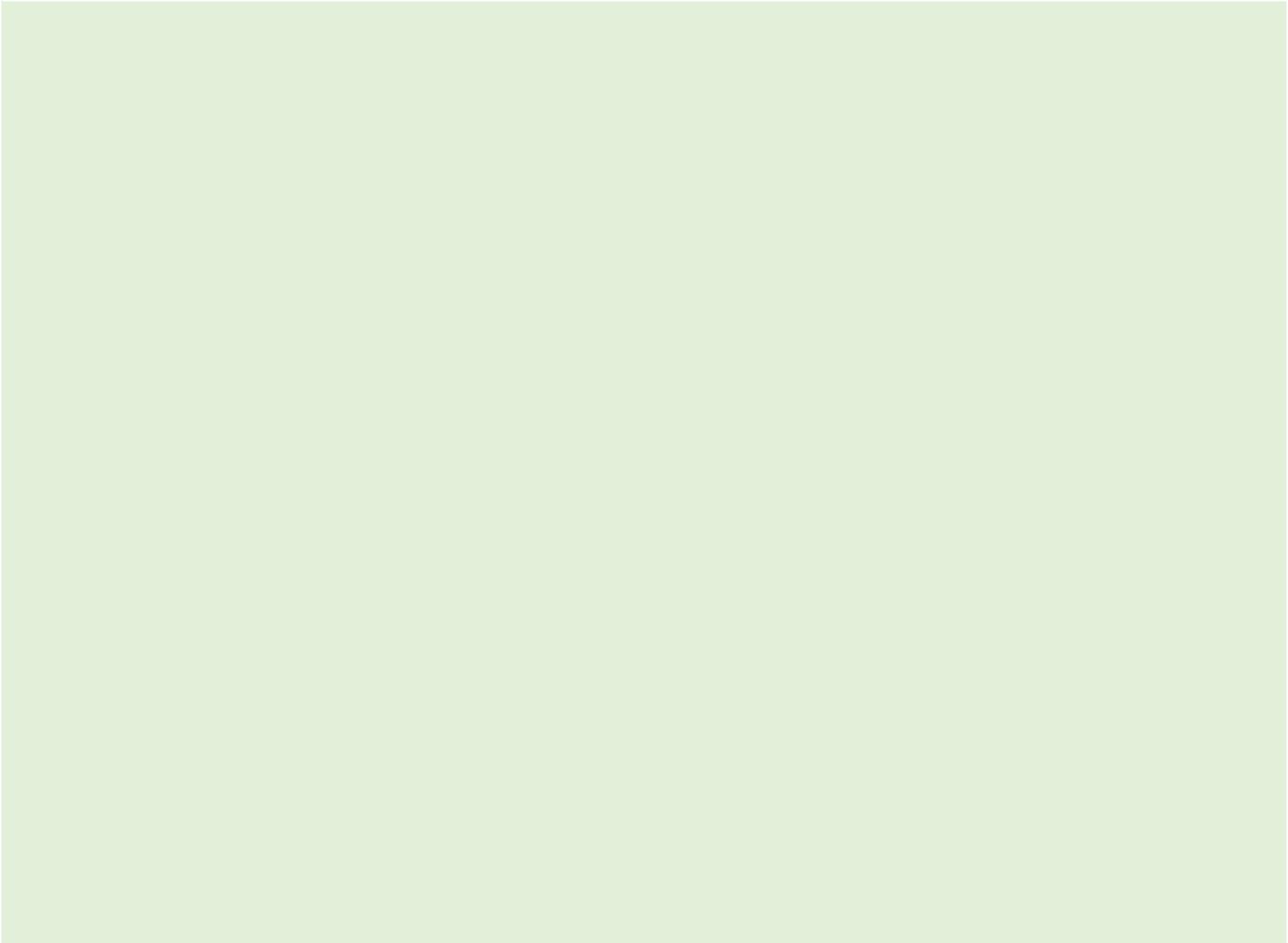
Sec. 1551.460. SINGLE UNDIVIDED RISK POOL. In implementing and administering the state consumer-directed health plan established under this subchapter, the board of trustees may not divide the self-funded risk pool of the group benefits program provided under this chapter or create a separate self-funded risk pool for that program.

Added by Acts 2015, 84th Leg., R.S., Ch. 1015 (H.B. [966](#)), Sec. 1, eff. September 1, 2015.



APPENDIX T

ERS EDITORIAL STYLE GUIDE
AND USAGE MANUAL AND THE
ERS BRAND GUIDELINES



APPENDIX U

INFORMATION SYSTEMS REQUIREMENTS DEVIATIONS AND INTERROGATORIES

Information Systems Requirements Deviations and Interrogatories

Respondent shall review the Deviation and Interrogatory instructions referenced at RFP Sections I.D.2. and I.D.3. Respondent shall complete the Interrogatories listed below by providing Respondent's answer following each question. **Respondent shall complete both PPO and DHMO sections if Respondent will be providing both plans. If Respondent is not providing services for both plans, then Respondent only needs to provide its Responses to either the PPO or DHMO sections.**

PPO RESPONSES

A. Deviations – Operations Requirements - PPO

A.1. Affirm that Respondent shall comply with all of the **Scope of Work – Information Systems Requirements – Operations Requirements** described in RFP Sections X.A.1. – X.A.21.

- Affirm Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each Deviation between Respondent's response and these requirements:

Respondent's Requested Deviation Detail:

A.2. Respondent shall provide its Deviations to the requirements at RFP Section X.A.4. If applicable, Respondent shall provide the following information:

A.2.a. Provide a description of the services Respondent performs offshore.

A.2.b. Provide the following information with regard to offshore data transmission:

A.2.b.i. If data is transmitted offshore, indicate the countries.

A.2.b.ii. Describe the type of data that is transmitted offshore.

A.2.b.iii. Identify (by name and physical address) the entity(ies) this data is transmitted to.

A.2.c. Provide the following information with regard to accessibility of offshore data:

A.2.c.i. If data is accessible offshore, indicate the countries.

A.2.c.ii. How is it accessible?

A.2.c.iii. Describe the type of data that is viewable offshore.

A.2.c.iv. Describe who has access to any offshore data.

A.2.c.v. Describe how this data is viewable.

A.2.c.vi. Describe the function of any data that is accessible offshore.

A.3. Respondent shall provide its Deviations to the requirement at RFP Section X.A.5., if applicable.

Respondent's Requested Deviation Detail:

B. Interrogatories – Operations Requirements - PPO

B.1. What type of background checks are performed on all company hires, particularly those that will have access to PII and HIPAA data?

B.2. What are the normal staffing hours (in CT) for the following?

Respondent's technical support team to respond to data and reporting questions:	
Respondent's data center:	

B.3. Describe Respondent's standardized methodology for resolving issues and implementing measurable action plans to resolve them.

B.4. Respondent shall provide the following:

The historical periodic scheduled maintenance schedule for 2017:	
The non-periodic maintenance which happened outside the scheduled period for 2017:	
A detailed report of all unscheduled outages, slowdowns, impairments, and other system events for 2017 which exceeded 5 minutes duration:	

B.4.a. Complete the schedule of hardware (system) and software changes.

Column 1: Briefly outline recent system changes and describe any planned or scheduled system changes and/or upgrades to Respondent's hardware, infrastructure and data centers that will be hosting ERS data and services being used between now and August 31, 2019.

Column 2: Detail all planned upgrades to Respondent's software affecting ERS data and services between now and August 31, 2019.

Description of System Changes & Upgrades*	Description of Software Changes*	Projected Implementation Date

**Scheduled from now through August 31, 2019*

B.4.b. What quality assurance processes are provided in Respondent's system to ensure accurate claims administration?

B.4.c. Describe how Respondent evaluates various aspects of a project to ensure that standards of quality are being met.

B.5. Describe how Respondent's organization's processes and systems (including test and/or production files) can accommodate the following three scenarios:

- Terminations by absence of records in the enrollment file;
- Retroactive enrollment dates (i.e., employee's start date is Oct. 7th and benefits are active to Oct. 1st); and
- Future effective dates on eligibility files.

Respondent shall describe the impact the above has on claims processing.

B.6. What quality assurance processes are provided in Respondent's system to ensure accuracy in programming of benefits?

B.7. Describe Respondent's process for implementing plan design changes.

B.8. How much advance notice is required for a change in the system?

C. Deviations – Data Interfaces Requirements - PPO

C.1. Affirm that Respondent shall comply with all of the **Scope of Work – Information Systems Requirements – Data Interfaces Requirements** described in RFP Sections X.B.1. – X.B.9.

- Affirm Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each Deviation between Respondent’s response and these requirements:

Respondent’s Requested Deviation Detail:

D. Interrogatories – Data Interfaces Requirements - PPO

D.1. Respondent shall provide a full description regarding business processes that shall include, but not be limited to, the following key elements:

Support of a point to point VPN with ERS;	
Explanation of how Respondent will utilize the interface files/data that ERS will provide;	
Protocols that Respondent will utilize when there is a file transmission problem or a corrupted bad interface file (or like scenario) with ERS; and	
Explanation of how information reported to ERS is to be derived from the source data file.	

D.2. If Respondent supplies an interface to ERS, then Respondent shall provide a full description of the interface file that shall include, but not be limited to, complete definitions of each field of the interface file.

D.3. Respondent shall provide documentation of its business policies and procedures related to the business process.

D.4. Respondent shall describe its standard web interface protocol.

D.4.a. What flexibility does Respondent have with regard to its standard web interface protocol approach?

D.5. What measures does Respondent take to ensure the security of interfaces, which would include, but not be limited to, data files, emails, print screens and email attachments that Respondent is sending/receiving to/from external sources (whether ERS or a third party)?

D.5.a. If ERS discontinues Respondent’s services during the Contract Term, how would ERS’ data be extracted? Respondent shall provide a detailed description of the format or structure of the extracted data.

- Would it be structured fields, XML, Bitmap?
- Would a data dictionary be provided for the extracted data?

D.6. Respondent shall confirm that it will only transmit and receive confidential and sensitive information via encrypted transmission protocols including site to site VPN, SFTP, TLS, or other industry accepted encryption methodology. Confirm

D.6.a. If Respondent cannot confirm Interrogatory D.6. above, Respondent shall provide a detailed description as to why not.

- D.7. Respondent shall provide its standard data and claims files for ERS' review. This file should include specifications that are required when ERS transfers Participant information.
- D.8. What is Respondent's standard interface protocol? Provide a detailed description.
- D.8.a. What flexibility does Respondent have with Respondent's standard approach? Provide a detailed description.
- D.9. Please list and describe all PHI and security breaches Respondent's organization has experienced with external reporting requirements, including, but not limited to, loss of equipment that contained client information, loss of files, unauthorized access to Respondent's networks within the last seven (7) years, and reporting of HIPAA breaches as required under the provisions of HIPAA.
- D.9.a. What investments has Respondent made over the past three (3) years in its technology to mitigate security breaches?
- D.10. Briefly describe Respondent's backup procedures for the system(s) to be used in the services proposed to ERS.

E. Deviations – Security Practices Requirements - PPO

E.1. Affirm that Respondent shall comply with all of the **Scope of Work – Information Systems Requirements – Security Practices Requirements** described in RFP Sections X.C.1. – X.C.12.

- Affirm Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each Deviation between Respondent's response and these requirements:

Respondent's Requested Deviation Detail:

F. Interrogatories – Security Practices Requirements - PPO

- F.1. Does Respondent have a full-time Information Security Officer or Chief Security Officer?
 Yes No
- If Respondent marked "Yes", Respondent shall describe how this role fits into Respondent's organizational chart.
- F.1.a. If Respondent marked "No" for Interrogatory F.1. above, Respondent shall provide a detailed description as to why not.
- F.2. Does Respondent have dedicated resources for information security efforts? Yes No
- F.2.a. If Respondent marked "No" for Interrogatory F.2. above, Respondent shall provide a detailed description as to why not.
- F.3. What are Respondent's minimum and maximum User ID lengths?

Minimum User ID Length	
Maximum User ID Length	

- F.4. Would Respondent support any kind of SSO solution for users of the ERS-based product?
 Yes No
- If yes, Respondent shall describe.
- F.5. What technology in the data center (servers, storage, and network infrastructure) which provides services to ERS is shared with other data center customers?

- F.6. What kind of network security devices are running in Respondent's data center(s) (e.g., data loss prevention tools, intrusion detection systems, intrusion prevention systems)?
- F.7. Describe in detail Respondent's practices and controls utilized to limit access and protect confidential and sensitive data in storage and in transit.
- F.8. Are network firewalls and other security equipment checked by independent third parties for vulnerabilities and possible exploits? Yes No
- F.8.a. If yes, how often?
- F.8.b. If Respondent marked "No" to Interrogatory F.8. above, Respondent shall provide a detailed description as to why not.
- F.9. In the event of a security breach, describe the process to notify ERS of the breach of ERS data, Respondent facilities or other types of Information Technology infrastructure breaches.
- F.10. Respondent shall describe how often its firewall and router configuration standards are reviewed. Respondent shall provide the last date its firewall and router configuration standards were reviewed.
- F.11. Respondent shall describe its processes and procedures for managing and patching known vulnerabilities. Is there a patch management solution in place, so that all system components and software are protected from known vulnerabilities by having the latest vendor supplied security patches installed? How often are systems checked? What was the last date Respondent's data center systems and user workstations were checked?
- F.12. Respondent shall describe its processes and procedures in place for responding to low, medium and high severity information security incidents. What is Respondent's process to rank such incidents? Does Respondent's company have forensic security experts on staff or is a third party contracted in the case of a breach?
- F.13. What anti-virus protection/programs does Respondent use? Is AV software deployed on all Respondent's and Respondent's contractor systems (such as servers, workstations, laptops) commonly affected by malicious software? Are all anti-virus programs capable of detecting, removing and protecting against all known types of malicious software (i.e., viruses, worms, spyware, Trojans, adware and rootkits)? How often are the .DAT files updated and are automatic AV scans enabled?
- F.14. Describe Respondent's Security Incident Management policies and procedures for the application as well as internal systems.
- F.14.a. Respondent shall provide a copy of this documentation.
- F.15. Respondent shall confirm it will follow highly restricted access policies behind any ERS-related point-to-point VPN setup in support of this Contract. Confirm
- F.15.a. If Respondent cannot confirm Interrogatory F.15. above, Respondent shall provide a detailed description as to why not. [REDACTED]
- F.16. Are Respondent's portable devices encrypted to protect the data in case of theft or loss?
 Yes No
- F.16.a. If Respondent did not mark "Yes" to Interrogatory F.16. above, Respondent shall provide a detailed description as to why not. [REDACTED]
- F.17. How does Respondent manage physical security of its data center? Who gets access, what are the hours of operation?
- F.18. What technology is in place to manage network and server security? Provide the name and the version of the technology used to manage the network and server security and describe the effectiveness of the technology.

- F.19. Describe how Respondent controls access to ERS' confidential data?
- F.20. How does Respondent secure backup tapes? Who has access to them onsite and offsite? Are they encrypted?
- F.20.a. Respondent shall confirm that they have the ability to encrypt ERS data using PGP compatible encryption. Confirm
- F.20.a.i. If Respondent cannot confirm Interrogatory F.20.a. above, Respondent shall provide a detailed description as to why not. [REDACTED]
- F.20.b. Describe the encryption technology that is being used.
- F.21. How is Respondent's application security managed and how is client data secured?
- F.22. Does Respondent have a formal information security program in place?
 Yes No
- F.22.a. Does Respondent have formal information security policies, procedures and standards?
 Yes No
- F.22.a.i. If yes, Respondent shall provide copies of their formal information security policies, procedures and standards. If Respondent considers this document confidential and proprietary, place this on Respondent's separate schedule as required at RFP Section I.F.1.b. However, Respondent shall provide this document for appropriate evaluation of Respondent's Proposal.
- F.22.b. Are employees required to periodically confirm their compliance with Respondent's information security policies, procedures and standards? Yes No
- F.22.b.i. If no, Respondent shall validate if their employees ever confirm compliance with Respondent's information security policies, procedures and standards and how often compliance is confirmed.
- F.22.c. Does Respondent have a user awareness campaign related to information security?
 Yes No
- F.22.c.i. If Respondent did not mark "Yes" to Interrogatory F.22.c. above, Respondent shall enumerate and provide a detailed description as to why not. [REDACTED]
- F.22.d. Respondent shall provide a full description of how Respondent monitors compliance.
- F.23. Are Respondent's desktop and laptop computers encrypted to protect data in case of theft or loss? Yes No
- F.23.a. If Respondent cannot confirm Interrogatory F.23. above, Respondent shall enumerate and provide a detailed description as to why not. [REDACTED]
- F.23.b. Describe the ability to use portable drives. If so, how are they protected?
- F.24. How does Respondent protect the privacy of GBP Participants? Respondent shall provide a detailed description.

G. Deviations – Business Resumption and Data Center Facilities Requirements - PPO

G.1. Affirm that Respondent shall comply with all of the **Scope of Work – Information Systems Requirements –Business Resumption and Data Center Facilities Requirements** described in RFP Sections X.D.1. – X.D.9.

- Affirm Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each Deviation between Respondent’s response and these requirements:

Respondent’s Requested Deviation Detail:

H. Interrogatories - Business Resumption and Data Center Facilities Requirements - PPO

H.1. Describe Respondent’s contingency plans and procedures for providing business continuity due to any event that might interrupt, delay or shut-down service that is related to Respondent’s services or products under this proposal, including that of any subcontractor upon whom Respondent relies in performing or providing services or products to or on behalf of ERS.

H.2. Describe who has physical access to Respondent’s data center facility and how the access is monitored.

H.3. Does the Respondent’s data center have formal Uptime Institute certification?
 Yes No

H.3.a. If yes, which certifications were granted? What year were they granted? Are the certifications still current? Yes No

H.3.b. If no, how does Respondent confirm that its data center conforms to the Uptime Tier III or Tier IV standards?

H.3.c. If Respondent’s data center does not have formal Uptime Institute certification, Respondent shall provide a detailed description as to why not.

H.4. How does Respondent confirm that its data center conforms to the Uptime Tier III or Tier IV standards; if the Respondent does not have a formal Uptime certification, how does the Respondent ensure that all critical data center systems associated with providing power and cooling to IT equipment can maintain uptime of at least 99.982% during any 12 month period?

H.5. What was the data center uptime for the previous 12 months (specify time period)?

H.6. Provide details regarding the redundant links for internet access that Respondent has in place for its data center, including redundant last-mile connectivity and diverse physical data-center network penetrations.

H.7. Who is Respondent’s data center provider(s)?

H.8. Briefly describe Respondent’s data backup and recovery procedures for the system(s) to be used in the services proposed to ERS.

H.9. Provide the names and a description of the hardware and software systems that Respondent will use to fulfill ERS’ contract.

H.10. For each hardware and software system, provide the following information:

H.10.a. When was this system implemented?

- H.10.b. When was the system last updated?
- H.10.c. Is there a future update being considered? Yes No
- H.10.d. If so, provide the date and description of the anticipated update.
- H.11. Respondent shall provide a copy of the disaster recovery plan and the disaster recovery test results to ERS. These should include, but not be limited to: (a) the Disaster Recovery plans plus a description of the changes from the previous year's plans, if any; and (b) the exercise test results conducted within the last twelve months of the disaster recovery and business continuity tests referencing the adequacy of these plans. The test results must include the RTO and RPO of the systems and applications which provide service to ERS. If these are a part of a SOC II Type 2 report, Respondent shall provide the portions of the report that refer to the normal, annual disaster recovery and business and continuity tests, plus copies of the service auditor's report. Respondent further agrees to be available for reasonable inquiry by ERS of the disaster recovery plan and tests.
- H.12. Respondent shall provide a summary of the latest disaster recovery test results to ERS and a summary of the disaster recovery programs. The test results should include the RTO and RPO of the systems and applications which provide service to ERS. The Respondent must attest annually, by signature, that the disaster recovery tests will ensure that systems which the Respondent uses to provide services to ERS will be available within X hours of outage and will experience a maximum Y hours of data loss (where X is the RTO and Y is the RPO). Respondent further agrees to be available for reasonable inquiry by ERS of the disaster recovery plan and tests.

I. Deviations – SOC-2 Report Requirements - PPO

- I.1. Affirm that Respondent shall comply with all of the **Scope of Work – Technology Services Requirements – SOC-2 Report Requirements** described in Sections X.E.1. – X.E.3.
- Affirm Affirm with the proposed Deviation
- If applicable, enumerate and provide a detailed description of each Deviation between Respondent's response and these requirements:
- Respondent's Requested Deviation Detail:

J. Interrogatories – SOC-2 Report Requirements - PPO

- J.1. **SOC reports.** Provide a full, un-redacted copy of the most recent SOC-2 type II report and results performed under the SSAE16 or SSAE18 SOC-2 Type II report or any other independent auditor report on the effectiveness of internal controls over operations and compliance of service to be provided under this RFP, including disaster recovery planning and testing, and data center facilities. This should include results of an independent, certified external security audit. Respondent shall also acknowledge and agree that ERS is entitled to review all such audit results on a yearly basis. If there is not a service organization control engagement performed, then provide a detailed explanation of how both information technology and operational control activities are assessed/evaluated to meet the services to be provided under this RFP.
- J.1.a. If applicable, provide a copy of Respondent's sponsoring or parent company's most recent SOC-2 report under SSAE 16 or SSAE18 SOC-2 Type II report or any other independent auditor report on the effectiveness of internal controls over operations, security, and compliance of service to be provided under the RFP.
- J.1.b. Respondent shall also acknowledge and agree that ERS is entitled to review all such audit results on a yearly basis.

J.2. If Respondent conducts its SOC-2 Type II control audits with an external firm, please identify the following:

Name of external firm:	██████████
Address of external firm:	██████████
Dates when firm performed the audits:	██████████

J.3. If any data centers, development, or data services are outsourced or subcontracted, Respondent shall provide copies of outsourcers' or subcontractors' SOC-2 under SSAE16 or SSAE18 SOC-2 Type II report or equivalent reports. ██████████

J.3.a. Respondent shall also confirm that ERS is entitled to review outsourcers' or subcontractors' SOC-2 under SSAE18 SOC-2 Type II report or equivalent reports annually. Confirm

DHMO RESPONSES

K. Deviations – Operations Requirements – DHMO

K.1. Affirm that Respondent shall comply with all of the **Scope of Work – Information Systems Requirements – Operations Requirements** described in RFP Sections X.A.1. – X.A.21.

Affirm Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each Deviation between Respondent's response and these requirements:

Respondent's Requested Deviation Detail: ██████████

K.2. Respondent shall provide its Deviations to the requirements at RFP Section X.A.4. If applicable, Respondent shall provide the following information:

K.2.a. Provide a description of the services Respondent performs offshore. ██████████

K.2.b. Provide the following information with regard to offshore data transmission:

K.2.b.i. If data is transmitted offshore, indicate the countries. ██████████

K.2.b.ii. Describe the type of data that is transmitted offshore. ██████████

K.2.b.iii. Identify (by name and physical address) the entity(ies) this data is transmitted to. ██████████

K.2.c. Provide the following information with regard to accessibility of offshore data:

K.2.c.i. If data is accessible offshore, indicate the countries. ██████████

K.2.c.ii. How is it accessible? ██████████

K.2.c.iii. Describe the type of data that is viewable offshore. ██████████

K.2.c.iv. Describe who has access to any offshore data ██████████

K.2.c.v. Describe how this data is viewable. ██████████

K.2.c.vi. Describe the function of any data that is accessible offshore. ██████████

K.3. Respondent shall provide its Deviations to the requirement at RFP Section X.A.5., if applicable.

Respondent's Requested Deviation Detail: ██████████

- K.4. What quality assurance processes are provided in Respondent's system to ensure accuracy in programming of benefits?
- K.5. Describe Respondent's process for implementing plan design changes.
- K.5.a. How much advance notice is required for a change in the system?

L. Interrogatories – Operations Requirements - DHMO

- L.1. What type of background checks are performed on all company hires, particularly those that will have access to PII and HIPAA data?
- L.2. What are the normal staffing hours (in CT) for the following?

Respondent's technical support team to respond to data and reporting questions:	
Respondent's data center:	

- L.3. Describe Respondent's standardized methodology for resolving issues and implementing measurable action plans to resolve them.
- L.4. Respondent shall provide the following:

The historical periodic scheduled maintenance schedule for 2017:	
The non-periodic maintenance which happened outside the scheduled period for 2017:	
A detailed report of all unscheduled outages, slowdowns, impairments, and other system events for 2017 which exceeded 5 minutes duration:	

- L.4.a. Complete the schedule of hardware (system) and software changes.

 Column 1: Briefly outline recent system changes and describe any planned or scheduled system changes and/or upgrades to Respondent's hardware, infrastructure and data centers that will be hosting ERS data and services being used between now and August 31, 2019.

 Column 2: Detail all planned upgrades to Respondent's software affecting ERS data and services between now and August 31, 2019.

Description of System Changes & Upgrades*	Description of Software Changes*	Projected Implementation Date

**Scheduled from now through August 31, 2019*

- L.4.b. What quality assurance processes are provided in Respondent's system to ensure accurate claims administration?
- L.4.c. Describe how Respondent evaluates various aspects of a project to ensure that standards of quality are being met.
- L.5. Describe how Respondent's organization's processes and systems (including test and/or production files) can accommodate the following three scenarios:
 - Terminations by absence of records in the enrollment file;
 - Retroactive enrollment dates (i.e., employee's start date is Oct. 7th and benefits are active to Oct. 1st); and
 - Future effective dates on eligibility files.

Respondent shall describe the impact the above has on claims processing.

M. Deviations – Data Interfaces Requirements - DHMO

M.1. Affirm that Respondent shall comply with all of the **Scope of Work – Information Systems Requirements – Data Interfaces Requirements** described in RFP Sections X.B.1. – X.B.9.

- Affirm Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each Deviation between Respondent’s response and these requirements:

Respondent’s Requested Deviation Detail:

N. Interrogatories – Data Interfaces Requirements - DHMO

N.1. Respondent shall provide a full description regarding business processes that shall include, but not be limited to, the following key elements:

Support of a point to point VPN with ERS;	
Explanation of how Respondent will utilize the interface files/data that ERS will provide;	
Protocols that Respondent will utilize when there is a file transmission problem or a corrupted bad interface file (or like scenario) with ERS; and	
Explanation of how information reported to ERS is to be derived from the source data file.	

N.2. If Respondent supplies an interface to ERS, then Respondent shall provide a full description of the interface file that shall include, but not be limited to, complete definitions of each field of the interface file.

N.3. Respondent shall provide documentation of its business policies and procedures related to the business process.

N.4. Respondent shall describe its standard web interface protocol.

N.4.a. What flexibility does Respondent have with regard to its standard web interface protocol approach?

N.5. What measures does Respondent take to ensure the security of interfaces, which would include, but not be limited to, data files, emails, print screens and email attachments that Respondent is sending/receiving to/from external sources (whether ERS or a third party)?

N.5.a. If ERS discontinues Respondent’s services during the Contract Term, how would ERS’ data be extracted? Respondent shall provide a detailed description of the format or structure of the extracted data.

- Would it be structured fields, XML, Bitmap?
- Would a data dictionary be provided for the extracted data?

N.6. Respondent shall confirm that it will only transmit and receive confidential and sensitive information via encrypted transmission protocols including site to site VPN, SFTP, TLS, or other industry accepted encryption methodology. Confirm

- N.6.a. If Respondent cannot confirm Interrogatory N.6. above, Respondent shall provide a detailed description as to why not.
- N.7. Respondent shall provide its standard data and claims files for ERS' review. This file should include specifications that are required when ERS transfers Participant information.
- N.8. What is Respondent's standard interface protocol? Provide a detailed description.
- N.8.a. What flexibility does Respondent have with Respondent's standard approach? Provide a detailed description.
- N.9. Please list and describe all PHI and security breaches Respondent's organization has experienced with external reporting requirements, including, but not limited to, loss of equipment that contained client information, loss of files, unauthorized access to Respondent's networks within the last seven (7) years, and reporting of HIPAA breaches as required under the provisions of HIPAA.
- N.9.a. What investments has Respondent made over the past three (3) years in its technology to mitigate security breaches?
- N.10. Briefly describe Respondent's backup procedures for the system(s) to be used in the services proposed to ERS.

O. Deviations – Security Practices Requirements - DHMO

O.1. Affirm that Respondent shall comply with all of the **Scope of Work – Information Systems Requirements – Security Practices Requirements** described in RFP Sections X.C.1. – X.C.12.

- Affirm
- Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each Deviation between Respondent's response and these requirements:

Respondent's Requested Deviation Detail:

P. Interrogatories – Security Practices Requirements - DHMO

P.1. Does Respondent have a full-time Information Security Officer or Chief Security Officer?
 Yes No

If Respondent marked "Yes", Respondent shall describe how this role fits into Respondent's organizational chart.

P.1.a. If Respondent marked "No" for Interrogatory P.1. above, Respondent shall provide a detailed description as to why not.

P.2. Does Respondent have dedicated resources for information security efforts? Yes No

P.2.a. If Respondent marked "No" for Interrogatory P.2. above, Respondent shall provide a detailed description as to why not.

P.3. What are Respondent's minimum and maximum User ID lengths?

Minimum User ID Length	
Maximum User ID Length	

P.4. Would Respondent support any kind of SSO solution for users of the ERS-based product?
 Yes No

If yes, Respondent shall describe.

- P.5. What technology in the data center (servers, storage, and network infrastructure) which provides services to ERS is shared with other data center customers?
- P.6. What kind of network security devices are running in Respondent's data center(s) (e.g., data loss prevention tools, intrusion detection systems, intrusion prevention systems)?
- P.7. Describe in detail Respondent's practices and controls utilized to limit access and protect confidential and sensitive data in storage and in transit.
- P.8. Are network firewalls and other security equipment checked by independent third parties for vulnerabilities and possible exploits? Yes No
- P.8.a. If yes, how often?
- P.8.b. If Respondent marked "No" to Interrogatory P.8. above, Respondent shall provide a detailed description as to why not.
- P.9. In the event of a security breach, describe the process to notify ERS of the breach of ERS data, Respondent facilities or other types of Information Technology infrastructure breaches.
- P.10. Respondent shall describe how often its firewall and router configuration standards are reviewed. Respondent shall provide the last date its firewall and router configuration standards were reviewed.
- P.11. Respondent shall describe its processes and procedures for managing and patching known vulnerabilities. Is there a patch management solution in place, so that all system components and software are protected from known vulnerabilities by having the latest vendor supplied security patches installed? How often are systems checked? What was the last date Respondent's data center systems and user workstations were checked?
- P.12. Respondent shall describe its processes and procedures in place for responding to low, medium and high severity information security incidents. What is Respondent's process to rank such incidents? Does Respondent's company have forensic security experts on staff or is a third party contracted in the case of a breach?
- P.13. What anti-virus protection/programs does Respondent use? Is AV software deployed on all Respondent's and Respondent's contractor systems (such as servers, workstations, laptops) commonly affected by malicious software? Are all anti-virus programs capable of detecting, removing and protecting against all known types of malicious software (i.e., viruses, worms, spyware, Trojans, adware and rootkits)? How often are the .DAT files updated and are automatic AV scans enabled?
- P.14. Describe Respondent's Security Incident Management policies and procedures for the application as well as internal systems.
- P.14.a. Respondent shall provide a copy of this documentation.
- P.15. Respondent shall confirm it will follow highly restricted access policies behind any ERS-related point-to-point VPN setup in support of this Contract. Confirm
- P.15.a. If Respondent cannot confirm Interrogatory P.15. above, Respondent shall provide a detailed description as to why not. [REDACTED]
- P.16. Are Respondent's portable devices encrypted to protect the data in case of theft or loss?
 Yes No
- P.16.a. If Respondent did not mark "Yes" to Interrogatory P.16. above, Respondent shall provide a detailed description as to why not. [REDACTED]
- P.17. How does Respondent manage physical security of its data center? Who gets access, what are the hours of operation?

- P.18. What technology is in place to manage network and server security? Provide the name and the version of the technology used to manage the network and server security and describe the effectiveness of the technology.
- P.19. Describe how Respondent controls access to ERS' confidential data?
- P.20. How does Respondent secure backup tapes? Who has access to them onsite and offsite? Are they encrypted?
- P.20.a. Respondent shall confirm that they have the ability to encrypt ERS data using PGP compatible encryption. Confirm
- P.20.a.i. If Respondent cannot confirm Interrogatory P.20.a. above, Respondent shall provide a detailed description as to why not. [REDACTED]
- P.20.b. Describe the encryption technology that is being used.
- P.21. How is Respondent's application security managed and how is client data secured?
- P.22. Does Respondent have a formal information security program in place?
 Yes No
- P.22.a. Does Respondent have formal information security policies, procedures and standards?
 Yes No
- P.22.a.i. If yes, Respondent shall provide copies of their formal information security policies, procedures and standards. If Respondent considers this document confidential and proprietary, place this on Respondent's separate schedule as required at RFP Section I.F.1.b. However, Respondent shall provide this document for appropriate evaluation of Respondent's Proposal.
- P.22.b. Are employees required to periodically confirm their compliance with Respondent's information security policies, procedures and standards? Yes No
- P.22.b.i. If no, Respondent shall validate if their employees ever confirm compliance with Respondent's information security policies, procedures and standards and how often compliance is confirmed.
- P.22.c. Does Respondent have a user awareness campaign related to information security?
 Yes No
- P.22.c.i. If Respondent did not mark "Yes" to Interrogatory P.22.c. above, Respondent shall enumerate and provide a detailed description as to why not. [REDACTED]
- P.22.d. Respondent shall provide a full description of how Respondent monitors compliance.
- P.23. Are Respondent's desktop and laptop computers encrypted to protect data in case of theft or loss? Yes No
- P.23.a. If Respondent cannot confirm Interrogatory P.23. above, Respondent shall enumerate and provide a detailed description as to why not. [REDACTED]
- P.23.b. Describe the ability to use portable drives. If so, how are they protected?
- P.24. How does Respondent protect the privacy of GBP Participants? Respondent shall provide a detailed description.

Q. Deviations – Business Resumption and Data Center Facilities Requirements - DHMO

Q.1. Affirm that Respondent shall comply with all of the **Scope of Work – Information Systems Requirements –Business Resumption and Data Center Facilities Requirements** described in RFP Sections X.D.1. – X.D.9.

- Affirm Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each Deviation between Respondent's response and these requirements:

Respondent's Requested Deviation Detail:

R. Interrogatories - Business Resumption and Data Center Facilities Requirements - DHMO

R.1. Describe Respondent's contingency plans and procedures for providing business continuity due to any event that might interrupt, delay or shut-down service that is related to Respondent's services or products under this proposal, including that of any subcontractor upon whom Respondent relies in performing or providing services or products to or on behalf of ERS.

R.2. Describe who has physical access to Respondent's data center facility and how the access is monitored.

R.3. Does the Respondent's data center have formal Uptime Institute certification?
 Yes No

R.3.a. If yes, which certifications were granted? What year were they granted? Are the certifications still current? Yes No

R.3.b. If no, how does Respondent confirm that its data center conforms to the Uptime Tier III or Tier IV standards?

R.3.c. If Respondent's data center does not have formal Uptime Institute certification, Respondent shall provide a detailed description as to why not.

R.4. How does Respondent confirm that its data center conforms to the Uptime Tier III or Tier IV standards; if the Respondent does not have a formal Uptime certification, how does the Respondent ensure that all critical data center systems associated with providing power and cooling to IT equipment can maintain uptime of at least 99.982% during any 12 month period?

R.5. What was the data center uptime for the previous 12 months (specify time period)?

R.6. Provide details regarding the redundant links for internet access that Respondent has in place for its data center, including redundant last-mile connectivity and diverse physical data-center network penetrations.

R.7. Who is Respondent's data center provider(s)?

R.8. Briefly describe Respondent's data backup and recovery procedures for the system(s) to be used in the services proposed to ERS.

R.9. Provide the names and a description of the hardware and software systems that Respondent will use to fulfill ERS' contract.

R.10. For each hardware and software system, provide the following information:

R.10.a. When was this system implemented?

- R.10.b. When was the system last updated?
- R.10.c. Is there a future update being considered? Yes No
- R.10.d. If so, provide the date and description of the anticipated update.
- R.11. A copy of the disaster recovery plan and the disaster recovery test results to ERS. These should include, but not be limited to: (a) the Disaster Recovery plans plus a description of the changes from the previous year's plans, if any; and (b) the exercise test results conducted within the last twelve months of the disaster recovery and business continuity tests referencing the adequacy of these plans. The test results must include the RTO and RPO of the systems and applications which provide service to ERS. If these are a part of a SOC II Type 2 report, Respondent shall provide the portions of the report that refer to the normal, annual disaster recovery and business and continuity tests, plus copies of the service auditor's report. Respondent further agrees to be available for reasonable inquiry by ERS of the disaster recovery plan and tests.
- R.12. A summary of the latest disaster recovery test results to ERS and a summary of the disaster recovery programs. The test results should include the RTO and RPO of the systems and applications which provide service to ERS. The Respondent must attest annually, by signature, that the disaster recovery tests will ensure that systems which the Respondent uses to provide services to ERS will be available within X hours of outage and will experience a maximum Y hours of data loss (where X is the RTO and Y is the RPO). Respondent further agrees to be available for reasonable inquiry by ERS of the disaster recovery plan and tests.

S. Deviations – SOC-2 Report Requirements - DHMO

- S.1. Affirm that Respondent shall comply with all of the **Scope of Work – Technology Services Requirements – SOC-2 Report Requirements** described in Sections X.E.1. – X.E.3.
- Affirm Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each Deviation between Respondent's response and these requirements:

Respondent's Requested Deviation Detail:

T. Interrogatories – SOC-2 Report Requirements - DHMO

- T.1. **SOC reports.** Provide a full, un-redacted copy of the most recent SOC-2 type II report and results performed under the SSAE16 or SSAE18 SOC-2 Type II report or any other independent auditor report on the effectiveness of internal controls over operations and compliance of service to be provided under this RFP, including disaster recovery planning and testing, and data center facilities. This should include results of an independent, certified external security audit. Respondent shall also acknowledge and agree that ERS is entitled to review all such audit results on a yearly basis. If there is not a service organization control engagement performed, then provide a detailed explanation of how both information technology and operational control activities are assessed/evaluated to meet the services to be provided under this RFP.
- T.1.a. If applicable, provide a copy of Respondent's sponsoring or parent company's most recent SOC-2 report under SSAE 16 or SSAE18 SOC-2 Type II report or any other independent auditor report on the effectiveness of internal controls over operations, security, and compliance of service to be provided under the RFP.
- T.1.b. Respondent shall also acknowledge and agree that ERS is entitled to review all such audit results on a yearly basis.

T.2. If Respondent conducts its SOC-2 control audits with an external firm, please identify the following:

Name of external firm:	
Address of external firm:	
Dates when firm performed the audits:	

T.3. If any data centers, development, or data services are outsourced or subcontracted, Respondent shall provide copies of outsourcers' or subcontractors' SOC-2 under SSAE16 or SSAE18 SOC-2 Type II report or equivalent reports. [REDACTED]

T.3.a. Respondent shall also confirm that ERS is entitled to review outsourcers' or subcontractors' SOC-2 under SSAE18 SOC-2 Type II report or equivalent reports annually. Confirm

APPENDIX V

IMPLEMENTATION AND PROJECT MANAGEMENT REQUIREMENTS DEVIATIONS AND INTERROGATORIES

Implementation and Project Management Requirements Deviations and Interrogatories

Respondent shall review the Deviation and Interrogatories instructions referenced at RFP Sections I.D.2. and I.D.3. Respondent shall complete the Interrogatories listed below by providing Respondent's answer following each question. **Respondent shall complete both PPO and DHMO sections if Respondent will be providing both plans. If Respondent is not providing services for both plans, then Respondent only needs to provide its Responses to either the PPO or DHMO sections.**

PPO RESPONSES

A. Deviations – Implementation Requirements - PPO

A.1. Affirm that Respondent shall comply with all of the ***Scope of Work – Implementation and Project Management Requirements*** described in RFP Sections XI.A.1. – XI.A.5.

Affirm Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each Deviation between Respondent's response and these requirements:

Respondent's Requested Deviation Detail:

B. Interrogatories – Implementation Requirements - PPO

If provided by the Respondent, an implementation credit will be used by ERS to help offset ERS' internal costs including, but not limited to, communications, data set-up, member education and the costs of dental plan enrollment set-up.

B.1. Confirm that Respondent is willing to provide implementation credit. Confirm

B.1.a. Confirm the amount of implementation credit Respondent will provide if awarded the Contract.

C. Deviations – Project Management Requirements - PPO

C.1. Affirm that Respondent shall comply with all of the ***Scope of Work –Implementation and Project Management Requirements - Project Management Requirements*** described in RFP Sections XI.B.1. – XI.B.2.

Affirm Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each Deviation between Respondent's response and these requirements:

Respondent's Requested Deviation Detail:

D. Interrogatories – Project Management Requirements - PPO

D.1. Describe how Respondent's Implementation Project Manager proposes to work with the ERS Project Manager and Implementation Team. How will the individuals on the team work together? What functional areas will be represented? If Respondent uses a specific approach or methodology, please describe it.

D.2. What type of logistical issues or concerns from a project management perspective does Respondent believe this project will face? (i.e., location of Respondent's Implementation Project Manager (offsite/onsite), resource team locations, communications, and subcontractors for printing or other outsourced services). Provide an explanation, including how these are mitigated.

- D.3. Based upon Respondent's understanding of the project scope, does Respondent anticipate needing to make any system and/or process changes to accommodate ERS? What are Respondent's internal processes and timelines associated with making any changes during implementation, both anticipated based on scope understanding or identified during implementation?
- D.4. Describe how Respondent's organization proposes to coordinate the activities and transference of information between the implementation team and the account management team following the project launch.
- D.5. Provide a description of the proposed project team structure and internal controls to be used during the course of the project, including any subcontractors.
- D.6. What is Respondent's proposed plan to achieve an Annual Enrollment readiness by May 1, 2019?
- D.7. What project approach/methodology does Respondent follow when working with customers on projects?
- D.8. Does Respondent have a formalized PMO practice? If not, then what is its structure?
- D.9. Does Respondent have a Project Management Institute certified PM that will work in conjunction with the ERS PMO? If not, then what type of resource do they assign? Will they have a backup to the primary resource?
- D.10. Does Respondent use Microsoft ("MS") Project and, if so, what version? If not, does Respondent's assigned PM know how to use MS Project?
- D.11. Respondent shall explain the difference between a work breakdown structure ("WBS") and a project schedule.
- D.12. How does Respondent work with customer PMOs in communicating project activities, (i.e., collaboration sites, meeting events, escalations, joint project monitoring tools, etc.)?
- D.13. How does Respondent coordinate project risk/issues with their customers, (i.e., identification, communication, mitigation, tools, etc.)?
- D.14. Does Respondent have historical PM artifacts from previous similar implementations, (i.e., WBS, Project Plans, Project Schedules, success measurements, etc.)?

DHMO RESPONSES

E. Deviations – Implementation Requirements - DHMO

- E.1. Affirm that Respondent shall comply with all of the ***Scope of Work – Implementation and Project Management Requirements*** described in RFP Sections XI.A.1. – XI.A.5.

Affirm Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each Deviation between Respondent's response and these requirements:

Respondent's Requested Deviation Detail:

F. Interrogatories – Implementation Requirements - DHMO

If provided by the Respondent, an implementation credit will be used by ERS to help offset ERS' internal costs including, but not limited to, communications, data set-up, member education and the costs of dental plan enrollment set-up.

- F.1. Confirm that Respondent is willing to provide implementation credit. Confirm

- F.1.a. Confirm the amount of implementation credit Respondent will provide if awarded the Contract. [REDACTED]

G. Deviations – Project Management Requirements - DHMO

- G.1. Affirm that Respondent shall comply with all of the **Scope of Work –Implementation and Project Management Requirements - Project Management Requirements** described in RFP Sections XI.B.1. – XI.B.2.

Affirm Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each Deviation between Respondent’s response and these requirements:

Respondent’s Requested Deviation Detail: [REDACTED]

H. Interrogatories – Project Management Requirements - DHMO

- H.1. Describe how Respondent’s Implementation Project Manager proposes to work with the ERS Project Manager and Implementation Team. How will the individuals on the team work together? What functional areas will be represented? If Respondent uses a specific approach or methodology, please describe it.
- H.2. What type of logistical issues or concerns from a project management perspective does Respondent believe this project will face? (i.e., location of Respondent’s Implementation Project Manager (offsite/onsite), resource team locations, communications, and subcontractors for printing or other outsourced services). Provide an explanation, including how these are mitigated.
- H.3. Based upon Respondent’s understanding of the project scope, does Respondent anticipate needing to make any system and/or process changes to accommodate ERS? What are Respondent’s internal processes and timelines associated with making any changes during implementation, both anticipated based on scope understanding or identified during implementation?
- H.4. Describe how Respondent’s organization proposes to coordinate the activities and transference of information between the implementation team and the account management team following the project launch.
- H.5. Provide a description of the proposed project team structure and internal controls to be used during the course of the project, including any subcontractors.
- H.6. What is Respondent’s proposed plan to achieve an Annual Enrollment readiness by May 1, 2019?
- H.7. What project approach/methodology does Respondent follow when working with customers on projects?
- H.8. Does Respondent have a formalized PMO practice? If not, then what is its structure?
- H.9. Does Respondent have a Project Management Institute certified PM that will work in conjunction with the ERS PMO? If not, then what type of resource do they assign? Will they have a backup to the primary resource?
- H.10. Does Respondent use Microsoft (“MS”) Project and, if so, what version? If not, does Respondent’s assigned PM know how to use MS Project?
- H.11. Respondent shall explain the difference between a work breakdown structure (“WBS”) and a project schedule.
- H.12. How does Respondent work with customer PMOs in communicating project activities, (i.e., collaboration sites, meeting events, escalations, joint project monitoring tools, etc.)?

- H.13. How does Respondent coordinate project risk/issues with their customers, (i.e., identification, communication, mitigation, tools, etc.)?
- H.14. Does Respondent have historical PM artifacts from previous similar implementations, (i.e., WBS, Project Plans, Project Schedules, success measurements, etc.)?

APPENDIX W

OPERATIONAL SPECIFICATIONS AND REQUIREMENTS DEVIATIONS AND INTERROGATORIES

Operational Specifications and Requirements Deviations and Interrogatories

Respondent shall review the Deviation and Interrogatory instructions referenced at RFP Sections I.D.2. and I.D.3. Respondent shall complete the Interrogatories listed below by providing Respondent's answer following each question. **Respondent shall complete both PPO and DHMO sections if Respondent will be providing both plans. If Respondent is not providing services for both plans, then Respondent only needs to provide its Responses to either the PPO or DHMO sections.**

PPO RESPONSES

A. Deviations - Account Management Requirements - PPO

A.1. Affirm that Respondent shall comply with all of the **Scope of Work – Operational Specifications and Requirements – Account Management Requirements** described in RFP Sections XII.A.1 – XII.A.4.a.

- Affirm Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each deviation between Respondent's response and these requirements:

Respondent's Requested Deviation Detail:

B. Interrogatories - Account Management Requirements - PPO

B.1. Briefly outline Respondent's Account Management Team philosophy.

B.1.a. Provide a description of the proposed Account Management Team's structure (including any subcontractors), its philosophy and internal controls to be used during the course of the project.

B.1.b. If Respondent contracts with a management company for some or all of its administrative services, please specify:

Name of Company:	
Physical address:	
Mailing address:	
Email address:	
Telephone number:	
Facsimile number:	
Describe the services that are provided:	
Reimbursement Method:	

B.1.c. How many other clients are now, and will be in the future, assigned to the proposed Account Management Team?

Number of Clients Currently Assigned to Respondent's Account Management Team	Number of Clients that will be assigned to Respondent's Account Management Team in the Future

B.1.d. For purposes of providing the services that are part of the RFP and Contract, will Respondent provide a designated staff or a dedicated staff?

B.1.e. Please indicate by title, staff that will be designated and staff that will be dedicated. Within description, indicate any licenses and/or certifications that designated and dedicated staff are

required to maintain will be kept current during any period of time that Respondent has a contract in place with ERS.

- B.1.f. If providing a designated staff, how many other clients are, and/or will be in the future, assigned to Respondent’s proposed account team that is assigned to service ERS?
- B.1.g. If Respondent indicated that it will provide a dedicated staff to service ERS, confirm that Respondent will provide a dedicated staff arrangement for the entire Contract Term.
 Confirm
- B.1.g.i. If Respondent cannot confirm Interrogatory B.1.g. above, Respondent shall provide a detailed description as to why not. [REDACTED]
- B.1.h. Respondent shall provide a detailed description of the manner in which Respondent proposes to administer the Dental Benefits plan to the Participants. Include responses to the following:

Account Manager/Account Representative(s);	
Claims processing;	
Customer service;	
Website management;	
Correspondence unit; and	
Publications distribution.	

