- TEXAS -
LOS FRESNOS
COMMUNITY WITH OPPORTUNITY

August 21, 2024

Whom It May Concern:

The City of Los Fresnos is requesting proposals for Group Health Insurance and Life Insurance. Also, we are requesting alternate bids for Dental and Vision Insurance.

Enclosed are copies of the advertisement, Request for Proposal, employee information and the Proposal Form. The deadline for submitting proposals is Monday, September 30, 2024 at 10:00 a.m.

If you should have any questions, please contact me at (956) 233-5768.

Sincerely,

Jacqueline Moya
City Secretary

CITY OF LOS FRESNOS
REQUEST FOR PROPOSALS FOR GROUP HEALTH