- B.1.h.1. Describe any business and/or administrative functions that are performed outside of the United States of America. Where are these functions performed?
- B.1.i. Where will the account representative be located? Will this individual have responsibility for other clients? If yes, how many?

C. Deviations - Administrative Requirements - PPO

C.1. Affirm that Respondent shall comply with all of the **Scope of Work – Operational Specifications and Requirements – Administrative Requirements** described in RFP Sections XII.B.1. – XII.B.12.

- Affirm
- Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each Deviation between Respondent’s response and these requirements:

Respondent’s Requested Deviation Detail: [REDACTED]

D. Interrogatories - Administrative Requirements - PPO

D.1. Describe the staff (including numbers of full-time equivalent employees) that Respondent and any subcontractor shall utilize to perform, deliver and provide the services, coverages, benefits, equipment, supplies and products requested herein. Respondent shall also provide the specific services to be performed by the subcontractors.

Respondent’s staff description: [REDACTED]
 Subcontractor staff description and specific services to be performed: [REDACTED]

D.1.a. How many of these employees are located in Texas? Describe the functions these employees perform.

Number of Respondent staff in Texas: 
Description of Respondent's staff functions:
If applicable, number of Subcontractor staff in Texas:
If applicable, description of Subcontractor staff functions: 

Insurance Coverage

D.1.b. Describe the various types of insurance coverage provided to protect ERS, the GBP, its Participants and the State. This should include, but not be limited to:

Risks covered: 
Name of insurance carrier: 
Levels and limits:
Deductibles: 

D.1.b.i. Respondent agrees to send ERS an updated declarations page from each such policy upon policy renewal for each year of the Contract. Yes No

Fraud and Abuse

D.1.c. Explain the procedures and systems Respondent uses to prevent, deter, detect and investigate fraud and related issues, and how such processes shall be used in connection with the GBP.

D.1.d. Discuss how Respondent would communicate with the Participant, physician(s), and ERS once a fraud or abuse problem is suspected or identified.

D.1.e. Discuss what measures Respondent employs to prevent and detect employee fraud (i.e., background checks, confidentiality agreements, and security monitoring equipment).

D.1.f. Provide a copy of Respondent's fraud plan.

D.1.g. Respondent agrees to comply with any additional policies that ERS develops in connection with the detection and prevention of fraud or abuse. Yes No

D.1.h. For the past two (2) year period, what percent of claims submitted to Respondent were denied because of misrepresentation and/or fraud?

D.1.i. Does Respondent utilize Independent Medical Evaluations ("IME") and Functional Capacity Evaluations ("FCE") for dental cases? Yes No

- a. Who performs the IMEs?
- b. Who performs the FCEs?
- c. Describe the general process (es) that would prompt their use.

D.1.j. Describe Respondent's most effective means to detect fraud, abuse and other improprieties.

Executive Summary

D.1.k. Provide an executive summary no longer than two (2) pages outlining significant features of Respondent's Proposal. The summary should highlight Respondent's philosophy, its experience with similar programs and the administrative approach presented in the Proposal.

Administrative or Policy Decisions

D.2. Are there any special manuals or folders maintained for administrative or policy decisions related to the Dental PPO Plans for Respondent's book of business? If yes, Respondent shall describe these manuals or folders.

- D.3. Describe in detail the facilities, procedures, and locations that Respondent intends to utilize in servicing those functions required under the Plans other than the processing of claims. This response should include a description of the following:
 - D.3.a. The actuarial personnel that will be available to confer with ERS' consulting actuary concerning rating and other financial issues.
 - D.3.b. Legal and other expertise available to assist ERS in the execution of its duties under the Contract.
 - D.3.c. Legal counsel in Austin, Texas that will handle administrative appeals and/or litigation related to GBP claims.
 - D.3.d. Dental professionals and/or the expertise of professionals who will be reviewing appeals related to GBP claims specific to the PPO plan.

Utilization Review

- D.4. Provide a detailed description of all aspects of the utilization review process that will apply to Participants. Respondent's response should include at least the following:
 - D.4.a. Whether the utilization review is performed by Respondent's staff or through a contract with a third party? Respondent Staff Third Party
 - D.4.b. If through a third party, identify the following:
 - Third Party Name: [Redacted]
 - Address: [Redacted]
 - Contact Name: [Redacted]
 - Contact Telephone Number: [Redacted]
 - D.4.c. What are the addresses and hours of operation for the facility or facilities from which utilization review activities shall be conducted?
 - Facility Address: [Redacted]
 - Hours of Operation: [Redacted]
 - D.4.d. Are licensed dental personnel on duty at all facilities during all hours of operation?
 Yes No
 - D.4.e. How many licensed dental professionals administer the utilization review program?
 - D.4.f. What are the titles of the licensed dental professionals who administer the utilization review program?
 - D.4.g. What credentials and/or qualifications are required for Respondent's utilization personnel?
 - D.4.h. What percentage of utilization review, referral, and pre-determination requests are referred to the dental director?

Utilization review	%
Pre-determination requests	%
Referrals	%
 - D.4.i. Respondent shall provide an explanation of how it tracks the percentage of claims that are referred to the dental director for review.
 - D.4.j. What is the process available to dental providers for the appeal of denied claims?
 - D.4.k. What are the utilization review procedures performed by network dental care providers?
 [Redacted]

- D.5. In what manner does Respondent conduct the following activities and how are the results of such activities used in the dental management process? Include the following information:
 - D.5.a. Development of profiles of PCD practice and referral patterns.
 - D.5.b. Monitoring of frequently used services.
 - D.5.c. Review of dentist's coding patterns.
 - D.5.d. Examinations of average cost per encounter by PCDs.
 - D.5.d.i. Respondent shall provide an explanation of the average examination cost per encounter by PCDs and how it is utilized in the dental management process.
- D.6. What is the methodology that Respondent uses in establishing dental protocols for the Vendor network?
 - D.6.a. Which protocols are used in the management of participant dental care?
 - D.6.b. How are the protocols used?
 - D.6.c. In what manner does a dental care provider obtain approval to deviate from the protocols when treating a patient with complications?
 - D.6.d. How does Respondent communicate the results of such activities to dental care providers? 
 - D.6.e. How are the results used to modify practice patterns?
- D.7. What is the organizational relationship that exists between corporate, regional and local dental management?
 - D.7.a. What are the distinct responsibilities that pertain to each level?
 - Corporate 
 - Regional 
 - Local 
 - D.7.b. What are the functions handled at each level? Include any arrangements involving dental protocol committees, utilization review groups, etc.
 - Corporate 
 - Regional 
 - Local 
- D.8. What is the size and expertise of the dental management staff assigned to each network location, if applicable?
 - D.8.a. Which of these personnel is staff versus contract?
 - D.8.b. Which of these personnel are full-time versus part-time? 
 - D.8.c. What are the general responsibilities of each staff member?
 - Staff: 
 - Contract: 
 - Full-time: 
 - Part-time 

D.8.d. Where is this staff located?

Staff:
Contract:
Full-time:
Part-time



E. Deviations – Customer Service Requirements - PPO

E.1. Affirm that Respondent shall comply with all of the **Scope of Work – Operational Specifications and Requirements – Customer Service Requirements** described in RFP Sections XII.D.1. – XII.D.12.

Affirm Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each Deviation between Respondent's response and these requirements:

Respondent's Requested Deviation Detail: 

F. Interrogatories – Customer Service Requirements - PPO

F.1. Describe the features of Respondent's Customer Service Unit by reflecting the following:

F.1.a. Describe Respondent's call center telecommunications system in detail.

F.1.b. Describe the manner in which the customer service unit may be accessed (e.g., web chat, phone, email).

F.1.c. Describe the Customer Service unit's hours of operation.

F.1.d. Describe how after hours calls are handled.

F.1.e. Can Respondent provide a separate toll-free telephone number for the Participants? If no, please explain. If yes, explain how the caller is routed to the appropriate CSR.

F.1.f. Describe any dedicated staff units to be assigned to ERS or that Respondent plans to assign to this account.

F.2. Briefly describe the frequency of Respondent's employee training, including the time period of training, rendered prior to providing customer services. 

F.3. Describe Respondent's internal dispute or appeal process that is available to Participants. Provide a detailed description including any independent review process.

F.4. Describe Respondent's customer satisfaction survey process. 

F.4.a. How often does Respondent conduct these surveys? Respondent shall provide a copy of the results of Respondent's most recent survey.

F.5. With regard to automated customer service support using voice response for routine questions, please provide the following:

F.5.a. Does Respondent currently provide any automated customer service support using voice response for routine questions? If yes, please give details of this service. This should include, but not be limited to how Participants can interact with the automated interactive system (e.g., via telephone, online or both.) 

F.5.b. If Respondent does not currently provide any automated customer service support using voice response for routine questions, please specify a date in the future, if any, that Respondent will be providing these services. If Respondent will not be providing this type of service in the future, please answer this question "N/A." 

- F.6. Does Respondent record all phone calls and notify all parties that their conversations are being electronically recorded and stored? Yes No
- F.6.a. How long does Respondent store electronically recorded phone calls? [REDACTED]
- F.7. How does Respondent ensure that its customer service representatives are providing timely and accurate information? [REDACTED]
- F.8. Does Respondent's customer service inquiry system allow representatives to record comments so that another customer service representative can review previous notes in order to assist Participants? Yes No
- F.8.a. If Respondent marked "No" for Interrogatory F.8. above, Respondent shall provide a detailed description as to how it can meet this objective. [REDACTED]
- F.9. Does Respondent have the ability to monitor live customer service calls? Yes No
- F.9.a. If Respondent marked "No" for Interrogatory F.9. above, Respondent shall provide a detailed description as to how it can meet this objective. [REDACTED]
- F.10. With regard to customer service inquiries, Respondent shall describe how patterns of customer service inquiries are monitored and tracked. [REDACTED]
- F.11. Respondent shall identify and describe the various reporting capabilities of its call center system. [REDACTED]
- F.12. Describe Respondent's calculation methodology applicable to the proposed call center metrics requirements referenced in **Appendix Y**. [REDACTED]
- F.13. Respondent shall refer to RFP Section XII.D.5. and provide its sample source documents. [REDACTED]
- F.14. Does Respondent expect to make major changes to its customer service organization or facilities within the next two (2) years (i.e., moving to a different location, reorganizing or merging units)? Yes No
- If yes, Respondent shall describe and provide an explanation. [REDACTED]
- F.15. With regard to written inquiries received by Respondent, provide the following:
- F.15.a. Describe Respondent's procedure for managing written inquiries. [REDACTED]
- F.15.b. What is Respondent's current standard response time with respect to questions requiring written communication? [REDACTED]
- F.16. Describe Respondent's procedure for handling customer service complaints, grievances and inquiries by providing the following:
- F.16.a. How does Respondent monitor first call resolution? [REDACTED]
- F.16.b. How does Respondent monitor Participant inquiries that do not get resolved during the initial call? [REDACTED]
- F.16.c. What customer complaint tracking system does Respondent use? [REDACTED]
- F.16.d. How long has Respondent's customer complaint tracking system been operational? [REDACTED]
- F.16.e. Does Respondent have plans within the next 36-months to implement a new complaint tracking system? If yes, please provide the date when Respondent plans to have this new system operational. [REDACTED]

- F.16.f. Describe Respondent's problem resolution policies and procedures. Respondent's description should include, but not be limited to, Respondent's procedures for escalation of complaints. [REDACTED]
- F.16.g. Describe any procedures for handling customer service complaints, grievances and inquiries that were not requested above, if any. [REDACTED]
- F.17. Describe the types of access (i.e., automated, interactive, etc.) Respondent provides to Participants in order that Participants can obtain the necessary information regarding dental services, coverages, benefits, equipment, supplies, products and providers.
- F.18. If Participants can upload documentation in support of Respondent transactions through Respondent's website, describe what file types are permitted for uploading. If Participants are not able to do this, please answer this question "N/A."
- F.19. How does Respondent's customer service system support Participants with disabilities? [REDACTED]
- F.20. Describe how the Participant is assisted if they speak languages other than English.
- F.21. Describe Respondent's ability to make immediate/emergency enrollment updates upon phone or email request from ERS.
- F.22. Describe the hours that Respondent's staff is available to handle immediate/emergency updates.
- F.23. Respondent shall provide a detailed description of the level of customization it will allow to ERS with regard to modifying, rewriting, editing, and updating the language contained within Respondent's CSR response scripts and IVR scripts.

G. Deviations – Claims Processing Requirements - PPO

G.1. Affirm that Respondent shall comply with all of the **Scope of Work – Operational Specifications and Requirements – Claims Processing Requirements** described in RFP Sections XII.E.1. – XII.E.10.

- Affirm Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each Deviation between Respondent's response and these requirements:

Respondent's Requested Deviation Detail: [REDACTED]

H. Interrogatories – Claims Processing Requirements - PPO

- H.1. Are claims processed internally, by a third party, or both?
 Internal Third party Both
- H.2. Provide a detailed description of Respondent's claims processing procedures. [REDACTED]
- H.3. What Provider encounter data is collected and on what frequency? [REDACTED]
- H.4. What is Respondent's procedure for processing patient-submitted paper claims? [REDACTED]
- H.5. What percentage of claims are received on paper? [REDACTED] %
- H.6. What is the average turnaround time for "paper" claim submissions? [REDACTED]
- H.7. What percentage of claims are received electronically? [REDACTED] %
- H.8. What is the average turnaround time for "electronic" claims submissions? [REDACTED]
- H.9. Where is the claim processing facility located? [REDACTED]

- H.10. Based on Respondent's Texas book of business, please list the top ten (10) providers in Respondent's network based on claim payments YTD for calendar year 2016, if applicable. Provide the name, city, and amount paid. [REDACTED]
- H.11. Describe Respondent's procedures for lost, returned, and uncashed checks. [REDACTED]
- H.12. Discuss the measures Respondent employs to protect Participant identity information (i.e., driver's license, social security number, etc.) [REDACTED]
- H.13. Discuss Respondent's collection process, both for Participant and/or dental providers, as it relates to terminated Participants that utilize dental benefits past their termination date. [REDACTED]
- H.14. Will this service be available to the GBP Dental Program? [REDACTED]
- H.15. Does Respondent have an available system that would provide real-time access to view claims to selected ERS users? Yes No
- H.15.a. If yes, fully describe the capabilities of this real-time system. [REDACTED]
- H.16. Does Respondent coordinate benefits with other dental carriers? Yes No
- H.17. If yes, describe Respondent's Coordination of Benefits process. [REDACTED]
- H.18. Discuss Respondent's capability to integrate dental and health information with other Vendors. [REDACTED]
- H.19. Is Respondent currently exchanging this type of information for any existing clients?
 Yes No
- If yes, what percent of Respondent's claim experience is integrated? [REDACTED]
- H.20. Discuss the financial impact such integration of information would have on the proposed rates reflected in Respondent's Price Proposal, **Appendix AA**. [REDACTED]
- H.21. In the office that would process GBP dental program claims, please provide:
- H.22. The number of clients for which Respondent processes claims; [REDACTED]
- H.23. The number of covered employees for whom Respondent processes claims: [REDACTED]
- H.24. The number of claims processors. [REDACTED]
- H.25. What additional responsibilities do claim processors have? (i.e., telephone inquiries, correspondence, filing, opening mail, etc.)? [REDACTED]
- H.26. Based on Respondent's Texas book of business, what percentage of paid claims are "in-network" versus "out-of-network" dental care providers, if applicable? [REDACTED]
- H.27. How is the performance of Respondent's claim management staff evaluated?
- H.28. Describe how Respondent's organization's processes and systems (including test and/or production files) can accommodate the following three (3) scenarios:
- Terminations by absence of records in the enrollment file;
 - Retroactive enrollment dates (i.e., employee's start date is Oct. 7th and benefits are active to Oct. 1st); and
 - Future effective dates on eligibility files.

Please describe the impact the above has on claims processing.

Closed Claims

H.29. Respondent shall describe their process and data requirements necessary to respond to any appeal requests received for claims processed for dates of service beginning on September 1, 2019.

Claims in Appeal

H.30. Respondent shall describe how it administers its appeal process, including first and second level appeals.

I. Deviations – Subcontractors Requirements - PPO

I.1. Affirm that Respondent shall comply with all of the **Scope of Work – Operational Specifications and Requirements – Subcontractors Requirements** described in RFP Sections XII.F.1. – XII.F.9.

- Affirm Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each Deviation between Respondent’s response and these requirements:

Respondent’s Requested Deviation Detail:

J. Interrogatories – Subcontractors Requirements - PPO

J.1. Does Respondent propose to use subcontractors in the performance, delivery and provision of services and products requested hereunder? Yes No

J.1.a. If applicable, provide the information below for each subcontractor and specify what services may be performed by each subcontractor. Any planned or proposed use of subcontractors by Respondent shall be clearly disclosed and documented in Respondent’s Proposal, including specification of the services that may be performed by each subcontractor. Further, Respondent shall provide complete information, prior to and, if requested by ERS, after execution of the Contract, regarding each subcontractor used by Respondent to meet the requirements of the Contract. List each in the following format:

Name:	<input type="text"/>
Physical address	<input type="text"/>
Mailing address:	<input type="text"/>
Email address:	<input type="text"/>
Telephone number:	<input type="text"/>
Services performed:	<input type="text"/>
Length of time contracted with subcontractor:	<input type="text"/>

K. Deviations – Respondent Program Reporting Requirements - PPO

K.1. Affirm that Respondent shall comply with all of the **Scope of Work – Operational Specifications and Requirements – Respondent Program Reporting Requirements** described in RFP Sections XII.G.1. – XII.G.15.

- Affirm Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each Deviation between Respondent’s response and these requirements:

Respondent’s Requested Deviation Detail:

L. Interrogatories – Respondent Program Reporting Requirements - PPO

- L.1. Based on the information provided at RFP Section XII.G., Respondent shall describe the reports to be provided by Respondent on a regular basis at no charge to ERS by including the following information:
- Title of Report;
 - Detailed description of the information provided in the report; and
 - Frequency provided (monthly, quarterly, annually). [REDACTED]
- L.2. Describe how the reports can be utilized to identify problems and monitor performance.
- L.3. Provide copies of Respondent's sample standard reporting package. [REDACTED]
- L.4. Describe how the reports listed above can be used to identify problems and monitor performance.
- Title of Report provided in Interrogatory L.1. above; and
 - How it is used to identify problems and monitor performance.
- L.5. Respondent shall describe its regularly requested *ad hoc* reports and other customized reports and their associated TAT.
- L.6. Separate from the required claims data file, how will Respondent provide ERS with the capability to conduct independent online queries, interface with Respondent's database in order to generate *ad hoc* reports and extract specific information?
- L.7. Respondent shall describe any unique reporting capabilities that differentiate Respondent from its competitors.
- L.8. Does Respondent perform an internal analysis of client-specific data to develop recommendations for program improvement? Yes No
- L.9. Describe the background and training for the personnel involved in this process. Include the experience of the personnel involved in recommending program improvements.
- L.10. Will Respondent provide a self-service portal to ERS? Yes No
- L.10.a. If Respondent marked "No" to Interrogatory L.10. above, Respondent shall provide a detailed description as to why not. [REDACTED]
- L.10.b. Respondent shall describe any type of portal or electronic method that ERS may use to view these reports including the timing and available delivery of reporting suite. [REDACTED]
- L.11. At what frequency are the reports provided by Respondent? [REDACTED]
- L.12. Provide a listing of all claims experience reports currently available, including production schedules, and the frequency Respondent will provide these reports.
- L.13. What is the source of the data and what specific benchmark information will Respondent provide?
- L.14. What administrative process is in place to address rejections or errors identified after loading the routine eligibility update information sent from the employer?
- L.15. Respondent shall list all the names of the personnel who has the ability to alter eligibility information in Respondent's organization.
- L.16. Does Respondent's system allow for and accept future Participant termination dates?
 Yes No

- L.16.a. If Respondent's system does not allow for and accept future Participant termination dates, Respondent shall provide a detailed description as to why not.
- L.17. Respondent shall describe its experience in and ability to provide claims-level data to a third-party. This information is being requested due to the requirement of Respondent to interact with ERS' consulting actuary.
- L.18. Are Respondent's reports available electronically? ERS expects the standard reports package to be provided at no additional cost.
- L.19. In addition to providing Respondent's current client reports list, please describe the methods used to access all reports electronically.

M. Interrogatories – Quality Assurance - PPO

- M.1. What is the name of the designated senior executive responsible for the QA program?
- M.2. What is the extent of the Dental Director's involvement in the QA program?
- M.3. What is the extent of participating dental care providers' involvement in the QA program?
- M.4. Respondent shall provide its discussion on the Quality of Care and Quality of Service issues as related to the QA program.
- M.5. Provide a copy of Respondent's current published policies and procedures for the QA program.
- M.6. What process does Respondent use for monitoring the QA program?
- M.6.a. Provide an explanation of the processes used for monitoring the QA program. Respondent's response should include:
 - M.6.i. Adequacies of patient care.
 - M.6.ii. Average annual PCD turnover rates.
 - M.6.iii. Member PCD transfer rates.
 - M.6.iv. Dental care provider satisfaction.
 - M.6.v. Adequacy of claims service.
 - M.6.vi. Member satisfaction surveys.
 - M.6.vii. How often surveys are conducted?
 - M.6.viii. The most recent results of the survey.
 - M.6.ix. Are dental care providers notified of the results? Yes No
 - M.6.x. Dental care provider compliance with expected utilization norms.
 - M.6.xi. Disciplinary and sanctioning information.
- M.7. Has Respondent network been reviewed by external agencies or industry organizations? Yes No
If yes, which ones?
- M.8. What were the overall results of the reviews?

- M.9. Provide a detailed explanation of the manner in which Respondent compensates dentists. Include explanations of the following:
- M.9.a. **Capitation.** How does Respondent capitate PCDs? Provide the minimum capitation requirements, if applicable.
- M.9.b. **Supplemental payments to PCDs.** How and when are supplemental payments made and what is the methodology Respondent utilizes to determine the amount of supplemental payment, if applicable?
- M.9.c. Payments to specialty dentists.
- M.9.d. Miscellaneous payments such as consulting fees and payments for emergency or out-of-area treatment.
- M.9.e. Considering all payments made to dentists by Respondent, as well as copayments from Participants, what percentage of the usual and customary charges do network dentists typically receive, if applicable? Respond separately for:
- PCDs:
 - Specialists:
- M.9.f. Allowable expense to an out-of-network provider, if applicable?
- M.10. Provide a listing of the names and total amounts paid for the ten Texas dentists receiving the largest capitation payments during 2017, if applicable.
- M.11. Provide a listing of the names and total amounts paid for the ten Texas dentists receiving the largest total payments during 2017.
- M.12. Describe the capitation payment scheme which Respondent uses if different from that described in TDI's rules, if applicable.
- M.13. Adjusting for plan changes, what is the underlying dental cost trend over the last four (4) years Respondent used in its fully insured pricing?
- M.14. After reviewing the RFP, are there any provisions Respondent would recommend ERS install to help limit risk selection on this fully voluntary dental plan? (i.e., plan design changes, eligibility rules, etc.)

DHMO RESPONSES

N. Deviations - Account Management Requirements - DHMO

- N.1. Affirm that Respondent shall comply with all of the **Scope of Work – Operational Specifications and Requirements – Account Management Requirements** described in RFP Sections XII.A.1 – XII.A.4.a.

Affirm Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each deviation between Respondent's response and these requirements:

Respondent's Requested Deviation Detail:

O. Interrogatories - Account Management Requirements - DHMO

- O.1. Briefly outline Respondent's Account Management Team philosophy.
- O.1.a. Provide a description of the proposed Account Management Team's structure (including any subcontractors), its philosophy and internal controls to be used during the course of the project.

O.1.b. If Respondent contracts with a management company for some or all of its administrative services, please specify:

Name of Company:	
Physical address:	
Mailing address:	
Email address:	
Telephone number:	
Facsimile number:	
Describe the services that are provided:	
Reimbursement Method:	

O.1.c. How many other clients are now, and will be in the future, assigned to the proposed Account Management Team?

Number of Clients Currently Assigned to Respondent's Account Management Team	Number of Clients that will be assigned to Respondent's Account Management Team in the Future

O.1.d. For purposes of providing the services that are part of the RFP and Contract, will Respondent provide a designated staff or a dedicated staff? Please indicate by title, staff that will be designated and staff that will be dedicated.

O.1.e. Please indicate by title, staff that will be designated and staff that will be dedicated. Within description, indicate any licenses and/or certifications that designated and dedicated staff are required to maintain will be kept current during any period of time that Respondent has a contract in place with ERS.

O.1.f. If providing a designated staff, how many other clients are, and/or will be in the future, assigned to Respondent's proposed account team that is assigned to service ERS?

O.1.g. If Respondent indicated that it will provide a dedicated staff to service ERS, confirm that Respondent will provide a dedicated staff arrangement for the entire Contract Term.
 Confirm

O.1.g.i. If Respondent cannot confirm Interrogatory O.1.g. above, Respondent shall provide a detailed description as to why not.

O.1.h. Respondent shall provide a detailed description of the manner in which Respondent proposes to administer the Dental Benefits plan to the Participants. Include responses to the following:

Account Manager/Account Representative(s);	
Claims processing;	
Customer service;	
Website management;	
Correspondence unit; and	
Publications distribution.	

O.1.i. Describe any business and/or administrative functions that are performed outside of the United States of America. Where are these functions performed?

O.1.j. Where will the account representative be located? Will this individual have responsibility for other clients? If yes, how many?

P. Deviations - Administrative Requirements - DHMO

P.1. Affirm that Respondent shall comply with all of the **Scope of Work – Operational Specifications and Requirements – Administrative Requirements** described in RFP Sections XII.C.1. – XII.C.6.c.

- Affirm Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each Deviation between Respondent’s response and these requirements:

Respondent’s Requested Deviation Detail:

Q. Interrogatories - Administrative Requirements - DHMO

Q.1. Describe the staff (including numbers of full-time equivalent employees) that Respondent and any subcontractor shall utilize to perform, deliver and provide the services, coverages, benefits, equipment, supplies and products requested herein. Respondent shall also provide the specific services to be performed by the subcontractors.

Respondent’s staff description:
Subcontractor staff description and specific services to be performed:

Q.1.a. How many of these employees are located in Texas? Describe the functions these employees perform.

Number of Respondent staff in Texas:
Description of Respondent’s staff functions:
If applicable, number of Subcontractor staff in Texas:
If applicable, description of Subcontractor staff functions:

Insurance Coverage

Q.1.b. Describe the various types of insurance coverage provided to protect ERS, the GBP, its Participants and the State. This should include, but not be limited to:

Risks covered:
Name of insurance carrier:
Levels and limits:
Deductibles:

Q.1.b.i. Respondent agrees to send ERS an updated declarations page from each such policy upon policy renewal for each year of the Contract. Yes No

Fraud and Abuse

Q.1.c. Explain the procedures and systems Respondent uses to prevent, deter, detect and investigate fraud and related issues, and how such processes shall be used in connection with the GBP.

Q.1.d. Discuss how Respondent would communicate with the Participant, physician(s), and ERS once a fraud or abuse problem is suspected or identified.

Q.1.e. Discuss what measures Respondent employs to prevent and detect employee fraud (i.e., background checks, confidentiality agreements, and security monitoring equipment).

Q.1.f. Provide a copy of Respondent’s fraud plan.

Q.1.g. Respondent agrees to comply with any additional policies that ERS develops in connection with the detection and prevention of fraud or abuse. Yes No

- Q.1.h. For the past two (2) year period, what percent of claims submitted to Respondent were denied because of misrepresentation and/or fraud?
- Q.1.i. Does Respondent utilize Independent Medical Evaluations (“IME”) and Functional Capacity Evaluations (“FCE”) for dental cases? Yes No
- a. Who performs the IMEs?
 b. Who performs the FCEs?
 c. Describe the general process (es) that would prompt their use.
- Q.1.j. Describe Respondent’s most effective means to detect fraud, abuse and other improprieties.

Executive Summary

- Q.1.k. Provide an executive summary no longer than two (2) pages outlining significant features of Respondent’s Proposal. The summary should highlight Respondent’s philosophy, its experience with similar programs and the administrative approach presented in the Proposal.

Administrative or Policy Decisions

- Q.2. Are there any special manuals or folders maintained for administrative or policy decisions related to the DHMO Plan for Respondent’s book of business? If yes, Respondent shall describe these manuals or folders.
- Q.3. Describe in detail the facilities, procedures, and locations that Respondent intends to utilize in servicing those functions required under the Plans other than the processing of claims. This response should include a description of the following:
- Q.3.a. The actuarial personnel that will be available to confer with ERS’ consulting actuary concerning rating and other financial issues.
- Q.3.b. Legal and other expertise available to assist ERS in the execution of its duties under the Contract.
- Q.3.c. Legal counsel in Austin, Texas that will handle litigation related to GBP claims.

Utilization Review

- Q.4. Provide a detailed description of all aspects of the utilization review process that will apply to Participants. Respondent’s response should include at least the following:
- Q.4.a. Whether the utilization review is performed by Respondent’s staff or through a contract with a third party? Respondent Staff Third Party
- Q.4.b. If through a third party, identify the following:
- Third Party Name:
- Address:
- Contact Name:
- Contact Telephone Number:
- Q.4.c. What are the addresses and hours of operation for the facility or facilities from which utilization review activities shall be conducted?
- Facility Address:
- Hours of Operation:
- Q.4.d. Are licensed dental personnel on duty at all facilities during all hours of operation?
 Yes No

- Q.4.e. How many licensed dental professionals administer the utilization review program?
- Q.4.f. What are the titles of the licensed dental professionals who administer the utilization review program?
- Q.4.g. What credentials and/or qualifications are required for Respondent's utilization personnel?
- Q.4.h. What percentage of utilization review, referral, and pre-determination requests are referred to the dental director?
- | | |
|----------------------------|---|
| Utilization review | % |
| Pre-determination requests | % |
| Referrals | % |
- Q.4.i. Respondent shall provide an explanation of how it tracks the percentage of claims that are referred to the dental director for review.
- Q.4.j. What is the process available to dental providers for the appeal of denied claims?
- Q.4.k. What are the utilization review procedures performed by network dental care providers?
- Q.5. In what manner does Respondent conduct the following activities and how are the results of such activities used in the dental management process? Include the following information:
- Q.5.a. Development of profiles of PCD practice and referral patterns.
- Q.5.b. Monitoring of frequently used services.
- Q.5.c. Review of dentist's coding patterns.
- Q.5.d. Examinations of average cost per encounter by PCDs.
- Q.5.d.i. Respondent shall provide an explanation of the average examination cost per encounter by PCDs and how it is utilized in the dental management process.
- Q.6. What is the methodology that Respondent uses in establishing dental protocols for the Vendor network?
- Q.6.a. Which protocols are used in the management of participant dental care?
- Q.6.b. How are the protocols used?
- Q.6.c. In what manner does a dental care provider obtain approval to deviate from the protocols when treating a patient with complications?
- Q.6.d. How does Respondent communicate the results of such activities to dental care providers?
- Q.6.e. How are the results used to modify practice patterns?
- Q.7. What is the organizational relationship that exists between corporate, regional and local dental management?
- Q.7.a. What are the distinct responsibilities that pertain to each level?
- | | |
|-----------|----------------------|
| Corporate | <input type="text"/> |
| Regional | <input type="text"/> |
| Local | <input type="text"/> |

Q.7.b. What are the functions handled at each level? Include any arrangements involving dental protocol committees, utilization review groups, etc.

Corporate
Regional
Local

Q.8. What is the size and expertise of the dental management staff assigned to each network location, if applicable?

Q.8.a. Which of these personnel is staff versus contract?

Q.8.b. Which of these personnel are full-time versus part-time?

Q.8.c. What are the general responsibilities of each staff member?

Staff:
Contract:
Full-time:
Part-time

Q.8.d. Where is this staff located?

Staff:
Contract:
Full-time:
Part-time

R. Deviations – Customer Service Requirements - DHMO

R.1. Affirm that Respondent shall comply with all of the **Scope of Work – Operational Specifications and Requirements – Customer Service Requirements** described in RFP Sections XII.D.1. – XII.D.12.

Affirm Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each Deviation between Respondent’s response and these requirements:

Respondent’s Requested Deviation Detail:

S. Interrogatories – Customer Service Requirements - DHMO

S.1. Describe the features of Respondent’s Customer Service Unit by reflecting the following:

S.1.a. Describe Respondent’s call center telecommunications system in detail.

S.1.b. Describe the manner in which the customer service unit may be accessed (e.g., web chat, phone, email).

S.1.c. Describe the Customer Service unit’s hours of operation.

S.1.d. Describe how after hours calls are handled.

S.1.e. Can Respondent provide a separate toll-free telephone number for the Participants? If no, please explain. If yes, explain how the caller is routed to the appropriate CSR.

S.1.f. Describe any dedicated staff units to be assigned to ERS or that Respondent plans to assign to this account.

S.2. Briefly describe the frequency of Respondent’s employee training, including the time period of training, rendered prior to providing customer services.

- S.3. Describe Respondent's internal dispute or appeal process that is available to Participants. Provide a detailed description including any independent review process.
- S.4. Describe Respondent's customer satisfaction survey process. [REDACTED]
- S.4.a. How often does Respondent conduct these surveys? Respondent shall provide a copy of the results of Respondent's most recent survey.
- S.5. With regard to automated customer service support using voice response for routine questions, please provide the following:
- S.5.a. Does Respondent currently provide any automated customer service support using voice response for routine questions? If yes, please give details of this service. This should include, but not be limited to how Participants can interact with the automated interactive system (e.g., via telephone, online or both.) [REDACTED]
- S.5.b. If Respondent does not currently provide any automated customer service support using voice response for routine questions, please specify a date in the future, if any, that Respondent will be providing these services. If Respondent will not be providing this type of service in the future, please answer this question "N/A." [REDACTED]
- S.6. Does Respondent record all phone calls and notify all parties that their conversations are being electronically recorded and stored? Yes No
- S.6.a. How long does Respondent store electronically recorded phone calls? [REDACTED]
- S.7. How does Respondent ensure that its customer service representatives are providing timely and accurate information? [REDACTED]
- S.8. Does Respondent's customer service inquiry system allow representatives to record comments so that another customer service representative can review previous notes in order to assist Participants? Yes No
- S.8.a. If Respondent marked "No" for Interrogatory S.8. above, Respondent shall provide a detailed description as to how it can meet this objective. [REDACTED]
- S.9. Does Respondent have the ability to monitor live customer service calls? Yes No
- S.9.a. If Respondent marked "No" for Interrogatory S.9. above, Respondent shall provide a detailed description as to how it can meet this objective. [REDACTED]
- S.10. With regard to customer service inquiries, Respondent shall describe how patterns of customer service inquiries are monitored and tracked. [REDACTED]
- S.11. Respondent shall identify and describe the various reporting capabilities of its call center system. [REDACTED]
- S.12. Describe Respondent's calculation methodology applicable to the proposed call center metrics requirements referenced in **Appendix Y**. [REDACTED]
- S.13. Respondent shall refer to RFP Section XII.D.5. and provide its sample source documents. [REDACTED]
- S.14. Does Respondent expect to make major changes to its customer service organization or facilities within the next two (2) years (i.e., moving to a different location, reorganizing or merging units)? Yes No
- If yes, Respondent shall describe and provide an explanation. [REDACTED]
- S.15. With regard to written inquiries received by Respondent, provide the following:
- S.15.a. Describe Respondent's procedure for managing written inquiries. [REDACTED]

- S.15.b. What is Respondent's current standard response time with respect to questions requiring written communication? [REDACTED]
- S.16. Describe Respondent's procedure for handling customer service complaints, grievances and inquiries by providing the following:
 - S.16.a. How does Respondent monitor first call resolution? [REDACTED]
 - S.16.b. How does Respondent monitor Participant inquiries that do not get resolved during the initial call? [REDACTED]
 - S.16.c. What customer complaint tracking system does Respondent use? [REDACTED]
 - S.16.d. How long has Respondent's customer complaint tracking system been operational? [REDACTED]
 - S.16.e. Does Respondent have plans within the next 36-months to implement a new complaint tracking system? If yes, please provide the date when Respondent plans to have this new system operational. [REDACTED]
 - S.16.f. Describe Respondent's problem resolution policies and procedures. Respondent's description should include, but not be limited to, Respondent's procedures for escalation of complaints. [REDACTED]
 - S.16.g. Describe any procedures for handling customer service complaints, grievances and inquiries that were not requested above, if any. [REDACTED]
- S.17. Describe the types of access (i.e., automated, interactive, etc.) Respondent provides to Participants in order that Participants can obtain the necessary information regarding dental services, coverages, benefits, equipment, supplies, products and providers.
- S.18. If Participants can upload documentation in support of Respondent transactions through Respondent's website, describe what file types are permitted for uploading. If Participants are not able to do this, please answer this question "N/A."
- S.19. How does Respondent's customer service system support Participants with disabilities? [REDACTED]
- S.20. Describe how the Participant is assisted if they speak languages other than English.
- S.21. Describe Respondent's ability to make immediate/emergency enrollment updates upon phone or email request from ERS.
- S.22. Describe the hours that Respondent's staff is available to handle immediate/emergency updates.
- S.23. Respondent shall provide a detailed description of the level of customization it will allow to ERS with regard to modifying, rewriting, editing, and updating the language contained within Respondent's CSR response scripts and IVR scripts.

T. Deviations – Subcontractors Requirements – DHMO

T.1. Affirm that Respondent shall comply with all of the **Scope of Work – Operational Specifications and Requirements – Subcontractors Requirements** described in RFP Sections XII.F.1. – XII.F.9.

- Affirm Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each Deviation between Respondent's response and these requirements:

Respondent's Requested Deviation Detail: [REDACTED]

U. Interrogatories – Subcontractors Requirements – DHMO

U.1. Does Respondent propose to use subcontractors in the performance, delivery and provision of services and products requested hereunder? Yes No

U.1.a. If applicable, provide the information below for each subcontractor and specify what services may be performed by each subcontractor. Any planned or proposed use of subcontractors by Respondent shall be clearly disclosed and documented in Respondent’s Proposal, including specification of the services that may be performed by each subcontractor. Further, Respondent shall provide complete information, prior to and, if requested by ERS, after execution of the Contract, regarding each subcontractor used by Respondent to meet the requirements of the Contract. List each in the following format:

Name:	
Physical address	
Mailing address:	
Email address:	
Telephone number:	
Services performed:	
Length of time contracted with subcontractor:	

V. Deviations – Respondent Program Reporting Requirements - DHMO

V.1. Affirm that Respondent shall comply with all of the **Scope of Work – Operational Specifications and Requirements – Respondent Program Reporting Requirements** described in RFP Sections XII.H.1. – XII.H.11.

- Affirm Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each Deviation between Respondent’s response and these requirements:

Respondent’s Requested Deviation Detail:

W. Interrogatories – Respondent Program Reporting Requirements - DHMO

W.1. Based on the information provided at RFP Section XII.H, Respondent shall describe the reports to be provided by Respondent on a regular basis at no charge to ERS by including the following information:

- Title of Report;
- Detailed description of the information provided in the report; and
- Frequency provided (monthly, quarterly, annually).

W.2. Describe how the reports can be utilized to identify problems and monitor performance.

W.3. Provide copies of Respondent’s sample standard reporting package.

W.4. Describe how the reports listed above can be used to identify problems and monitor performance.

- Title of Report provided in Interrogatory W.1. above; and
- How it is used to identify problems and monitor performance.

W.5. Respondent shall describe its regularly requested *ad hoc* reports and other customized reports and their associated TAT.

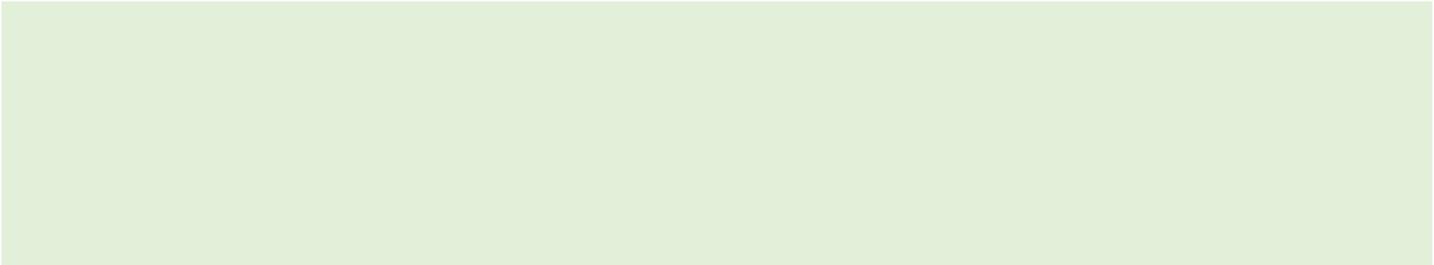
- W.6. Separate from the required claims data file, how will Respondent provide ERS with the capability to conduct independent online queries, interface with Respondent's database in order to generate *ad hoc* reports and extract specific information?
- W.7. Respondent shall describe any unique reporting capabilities that differentiate Respondent from its competitors.
- W.8. Does Respondent perform an internal analysis of client-specific data to develop recommendations for program improvement? Yes No
- W.9. Describe the background and training for the personnel involved in this process. Include the experience of the personnel involved in recommending program improvements.
- W.10. Will Respondent provide a self-service portal to ERS? Yes No
- W.10.a. If Respondent marked "No" to Interrogatory W.10. above, Respondent shall provide a detailed description as to why not. [REDACTED]
- W.10.b. Respondent shall describe any type of portal or electronic method that ERS may use to view these reports including the timing and available delivery of reporting suite. [REDACTED]
- W.11. At what frequency are the reports provided by Respondent? [REDACTED]
- W.12. Provide a listing of all claims experience reports currently available, including production schedules, and the frequency Respondent will provide these reports.
- W.13. What is the source of the data and what specific benchmark information will Respondent provide?
- W.14. What administrative process is in place to address rejections or errors identified after loading the routine eligibility update information sent from the employer?
- W.15. Respondent shall list all the names of the personnel who has the ability to alter eligibility information in Respondent's organization.
- W.16. Does Respondent's system allow for and accept future Participant termination dates?
 Yes No
- W.16.a. If Respondent's system does not allow for and accept future Participant termination dates, Respondent shall provide a detailed description as to why not.
- W.17. Respondent shall describe its experience in and ability to provide claims-level data to a third-party. This information is being requested due to the requirement of Respondent to interact with ERS' consulting actuary.
- W.18. Are Respondent's reports available electronically? ERS expects the standard reports package to be provided at no additional cost.
- W.19. In addition to providing Respondent's current client reports list, please describe the methods used to access all reports electronically.

X. Interrogatories – Quality Assurance Requirements - DHMO

- X.1. What is the name of the designated senior executive responsible for the QA program?
- X.2. What is the extent of the Dental Director's involvement in the QA program?
- X.3. What is the extent of participating dental care providers' involvement in the QA program?
- X.4. Respondent shall provide its discussion on the Quality of Care and Quality of Service issues as related to the QA program.

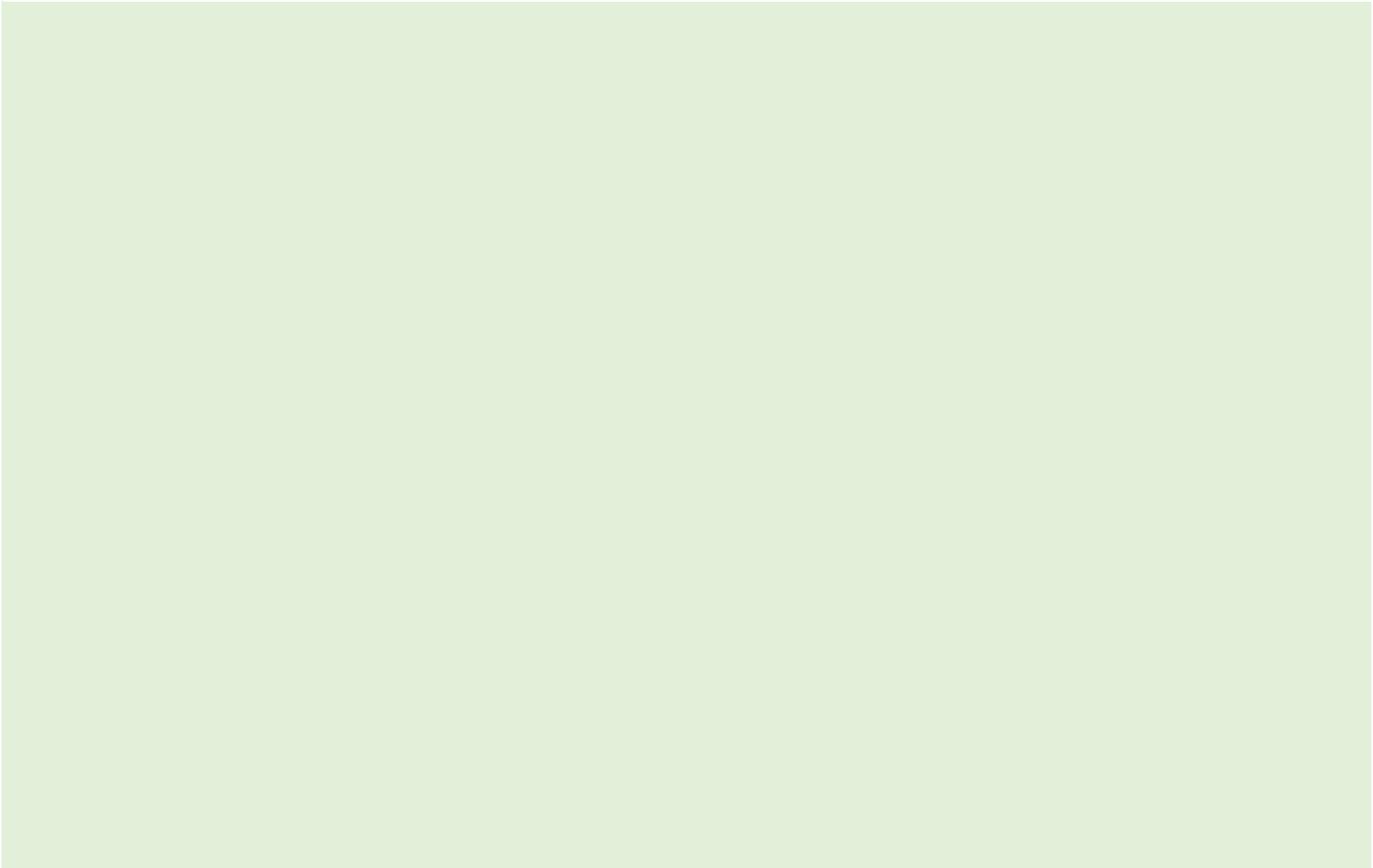
- X.5. Provide a copy of Respondent's current published policies and procedures for the QA program.
- X.6. What process does Respondent use for monitoring the QA program?
- X.6.a. Provide an explanation of the processes used for monitoring the QA program. Respondent's response should include:
- X.6.i. Adequacies of patient care.
- X.6.ii. Average annual PCD turnover rates.
- X.6.iii. Member PCD transfer rates.
- X.6.iv. Dental care provider satisfaction.
- X.6.v. Adequacy of claims service.
- X.6.vi. Member satisfaction surveys.
- X.6.vii. How often surveys are conducted?
- X.6.viii. The most recent results of the survey.
- X.6.ix. Are dental care providers notified of the results? Yes No
- X.6.x. Dental care provider compliance with expected utilization norms.
- X.6.xi. Disciplinary and sanctioning information.
- X.7. Has Respondent network been reviewed by external agencies or industry organizations?
 Yes No
- If yes, which ones?
- X.8. What were the overall results of the reviews?
- X.9. Provide a detailed explanation of the manner in which Respondent compensates dentists. Include explanations of the following:
- X.9.a. **Capitation.** How does Respondent capitate PCDs? Provide the minimum capitation requirements, if applicable.
- X.9.b. **Supplemental payments to PCDs.** How and when are supplemental payments made and what is the methodology Respondent utilizes to determine the amount of supplemental payment, if applicable?
- X.9.c. Payments to specialty dentists.
- X.9.d. Miscellaneous payments such as consulting fees and payments for emergency or out-of-area treatment.
- X.9.e. Considering all payments made to dentists by Respondent, as well as copayments from Participants, what percentage of the usual and customary charges do network dentists typically receive, if applicable? Respond separately for:
- PCDs:
 - Specialists:
- X.9.f. Allowable expense to an out-of-network provider, if applicable?
- X.10. Provide a listing of the names and total amounts paid for the ten Texas dentists receiving the largest capitation payments during 2017, if applicable.

- X.11. Provide a listing of the names and total amounts paid for the ten Texas dentists receiving the largest total payments during 2017.
- X.12. Describe the capitation payment scheme which Respondent uses if different from that described in TDI's rules, if applicable.
- X.13. Adjusting for plan changes, what is the underlying dental cost trend over the last four (4) years Respondent used in its fully insured pricing?
- X.14. After reviewing the RFP, are there any provisions Respondent would recommend ERS install to help limit risk selection on this fully voluntary dental plan (i.e., plan design changes, eligibility rules, etc.)?



APPENDIX X

ACCOUNTING AND FUNDING REQUIREMENTS DEVIATIONS AND INTERROGATORIES



Accounting and Funding Requirements Deviations and Interrogatories

Respondent shall review the Deviation and Interrogatory instructions referenced at RFP Sections I.D.2. and I.D.3. Respondent shall complete the Interrogatories listed below by providing Respondent's answer following each question. **Respondent shall complete both PPO and DHMO sections if Respondent will be providing both plans. If Respondent is not providing services for both plans, then Respondent only needs to provide its Responses to either the PPO or DHMO sections.**

PPO RESPONSES

A. Deviations – Funding Methodology Requirements - PPO

A.1. Affirm that Respondent shall comply with all of the ***Scope of Work – Accounting and Funding Requirements – Funding Methodology Requirements*** described in RFP Section XIII.A.1

Affirm Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each Deviation between Respondent's response and these requirements:

Respondent's Requested Deviation Detail:

B. Deviations – Funding and Claims Reimbursement Methodology – PPO

B.1. Affirm that Respondent shall comply with all of the ***Scope of Work – Accounting and Funding Requirements – Funding and Claims Reimbursement Methodology – PPO Only*** described in RFP Sections XIII.B.1. – XIII.B.8.

Affirm Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each Deviation between Respondent's response and these requirements:

Respondent's Requested Deviation Detail:

C. Interrogatories – Funding and Claims Reimbursement Methodology – PPO

C.1. RFP Sections XIII.B.3. – XIII.B.3.b. describe ERS' current and preferred payment and claims reimbursement methodology. Respondent shall describe its proposed processes for the self-funded arrangement requirements.

D. Deviations – W-2 and W-9 Submissions - PPO

D.1. Affirm that Respondent shall comply with all of the ***Scope of Work – Accounting and Funding Requirements – W-2 and W-9 Submissions*** described in RFP Sections XIII.D.1. – XIII.D.2.

Affirm Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each Deviation between Respondent's response and these requirements:

Respondent's Requested Deviation Detail:

E. Interrogatories – W-2 and W-9 Submissions - PPO

- E.1. What will be the entity name on the W-2, Wage and Tax Statement and W-9 Request for Taxpayer identification Number and Certification forms?
- E.2. What will be the entity name on the DDA and the bank where ERS will submit the Administrative Fee?
- E.3. Confirm that Respondent agrees to cooperate with the State, as necessary, in order for the State to properly prepare Form W-2s. Confirm

F. Deviations – Financial Stability - PPO

- F.1. Affirm that Respondent shall comply with all of the **Scope of Work – Accounting and Funding Requirements - Financial Standing** described in RFP Sections XIII.E.1. – XIII.E.2.
 Affirm Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each Deviation between Respondent’s response and these requirements:

Respondent’s Requested Deviation Detail:

G. Interrogatories – Financial Stability - PPO

- G.1. Respondent shall provide a copy of its most recent audited or reviewed financial statements. The financial statements should include, but not be limited to, Balance Sheet, Income Statement, Statement of Retained Earnings or Statement of Stockholders’ Equity, Statement of Cash Flows, and Notes to the Financial Statements.
- G.1.a. If applicable, specify the name and address of any sponsoring or parent corporation or others who provide financial support to Respondent. Describe any understandings, legal relationships or financial agreements with respect to sponsorship or other financial support of Respondent with any other entity, i.e., guarantees, letters of credit, etc. What are maximum limits of additional financial support?
- G.1.a.i. Provide a copy of the sponsoring organization's most recent audited financial statement if any such entity provides financial support to Respondent. The financial statements should include, but not be limited to, Balance Sheet, Income Statement, Statement of Retained Earnings or Statement of Stockholders’ Equity, Statement of Cash Flows, and Notes to the Financial Statements.
- G.1.b. Identify Respondent’s independent auditor and, if applicable, the independent auditor for Respondent’s sponsoring organization.
- G.1.c. If Respondent’s company is a subsidiary or affiliate of another company, provide a full disclosure of all direct or indirect ownership.
- G.1.d. Can Respondent accompany the daily funding request with a detailed payroll register including taxes? Yes No
 If yes, provide a copy of the report.
- G.1.e. Describe how Respondent handles the following:

Stale dated checks;	
Tracking; and	
Reporting, etc.	

DHMO RESPONSES

H. Deviations – Funding Methodology Requirements - DHMO

H.1. Affirm that Respondent shall comply with all of the **Scope of Work – Accounting and Funding Requirements – Funding Methodology Requirements** described in RFP Section XIII.A.1.

- Affirm Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each Deviation between Respondent's response and these requirements:

Respondent's Requested Deviation Detail:

I. Deviations – Funding and Claims Reimbursement Methodology – DHMO

I.1. Affirm that Respondent shall comply with all of the **Scope of Work – Accounting and Funding Requirements – Funding and Claims Reimbursement Methodology – DHMO Only** described in RFP Sections XIII.C.1. – XIII.C.9.

- Affirm Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each Deviation between Respondent's response and these requirements:

Respondent's Requested Deviation Detail:

J. Deviations – W-2 and W-9 Submissions - DHMO

J.1. Affirm that Respondent shall comply with all of the **Scope of Work – Accounting and Funding Requirements – W-2 and W-9 Submissions** described in RFP Sections XIII.D.1. – XIII.D.2.

- Affirm Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each Deviation between Respondent's response and these requirements:

Respondent's Requested Deviation Detail:

K. Interrogatories – W-2 and W-9 Submissions - DHMO

K.1. What will be the entity name on the W-2, Wage and Tax Statement and W-9 Request for Taxpayer identification Number and Certification forms?

K.2. What will be the entity name on the DDA and the bank where ERS will submit the Administrative Fee?

K.3. Confirm that Respondent agrees to cooperate with the State, as necessary, in order for the State to properly prepare Form W-2s. Confirm

L. Deviations – Financial Stability - DHMO

L.1. Affirm that Respondent shall comply with all of the **Scope of Work – Accounting and Funding Requirements - Financial Standing** described in RFP Sections XIII.E.1. – XIII.E.2.

- Affirm Affirm with the proposed Deviation

If applicable, enumerate and provide a detailed description of each Deviation between Respondent's response and these requirements:

Respondent's Requested Deviation Detail:

M. Interrogatories – Financial Stability - DHMO

M.1. Respondent shall provide a copy of its most recent audited or reviewed financial statements. The financial statements should include, but not be limited to, Balance Sheet, Income Statement, Statement of Retained Earnings or Statement of Stockholders' Equity, Statement of Cash Flows, and Notes to the Financial Statements.

M.1.a. If applicable, specify the name and address of any sponsoring or parent corporation or others who provide financial support to Respondent. Describe any understandings, legal relationships or financial agreements with respect to sponsorship or other financial support of Respondent with any other entity, i.e., guarantees, letters of credit, etc. What are maximum limits of additional financial support?

M.1.a.i. Provide a copy of the sponsoring organization's most recent audited financial statement if any such entity provides financial support to Respondent. The financial statements should include, but not be limited to, Balance Sheet, Income Statement, Statement of Retained Earnings or Statement of Stockholders' Equity, Statement of Cash Flows, and Notes to the Financial Statements.

M.1.b. Identify Respondent's independent auditor and, if applicable, the independent auditor for Respondent's sponsoring organization.

M.1.c. If Respondent's company is a subsidiary or affiliate of another company, provide a full disclosure of all direct or indirect ownership.

M.1.d. Can Respondent accompany the daily funding request with a detailed payroll register including taxes? Yes No

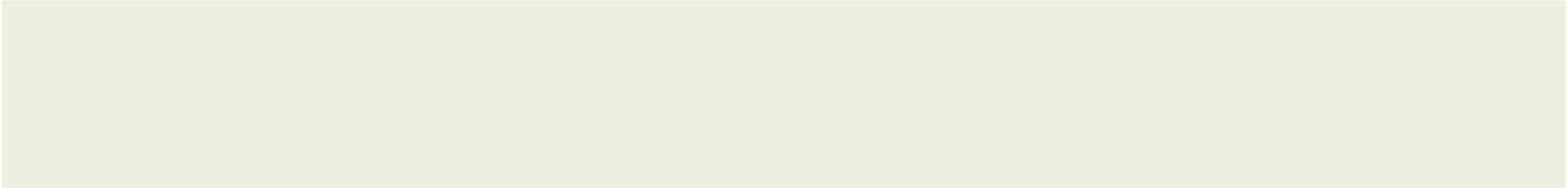
If yes, provide a copy of the report.

M.1.e. Describe Respondent's reserving methodology for determination of each of the following reserves for each Dental Plan:

Reserve for future payments on approved claims;	
Reserve for pending claims;	
Reserve for accrued but unpaid payments; and	
Reserve for incurred but unreported claims.	

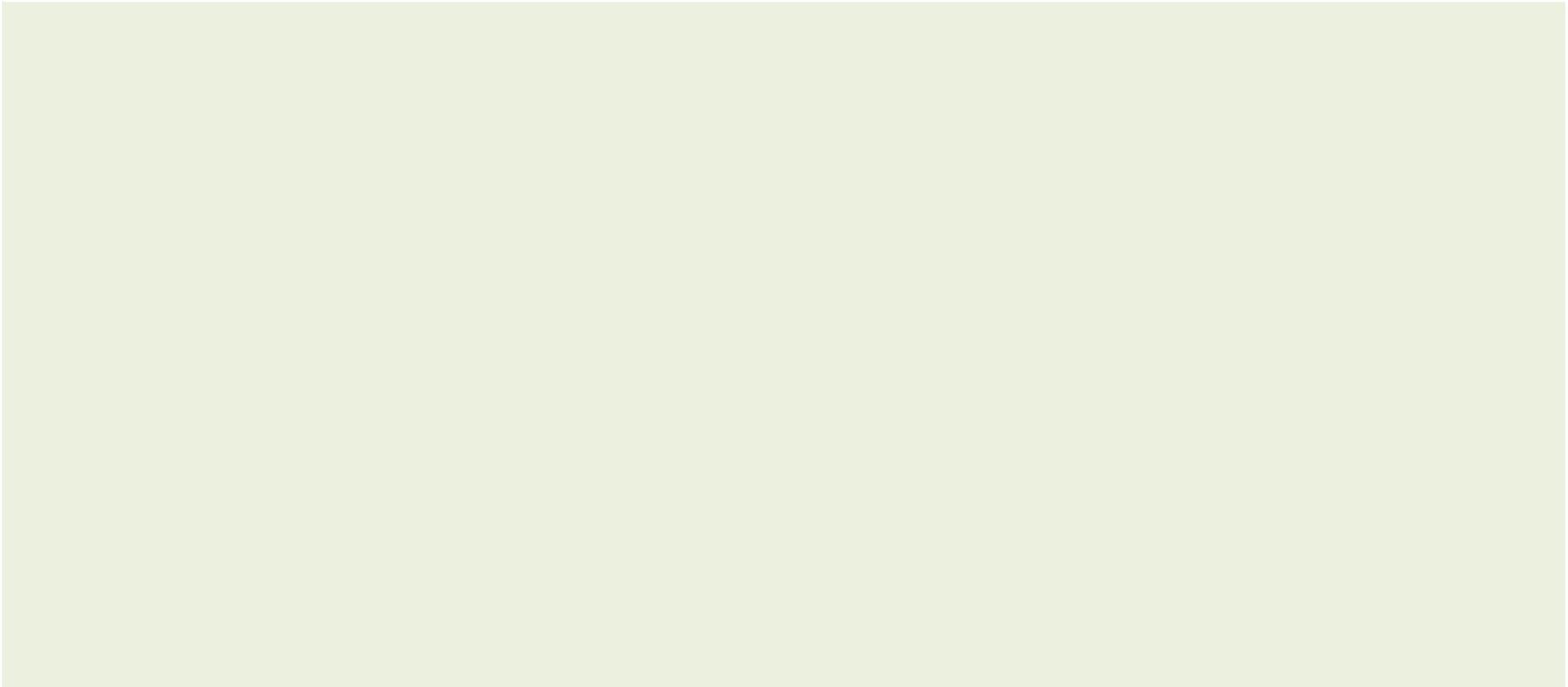
M.1.f. Describe how Respondent handles the following:

Stale dated checks;	
Tracking; and	
Reporting, etc.	



APPENDIX Y

CALL CENTER METRICS



CALL CENTER METRICS PROPOSED VENDOR REQUIREMENTS

Call Center Metric	Definition	Expressed As
Total Call Volume*	Total calls received	Total #
Blockage Rate*	Percent of Total Call Volume, which cannot be routed to the ACD system (caller receives busy signal or other indication of non-connection). May be due to insufficient number of trunks or the ACD system being programmed to block calls.	Percent
ACD Call Volume	Total calls received by the ACD for routing.	Total #
Self-Service Rate	Percent of ACD Call Volume where the caller opts to use only the IVR (i.e., caller doesn't opt to speak with agent). This is only relevant if there are significant self-service offerings.	Percent
Abandonment Rate*	Percent of ACD calls where caller opted to speak with an agent but hung up while waiting (in the queue) for agent to answer. Calculation should omit calls waiting for under the prescribed SL wait time.	Percent
Average Speed of Answer (ASA)*	Seconds of delay between the time a caller opts to speak with an agent and the call is answered by an agent. <u>Goal is TBD.</u>	Seconds
Service Level*	Percent of calls received by ACD that are answered by an agent within the prescribed goal. Calculation should omit short abandons, <u>Goal is TBD.</u>	Percent
Average Handle Time	Average minutes/seconds of talk and hold time and wrap up time (i.e., total time between agent answering call until agent concludes call).	# of seconds
Call Quality*	Monthly average score of all calls monitored based on ERS Quality Guidelines	Percent
Customer Satisfaction (CSAT)*	Surveys of Call Center Staff should reflect a CSAT score threshold to be determined. Population size, report format and survey tool to be determined/approved by ERS.	To Be Determined

ACD - Automatic Call Distributor

Programmable device at a call center that routes incoming calls to targets within that call center. Typical system offers enhanced features such as call queuing, multiple message ports and detailed traffic reports.

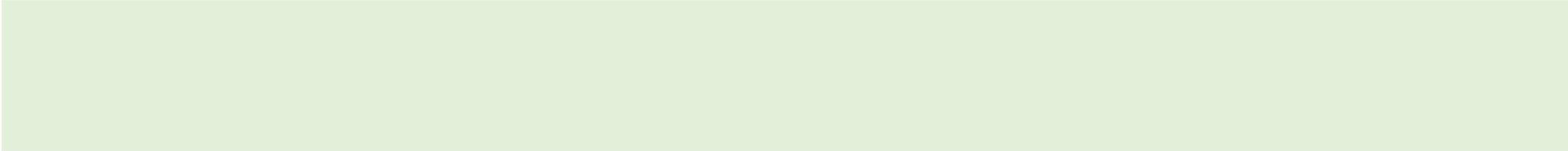
IVR - Interactive Voice Response

Automated call handling systems where the user interacts with a computer controlled voice signal. The interaction can be through the use of a touch-tone telephone or through speech recognition.

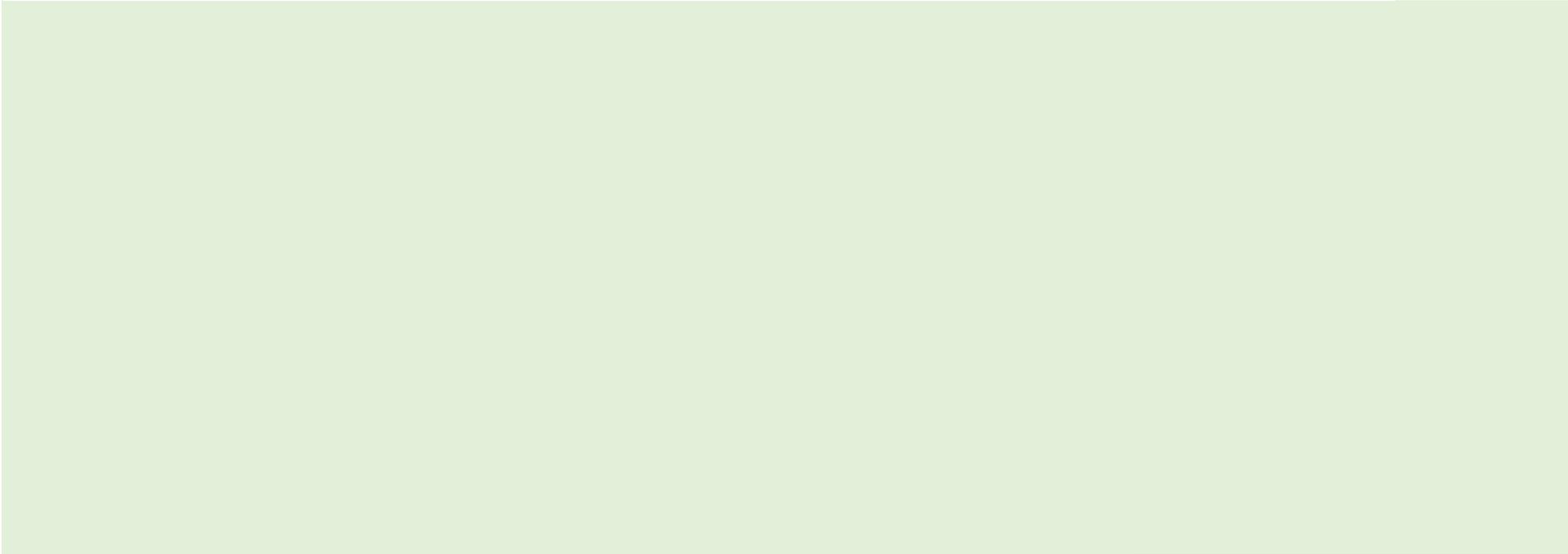
*Required Vendor Reporting

Linked to Performance Guarantees

Appendix Y. Call Center Metrics



APPENDIX Z
EXAMPLE DENTAL CLAIMS
RECONCILIATION FILE LAYOUT





Interface Name: DENTAL CLAIMS RECONCILIATION DATA FILE

File Summary Info

The purpose of this file is to provide a format in which to send ERS all of the reconciliation data relating to claims data to ERS. This file should be sent on the secured FTP site setup in ERS' network where the file is picked up and loaded into a staging table for processing.

File Name:	ERS_VendorName_ReconFile_MMDDCCYY_001.TXT.PGP	Examples for the Nodes of the filename: ERS - Static Value Vendor Name - Static value for name of vendor FileContent - Static value containing short description of file content MMDDCCYY - File Creation Date FileLayoutVersionNumber - Static value provided by ERS NOTE: Special characters are not allowed in the file name
Data Structure:	Fixed	ERS will only accept fixed width files for loading into the data warehouse.
Record Length(s):	800	Each record in the file must be the same length.
Frequency:	Monthly	
Approximated file arrival date and time:	15 th of each month	If possible provide an approximated arrival time of the file in military time.
Header Record:	Required	The Header record is the same for all vendors and file types
Detail Record:	Required	See the worksheet for each file type.
Trailer Record:	Required	The Trailer record is the same for all vendors and file type.
Column Headings:	No	
Supporting Documentation/Comments:		This file is broken down by the Header Record, Detail Record and Trailer Record.
Program/SSIS Package Name:		ERS programatic load routine identifying name.

	A	B	C	D	E	F	G	H	I	J	K
1	DENTAL CLAIMS RECONCILIATION DATA FILE										
2											
3	Reconciliation File Header Record										
4	Column #	Field Name	Field Description	Field Type	Maximum Field Length	Start Position	End Position	Valid Values	Format	ERS Comments	Vendor Comments
5	1	Record Type	Type of record (H=header)	Char	1	1	1	H			
6	2	File Period Begin Date	Beginning date of the file. Example, if the file is a monthly file then this date should reflect the beginning of the month.	Date	10	2	11		CCYY-MM-DD		
7	3	File Period End Date	Ending date of the file. Example, if the file is a monthly file then this date should reflect the end date of the month.	Date	10	12	21		CCYY-MM-DD		
8	4	File Creation Date	Date the file itself was created	Date	10	22	31		CCYY-MM-DD		
9	5	File Layout Version Number	Version of the file layout assigned by ERS	Char	3	32	34		001		
10	6	Filler	Filler	Char	766	35	800				
11											
12	Reconciliation File Detail Record										
13	Column #	ERS Field Name	Description	Field Type	Max Length	Start position	End Position	Valid Values	Format	ERS Comments	Vendor Comments
14	1	RecordType	Type of record (D=Detail)	Char	1	1	1	D			
15	2	BankCustID	Customer ID assigned by Banking	Number	10	2	11				
16	3	ContractNumber	Policy Number.	Number	10	12	21				
17	4	PlanID	Plan ID assigned by Banking	Char	10	22	31				
18	5	BankAcctNumber	Customer Benefit Bank Account	Char	15	32	46				
19	6	TransactionDate	Date Transaction Charged to Customer Benefit Account	Date	10	47	56		CCYY-MM-DD		
20	7	TransactionPaymentType	Transaction Type Designation (Paid by Check, EFT, etc...)	Char	10	57	66				
21	8	TransactionAmount	Amount of the Transaction	Decimal(16,2)	16	67	82				
22	9	ItemNumber	The check number of the check going out to the provider or member.	Number	10	83	92				
23	10	ClaimNumber	Claim Number	Number	15	93	107				
24	11	EmployeeFirstName	Employee First Name	Char	25	108	132				
25	12	EmployeeLastName	Employee Last Name	Char	15	133	147				
26	13	EmployeeMiddleInitial	Employee Middle Initial	Char	1	148	148				
27	14	DependentFirstName	Dependent First Name	Char	25	149	173				
28	15	DependentLastName	Dependent Last Name	Char	15	174	188				
29	16	DependentMiddleInitial	Dependent Middle Name	Char	1	189	189		CCYY-MM-DD		
30	17	EmployeeSSN	Employee Social Security Number	Number	9	190	198		CCYY-MM-DD		
31	18	CustNameSuffix	Suffix from Customer Structure	Char	10	199	208				
32	19	CustClaimAcctNumber	Claim Account Number from Customer Structure	Char	15	209	223				
33	20	DateOfService	Date Service was Performed	Date	10	224	233				
34	21	ClaimSystemTransactionDate	Date Transaction Received from Claim Accounting System	Date	10	234	243				
35	22	TransactionRecordedMonth	Month transactions are recorded	Number	2	244	245				
36	23	Filler	Filler	Char	555	246	800				
37											
38	Reconciliation File Footer Record										
39	Column #	Field Name	Field Description	Field Type	Maximum Field Length	Start Position	End Position	Valid Values	Format	ERS Comments	Optum Comments
40	1	Record Type	Type of record (F=footer)	Char	1	1	1	F			
41	2	File Detail Record Count	Number of detail records in the file	Number	8	2	9				
42	3	Total Signed Claim Amount	Summed transaction amount for all Recon records in the file	Decimal(16,2)	16	10	25				
43	4	Filler	Filler	Char	775	26	800				
44											

	A	B	C	D	E	F	G	H	I	J	K
1	DENTAL CLAIMS RECONCILIATION DATA FILE										
2											
3	Reconciliation File Header Record										
4	Column #	Field Name	Field Description	Field Type	Maximum Field Length	Start Position	End Position	Valid Values	Format	ERS Comments	Vendor Comments
5	1	Record Type	Type of record (H=header)	Char	1	1	1	H			
6	2	File Period Begin Date	Beginning date of the file. Example, if the file is a monthly file then this date should reflect the beginning of the month.	Date	10	2	11		CCYY-MM-DD		
7	3	File Period End Date	Ending date of the file. Example, if the file is a monthly file then this date should reflect the end date of the month.	Date	10	12	21		CCYY-MM-DD		
8	4	File Creation Date	Date the file itself was created	Date	10	22	31		CCYY-MM-DD		
9	5	File Layout Version Number	Version of the file layout assigned by ERS	Char	3	32	34		001		
10	6	Filler	Filler	Char	766	35	800				
11											
12	Reconciliation File Detail Record										
13	Column #	ERS Field Name	Description	Field Type	Max Length	Start position	End Position	Valid Values	Format	ERS Comments	Vendor Comments
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SECOND AMENDED REQUEST FOR PROPOSAL



200 E. 18TH STREET, AUSTIN, TEXAS 78701 | P. O. BOX 13207, AUSTIN, TEXAS 78711-3207 | (877) 275-4377 TOLL-FREE | WWW.ERS.STATE.TX.US

AMENDED JUNE 22, 2018

May 25, 2018

Qualified Dental Respondent

RE: Request for Proposal to Provide a Dental Preferred Provider Organization and/or Dental Health Maintenance Organization Plan(s) under the Texas Employees Group Benefits Plan

To Whom It May Concern:

The Employees Retirement System of Texas ("ERS") is issuing a Request for Proposal seeking a qualified entity ("Respondent") to provide one or both of the following dental programs and/or services: a) a self-funded Dental Preferred Provider Organization Plan ("PPO"), and b) a fully-insured dental health maintenance organization ("DHMO") throughout Texas.

The Contract will be for a period beginning upon execution of the Contract by ERS, and the provisions of the Dental Plans will begin upon execution of the Contract and extend for a period of six (6) years, subject to the terms of the Contract.

If you have any questions regarding the RFP and/or the solicitation process, please submit your inquiry directly to: ivendorquestions@ers.texas.gov.

Thank you for your interest in doing business with ERS.

Employees Retirement System of Texas

SECOND AMENDED REQUEST FOR PROPOSAL

RFP No. 327-94828-180525

Request for Proposal to Provide a Dental Preferred Provider Organization and/or Dental Health Maintenance Organization Plan(s) under the Texas Employees Group Benefits Program



May 25, 2018

[AMENDED JUNE 22, 2018]

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I. General Instructions

A. Background

A.1. The Employees Retirement System of Texas is a constitutional trust fund established as mandated by Article XVI, Section 67, Texas Constitution, and further organized pursuant to Subtitle B, Title 8, Tex. Gov't. Code, as well as 34 Tex. Admin. Code § 61.1, *et seq.* ERS invests and administers trust funds as a fiduciary for the exclusive benefit of the members and annuitants of the system. ERS administers all operations funded by trust assets for the same purpose. ERS is also trustee for the Employees Life, Accident, and Health Insurance Benefits Fund within the GBP. ERS administers health insurance benefits, life insurance and other optional benefits on behalf of Participants in the GBP. Participants are those persons eligible to participate in these programs per the Texas Employees Group Benefits Act as set forth in Chapter 1551 of the Tex. Ins. Code.

B. Request for Proposal Summary

B.1. ERS seeks responses from qualified Respondents willing and capable of providing the following dental plans and/or services in accordance with Tex. Ins. Code, Chapter 1551:

- (a) Self-funded Dental PPO Plan; and/or
- (b) Fully-insured DHMO.

B.1.a. The dental services requested in RFP Article I, Section B.1.(a) – (b) above will be provided during the Contract Term. The term of the Contract is for six (6) years, which begins upon execution of the Contract by ERS and is anticipated to extend through August 31, 2025, subject to the terms of the Contract. ERS anticipates the Contract to be awarded at and executed following ERS' March 2019 Board Meeting.

B.1.b. The dental services requested and described in the RFP have been segregated into two (2) separate service plans options as listed above. While a Respondent can provide Proposals for both service plans, ERS will evaluate Proposals received under each service plan separately. ERS reserves the right to select one Respondent to provide both service plans or a different Respondent for each service plan. Alternatively, ERS could select no Respondent for either or both service plans.

B.1.c. Respondent shall indicate the services and/or plan(s) it will be responding to in **Appendix AA**.

B.1.d. Respondent shall complete both PPO and DHMO sections if Respondent will be providing both plans. If Respondent is not providing services for both plans, than Respondent only needs to provide its Responses to either the PPO or DHMO services.

C. Schedule of RFP Process

C.1. The RFP process is organized to be conducted in accordance with the following schedule. ERS reserves the right to change any and all deadlines below at any time.

On or After May 25, 2018		Publication of RFP on ERS' Server, with notice posted to ESBD.
Upon publication of the RFP		ERS will accept questions from prospective Respondents regarding the RFP.
June 7, 2018	4:00 p.m. (CT)	Submission deadline for all email RFP questions.
June 20, 2018	5:00 p.m. (CT)	ERS will complete the posting of all relevant RFP Questions and Answers to ERS' Server.

July 19, 2018	10:00 a.m. (CT)	Proposal submission deadline.
On or around October 2018		Face to Face Interview, BAFO Submission, if applicable, and Site Visits, if applicable.
March 2019		Dental Provider Selection
Upon Contract Execution		Contract Term begins; Begin implementation of Dental Plans
September 1, 2019		Begin Dental Plans

D. Proposal Submission

- D.1. Respondent is encouraged to submit a Proposal, including all requested responsive materials, to provide the services specified within the RFP and in accordance with the attached Contract (**Appendix B**) and any attached exhibits. Respondent shall provide a comprehensive response outlining its capabilities and services requested within the RFP.
- D.2. **Deviation Instructions.** Deviations are allowed to the RFP Requirements sections only and must be provided at the corresponding Deviations sections within each Appendix. **For further clarity, some Articles contain Background sections, and Deviations to the Background sections are not permissible and will not be considered by ERS.** For information on Deviations to the Contractual Agreement, BAA, DSBNA, and/or Performance Guarantees, refer to RFP Sections VI.A.3 and VI.A.8.a. – VI.A.8.c. ERS is not obligated to accept or agree to any Deviations. If ERS chooses to accept proposed Deviation(s), ERS will convey that acceptance in writing to Respondent, and the approved Deviation(s) will become part of the final Contractual Agreement. Deviations will not warrant dismissal of Respondent's Proposal; however, Deviations will be considered by ERS when scoring Respondent's Proposal. Respondent assumes the responsibility of identifying all Deviations and, if not identified, all requirements of the RFP stipulated must be fulfilled at no additional expense to ERS.
- D.3. **Interrogatory Instructions.** Respondent shall provide truthful and accurate answers to all of the interrogatories presented in their corresponding Appendices. All interrogatories shall be answered in detail and sufficiently describe Respondent's position on each interrogatory. Respondent is responsible for responding to the interrogatories in a manner that allows ERS to have a complete understanding of its intent. **Interrogatory responses that are incomplete or vague may negatively impact Respondent's score. Respondent shall carefully define any key words or phrases included in its interrogatory responses that are not otherwise defined in the Contract or RFP. References to a prior response or separate document are not permissible, unless the corresponding interrogatory specifically provides such an option.** Respondent's Proposal shall use the terms defined in the Contract and the RFP only as they are defined herein.
- D.3.a. Respondent acknowledges, understands and agrees that its responses to the interrogatories and all other provisions of the RFP are material and will be relied on by ERS in connection with ERS' scoring and recommendation to the Board of a Respondent to provide the services specified in the RFP.

Note: If Respondent considers any of the information requested in the RFP to be confidential and/or proprietary, Respondent must list this information on a separate schedule as required at RFP Section I.F.1.b. However, Respondent must provide copies of all requested information and/or documents with its Proposal to allow for ERS' complete and comprehensive evaluation of Respondent and its Proposal.

- D.4. **Proposal Submission Deadline.** All Proposals must be received by ERS no later than the deadline specified in the schedule. ERS reserves the right to determine that any Proposal received after the specified date and time is nonresponsive.
- D.5. **Content.** Respondent's Proposal must sufficiently address all of the requirements of the RFP, and it must contain all supporting materials and documentation requested in the RFP. Failure to comply with any Proposal content requirements may result in the Proposal being deemed nonresponsive. Respondent shall refer to the Deliverables Checklist at the back of the RFP for more detail regarding the format in which ERS expects Respondent's Proposal to be submitted. Respondent is responsible for identifying and ensuring the submission of all RFP requested materials and documentation; Respondent shall use the Deliverables Checklist only as a guide and not as a comprehensive list of the materials and documentation requested herein.
- D.6. **Format.** All of Respondent's Proposal materials and documentation shall be packaged collectively in one (1) sealed container. Paper copies of Respondent's Proposal shall be submitted in separate, loose leaf three-ring binders with the name of Respondent's organization, RFP Number, and "**Dental RFP**" on the front and spine of the binder and shall be tab-indexed in accordance with the format prescribed in the Deliverables Checklist at the back of the RFP. If Respondent's Proposal does not fit in one binder, ERS will accept multiple binders, but they must be numbered as Volume I, Volume II, etc. on the front and spine of the binder. All of Respondent's Proposal paper copies shall be printed on only single-sided papers. Plastic spine-bound or wire bound submissions are highly discouraged. Respondent shall include only the information requested. Respondent's Proposal submission shall include:
- One (1) printed original labeled "**Dental RFP - Proposal Original**" and three (3) additional printed copies, each labeled "**Dental RFP - Proposal Duplicate**," and must be submitted with all requested supporting documentation. The formatting of the submission shall be in accordance with the RFP Deliverables Checklist at the back of the RFP.
 - Two (2) digital copies of Respondent's Proposal shall be submitted in Word format, unencrypted, not password protected, and on disc(s) or USB Thumb Drives labeled **Dental RFP – Proposal Duplicate**.
 - In addition to submitting the Proposal original, three (3) printed copies, and two (2) digital copies on discs or USB Thumb Drive as outlined above, Respondent shall submit the following in order to protect and prevent inadvertent access to its confidential and/or proprietary information:
 - One (1) disc or USB Thumb Drive that contains all information Respondent considers confidential and/or proprietary labeled "**Dental RFP – Confidential and/or Proprietary Information**" which must contain the information in Word format, unencrypted, and non-password protected. Furthermore, RFP Section I.F.1.b. provides additional instructions specific to labeling confidential and/or proprietary information contained within Respondent's Proposal.
 - A paper schedule listing all Proposal materials and/or documentation Respondent considers confidential and/or proprietary. Refer to RFP Section I.F.1.b., Public Information Act (Labeling of Confidential and/or Proprietary Information), for more information on this requirement;
 - One (1) disc or USB Thumb Drive that contains all information that Respondent considers public labeled "**Dental RFP – Public Information**" which must contain the information in Word format, unencrypted, and not password protected;
 - ERS is not responsible for receipt of any Proposal that is not labeled, packaged or delivered properly. All bid materials shall include complete, properly executed, and detailed supporting documentation as required.
 - Respondent shall mail or deliver its sealed Proposal to ERS at the following address so that it is received by ERS by the submission deadline noted above:

Office of Procurement and Contract Oversight
Employees Retirement System of Texas
Physical Address: 200 E. 18th Street, Austin, Texas 78701
Mailing Address: P.O. Box 13207, Austin, Texas 78711-3207

- The mailing label for the Proposal shall be clearly marked as: **Dental RFP**.
- Failure to provide the correct number of Proposals and in the format requested may result in Respondent being eliminated from further consideration. All Proposals shall be valid throughout the entire RFP process.

D.7. **Proposal Signature Requirements.** One of Respondent's Authorized Representatives (as reflected on the Incumbency Certificate) shall execute, in **blue ink**, the Signature Pages attached as **Appendix A**. The signatures of Respondent's Authorized Representative on the Proposal's signature pages and all other related documents submitted by Respondent reflect Respondent's agreement with: the truth and accuracy of all statements, warranties and representations contained in the Proposal and all other documents submitted by Respondent. The signatures further reflect Respondent's authorization for ERS to rely on same for all purposes in connection with the RFP/Proposal process. Respondent's executed Signature Pages shall be submitted with its Proposal.

E. General Information and Provisions

- E.1. **Doing Business with ERS.** General information regarding doing business with ERS can be found by accessing the following link to ERS' website: <http://www.ers.texas.gov/Vendors>.
- E.2. **Agent of Record.** ERS shall not designate an agent of record or any other such company employee or commissioned representative to act on behalf of either ERS or Respondent. Any requests for ERS to provide such designation shall be rejected.
- E.3. **Vendor Performance Tracking System.** In accordance with Section 2155.089, Tex. Gov't Code, ERS may use the Texas Comptroller's Vendor Performance Tracking System to report vendor performance after the Contract is completed or otherwise terminated.
- E.4. **Prohibited Communications.** Other than as allowed for in the RFP, all Respondents (including prospective Respondents) and their representatives shall not contact ERS employees or officials regarding any aspect of the RFP, including by telephone, email or in person, throughout the bidder selection process, from RFP publish date to Contract award date. All communications must be directed at ivendorquestions@ers.texas.gov. Failure of a Respondent or its representatives to follow this process may be grounds for disqualification.
- E.5. **RFP and RFP Addenda Postings.** Respondent is responsible for reviewing and responding to the RFP materials available on ERS' Server. ERS' Server provides interested Respondents with an electronic version of the RFP, its attachments, and responses to relevant vendor questions pertaining to the RFP. In addition, notice of the RFP was posted on ESBD. To access the RFP on ERS' Server, Respondent shall email a request to ivendorquestions@ers.texas.gov. In the request, Respondent must reference the "**Dental RFP**" in the subject line. Upon receipt of Respondent's request, a User ID and password will be provided that will permit Respondent to access the RFP. It is Respondent's responsibility to check ERS' Server.
- E.5.a. Should it be necessary, at ERS' discretion, to revise the RFP, or if ERS determines that any additional information is needed to clarify the provisions of the RFP, an Addendum will be posted on ERS' Server. In addition, ERS will publish notice of such posting on ESBD. Respondents should check ERS' Server and the ESBD frequently for updates. Respondents are required to acknowledge each Addendum on the appropriate signature page (**See Appendix A**).
- E.6. **RFP Questions.** Interested vendors are allowed to email RFP-related questions to ERS during the time period stated in the RFP schedule referenced in RFP Section I.C.1. Questions should be emailed to ivendorquestions@ers.texas.gov with the subject line: "**Dental RFP**." Emails without this notation in the subject line may not receive a response. Upon receipt of each vendor's email, ERS may send an acknowledgement to the requesting vendor that its question has been received. However, if an acknowledgment is not received, Respondent is solely responsible for verifying ERS' receipt of its questions by sending a follow-up email with the same subject line. ERS reserves the right to disregard questions received after the vendor questions submission deadline stated in the RFP schedule.
- E.6.a. Please note that this question and answer process is not designed to facilitate contract negotiations. Questions related to **Appendices B, C, D, and G** will neither be answered nor

posted. Contract negotiations are addressed during a separate process. See RFP Section VI.A.3. of the RFP regarding Contract deviations for additional information.

- E.7. **Confidentiality and Nondisclosure Agreement.** The Experience Data and File Layouts contained in **Appendix J and Appendix K** are confidential; therefore, Respondent must execute a Nondisclosure Agreement to obtain the information in these appendices. The Nondisclosure Agreement is located at **Appendix L**, and Respondent shall email its properly executed Nondisclosure Agreement to ERS at ivendorquestions@ers.texas.gov. Upon receipt by ERS of Respondent's executed Nondisclosure Agreement, ERS will arrange for Respondent to obtain, the Claims Data and File Layout information.
- E.8. **Retention of Proposals.** All Proposals submitted become the sole property of ERS and will be retained in accordance with ERS' records retention requirements.
- E.9. **Notification of Withdrawal of Proposal.** A Proposal may be withdrawn prior to the deadline specified for Proposal submission through formal written notice, signed by an Authorized Representative of Respondent, and accepted by ERS.
- E.10. **Reserved Rights.** ERS retains the right to approve the Proposal that is in the best interests of ERS, the GBP, its Participants, and the State. In its selection, ERS shall take into consideration the criteria specifically described in RFP Article II. Proposal Evaluation.
- E.10.a. ERS reserves the right to rebid this solicitation if ERS deems a rebid to be in the best interests of ERS, the GBP, its Participants, and the State. ERS is under no legal requirement to execute a Contract on the basis of the RFP.
- E.10.b. ERS reserves the right to waive any immaterial deviation or defect in a Proposal. ERS' waiver of an immaterial deviation or defect shall in no way modify the RFP documents or excuse Respondent from full compliance with the RFP requirements.
- E.11. **Costs Incurred for Proposal Preparation.** ERS will not pay any costs incurred by Respondent in the preparation of a Proposal.
- E.12. **Disclosure of Interested Parties.** The Contract is subject to Section 2252.908 of the Tex. Gov't Code. As such, Respondents that are selected as Finalists will be required to complete Form 1295 on the Texas Ethics Commission's electronic system located at https://www.ethics.state.tx.us/whatsnew/elf_info_form1295.htm. ERS will notify you if you need to complete Form 1295.
- E.13. **Board Rules.** The Board has sole rulemaking authority in connection with the GBP pursuant to Chapter 1551, Tex. Ins. Code. In the event of a conflict of laws or regulations, then ERS' interpretation of the applicability and controlling status of the law or rules shall control. The Board Rules are located at Title 34, Part 4, Tex. Admin. Code. The Board Rules, including any amendments, are a part of any Contract executed in accordance with the RFP for all purposes as if they were contained verbatim therein. Respondent agrees to comply will all such Board Rules, and all applicable laws and regulations, both state and federal.
- E.14. **Benefit Determination.** The calculation of the amount of benefits to which any Participant is entitled shall initially rest with Respondent. However, the final determination of the extent of the benefit to which any Participant is entitled shall be made solely and exclusively by the Board in accordance with Section 1551.357, Tex. Ins. Code, as amended, except as qualified or limited by applicable federal law.
- E.15. **The Employee Retirement Income Security Act of 1974.** As a State government plan, the GBP is not subject to ERISA; however, Respondent shall assume the same fiduciary responsibilities that apply to ERISA plan administrators for all claims processing and payments, adjudication and appeals.
- E.16. **Changes Required by Statute, Regulation, Court Orders, or Program Funding.** ERS acknowledges that certain factors may change conditions with regard to Respondent's services under the Contract. Some factors that may affect Respondent include, but are not limited to:
- Changes in federal and state statutes, regulations, and new court decisions and administrative rulings;
 - Changes in anticipated funding by the Texas Legislature; and
 - Changes in the Dental Plan(s) plan design.

- E.16.a. Respondent agrees to make a good faith effort to comply with any additional responsibilities or changes to the Dental Program(s), imposed as a result of the above factors, and other similar factors that may arise, requiring plan design changes and/or an increase or decrease of Respondent's fees and to cooperate with ERS to effect any such changes and to execute any agreements that may be required as a result. However, should a mandated change materially affect Respondent's obligations under the Contract, ERS reserves the right to negotiate with Respondent regarding any fee increase or decrease that may be appropriate under the circumstances, as provided in the Contract.
- E.17. **ERS Actuary.** ERS retains a consulting actuary to advise the ERS staff and management on insurance and other financial matters related to the GBP. The consulting actuary also assists and advises the Board on benefit plan designs, application reviews, rating analysis, and certain audit related activities as described herein. Respondent shall work with ERS' consulting actuary as necessary to perform the requirements of the RFP and Contract.
- E.18. **Glossary of Terms.** A list of definitions applicable to certain terms used in the RFP are referenced in **Article XV**.
- E.19. **Posting of Contract.** The Dental PPO Contract is subject to Section 2261.253 of the Texas Government Code. In accordance with this section, ERS shall post on its external website the executed Contract, including applicable non-confidential exhibits. The executed Dental PPO Contract will remain posted on ERS' external website until the Dental PPO Contract expires or is completed.
- E.19.a. The DHMO Contract is not subject to Section 2261.253 of the Texas Government Code and, therefore, will not be posted to ERS' external website.

F. Public Information Act

- F.1. ERS is required to provide access to certain records in accordance with the provisions of the PIA. Respondent is required to make any information pursuant to the RFP and Contract, and not otherwise excepted from disclosure under the PIA, available in a format that is accessible by the public at no additional charge to ERS.
- F.1.a. During the evaluation process, ERS shall make reasonable efforts as allowed by law to maintain Proposals in confidence and shall release Proposals only to personnel involved with the evaluation of the Proposals and implementation of the Contract unless otherwise required by law. However, ERS cannot prevent the disclosure of public documents and may be required by law to release documents that Respondent considers confidential and proprietary.
- F.1.b. **Labeling of Confidential and/or Proprietary Information.** In order to protect and prevent inadvertent disclosure of confidential information submitted in support of its Proposal in accordance with the PIA, Respondent is required to supply, in good faith and with legally sufficient justification, ***a separate schedule of all pages considered by Respondent to contain any confidential and/or proprietary information*** in addition to the discs or USB Thumb Drive discussed above (see RFP Section I.D.6.)

Respondent shall mark its confidential and/or proprietary information each time it submits information to ERS, whether in its original Proposal and/or in any supplemental information submitted to ERS. Upon conclusion of the evaluation process, ERS will request Respondents submits updated and final versions of the following: (a) one (1) disc or USB Thumb Drive that contains ALL information Respondent deems confidential and/or proprietary; (b) one (1) disc or USB Thumb Drive that contains ALL information Respondent deems public; and (c) a final paper schedule documenting everything that Respondent deems to be confidential and/or proprietary. By execution of the Signature Pages (attached as **Appendix A**), Respondent warrants and represents that all information that it, in good faith and with legally sufficient justification, considers properly excepted from disclosure under the PIA will be clearly labeled as confidential upon submission to ERS. Respondent's signature further reflects that all documents submitted and not marked "confidential" shall be considered public information. By submitting a Proposal, Respondent acknowledges and agrees that all public information submitted by Respondent in response to the RFP may be fully disclosed by ERS without liability and without prior notice to or consent of Respondent or any of its subcontractors or agents.

- F.1.c. Respondent further understands and agrees that, upon ERS' receipt of a PIA request for Respondent's information, ERS will provide the requestor the information submitted on Respondent's "Public Information" disc or USB Thumb Drive. If Respondent fails to submit its confidential and/or proprietary information as described herein, ERS shall consider all of the information to be public, and it will be released without notification to Respondent upon receipt of a PIA request.
- F.1.d. To the extent the public version of Respondent's Proposal contains Protected Materials, Respondent acknowledges that such Protected Materials may be disclosed, publically displayed, published, reproduced and/or distributed by ERS pursuant to the PIA, or as otherwise required by law. Respondent warrants and represents that it owns, or has obtained all necessary permissions with respect to the use of, the Protected Materials and hereby grants ERS an irrevocable, perpetual, non-exclusive, royalty-free license to display, publish, reproduce, distribute or otherwise use the Protected Materials solely for the purpose of compliance with applicable laws. Respondent shall indemnify and hold harmless ERS, its trustees, officers, directors, employees, and contractors, as well as any trust managed by ERS, from and against any claim of infringement of the Protected Materials resulting from ERS' use of the Protected Materials as set forth herein.
- F.1.e. Upon receipt of a PIA request, ERS will submit the information contained on Respondent's "Confidential and Proprietary" disc or USB Thumb Drive to the Texas Attorney General to issue a ruling on whether the information is excepted from public disclosure.
- F.1.f. It is Respondent's sole obligation to advocate in good faith and with legally sufficient justification the confidential or proprietary nature of any information it provides to ERS. Respondent acknowledges and agrees that ERS shall have no obligation or duty to advocate the confidentiality of Respondent's material to the Texas Attorney General, to a court, or to any other person or entity. Respondent acknowledges and understands that the Texas Attorney General may nonetheless determine that all or part of the claimed confidential or proprietary information shall be publicly disclosed.
- F.1.g. In addition, Respondent specifically agrees that ERS may release Respondent's information, including alleged confidential or proprietary information, upon request from individual Participants, Employers or committees of the Texas Legislature where needed for legislative purposes, as provided for in the PIA, or to any other person or entity as otherwise required by law.

G. Historically Underutilized Business

- G.1. **Historically Underutilized Business.** In accordance with Tex. Gov't Code, Chapter 2161, Subchapter F and Tex. Admin. Code, Title 34 Part 1, Chapter 20, Subchapter B, ERS makes a good faith effort to assist HUBs in receiving agency contract awards and expects Respondent to make a good faith effort to use HUBs as subcontractors.
- G.1.a. As appropriate, Respondent shall provide the following information in the submitted Proposal response materials:
- If Respondent is certified as a Texas HUB, provide the TBPC VID/Certification Number.
 - If an engagement is awarded, and Respondent plans to engage a subcontractor for all or any of the Contract services, Respondent shall identify all proposed HUB subcontractors. The required forms with video instructions can be found at the following website:
- <https://comptroller.texas.gov/purchasing/vendor/hub/>
- G.1.b. **HSP Prime Contractor Progress Assessment Report.** All HUB and non-HUB subcontractor information shall be reported to ERS using the HSP Prime Contractor Progress Assessment Report form. The report shall be submitted to the Office of Procurement and Contract Oversight's Purchasing Section. The report shall be submitted monthly even during the months no invoice is submitted to ERS. All payments made to subcontractors shall be reported. ERS may verify the amounts being reported as paid by requesting copies of cancelled checks paid to subcontractors.

II. Proposal Evaluation

A. General Evaluation Information

A.1. Proposals submitted in response to the RFP will be evaluated and selected on the basis of the evaluation criteria and selection process as outlined in this Article.

B. Preliminary Review Phase

B.1. ERS will date and time-stamp each Proposal when received. ERS will not conduct a public reading of all Respondent's names after acceptance of Proposals.

B.2. ERS will evaluate Proposals to provide the PPO service plan separately from those Proposals to provide the HMO service plan.

B.3. For the Preliminary Review Phase, ERS will evaluate Proposals based on the following evaluation criteria on a pass/fail basis:

- Minimum Requirements (Refer to **Appendix M**);
- Responsiveness;
- Compliance with the RFP; and
- All other vendor performance checks required by the Texas Comptroller of Public Accounts.

B.4. If a Proposal fails any of the above criteria, it will be ineligible for subsequent phased scoring. Based on more in-depth review, ERS reserves the right to determine a Proposal is noncompliant with the RFP after the Preliminary Review Phase. A Proposal may also be disqualified at any time it becomes apparent such Proposal is nonresponsive.

C. Proposal Review Phase

C.1. **Proposal Weights.** In addition to pass/fail items noted below, at RFP Section II.E, proposals that pass the Preliminary Review Phase will be evaluated as follows:

Evaluation Criteria - PPO	Weight
Price Proposal (score determined by Respondent's response to Appendix AA)	40%
Network, Operational Capabilities and Services (score determined by Respondent's response to Appendices N, P, Q, R, U, V, W, and X)	60%

Evaluation Criteria - DHMO	Weight
Price Proposal (score determined by Respondent's response to Appendix AA)	30%
Network, Operational Capabilities and Services (score determined by Respondent's response to Appendices N, P, Q, R, U, V, W, and X)	70%

C.2. The scores received in the Proposal Review Phase are carried forward and used as the basis for the Finalists Review Phase scores. A Finalist's scores may then be revised up or down by the relevant ERS evaluator, based on information obtained regarding Contractibility, Legal Requirements and Regulatory Compliance, as well as through the due diligence processes described in RFP Section II.D.3.

D. Finalists Review Phase

D.1. **Site Visits.** ERS reserves the right to perform site visits at ERS' expense to Finalists' operational center, call center, and/or data center facilities by ERS' designated staff. If applicable, each Finalist will be notified of the site visit date(s) and will be provided with an agenda for the site visit. The site visit will be scored on a pass/fail basis. Additionally, relevant information received during the site visit(s) will be reflected in the Network, Operational Capabilities and Services score.

- Operational Site Visit. ERS will need access to actual work site location(s) to observe and assess operational capabilities. Areas of interest include, but would not be limited to, claims processing, operational and/or administrative services, operational system demonstrations, and customer call shadowing/observations.
- Data Center and Security Operations Center Site Visits. ERS will need access to actual data and security operations center(s) to observe and assess the data and security operations center(s) capabilities. Areas of interest include, but would not be limited to, physical access security, operations, and environment control/mechanisms, process and procedures/artifacts, monitoring of firewall (e.g., project management, business requirements, overall SDLC overview, Threat Intelligence, IPS, DLP, AV, and NOC monitors, as well as any war room facilities), and business continuity plan, disaster recovery plan and latest disaster recovery test results.

D.2. **Face to Face Interview and BAFO.** Finalists may be required to attend a Face to Face interview session at an ERS-designated time and location. The information obtained during this session will be accounted for in the Network, Operational Capabilities and Services score. ERS may also hold separate in-person meetings with each Finalist regarding its Price Proposal, legal/contractual matters, and/or information technology-related matters prior to or in conjunction with the Face to Face interview. Each Face to Face interview may include an oral presentation by Finalist and a question and answer session in which Finalist will answer questions regarding its Proposal. Each Finalist will receive additional instructions outlining ERS' expectations. Finalists may be required to provide a BAFO prior to or at this time.

When scoring the Face to Face interviews and BAFOs, new or clarified information gathered may affect Finalists' scores. More specifically, in the Finalists Review Phase, the scores received in the Proposal Review Phase are carried forward and used as the basis for the Finalists Review Phase scores. A Finalist's scores may then be revised up or down by the relevant ERS evaluator, based on the Finalist's BAFO and information obtained in the Face to Face interview and related Clarification responses, as is discussed above for site visits.

D.3. **Respondent's Past Performance.** Respondent's past performance will consist of the following:

D.3.a. **Reference Checks.** ERS has the discretion to check any of the references provided in **Appendix O** of the RFP. ERS is not limited to contacting references provided by Respondent, but may also contact other appropriate persons or entities in connection with ERS' due diligence process. If Respondent has performed similar or the same services for ERS in the past ten (10) years, ERS may also rely on its own experience with Respondent as part of this check.

D.3.b. **Other Performance Checks.** ERS will perform all other vendor performance checks required by the Texas Comptroller of Public Accounts. This includes, but is not limited to, reviewing Respondent's vendor performance as reported in the Texas Comptroller's Vendor Performance Tracking System in accordance with Section 2262.055 of the Tex. Gov't Code. Additional information may be found at the following website:

<http://www.txsmartbuy.com/vpts>

E. Pass/Fail

E.1. **Pass/Fail.** The following will be scored on a pass/fail basis:

- Contractibility;
- Legal Requirements and Regulatory Compliance (RFP Section VI.B and **Appendix N**);
- Full, unredacted SOC-2 Report(s) or equivalent reports, as requested at RFP Section X.E.;
- Site visits; discussed in more detail in RFP Section II.D.1. above;

- Vendor Past Performance discussed in more detail in RFP Section I.E.3.; and
- Responses to Financial Stability requested at RFP Section XIII.E.

These sections may be evaluated during the Proposal Review Phase, but depending on relevant information submitted in the Proposal and the status of any Clarifications and/or Contract negotiations, as applicable, these sections may not be finally evaluated until the Finalists Review Phase. Regardless, ERS reserves the right to begin evaluating these responses (including asking clarification questions, discussed below at RFP Section F.) prior to the Finalists Review Phase.

- E.2. A “pass” for Contractibility is based upon a Finalist signing Contractual Agreements acceptable to ERS, either by signing the Contractual Agreements and any amendments provided by ERS during the evaluation process (if applicable) without Deviations or with Deviations accepted by or negotiated with ERS. Failure to reach agreement on the Contractual Agreements may result in a “fail.” ERS will not fail a Respondent based solely on the fact that Respondent provided Deviations to the Contractual Agreements submitted with the Statement of Qualifications. ERS will only recommend a Finalist to the Board that has signed a Contract acceptable to ERS.

F. Clarification Request Process

- F.1. At any point in the evaluation process, there may be a need to ask follow-up or Clarification questions. ERS may schedule a conference call or an in-person meeting with Respondent to ensure Respondent understands the Clarification questions either before or after requesting a written answer in response. The responses will be incorporated into the review process as Clarifications and may affect the relevant scores and/or be incorporated into any of the Contractual Agreements, as applicable. Mutually agreed Clarifications of the RFP terms and conditions shall be attached to the executed Contract. Respondents are encouraged to submit complete responses, including any documents requested, with their original Proposal so that minimal Clarifications may be necessary. While ERS reserves the right to ask Clarification questions during any phase, Respondents who fail to provide complete information within their Proposal risk being disqualified or scoring too low to be considered a Finalist or being awarded a Contract.

G. Dental Services Provider Award

- G.1. After Finalists Review Phase is completed, ERS staff will meet with Executive Office to discuss the results of the process and their recommendation for award. Then, ERS staff will present information to the Board for decision. The Board will announce its award of the Contract to the chosen Respondent during a public meeting, which is anticipated to take place at the March 2019 Board meeting. Information regarding Board meetings, including how the public can access Board presentations, may be found on ERS’ website at www.ers.texas.gov.

III. Dental PPO and DHMO Plan(s) Background and Requirements

This Article provides background and requirements for the Dental PPO and DHMO coverages under the GBP. The Dental PPO coverage is self-funded and administered strictly under an administrative services Contract. The DHMO is fully insured. Respondent shall note that deviations to any subsection within this article are not permissible and will not be accepted by ERS. **This Article is for informational purposes only.**

A. Dental Eligibility and Enrollment Periods – PPO and DHMO

Respondent shall acknowledge and comply with the instructions provided at RFP Section I.D.2., specifically with regard to the provision that Deviations to this subsection, Dental Benefits and Enrollment Periods Background, are not permissible and will not be accepted by ERS.

Dental Plans Eligibility

- A.1. **Eligible employees and retirees.** There are approximately two hundred (200) state agencies, higher education institutions and other entities that employ or formerly employed eligible employees or retirees. Approximately 350,000 employees and retirees are eligible for Dental PPO and DHMO plan coverage. Dental benefits are also available to their eligible dependents.
- A.2. ERS is responsible for determining the eligibility for Participants in the GBP and for reporting eligibility for coverage.
 - Full-time and part-time employees, retirees and their dependents are eligible for benefits.
 - Dependent children can be covered through the end of the month following their 26th birthday. Dependent children must be unmarried to be eligible for dental insurance.
- A.3. All enrollment, billing, collection and other administrative matters shall be handled directly by ERS. Chapter 1551 of the Tex. Ins. Code states that the Executive Director of ERS has exclusive authority to decide all questions relating to enrollment in or payment of claims arising from program or coverage provided under the Act. Any decision by the Executive Director under this section may be appealed only to the Board. An appeal to the Board is a contested case under the Administrative Procedure Act (Tex. Gov't Code, Chapter 2001).

The Rules of ERS, Title 34, Part IV., Chapter 81, Section 9 of the Tex. Admin. Code, define the Grievance Procedure that is available to persons participating in the Dental PPO plan. This provision shall be cited in the Certificate of Coverage provided to the Participant.
- A.4. The Dental PPO and DHMO may not include a pre-existing condition provision that would limit an employee's or retiree's right to enroll in the plans except as described herein. Evidence of insurability shall not be required for employees or retirees to enroll in the Dental PPO nor DHMO.

B. Dental Preferred Provider Plan

- B.1. **Dental PPO Background.** The Dental PPO plan was added to the GBP on September 1, 2009 under a self-funded arrangement. Dental benefits are available under the Dental PPO plan to eligible employees, retirees and dependents anywhere in the United States or Canada and allow the Participant to utilize a dentist of choice. However, a preferred provider network option is available to maximize benefits.
- B.2. **Dental PPO Enrollment.** The Dental PPO plan is offered on an optional, employee-pay-all basis; therefore, ERS cannot affirm nor guarantee any level of participation. GBP participation in the Dental PPO plan for the past five (5) years is listed below:

Fiscal Year	Members	Dependents	Total Enrollment	Year-over-Year Change (%)
FY13	140,832	119,248	260,080	

FY14	148,497	123,215	271,712	4.5%
FY15	155,466	126,930	282,396	3.9%
FY16	165,402	134,227	299,629	6.1%
FY17	170,389	136,976	307,365	2.6%

B.3. **Dental PPO Utilization.** The total amount paid for claims incurred by the Dental PPO plan for the past five (5) years is listed below:

Fiscal Year	Total Claims Paid
FY 2013	67,692,073
FY 2014	70,895,138
FY 2015	73,422,127
FY 2016	79,866,421
FY 2017	90,784,320

B.4. **Dental PPO Grievance and Appeals Process.** As a self-funded plan, the Dental PPO will follow ERS' grievance and appeals process. If the Participant is not satisfied with Respondent's resolution, the Participant may go through the grievance process found in the Board Rules.

B.4.a. The Board Rules, Title 34, Part 4, § 81.9 Tex. Admin. Code, describes the claims denial grievance procedure that is available to a GBP participant. In accordance with § 81.9 Tex. Admin. Code, the grievance procedures for the Dental PPO Plan shall be set forth in the Plan's Master Benefit Plan Document (MBPD).

B.4.b. The Board Rules and MBPD define the grievance administration process, as well as the mandated timelines that a GBP participant must comply with when filing an appeal connected to a claims denial. In the event of a conflict between the MBPD and the Board Rules, then the Board Rules shall control.

B.4.c. Respondent shall provide support for the grievance and appeals process. Among the requirements are Respondent's maintenance of adequate staff to produce appeal, grievance and reconsideration of claim rights letters to Participants who request ERS' review of a claim determination, to provide applicable medical and claim/application related opinions, records and expertise to ERS, to conduct professional staff reviews of claim determinations and the provision of legal representation to Respondent in administrative hearings under Tex. Ins. Code, Chapter 1551 and Chapter 2001, Tex. Gov't Code.

C. Dental Health Maintenance Organization

C.1. **DHMO Program Background.** The DHMO is available to employees who live or work in the Texas service area. Benefits are directed by a PCD who is selected by Participants from a list of approved providers. Employees and dependents may choose different PCDs. Dependents who live out of the service area may be enrolled, but must return to the service area and use their PCD to receive dental care, except for emergency services. The DHMO has been administered by HumanaDental since September 1, 2009.

C.2. **DHMO Enrollment.** The DHMO plan is offered on an optional, employee-pay-all basis; therefore, ERS cannot affirm nor guarantee any level of participation. GBP participation in the DHMO plan for the past five (5) years is listed below:

Fiscal Year	Members	Dependents	Total Enrollment	Year-over-Year Change (%)
FY13	81,143	66,429	147,572	
FY14	80,259	62,409	142,668	-3.3%
FY15	76,312	56,770	133,082	-6.7%

FY16	74,666	54,278	128,944	-3.1%
FY17	71,958	51,553	123,511	-4.2%

C.3. **DHMO Historical Plan Expenditures.** Total premiums paid to the DHMO plan for the past five (5) years are reflected in the table below:

Fiscal Year	Total Premiums Paid
FY 2013	13,983,025
FY 2014	14,579,050
FY 2015	14,982,423
FY 2016	13,910,695
FY 2017	13,495,137

C.4. **DHMO Plan Design.** ERS intends for the majority of dental care to be provided by a Primary Care Dentist (“PCD”) who accepts the prescribed copayments. The network of PCDs should include an adequate number of general dentists.

C.4.a. ERS recognizes that, in some instances, specialty dental care shall be necessary and that a contracting specialty dentist shall perform necessary dental care. The Member shall receive not less than a 25% reduction for the necessary dental care from the specialty dentist’s UC.

C.4.b. ERS recognizes that emergency situations shall arise from time to time. It is ERS’ intent that emergency services are arranged for by the patient’s PCD in order for the Member to utilize the schedule of dental benefits. The DHMO should establish a toll-free number for Participants to utilize for contacting the DHMO carrier for emergency referrals when their PCD is not available. In such instances, patients may be referred to a dentist (preferably a participating dentist) for palliative treatment only and the patient’s copayment for palliative treatment shall be as indicated in the Schedule of Dental Benefits. DHMO shall be responsible for any provider charge in excess of the patient’s listed copayments. However, the DHMO is not financially responsible if the patient does not contact DHMO for emergency referral assistance.

C.5. **General Dentists.** Covered dental services, shown in the DHMO Schedule of Benefits, shall be provided by general dentists at the dental office location, except for referral care to specialty dentists when approved by Respondent or out-of-area emergency dental care. The DHMO Schedule of Benefits shows the copayment that applies to covered dental services. The plan participant is responsible for making the copayment to the general dentist. Covered services include only services in the schedule. Any services not specifically listed are the responsibility of the Member and are payable at the dentist’s usual and customary charge.

C.5.a. The primary providers for the DHMO plan are typically general dentists and pediatric dentists for young children; however, the determination of primary providers will be at the discretion of Respondent.

C.6. **Specialty Dentists.** When the Participant’s individual case circumstances or the severity of a Participant’s condition are such that the covered dental procedure cannot be performed by a general dentist, the general dentist may refer you to a specialty dentist for dental care. Specialty dentists include Oral Surgeons, Orthodontists, Endodontists, Periodontists, Pedodontists, Prosthodontists and Pediatric Dentists if the Pediatric Dentist is not selected as a child’s general dentist. The specialty dentist shall provide the services to a covered person with a copayment of not more than 75% of the dentist’s usual and customary charge for the service.

C.7. **Copayment Amount.** A copayment amount applies to some dental services. The covered person is responsible for paying the copayment amount to the dentist. The copayment amount is due at the time the services are rendered.

C.8. **Grievance and Complaint Process.** As a fully-insured plan, the DHMO’s grievance and complaint procedure shall be in compliance with all applicable statutes and regulations, including, but not limited to, rules and regulations of the TDI, as amended.

- C.8.a. Respondent to the DHMO plan shall ensure each appeal for complaint resolution shall be resolved in accordance with regulations and timelines established by TDI. The processes developed must conform to TDI regulations and provide all mandated disclosures of participant rights, including their right to contact TDI regarding their respective appeal request.
- C.8.b. Furthermore, the DHMO's Evidence of Coverage (EOC) shall fully disclose the grievance and complaint procedure, including all mandated timelines that a person participating in the DHMO must comply with when filing an appeal on a claims denial.

IV. Minimum Requirements

Respondents must meet all of the Minimum Requirements listed in **Appendix M**. Failure to satisfy the Minimum Requirements shall result in the disqualification of Respondent's Proposal. ERS will not accept Deviations to the Minimum Requirements. Respondent shall complete and submit **Appendix M** as a part of its Proposal.

V. Respondent's Organizational and Reference Information

The section allowing for the Interrogatories for this Article can be found at **Appendix O**. Respondent shall complete and submit **Appendix O** as a part of its Proposal. Deviations to **Appendix O** are not permissible and will not be considered by ERS.

VI. Legal Requirements and Regulatory Compliance

This Article provides the legal requirements and regulatory compliance for the Dental services under the GBP. The section allowing for Deviations and the Interrogatories for this Article can be found at **Appendix N**. Respondent shall complete and submit **Appendix N** as a part of its Proposal.

A. Contractual Matters – PPO and DHMO

- A.1. ERS will evaluate Contractibility based upon Respondent signing a Contractual Agreement, BAA and DSBNA acceptable to ERS. Contractibility will be evaluated on a pass/fail basis. See RFP Section II.E.1. for further information regarding the scoring of Contractibility.
- A.2. **Incumbency Certificate.** Each of Respondent's authorized signatories shall execute the Incumbency Certificate attached as **Appendix E** to the RFP. By executing the Incumbency Certificate, each signatory represents and warrants that he or she is authorized to execute agreements and other documents on behalf of Respondent.
- A.3. **Contractual Agreement, Business Associate Agreement, and Data Security and Breach Notification Agreement.** Execution of the Contractual Agreement, BAA and DSBNA, attached as **Appendices B, C and D**, are **preferred submissions** of the RFP. ERS prefers that the Contractual Agreement, BAA and DSBNA be signed and returned without deviation with the Proposal submission. However, if Respondent in good faith determines that it does not agree with the provisions of the Contractual Agreement, BAA or DSBNA in the forms attached as **Appendices B, C and D**, Respondent may submit Deviations to the terms. If Deviations are submitted, they must include specific language rather than vague suggestions that certain provisions require discussion. Such specific language should be shown as redlined changes within the form provided. Any such Deviations will be considered by ERS; however, ERS will not be obligated to accept or agree to any such Deviations.
- A.3.a. Respondent agrees to act in good faith and to cooperate with ERS in the execution of the Contract. ERS specifically reserves the right to revise any or all RFP or Contract provisions set forth at any time prior to ERS' execution of a Contract where ERS deems it to be in the best interests of ERS, the GBP, its Participants, and the State.
- A.3.b. ERS reserves the right to revise the RFP and/or Contract provisions set forth at any time prior to ERS' execution of a Contract where ERS deems it to be in the best interests of ERS, the GBP, its Participants and the State.
- A.3.c. On or before the recommendation and approval by the Board, Respondent shall execute a Contract provided by and satisfactory to, ERS.
- A.4. **Contract Term and Chronology of Responsibility.** The term of the Contract is for six (6) years, which begins upon execution of the Contract by ERS and is anticipated to extend through August 31, 2025, subject to the terms of the Contract.
- A.4.a. ERS and Respondent agree and acknowledge that there are duties and obligations specified by the Contract to be performed prior to execution of the Contract and following the Contract Term, and each agrees to perform all such duties and obligations, and all damage provisions included herein and in the Contract shall thereby be in effect. Such prerequisites, duties and obligations include, but are not limited, to the following:
- Selection by the Board, which is anticipated for the March 2019 Board meeting;
 - Execution of the Contractual Agreement and all Exhibits by both parties;
 - Any and all activities required by Respondent to effectively implement the requirements of the Contract; and
 - Coordination and cooperative work between Respondent and other GBP Contracted Vendors, including execution of non-disclosure agreements.
- A.5. **Information Security.** Respondent shall comply with the Privacy Act of 1974 as amended by the Computer Matching and Privacy Protection Act of 1988, the Identity Theft Enforcement and

Protection Act, Chapter 521, Tex. Bus. & Com. Code, and information security standards as outlined in Tex. Admin. Code, Title 1, Part 10, Ch. 202. Further, Respondent shall comply with the requirements in the "Privacy Rule" adopted pursuant to the federal Health Insurance Portability and Accountability Act of 1996 [Pub. L. No. 104-191], amended by the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009, and the implementing regulations issued and amended by the U.S. Department of Health and Human Services Secretary (45 C.F.R. Parts 160 and 164) (hereinafter referred to as "HIPAA") for handling and use of personal health information ("PHI") as more fully outlined in **Appendix D**, DSBNA, and **Appendix C**, BAA, and use processes to support the secure handling of files. Compliance is required for data handling and transfer (data in transit) and storing data (data at rest). Execution of the DSBNA and BAA will be required prior to final execution of the Contract.

- A.6. **Data Sharing.** ERS' data shall be excluded from any type of data sharing arrangement.
- A.7. **Non-Disclosure Agreements.** Respondent shall enter into a non-disclosure agreement with any other GBP Contracted Vendor, if applicable, prior to the commencement of the Service Period.
- A.8. **Performance Guarantees.** The Contract will include Performance Guarantees (as attached to the RFP as **Appendix G for PPO; Appendix G-1 for DHMO**) and other legal remedies to ensure proper administration of the Dental PPO and DHMO plans. Respondent shall refer to **Appendix G for PPO and Appendix G-1 for DHMO** for a comprehensive listing of the Performance Guarantees for the applicable dental insurance plan.
 - A.8.a. Respondent may submit Deviations to the Performance Guarantees. If Deviations are submitted, they must include specific language rather than vague suggestions that certain provisions require discussion. Such specific language should be shown as redlined changes within the form provided. Any such Deviations will be considered by ERS; however, ERS will not be obligated to accept or agree to any such Deviations.
 - A.8.b. ERS reserves the right to add or modify Performance Guarantees as a result of identifying or developing key processes during the RFP process and Contract Term.
 - A.8.c. As disclosed in Appendix G: For the PPO, the calculation of the Performance Guarantee assessment shall be based on Plan Enrollment. Plan Enrollment will be determined by ERS and calculated by annualizing the enrollment counts received for September 1st each fiscal year.

The Performance Guarantee assessment shall be calculated using the Annualized Administrative Fees as a basis or an amount larger highlighting the Respondent's commitment to ERS, the GBP, its Participants, and the State. The Assessment Amount Calculation includes a Severity Level. The corresponding severity calculation shall be applied to the Monthly Average Premiums Paid basis. A full description of the Performance Guarantee assessment calculations is provided on page 6 of the Appendix.
 - A.8.d. As disclosed in Appendix G-1: For the DHMO, the calculation of the Performance Guarantee assessment shall be based on Plan Enrollment. Plan Enrollment will be determined by ERS using the annual enrollment numbers for the Plan(s) from the September 1st enrollment each plan year.

The Performance Guarantee assessment shall be calculated using the Monthly Average Premiums Paid as a basis or an amount larger highlighting the Respondent's commitment to ERS, the GBP, its Participants, and the State. The Assessment Amount Calculation includes a Severity Level. The corresponding severity calculation shall be applied to the Monthly Average Premiums Paid basis. A full description of the Performance Guarantee assessment calculations is provided on page 5 of the Appendix.

B. Prohibited Interest – PPO and DHMO

Deviations to this Section are not permitted.

- B.1. Except as a Participant in the GBP, a Board member or employee of ERS may not have a direct or indirect interest in the gains or profits of any Contract executed by ERS pursuant to the RFP, and may not receive any payment or emolument for any service performed by Respondent.
 - B.1.a. In the event that a Participant in the GBP, Board member or employee of ERS receives any payment from Respondent for any services performed for Respondent, for being awarded the

Contract or for any gains or profits from any Contract executed by ERS pursuant to the RFP, ERS may terminate its relationship with Respondent immediately, and ERS reserves the right to seek any legal, equitable or contractual relief to which it may be entitled. Under such circumstances, Respondent shall complete any outstanding transactions with ERS as soon as possible. In its discretion, ERS may choose not to consider any further Proposals from Respondent.

- B.1.b. By submitting its Proposal, Respondent warrants and represents that it does not have, nor shall it permit, any conflicts of interest that would impair its ability to perform the services required by the Contract in the best interests of ERS, the GBP, its Participants and the State.

C. Terms of Use Requirements – PPO and DHMO

- C.1. Respondent shall agree that its Terms of Use for any website, mobile application or other technology solution shall not apply, shall be null and void and shall have no force or effect as if its Terms of Use did not exist as to any and all ERS staff and Participants.

VII. Dental PPO and DHMO Structure and Administration Requirements

This Article presents the requirements and specifications for Respondent to administer the self-funded Dental PPO Plan and/or to underwrite and administer the fully insured DHMO under the GBP. Respondent shall provide a level of benefits and services that are at least consistent with those currently offered to Participants under the Dental Plans.

The Dental PPO Plan Contract to be executed in accordance with this document shall involve no insurance or reinsurance. The Contract for Respondent's services shall at minimum include, but not be limited to: administrative services, dental network management and credentialing used in connection with the Dental Programs, as described in the RFP, and shall be executed in accordance with the requirements outlined in the Contract. Other financial requirements may be further outlined in other areas of the RFP.

Respondent understands and accepts that it is bound by various statutory, regulatory and fiduciary duties and responsibilities and, therefore, Respondent expressly agrees that it shall accept and abide by such duties and responsibilities when acting on behalf of the GBP pursuant to this engagement. Respondent shall administer the Dental Programs in a manner consistent with applicable laws, both state and federal, including the Board Rules, and at the direction of the ERS' Board, its Executive Director, and ERS' staff. The cost of the requirements described herein shall be recovered by Respondent only by making provisions for such expenses in Respondent's Price Proposal in **Appendix AA**.

The section allowing for Deviations and the Interrogatories for this Article can be found at **Appendix P**. Respondent shall complete and submit **Appendix P** as a part of its Proposal.

A. Dental PPO Plan Benefits Requirements

- A.1. **PPO Schedule of Dental Benefits.** The current PPO Schedule of Dental Benefits is disclosed within the Plan's Master Benefit Plan Document, which is located at: <http://apps.humana.com/marketing/documents.asp?file=1767584>, with expected plan design changes effective September 1, 2018, that are to be considered in Respondent's Proposal. These plan design changes are fully described in **Appendix H**.
- A.1.a. The Dental PPO Schedule of Dental Benefits will be updated to reflect the benefit plan changes reflected in **Appendix H** for FY2019, which begins September 1, 2018.
- A.1.b. ERS will not consider other plan designs other than that presented herein, and, accordingly, deviations from these specifications shall not be accepted, except as requested by ERS.
- A.2. **Billing, Administrative Matters.** All enrollment, billing, collection and other administrative matters shall be handled directly by ERS. Chapter 1551 of the Tex. Ins. Code provides that the Executive Director of ERS has exclusive authority to decide all questions relating to enrollment in or payment of claims arising from program or coverage provided under the Act. Any decision by the Executive Director under this section may be appealed only to the Board. An appeal to the Board is a contested case under the Administrative Procedure Act (Tex. Gov't Code, Chapter 2001).
- A.3. **Coordination of Benefits.** Respondent shall include a provision regarding COB with its Proposal. Respondent shall collect other insurance information for the purposes of COB. Respondent is required to coordinate benefits with any group plan (other than a GBP-sponsored plan) under which a GBP Participant has coverage. Respondent is not relieved of the duty to provide covered services as a result of such COB. If a GBP Participant is eligible to receive benefits under another group plan, Respondent shall coordinate benefits.

B. Dental Health Maintenance Organization Benefits Requirements

- B.1. **Coordination of Benefits.** The DHMO's response should include a provision regarding COB. The DHMO shall collect other dental insurance information for the purposes of COB. The DHMO is required to coordinate benefits with any group plan (other than a GBP-sponsored plan) under which a GBP Participant has coverage. The DHMO is not relieved of the duty to provide covered services

as a result of such COB. If a GBP Participant is eligible to receive benefits under another group plan for services provided at the DHMO's expense, the DHMO shall coordinate benefits.

B.2. **DHMO Schedule of Benefits.** The proposed DHMO Schedule of Benefits, including the required benefits and Member copayment levels to be provided under the fully insured DHMO plan, is located at: <http://apps.humana.com/marketing/documents.asp?file=1384318>.

B.2.a. ERS does not wish to consider plan designs other than that presented within the RFP. Respondent should submit their Proposal based on the current ERS DHMO plan design.

C. COBRA Administration Requirements – PPO and DHMO

C.1. **COBRA.** Respondent shall assist ERS in the administration of the Consolidated Omnibus Budget Reconciliation Act, Public Law 99-272 (“COBRA”). Respondent shall administer coverage for those categories of Participants who have lost or shall lose coverage as a result of a qualifying event as defined in Title X of COBRA. Any such Participant is entitled to elect to continue coverage under this Contract in accordance with the provisions set forth in COBRA, and as administered by ERS, in accordance with its administrative practices. ERS and/or the employing department shall handle enrollment of participants in COBRA continuation coverage and collection of premiums.

For both the Dental PPO and DHMO plans, during any interim period between cancellation of insurance due to a qualifying event and enrollment in COBRA continuation coverage, Respondent shall provide to any qualified beneficiaries under COBRA continuation coverage, on a fee-for-service basis, the identical services that are available to a non-COBRA GBP Participant, and will, upon receipt of confirmation of COBRA enrollment from ERS, refund to the COBRA participant all fees paid less any appropriate copayment amounts.

A qualified Participant who has elected to continue coverage in accordance with COBRA, may permanently move outside of Respondent's service area and maintain his/her coverage in accordance with state requirements. However, coverage may be limited to only emergency services outside of the service area.

C.1.a. ERS will pay the DHMO for COBRA Participants based on the chart below that reflects how the rate structure for COBRA will be applied.

COBRA Participant Category	Applicable Rate
Spouse Only	Member Only
Child Only	Member Only
Children Only	Member & Child(ren)
Spouse & Child(ren)	Member & Child(ren)

D. Coordination with Other GBP Contracted Vendors Requirements - PPO and DHMO

D.1. Respondent shall coordinate with all other GBP Contracted Vendors as required by ERS. Respondent shall refer to the table in **Appendix F** for a complete list of other GBP Contracted Vendors.

D.2. Respondent shall establish non-disclosure agreements with ERS and other GBP Contracted Vendors, as necessary.

VIII. Provider Network and Service Area Requirements

An established broad-based, quality dental provider network within the state of Texas is an important factor in the dental review process. ERS desires the broadest possible dental provider service area with adequate numbers of dental providers across the State. ERS will not consider a network provider as part of Respondent's established network based on a provider's verbal agreement, letter of intent or similar.

The section allowing for Deviations and the Interrogatories for this Article can be found at **Appendix Q**. Respondent shall complete and submit **Appendix Q** as a part of its Proposal.

A. DHMO Provider Network Requirements

- A.1. **Provider Accessibility and Availability.** The DHMO shall offer complete flexibility in a Participant's selection of a primary dentist, within the selected network. The DHMO must provide documentation on disc(s) using ERS' required format (included in this Article) to demonstrate that the proposed provider network contains a sufficient number of dental care providers to serve the GBP Participants. Separate documentation shall be provided for each of the following: (i) designated dentists; and (ii) specialty care dentists.
- A.1.a. ERS will utilize GeoAccess software as one of its tools to assess the DHMO's established network, as well as determine provider network availability and accessibility in accordance with the TDI access rules. ERS may also use its own discretion in reviewing provider networks. ERS' access standard will be one (1) Primary Care Dentist within thirty (30) miles and (1) specialty care dentist within seventy-five (75) miles. Geographic location is considered from either GBP Participants' residential address or place of employment. Each Respondent shall submit documentation of its existing provider network as of January 1, 2018, in the prescribed ERS format.
- A.1.b. The DHMO shall utilize a designated primary dentist to direct the DHMO benefits to a Participant utilizing the network. Functioning as a gatekeeper, the designated primary dentist will direct and coordinate a Participant's dental care. To be eligible for benefits, a Participant shall first utilize the designated primary dentist. All services and supplies shall be authorized by the designated primary dentist for the DHMO benefits. A Participant will be allowed to change primary dentists, and such changes will be effective no later than the first of the following month. The DHMO may limit this change to one per month. Network providers shall collect the applicable copayment from all GBP Participants enrolled in the DHMO.
- A.1.c. There shall be a sufficient number of participating primary dentists (including Pedodontists, Orthodontists, Periodontists, Endodontists, Oral Surgeons, etc.) to serve the needs of State and higher education employees, retirees and their dependents. A primary dentist is one who has contracted to provide services based on the copayments listed in the DHMO Schedule of Benefits. In addition, there shall be a sufficient number of participating specialty dentists who have contracted to provide services at not less than a 25% discount as indicated in the DHMO Schedule of Benefits.
- A.2. **Dental Care DHMO Provider Contracts (all the provisions survive the termination of the Contract).**
- A.2.a. The DHMO shall maintain adequate protections, whether through guarantees, subordinated debt, required surplus contributions by stockholders, or dental care provider(s) contracts containing indemnification and hold harmless provisions, or by any other means or combination thereof, whereby dental care provider(s) may not seek from GBP Participants, ERS or the State payment of debts that are the responsibility of the DHMO and whereby ERS, the State and GBP Participants are protected from any obligation for payments which are the responsibility of the DHMO.
- A.2.b. For payment of services under the DHMO plan, if any dental care provider(s) requests that a GBP Participant waive his/her rights to not be liable for payments owed by Respondent, requests that the GBP Participant agree to pay for services that are the DHMO's responsibility, or initiates any actions whatsoever, including correspondence, telephone calls or personal visits, to collect payments from ERS, the State or GBP Participants for payment of services rendered over and above allowable copayments, excluding services not covered under this plan, the DHMO or its successor shall initiate and maintain such action necessary to stop the dental care provider(s) or

his employee, agent, trustee, or successor in interest from maintaining any action against ERS, the State or any GBP Participant to collect or otherwise take any responsibility for any amounts owed to dental care provider(s) by the DHMO.

- A.2.c. The DHMO shall defend, indemnify and hold harmless GBP Participants, ERS and the State against any and all claims, costs, damages, lawsuits, settlements, judgments, penalties, and expenses (including attorney’s fees) of whatsoever kind or nature arising out of the failure, inability, or refusal of the DHMO, its agents, employees and/or subcontractors to pay dental care provider(s) for covered services or supplies and for any alleged malpractice or malfeasance of the DHMO, its agents, employees and/or subcontractors or any of its dental care providers. The Contract will expand on this requirement.
- A.2.d. In the event the DHMO terminates its contract with any participating primary dentist, the DHMO shall make reasonable efforts to notify affected current Members in writing. The written notice shall include the name of the terminating dentist or dental group, the names of other dental care provider(s) available to the Members, and the effective dates of the changes.
- A.2.e. The DHMO shall ensure that its dental care provider(s) do not directly market to GBP Participants.
- A.2.f. ERS will have the right to review all arrangements or agreements between the DHMO and a participating dentist. A selected DHMO shall provide ERS with a sample dental provider contract upon request.
- A.2.g. The selected Dental Respondent shall maintain the Board-approved network as reflected in **Appendix G, Performance Guarantees.**
- A.2.h. **List of Texas Counties DHMO Plans**

	COLORADO	GRAY	KING	OLDHAM	TITUS
ANDERSON	COMAL	GRAYSON	KINNEY	ORANGE	TOM GREEN
ANDREWS	COMANCHE	GREGG	KLEBERG	PALO PINTO	TRAVIS
ANGELINA	CONCHO	GRIMES	KNOX	PANOLA	TRINITY
ARANSAS	COOKE	GUADALUPE	LA SALLE	PARKER	TYLER
ARCHER	CORYELL	HALE	LAMAR	PARMER	UPSHUR
ARMSTRONG	COTTLE	HALL	LAMB	PECOS	UPTON
ATASCOSA	CRANE	HAMILTON	LAMPASAS	POLK	UVALDE
AUSTIN	CROCKETT	HANSFORD	LAVACA	POTTER	VAL VERDE
BAILEY	CROSBY	HARDEMAN	LEE	PRESIDIO	VAN ZANDT
BANDERA	CULBERSON	HARDIN	LEON	RAINS	VICTORIA
BASTROP	DALLAM	HARRIS	LIBERTY	RANDALL	WALKER
BAYLOR	DALLAS	HARRISON	LIMESTONE	REAGAN	WALLER
BEE	DAWSON	HARTLEY	LIPSCOMB	REAL	WARD
BELL	DE WITT	HASKELL	LIVE OAK	RED RIVER	WASHINGTON
BEXAR	DEAF SMITH	HAYS	LLANO	REEVES	WEBB
BLANCO	DELTA	HEMPHILL	LOVING	REFUGIO	WHARTON
BORDEN	DENTON	HENDERSON	LUBBOCK	ROBERTS	WHEELER
BOSQUE	DICKENS	HIDALGO	LYNN	ROBERTSON	WICHITA
BOWIE	DIMMIT	HILL	MADISON	ROCKWALL	WILBARGER
BRAZORIA	DONLEY	HOCKLEY	MARION	RUNNELS	WILLACY
BRAZOS	DUVAL	HOOD	MARTIN	RUSK	WILLIAMSON
BREWSTER	EASTLAND	HOPKINS	MASON	SABINE	WILSON
BRISCOE	ECTOR	HOUSTON	MATAGORDA	SAN AUGUSTINE	WINKLER
BROOKS	EDWARDS	HOWARD	MAVERICK	SAN JACINTO	WISE
BROWN	EL PASO	HUDSPETH	MCCULLOCH	SAN PATRICIO	WOOD
BURLESON	ELLIS	HUNT	MCLENNAN	SAN SABA	YOAKUM
BURNET	ERATH	HUTCHINSON	MCMULLEN	SCHLEICHER	YOUNG
CALDWELL	FALLS	IRION	MEDINA	SCURRY	ZAPATA
CALHOUN	FANNIN	JACK	MENARD	SHACKELFORD	ZAVALA
CALLAHAN	FAYETTE	JACKSON	MIDLAND	SHELBY	
CAMERON	FISHER	JASPER	MILAM	SHERMAN	
CAMP	FLOYD	JEFF DAVIS	MILLS	SMITH	
CARSON	FOARD	JEFFERSON	MITCHELL	SOMERVELL	
CASS	FORT BEND	JIM HOGG	MONTAGUE	STARR	
CASTRO	FRANKLIN	JIM WELLS	MONTGOMERY	STEPHENS	
CHAMBERS	FREESTONE	JOHNSON	MOORE	STERLING	
CHEROKEE	FRIO	JONES	MORRIS	STONEWALL	
CHILDRESS	GAINES	KARNES	MOTLEY	SUTTON	
CLAY	GALVESTON	KAUFMAN	NACOGDOCHES	SWISHER	
COCHRAN	GARZA	KENDALL	NAVARRO	TARRANT	
COKE	GILLESPIE	KENEDY	NEWTON	TAYLOR	
COLEMAN	GLASSCOCK	KENT	NOLAN	TERRELL	
COLLIN	GOLIAD	KERR	NUECES	TERRY	
COLLINGSWORTH	GONZALES	KIMBLE	OCHILTREE	THROCKMORTON	

- A.2.i. The DHMO may elect to submit a response for any or all Texas counties for which it has been approved by TDI. It is not required that the proposed service area(s) be contiguous between counties.

Note: RFP Section VIII.A.7. below shows an example of the format to be used when submitting counties on the service area for the DHMO component. The file shall be in Excel format.

A.3. **Provider Accessibility and Availability Format**

For each service area included in the DHMO Proposal, the DHMO shall provide one Provider Network Excel file, including one (1) worksheet for the primary dentist and one (1) worksheet for the specialty dental providers. As an example, a DHMO submitting a response for three (3) different service areas shall submit three (3) separate Excel files. Each Excel file shall contain two (2) separate worksheets, one for each of the two (2) required networks: primary dentists and specialty care dentists.

- A.3.a. Failure to properly identify the data may result in a delay in the review of Respondent’s Proposal. NOTE: The documentation required is more than what is primarily listed in the DHMO’s provider directory.

- A.3.b. The DHMO should direct any questions regarding these requirements to the iVendor mailbox at: ivendorquestions@ers.texas.gov during the question and answer period stated at RFP Section I.C.1.

A.4. **Formatting Requirements.** Data shall be in Excel format and in an unaltered form. **No other format will be accepted.**

- A.4.a. All required data fields shall be completed and filled in. If not, the Proposal will **not** be considered complete. **Blank records, abbreviated names or extra fields are not acceptable.**

- A.4.b. Only specialty codes provided by ERS are valid. See the list of specialty codes included in this Article.

- A.4.c. Format Examples – (fixed length Excel spreadsheet)

Below is the listing of the data required for each provider type to assist Respondent in creating the files.

- A.5. **Reporting of Primary Dentist Network.** The following is the format that **shall** be used to create the primary dentist network Excel worksheets. The primary dentist network must be submitted in a separate Excel file.

Table 1 – Primary Dentist Network – (13 Fields - Fixed Length)

Field Names	Description	Size	Type	Bytes
**	Filler Text	2	Text	1-2
LIC#	Dentist’s License number assigned by the Texas Board of Dental Examiners	5	Text(alpha/numeric)	3-7
LAST NAME	Dentist’s Last Name	30	Text	8-37
FIRST NAME	Dentist’s First Name	25	Text	38-62
MIDDLE INITIAL	Dentist’s Middle Initial	2	Text	63-64
ADDRESS 1	Street Address of dentist’s office NO P.O. Boxes, Bldg. Name, Suite #, or Floor	30	Text	65-94
ADDRESS 2	Complete second location address, including city and ZIP code	30	Text	95-124
CITY	City of dentist’s office (Address 1)	25	Text	125-149
ZIP Code	Street address ZIP code of dentist’s office (Address 1)	5	Number	150-154

County	Physical location of dentist's primary office			
SPEC	GD = General Dentistry E = Endodontics O = Orthodontics P = Periodontics Pe = Pedodontics Pr = Prosthodontics S = Oral Surgery L= Limited Care	4	TEXT	155-158
STATUS	O = Open Practice C = Closed Practice	3	Text	159-161
AFF	Affiliated w/a Group practice or DSO Y = Yes N = No	3	Text	162-164
GROUP or DSO NAME	Name of the practice	30	Text	165-194
COUNTY	Texas County where dentist office is physically located	25	Text	195-219

Filler	Lic .#	Last Name	First Name	MI	Address 1	Address 2	City	Zip	Spec	O/C	Aff	Group Name	County
**		Jones	John	F	10 Main St, 2 nd Floor	151 South Taylor	Austin	78701	Pe	O	Y	Dental Group	Travis

A.6. **Reporting of Specialty Care Dentists.** The following is the format that **shall** be used to create the specialty care dentist network. The specialty care dentist network must be submitted in a separate Excel file.

Table 2 – Specialty Care Dentist Network – (12 Fields - Fixed Length)

Field Names	Description	Size	Type	Bytes
**	Filler Text	2	Text	1-2
LIC#	Dentist's License number assigned by the Texas Board of Dental Examiners	5	Text (alpha/numeric)	3-7
LAST NAME	Dentist's Last Name	30	Text	8-37
FIRST NAME	Dentist's First Name	25	Text	38-62
MIDDLE INITIAL	Dentist's Middle Initial	2	Text	63-64
ADDRESS 1	Street Address of dentist's office NO P.O. Boxes, Building Name, Suite #, or Floor	30	Text	65-94
ADDRESS 2	Complete second location address including city and ZIP code	30	Text	95-124
CITY	City of Dentist's Office	25	Text	125-149
ZIP Code	Street address ZIP code of dentist's office	5	Number	150-154
SPECIALTY	E = Endodontics O = Orthodontics P = Periodontics Pr = Prosthodontics S = Oral Surgery OTH- ALL OTHER SPECIALTIES	4	Text	155-158
AFF	Affiliated w/a Group practice or DSO Y = Yes N = No	3	Text	159-161
GROUP NAME	Name of the group practice or DSO	30	Text	162-191

COUNTY	Texas County where group or DSO is physically located	25	Text	192-216
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Filler	Med . Lic. #	Last Name	First Name	MI	Address 1	Address 2	City	Zip	Spec	Aff	Group Name	County
**		Smith	Jane	M	10 Medical Blvd Suite 250	25 Jones St.	Long view	75603	P	N		Gregg

- A.7. **Documentation.** Supporting data for each service area submitted shall include:
- A.7.a. The DHMO shall submit a copy of its TDI's date stamped approved service area documentation. **NOTE:** Only service areas approved by TDI on or before January 1, 2018 are to be submitted in the DHMO's Proposal.
 - A.7.b. The DHMO shall provide map(s) that are comprised of complete counties boldly outlining each proposed service area.
 - A.7.c. Service area in ERS format, listing the counties for the proposed service area. The file should be saved in Excel format.

B. Dental PPO Provider Network Requirements

- B.1. **Provider Access and Availability.** For Dental PPO benefits, Respondent will offer complete flexibility in a Participant's selection of a dentist. Respondent shall provide documentation using ERS-required format to demonstrate that the proposed provider network contains a sufficient number of dental care providers to serve GBP Participants. Separate documentation shall be provided for each of the following: (i) general dentists; and (ii) specialty care dentists. Documentation for each of these proposed and established networks shall be provided in the ERS-prescribed format.
- B.1.a. ERS will utilize GeoAccess software as one of its tools to assess the provider's established network, as well as determine provider network availability and accessibility in accordance with the TDI access rules. ERS may also use its own discretion in reviewing provider networks. ERS' access standard will be one (1) Primary Care Dentist within thirty (30) miles and one (1) specialty care dentist within seventy-five (75) miles. Geographic location is considered from either GBP Participants' residential address or place of employment. Each Respondent shall submit documentation of its provider network (for the PPO component) as of January 1, 2018 in the prescribed ERS format.
 - B.1.b. Participants enrolling in the Dental PPO plan do not have to designate a general dentist to obtain PPO benefits, but they must use a participating network dentist to receive the highest level of PPO benefits and/or to not be subject to balance billing. The proposed network should be extensive and offer a high level of access. The Proposal response shall utilize the ERS-required format to document its proposed network.
 - B.1.c. **National PPO Network.** Dental PPO plan will provide a National PPO Network that will meet the specified provider access, availability and network requirements.
- B.2. **Dental Care PPO Provider Contracts (all the provisions survive the termination of the Contract).**
- B.2.a. Respondent shall maintain adequate protections, whether through guarantees, subordinated debt, required surplus contributions by stockholders, or dental care provider(s) contracts containing indemnification and hold harmless provisions, or by any other means or combination thereof, whereby dental care provider(s) may not seek from GBP Participants, ERS or the State payment of debts that are the responsibility of Respondent, and whereby ERS, the State and GBP Participants are protected from any obligation for payments which are the responsibility of Respondent.
 - B.2.b. For payment of services on the Dental PPO plan, if any dental care provider(s) requests that a GBP Participant waive his/her rights to not be liable for payments owed by Respondent, requests that

the GBP Participant agree to pay for services that are Respondent's responsibility or initiates any actions whatsoever, including correspondence, telephone calls or personal visits, to collect payments from ERS, the State or any GBP Participants for payment of services rendered over and above allowable copayments, excluding services not covered under this plan, and excluding services over and above the plan's maximum annual or lifetime benefits, Respondent or its successor shall initiate and maintain such action necessary to stop the dental care provider(s) or his employee, agent, trustee, or successor in interest from maintaining any action against ERS, the State or any GBP Participant to collect or otherwise take any responsibility for any amounts owed to dental care provider(s) by Respondent.

- B.2.c. Respondent shall defend, indemnify and hold harmless GBP Participants, ERS and the State against any and all claims, costs, damages, lawsuits, settlements, judgments, penalties, and expenses (including attorney's fees) of whatsoever kind or nature arising out of the failure, inability, or refusal of Respondent, its agents, employees and/or subcontractors to pay dental care provider(s) for covered services or supplies and for any alleged malpractice or malfeasance of Respondent, its agents, employees and/or subcontractors or any of its dental care providers. The Contract will expand this requirement.
- B.2.d. Respondent shall ensure its dental care provider(s) do not directly market to GBP Participants.
- B.2.e. The selected Respondent shall provide ERS with a sample dental provider contract upon request.
- B.3. **Provider Accessibility and Availability Format.** Respondent shall provide a provider network Excel file that contains the proposed PPO network. The Excel file shall contain one (1) worksheet for general dentists and one (1) worksheet for specialty dental providers.
 - B.3.a. Failure to properly identify the data may result in a delay in the review of the Respondent's Proposal. **Note:** The documentation required is more than what is generally listed in the Respondent's provider directory.
- B.4. **Formatting Requirements.** Please note the following when preparing the Excel files:
 - B.4.a. The file shall be in an Excel format. **No other format will be accepted.**
 - B.4.b. All required data fields shall be completed and filled in. If not, the Proposal will **not** be considered complete. **Blank records, abbreviated names or extra fields are not acceptable.**
 - B.4.c. Only specialty codes provided by ERS are valid. See the list of specialty codes included in this Article.
 - B.4.d. Format Examples – (fixed length Excel spreadsheet). Below is the listing of the data required for each provider type to assist Respondent in completing the Excel file.
- B.5. **Reporting of Participating General Dentists (PPO only).** The following is the format that **shall** be used to create the participating general dentist network Excel file. The participating general dentist network must be submitted in a separate worksheet on the Excel file.

Table 3 – Participating General Dentist Network – (12 Fields - Fixed Length)

Field Names	Description	Size	Type	Bytes
**	Filler Text	2	Text	1-2
LIC#	Dentist's License number assigned by the Texas Board of Dental Examiners	5	Text(alpha/numeric)	3-7
LAST NAME	Dentist's Last Name	30	Text	8-37
FIRST NAME	Dentist's First Name	25	Text	38-62
MIDDLE INITIAL	Dentist's Middle Initial	2	Text	63-64
ADDRESS 1	Street Address of dentist's office (No. P.O. Boxes, Building Name, Suite #, or Floor)	30	Text	65-94

ADDRESS 2	Complete second location address including city and ZIP code	30	Text	95-124
CITY	City of dentist's office	25	Text	125-149
ZIP Code	Street address ZIP code of dentist's office	5	Number	150-154
SPECIALTY	E = Endodontics	4	Text	155-158
	O = Orthodontics			
	P = Periodontics			
	Pr = Prosthodontics			
	S = Oral Surgery			
	OTH- ALL OTHER SPECIALTIES			
AFF	Affiliated w/a group practice or DSO: Y- YES; N- No	3	Text	159-161
GROUP NAME	Name of the group practice or DSO	30	Text	162-191
COUNTY	Texas County where dentist office is physically located	25	Text	192-215

Filler	Med Lic. #	Last Name	First Name	MI	Address 1	Address 2	City	Zip	Spe c	Aff	Group Name	Count y
**		Smith	Jane	M	10 Medical Blvd Suite 250	25 Jones St.	Long view	75603	P	N		Gregg

B.6. **Reporting of Participating Specialty Care Dentists (PPO only).** The following is the format that **shall** be used to create the specialty care dentist network Excel file. The specialty care dentist network must be submitted in a separate worksheet on an Excel file.

Table 4 – Specialty Care Dentist Network – (12 Fields - Fixed Length)

Field Names	Description	Size	Type	Bytes
**	Filler Text	2	Text	1-2
LIC#	Dentist's License number assigned by the Texas Board of Dental Examiners	5	Text(alpha/numeric)	3-7
LAST NAME	Dentist's Last Name	30	Text	8-37
FIRST NAME	Dentist's First Name	25	Text	38-62
MIDDLE INITIAL	Dentist's Middle Initial	2	Text	63-64
ADDRESS 1	Street address of dentist's office (NO P.O. Boxes, Building Name, Suite #, or Floor)	30	Text	65-94
ADDRESS 2	Complete second location address including city and ZIP code	30	Text	95-124
CITY	City of dentist's office	25	Text	125-149
ZIP Code	Street address ZIP code of dentist's office	5	Number	150-154

SPECIALTY	E = Endodontics	4	Text	155-158
	O = Orthodontics			
	P = Periodontics			
	Pr = Prosthodontics			
	S = Oral Surgery			
	OTH- ALL OTHER SPECIALTIES			
AFF w/Group	Affiliated w/a group practice: Y- YES; N- No	3	Text	159-161
AFF w/Group	Affiliated w/a DSO: Y –YES; N- No	3	Text	162-164
GROUP NAME	Name of the group practice or DSO	30	Text	165-194
COUNTY	Texas county where dentist’s office is physically located	25	Text	195-219

Filler	Med. Lic.#	Last Name	First Name	MI	Address 1	Address 2	City	Zip	Spec	Aff	Group Name	County
**		Smith	Jane	M	10 Medical Blvd Suite 250	25 Jones St.	Longview	75603	P	N		

B.7. Respondent should direct any questions regarding these requirements to the iVendor mailbox at: ivendorquestions@ers.texas.gov during the question and answer period stated at RFP Section I.C.1.

B.8. **Documentation.** Supporting data for each service area submitted shall include:

B.8.a. The PPO shall provide map(s) that are comprised of complete counties boldly outlining each proposed service area.

B.8.b. Service area Excel file in ERS format, listing the counties for the proposed service area in separate folders on the Excel file (PPO component).

The file should be saved text or in Excel format.

C. Network Management Requirements – PPO and DHMO

C.1. **Network Management.** Respondent shall provide all services specified herein, including, but not limited to, the following:

C.2. Respondent shall provide initial and ongoing recruitment, credentialing and contracting with a sufficient number of qualified and duly licensed Dental Care Providers, as defined herein, in good standing with the State, to provide the full range of covered benefits and services in the network service areas. Respondent shall provide ongoing management of dental network providers in accordance with applicable laws, regulations, credentialing criteria, and provider contracting provisions.

C.2.a. Respondent shall provide initial and ongoing provider education to ensure that dental network providers are familiar with and knowledgeable of the benefits (including any benefit design changes) and other plan provisions.

C.2.b. Respondent shall provide ongoing review of the fees paid to dental network providers and recommend adjustments as appropriate, subject to consultation with and approval by ERS.

C.3. As it relates to the management of the dental network, Respondent shall provide ongoing utilization management, including monitoring and enforcement of compliance with dental protocol.

- C.4. As it relates to the management of the dental network, Respondent shall provide ongoing review of complaints received from Participants and providers and respond as necessary and appropriate; monitor the denials of benefits made under the utilization management program to maintain the appropriateness of the dental protocol; and provide information to ERS about the utilization management program as requested.
- C.5. When requested by ERS and continually throughout the length of the contract, selected vendor shall recruit additional dental providers for the network on a general, regional and/or specific basis.

IX. Scope of Work – Communication Requirements

This Article describes Respondent's requirements in communicating with Participants and potential Participants, employers, ERS staff, and other constituents, as further described herein. Respondent shall administer the Plans in a manner consistent with all applicable state and federal laws, regulations and Board Rules, and at the direction of the ERS Board, its Executive Director, and ERS staff. Any start-up costs and the cost of the requirements described herein shall be recovered by Respondent only by making provision for such expenses in Respondent's Price Proposal in **Appendix AA**.

The section allowing for Deviations and the Interrogatories for this Article can be found at **Appendix R**. Respondent shall complete and submit **Appendix R** as a part of its Proposal.

A. Program Specific Overview Requirements – PPO and DHMO

- A.1.a. Respondent's communication materials designed for the Participants cannot, and Respondent represents and warrants that it shall not, advertise or promote coverage, services, products or materials, other than those relating to Respondent's participation in the GBP Dental Program. Prior approval of all communication material's design and content shall follow a formal process that requires ERS' documented authorization. In all cases, Respondent is not allowed to disseminate materials or information relating to the Dental Programs without prior written ERS approval. The final materials used by Respondent shall not differ in form or utility from those approved by ERS. The communication requirements listed herein may not specifically apply to the Dental PPO or DHMO Provider. Respondent shall provide its communication requirement Deviations within **Appendix R**. Respondent shall provide the information that is only applicable to its Plan.
- A.1.b. In all cases, Respondent's communication materials, whether disseminated via the Internet, written, or in person, shall be in ERS' required format according to deadlines to be set by ERS and approved by ERS prior to dissemination. Respondent will be required to submit to ERS, for prior approval, draft copies of all proposed communications to include, but not be limited to: PowerPoint presentations, all scripts to be used by Respondent's CSRs and/or for presentations and newspaper/press releases, for SE or for any other GBP-specific purpose (as required in the latest version of the *Marketing Guidelines for GBP and Other ERS Vendors*). The final materials used by Respondent shall not differ in any way from those approved by ERS without ERS' permission. **Respondent shall provide all finalized communication materials as directed by ERS' BCom representative.**
- A.2. **Prohibition.** Respondent shall not discuss, advertise, distribute, or in any manner allude to coverage, products, or materials other than those approved by ERS. This prohibition also applies to the GBP-specific websites to be used by Participants.
- A.3. **Customized GBP-Specific Materials.** Respondent shall have the ability to develop and customize communication materials designed for Participants, State Agencies and higher education employers. Respondent shall provide this material electronically to ERS in a format that allows for electronic view of formatting and electronic editing.
 - A.3.a. GBP-specific materials shall be designed to ERS' specifications, which may include electronic, printed, and mailed newsletters, handouts, brochures, booklets, tutorials, video presentations, required letters and enrollment materials and forms. Respondent shall not distribute these communication materials until they have gone through a formal review process at ERS as discussed in RFP Sections IX.A.7. and IX.A.8. below.
 - A.3.a.i. In addition to the ERS-specific materials, ERS may suggest refinements to other materials and will work with Respondent to modify materials as needed. These include operating documents such as system-generated Participant letters, MBPD, claim approval and denial letters, other claims processing documents, promotional items and all other program communications.
 - A.3.b. Respondent shall customize communications as deemed necessary by ERS' BCOM representative.

- A.4. **Plain Language Requirement.** Respondent is responsible for a wide variety of communication materials explaining the Plans to Participants. ERS requires Respondent to comply with TDI's plain language requirements as outlined in the Tex. Admin. Code, Title 28, Part 1, Chapter 3, subchapter G § 3.602, and as amended in the future, for all communication materials. Material submitted to ERS for approval should be at the 8th-grade reading level with limited use of jargon. The material shall conform to ERS' branding and communication guidelines. In addition, the material shall be subject to editing and customization, including legal disclaimers and other standard language.
- A.5. **ADA and Section 508 Accessibility and Compliance.** Communication to Participants shall be clear and understandable, using terminology familiar to Participants, customized, as required by ERS, to conform with the benefit plan design and must be approved by ERS prior to dissemination. All Respondent communication materials shall meet ADA and Section 508 requirements for accessibility, including any amendment thereto.
- A.5.a. Communication material shall be available in both print and electronic forms. Certain communication material may be made available electronically, only as long as printed materials can be provided upon request to Participants. Accommodations shall be made for individuals with visual and/or hearing impairments in the development, production, and deployment of all communication materials, including information disseminated via the Internet that complies with ADA and Section 508.
- A.6. **Respondent Training Requirement.** Respondent's Account Management Team shall have designated and GBP-knowledgeable staff and resources available to provide training as needed to ERS staff, employers, and Participants. Training may be conducted in person in individual or group settings or via webcast or conference call. Training related to Respondent's internal operations shall be provided to ERS Customer Benefits, Benefit Contracts, and BCOM staff upon ERS' request. Staff training shall occur on an as-needed basis as specified by ERS throughout the year based on changes to operations or Plan design. Respondent should have resources sufficient to accommodate benefits coordinator training, SE and FE fairs, ERS hosted fairs and employer fairs each year. ERS must approve training agendas and materials for external training. Training will be designed to meet specific learning goals. Respondent should be able to provide web-based training in addition to in-person training.
- A.7. **Respondent Communication Materials.** BCOM shall assign a communications account manager to manage communication material for review and approval. Respondent shall assign a communications representative to work with the BCOM divisional designee(s), and this representative must be familiar with the applicable GBP program(s). Respondent shall provide communication strategy, maintain a log of communication activities, and attend regularly scheduled meetings with ERS to discuss communications and regularly review, revise and update, where necessary, all information contained on its website that relates to or may be used by any Participant. All communication materials must be approved by the BCOM divisional designee prior to Respondent sending, disseminating or otherwise providing such written or oral communications to any person or entity. On occasion, Respondent may obtain approval from the BCOM divisional designee(s) for a faster TAT, but this will be solely at the BCOM divisional designee's discretion.
- A.7.a. Respondent shall meet with ERS staff to devise a communication strategy that may or may not include documents submitted with the RFP.
- A.7.b. Respondent shall assign a dedicated communications specialist to meet and work with ERS staff to strategize, track, and produce the communication materials.
- A.8. **Communication/Marketing Material Review Process.** Communication materials are considered "approved" when a final, watermarked "printer's proof" or "test email" is delivered to ERS and subsequently approved by BCOM's divisional designee, in writing with a watermarked final version. Respondent may not alter a watermarked final version in any way without ERS' permission.
- A.8.a. Respondent shall provide copies of all final and approved materials in a binder for the Assistant Director of Benefit Contracts or designee's file.
- A.9. **Advertising and other Communications.** Respondent is required to obtain ERS' approval for all proposed newspaper, web, and social media advertisements used to promote GBP benefits programs.
- A.10. **Media Releases.** Unless required by law, Respondents are not authorized to make or participate in any media releases pertaining to this procurement, the bid, the Contract, or the services to which they relate without the prior written approval of ERS, and then only in accordance with explicit

written instructions from ERS. If required by law, Respondent shall first give written notice to ERS of such requirement. If contacted by the media, Respondent agrees to notify ERS' Assistant Director of Benefit Contracts, or designee, in lieu of responding immediately to such media inquiries.

- A.11. **Media Inquiries.** Respondent shall provide ERS with its process and protocols for responding to general media inquiries. Respondent shall notify ERS when it anticipates media coverage that could raise questions among Participants and other constituencies **before** the coverage is expected to occur. When appropriate, Respondent will work with ERS to develop answers to potential questions from Participants and other constituents before coverage occurs.

Information about Participants is considered confidential under Texas law. For media inquiries specifically related to Participants, Respondent shall follow the process outlined below:

- Respond to the media representative in a timely way, but only acknowledge receipt of the inquiry and provide an expected timeframe to respond more fully.
- Immediately provide a high-priority written notification to the Assistant Director of Benefit Contracts or designee, outlining all details related to the media's inquiry and all known facts of the related circumstances.
- Wait for instructions or, as needed, work with ERS to determine how to respond.
- Respond to the media as determined by ERS. (In many cases, ERS may respond to the media directly and request that Respondent not respond at all.)

- A.12. **Quality Control.** Respondent shall ensure that all communication materials submitted to ERS will reflect quality production, accuracy, timeliness, and thorough review. All GBP-approved benefit and legal documents, website content, GBP-specific media responses, required reports (to include *ad hoc* reports), and dated materials shall reflect the following criteria:

- Appropriate Fiscal Year or Calendar Year;
- Accurate data related exclusively to the GBP, unless otherwise specified by ERS;
- Appropriate GBP-specific language and standards as outlined in the ERS Marketing Guidelines for GBP and Other ERS Vendors; and
- Other information if requested by ERS.

- A.12.a. All such materials shall be provided within the required timelines as directed by ERS staff and/or its consultants and may not be released to outside sources without prior ERS consent.

- A.12.b. Following ERS' review and once edited materials have been provided to Respondent, Respondent shall conform to all documents by ERS' designated deliverable dates.

- A.13. **Requests for Communication Materials.** Respondent shall, at its expense, respond to all Participants' requests for mailed materials as stipulated within the Performance Guarantees, **Appendix G**. Communication materials include all Member facing communications including, but not limited to:

- Fliers;
- Brochures;
- Master Benefit Plan Document;
- Summary of Benefits;
- Welcome Packet;
- ID Cards;
- Member Letters; and
- FAQ's.

- A.14. **Respondent Name Change.** If a name change occurs for Respondent and results in a cost to ERS in publication, Respondent shall be billed for the amount of the expense.

- A.15. **State Agency Contacts.** Many of the two hundred seventy-five (275) State Agencies have a staff member dedicated to benefits enrollment and education called a BC. Respondent shall have resources dedicated to respond to BCs and other State Agency contacts. Respondent shall provide escalated customer service as well as training and educational presentations/materials to State Agencies throughout the year upon request.

- A.15.a. Respondent shall process requests from State Agencies for printed Plan communication materials for their employees at benefit fairs. Respondent shall also process requests from Participants for printed communication materials upon request. In addition, Respondent may be asked to provide materials to other organizations such as the Executive Women in Texas Government, the Texas

Association of State Human Resource Managers, the Texas Public Employees Association and the Texas State Employees Union, at Respondent's expense.

- A.16. **Presentations and Events.** Respondent shall have a GBP-knowledgeable representative available to attend numerous ERS-sponsored events throughout the year to include, but not be limited to:
- SE and FE fairs (additional resources will be needed during the enrollment period);
 - Wellness fairs;
 - Benefit seminars hosted by ERS throughout the State;
 - Various association events and conferences; and
 - Benefit webinars.
- A.16.a. ERS may ask that Respondent work directly with State Agencies, ERS, and other vendors to coordinate SE and FE fairs and other fairs.
- A.16.b. Respondent shall provide at least one (1) knowledgeable representative at every fair in locations throughout the State who is well versed in the Plans. At ERS' discretion, Respondent may be required to increase representation to (2) knowledgeable representatives at GBP SE/FE Fairs/Information meetings where the audience attendance is expected to exceed 100 attendees.
- If Respondent is preparing a response for both the Dental PPO and DHMO Plans, then be advised that attendance at GBP SE/FE Fairs shall be plan-specific. It is ERS' expectation that for each GBP SE/FE Fairs, Respondent shall provide separate representatives for the Dental PPO and DHMO plans; representatives will not be "shared" across dental plans, which reduce the number representatives available to Participants at GBP SE/SE Fairs.
- A.16.c. The dedicated resource(s) must be experienced presenters able to communicate effectively to large groups. Many events will require the representative(s) to set up and staff an information table to offer GBP-approved communication materials and individualized customer service.
- A.16.d. ERS' BCOM divisional designee(s) will designate those events for which Respondent's attendance is required. Respondent acknowledges and accepts that additional obligations and enhancements to these requirements may become necessary should benefit plan changes or other circumstances warrant.
- A.16.e. Respondent should be prepared to accommodate requests for attendance to non-ERS-sponsored events to promote the Plans.
- A.16.f. Respondent shall work with ERS, GBP employers and other vendors to coordinate attendance and resources for SE/FE and other fairs.
- A.17. **Enrollment Campaign.** Respondent shall create custom communication materials for each enrollment campaign. This material includes, but is not limited to:
- An enrollment presentation to be recorded and posted on the ERS website and delivered upon request at enrollment events;
 - Targeted enrollment communication brochures;
 - Welcome Letter to new Participants;
 - Brochures explaining Plan changes and updates;
 - Explanation of Benefits – Fact Sheet;
 - General Plan information; and
 - Enrollment information on Respondent's website.
- A.18. **Annual Enrollment Periods.** ERS conducts two (2) enrollment periods on an annual basis - SE and FE.
- A.18.a. The SE period for Active Employees and Retirees not eligible for Medicare to make changes to their GBP benefits elections will be held typically during the months of June, July and/or August. The effective date for these election changes is September 1st. Respondent shall have its enrollment materials and any other necessary documents prepared for SE no later than the first week in May of each year or as otherwise directed by ERS.
- A.18.b. During each SE, Members may elect coverage in either the Dental PPO or the DHMO. Members may also add or drop dependents from their coverage.

- A.18.c. The FE period for Medicare-eligible Retirees to make changes to their GBP benefits elections will be held typically during the month of November. The effective date for these changes is January 1st. Respondent shall have its enrollment materials and any other necessary documentation prepared for FE no later than the first week of September of each year or as otherwise directed by ERS.
- A.18.d. Participants are responsible for their own benefit elections. Benefits enrollment for Participants is made available via online access and by contacting ERS during the SE/FE period. Participants may be asked to complete a paper form for reporting a QLE.
- A.19. **Fair/Event Schedule.** In 2017 for Plan Year 2018, ERS held 40 Summer Enrollment fairs and will hold nine (9) Fall Enrollment fairs throughout the State. GBP Contract Vendors are expected to attend and provide written materials in support of these enrollment fairs.
- A.20. **Annual Enrollment Communications.** ERS currently conducts the following comprehensive communications tactics for each enrollment period discussed previously at RFP Section IX.A.18.:
- Multiple statewide enrollment fairs that include participation by vendors of specific GBP Programs;
 - Enrollment presentations to be delivered at enrollment fairs and recorded and posted on ERS' website;
 - Targeted enrollment communication booklets;
 - Personalized enrollment statements with information on each Participant's current enrollments and programs they are eligible to participate in;
 - Brochures/handouts explaining Plan changes and updates;
 - Mail-in enrollment forms;
 - Information on how to make enrollment changes/elections online, with the help of their State Agency BC, via phone or by mail; and
 - General Plan information.

ERS' BCOM divisional designee(s) will provide the dates and times of the SE/FE fairs when they become available.

B. Ongoing Member Communications Requirements – PPO only

- B.1. Respondent shall provide a dedicated communication specialist(s) to meet and work with ERS staff to produce the communication materials during the implementation process.
- B.2. Respondent shall provide communication materials to ERS during the implementation process and on an as-needed basis throughout the Contract Term, which must allow ERS to customize formatting, language, and content, as well as make certain communication materials available in printed copies. ERS' current ongoing communication materials include, but are not limited to:
- Master Benefit Plan Document;
 - Member Handbook;
 - Welcome packet;
 - Brochures and newsletters;
 - Respondent's GBP-specific website;
 - Presentations;
 - Annual Enrollment and Welcome letters;
 - Provider directory, including specific disclaimer stating that the list of providers is subject to change.
 - Standard messaging for various systems' downtime;
 - Announcement letters;
 - Consumer-targeted educational materials;
 - News releases/Contract signing announcements;
 - All advertising materials in association with the Dental Plans;
 - Annual HIPAA exemption notice and benefit changes summary;
 - Articles for ERS newsletters;
 - News updates for ERS website;
 - *Ad hoc* publications;
 - Token giveaways for enrollment fairs and events; and
 - Other related statements.

- B.2.a. Respondent shall work with ERS staff to produce the MBPD subsequent to the Contract award. The web version shall not differ from that approved by ERS and published on Respondent's GBP-specific website.
- B.2.b. Respondent shall disseminate only GBP-specific approved materials at all events. Disseminating unapproved material, or material that is not customized for GBP Participants, could result in the levying of Performance Guarantees as referenced in **Appendix G** and/or other legal remedies available to ERS in the Contract.
- B.2.c. Any cost for these forms and other communication-related materials should be included as a part of Respondent's proposed administrative fees and/or premium rates. ERS shall retain the right to change or modify such material to accommodate ERS' specific needs.
- B.3. Respondent may in the future be asked to design and/or print certain ERS communication materials on behalf of ERS. These materials are in addition to the communication materials that Respondent must produce as part of the Contract and must be approved by ERS in advance of such printing in accordance with ERS' previously described format review process. Each year, Respondent will secure a print/fulfillment vendor on ERS' behalf and invoice ERS when the printing job is completed.
- B.3.a. These tasks include, but are not limited to:
- Setting print/fulfillment bid specifications with assistance from ERS staff.
- B.4. **Confidential Information.** Materials that contain protected health information (as defined by HIPAA) or other confidential information such as the Participant ID number must be mailed in an envelope or other mailing service device designed to secure the confidential information from casual viewers.
- B.5. **Master Benefit Plan Document and Member Handbook.** The Dental PPO shall provide to the Assistant Director of Benefit Contracts or designee:
- **Master Benefit Plan Document.** The Dental PPO shall provide for FY20 the MBPD draft with its Proposal and by the first business day in April for subsequent plan years for ERS' review. See the MBPD *describing the State of Texas Dental Choice PlanSM* referenced at: <http://apps.humana.com/marketing/documents.asp?file=1767584> to use in preparation of Respondent's MBPD draft.
 - **Member Handbook.** The Dental PPO shall provide a draft of the Member Handbook with its Proposal and a final draft version by April 15 for ERS' review. See the *Member Handbook for the Dental PPO*, to use in preparation of Respondent's Member Handbook, as referenced at: <http://apps.humana.com/marketing/documents.asp?file=2820610>.
- The Member Handbook is comprehensive benefit plan summaries that interpret the MBPD for Participants in layman's terms. This is the primary reference source for Participants explaining the plan design and covered benefits.
- The Dental PPO is required to provide the MBPD and Member Handbook along with any supplemental information and/or their amendments within thirty (30) calendar days of ERS' request and by the first business day in April for subsequent plan years of the plan year as appropriate.
- B.6. **Master Benefit Plan Document Approval/Delivery Requirements.** The Dental PPO shall submit a proposed MBPD on a separate CD-ROM or USB Thumb Drive for ERS' review and approval with its Proposal. The Dental PPO shall work with ERS to finalize all plan documents no later than August 1st of each plan year unless directed otherwise by ERS. ERS requires the MBPD be printed only at the request of a Participant; therefore, the final printed product shall not differ from that approved by ERS and published on the Dental PPO's GBP-specific website.
- B.6.a. The Dental PPO shall provide a finalized and executed MBPD to the Benefit Contracts' Assistant Director no later than sixty (60) calendar days prior to the start of each plan year, and once executed shall make it available on the GBP-specific website within five (5) business days of receiving approval by ERS. The Dental PPO shall follow ADA guidelines and provide an HTML version and printable version for download by the Participant.
- B.6.b. All Participants shall have access to the MBPD as directed herein or as instructed by ERS. The Dental PPO shall be prepared to mail the MBPD upon the request of a Participant no later than five

(5) business days. The Dental PPO understands, agrees and acknowledges that the Contract between ERS and Respondent shall control over the MBPD.

B.6.c. Subsequent to Annual Enrollment, the Dental PPO shall mail the MBPD within five (5) business days of the transfer of the final enrollment file at the end of Annual Enrollment, but no later than the date to be announced. For on-going MBPD requests, the Dental PPO shall send the MBPD to current membership, including dependents, when a change is reported, within five (5) business days after Respondent receives the enrollment information.

B.7. **PPO Welcome Packets.** The Dental PPO's packets shall be produced for FY20 by the selected Dental PPO and mailed to approximately 285,000 GBP Participants during Annual Enrollment at ERS' direction. The Welcome Packet is mailed to new Participants following initial enrollment. The Dental PPO shall coordinate with other appropriate GBP Vendors as appropriate to provide supplementary program information to be included in the Welcome Packets. New enrollment packets shall be mailed by the Dental PPO throughout all plan years to new hires. A proposed sample of a Dental PPO packet used to identify the Dental PPO to the GBP Dental Program Participants shall be included in the Dental PPO's Proposal. This packet should contain, but not be limited to, the following materials:

- Welcome Letter;
- Fact Sheet;
- Benefits Summary;
- Information on value added benefits;
- Respondent's customer service contact information;
- Provider directory;
- HIPAA Exemptions; and
- Sample EOB.

B.8. **PPO Annual Enrollment or Welcome Letter.** The Welcome Letter should contain information about the Dental PPO and announce any plan changes from the previous plan year. The communication piece shall contain instructions on how to access information and forms using the website and include the customer service address, phone numbers, and hours of operation. The Dental PPO's Welcome Letter shall be available at the same time the two page Fact Sheets are available to BC's.

B.9. **Plan Fact Sheet.** The Fact Sheet shall consist of no more than two (2) front and back, 8.5 x 11 size pages. Once the Fact Sheet contents are approved by the BCOM divisional designee, Respondent shall distribute to employees through BCs (date to be announced) and shall be mailed directly to the Participant by Respondent within five (5) business days of their request. Respondent agrees to reflect all Fact Sheet information on the GBP-specific website as further outlined herein.

The Plan Fact Sheet shall include, but not be limited to, the following information:

- Respondent's Customer Service contact information, including the phone numbers, email and physical address, and hours of operation;
- ERS' website address; and
- Respondent's URL to Privacy Policy.

B.10. **PPO Identification ("ID") Cards.** The Dental PPO Respondent shall issue the ID cards in accordance with RFP Sections IX.B.10. – IX.B.10.c.

Respondent shall issue ID cards to all new Participants, including dependents, who enrolled during Annual Enrollment and subsequent to Annual Enrollment, when a change is reported. Respondent shall refer to RFP Section XII.B.12 for more detail regarding these requirements.

B.10.a. Respondent shall provide a toll-free customer service number. Respondent shall submit an electronic mock-up of a proposed GBP-specific ID card with Respondent's Proposal. Failure to produce GBP-specific ID cards as outlined herein may result in a monetary assessment as reflected in the Performance Guarantees, **Appendix G** and/or other legal remedies available to ERS in the Contract.

B.10.b. ID card delivery requirements are fully discussed at RFP Section XII.B.12., Operational Specifications.

B.10.c. Respondent is responsible for the production and any mailing costs associated with the delivery of ID cards to Participants. Additional ID card requirements are located in RFP Section XII.B.12,

Operational Specifications. The cost of the ID card requirements described herein shall be recovered by Respondent only by making provisions for such expenses in Respondent's Price Proposal in **Appendix AA**.

- B.11. **PPO Provider Information.** No provider may be listed on Respondent's website or distributed to the program Participants through Respondent's customer service unless a signed Contract with the provider is in place. In the event Respondent provides incorrect information and a Participant seeks dental treatment based on that information, Respondent agrees to recognize and be financially responsible for any services rendered by that provider, under the terms of the Contract, as if the provider had been under Contract.
- B.12. **PPO Provider Directories.** Respondent shall not be required to provide printed versions of its Provider Directories, but copies (or materials which become stale dated at the time of printing) shall be provided to the GBP Participant upon request and such hard copy material(s) shall be **received** by the Participant no later than seven (7) business days from the date of request. In addition, a published Directory shall be accessible at all times online.

C Ongoing Member Communications Requirements – DHMO only

- C.1. Respondent shall provide a dedicated communication specialist(s) to meet and work with ERS staff to produce the communication materials during the implementation process.
- C.2. Respondent shall provide communication materials to ERS during the implementation process and on an as-needed basis throughout the Contract Term, which must allow ERS to customize formatting, language, and content, as well as make certain communication materials available in printed copies. ERS' current ongoing communication materials include, but are not limited to:
- Evidence of Coverage;
 - Welcome packet;
 - Brochures and newsletters;
 - Respondent's GBP-specific website;
 - Presentations;
 - Annual Enrollment and Welcome letters;
 - Provider directory, including specific disclaimer stating that the list of providers is subject to change.
 - Standard messaging for various systems' downtime;
 - Announcement letters;
 - Consumer-targeted educational materials;
 - News releases/Contract signing announcements;
 - All advertising materials in association with the Dental Plans;
 - Annual HIPAA exemption notice and benefit changes summary;
 - Articles for ERS newsletters;
 - News updates for ERS website;
 - *Ad hoc* publications;
 - Token giveaways for enrollment fairs and events; and
 - Other related statements.
- C.2.a. Respondent shall disseminate only GBP-specific approved materials at all events. Disseminating unapproved material, or material that is not customized for GBP Participants, could result in the levying of Performance Guarantees as referenced in **Appendix G-1** and/or other legal remedies available to ERS in the Contract.
- C.2.b. Any cost for these forms and other communication-related materials should be included as a part of Respondent's proposed administrative fees and/or premium rates. ERS shall retain the right to change or modify such material to accommodate ERS' specific needs.
- C.3. Respondent may in the future be asked to design and/or print certain ERS communication materials on behalf of ERS. These materials are in addition to the communication materials that Respondent must produce as part of the Contract and must be approved by ERS in advance of such printing in accordance with ERS' previously described format review process. Each year, Respondent will secure a print/fulfillment vendor on ERS' behalf and invoice ERS when the printing job is completed.
- C.4. **Confidential Information.** Materials that contain protected health information (as defined by HIPAA) or other confidential information such as the Participant ID number must be mailed in an

envelope or other mailing service device designed to secure the confidential information from casual viewers.

- C.5. **DHMO - Evidence of Coverage.** The DHMO understands, agrees and acknowledges that the Contract between ERS and the DHMO shall control over the EOC in connection with the contractual relationship between ERS and the DHMO. The EOC shall provide a detailed description of a Participant's benefits for the fiscal year, explain a Participant's rights and provide the rules to follow when using the DHMO coverage for dental care. As such, the DHMO is required to make the EOC available to Participants in both electronic and printed formats.
- C.5.a. The DHMO is required to produce a printed EOC for FY20 as well as to publish it on its GBP-specific website. The DHMO shall submit a proposed EOC on a separate CD-ROM (in Word or Excel document, no PDF documents will be accepted) and include a sample ID card in its Proposal materials. The DHMO currently participating in the GBP shall submit a version with tracked changes of their proposed EOC with its Proposal materials using their current GBP EOC as the starting point. The tracked change version shall indicate ALL proposed revisions.
- C.5.b. A DHMO's failure to provide a tracked change version of their proposed EOC for the upcoming fiscal year may result in a monetary assessment as reflected in the Performance Guarantees, **Appendix G-1** and/or other legal remedies available to ERS in the Contract. Once the EOC has been reviewed by ERS and all edits made, the EOC shall be submitted to TDI for approval. All EOC modifications required by TDI shall be provided to ERS, as well as any subsequent EOC revisions occurring during the fiscal year. The DHMO shall inform ERS in writing once the EOC has received TDI approval. ERS requires that printed copies of the TDI-approved EOC be immediately available to requesting Participants within three (3) business days of TDI approving the document, but no later than forty-five (45) calendar days following the start of the fiscal year. The final published EOC posted on the DHMO's GBP-specific website shall not differ from that which was approved by TDI and provided to Participants in printed form.
- C.5.c. The EOC shall include an identical copy of the Summary of DHMO Benefits, as described in this document, a complete list of limitations and exclusions, including all plan provisions and the TDI-approved member complaint and appeal process. The DHMO is required to include the GBP-specific eligibility rules as found in the Board of Trustee Rules, Tex. Admin. Code, Title 34, Part 4, § 81.5.
- C.6. **DHMO EOC Approval/Delivery Requirements.** A proposed, final draft of the DHMO's EOC for FY20 shall be published and reflected in the DHMO's test website available thirty (30) days prior to AE. The DHMO's EOC revisions, as requested by ERS, shall be complete and all information accurately reflected on the live DHMO's website by the first business day of July or the DHMO risks a monetary assessment as reflected in the Performance Guarantees, **Appendix G-1** and/or other legal remedies available to ERS in the Contract.
- C.6.a. The DHMO shall submit its finalized EOC to TDI so that one (1) disc version (in Word or Excel format, no PDF documents will be accepted) of the DHMO's FY20 EOC shall be received by ERS' Benefit Contracts division no later than forty-five (45) calendar days following the start of the fiscal year.
- **New Enrollees.** The EOC shall be mailed to all new enrollees who request a printed copy within five (5) business days after the DHMO receives the Participant's request. For all other purposes, the EOC's publication on the DHMO's website shall be provided as required herein.
 - **Current DHMO Membership.** Within thirty (30) days following TDI's approval, the EOC and applicable amendments shall be published on the DHMO's website and shall be mailed within five (5) business days to all currently enrolled Participants if a printed copy is requested.
- C.7. **DHMO Member Handbook.** The Dental DHMO shall provide to the Assistant Director of Benefit Contracts or designee a draft of the Member Handbook with its Proposal and a final draft version by April 15th for ERS' review. See the *Member Handbook for the Dental DHMO*, to use in preparation of Respondent's Member Handbook, as referenced at: <http://apps.humana.com/marketing/documents.asp?file=1384331>. The Member Handbook is comprehensive benefit plan summaries that interpret the EOC for Participants in layman's terms. This is the primary reference source for Participants explaining the plan design and covered benefits.
- C.8. **DHMO Annual Enrollment or Welcome Letter.** The Welcome Letter should contain information about the DHMO. For the currently participating DHMO, an Annual Enrollment letter announcing

any benefit changes from the previous year, shall be mailed to the current membership one (1) week prior to the start of the new fiscal year. The Welcome Letter shall contain instructions on how to access information and forms using the website, and include the customer service address, phone numbers, and hours of operation. The DHMO shall not utilize a postcard or flyer format for the Welcome Letter. For new GBP DHMO, the Welcome Letter should provide Participants with general information about the DHMO's benefit designs, including customer service address, phone numbers, and hours of operation. The DHMO's Welcome Letter should be available at the same time the two-page Fact Sheets are available to BCs.

- C.9. **Plan Fact Sheet.** The Fact Sheet shall consist of no more than two (2) front and back, 8.5 x 11 size pages. Once the Fact Sheet contents are approved by the BCOM divisional designee, Respondent shall distribute to employees through BCs (date to be announced) and shall be mailed directly to the Participant by Respondent within five (5) business days of their request. Respondent agrees to reflect all Fact Sheet information on the GBP-specific website as further outlined herein.

The Fact Sheet shall include, but not be limited to, the following information:

- Respondent's Customer Service contact information, including the phone numbers, email and physical address, and hours of operation;
- ERS' website address; and
- Respondent's URL to Privacy Policy.

- C.10. **DHMO Identification ("ID") Cards.** The DHMO Respondent shall issue the ID cards in accordance with RFP Sections IX.C.10. – IX.C.10.c.

Respondent shall issue ID cards to all new Participants, including dependents, who enrolled during Annual Enrollment and subsequent to Annual Enrollment, when a change is reported. Respondent shall refer to RFP Sections XII.C.6. – XII.C.6.c. for more detail regarding these requirements.

- C.10.a. Respondent shall provide a toll-free customer service number. Respondent shall submit an electronic mock-up of a proposed GBP-specific ID card with Respondent's Proposal. Failure to produce GBP-specific ID cards as outlined herein may result in a monetary assessment as reflected in the Performance Guarantees, **Appendix G-1** and/or other legal remedies available to ERS in the Contract.

- C.10.b. ID card delivery requirements are fully discussed at RFP Sections XII.C.6. – XII.C.6.c., Operational Specifications.

- C.10.c. Respondent is responsible for the production and any mailing costs associated with the delivery of ID cards to Participants. Additional ID card requirements are located in RFP Sections XII.C.6. – XII.C.6.c., Operational Specifications. The cost of the ID card requirements described herein shall be recovered by Respondent only by making provisions for such expenses in Respondent's Price Proposal in **Appendix AA**.

- C.11. **DHMO Provider Information.** No provider may be listed on Respondent's website or distributed to the program Participants through Respondent's customer service unless a signed Contract with the provider is in place. In the event Respondent provides incorrect information and a Participant seeks dental treatment based on that information, Respondent agrees to recognize and be financially responsible for any services rendered by that provider, under the terms of the Contract, as if the provider had been under Contract.

- C.12. **DHMO Provider Directories.** Respondent shall not be required to provide printed versions of its Provider Directories, but copies (or materials which become stale dated at the time of printing) shall be provided to the GBP Participant upon request and such hard copy material(s) shall be **received** by the Participant no later than seven (7) business days from the date of request. In addition, a published Directory shall be accessible at all times online.

D. Website Specifications Requirements- PPO and DHMO

- D.1. **GBP Customizable Website.** Respondent shall publish and maintain a custom website for GBP Participants and prospective Participants in a format prescribed by ERS. Neither Respondent nor its subcontractors can advertise or link to products or services without the express prior written permission of the BCOM divisional designee.

The GBP website shall be directly linked to the ERS homepage. The GBP website shall be in final form and linked as required by ERS no later than the last week of June of each year or otherwise directed by ERS. Respondent's failure to provide the GBP-specific website as outlined below may result in a monetary assessment as reflected in the Performance Guarantees, **Appendix G** and/or other legal remedies available to ERS in the Contract.

- D.1.a. Respondent shall ensure that its Plan specific website will be functioning by the date specified by ERS.
- D.2. **Proposed Content for Customizable Website Materials.** Respondent shall work with ERS to determine the website development and "go live" timeline for the Plan's configurable website. Respondent shall provide ERS with a website development and "go live" timeline, requirements document, website frames and website manuscript detailing all the content to be used throughout the website for review. Respondent shall work with ERS to finalize the web frames and content by the agreed upon due dates.
- D.3. **Respondent Customizable "Test" website.** Once the agreed upon content for the customizable website is placed in Respondent's test or development site, Respondent shall provide ERS with a link, username and password to review the site. Respondent shall provide ERS with a test site for review at a time to be determined by ERS. The website should be linked to the ERS website with all information and components. Respondent's test website shall transition from a test phase to fully operational as agreed upon between ERS and Respondent.
- D.3.a. Respondent's GBP-specific home page shall include the following primary access links:
- Respondent's Privacy Plan;
 - Customer Service contact information;
 - Member Handbook;
 - Benefits brochure;
 - Coverages;
 - Limitations and exclusions;
 - Forms;
 - Master Benefit Plan Document;
 - EOC;
 - Provider directory;
 - A page for frequently asked questions;
 - A glossary of frequently used terms;
 - On demand real time provider information and search capabilities;
 - Search function; and
 - Link to ERS website.
- D.3.b. Respondent's custom home page shall include both Respondent's logo and ERS' logo as required by the latest version of the *Marketing Guidelines for GBP and ERS Vendors*.
- D.4. **GBP Configurable Claims Website.** Respondent shall publish and maintain a configurable claims website. This website should contain applicable Participant account information. Neither Respondent nor its subcontractors can advertise or link to products or services without the express prior written permission of the BCOM divisional designee.
- D.5. **Proposed Content for Configurable Website.** Respondent will be required to submit a URL address, all screen shots, and instructions on how to access Respondent's test website that allows ERS to perform a due diligence review of Respondent's claims site prior to implementation. Respondent shall provide a live demonstration of the site's functionality to ERS staff. Respondent shall also provide a link with a dummy username and password to the configurable test website for ERS' independent review. Respondent shall provide documentation of a test plan, test scripts (i.e., to ensure all links are working), completion of testing, and final sign off. Respondent's test website shall transition from a test phase to fully operational as agreed upon between ERS and Respondent.
- D.6. **Respondent Website Technical Specifications.** Respondent shall adhere to all website access, format, content, and technical requirements outlined in both the ADA and Section 508.
- D.7. **Section 508 Compliance and Accessibility.** Respondent shall comply with Section 508. Participants with disabilities must have access to and use of information and data that is comparable to the access to and use of information and data by Participants who do not have

disabilities. All Participants should get a full and complete understanding of the information contained on Respondent's website as well as the full and complete ability to interact with the site.

D.7.a. If Respondent is not currently Section 508 compliant, Respondent shall provide a timeline indicating when it will implement these requirements in **Appendix R**, Sections F.2.b. and M.2.b.

D.8. **Internet Accessibility Specifications.** In addition to ADA and Section 508 requirements, Respondent shall adhere to the following website guidelines: Respondent's website should be supported on HTML5 compliant browsers and compatible with a wide spectrum of web browsers, including:

- Internet Explorer 9.0 or newer;
 - Google Chrome;
 - Mozilla Firefox; and
 - Apple Safari 9.0 or newer.
- A method shall be provided that permits users to skip repetitive navigation links.
 - Documents should be organized so they are readable by a screen reader.
 - Tables must have appropriate column and row headers. Markup shall be used to associate data cells and header cells for data tables.
 - Site must be understandable when JavaScript is turned off.
 - If you use Flash content, alternatives to access the information must be provided.
 - All images must have alternate text that is descriptive.
 - Online forms must allow people using assistive technology to access the information, field elements, and functionality required for completion and submission of the form, including all directions and cues. This should not be mouse dependent.
 - When a timed response is required, the user shall be alerted and given sufficient time to indicate more time is required.
 - Recommend that testing be done for broken links. All links should have appropriate text to convey where the link will go. Do not use "click here."

D.8.a. If applicable, Respondent must ensure the products procured by ERS under the Contract comply with the State Accessibility requirements for electronic and information resources specified in 1 Tex. Admin. Code Chapter 213.

D.8.b. Respondent's GBP-specific home page shall include the GBP dental plan logo and the ERS logo as required by the latest version of the Marketing Guidelines for GBP and ERS Vendors, located in the ERS Editorial Style Guide and Usage Manual, **Appendix T**, and the ERS Brand Guidelines, **Appendix T**.

D.8.c. The final approved Respondent website shall provide real-time data related to the dental provider network. Participants shall be capable of obtaining the same information using the website as they would if they were to contact a Respondent CSR.

E. Respondent Website Content Requirements – PPO and DHMO

E.1. **Customizable Plan Website.** All content for the GBP customizable website shall be approved by ERS prior to publication. The website must be functioning prior to SE and no later than the first week of May for SE, or as otherwise directed by ERS. The final materials used by Respondent shall not differ in form or utility from those approved by ERS. Respondent's customizable website shall include the following:

E.2. **Plan Year Information.** The custom home page shall include the following information:

- Information that welcomes new Participants and introduces the Participant to Respondent and summarizes the basic coverage benefits;
- Direct link to ERS' website;
- Current dates and other information for SE (with removal of this information from the site based on seasonal needs, as directed by ERS); and
- Helpful phone numbers and websites.

E.3. **Link to Provider Look-Up and/or Provider Directory** to include following information:

- Instructions on selecting a PCD;

- Provider Look-up shall be updated real-time. Users should be able to search by ZIP code and get a map and directions to the provider's office. It should indicate that the provider is: a PCD or specialist and indicate network affiliation; (i.e., independent vs. group practice) and if he or she is accepting new patients. Each PCD shall have an assigned unique office or provider code number. Respondent shall include a disclaimer that providers are subject to change; and
- Instructions on how to change designated PCD.

E.4. **Link to Respondent's Privacy Plan**

E.5. **Link to Customer Service Page** to include the following information:

- Phone numbers and hours of operation;
- Physical address of Plan site;
- Link to Respondent's Complaint Process;
- An email address or a link to a mailbox for Participants to send customer complaints and questions directly to Respondent. Respondent should respond to email complaints/inquiries by the end of the next business day. A tracking system for email complaints shall be in place that is similar to the tracking of telephone complaints that provide complaint responses to ERS;
- Any applicable interactive forms (i.e., claims forms);
- Link to Plans' Appeals/Grievance process; and
- Any applicable fillable forms.

E.6. **Link to Benefits** to include the following information:

- Annual Enrollment or Welcome Letter stating changes (if applicable) from the previous year;
- Master Benefit Plan Document;
- EOC, including any riders to comply with the Schedule of Dental Benefits. The EOC shall contain the policies and exclusions as required by TDI. The FY20 EOC shall be published on the website within thirty (30) business days after TDI's approval; and
- Member Handbook.

E.7. **Link to resources such as:**

- Access videos, tutorials, and other educational materials;
- Fact Sheets; and
- Brochures.

E.8. **The ability for Participants to:**

- Log into their online account with Respondent;
- Search the full website using a key word and/or phrase;
- Review Frequently Asked Questions and Answers;
- Review overviews of each GBP Program, including Dental program information;
- View the Plans and/or ERS logo;
- Find the GBP-dedicated phone number; and
- Provide a link that returns the viewer to the ERS home page.

E.8.a. **Configurable website content:** Respondent's configurable website shall include, but not necessarily be limited to, the following:

The ability for Participants to conduct self-service transactions to:

- Locate a PCD based on specific geographic requirements;
- Easily access Participant account information including claim information;
- Print fillable forms;
- Lodge a service complaint to escalate unresolved complaints and to request a telephone call back within one (1) business day;
- See and print an annual summary of out-of-pocket expenses for dental services, suitable for submission to the Internal Revenue Service for income tax purposes and to the flexible benefits administrator for Section 125 claims;
- Communicate with CSR using live chat, if available;
- Search the full website using a key word and/or phrase;
- Review Frequently Asked Questions and Answers;
- Review overviews of each GBP Program, including Dental program information;
- View the Plans and/or ERS logo;
- Find the GBP-dedicated phone number;

- Log out; and
- Provide a link that returns the viewer to the ERS home page.

E.8.b. Respondent shall not reference any web address other than the ERS-specific website, and confirms that it will provide a GBP-dedicated toll-free customer service number.

X. Scope of Work – Information Systems Requirements

This Article describes the Information Systems Requirements including data access restrictions, security practices, business resumption and data center facilities. Respondent shall administer the Plans in a manner consistent with all applicable state and federal laws and regulations, as well as the Board Rules and at the direction of the ERS Board, its Executive Director, and ERS staff. The cost of the requirements described herein shall be recovered by Respondent only by making provisions for such expenses in Respondent's Price Proposal in **Appendix AA**.

The section allowing for Deviations and the Interrogatories for this Article can be found at **Appendix U**. Respondent shall complete and submit **Appendix U** as a part of its Proposal.

A. Operations Requirements – PPO and DHMO

- A.1. Respondent understands, acknowledges and agrees that all operations, staff and facilities being proposed in support of the Contract will be located onshore within the United States.
- A.2. All products and related services, including, but not limited to, access to and retention of ERS and Participant-related data, shall be done and performed solely within the United States.
- A.3. Respondent agrees that: (1) data relevant to the administration of this program will not be transmitted outside of the United States, (2) no one outside the United States will have access to ERS' or Participant's confidential information, and (3) ERS' and Participant information is not viewable outside of the United States, in the fulfillment of contracted services. However, individual member accounts may access their personal accounts from outside the United States.
- A.4. Respondent agrees that all development activities (including production, quality control and testing) are performed solely within the 50 states of the United States and exclusively in Respondent's facilities, or in contracted facilities meeting the requirements of the RFP, including assessments by ERS during the Contract Term.
- A.5. Respondent's subcontractors or independent contractors will prevent any person or entity located outside the United States from having access to any and all ERS, GBP, and program information, including, but not limited to, confidential or Participant-related information and data, in the fulfillment of contracted services.
- A.6. In the event ERS provides Respondent with the opportunity to view ERS' enrollment system through web access, Respondent shall have the capabilities in place to support this access, to include, but not be limited to:
- Access ERS' enrollment data via web access sixty (60) days prior to the go-live date;
 - Utilize the enrollment information to assist in the verification of coverage; and
 - Provide customer service staff proficient with the web access to ERS enrollment data during all ERS-designated customer service hours.
- A.7. Respondent shall be required to have site-to-site secure VPN tunnel capability using Internet Protocol Security between Respondent's data center(s) and ERS, or other GBP Contracted Vendors and Employers for selected data.
- A.8. Texas Business and Commerce Code 521.001, *et seq.* Respondent shall comply with the Identity Theft Enforcement and Protection Act as required therein.
- A.9. All of ERS' data and metadata, as created, maintained and supported by Respondent, shall at all times remain the property of ERS notwithstanding the fact that such records may be stored upon or within one (1) or more computer or data retention systems owned, operated, or leased by Respondent. ERS is entitled to a full data model for such data.
- A.10. Respondent shall maintain a complete and accurate reporting system, and provide for the retention, maintenance, and storage of all Respondent, other GBP Contracted Vendors and Participant records for appropriate reporting to ERS on a quarterly basis. Respondent shall securely maintain

all such records in accordance with the Contractual Agreement, and shall make such records accessible and available to ERS for inspection and audit upon ERS' request.

- A.11. In the event Respondent is scheduled to destroy records in advance of the Contract retention period, Respondent shall contact ERS for approval prior to the destruction of the records. If ERS approves destruction, verification of the destroyed records shall be required at ERS' direction. Upon ERS' request, an archival copy of records must be delivered to ERS before destruction by Respondent.
- A.12. At all reasonable times, ERS or its representatives shall have fully documented access to all of Respondent's ERS records. To the extent that any such records are to be maintained upon a computer system or any other data retention system, which is not owned by Respondent, Respondent shall provide ERS with assurances from the owner of such computer facilities, satisfactory to ERS, of continued availability and security of such records at all times. ERS must be permitted to personally inspect such facilities and systems.
- A.13. Respondent shall provide monthly updates on planned changes for standard updates to hardware and software components, and specify in detail how any such planned changes or updates will affect the end users. These notifications shall be sent to ERS on a scheduled day each month. Respondent is required to notify ERS of all such changes at least fourteen (14) days in advance of making such changes. All significant software (that is, major software releases, e.g. 3.X to 4.X) or hardware upgrades require a sixty (60) day prior notification to ERS.
- A.14. Respondent shall guarantee that the Internet Availability Rate for each Fiscal Year shall be that required in the Performance Guarantees, attached hereto as **Appendix G** for PPO and **Appendix G-1** for DHMO.
- A.15. Respondent shall provide testing environments for all circumstances utilized prior to rolling out program changes that run the logic to achieve predicted outcomes of programming prior to pushing-out a new process or enhancement/modification of an existing program.
- A.16. Respondent shall not implement any major system and/or platform changes during the implementation period and/or other critical time periods as identified by ERS (such as annual enrollment,) without ERS' prior written consent.
- A.17. Respondent shall provide ERS with priority positioning for delivery of *ad hoc* system service requests, website modifications, and/or issue resolutions. Respondent shall designate a Technical Consultant to lead the management of all technical issues, including, but not limited to, system service requests. The TC shall ensure that all ERS system requests and issues are thoroughly analyzed and given priority positioning to ensure prompt resolution. Respondent shall provide competent, focused attention to ERS' system requests/issues. Respondent shall use its best efforts to implement all ERS system requests and to correct all ERS system issues as soon as reasonably practicable, but in no event later than thirty (30) calendar days from receipt of ERS' written notification to Respondent of the request/issue. ERS shall fully supply any and all information reasonably necessary for Respondent to complete the requested services as outlined herein. If an ERS request cannot be implemented by Respondent within thirty (30) calendar days from the date of ERS' request, then Respondent shall provide ERS with a written explanation as to why the issues cannot be resolved within this timeframe and provide ERS with a written plan for implementation, to include a timeline for resolution, within five (5) business days from receipt of Respondent's written notification as noted above. These requirements do not apply to disaster recovery matters.

An example of a system issue includes, but is not limited to:

Eligibility and/or benefit modifications shall be reviewed, responded to, and approved by Respondent within fifteen (15) business days of such request. If changes to the modifications are required, Respondent shall notify ERS and set up weekly updates until ERS agrees that the modifications meet ERS' operating requirements. After eligibility and/or benefit modifications have been mutually agreed upon, Respondent shall complete the eligibility and/or benefit project, including required testing, within forty-five (45) calendar days from ERS' approval.

- A.18. **Testing Prior to Rolling Out Program Changes.** Respondent shall provide testing environments for all circumstances utilized prior to implementing program changes that run the logic to achieve predicted outcomes of programming prior to pushing-out a new process or enhancement/modification of an existing program.
- A.19. **XML.** Respondent shall be prepared to provide ERS with XML-tagged content for purposes of extracting content on Respondent websites through "feeds."

- A.20. Respondent shall act in good faith and cooperate with ERS in the implementation of a SSO environment with respect to ERS' external website and Respondent's website. As further described in the Contract, ERS Participant records are confidential by law, and ERS maintains other records and information that Respondent shall have access to and which Respondent must keep confidential. Additionally, the Contract contains prohibitions on using GBP Participant information for marketing purposes. At a date to be determined by ERS, Respondent must cooperate with ERS in implementing a SSO environment that complies with these provisions of the Contract.
- A.21. **Background Checks.** Respondent shall perform background checks on all company hires that will have access to PII and HIPAA data.

B. Data Interfaces Requirements – PPO and DHMO

- B.1. Respondent shall have the ability to transmit and receive confidential and sensitive information via encrypted transmission protocols including site-to-site VPN, SFTP, and TLS.
- B.2. Respondent shall have the ability to transmit and receive SFTP batch files of public health information and batch files of confidential and sensitive information already encrypted at rest, with 2048-Bit asymmetric keys using PGP or GPG.
- B.3. Respondent receives monthly Enrollment Interface Files via SFTP and updates its records accordingly. ERS' current eligibility file provides Respondent with additions and changes. Terminations are reflected by omission of a participant from the file (term by omission). Respondent guarantees that it shall process all processable maintenance eligibility transactions received from ERS as required in **Appendix G**, Performance Guarantees.
- B.4. ERS reports future effective dates at the end of SE/FE and throughout the year on each eligibility file. ERS will send these records between 30 and 90 days in advance of the effective date.
- B.5. Respondent guarantees that any electronic file transfer or eligibility transaction failure(s) will be resolved as soon as possible, but in no event later than the time required in **Appendix G**, Performance Guarantees.
- B.6. The file layouts that ERS uses to report eligibility to Respondent and receive claims data from Respondent on a weekly, monthly, and SE/FE basis are included as **Appendix J**. Respondent must meet all requests stated in **Appendix J** or offer their standard file layout for ERS to review for consideration. File layouts shall adhere to the following:
- File naming conventions and file formats, as set forth by ERS during Implementation;
 - Claims files must be marked to identify unique claims with claim keys; and
 - Replacement files should include previously submitted data for the specified date range.

Respondent shall be fully capable of accepting and processing all File Interfaces forty-five (45) business days before the go-live date. ERS will define the file layouts as specified in **Appendix J**. Claims files from Respondent to ERS are to be ready for go-live in February 2019 with January 2019 processed claims.

ERS is responsible for determining the eligibility of Participants in the Dental Program and for reporting coverage. ERS provides a 100% weekly Enrollment Interface File via SFTP. Respondent's corresponding enrollment records shall be updated within twenty-four (24) hours of receipt of the SFTP file to reflect any adjustments based on the data provided by ERS as required in **Appendix G**, Performance Guarantees and/or other legal remedies available to ERS in the Contract.

- B.7. **Enrollment/Eligibility.** Respondent shall implement automated enrollment (i.e., via telephone and Internet) and accept enrollment via verbal instruction from an ERS authorized representative. Respondent shall adjust appropriate information in its enrollment system immediately upon receiving updated Participant eligibility information from an ERS representative. Although Respondent is currently required to accept enrollment via the 100% weekly Enrollment File, future enhancements may require Respondent to accept enrollment on a real-time basis.
- B.7.a. ERS reports future effective dates. Specifically, ERS is able to provide Members' eligibility data with coverage effective dates up to 90 days before said effective date.

There may exist, to a limited extent, enrollments that must occur via verbal instructions from an ERS authorized representative. The ERS representative will call the service provider to enroll a Member in the service providers system with immediate coverage. The Member will also be provided on the next regularly scheduled data file.

- B.8. ERS shall report future effective dates for changes during Annual Enrollment. Respondent shall be prepared to accept reporting of future effective dates by the first business day in August.
- B.9. For the purpose of responding to the RFP, Respondent may recover costs involved in the adaptation of their system requirements to those set forth by ERS only through the Price Proposal in **Appendix AA**.

C. Security Practices Requirements – PPO and DHMO

- C.1. Respondent shall ensure that ERS data stored at Respondent's site is encrypted at rest.
- C.2. Respondent shall ensure the security, confidentiality, integrity, and availability of Participant and GBP information in accordance with all applicable laws and regulations, both state and federal, including the Board Rules.
- C.3. TLS version 1.2 or better protocols shall be used for the exchange of personal identifying information over HTTPs. Respondent shall support SFTP protocol with SSH to encrypt the data exchanged in transit.
- C.4. Requirements include, but are not limited to, the use of SFTP and PGP encryption protocols. Respondent shall be prepared to accept eligibility data and reporting via SFTP forty-five (45) days prior to go-live.
- C.5. Electronic communications including, but not limited to, email and file transfers between Respondent and ERS shall be encrypted to protect Participants' confidential information. Respondent shall establish forced TLS protocols with ERS for email communications.
- C.6. To protect the confidentiality of Participant information, Respondent shall provide access to any information reasonably related to the GBP, the Plans, the Participants, and the services, coverage, benefits, supplies and products specified hereunder using TLS version 1.2 or higher encryption protocols. This access, at a minimum, shall also give ERS the ability to view, download and print such Participant information.
- C.7. ERS does not allow VPN split tunneling for client VPN's. Respondent shall ensure that it will not allow VPN split tunneling on client VPN's, including those possibly used for technical support.
- C.8. All of ERS' data, as maintained by Respondent, shall at all times remain the property of ERS notwithstanding the fact that such records may be stored upon or within one (1) or more computer or data retention systems owned, operated, or leased by Respondent. ERS is entitled to a full data model for such data.
- C.9. All computing devices (i.e., laptops, desktops, and servers) and storage devices that contain, process, or interact with ERS data shall be encrypted at rest. If ERS data is to be transmitted, the transmission shall be encrypted as well. Respondent must be capable of remotely deleting all ERS data, if needed.
- C.10. Respondent shall provide non-repudiation services up to and including second factor authentication for Respondent's employees, contractors, and service providers capable of accessing ERS data outside Respondent's physical facilities using a VPN or other remote access methods.
- C.11. The information entrusted to ERS is a valuable asset belonging to the Participants. The confidentiality of such information must be protected from unauthorized or accidental disclosure, modification, use, or destruction. Prudent steps must be taken to ensure its confidentiality, integrity, and availability are never compromised, including by any subcontractor upon whom Respondent relies in performing or providing services or products to or on behalf of ERS. Respondent shall maintain an Information Security Policy acceptable to ERS that outlines its management's direction and support for its Information Security program. This policy shall provide a uniform set of information security policies and procedures for protecting ERS and Participant data. Respondent's Information Security Policy documentation and independent audits of Respondent's adherence shall be available to ERS upon ERS' request.

- C.12. Respondent's system shall be capable of supporting an alphanumeric User ID other than Social Security Number.

D. Business Resumption and Data Center Facilities Requirements – PPO and DHMO

- D.1. Respondent shall ensure that the systems that ERS would use during a disaster undergo annual disaster recovery tests.
- D.1.a. Respondent confirms that its data center conforms to the Uptime Tier III or Tier IV standards; if the Respondent does not have formal Uptime certification, the Respondent confirms that all critical data center systems associated with providing power and cooling to IT equipment can maintain uptime of at least 99.982% during any 12-month period.
- D.1.b. The Respondent tracks the annual uptime of the systems and applications that will provide service to ERS.
- D.2. Respondent shall ensure that it has an alternate site to provide services if the assigned primary site is unavailable for a test or disaster declaration.
- D.3. Respondent's primary and alternate sites shall both be located in the 48 continental United States.
- D.4. Respondent must maintain contingency plans and procedures which provide business continuity due to any event that might interrupt, delay or shut-down service that is related to Respondent's services or products under this proposal, including that of any subcontractor upon whom Respondent relies in performing or providing services or products to or on behalf of ERS.
- D.5. Respondent shall ensure all systems associated with ERS application delivery and data storage are physically secured in an access-restricted environment.
- D.6. Respondent acknowledges, accepts and agrees that ERS must be permitted to personally inspect Respondent's data center facilities and systems on an annual basis or when ERS deems it necessary.
- D.7. Respondent shall maintain duplicate or back-up computer encrypted data files in a secure, hardened facility that provides environmental and access controls. Respondent shall utilize 256-Bit symmetric key AES encryption standards or better for tapes or equivalent backup media.
- D.8. Respondent shall deliver to ERS' Account Manager one of the following on an annual basis:

1. Disaster recovery plan and the disaster recovery test results

These documents shall include, but will not be limited to, the following:

- a) the Disaster Recovery plans plus a description of the changes from the previous year's plans, if any; and
- b) the exercise test results conducted within the last twelve (12) months of the disaster recovery; and
- c) business continuity tests referencing the adequacy of these plans.

The test results must include the Recovery Time Objective ("RTO") and Recovery Point Objective ("RPO") of the systems and applications, which provide service to ERS.

If these are a part of a SOC II Type 2 report, Respondent shall provide the portions of the report that refer to the normal, annual disaster recovery and business and continuity tests, plus copies of the service auditor's report. Respondent further agrees to be available for reasonable inquiry by ERS of the disaster recovery plan and tests.

Or,

2. Summary of the latest disaster recovery test results and a summary of the disaster recovery programs

- The test results should include the RTO and RPO of the systems and applications, which provide service to ERS.
- The Respondent must attest annually, by signature that the disaster recovery tests will ensure that systems, which the Respondent uses to provide services to ERS, will be available within X hours of outage and will experience Y hours of data loss.
- Respondent further agrees to be available for reasonable inquiry by ERS of the disaster recovery plan and tests.

D.9. **IVR System.** Respondent shall provide all annual updates and/or equipment re-configuration recommendations for future years no later than the first business day of May of each subsequent year. Respondent is required to communicate and submit to ERS, for prior approval, all changes, updates and re-configurations that directly affect ERS.

E. SOC-2 Report Requirements – PPO and DHMO

Respondent shall acknowledge that SOC-2 Reports are scored on a pass/fail basis as stated at RFP Section II.E.1. Failure to provide the requested information may result in a failing score. ERS expects Respondent to provide a fully-unredacted SOC-2 Report or equivalent report to complete its review of the Proposal.

- E.1. **SOC-2.** Respondent shall acknowledge and agree to provide a full, un-redacted copy of the most recent SOC-2 report performed under SSAE16 or SSAE18 SOC-2 Type II report or equivalent reports that describes the tests performed and provides the results of those tests or any other independent external audit on the effectiveness of internal controls over operations, security, and compliance of services to be provided under the RFP during a specific period, including disaster recovery planning and testing, and data center facilities. This should include results of an independent, certified external security audit.
- E.1.a. Respondent shall also acknowledge and agree that ERS is entitled to review all such audit results on a yearly basis.
- E.2. Respondent shall acknowledge and agree that ERS is entitled to review Respondent's sponsoring or parent company's most recent SOC-2 report under SSAE 16 or SSAE18 SOC-2 Type II report or any other independent auditor report on the effectiveness of internal controls over operations, security, and compliance of service results on an annual basis.
- E.3. Respondent shall acknowledge and agree that ERS is entitled to review outsourcers' or subcontractors' SOC-2 Report(s) under SSAE16 or SSAE18 SOC-2 Type II report or equivalent reports annually.

XI. Scope of Work – Implementation and Project Management Requirements

This Article describes Respondent's Implementation and Project Management specifications and requirements. The cost of the requirements described herein shall be recovered by Respondent only by Respondent making provisions for such expenses in Respondent's Price Proposal, **Appendix AA**.

The section allowing for Deviations and the Interrogatories for this Article can be found at **Appendix V**. Respondent shall complete and submit **Appendix V** as a part of its Proposal.

A. Implementation Requirements - PPO and DHMO

- A.1. Respondent approved by the Board should be prepared to attend an implementation kick-off meeting as soon as possible following the Board's approval to include, but not be limited to, discussion of Respondent's customer service, finance requirements, account management requirements, technological requirements, communication requirements, and SE/FE meeting responsibilities.
- A.1.a. Within three (3) business days following the Board selection, Respondent shall provide to the Benefit Contracts Assistant Director, or designee, a complete listing of Respondent's Implementation and Project Management Teams. The list shall identify an account "key point of contact" responsible for the implementation, coordination, and maintenance of the business relationship and continuity pertaining to all business matters in support of the Contract during the Implementation Period. Respondent's Implementation Teams' contact lists should reflect key contact information (office, fax, and cell phone numbers, email and physical addresses).
- A.2. **Implementation Period.** The period of time beginning with the selection of Respondent by the Board and ERS' execution of the Contract, to the point at which Respondent assumes full responsibility for the duties specified hereunder, shall be known as the "Implementation Period." Respondent and the ERS Project Manager shall work together to prepare a mutually agreed-upon schedule for completion. Any schedule agreed upon must provide that the Contract, and any requirements necessary for Respondent to perform all obligations required under the Contract, must be fully tested, implemented and ready for service to ERS, the contracted plan(s) and the Participants absolutely no later than August 31, 2018.
- A.2.a. During the Implementation Period, Respondent will:
- Maintain an appropriate, sufficient and qualified Implementation Team. ERS reserves the right to require Respondent to add additional staff or to remove staff from the Implementation Team.
 - Not permit any current or prospective business, projects or other matters to interfere in any manner with the smooth and timely implementation of the Plans.
 - Understand and agree that time is of the essence in the performance of the Contract and in the implementation of the Plans.
 - Acknowledge and agree that ERS, the GBP, its Participants and the State shall suffer irreparable harm if the Plans are not fully and completely implemented on or before August 31, 2019.
 - To the extent the liquidated damages and/or other provisions of the Contract require prior notice, Respondent hereby waives such prior notice during the Implementation Period.
 - ERS may immediately assess against Respondent the agreed upon liquidated damages, and/or the Performance Guarantees in **Appendix G** for PPO and **Appendix G-1** for DHMO and/or implementation of other legal remedies available to ERS in the Contract, without prior notice, in the event Respondent fails, refuses or if it reasonably appears that Respondent will fail or refuse to complete or perform or will not be capable of completing or performing any aspect of the Contract in connection with the timely and smooth implementation of the Plans.

- All communication materials dealing with the implementation, including Participant communication materials, call center staff training materials, IVR, and website design are subject to ERS' review and approval.
- A.3. **Implementation Team.** The required representatives for the Implementation Team are listed in RFP Sections XI.A.4. – XI.A.5. below. Respondent shall ensure a smooth transition, without exception, of all ERS communication processes and requirements as follows:
- Respondent shall inform, via email notification, the Benefit Contracts Assistant Director, or designee, in advance of any planned periods of unavailability by the Implementation Team's key point of contact.
 - In any instance where an Implementation Team key point of contact is not available to ERS, Respondent shall immediately secure and provide details of alternate coverage sufficient to meet ERS' expectations.
 - Should staffing adjustments or additional team members become necessary to support the account functions, Respondent shall dedicate such appropriate staff as required by and acceptable to ERS.
- A.3.a. Respondent shall notify the Assistant Director of Benefit Contracts or designee with any anticipated changes to the Implementation Team structure.
- A.4. **Implementation Team Leadership.** The Implementation Team shall be led by an Implementation Project Manager to coordinate and expedite all Contract requirements as outlined and prioritized by ERS, to ensure complete continuity, without exception, of all interactive functions, deliverables, and objectives for the Plans prior to and during the Contract's onset.
- A.4.a. Respondent must assign a communications lead on staff who is dedicated to the ERS program. Communication requirements are fully described in Article IX.
- A.5. **Implementation Project Manager.** At a minimum, the Implementation Team shall have both a dedicated Implementation Project Manager and a designated back-up Implementation Project Manager with availability to ERS staff throughout the Implementation Period and be accessible to ERS during regular business hours (7:00 a.m. – 5:00 p.m. CT), or as otherwise deemed necessary by ERS, during the Implementation Period. The Implementation Project Manager shall serve as ERS' primary contact throughout the Implementation Period and will have immediate access to those able to make binding decisions for Respondent.

B. Project Management Requirements – PPO and DHMO

- B.1. ERS' Enterprise Planning Office is responsible for project management services that will ensure the proper planning, procedures and protocols are in place to implement the Plans prior to the September 1, 2019 go-live date.
- B.1.a. ERS engages an ERS Project Manager to manage the implementation activities from ERS' perspective. It is ERS' expectation that the ERS Project Manager will work with Respondent's Implementation Project Manager as the primary point of contact regarding all implementation activities and endeavors; all information will be disseminated through these two individuals. Typically, the ERS Project Manager and Respondent's Implementation Project Manager communicate daily, or at an appropriate frequency as determined by ERS, to identify any changes, impacts, risks, and updates to the project status, schedule, and risk and issues log. These are then communicated to the team members as needed.
- B.1.b. ERS requires the following regarding Respondent and its project management services:
- Respondent will have an Implementation Project Manager who will be responsible for the oversight and management of implementation activities from Respondent's perspective.
 - Respondent's Implementation Project Manager will be ERS' primary point of contact during the implementation.
 - There will be one master project schedule from which both Respondent and ERS will work; the schedule must be in a format accessible by ERS, which is currently Microsoft Project or Excel.
 - Respondent will be responsible for the management, retention, and transference of all implementation documentation. This includes, but is not necessarily limited to: project schedule; meeting minutes and risk and issues log.
 - ERS stores all project documentation within SharePoint, which is not accessible by Respondent. However, Respondent is expected to provide all project documentation to the

ERS Project Manager within a timeframe to be determined mutually between Respondent and ERS for uploading into the SharePoint environment.

- Respondent will ensure all items that are to be operationalized after project go-live have been transferred to the appropriate party with the level of information necessary to ensure full understanding. Items for transference to operations will also be thoroughly captured in the project documentation.

B.1.c. Respondent shall provide information regarding its project management services as requested below. In addition, if Respondent is selected as a Finalist, it will be asked to expand further on its project management services.

B.2. If Respondent is selected as a Finalist, Respondent shall provide a comprehensive description of Respondent's project management services including the following elements:

- **Project Approach/Methodology.** Include a complete description of Respondent's proposed approach and methodology for the project. Respondent's response to these requirements should convey Respondent's understanding of the proposed project.
- **Project Team Structure/Internal Controls.** Provide a description as to how ERS' Project Manager will work with Respondent's Implementation Project Manager. Provide a description of the proposed project team structure and internal controls to be used during the course of the project including any subcontractors.
- **Proposed Implementation Schedule.** Include all project requirements and the proposed tasks, services, and activities necessary to accomplish the scope of the project defined in the RFP. This schedule must contain sufficient detail to convey Respondent's knowledge of the subjects and skills necessary to successfully complete the project. Include any proposed required involvement by ERS staff. Respondent may also present any creative approaches that might be appropriate and may provide any pertinent supporting documentation.
- **Project Schedule.** Include a proposed project schedule indicating when the milestones or elements of the work would be completed by Respondent and ERS staff.
- **Outcomes and Performance Measurement.** Describe the impacts/outcomes Respondent proposes to achieve including how these outcomes would be monitored, measured and reported to the ERS Project Manager.
- **Risks and Mitigation.** Respondent must identify potential risks and mitigation that are considered significant to the implementation success. Include a description of how Respondent's Implementation Project Manager will effectively communicate these risks to the ERS Project Manager.
- **Deliverables.** Fully describe deliverables to be submitted under the proposed Contract.

XII. Scope of Work - Operational Specifications and Requirements

This Article describes the general operational specifications including account management, administrative requirements and functions, customer service, and the statistical reporting requirements. Respondent shall administer the Plans in a manner consistent with all applicable state and federal laws and regulations, as well as the Board Rules and at the direction of the ERS Board, its Executive Director, and staff. The cost of the requirements described herein shall be recovered by Respondent only by making provisions for such expenses in Respondent's Price Proposal in **Appendix AA**.

The section allowing for Deviations and the Interrogatories for this Article can be found at **Appendix W**. Respondent shall complete and submit **Appendix W** as a part of its Proposal.

A. Account Management Requirements – PPO and DHMO

- A.1. **Respondent's Contact List.** No later than the tenth (10) business day following the Board selection, Respondent shall provide to ERS' Benefit Contracts' Assistant Director, or designee, a complete listing of Respondent's account management and account executive contacts assigned to support the Contract. The list shall be consistent with the organizational charts that Respondent is required to provide with its Proposal and specified in **Appendix O.A.5.**, and it should identify a dedicated account manager responsible for the ongoing maintenance of the business relationship and continuity pertaining to all business matters in support of the Contract post-implementation and other personnel identified at RFP Sections XI.A.4. and XI.A.5. Respondent's contact list should reflect key contact information (office, fax, and cell phone numbers, email and physical addresses) for each representative. Respondent shall ensure a smooth transition, without exception, of all ERS communication processes and requirements as follows:
- Respondent shall inform, via email notification, the Benefit Contracts' Assistant Director, or designee, in advance of any planned periods of unavailability by the Account Management Team's key point of contact.
 - In any instance where an Account Management Team key point of contact is not available to ERS, Respondent shall immediately secure and provide details of alternate coverage sufficient to meet ERS' expectations.
 - Should staffing adjustments or additional team members become necessary to support the account functions, Respondent shall dedicate such appropriate staff as required by and acceptable to ERS.
- A.2. ERS strongly believes that the account service relationship is the critical link in developing and maintaining a strong working relationship dedicated toward the achievement of the Plans' objectives. As such, Respondent shall be committed to providing ERS with a service attention that is at the highest levels in the industry and fully consistent with ERS' expectations. ERS shall define the criteria for measurement and evaluation of service performance.
- A.3. **Account Management Team.** Respondent shall establish and maintain throughout the Contract Term an Account Management Team that will work directly with ERS staff. This Account Management Team shall include an account executive, account manager, customer service manager, practicing attorney, benefits/operational manager, person responsible for preparing reports, information systems manager, financial manager, and communications manager. The account manager should be dedicated; however, all other personnel may be designated. Approval of the Account Management Team rests with ERS.
- A.3.a. The experience and professional qualifications of Respondent's Account Management Team are critical elements in awarding this Contract. ERS may, at any time, request the removal or reassignment of Respondent's staff, or the staff of any subcontractor, in connection with Respondent's performance under this Contract.
- A.3.b. Any licenses and/or certifications that Respondent and/or its staff are required to maintain will be kept current during any period of time that Respondent has a contract in place with ERS.

- A.3.c. The Account Management Team shall be thoroughly familiar with all of Respondent's functions that relate directly or indirectly to the ERS account.
- A.3.d. The Account Management Team shall provide all services specified in the RFP and be available Monday through Friday from 8:00 a.m. to 6:00 p.m., CT, excluding national holidays.
- A.4. **Account Executive Team.** Respondent shall also designate an Account Executive Team composed of Respondent's executive management personnel assigned to the GBP's account.
- A.4.a. Respondent shall provide a minimum of two (2) per Fiscal Year face to face reviews to ERS on the utilization and performance of the Plans. The reviews shall include, but not be limited to, a presentation of the following information:
 - Industry trends and best practices;
 - Plan recommendations; and
 - Other cost saving recommendations.

B. Administrative Requirements – PPO Only

- B.1. Respondent shall provide the Benefit Contracts Assistant Director or designee with written notice in accordance with the Performance Guarantees currently in existence prior to effecting any changes to its operations, program, and/or website modifications that may impact the administration, delivery, promotion or operations of the program that may affect ERS, the Plans, and/or Participants.
 - B.1.a. Respondent shall provide general administrative, legal, technical, and statistical support to assist ERS in the operation of the Plans and shall recover any associated costs only by making provisions in Respondent's Price Proposal, **Appendix AA.**
 - B.1.b. Respondent shall provide the GBP with priority placement in all aspects of Contract performance provided by Respondent.
 - B.1.c. ERS requires Respondent to meet with ERS staff and/or Board as requested to discuss the status of the Plans in terms of utilization patterns and costs, as well as to propose new ideas that may benefit the GBP and its Participants.
- B.2. **Reporting and Data Analytics.** Program reporting shall be plan-specific unless otherwise indicated by ERS.

Furthermore, Respondent shall provide ERS access to a designated reporting and analytical team to advise and support ERS to include, but not be limited to:

 - Provide claims specific information and files;
 - Create statistical reports;
 - Develop templates for ERS data;
 - Benchmarking analysis;
 - Trend analysis; and
 - Ad hoc reporting requests.
- B.3. **Meetings.** Respondent shall develop meeting agendas, coordinate meetings and provide documentation of actions in the form of meeting minutes for designated meetings with ERS at a scheduled time agreed upon by ERS and Respondent to include, but not be limited to:
 - Operational; and
 - Communications.
- B.3.a. Respondent shall use ERS' meeting agenda template and provide meeting agendas one (1) day prior to the scheduled meetings.
- B.3.b. Respondent shall provide the meeting minutes within four (4) business days from the day of the scheduled meeting for ERS' review and approval.
- B.4. **Periodic Audits.** ERS may contract with an auditing firm to conduct periodic audits of Respondent. Respondent shall cooperate with and support the efforts of the auditors. Neither ERS nor the

auditors will be required to indemnify Respondent for any costs incurred in connection to these audits.

- B.4.a. ERS or any of its duly authorized representatives shall have access to any GBP-related information during the term of the Contract and until the expiration of seven (7) years after the final payment is made under the Contract. This includes access to and the right to examine any pertinent books, documents, papers, and records of Respondent involving transactions relating to the Contract. In the event any claim, dispute, or litigation arises concerning the Contract, the period of access and examination described above may continue until the disposition of such claim, dispute, or litigation has been deemed final.
- B.4.b. ERS will determine the scope of the audit and Respondent shall fully support the activities of and in good faith cooperate with the auditor. Respondent shall not designate any "black out" periods of time when any audit may be conducted on behalf of ERS. In addition, if ERS or any of its duly authorized representatives or designees request records, data, information, report analysis rebuttals, and/or other information of Respondent, timely release of all information requested shall be required by Respondent.
- B.4.c. Respondent's support shall include maintaining readily available data that is accessible electronically as well as through hard copy. Neither ERS nor the auditor shall reimburse or indemnify Respondent for any cost incurred or any claim that may arise in connection with or relating to these audits.
- B.5. **Administrative Audit.** As Plan administrator for the GBP, ERS may access, request, and audit documents related to the Plans and Participant records as required for purposes of administering the GBP.
- B.6. **Annual Audit of Respondent.** Pursuant to Chapter 1551.062(b)(2) of the Tex. Ins. Code, ERS shall commission an annual audit of Respondent's claims administration by an independent auditor to determine the adequacy, timeliness, and accuracy of Respondent's procedures and performance for the prior year. ERS may, in its discretion, conduct other audits of Respondent when and in the manner ERS deems necessary.
- B.6.a. ERS' annual audit will be at ERS' expense except that should the independent auditor find errors in excess of \$10,000, Respondent must reimburse ERS for the errors and cover the cost of the independent auditor.
- B.7. **Fraud and Abuse Detection.** Respondent shall use a comprehensive plan, including automated systems, to prevent and detect fraud and misuse of the program, overpayments, wrongful or incorrect payments, and falsification of eligibility, verification of enrollment and unnecessary and/or wrongful medical practices and abuses. Respondent shall comply with all applicable state and federal laws and regulations and shall also comply with all ERS policies, and is encouraged to develop additional safeguards as allowed by law. Respondent understands that ERS may develop further policies in connection with the detection and prevention of fraud or abuse.
- B.7.a. Respondent shall also conduct thorough, diligent, and timely investigations with regard to fraudulent and suspicious claims, and report all such suspicious claims to ERS' Benefit Contracts division.
- Respondent shall investigate unusual or suspicious claim submissions and materials to determine all relevant circumstances and report to ERS its findings.
 - Respondent shall provide a toll-free number and an Internet link for Participants to report fraud and abuse.
 - Respondent shall report the total number of dollars recovered through fraud-related investigation activities monthly.
- B.7.b. The Contract contains additional anti-fraud and abuse requirements. Examples of practices for preventing and detecting Dental coverage fraud and abuse include, but are not limited to:
- Enhancing prospective dental services utilization review to prevent waste;
 - Using technology at the point of service to prevent abuse and errors;
 - Using data and education to change provider behavior; and
 - Auditing claims data to profile both providers and clients.
- B.8. **PPO Clinical Oversight.** Respondent shall perform a broad array of valuable functions in the area of clinical oversight in the administration of the PPO Plan to include, but should not be limited to:

- **Utilization Review.** Reviews and analyses of coding practices to detect inappropriate use and possible fraud of FDA and ADA guidelines. Effective utilization reviews often result in cost savings for the Dental PPO Plan and improved quality of care of the Participants.
 - **Prepayment Claims Review.** Reviews prior to claim payments to ensure benefits are being paid appropriately in accordance with the Master Benefit Plan Document for the PPO Plan.
 - **Dental Policy Development.** Utilize information from current evidence-based research to ensure that policies provide acceptable care, support American Dental Association's ("ADA") code revision cycle, determine when policy changes are needed to maintain appropriate care (e.g., support system edits and/or alerts when additional reviews are necessary based on submitted CDT codes).
- B.9. **Online Access.** Respondent shall provide to ERS' authorized representatives online access to any information reasonably related to the Plans, the Participants, and the services, coverages, benefits, supplies and products specified hereunder. Such online access, at a minimum, must give ERS the ability to view, download and print such information. Thus, any information regarding the services, coverage, benefits, supplies or products that Respondent is required to perform, deliver or provide in connection with the GBP shall be fully accessible and available to ERS via online access.
- B.10. **Employee Identification Number.** Current Participant enrollment reporting is based on each Participant's ID number.
- B.10.a. Respondent's system shall have the capability to manage an eleven (11) digit ID number in its reporting system. Respondent shall be capable of identifying Participants based on the enrollment information submitted by ERS.
- Respondent shall note that the eleven (11) digit Employee Identification Number is assigned by ERS, and it is numeric only. There are either one or two leading zeros and three trailing zeros. Respondent may generate its own unique number, but this will need to tie to the Employee Identification Number reported on the eligibility file. ERS prefers that Members be able to use the ERS provided Employee Identification Number to authenticate and access services by phone, internet and other interaction methods when contacting Respondent directly. This is not intended to extend to accessing direct care providers.
- B.11. **Insurance Coverage.** Respondent must have sufficient liability insurance that is in full force at the time the face to face interview takes place and throughout the Contract Term, and must furnish proof of such insurance at the face to face interview.
- B.12. **Identification ("ID") Cards.** Respondent shall issue ID cards to all new Participants, including dependents, who enrolled during Annual Enrollment and subsequent to Annual Enrollment as outlined as reflected in the Performance Guarantees, **Appendix G**. See **Article IX Scope of Work – Communication Requirements** for further provisions regarding ID Cards for the PPO Plan.

C. Administrative Requirements – DHMO Only

- C.1. Respondent shall provide the Benefit Contracts Assistant Director or designee with written notice in accordance with the Performance Guarantees currently in existence prior to effecting any changes to its operations, program, and/or website modifications that may impact the administration, delivery, promotion or operations of the program that may affect ERS, the Plans, and/or Participants.
- C.1.a. ERS requires Respondent to meet with ERS staff and/or Board as requested to discuss the status of the Plans in terms of utilization patterns and costs, as well as to propose new ideas that may benefit the GBP and its Participants.
- C.2. **Reporting and Data Analytics.** Program reporting shall be plan-specific unless otherwise indicated by ERS.
- C.3. **Meetings.** Respondent shall develop meeting agendas, coordinate meetings and provide documentation of actions in the form of meeting minutes for designated meetings with ERS at a scheduled time agreed upon by ERS and Respondent to include, but not be limited to:
- Operational; and
 - Communications.

- C.3.a. Respondent shall use ERS' meeting agenda template and provide meeting agendas one (1) day prior to the scheduled meetings.
- C.3.b. Respondent shall provide the meeting minutes within four (4) business days from the day of the scheduled meeting for ERS' review and approval.
- C.4. **Fraud Detection.** Respondent shall use comprehensive plan, including automated systems, to prevent and detect fraud and misuse of the plan, overpayments, wrongful or incorrect payments, falsification of eligibility, unusual or extraordinary charges and verification of enrollment and unnecessary medical treatment. Respondent shall also conduct thorough, diligent, and timely investigations with regard to fraudulent and suspicious claims. It is the expectation of ERS that Respondent will conduct thorough, diligent, and timely investigations with regard to fraudulent and suspicious claims, and report all such suspicious claims to ERS' Benefit Contracts division. The Contract may contain anti-fraud and abuse requirements. Examples of practices for preventing and detecting Dental coverage fraud and abuse include, but are not limited to:
- Enhancing prospective dental services utilization review to prevent waste;
 - Using technology at the point of service to prevent abuse and errors;
 - Using data and education to change provider behavior; and
 - Auditing claims data to profile both providers and clients.
- C.5. **Employee Identification Number.** Current Participant enrollment reporting is based on each Participant's ID number.
- C.5.a. Respondent's system shall have the capability to manage an eleven (11) digit ID number in its reporting system. Respondent shall be capable of identifying Participants based on the enrollment information submitted by ERS.
- Respondent shall note that the eleven (11) digit Employee Identification Number is assigned by ERS, and it is numeric only. There are either one or two leading zeros and three trailing zeros. Respondent may generate its own unique number, but this will need to tie to the Employee Identification Number reported on the eligibility file. ERS prefers that Members be able to use the ERS provided Employee Identification Number to authenticate and access services by phone, internet and other interaction methods when contacting Respondent directly. This is not intended to extend to accessing direct care providers.
- C.6. **Identification ("ID") Cards.** Respondent shall issue ID cards to all new Participants, including dependents, who enrolled during Annual Enrollment and subsequent to Annual Enrollment as outlined as reflected in the Performance Guarantees, **Appendix G-1**. See **Article IX Scope of Work – Communication Requirements** for further provisions regarding ID Cards for the DHMO Plan.
- C.6.a. Respondent shall send an ID card to all new adult Participants who enrolled during AE within five (5) business days of the transfer of the final enrollment file at the end of AE. If Respondent has not received the Participant's PCD information by the date of the final enrollment file, then Respondent shall assign a PCD and include a letter with the card instructing the Participant to contact Respondent to change the PCD if necessary. A draft copy of the proposed instructions shall be included in Respondent's Proposal materials.
- C.6.b. Subsequent to AE, Respondent shall issue ID cards within five (5) business days of the successful transfer of the enrollment file to Respondent. For on-going ID Cards, Respondent shall send a new ID card to all adult Participants when a change is reported, within five (5) business days following Respondent's receipt of the enrollment information. Once initially distributed, ID cards do not need to be replaced unless changes are made to Participant's name, or covered dependents.
- C.6.c. In order to facilitate the issuance of the ID cards, Respondent shall assign each designated dentist with an office code or Provider ID number. Respondent shall use the same Office Code/Provider ID number in its printed material and website. Respondent shall use the Office Code/Provider ID number layout below.

Office Code/Provider ID number Record Layout
Field Names (218 bytes)

Column	Field Name	Format	Length
1	XBA_SSN_NBR	X	9
10	XBA_HLTH_CAR_CD	X	2

Column	Field Name	Format	Length
12	XBA_PTCPT_LAST_NM	X	40
52	XBA_PTCPT_FIRST_NM	X	20
72	XBA_PTCPT_MID_NM	X	20
92	XBA_PCP_NBR	X	15
107	XBA_DPEN_SSN_NBR	X	9
116	XBA_DPEN_LAST_NM	X	40
156	XBA_DPEN_FIRST_NM	X	20
176	XBA_DPEN_MID_NM	X	20
196	XBA_DPEN_BIRTH_DT	X	8
204	XBA_DPEN_PCP_NBR	X	15

D. Customer Service Requirements - PPO and DHMO

- D.1. Respondent's Customer Call Center shall be located within the United States and preferably within the State. Respondent shall establish and provide staffing of a dedicated call center and customer service team and shall be adequately staffed to manage Dental Plans questions and provide resolution of complaints, clarifications, and escalated issues, as well as be fully trained and functioning prior to the go-live date.
- D.2. **Call Center/Customer Service Team.** Respondent shall have the ability to track and report performance of call center metrics. The Customer Service Team must be functioning prior to implementation, the next open enrollment period, or at the direction of ERS.
- D.2.a. The hours of operation for Respondent's Customer Service Team shall be, at a minimum, Monday through Friday from 8:00 a.m. to 7:00 p.m. CT., excluding national holidays.
- D.2.b. Respondent shall provide a dedicated Call Center/Customer Service Team.
- D.3. **Call Center Specialists.** Respondent shall designate as many call center specialists as necessary whose sole responsibility shall be to respond to and resolve, within a reasonable timeframe as determined by ERS, Plan-related customer service needs. Respondent shall jointly monitor and adjust staffing levels as work and service requirements demand. Respondent warrants and represents that it shall provide thorough training of the Customer Service Team. Any training deficiencies noted by ERS shall be immediately rectified by Respondent to ERS' sole satisfaction.
- D.4. **Back-up Staffing.** Respondent shall designate additional staff, as needed, to update and maintain Plan-related records and accounts. This staff will also provide additional support for Respondent's Customer Service Team.
- D.5. **Call Center Management Criteria.** Respondent shall establish toll free lines (telephone and facsimile). Respondent shall also employ appropriate and adequate customer service staff to maintain service levels, abandonment rate and blockage rate as referenced in the **Appendix Y**, Call Center Metrics, and **Appendix G** and **Appendix G-1**, Performance Guarantees. Respondent shall provide in its Proposal the methodology and sample source documents used by Respondent to arrive at the reporting requirements for the call center metrics referenced in **Appendix Y**, *Call Center Metrics*.
- D.5.a. Respondent shall have the ability to send recorded telephone call records to ERS upon request.
- D.6. **Access for Hearing Impaired.** Respondent's Call Center shall be equipped with Telephone Device for the Deaf ("TDD") or Teletype ("TTY") in order to serve the hearing-impaired population.
- D.7. **Language Accessibility.** Respondent's Call Center shall have staff available to provide language translation services to meet the service level objectives defined in **Appendix Y**, Call Center Metrics, and **Appendix G**, Performance Guarantees. This may be provided by using a language translation organization.
- D.8. **Benefits Coordinator Access.** Respondent shall provide the necessary resources and technology to adequately assist BCs with questions and concerns.
- D.9. **Enrollment Verification.** To assist Respondent in verifying enrollment, ERS provides online access to its enrollment system, ERS OnLine. Online access is available through Respondent's Internet provider and shall be operational one (1) week prior to implementation or as directed by

ERS. Staff trained on ERS' enrollment system shall be available during all customer service open hours.

- D.9.a. **Verification of GBP Participants Coverage.** Respondent shall accept verbal verification of a Participant's coverage by an authorized representative of ERS or verify the Participant's coverage through utilization of ERS Online. Coverage shall be updated in Respondent's system prior to receipt of the next ERS weekly enrollment information.
- D.10. **Quality Assurance Review.** Respondent shall conduct an ongoing quality assurance review to be monitored via periodic Participant surveys and other reporting mechanisms.
- D.11. **Review of Complaints.** Respondent shall provide an ongoing review of complaints received from Participants and providers and respond as necessary and appropriate, monitor the denials of benefits made under the utilization management program to maintain the appropriateness of the program, and provide information about the utilization management program to ERS as requested.
- D.12. Respondent shall provide highly customizable call center related dialogue materials in an electronic format to ERS at an ERS-designated time. ERS intends to work with Respondent to modify the below scripts during implementation and on an ongoing basis throughout the Contract Term, as needed. These materials will include, but are not limited to:
- CSRs' response scripts; and
 - IVR scripts.

E. Claims Processing Requirements – PPO Only

- E.1. **Claim Payments.** Respondent shall pay all claims in an accurate and timely manner based on the data provided by ERS and in accordance with all rules described within the RFP and as described in **Appendix G**, Performance Guarantees.
- E.2. Respondent shall ensure that all staff assigned to ERS' account in any capacity including, but not limited to, claims processing are fully trained, are GBP-knowledgeable, and have expertise in their respective fields prior to being assigned to ERS' account.
- E.3. Respondent shall process all claims in a manner consistent with all applicable state and federal laws and regulations, as well as the Board Rules, the MBPD, Tex. Ins. Code, Chapter 1551, and at the direction of the ERS Board, its Executive Director, and ERS staff. In the event the above is unclear, Respondent shall agree to contact the Assistant Director of Benefits Contracts or designee for resolution. Respondent's failure to process the claims as stated herein may result in, among other remedies, a monetary assessment as reflected in the Performance Guarantees, **Appendix G**.
- E.4. Respondent must have in place a pre-release quality review process to monitor the quality of claim processing prior to release of initial dental payments.
- E.5. When an error in processing has been identified, Respondent shall conduct quality assurance. Quality assurance reviews shall be done within thirty (30) days following the identification of the initial error. If the error results in an overpayment, Respondent shall reimburse ERS and Participants shall be held harmless. If the error results in an underpayment, Respondent shall issue payments upon completion of the quality assurance reviews.
- E.6. Respondent shall compile and provide ERS with all documents associated with a Participant's appeal that goes through ERS' grievance process in a manner prescribed by ERS.
- E.7. General requirements for claims processing include, but are not limited to, the following:
- Review claims for eligibility under the Dental Programs;
 - Process the Dental Program Participants' submitted non-network claims; claim payment shall include an EOB; and
 - Dental claims filed by the Participants shall be processed within five (5) calendar days of submission unless additional information and/or investigation are required.
- E.8. In the event Respondent issues excess payments or payments for ineligible claims or Participants, it will:

- Take all steps necessary to recover the overpayment, including recoupment (offset) from Participants, dental care provider or subsequent claims payments.
 - Assume 100% liability for overpayments, which result from errors attributable to Respondent in whole or in part.
 - Within ninety (90) calendar days following identification of a Respondent's error, in whole or in part, Respondent shall return to ERS all overpayments regardless of recovery status with regard to the Dental PPO plan.
 - Refrain from initiating litigation to recover such overpayment unless authorized by ERS.
 - Reimburse ERS for any dental service to a former Dental Program Participant reported by ERS as no longer a plan Participant, if such notification is received by Respondent at least two (2) full business days prior to the date of service with regard to the Dental PPO plan.
- E.9. Respondent shall process and pay Dental Program claims using its own funds first before seeking reimbursement from ERS. The required reimbursement methodology is described in RFP Article XIII, Accounting and Funding Requirements at RFP Section XIII.B. and in the Contract.
- E.10. Respondent shall maintain a complete and accurate claims reporting system and provide for the retention, maintenance, and storage of all payment records with provision for appropriate reporting to ERS. Respondent shall maintain all such records throughout the term of the Contract, and for at least seven (7) years following the end of the Contract, and shall make such records accessible and available to ERS for inspection and audit upon ERS' request at no additional expense to ERS. In the event Respondent is scheduled to destroy payment records, Respondent shall contact ERS for approval prior to the destruction of the payment records. If ERS approves destruction, verification of the destroyed records shall be required at ERS' direction.

F. Subcontractors Requirements – PPO and DHMO

- F.1. Any planned or proposed use of subcontractors by Respondent shall be clearly disclosed and documented in Respondent's Proposal submission.
- F.2. Respondent shall accept the following requirements:
- Respondent shall be solely responsible for all subcontracted activities in support of the benefits and services outlined in any executed agreement with ERS; and
 - If Respondent subcontracts any part of the outlined benefits and services, the subcontractor(s) are subject to reviews and acceptance by ERS throughout the Contract Term.
- F.3. Respondent shall be completely responsible for all services performed and for fulfillment of its obligations under the Contract, even if such services are delegated to a subcontractor. No subcontract shall relieve Respondent of responsibility for the services. Respondent shall manage all quality and performance, project management and schedules for subcontractors. Respondent shall be held solely responsible and accountable for the completion of all work for which Respondent has subcontracted. Respondent is solely responsible for the acts and omissions of its subcontractors and for assuring that subcontractors meet all of the requirements of the Contract.
- F.4. Respondent shall be responsible for ensuring that its subcontractors are licensed, if applicable, and that they will comply with all applicable laws and regulations, both state and federal, and requirements of any organization or entity with any oversight authority over them.
- F.5. **Subcontractor Staff Requirements.** Subcontractors providing services under the Contract shall meet the same service requirements and provide the same quality of service required of Respondent.
- F.5.a. Subcontractors must reside in the United States. All work performed by subcontractors must be performed in the United States.
- F.6. **Primary Contact.** Respondent shall be the primary contact for ERS and subcontractors.
- F.7. **Background Checks.** ERS retains the right to check subcontractor's background or otherwise gather information regarding subcontractor to make a determination to approve or reject the use of a submitted subcontractor. Any negative responses may result in ERS' disqualification of the subcontractor.
- F.8. **Right to Request Removal.** ERS reserves the right to request the removal of Respondent's subcontractor staff deemed unsatisfactory to ERS.

F.9. **Subcontractor Expense.** Subcontracting shall be at Respondent's expense.

G. Respondent Program Reporting Requirements – PPO Only

G.1. ERS retains a consulting actuary on insurance matters. The consulting actuary assists and advises the ERS staff on benefit plan design, Proposal review, and Respondent Price Proposal analysis. ERS staff or the consulting actuary may, from time to time, request that Respondent provide additional information specific to the Dental Program. Respondent shall cooperate with and act in good faith in working with ERS and/or the consulting actuary and shall be prepared to respond to these requests promptly.

G.1.a. Respondent shall submit on a monthly basis to ERS' consulting actuary and to an ERS agency designee, via SFTP, within a site-to-site VPN tunnel and the file shall be encrypted with ERS' public key (PGP), all Dental PPO claims processed during the previous calendar month. This data shall be used by ERS' Benefit Contracts Underwriting, Data Analysis, and Reporting team to analyze claims experience and reconcile the weekly invoices. Notwithstanding the foregoing, ERS shall at all times have online access to such information at no additional charge. The file must be in a fixed width, non-delimited format and it must contain a File Header Record, Claims Detail Records, and a File Footer/Trailer Record. The detailed Dental PPO claims file shall include at least the following information for each claim record:

- Record Type Identifier
- Service Date;
- Subscriber's Unique Employee Identification Number (Emplid);
- Subscriber's SSN
- Subscriber's Last Name
- Subscriber's First Name
- Subscriber's Middle Initial (if available)
- Subscriber's Gender
- Subscriber's Date of Birth
- Patient Relationship Code;
- Patient's SSN
- Patient's Last Name
- Patient's First Name
- Patient's Date of Birth
- Patient's Zip Code
- Patient's Gender
- Patient's Dependent Beneficiary Code (ERS' unique two-digit ID number)
- Dentist's Provider Number;
- Dentist's Name;
- Date Dentist Paid;
- In-Network Indicator;
- Charge Amount;
- Allowable Amount;
- COB Amount;
- Deductible Amount;
- Participant Copayment;
- Coinsurance Amount;
- Plan Payment;
- Dentist's Usual and Customary Charge; and
- Appropriate ADA procedure code.

G.1.b. The File Header Record must contain the following:

- Record Type Identifier
- File Period Begin Date
- File Period End Date
- File Creation Date/Time
- ERS Specific File Layout Version Number

G.1.c. The File Footer/Trailer Record must contain the following:

- Record Type Identifier
- Count of all records in the file

- Total Deductible Amount
 - Total Participant Copayment
 - Total Plan Payment
 - Total Dentist's UC Charge
- G.2. Respondent shall notify Benefit Contracts' Assistant Director or designee of all identified issues in connection with reports and/or audit findings and provide supporting documentation for all such reports.
- G.3. **Management Reporting Requirements.** ERS may, from time to time on an *ad hoc* basis, request that Respondent prepare customized reports on a timely basis at no additional cost to ERS. Respondent shall be required to provide data analysis and GBP-specific reports as specified by ERS. A list of Respondent's current client reports shall be included in Respondent's Proposal.
- G.3.a. All of ERS requested *ad hoc* reports from Respondent will be produced and provided to ERS at no additional cost to ERS.
- G.4. Following contract award, ERS will determine the required administrative reports and specify reporting frequency. Respondent's required reporting shall include, but not be limited to, the following:
- Performance Guarantees;
 - Call Center Statistics as referenced in **Appendix Y**;
 - Utilization and Experience History;
 - Statistical information (i.e., Lag report);
 - Complaints; and
 - Fraud, Waste and Abuse.
- G.4.a. Reports shall vary in frequency and scope based on ERS' designation after selection of Respondent and execution of the Contract as reflected herein. However, all reports provided by Respondent shall reflect quality production with attention to detail, accurate data, and meet additional requirements as specified by ERS. Costs associated with reporting shall be included in Respondent's Price Proposal, RFP **Appendix AA**.
- G.4.b. To ensure the accuracy of the self-reported information and reliability of Respondent's internal operational controls, Respondent shall provide documentation verifying all reported statistics associated with the Performance Guarantees referenced in **Appendix G** and/or other legal remedies available to ERS in the Contract. The document type and due date shall be specified by ERS.
- G.5. **Annual Reporting Requirements.** Respondent shall be required to submit GBP utilization and cost data by ADA code on an annual basis using ERS-prescribed format by January 15th following the end of the fiscal year. For example: by January 15, 2021, participating Respondent shall be required to provide utilization and cost data for the experience period September 1, 2019 through August 31, 2020. ERS' Respondent website contains an example of the required information and data formats for FY20 along with instructions for completing the tables at: <https://www.ers.texas.gov/vendors/contracts/>. These obligations survive the termination of the Contract for any reason, and Respondent is required to provide the required experience information for the previous fiscal year regardless of whether or not Respondent continues as a participating vendor under the GBP.
- G.5.a. **Other Annual Reporting Requirements.** Outside of what is listed above in RFP Sections XII.G.4 and XII.G.5., Respondent shall also be required to provide annual reports, which may include, but not be limited to: Annual certificate of compliance with DSBNA, Financial reports, etc.
- G.6. **Quarterly Reporting Requirements.** Respondent shall provide reports as reflected below using either GBP-specific or book of business statistics: Utilization and Cost Data by CDT. The data shall include the entire previous quarter and shall be received in the ERS-prescribed format, via email, by the 20th of the month following quarter end. Failure to provide the required data may result in a monetary performance assessment as required in the Performance Guarantees, **Appendix G** and/or other remedies available to ERS in the Contract. The required data and format are subject to change as required by ERS. **The current requirements are:**
- G.7. **Utilization and Cost Data by CDT.** Respondent shall submit GBP utilization data by ADA code. ERS' vendor website contains an example of the required information and data formats for FY15

along with instructions for completing the tables located at: <https://www.ers.texas.gov/vendors/contracts/> under UC Data Tables.

G.8. **Monthly Reporting Requirements.** Respondent shall provide the following reports as reflected in Section XII.G.14. below using GBP-specific unless otherwise indicated by ERS.

G.8.a. The data shall include the entire previous month, and shall be received in the ERS-prescribed format via email by the 20th of the following month. Failure to provide the required data may result in a monetary assessment as required in the Performance Guarantees, **Appendix G** and/or other legal remedies available to ERS in the Contract. The required data and format are subject to change as required by ERS. The current requirements are:

G.8.b. **Monthly Administrative Performance Report.** This document reflects the specific Contract performance areas upon which Respondent must report each month. The last tab of the document reflects the calculation and methodology used to identify the reported measure. On an annual basis, Respondent will be responsible for providing ERS with the source document in order to allow ERS the opportunity to certify that the self-reported data is accurate. A sample monthly administrative performance report is referenced in **Appendix Z**.

G.9. **Trends and Variance Reporting.** ERS shall utilize information reported by Respondent to proactively monitor trends and to identify/address variances on the targeted Respondent performance requirements. ERS shall specify the reporting timelines and formats. Some formats shall include a column indicating a performance standard for the item being reported that ERS shall use as a benchmark to monitor compliance and to analyze the reported statistics. The standard to be reported is based on availability in the following order of priority:

- Stated in the Contract;
- As required by applicable statute or regulation;
- Respondent's internal standard; and
- Generally accepted industry standard.

G.10. **Self-reported Information.** To ensure the accuracy of the self-reported information and reliability of Respondent's internal operational controls, Respondent shall provide documentation verifying the statistics. The document type and due date shall be specified by ERS.

The statistics required to be reported by Respondent include, but are not limited to:

- The number of written and emailed complaints received from GBP Participants, and the average length of time to resolve those complaints. Complaints shall be resolved within thirty (30) calendar days.
- The number of and percentage of ID cards, MBPDs and/or EOCs mailed within five (5) business days of Respondent's receipt of enrollment data from ERS or Participant request.
- Answer time, in seconds, for calls in the queue.
- Average call-blockage rate.
- GBP-specific dollars recovered through fraud investigation activity.
- Respondent shall report established standards for access to appointments and indicate in what percentage of cases its Providers satisfy the established access standard for the following:
 - Routine exams;
 - X-rays;
 - Cleanings; and
 - Palliative Treatment/Emergency Care.

G.11. **Monthly Provider Network Additions and Terminations Detail Report.** This information is utilized by ERS to proactively monitor and respond to changes in the provider network. The following data elements are required in the ERS-prescribed format: Provider Name, Provider Specialty, Full Provider Address, Provider Network Additions and Terminations, by Primary Care, Specialty and Facility, Date Provider Added To or Terminated from the Network, and Date Add/Term received by Respondent.

G.12. **Membership Report.** Respondent shall report, as required by ERS post Board selection, the number of enrollees for both state and higher education employees, including those with coverage for Member Only, Member and Spouse, Member and Child(ren), and Member and Family. The report shall include statistics for each of these categories for the following:

- State Members;
- Higher Education Members;

- Total Members;
- State Participants;
- Higher Education Participants; and
- Total Participants.

G.13. **Claims Lag Report.** Respondent shall be required to submit a claim lag report containing the monthly amount of paid claims by month incurred.

G.14. **Monthly Premium and Claim Report.** Respondent shall provide ERS' Benefit Contracts Assistant Director or designee with a monthly comparison of paid/billed premiums to the paid claims for the month. The specifics of the report will be determined post contract award.

G.15. **Special Reporting Requirements.** Respondent shall provide ERS with knowledgeable dedicated personnel resources to provide various reports and analytical data as requested by ERS. This data shall be used by ERS to analyze the Dental Plans. The information shall include current and previous year data. Special reporting requirements shall include, but not be limited to, the following:

- Trend Reporting;
- Cost Management & Fraud Report;
- Grievance Reporting as directed by ERS; and
- Other *ad hoc* reports.

ERS may request Respondent to provide additional, customized *ad hoc* reports. Respondent shall cooperate, act in good faith in working with ERS, and shall be prepared to respond to these requests promptly at no additional costs to ERS. Respondent shall provide normative data against which ERS can benchmark its plan.

H. Respondent Program Reporting Requirements- DHMO Only

H.1. Respondent shall notify Benefit Contracts' Assistant Director or designee of all identified issues in connection with reports and/or audit findings and provide supporting documentation for all such reports.

H.2. **Management Reporting Requirements.** ERS may, from time to time on an *ad hoc* basis, request that Respondent prepare customized reports on a timely basis at no additional cost to ERS. Respondent shall be required to provide data analysis and GBP-specific reports as specified by ERS. A list of Respondent's current client reports shall be included in Respondent's Proposal.

H.2.a. All of ERS requested *ad hoc* reports from Respondent will be produced and provided to ERS at no additional cost to ERS.

H.3. Following contract award, ERS will determine the required administrative reports and specify reporting frequency. Respondent's required reporting shall include, but not be limited to, the following:

- Performance Guarantees;
- Call Center Statistics as referenced in **Appendix Y**;
- Utilization and Experience History;
- Statistical information (i.e., Lag report);
- Complaints; and
- Fraud, Waste and Abuse.

H.3.a. Reports shall vary in frequency and scope based on ERS' designation after selection of Respondent and execution of the Contract as reflected herein. However, all reports provided by Respondent shall reflect quality production with attention to detail, accurate data, and meet additional requirements as specified by ERS. Costs associated with reporting shall be included in Respondent's Price Proposal, RFP **Appendix AA**.

H.3.b. To ensure the accuracy of the self-reported information and reliability of Respondent's internal operational controls, Respondent shall provide documentation verifying all reported statistics associated with the Performance Guarantees referenced in **Appendix G-1** and/or other legal remedies available to ERS in the Contract. The document type and due date shall be specified by ERS.

- H.4. **Annual Reporting Requirements.** Respondent shall be required to submit GBP utilization and cost data by ADA code on an annual basis using ERS-prescribed format by January 15th following the end of the fiscal year. For example: by January 15, 2021, participating Respondent shall be required to provide utilization and cost data for the experience period September 1, 2019 through August 31, 2020. ERS' Respondent website contains an example of the required information and data formats for FY20 along with instructions for completing the tables at: <https://www.ers.texas.gov/vendors/contracts/>. These obligations survive the termination of the Contract for any reason, and Respondent is required to provide the required experience information for the previous fiscal year regardless of whether or not Respondent continues as a participating vendor under the GBP.
- H.4.a. Respondent shall also be required to provide an annual report in Excel format that shows the number of GBP Participants assigned to each of Respondent PCDs. The report shall include the PCD's last name, first name, license number (issued by the Texas Board of Dental Examiners), office, ZIP Code and the number of GBP participants assigned. For example:

Table 2- Report Example

Last Name	First Name	License Number	ZIP Code	Number of GBP Participants
Brown	John	A7777	78701	5
Doe	Jane	B8888	75238	20
Smith	Joe	C9999	77041	10

- H.5. **Other Annual Reporting Requirements.** Outside of what is listed above in RFP Sections XII.H.4 and XII.H.5., Respondent shall also be required to provide annual reports, which may include, but not be limited to: Annual certificate of compliance with DSBNA, Financial reports, etc.
- H.6. **Monthly Reporting Requirements.** Respondent shall provide the following reports as reflected in Section XII.H.10. below using GBP-specific unless otherwise indicated by ERS.
- The data shall include the entire previous month, and shall be received in the ERS-prescribed format via email by the 20th of the following month. Failure to provide the required data may result in a monetary assessment as required in the Performance Guarantees, **Appendix G** and/or other legal remedies available to ERS in the Contract. The required data and format are subject to change as required by ERS. The current requirements are:
- H.7. **Monthly Administrative Performance Report.** This document reflects the specific Contract performance areas upon which Respondent must report each month. The last tab of the document reflects the calculation and methodology used to identify the reported measure. On an annual basis, Respondent will be responsible for providing ERS with the source document in order to allow ERS the opportunity to certify that the self-reported data is accurate. A sample monthly administrative performance report is referenced in **Appendix Z**.
- H.7.a. ERS shall utilize information reported by Respondent to proactively monitor trends and to identify/address variances on the targeted Respondent performance requirements. ERS shall specify the reporting timelines and formats. Some formats shall include a column indicating a performance standard for the item being reported that ERS shall use as a benchmark to monitor compliance and to analyze the reported statistics. The standard to be reported is based on availability in the following order of priority:
- Stated in the Contract;
 - As required by applicable statute or regulation;
 - Respondent's internal standard; and
 - Generally accepted industry standard.
- H.7.b. To ensure the accuracy of the self-reported information and reliability of Respondent's internal operational controls, Respondent shall provide documentation verifying the statistics. The document type and due date shall be specified by ERS.

The statistics required to be reported by Respondent include, but are not limited to:

- The number of written and emailed complaints received from GBP Participants, and the average length of time to resolve those complaints. Complaints shall be resolved within thirty (30) calendar days.
- The number of and percentage of ID cards, MBPDs and/or EOCs mailed within five (5) business days of Respondent's receipt of enrollment data from ERS or Participant request.
- Answer time, in seconds, for calls in the queue.
- Average call-blockage rate.
- GBP-specific dollars recovered through fraud investigation activity.
- Respondent shall report established standards for access to appointments and indicate in what percentage of cases its Providers satisfy the established access standard for the following:
- Routine exams;
 - X-rays;
 - Cleanings; and
 - Palliative Treatment/Emergency Care.

H.8. **Monthly Provider Network Additions and Terminations Detail Report.** This information is utilized by ERS to proactively monitor and respond to changes in the provider network. The following data elements are required in the ERS-prescribed format: Provider Name, Provider Specialty, Full Provider Address, Provider Network Additions and Terminations, by Primary Care, Specialty and Facility, Date Provider Added To or Terminated from the Network, and Date Add/Term received by Respondent.

H.9. **Membership Report.** Respondent shall report, as required by ERS post Board selection, the number of enrollees for both state and higher education employees, including those with coverage for Member Only, Member and Spouse, Member and Child(ren), and Member and Family. The report shall include statistics for each of these categories for the following:

- State Members;
- Higher Education Members;
- Total Members;
- State Participants;
- Higher Education Participants; and
- Total Participants.

H.10. **Monthly Premium and Claim Report.** Respondent shall provide ERS' Benefit Contracts Assistant Director or designee with a monthly comparison of paid/billed premiums to the paid claims for the month. The specifics of the report will be determined post contract award.

H.11. **Special Reporting Requirements.** Respondent shall provide ERS with knowledgeable dedicated personnel resources to provide various reports and analytical data as requested by ERS. This data shall be used by ERS to analyze the Dental Plans. The information shall include current and previous year data. Special reporting requirements shall include, but not be limited to, the following:

- Trend Reporting;
- Cost Management & Fraud Report;
- Grievance Reporting as directed by ERS; and
- Other *ad hoc* reports.

ERS may request Respondent to provide additional, customized *ad hoc* reports. Respondent shall cooperate, act in good faith in working with ERS, and shall be prepared to respond to these requests promptly at no additional costs to ERS. Respondent shall provide normative data against which ERS can benchmark its plan.

XIII. Scope of Work – Accounting and Funding Requirements

Respondent shall recover any costs related to the requirements set forth in this Article by ERS only through Respondent's Price Proposal, **Appendix AA**.

The section allowing for Deviations and the Interrogatories for this Article can be found at **Appendix X**. Respondent shall complete and submit **Appendix X** as a part of its Proposal.

A. Funding Methodology Requirements

- A.1. **Payment of Administrative Fee.** Each month the total administrative fee or premium under the insured plan will be determined by multiplying the number of employees and retirees enrolled by the administrative fee and/or premium. ERS will collect the contributions made by the Participants and remit the administrative fee/premium to Respondent within fifteen (15) days of the end of the month for which it is applicable. ERS will pay based on internal enrollment systems and Respondent can reconcile as needed.

B. Funding and Claims Reimbursement Methodology – PPO Only

- B.1. **State Contribution.** The State makes no contribution toward the cost of dental coverage.
- B.2. **Employee Contribution.** Employees and Retirees shall pay the entire premium for dental coverage. This cost may be paid through payroll deduction and is paid with pre-tax dollars.
- B.3. **Funding Methodology.** Each month, ERS will collect the Member contributions and hold such contributions in a fund that is designed solely for the payment of expenses incurred under the GBP. Remittance of funds to Respondent will be made in accordance with one of the following two (2) options as listed below. Respondent shall state which option Respondent will be performing within its Proposal.
- B.3.a. **Reimbursement of Claims - Option 1: Pay on Issuance.** Under a self-funded arrangement, Respondent will process and pay all claims submitted under the plan as described herein. The claims will be paid by Respondent through the issuance of drafts or checks on Respondent's account. On the first working day of each week, Respondent will present an invoice to ERS for all claim payments issued during the previous week. Within one (1) workday following receipt of the invoice, ERS will process and submit the payment voucher to the State Comptroller for payment. It is anticipated that authorization will be returned to ERS within four (4) working days and, upon receipt by ERS, will be immediately deposited into Respondent's account at its designated financial institution. Although Respondent will be responsible for maintaining sufficient funds to provide for the cash benefits, which become payable under the plan described in RFP Section III.B., Respondent will have no risk for the sufficiency of plan contributions. Due to the timing of the claims reimbursements, Respondent may be required to advance two (2) weeks of claims payments. Recently, two (2) weeks of claims payments have averaged around \$3 million.

In the event that the voucher is not presented to ERS as specified herein, ERS' Finance division will make reasonable efforts to contact Respondent by telephone and email to obtain the voucher. ERS will follow the process described above at RFP Section XIII.B.3.a.

Under this option, Respondent will provide resources and all applicable reporting to manage stale date check identification, reissuance processing, and remittance of stale date funds to ERS at no additional costs to ERS, the GBP, its Participants, and the State.

- B.3.b. **Reimbursement of Claims - Option 2: Pay on Presentment.** Respondent shall process and pay all self-funded claims submitted under the Plans as described herein and in the Contract. Respondent, through the issuance of drafts or through Electronic Funds Transfer, shall pay the claims from Respondent's account.

Respondent's self-funded banking system is built on assignment of customer liability based on when checks are "cashed" versus when checks are "issued". Respondent will open and administer a DDA on ERS' behalf, which supports claim payments they make on ERS' behalf. The account is under Respondent's tax ID number and Respondent retains ownership and control of the account; however, the funds within the account are those of ERS and will only be used to fund Plan activity. Any bank charges related to transactions and/or overdraft fees are the responsibility of Respondent.

Each business day, Respondent shall present a funding request to ERS before 8:00 AM CT via email requesting reimbursement for all payments that were actually presented for payment during the previous business day. ERS will then deposit the requested funds into the designated DDA via electronic funds transfer. A detailed payroll register report including taxes must accompany each funding request. It will be the responsibility of Respondent to request a pre-funding request for state and federal holidays. Respondent shall be responsible for maintaining sufficient funds to provide for the costs incurred.

As a reimbursement process, claims will be paid in arrears. The funding of the reimbursement process will be determined and agreed upon by both parties during the implementation process.

Under this option, Respondent will provide resources and all applicable claims reporting to identify the invoicing to the claims, referenced in **Appendix Z**.

- B.4. **Administrative Fee.** In responding to this RFP, Respondent is required to guarantee a single per capita throughout the Contract Term.
- B.4.a. The administrative fee proposed by the Respondent should be adequate to cover all administrative expenses incurred during the period of the Contract and during any runoff period following termination of the Contract.
- B.4.b. Chapter 1551, Tex. Ins. Code, exempts the GBP from taxes on administrative services fees. The administrative fee should not include any provisions for such taxes.
- B.5 **Payment of Claims – Responsibility of Respondent.** Respondent will be liable for adjudicating 100% of the claims incurred during the period of the Contract.
- B.6. **Runoff.** Following expiration or termination of the Contract for any reason, Respondent shall continue to be responsible for processing and paying claims incurred during the term of the Contract. The cost of such runoff administration shall be reflected in the proposed administrative fee provided in **Appendix AA**, Price Proposal.
- B.7. **Annual Experience Accounting.** Within ninety (90) days after the end of each Contract year, Respondent must provide ERS with an accounting of the Dental PPO plan financial experience under the Contract. The accounting shall include monthly enrollment, paid claims, and administrative fees, if any. (This accounting is required by Tex. Ins. Code, Chapter 1551.) In addition, Respondent shall provide ERS with such other experience data and accounting information as ERS shall reasonably require. Additional information in this regard may be provided post Contract award.
- B.8. **Maintenance of Benefits.** No Participant shall experience a loss of coverage or reduction of benefits due to a change in the Dental PPO plan Respondent that occurs as a result of this process.

C. Funding and Claims Reimbursement Methodology – DHMO Only

- C.1. **State Contribution.** The state makes no contribution toward the cost of dental coverage.
- C.2. **Employee Contribution.** Employees and retirees shall pay the entire premium for dental coverage. This cost may be paid through payroll deduction.
- C.3. **Premium Rate Requirements.** Premium rates shall be uniform throughout the State.

- C.4. **Determination of Premium Rates.** The DHMO is required to guarantee a single set of premium rates for the first three (3) years of the Contract.
- C.4.a. The DHMO is required to commit to good faith discussions with ERS prior to February 1, 2021, regarding rates for the last three (3) years of the Contract.
- C.4.b. In order to obtain ERS' approval of renewal rates for the last three (3) years of the Contract, the DHMO shall provide full documentation of the renewal rate determination and shall demonstrate to the satisfaction of ERS the appropriateness of the renewal rates.
- C.5. **Capitation Payments to Dentists.** ERS has determined that capitation rates are critical to maintaining a network of dentists sufficient to provide adequate access for GBP Participants. The DHMO may pay dentists capitation rates at any level; however, evaluation of Proposals will include the relationship of capitation to Plan copayments and the value this brings to the Participant. The DHMO shall only recover such capitation rates as reflected in **Appendix AA.E.4.**
- C.6. **ERS Administrative Expenses.** The Act provides that ERS may withhold a portion of the total premium paid under the program to provide for ERS' administrative expenses. ERS is not presently withholding for administrative expenses, but it has not made a decision with respect to the withholding of such an amount for FY20. Proposed rates should not include provision for ERS' administrative expenses. If ERS chooses to include an administrative fee during the term of the Contract, the DHMO premium rates will be adjusted to reflect such action.
- C.7. **Premium Rates.** Consideration should be given to the following in developing the premium rates:
 - C.7.a. The DHMO will have full liability for all claims incurred during the period of the Contract, including those claims incurred under the Contract but not submitted for payment until after termination of the Contract.
 - C.7.b. The liability of ERS, the state, and its Participants will be strictly limited to the premiums collected under the Contract. The DHMO will be at risk for any liability in excess thereof.
 - C.7.c. No state premium or maintenance taxes will be levied on the DHMO selected to underwrite the DHMO plan in accordance with Chapter 1551, Tex. Ins. Code.
 - C.7.d. The DHMO will receive the premium payment for a given month within forty-five (45) days following the due date for that month.
 - C.7.e. The premium should include provision for all administrative services described herein.
- C.8. **Maintenance of Benefits.** No Participant shall experience a loss of coverage or reduction of benefits due to a change in DHMO that occurs as a result of this process.
- C.9. The DHMO shall submit a proposed set of rates for the Benefits as described in the DHMO Schedule of Benefits, referenced at: <http://apps.humana.com/marketing/documents.asp?file=1384318>, by completing **Appendix AA.E.1.** Since ERS will accept no deviations from the DHMO Schedule of Benefits, do not provide a separate benefit schedule as part of the Proposal.

D. W-2 and W-9 Submissions – PPO and DHMO

- D.1. **Form W-2, Wage and Tax Statement.** If applicable, Respondent shall provide an executed IRS Form W-2, Wage and Tax Statement, upon Contract execution. The Legal name on the W-2 Statement for both the DDA and the bank where ERS will submit the Administrative Fee should reflect the legal name in the contract even if Respondent has two different Employer identification numbers or a parent company listed in the contract.
- D.2. **Required Content and W.9.** Respondent shall provide an executed IRS Form W-9, Request for Taxpayer Identification Number and Certification, upon Contract execution. The Legal name on the Request for Taxpayer Identification Number and Certification W-9 for both the DDA and the bank where ERS will submit the Administrative Fee should reflect the legal name

in the contract even if Respondent has two different Employer identification numbers or a parent company listed in the contract.

E. Financial Stability – PPO and DHMO

- E.1. Financial stability is scored on a pass/fail basis as referenced in RFP Section II.E.2. Respondent warrants and represents that it is in good financial stability, not in any form of bankruptcy or the zone of insolvency, and is current in the payment of all taxes and fees, including, but not limited to, state franchise taxes. In this regard:
 - E.1.a. Respondent will be required to attest to its financial stability by execution of the Signature Page attached hereto within **Appendix A**.
 - E.1.b. Respondent agrees to deliver, on an annual basis, audited or reviewed financial statements, including audited or reviewed financial statements from any sponsoring or parent corporation, if applicable. These financial statements should include, but not be limited to, Balance Sheet, Income Statement, Statement of Retained Earnings or Statement of Stockholders' Equity, Statement of Cash Flows, and Notes to the Financial Statements. Respondent further agrees to be available for reasonable inquiry by ERS of these financial statements.
- E.2. **Annual Experience Accounting.** Within ninety (90) days of the end of each Contract year, Respondent will provide a detailed financial report covering the Plans. The report will include monthly enrollment, administrative fees and/or contributions, paid claims and estimated incurred claims. The report will also provide a listing of outstanding claimants, which will include the estimated reserves for future payments.

The reserve determination will be accompanied with full documentation.

XIV. Price Proposal

This Article provides general information on the price proposal submission. The section allowing for Deviations and the Interrogatories for this Article can be found at **Appendix AA [Amended June 20, 2018]**. Respondent shall complete and submit **Appendix AA [Amended June 20, 2018]** as a part of its Proposal.

A. General Information

- A.1. **Enrollment.** The Enrollment history shown in **Appendix K**, Experience Data and Instructions, will be utilized by ERS to facilitate proposal analysis. Respondent must recognize that a variety of factors will influence future dental Plan enrollment. These factors include, but are not limited to increases in employee salary and changes in payroll deduction amounts.
- A.2. **Premium taxes.** In accordance with Chapter 1551, Tex. Ins. Code, no premium, maintenance or administrative services taxes or fees will be levied on coverages provided under the GBP. Respondent selected to administer the coverages described herein should not include recovery of such taxes or fees in the fees and/or premiums proposed herein.
- A.3. **Legislative Mandate.** If, subsequent to the submission of a Proposal prepared in response to these specifications, federal or state legislation or regulation is enacted or interpreted in a manner that materially impacts the coverages which are the subject of the RFP, ERS shall enter into good faith negotiations with Respondent selected to administer the Plans to arrive at mutually agreeable adjustments to the administrative fees and/or premium rates submitted in response to these specifications so as to appropriately reflect the anticipated impact of such legislation.
- A.4. Respondent shall guarantee the rates and fees stated in **Appendix AA [Amended June 20, 2018]** during any period following renewal or extensions as provided for in the Contract.
- A.5. Respondent shall note that ERS currently has approximately 350,000 employees and retirees who are eligible for dental coverage.

XV. Glossary of Terms

The following provides definitions of terms, acronyms, abbreviated phrases and other terms used in the RFP. These defined terms are capitalized when used throughout the RFP. Please use this section as a reference because the terms will not be defined within the text of the RFP.

ACA: Patient Protection and Affordable Care Act of 2010.

Account Executive Team: Respondent's executive staff responsible for managing the ERS relationship and ensuring the relationship is managed with high standards. Respondent's Account Executive Team will be familiar with the totality of Respondent's products and services and how to leverage these to best meet ERS' business goals and objectives.

Account Management Team: Respondent's staff assigned to work directly with ERS during the Contract Term.

Act: The Texas Employees Group Benefits Act located in Chapter 1551 of the Tex. Ins. Code

ADA: Americans with Disabilities Act of 1990, as amended.

Addendum: A modification or addition to the initially published Request for Proposal.

ANSI: American National Standards Institute coordinates the voluntary development and use of U.S. information technology standards, within the public and private sectors, pertaining to programming languages, electronic data interchange, telecommunications, and physical electronic media.

Authorized Representative (for Respondent): The Chief Executive Officer or other authorized officer who is at a Vice President or higher level of Respondent's organization who is authorized to bind the organization.

Anti-Virus: Computer software used to prevent or detect and remove malicious software.

BAA: Business Associate Agreement, **Appendix C** to the RFP.

BAFO: Finalist's Best and Final Offer.

BC or Benefits Coordinator: An State agency or higher education institution staff member dedicated to benefits enrollment and education at the Employer level. ERS is the Benefits Coordinator for Retirees.

BCOM: ERS' Benefits Communications division; the division conducts ongoing communications operations directed to Participants, Employers and other Stakeholders. BCOM's goal is to provide accurate, understandable and engaging information about how State employee and retiree benefits work within a context that helps diverse audiences recognize the value and importance of those benefits.

Bit: The basic unit of information in computing and digital communications.

Board: The Board of Trustees for the Employees Retirement System of Texas.

Board Rules: Rules of the Board of Trustees of the Employees Retirement System of Texas located at Title 34, Part 4, Tex. Admin. Code, including any amendments thereto. The Board Rules are located at [http://texreg.sos.state.tx.us/public/readtac\\$ext.ViewTAC?tac_view=3&ti=34&pt=4](http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=3&ti=34&pt=4).

Call Center: A centralized location where Respondent's staff will manage inbound and outbound telephone calls related to Dental services.

COC or Certificate of [Insurance] Coverage: Pursuant to Section 1551.059, the Board of Trustees shall provide for issuance to each employee or annuitant participating in the group benefits program a certificate of coverage that states:

- (1) the benefits to which the participant is entitled;
- (2) to whom the benefits are payable;
- (3) to whom a claim must be submitted; and

(4) the provisions of the plan document, in summary form, that principally affect the Participant.

Chapter 1551, Tex. Ins. Code: In 1975, the Texas Legislature passed Senate Bill 90, which created a health insurance program known as the GBP. The program was implemented to meet the stated purposes of the Texas Employees Group Benefits Act, under Chapter 1551, Tex. Ins. Code which is located at **Appendix S** of the RFP.

Chief Security Officer or Information Security Officer: Respondent's senior level executive responsible for establishing and maintaining Respondent's information assets and technologies and ensuring the information systems, assets, and technologies are adequately secure.

Clarifications: Clarifications consist of the clarification questions posed by ERS as well as Respondent's clarification responses to those questions. Clarification are mutually agreed upon by ERS and Respondent and are attached to the executed Contract as **Exhibit C**.

COB: Coordination of Benefits.

COBRA: Consolidated Omnibus Budget Reconciliation Act, Public Law 99-271.

Contract: The contractual agreement between ERS and Respondent, which includes, but is not limited to, the Contractual Agreement (**Appendix B**) and all of the exhibits and appendices thereto.

Contract Term: The term of the Contract is for six (6) years, which begins upon execution of the Contractual Agreements by ERS and is anticipated to extend through August 31, 2025, subject to the terms of the Contractual Agreement.

Contract Termination Date: Subject to the terms of the Contract, six (6) years from the date of execution by ERS, unless terminated, renewed or extended as provided for in the Contract.

Contractibility: The degree to which ERS finds Respondent a viable Vendor, specifically in terms of the Contract. Refer to RFP Section II.E.2. for more detail.

Contractual Agreement: The Contractual Agreement attached hereto as **Appendix B** to the RFP.

CPA: Texas Comptroller of Public Accounts.

CSR or Customer Service Representative: CSRs interact with Participants to provide answers to inquiries involving the Texas Employees Group Benefits Program.

CT: Central Time.

Customer Service Team: Respondent's staff trained to manage GBP-related questions and provide for resolution of complaints, clarifications, and escalated issues.

CY or Calendar Year: A calendar year begins annually on January 1 and ends on December 31 of the same year. The Calendar Year shall be determinative for Contract reporting requirements.

.DAT: The files which are used to store the Anti-Virus signatures and other information used by the Anti-Virus Application.

DDA or Demand Deposit Account: A demand deposit account is an account from which deposited funds can be withdrawn at any time without any advance notice to the depository institution.

Dental Choice: State of Texas Dental Choice PlanSM.

Dental PPO: Dental Preferred Provider Organization. The self-funded dental preferred provider organization PPO plan. Also referred to as the State of Texas Dental Choice PlanSM.

DSO or Dental Service Organization: A DSO is an independent business support operation that contracts with dental practices and provides business management and support to dental practices, including non-clinical operations. Sometimes referred to as "corporate dentistry" in connection with dental chains.

Dental Specialists: Dental Specialists include Oral Surgeons, Orthodontists, Endodontists, Periodontists, Pedodontists, and Prosthodontist who treat dental conditions as referred by a general dentist.

Deviation: A proposed deviation from a requirement contained in the RFP or the Contract. Deviations to background information or other ERS information only articles are not permissible and will not be considered by ERS.

DHMO: Dental Health Maintenance Organization.

DSBNA: Data Security and Breach Notification Agreement, **Appendix D** of the RFP.

Eligible/Eligibility: ERS administers insurance benefits for employees and qualified family members and will, therefore, determine whether individuals meet the requirements to be enrolled in the GBP benefits.

Employee: A person who is eligible to enroll for GBP benefits.

Employer: A commission, board, department, division, Institution of Higher Education, or other agency of the state of Texas created by Texas constitution or statutes. The term also includes the Texas Municipal Retirement System, the Texas County and District Retirement System, the Teacher Retirement System of Texas and ERS. State Agencies, Institutions of Higher Education and other governmental or quasi-governmental employers within the State whose employees or annuitants are authorized by the Act to participate in the GBP.

EOB: Explanation of Benefits.

EOC: Evidence of Coverage.

EOI or Evidence of Insurability: Also known as proof of good health. EOI is an application process in which one provides information on the condition of their health, or their dependent's health, to obtain certain insurance coverage. No evidence of insurability shall be required for employees or retirees to enroll in the dental plans.

ERISA: The Employee Retirement Income Security Act of 1974. ERISA is a federal law that imposes minimum standards for most voluntarily established pension and health plans in private industry to provide protection for individuals in these plans. ERS is not subject to the provisions of ERISA.

ERS: The Employees Retirement System of Texas.

ERS Project Manager: The project manager assigned by ERS to oversee implementation and other project management duties associated with the RFP and Contract.

ERS' Server: The server in which ERS posts solicitations and documents related to such solicitations, such as addenda and answers to questions. ERS' Server is located at <https://ftpsrvr.ers.texas.gov/EFTClient/Account/Login.htm>.

ESBD: Electronic State Business Daily, located at: www.txsmartbuy.com/sp. ESBD is the electronic marketplace where State bid opportunities over \$25,000 are posted. ERS posts notice of RFP publication and notification of any Addendum on ESBD.

ESBD Notice: A notice published on ESBD related to this solicitation.

Face to Face Interview: Presentation by Respondent held at an ERS-designated location during the Finalists Review Phase.

Facility: Dentists, dental practice facilities or clinics.

FE or Fall Enrollment: The enrollment period that takes place in the fall.

Finalists: The top-ranked Respondents based on the results from the Preliminary Review and Proposal Review Phases.

Finalists Review Phase: The phase in which top-ranked Respondents from the Proposal Review Phase move forward for further consideration by ERS.

Fiscal Year or FY: The Fiscal Year begins annually on September 1 and ends on August 31 of the following year.

GBP: The Texas Employees Group Benefits Program as provided under Chapter 1551 of the Tex. Ins. Code

GBP Contracted Vendors: The Vendors who provide administration services for the GBP plans.

GPG: Gnu Privacy Guard. A command line tool allows for encryption and signing of data and communications that includes a key management system, as well as access modules for all kinds of public key directories.

Group Practice: A Group Practice is a practice that includes two or more dentists practicing under one (1) tax ID number and is not a DSO chain operation.

HCRA: Health Care Reimbursement Account.

HealthSelectSM: HealthSelectSM of Texas, the statewide health insurance benefit plan self-funded by the Employees Life, Accident and Health Insurance and Benefits Fund, as administered by ERS and a qualified carrier or administering firm. It includes in-area and out-of-state benefits, a Medicare-Eligible plan, and the Consumer Directed HealthSelectSM plan.

HIPAA: The federal Health Insurance Portability and Accountability Act of 1996 [Pub. L. No. 104-191], amended by the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009, and the implementing regulations issued and amended by the U.S. Department of Health and Human Services Secretary (45 C.F.R. parts 160 and 164), as amended.

HSP: A Historically Underutilized Business Subcontracting Plan, as the term is used in the Tex. Gov't Code, Chapter 2161.

HTML: Hypertext Markup Language: the set of markup symbols or codes inserted in a file intended for display on a World Wide Web browser page. HTML tells the Web browser how to display a Web page's words and images for the user.

HTTP: Hypertext Transfer Protocol.

HUB: A historically underutilized business, as defined in Tex. Gov't Code, Chapter 2161, Subchapter F.

Implementation Period: The period of time beginning with ERS' execution of the Contract through the point at which Respondent assumes full responsibility for provision of Dental services (as defined in the Contract).

Implementation Plan: The project schedule agreed-upon by ERS and Respondent indicating when milestones or elements of the work would be completed by Respondent and ERS staff.

Implementation Project Manager: The person responsible for managing Respondent's implementation team and for implementation, coordination, and maintenance of the business relationship and continuity pertaining to all business matters in support of the Contract during the Implementation Period.

Implementation Team: Respondent's staff that is fully devoted to implementation of the services.

Information Security Policy: Respondent's policies and/or procedures that outline its information security program.

Information Technology: The study or use of systems (computers and telecommunications) for storing, retrieving, and sending information.

Institution of Higher Education: A public junior college, senior college or university, or any other institution of higher education within the meaning and jurisdiction of Chapter 61, Texas Education Code. This definition does not include an entity in The University of Texas System, as described in Section 65.02, Texas Education Code, or an entity in The Texas A&M University System, as described in Subtitle D, Title 3, Texas Education Code, including the Texas Veterinary Medical Diagnostic Laboratory.

IRS: Internal Revenue Service.

IVR: Interactive voice system.

LFSA: Limited Flexible Spending Account.

Marketing Guidelines for GBP and Other ERS Vendors: Marketing guidelines found in the *ERS Editorial Style Guide & Usage Manual* located at: http://www.ers.texas.gov/ERS_Guidelines/.

MBPD or Master Benefit Plan Document: Describes the **STATE OF TEXAS DENTAL CHOICE PLANSM**. Current copy of the MBPD is located at: <http://apps.humana.com/marketing/documents.asp?file=1767584>.

Member: For purposes of the RFP, a Member is an Employee, Retiree or other person eligible to participate in the GBP as provided under Chapter 1551, Tex. Ins. Code and **who is not a dependent**.

Minimum Requirements: Requirements set forth by ERS that Respondent must meet as set forth in Article IV. Failure to satisfy the Minimum Requirements shall result in the disqualification of Respondent's Proposal. ERS will not accept deviations to the Minimum Requirements.

Nondisclosure Agreement: The Confidentiality and Nondisclosure Agreement, which must be requested by Respondent and returned to ERS if Respondent will propose to provide the services requested at RFP Section VI.A.7.

Participant: An individual eligible under applicable law to receive health benefits, life insurance and other optional benefits under the GBP. **Participants include Members and their dependents.**

Participant ID: A Participant's unique employee identification number.

PCD: Primary Care Dentist.

PEPM: Per Employee Per Month, includes members and retirees.

Performance Guarantees: The performance standards guaranteed by Respondent attached as **Appendix G** to the RFP.

PGP: Pretty Good Privacy; a data encryption and decryption computer program that provides cryptographic privacy and authentication for data communication.

PIA: Texas Public Information Act, Chapter 552 of the Tex. Gov't Code, as amended.

PPO: Preferred Provider Organization.

Preliminary Review Phase: The phase in which ERS evaluates Proposals for Minimum Requirements and compliance with the RFP on a pass/fail basis.

Proposal: The document prepared and submitted by Respondent that is responsive to the RFP.

Proposal Review Phase: The phase in which ERS evaluates Proposals from all Respondents who pass the Preliminary Review Phase.

Protected Materials: Patents, trademarks, copyrights and other intellectual property embodied in the public version of Respondent's Proposal.

QA: Quality Assurance program.

QLE: A Qualifying Life Event, as specified in Section 81.7 of Chapter 1551, Tex. Ins. Code.

Respondent: A qualified vendor submitting a Proposal in response to the RFP. For purposes of the Contract, including the RFP, Respondent refers to the contracting entity and its organization, including Respondent's personnel, its officers, directors, employees, representatives, agents, and any subcontractors and independent contractors that will provide the services requested in the RFP.

Retiree: A retiree from the state is an employee whose service credit must be established (not withdrawn) with ERS at the time of retirement, and the employee must be at least age 60 with a minimum of five (5)

years of service credit. An ERS member may retire under the rule of 80 if years and months of service credit (at least five (5) years) and years and months of age equal or exceed 80.

RFP: Request for Proposal in reference to this solicitation for Dental services.

Section 508: Section 508 of the Rehabilitation Act of 1998 (29 U.S.C. 794d), as amended by the Workforce Investment Act of 1998 (P.L. 105-220), August 7, 1998.

SFTP or Secure File Transfer Protocol: A network protocol that provides file transfer and manipulation functionality over any reliable data stream.

Signature Pages: The pages requiring the signature of Respondent's Authorized Representative, which are attached as **Appendix A** of the RFP.

SOC-2 Report or Service Organization Controls, Type 2 Report: Service Organization Controls provide a series of accounting standards that measure the effectiveness of internal controls over operations. The SOC-2 Report focuses on businesses' non-financial reporting controls related to security, availability, processing integrity, confidentiality, and privacy of a system, which is different from the SOC-1 report, as the SOC-1 report, is focused on the financial reporting controls.

SSAE16/SSAE18 or Statement of Standards for Attestation Engagements: Standards imposed for SOC reports.

SSO: Single Sign-on.

State: State of Texas.

State Agency: A commission, board, department, division, or other agency of the State created by the constitution or statutes of this State.

SE or Summer Enrollment: The enrollment period that takes place in the summer.

System Availability Rate: The percentage of available hours that Respondent's Internet site is operational, excluding scheduled and pre-approved maintenance time, measured on a Calendar Year basis.

TAT: Turn Around Time.

TC or Technical Consultant: The person that ensures that all ERS system requests and issues are thoroughly analyzed and given priority positioning to ensure prompt resolution.

TDI: Texas Department of Insurance.

Tex. Admin. Code: Texas Administrative Code.

Tex. Gov't Code: Texas Government Code.

Tex. Ins. Code: Texas Insurance Code.

TLS or Transport Layer Security: A protocol that ensures privacy between communicating applications and their users on the Internet.

Trojans: Programs that create a backdoor on a computer that gives malicious users access to the system, possibly allowing confidential or personal information to be compromised.

TST: Texas State Treasury.

U.S. or United States: The United States of America.

Uptime Tier and Uptime Institute: The Uptime Institute is an unbiased advisory organization focused on improving the performance, efficiency, and reliability of business critical infrastructure through innovation, collaboration, and independent certifications, and it sets the standards known as the Uptime Tier III and Uptime Tier IV standards as requested at **Appendix U**.

UC: Usual and customary charge.

VPN or Virtual Private Network: A network that is constructed by using public wires - usually the Internet - to connect to a private network, such as a company's internal network.

WCAG: Web Content Accessibility Guidelines.

XML: Extensible Markup Language. A markup language that defines a set of rules for encoding documents in a format, which is both human-readable and machine-readable.

XVI. Dental RFP Deliverables Checklist

Order of Return: The Respondent is required to submit all Proposal materials in the order prescribed in this checklist.

For additional information, please refer to RFP Section I.D.6.

- One (1) printed original labeled “**Dental RFP - Proposal Original**”
- Three (3) additional printed copies, each labeled “**Dental RFP - Proposal Duplicate**”
- Two (2) digital copies of Respondent’s Proposal shall be submitted in Word format, unencrypted, not password protected, and on disc(s) or USB Thumb Drives labeled **Dental RFP – Proposal Duplicate**
- One (1) disc or USB Thumb Drive that contains all information Respondent considers confidential and/or proprietary labeled “**Dental RFP – Confidential and/or Proprietary Information**”
- One (1) disc or USB Thumb Drive that contains all information that Respondent considers public labeled “**Dental RFP – Public Information**”

NOTE: Keep this Checklist for your records. Do not return with your submission.

PAPER FORMAT	RFP SECTION REFERENCE
TAB A – Respondent’s answers to the Interrogatories to the Minimum Requirements	Appendix M
TAB B – Respondent’s answers to the Interrogatories to Respondent’s Organizational and Reference Information	Appendix O
TAB C – Respondent’s Deviations and answers to the Interrogatories to the Legal Requirements and Regulatory Compliance	Appendix N
TAB D – Respondent’s Deviations and answers to the Interrogatories to the Dental PPO and DHMO Structure and Administration Requirements	Appendix P
TAB E – Respondent’s Deviations and answers to the Interrogatories to the Provider Network and Service Area Requirements	Appendix Q
TAB F – Respondent’s Deviations and answers to the Interrogatories to the Communication Requirements	Appendix R
TAB G – Respondent’s Deviations and answers to the Interrogatories to the Information Systems Requirements	Appendix U
TAB H – Respondent’s Deviations and answers to the Interrogatories to the Implementation and Project Management Requirements	Appendix V
TAB I – Respondent’s Deviations and answers to the Interrogatories to the Operational Specifications and Requirements	Appendix W
TAB J – Respondent’s Deviations and answers to the Interrogatories to the Accounting and Funding Requirements	Appendix X
TAB K – Respondent’s Deviations and answers to the Interrogatories to the Price Proposal	Appendix AA

PAPER FORMAT	RFP SECTION REFERENCE
TAB L - REQUESTED MATERIALS:	
TAB 1 – General Instructions Executed RFP Signature Pages (Appendix A)	RFP Article I, Sections D.7. & E.1.a.
TAB 2 – Separate schedule of all pages containing confidential and/or proprietary information.	RFP Article I, Section D.6. & F.1.b.
TAB 3 – HUB information, if applicable	RFP Article I, Sections G.1 – G.1.a.
TAB 4 – Mimimum Requirements A copy of each business or professional license and/or certification with Respondent’s Proposal, including Respondent’s current Texas license	Appendix M, Section A.1.a.
TAB 5 – Organizational and Reference Information Provide copies of the Organizational Charts for PPO	Appendix O, Section A.5.
TAB 6 – Provide copies of the Organizational Charts for DHMO	Appendix O, Section C.5.
TAB 7 - Legal Requirements and Regulatory Compliance Executed Incumbency Certificate (Appendix E)	RFP Article VI, Section A.2.
TAB 8 - Execution of the Contractual Agreement for PPO is a preferred submission - (Appendix B). If not submitting an executed contract, provide Deviations thereto.	RFP Article VI, Section A.3.; Appendix N, Section A.1.
TAB 9 - Execution of the Business Associate Agreement for PPO is a preferred submission. If not providing an executed BAA, provide Deviations thereto. (Appendix C)	RFP Article VI, Section A.3.; Appendix N, Section A.1.
TAB 10 - Execution of the Data Security and Breach Notification Agreement for PPO is a preferred submission. If not providing an executed Data Security and Breach Notification Agreement, provide Deviations thereto. (Appendix D)	RFP Article VI, Section A.3.; Appendix N, Section A.1.
TAB 11 - Redlined deviations to the Performance Guarantees for PPO , if applicable (Appendix G)	Appendix N, Section A.2.
TAB 12 - A copy of each entity’s Certificate of Formation for PPO (including any amendments)	Appendix N, Section C.4.e.1.
TAB 13 - A corporate charter or other equivalent formation document (including any amendments) from the jurisdiction of formation, if not formed in Texas for PPO	Appendix N, Section C.4.e.2.
TAB 14 - A copy of any assumed name certificates filed in Texas for PPO	Appendix N, Section C.4.e.3.

PAPER FORMAT	RFP SECTION REFERENCE
TAB 15 - Evidence of good standing in its jurisdiction of incorporation or formation for PPO	Appendix N, Section C.4.g.
TAB 16 -- Evidence of Respondent's Certificate of Authority to conduct business in Texas, if Respondent was not formed in Texas for PPO	Appendix N, Section C.4.i.
TAB 17 - A copy of Respondent's Texas Franchise Tax Account Status Report for PPO	Appendix N, Section C.4.j.
TAB 18 - Copies of ratings and reports on Respondent issued by independent rating organizations or similar entities, such as those issued by A.M. Best's, Moody's, Standard and Poor's for PPO	Appendix N, Section C.4.n.
TAB 19 - Execution of the Contractual Agreement is a preferred submission. If not submitting an executed contract, provide Deviations thereto for DHMO . (Appendix B)	RFP Article VI, Section A.3.; Appendix N, Section D.1.
TAB 20 - Execution of the Business Associate Agreement (BAA) is a preferred submission. If not providing an executed BAA, provide Deviations thereto for DHMO . (Appendix C)	RFP Article VI, Section A.3.; Appendix N, Section D.1.
TAB 21 - Execution of the Data Security and Breach Notification Agreement is a preferred submission. If not providing an executed Data Security and Breach Notification Agreement, provide Deviations thereto for DHMO . (Appendix D)	RFP Article VI, Section.A.3.; Appendix N, Section D.1.
TAB 22 – Red-lined deviations to the Performance Guarantees for DHMO , if applicable (Appendix G-1)	Appendix N, Section D.2.
TAB 23 - A copy of each entity's Certificate of Formation (including any amendments) for DHMO	Appendix N, Section F.4.e.1.
TAB 24 - A corporate charter or other equivalent formation document (including any amendments) from the jurisdiction of formation, if not formed in Texas for DHMO	Appendix N, Section F.4.e.2.
TAB 25 - A copy of any assumed name certificates filed in Texas for DHMO	Appendix N, Section F.4.e.3.
TAB 26 - Evidence of good standing in its jurisdiction of incorporation or formation for DHMO	Appendix N, Section F.5.g.
TAB 27 - Evidence of Respondent's Certificate of Authority to conduct business in Texas, if not formed in Texas for DHMO	Appendix N, Section F.5.i.
TAB 28 - A copy of Respondent's Texas Franchise Tax Account Status Report for DHMO	Appendix N, Section F.5.j.
TAB 29 - Copies of ratings and reports on Respondent issued by independent rating organizations or similar entities, such as those issued by A.M. Best's, Moody's, Standard and Poor's for DHMO	Appendix N, Section F.5.n.
TAB 30 – PPO submit its proposed self-funded Proposal	Appendix P, Section B.1.
TAB 31 - DHMO submit its rates	Appendix P, Section D.1.

PAPER FORMAT	RFP SECTION REFERENCE
<p>TAB 32 – Provider Network and Service Area Requirements</p> <p>DHMO must provide documentation of the TDI approved provider network as of January 1, 2018 in the prescribed ERS format. For each service area included in the DHMO Proposal, the DHMO shall provide one Provider Network Excel file, including one (1) worksheet for the primary dentist and one (1) worksheet for the specialty dental providers. As an example, a DHMO submitting a response for three (3) different service areas shall submit three (3) separate Excel files. Each Excel file shall contain two (2) separate worksheets, one for each of the two (2) required networks: primary dentists and specialty care dentists</p>	<p>RFP Article VIII, Section A.1.</p>
<p>TAB 33 – DHMO shall submit a copy of its TDI's date stamped approved service area documentation for service areas approved by TDI on or before January 1, 2018</p>	<p>RFP Article VIII, Section A.7.a.</p>
<p>TAB 34 - DHMO shall provide map(s) that are comprised of complete counties boldly outlining each proposed service area.</p>	<p>RFP Article VIII, Section A.7.b.</p>
<p>TAB 35 - DHMO - Service area in ERS format, listing the counties for the proposed service area. The file should be saved in Excel format</p>	<p>RFP Article VIII, Section A.7.c.</p>
<p>TAB 36 - For Dental PPO benefits, Respondent will offer complete flexibility in a Participant's selection of a dentist. Respondent shall provide documentation using ERS-required format to demonstrate that the proposed provider network contains a sufficient number of dental care providers to serve GBP Participants. Separate documentation shall be provided for each of the following: (i) general dentists; and (ii) specialty care dentists. Documentation for each of these proposed and established networks shall be provided in the ERS-prescribed format</p>	<p>RFP Article VIII, Section B.1.</p>
<p>TAB 37 - Respondent shall provide a provider network Excel file that contains the proposed PPO network. The Excel file shall contain one (1) worksheet for general dentists and one (1) worksheet for specialty dental providers</p>	<p>RFP Articles VIII, Section B.3</p>
<p>TAB 38 - Map(s) that are comprised of complete counties boldly outlining each proposed service area (PPO)</p>	<p>RFP Article VIII, Section B.8.a.</p>
<p>TAB 39 - Service area Excel file in ERS format, listing the counties for the proposed service area in separate folders on the Excel file (PPO)</p>	<p>RFP Article VIII, Section B.8.b.</p>
<p>TAB 40 - PPO - A copy of GBP Utilization of CDT Codes (Appendix I)</p>	<p>Appendix Q, Section D.13.</p>
<p>TAB 41 - A copy of Respondent's proof of NCQA accreditation or certification for PPO</p>	<p>Appendix Q, Section D.26.</p>
<p>TAB 42 - DHMO - A copy of GBP Utilization of CDT Codes (Appendix I)</p>	<p>Appendix Q, Section F.12.</p>
<p>TAB 43 - A copy of Respondent's proof of NCQA accreditation or certification for DHMO</p>	<p>Appendix Q, Section F.25.</p>
<p>TAB 44 – Communication Requirements</p> <p>Provide a proposed draft of the Member Handbook for PPO</p>	<p>RFP Article IX, Section B.5.</p>

PAPER FORMAT	RFP SECTION REFERENCE
TAB 45 – Provide a proposed sample of a Dental PPO Welcome Packet	RFP Article IX, Section B.7.
TAB 46 – Submit an electronic mock-up of a proposed GBP-specific ID card for PPO	RFP Article IX, Section B.10.a.
TAB 47 – Dental DHMO to submit a draft of the Member Handbook	RFP Article IX, Section C.7.
TAB 48 – Submit a proposed EOC on a separate CD-ROM (with tracked changed modifications if a current Vendor, no tracked changes if a new Vendor) for DHMO	RFP Articles IX, Sections C.5. – C.5.c.
TAB 49 – Submit an electronic mock-up of a proposed GBP-specific ID card for DHMO	RFP Article IX, Section C.10.a.
<p>TAB 50 - Provide samples and/or copies of the enrollment marketing packets Respondent will provide to Participants. This response should include, but not be limited to, the items discussed at RFP Article IX, Section A.17. which are as follows:</p> <ul style="list-style-type: none"> • An enrollment presentation to be recorded and posted on the ERS website and delivered upon request at enrollment events; • Targeted enrollment communication brochures; • Welcome Letter to new Participants; • Brochures explaining Plan changes and updates; • Explanation of Benefits – Fact Sheet; • General Plan information; and • Enrollment information on Respondent’s website. (PPO) 	RFP Article IX, Section A.17.; Appendix R, Section B.1.
TAB 51 - Copies of Respondent’s generic communications used for plans similar to the Plans. Respondent’s response should include, but not be limited to, enrollment marketing packets. (PPO)	Appendix R, Section B.7.
TAB 52 - A copy of Respondent’s sample Fact Sheets for PPO	RFP Article IX, Section B.9.; Appendix R, Section D.1.
<p>TAB 53 – Communication Requirements</p> <p>The Dental PPO shall provide for FY20 a proposed draft of the MBPD and on a separate CD-ROM or USB Thumb Drive</p>	RFP Article IX, Section B.6.; Appendix R, Section D.2.
TAB 54 - A copy of a report from an independent provider evidencing its organization’s Section 508 compliance. If Respondent is not currently Section 508 compliant, Respondent shall provide a timeline indicating when it will implement these requirements for PPO	RFP Article IX, Sections A.5 – A.5.a.; Appendix R, Section F.2.
<p>TAB 55 - Samples and/or copies of the enrollment marketing packets Respondent will provide to Participants. This response should include, but not be limited to, the following items:</p> <ul style="list-style-type: none"> • An enrollment presentation to be recorded and posted on the ERS website and delivered upon request at enrollment events; • Targeted enrollment communication brochures; • Welcome Letter to new Participants; • Brochures explaining Plan changes and updates; • Explanation of Benefits – Fact Sheet; • General Plan information; and • Enrollment information on Respondent’s website. (DHMO) 	Appendix R, Section I.1.

TAB 56 - Copies of Respondent's generic communications used for plans similar to the Plans. Respondent's response should include, but not be limited to, enrollment marketing packets. (DHMO)	Appendix R, Section I.7.
PAPER FORMAT	RFP SECTION REFERENCE
TAB 57 - A copy of Respondent's sample Fact Sheets for DHMO	RFP Article IX, Section C.9.; Appendix R, Section K.1.
TAB 58 - A copy of a report from an independent provider evidencing its organization's Section 508 compliance. If Respondent is not currently Section 508 compliant, Respondent shall provide a timeline indicating when it will implement these requirements. (DHMO)	Appendix R, Section M.2.
TAB 59 – Information Systems Requirements A copy of Respondent's business policies and procedures related to the business process for PPO	Appendix U, Section D.3.
TAB 60 - A copy of Respondent's standard data and claims files which should include specifications that are required when ERS transfers Participant information for PPO	Appendix U, Section D.7.
TAB 61 - A copy of Respondent's Security Incident Management policies and procedures for the application and for internal systems for PPO	Appendix U, Sections F.14. - F.14.a.
TAB 62 - Copies of Respondent's formal information securities policies, procedures and standards for PPO	Appendix U, Sections F.22.a.i.
TAB 63 - Copy of disaster relief plan and disaster the disaster recovery test results for PPO	Appendix U, Section H.11.
TAB 64 - Summary of the latest disaster recovery test results for PPO	Appendix U, Section H.12.
TAB 65 - Provide a full, un-redacted copy of the most recent SOC-2 type II report and results performed under the SSAE16 or SSAE18 SOC-2 Type II report or any other independent auditor report on the effectiveness of internal controls over operations and compliance of service to be provided under this RFP, including disaster recovery planning and testing, and data center facilities. This should include results of an independent, certified external security audit. Respondent shall also acknowledge and agree that ERS is entitled to review all such audit results on a yearly basis. If there is not a service organization control engagement performed, then provide a detailed explanation of how both information technology and operational control activities are assessed/evaluated to meet the services to be provided under this RFP. (PPO)	Appendix U, Section J.1.
TAB 66 – If applicable, provide a copy of Respondent's sponsoring or parent company's most recent SOC-2 report under SSAE 16 or SSAE18 SOC-2 Type II report or any other independent auditor report on the effectiveness of internal controls over operations, security, and compliance of service to be provided under the RFP, if applicable for PPO	Appendix U, Section J.1.a.
TAB 67 - If any data centers, development, or data services are outsourced or subcontracted, copies of outsourcers' or subcontractors' SOC-2 under SSAE16 or SSAE18 SOC-2 Type II report or equivalent reports for PPO	Appendix U, Section J.3.

TAB 68 - A copy of Respondent's business policies and procedures related to the business process for DHMO	Appendix U, Section N.3.
PAPER FORMAT	RFP SECTION REFERENCE
TAB 69 - A copy of Respondent's standard data and claims files, including specifications that are required when ERS transfers Participant information for DHMO	Appendix U, Section N.7.
TAB 70 – A copy of Respondent's Security Incident Management policies and procedures for the application and for internal systems for DHMO	Appendix U, Sections P.14. – P.14.a.
TAB 71 - A copy of Respondent's formal information securities policies, procedures and standards for DHMO	Appendix U, Section P.22.a.i.
TAB 72 – Copy of disaster relief plan and disaster the disaster recovery test results for DHMO	Appendix U, Section R.11.
TAB 73 - Summary of the latest disaster recovery test results for DHMO	Appendix U, Section R.12.
TAB 74 - Provide a full, un-redacted copy of the most recent SOC-2 type II report and results performed under the SSAE16 or SSAE18 SOC-2 Type II report or any other independent auditor report on the effectiveness of internal controls over operations and compliance of service to be provided under this RFP, including disaster recovery planning and testing, and data center facilities. This should include results of an independent, certified external security audit. Respondent shall also acknowledge and agree that ERS is entitled to review all such audit results on a yearly basis. If there is not a service organization control engagement performed, then provide a detailed explanation of how both information technology and operational control activities are assessed/evaluated to meet the services to be provided under this RFP for DHMO	Appendix U, Section T.1.
TAB 75 – If applicable, a copy of Respondent's sponsoring or parent company's most recent SOC-2 report under SSAE 16 or SSAE18 SOC-2 Type II report or any other independent auditor report on the effectiveness of internal controls over operations, security, and compliance of service to be provided under the RFP, if applicable for DHMO	Appendix U, Section T.1.a.
TAB 76 - If any data centers, development, or data services are outsourced or subcontracted, copies of outsourcers' or subcontractors' SOC-2 under SSAE16 or SSAE18 SOC-2 Type II report or equivalent reports for DHMO	Appendix U, Section T.3.
TAB 77 – Operational Specifications and Requirements Provide a copy of Respondent's fraud plan for PPO	Appendix W, Section D.1.f.
TAB 78 - A copy of the results of Respondent's most recent customer satisfaction survey for PPO	Appendix W, Section F.4.a.
TAB 79 - A copy of Respondent's sample source documents used by Respondent to arrive at the reporting requirements for the call center metrics referenced in Appendix Y. (PPO)	Appendix W, Section F.13.
TAB 80 - Copies of Respondent's sample standard reporting package for PPO	Appendix W, Section L.3.

TAB 81 - A copy of Respondent's current published policies and procedures for the QA program for PPO	Appendix W, Section M.5.
PAPER FORMAT	RFP SECTION REFERENCE
TAB 82 - A copy of Respondent's fraud plan for DHMO	Appendix W, Section Q.1.f.
TAB 83 - A copy of the results of Respondent's most recent customer satisfaction survey for DHMO	Appendix W, Section S.4.a.
TAB 84 - Copies of Respondent's sample source documents (refer to Section XII.D.5.) for DHMO	Appendix W, Section S.13.
TAB 85 - Copies of Respondent's sample standard reporting package for DHMO	Appendix W, Section W.3.
TAB 86 - A copy of Respondent's current published policies and procedures for the QA program for DHMO	Appendix W, Section X.5.
TAB 87 – Accounting and Funding Requirements Respondent shall provide a copy of its most recent audited or reviewed financial statements. The financial statements should include, but not be limited to, Balance Sheet, Income Statement, Statement of Retained Earnings or Statement of Stockholders' Equity, Statement of Cash Flows, and Notes to the Financial Statements (PPO)	Appendix X, Section G.1.
TAB 88 - Provide a copy of the sponsoring organization's most recent audited financial statement if any such entity provides financial support to Respondent. The financial statements should include, but not be limited to, Balance Sheet, Income Statement, Statement of Retained Earnings or Statement of Stockholders' Equity, Statement of Cash Flows, and Notes to the Financial Statements (PPO)	Appendix X, Section G.1.a.i.
TAB 89 - Provide a copy of the report of the daily funding request with a detailed payroll register including taxes (PPO)	Appendix X, Section G.1.d.
TAB 90 - Respondent shall provide a copy of its most recent audited or reviewed financial statements. The financial statements should include, but not be limited to, Balance Sheet, Income Statement, Statement of Retained Earnings or Statement of Stockholders' Equity, Statement of Cash Flows, and Notes to the Financial Statements (DHMO)	Appendix X, Section M.1.
TAB 91 - A copy of the sponsoring organization's most recent audited financial statement if any such entity provides financial support to Respondent for DHMO	Appendix X, Section M.1.a.i.
TAB 92 - Provide a copy of the report of the daily funding request with a detailed payroll register including taxes (DHMO)	Appendix X, Section M.1.d.
TAB 93 - Complete the GBP Utilization of CDT Codes fee schedule using the average allowable cost for network providers. This fee schedule needs to contain information for each 3-digit zip code in Texas. If the respondent is proposing to use more than one (1) network, provide a separate fee schedule for each network proposed. (Appendix I)	Appendix AA, Section C.3.

XVII. Appendices

- A. Signature Pages
- B. Contractual Agreement
- C. Business Associate Agreement
- D. Data Security and Breach Notification Agreement
- E. Incumbency Certificate
- F. Other GBP Contracted Vendors
- G. Performance Guarantees
- H. Dental PPO Plan Design Changes
- I. GBP Utilization CDT Codes
- J. Weekly/Monthly File Layouts
- K. Experience Data:
 - Experience Data Instructions
 - A. GBP Enrollment and Premium History
 - B. Total Program Enrollment
 - C. Dental Plan Enrollment Demographics
 - D. Plan Enrollment by County
 - E. Plan Enrollment by ZIP Code
 - F. Dental Plan Rate History
 - G. Dental PPO Plan Claims Lag Report
 - H. Dental PPO Plan Utilization Data
 - I. Dental HMO Plan Utilization Data
 - J. Dental PPO Plan Enrollment and Claims by Zip Code
 - K. Dental PPO Plan Claims Experience
- L. Nondisclosure Agreement
- M. Minimum Requirements
- N. Legal Requirements and Regulatory Compliance Deviations and Interrogatories
- O. Respondent's Organizational and Reference Information Interrogatories
- P. Dental PPO and DHMO Structure and Administration Requirements Deviations and Interrogatories
- Q. Provider Network and Service Area Requirements Deviations and Interrogatories
- R. Communication Requirements Deviations and Interrogatories
- S. Chapter 1551 Texas Insurance Code
- T. ERS Editorial Style Guide and Usage Manual and the ERS Brand Guidelines
- U. Information Systems Requirements Deviations and Interrogatories
- V. Implementation and Project Management Requirements Deviations and Interrogatories
- W. Operational Specifications and Requirements Deviations and Interrogatories
- X. Accounting and Funding Requirements Deviations and Interrogatories

- Y. Call Center Metrics
- Z. Example Dental Claims Reconciliation File Layout
- AA. Price Proposal Deviations and Interrogatories

[AMENDED JUNE 20, 2018]

APPENDIX AA

**PRICE PROPOSAL
DEVIATIONS AND
INTERROGATORIES**

Price Proposal Deviations and Interrogatories

Respondent shall review the Deviation and Interrogatory instructions referenced at RFP Sections I.D.2. and I.D.3. Respondent shall review and complete the Interrogatories listed below by providing Respondent's answer following each question and/or statement. **Respondent shall complete both PPO and DHMO sections if Respondent will be providing both plans. If Respondent is not providing services for both plans, then Respondent only needs to provide its Responses to either the PPO or DHMO sections.**

A. Interrogatories - Services and/or Plans

- A.1. Respondent shall indicate the RFP services and/or plan(s) it is responding to by making an "X" in the box below:

Programs and/or Services	Offered
Self-funded Dental PPO Plan; and/or	
Fully-insured DHMO	

- A.1.a. From the response(s) provided in the box above, Respondent shall provide the fees associated with the services and/or plans that Respondent will be providing in the Sections below.

B. Deviations – PPO Price Proposal

- B.1. Affirm that Respondent shall comply with all of the requirements of the **Price Proposal** as described in **RFP Article XIV** and be bound to the PPO fees Respondent provided in response to **Appendix AA**.

Affirm Affirm with the proposed Deviations

If applicable, enumerate and provide a detailed description of each of the Deviations between Respondent's Response and these requirements.

Respondent's Requested Deviations Detail:

C. Interrogatories - Dental PPO Price Proposal

- C.1. The proposed Dental PPO administrative fee provided below must be guaranteed for the full term of the Contract.

	Per Member Per Month
Administrative Fee Per Member Per Month* (1)	\$

- C.2. Respondent shall allocate the administrative fee among the services specified below.

	Per Member Per Month
Marketing/Sales	
Claims Processing	
Network Management	
Other Administration	
Risk/Profit	
Banking Arrangements	
Total Administrative Fee*	

*This value should match the value listed in C.1. above.

- C.3. **Appendix I**, GBP Utilization of CDT Codes, is an EXCEL file containing a fee schedule for various CDT codes. Complete this fee schedule using the average allowable cost for network providers. This fee schedule needs to contain information for each 3-digit zip code in Texas. If the respondent is proposing to use more than one (1) network, provide a separate fee schedule for each network proposed.

Footnote:

- (1) The administrative fee is applicable only to Members, as defined in this RFP. The administrative fee does not apply to dependents.

D. Deviations – DHMO Price Proposal

- D.1. Affirm that Respondent shall comply with all of the requirements of the **Price Proposal** as described in **RFP Article XIV** and be bound to the DHMO fees Respondent provided in response to **Appendix AA**.

- Affirm Affirm with the proposed Deviations

If applicable, enumerate and provide a detailed description of each of the Deviations between Respondent's Response and these requirements.

Respondent's Requested Deviations Detail:

E. Interrogatories - Dental Health Maintenance Organization Price Proposal

- E.1. The proposed DHMO premium rates provided below must be guaranteed for the first three (3) years of the Contract term. Rates for the last three (3) years of the Contract term are subject to negotiation as specified in **E.6**. below. Use the rating relativities in E.2 below in developing the premium rates.

	Monthly Rates(1)(2)
Member Only	
Member & Spouse	
Member & Child(ren)	
Member & Family	
Spouse Only	
Child(ren)	
Spouse & Child(ren)	

- E.2.

	Required Rating Relativities (1)
Monthly Rates (2,3)	
Member Only	1.0
Member & Spouse	2.00
Member & Child(ren)	2.40
Member & Family	3.40
Spouse Only	1.00
Child(ren) Only	1.40
Spouse & Child(ren)	2.40

E.3. Respondent shall provide administrative charges included in the DHMO premium rates:

	Per Member Per Month
Payment to Provider	
Sales/Marketing	
Commission	
Network Management	
Claims Processing	
Other Administration	
Risk/Profit	
Banking Arrangements	
Total	

E.4. Respondent shall provide capitation rates, if any, included in the DHMO premium rates:

Participant Category	Average Monthly Capitation per Participant
Employee	
Spouse	
Child (each)	

E.5. Using the following table, Respondent shall provide the projected percentage of DHMO premium expected to be allocated to each of the following:

	Percentage of Total Premium
Payments to Dentists	
Capitation to Primary Dentists	%
Supplemental Payments to Primary Dentists	%
Payments to Specialists	%
Marketing	
Miscellaneous Payments (consulting fees, emergencies, etc.)	%
Administration and Profit	%
Total	100%

E.5. Using the following table, Respondent shall provide the projected percentage of DHMO premium expected to be allocated to each of the following:

	Percentage of Total Premium
Payments to Dentists	
Capitation to Primary Dentists	%
Supplemental Payments to Primary Dentists	%
Payments to Specialists	%
Marketing	
Miscellaneous Payments (consulting fees, emergencies, etc.)	%
Administration and Profit	%
Total	100%

E.6. During the second fiscal year of guaranteed rates, if the DHMO desires to continue with the GBP beyond the third year, the DHMO will be required to commit to good faith discussions with ERS prior to February 1st of 2021, regarding rates for the succeeding fiscal year. [Amended June 20, 2018]

Footnotes:

- (1) The proposed premium rates for DHMO are required to satisfy the indicated rating relationships specified in E.2. above. For example, the Member & Child(ren) rate is required to be 2.40 times the Member Only rate.
- (2) Rates should be rounded to the nearest \$.01.

[AMENDED JUNE 22, 2018]

**APPENDIX A
SIGNATURE PAGES**

**STATEMENT OF OFFICER REGARDING
SECOND AMENDED RFP, PROPOSAL AND FINANCIAL STANDING**

(1) My name is _____.

(2) I am the _____ (Title) of
_____ (Company Name) ("my Company").

(3) I do solemnly swear/affirm that I am duly authorized to sign this statement on behalf of my Company.

(4) I have completely read and understand the Employees Retirement System of Texas' Second Amended Request for Proposal No. 327-94828-180525 to Provide Dental Preferred Provider Organization and/or Dental Health Maintenance Organization Plan(s), including all attachments thereto ("ERS' Second Amended RFP"). Each section of ERS' Second Amended RFP includes statements of fact regarding how ERS expects the services to be administered and ERS' requirements. I acknowledge that ERS will presume that my Company agrees with and will comply with each ERS requirement unless my Company specified its deviations therefrom in its Proposal in accordance with ERS' Second Amended RFP instructions.

(5) I have reviewed the information contained within my Company's proposal to ERS' Second Amended RFP. The information presented in my Company's proposal is complete, true, accurate, and in full compliance with ERS' Second Amended RFP, except as specifically indicated in my Company's proposal.

(6) My Company is in good financial standing, not in any form of bankruptcy, and current in the payment of all taxes and fees.

(7) My Company represents and warrants to the truth and accuracy of all statements, warranties and representations contained in the Proposal and other documents submitted by my Company.

By: _____
Signature of Officer

Printed Name: _____

Title: _____

Date: _____

**STATEMENT OF OFFICER REGARDING
CONFLICTS OF INTEREST CONTRACTUAL PROVISIONS**

(1) My name is _____.

(2) I am the _____ (Title) of
_____ (Company Name) ("my Company").

(3) I solemnly swear/affirm that I am duly authorized to sign this statement on behalf of my Company.

(4) I hereby attest that I have read and understand Article 17, "Conflicts of Interest," of the Contractual Agreement ("Conflicts of Interest Provisions").

(5) I further attest that (check one):

My Company has not engaged in any actions that are or could be perceived to be a conflict of interest, appearance of impropriety or Prohibited Communication (as defined in the Contractual Agreement), as these concepts are further described in the Conflicts of Interest Provisions.

My Company has engaged in the following actions that are or could be perceived to be a conflict of interest, appearance of impropriety or Prohibited Communication (as defined in the Contractual Agreement), as these concepts are further described in the Conflicts of Interest Provisions:

My Company has also taken the following actions or proposes to take the following actions to cure, avoid, or mitigate such issues or potential issues:

Please use additional pages as necessary to fully respond to (5).

(6) I further attest that, if any time after the submittal of my Company's response to the Employees Retirement System of Texas' Second Amended Request for Proposal 327-94828-180525 to Provide Dental Preferred Provider Organization and/or Dental Health Maintenance Organization Plan(s), Company's Response) but before award of the work under such proposal, my Company discovers or is made aware of an actual or perceived conflict of interest, appearance of impropriety or Prohibited Communication that pre-existed the submittal of Company's Response or arose thereafter, I will immediately disclose such interest, appearance or communication in writing to ERS.

[SIGNATURE PAGE FOLLOWS ON NEXT PAGE.]

By: _____

Signature of Officer

Printed Name: _____

Title: _____

Date: _____

**STATEMENT OF OFFICER REGARDING
CONFIDENTIAL AND/OR PROPRIETARY INFORMATION**

1. My name is _____.
2. I am the _____ (Title) of _____ (Company Name) ("my Company").
3. I do solemnly swear/affirm that I am duly authorized to sign this statement on behalf of my Company.
4. I have completely read and understand the sections of the Employees Retirement System of Texas' ("ERS") Second Amended Request for Proposal No. 327-94828-180525 to Provide Dental Preferred Provider Organization and/or Dental Health Maintenance Organization Plan(s), ("ERS' Second Amended RFP") that relate to Confidential and/or Proprietary Information.
5. I have reviewed the information that I believe, in good faith and with legally sufficient justification, is my Company's Confidential and/or Proprietary information. My Company has submitted its Confidential and Proprietary information with its proposal to ERS in accordance with ERS' Second Amended RFP instructions.
6. I understand that each time my Company submits information to ERS, my Company must submit any information that we believe, in good faith and with legally sufficient justification, is confidential and/or proprietary, and that the information must be submitted in accordance with ERS' Second Amended RFP instructions.
7. I understand that, to the extent my Company finds it necessary, I should have my Company's corporate and/or outside counsel review my Company's proposal to determine the information that should be considered Confidential and/or Proprietary before I submit it to ERS.
8. I further understand that, upon ERS' receipt of a Texas Public Information Act request, ERS will provide the requestor the information provided by my Company on any CD (or DVD) that my Company has labeled "Public" information without any prior notification to my Company.
9. I also understand that, should my Company fail to submit its Confidential and/or Proprietary information as outlined in ERS' Second Amended RFP, that ERS will presume that all information submitted by my Company is public information and subject to disclosure.

By: _____
Signature of Officer

Printed Name: _____

Title: _____

Date: _____

STATEMENT OF OFFICER REGARDING INFORMATION SECURITY AND CONFIDENTIALITY REQUIREMENTS

1. My name is _____.

2. I am the _____ (Title) of _____ (Company Name) ("my Company").

3. I do solemnly swear/affirm that I am duly authorized to sign this statement on behalf of my Company.

4. I have completely read and understand the sections of the Employees Retirement System of Texas' ("ERS") Second Amended Request for Proposal No. 327-94828-180525 to Provide Dental Preferred Provider Organization and/or Dental Health Maintenance Organization Plan(s), under the Texas Employees Group Benefits Program ("ERS' Second Amended RFP") that relate to information system requirements and the confidentiality and security of ERS' information, including the Contractual Agreement, Data Security and Breach Notification Agreement, Business Associate Agreement, and Confidentiality and Nondisclosure Agreement attached thereto.

5. My Company agrees to adhere to the information system requirements and the requirements related to the confidentiality and security of ERS' information as specified in ERS' Second Amended RFP, including the Contractual Agreement, Data Security and Breach Notification Agreement, Business Associate Agreement, and Confidentiality and Nondisclosure Agreement attached thereto, except as specifically indicated in my Company's proposal to ERS' Second Amended RFP. I acknowledge and agree that exceptions noted in my Company's proposal, if any, will not be a part of my Company's Contractual Agreement with ERS unless they are accepted by ERS in writing.

UNDER PENALTIES OF PERJURY, I DECLARE THAT I HAVE READ THE FOREGOING STATEMENT AND THAT THE FACTS STATED THEREIN ARE TRUE.

*By: _____
Signature of Officer (*Must be notarized & signed in blue ink)

Printed Name: _____

Title: _____

ACKNOWLEDGMENT OF RECEIPT OF ADDENDA

The undersigned Respondent hereby acknowledges receipt of the following Addenda*:

Addendum Number	Date of Addendum	Initials Acknowledging Receipt
1	June 20, 2018	
2	June 22, 2018	

No Addendum Posted

By: _____
Signature of Officer

Printed Name: _____

Title: _____

Name of Company: _____

Date: _____

*Please note that the Answers to Vendors' Questions does not constitute an Addendum.

**Antitrust Certification Statement
(Texas Government Code § 2155.005)**

I affirm under penalty of perjury of the laws of the State of Texas that:

- (1) I am duly authorized to execute this contract on my own behalf or on behalf of the company, corporation, firm, partnership or individual (Company) listed below;
- (2) In connection with this bid, neither I nor any representative of the Company have violated any provision of the Texas Free Enterprise and Antitrust Act, Texas Business and Commerce Code Chapter 15;
- (3) In connection with this bid, neither I nor any representative of the Company have violated any federal antitrust law; and
- (4) Neither I nor any representative of the Company have directly or indirectly communicated any of the contents of this bid to a competitor of the Company or any other company, corporation, firm, partnership or individual engaged in the same line of business as the Company.

By:

Signature of Officer

Printed Name:

Title:

Name of Company:

Date:

— BRAND GUIDELINES —

ERS

EMPLOYEES  RETIREMENT
SYSTEM OF TEXAS

VERSION 7

OCTOBER 2016

SUBJECT TO CHANGE

INTRODUCTION

The Employees Retirement System of Texas brand reflects our commitment to our members – it reflects our sense of pride, work ethic and fiscal responsibility.

Our brand means more than just benefits and investments. Our organization has a strong sense of care and commitment to our members that goes beyond administering contracts and maintaining our trust fund. But we also must balance this sense of responsibility within the boundaries of what we can control.

It's important you understand the key components of our brand, what it means, how to correctly use it and how we promote it. Each of us makes a difference in how we communicate and shape our brand, whether you answer the phones, develop contracts, plan our investments, review our finances, manage our technology or communicate our news.

Enclosed you'll find:

- **ERS Key Messages**
- **Logo Specifications and Guidelines**
- **Color Specifications**
- **Font Guidelines**
- **Templates**
- **Brand Photography**
- **Frequently Asked Questions**

WHO WE ARE:

The Employees Retirement System of Texas (ERS) manages the contracts of retirement, health and other insurance benefits including a flexible spending account and investment accounts for Texas state employees and retirees. We also manage and invest the ERS Trust for the sole benefit of retirement system members.

PROMISE AND PURPOSE:

Benefits to honor your service to Texas.

KEY MESSAGES:

Anticipating Your Needs

Today, our investment and insurance specialists are discussing a day in your future – whether it brings an addition to your family or a transition to your next adventure – and anticipating your benefit needs for that moment.

WORKING TOGETHER FOR YOUR BENEFIT

ERS has experts ranging from insurance buyers and retirement investors to legislative liaisons and benefit counselors working everyday to decrease costs, increase offerings, to assist you with your benefits and to help you on your way.

CONVEYING PREMIUM BENEFIT PRODUCTS

Over time, a state employee's income is magnified by ERS' products: a defined retirement plan with a supplemental savings option, and a comprehensive health insurance plan with a supplemental savings option.

INVESTING WITH CARE

Our trust fund specialists take great care in managing your retirement savings by finding reliable investments that offer a fair return while avoiding undue risk.

HOW WE USE THESE MESSAGES:

- **Communication materials**
- **Online materials**
- **Presentations**
- **Videos**

All materials used externally that contain the above messages and/or ERS logo should be reviewed and approved by the Benefits Communications division prior to distribution.

LOGO SPECIFICATIONS AND GUIDELINES

The Employees Retirement System of Texas logo is the primary graphic element of the ERS brand.

The ERS logo should never be altered or displayed in any way other than as outlined within the ERS brand guidelines.

The logo must have 0.25" of white space around the entire logo.

Whenever possible, use the color logo in all print marketing materials, and communications.

To ensure legibility, the logo should not be used smaller than 1" in width.

Whenever the logo is used online the text below the lines are removed.

When printing in black and white, use the black logo.

The White logo may be used only when approved by the Benefits Communications division.

Please contact the ERS Benefits Communications division for information about branding issues or to request an electronic version of the logo.



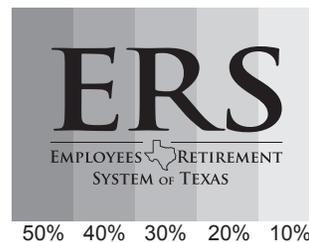
SECONDARY LOGOS



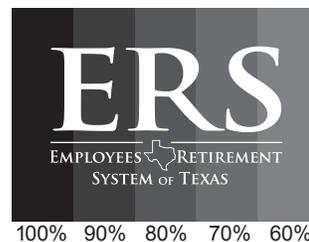
Used when logo width is 1" or when used online



Operations Work Shirt logo



Black ERS logo



White ERS logo

LOGO SPECIFICATIONS AND GUIDELINES

When using the ERS logo with third party administrator or program logos:



Always ensure that all logos appear equal in stature.

Always place the ERS logo on the left hand side of the other logo.



Never place the other logo closer than the minimum clear space to the ERS logo.



LOGO SPECIFICATIONS AND GUIDELINES

It is everyone's responsibility to maintain consistency in the use of the ERS logo and style guidelines and eliminate the potential for misuse or abuse of the agency's identity.



The ERS logomark should never be altered in any way, shape or form.



To protect the logo's integrity, backgrounds must never compete with its legibility.



White is the preferred background for presenting the ERS Logomark, unless approved by Benefits Communications.



Please contact ERS Benefits Communications about ERS logo issues.



COLOR SPECIFICATIONS AND GUIDELINES

Do not modify either the Pantone or process color mix.

PRIMARY COLORS

PRINT

PMS 575
CMYK: 48/0/100/53

PMS 575 - 50%
CMYK: 24/0/50/27

PMS 575 - 25%
CMYK: 23/9/33/0

PMS 161
CMYK: 44/53/70/23

PMS 575 - 50%
CMYK: 29/34/44/0

PMS 575 - 25%
CMYK: 13/15/19/0

PMS 1205 - 50%
CMYK: 0/5/31/0

CMYK: 0/0/0/100

CMYK: 0/0/0/83

WEB

#567632
RGB: 86/118/50

#a3bd7b
RGB: 163/189/50

#cedbaf
RGB: 6/219/175

#573215
RGB: 87/50/21

#b19d8d
RGB: 177/157/141

#d8cec6
RGB: 216/206/198

#fff6dd
RGB: 255/246/221

#00000
RGB: 0/0/0

#535253
RGB: 83/82/83

SECONDARY COLORS

CMYK: 74/36/47/9
RGB: 73/126/126

CMYK: 95/69/20/5
RGB: 20/88/141

CMYK: 0/100/100/0
RGB: 246/0/0

CMYK: 14/28/100/0
RGB: 224/179/20

FONT GUIDELINES

Arial is the primary typeface for ERS.

Goudy Old Style is used as a secondary typeface. It is not to be used online.

FONTS

ARIAL

Arial

Arial Italic

Arial Bold

Arial Bold Italic

GOUDY OLD STYLE

Goudy Old Style Regular

Goudy Old Style Italic

Goudy Old Style Bold

ERS TEMPLATES

Templates are available on focalpoint and are to be used for all agency documents.

POWERPOINT

Widescreen (16:9) Agency Template

Subtitle




Section Header Slide

Title is 32 pt Goudy Old Style
Subtitle 28 pt Goudy Old Style Italic



- Body is 24 pt Arial narrow regular. Uses master "Title and text only content"
- 1st level bullet is 24 pt Arial narrow regular
- 2nd level bullet is 24 pt Arial narrow regular
- 3rd level bullet is 24 pt Arial narrow regular

Agenda item descriptor placeholder NOTE: Footer if needed

Title is 32 pt Goudy Old Style
Subtitle 28 pt Goudy Old Style Italic



Body is 24 pt Arial narrow regular – Uses master "Title and 2 column text content"

- 1st level bullet is 24 pt Arial narrow regular
- 2nd level bullet is 24 pt Arial narrow regular
- 3rd level bullet is 24 pt Arial narrow regular

2nd column of text content

- 1st level bullet is 24 pt Arial narrow regular
- 2nd level bullet is 24 pt Arial narrow regular
- 3rd level bullet is 24 pt Arial narrow regular

Agenda item descriptor placeholder

Title is 32 pt Goudy Old Style
Subtitle 28 pt Goudy Old Style Italic



- Uses master "Title with text and graphic content"
- Nam eu nulla.
- Donec lobortis purus vel uma.
- Nunc laoreet lacinia nunc.

Agenda item descriptor placeholder

Table style 1
Uses master "Table"



	Column 1	Column 2	Column 3
Row 1	ERS 65 with 10 years service credit, or Rule of 80	ERS 65 with 10 years service credit, or Rule of 80	ERS 65 with 10 years service credit, or Rule of 80
Row 2	ERS No reduction	ERS 5% per year under 60, capped at 25%	ERS 5% per year under 62, no cap
Row 3	ERS 36 months	ERS 48 months	ERS 60 months
Row 4	ERS 2.3%	ERS 2.3%	ERS 2.3%
Row 5	ERS Yes	ERS No	ERS No
Row 6	ERS Yes	ERS Yes	ERS Yes*

*unused annual leave can only increase the annuity if it's not taken as a lump sum

Agenda item descriptor placeholder

MICROSOFT WORD

HEADING 1

HEADING 2

Body copy is Style "Normal".
Lorem ipsum dolor sit amet, consectetur adipiscing elit. Nam eu nulla. Donec lobortis purus vel uma. Nunc laoreet lacinia nunc. In volutpat sodales ipsum. Sed vestibulum. Integer in ante.

Sed posuere ligula rhoncus erat. Fusce urna duis, sollicitudin ac, pulvinar quis, tristique et, risus. Quisque a nunc eget nibh interdum fringilla. Fusce dapibus odio in est. Nunc egestas mauris ac leo. Nullam orci.

Bullets are style bullet "1st level", "bullet 2nd level", and "bullet 3rd level".

- Style bullet "1" level
- o Style bullet "2" level
- o Style bullet "3" level

Numbered list styles are "numbered list 1" and "numbered list 2".

1. Numbered list 1
2. Numbered list 2

a. Style numbered list 1

b. Numbered list 2

1 column table style is "table title"

Column 1	Column 2	Column 3	Column 4
Row 1			
Row 2			
Row 3			
Row 4			
Row 5			

2 column table is made by inserting text box, then insert table into that text box

Footer Date 1

INTER OFFICE MEMO



201 E. 18TH STREET, AUSTIN, TEXAS 78701 | P.O. BOX 13203, AUSTIN, TEXAS 78711-3207 | (877) 275-4377 TDD: (512) 475-1111 WWW.ERSSTATE.TX.GOV

INTEROFFICE MEMORANDUM

DATE:

TO:

FROM:

SUBJECT:

ERS interoffice memorandums are typed block style with a non-justified right margin and printed on ERS letterhead. The font style is "Arial" and the character size is 10 points. (2 returns between paragraphs) In order for the letter to print properly on ERS letterhead, the following margins should be used:

Top 1"
Bottom 1"
Left 0.75"
Right 0.75"

ERS TEMPLATES

Templates are available on focalpoint and are to be used for all agency documents.

FAX FORM

ERS
EMPLOYEES RETIREMENT SYSTEM OF TEXAS
200 E. 18th Street, Austin, Texas 78701

Date: _____ **Fax**

From: _____
Phone: _____
Fax Number: _____
Email: _____
Send to: _____
Company: _____
Fax Number: _____

Total pages including cover: _____

Urgent Reply ASAP Please comment Please Review For your information As discussed

Comments: _____

IMPORTANT NOTICE:
This communication, including any attachments, may contain confidential information and is intended only for the individual or entity to whom it is addressed. Any review, dissemination, or copying of this communication by anyone other than the intended recipient is strictly prohibited. If you are not the intended recipient, please contact the sender at the phone number listed, delete and destroy all copies of the original message. The opinions expressed by the sender may not necessarily be those of the Employees Retirement System of Texas (ERS).

AGENDA FORM

ERS
EMPLOYEES RETIREMENT SYSTEM OF TEXAS

AGENDA
Department _____
Time _____
Date _____
Location _____

Discussion Topics:

1. Topic _____
2. Topic _____
3. Topic _____

EMAIL SIGNATURE

Do not use stationery backgrounds or any color backgrounds on email.

Your Name
Your Title
(512) Phone
EMPLOYEES RETIREMENT SYSTEM OF TEXAS
ERS

Your Name
Your Title
(512) Phone
EMPLOYEES RETIREMENT SYSTEM OF TEXAS

ERS TEMPLATES – ERS LETTERHEAD

Letterhead for internal, computer generated, or external communications.
Body text is Arial Regular 10 pt., ragged right margin. Left margin .75". Right margin .75"



200 E. 18TH STREET, AUSTIN, TEXAS 78701 | P. O. BOX 13207, AUSTIN, TEXAS 78711-3207 | (877) 275-4377 TOLL-FREE | WWW.ERS.STATE.TX.US

[Current Date] (4 returns)

[(Mr.) (Ms.) (The Honorable) Firstname Lastname]
[Job Title]
[Mailing Address]
[City, State Zip] (2 returns)

Dear Ms. (Mr) Lastname: (2 returns)

Outgoing ERS correspondence is to be typed block style with a non-justified right margin and printed on ERS letterhead. The font style is "Arial" and the character size is 10 points. (2 returns between paragraphs)
In order for the letter to print properly on ERS letterhead, the following margins should be used:

Top 1.5"
Bottom 1"
Left 0.75"
Right 0.75"

The margins in word documents can be changed through accessing the "Page Setup" in the "File" menu in Microsoft Word.

Mr. (Ms.) (The Honorable) Firstname Lastname]
[Date]
Page 2 (6 returns)

If the outgoing correspondence requires use of an additional page or pages, follow the sample above as a header for the continued page(s).

The proper margin settings for continuation pages are as follows:

Top 1"
Bottom 0.5"
Left 0.75"
Right 0.75"

Continuation pages should be printed on blank bond paper of equal quality as the ERS letterhead. (2 returns)

Sincerely, (4 returns)

[PORTER WILSON]
[Executive Director] (2 returns)

[PW:xxx] (2 returns)

[Enclosure] (2 returns)

cc: [(Mr.) (Ms.) Firstname Lastname], Title

ERS TEMPLATES - EXECUTIVE OFFICE LETTERHEAD

Printed letterhead for external communications.

Body text is Arial Regular 10 pt., ragged right margin. Left margin 2". Right margin .75".



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PORTER WILSON
EXECUTIVE DIRECTOR

I. CRAIG HESTER
CHAIR

DOUGLAS DANZEISER
VICE-CHAIR

BOARD OF TRUSTEES
ILESA DANIELS
CYDNEY C. DONNELL
BRIAN D. RAGLAND
JEANIE WYATT

ERS APPROVED LOGOS

For brand guidelines on each individual logo, contact the Benefits Communications division.



BRAND PHOTOGRAPHY AND ILLUSTRATIONS

Please request photographs and illustrations from the Benefits Communications division.

FREQUENTLY ASKED QUESTIONS

I'd like to insert the logo into my presentation – who do I contact to get the image?

We've provided a presentation [template](#) that includes the correct logo. All logo requests should be directed to the Benefits Communications division.

Can I use the brand messages within internal materials – do you need to approve those?

There is no need for Benefits Communications to review internal materials.

Does the logo always have to be in color?

A color logo should be used whenever possible. There is a one-color and black and white version of the logo available; check with Benefits Communications for guidance and approval on using this for any external materials.

Where can I find the brand guidelines and the online toolbox containing templates, etc.?

The online brand toolbox can be found on focalpoint. You should download the templates from the guide for each situation, since brand standards and specifications may change over time.

We use a special email signature in our division – do we have to conform to the ERS brand email signature?

Yes, every ERS employee should use the ERS email brand signature so that we present a united, consistent brand identity. If you have any problems or questions, contact Benefits Communications.

If you have suggestions on adding questions to this guide, please forward your ideas to Benefits Communications.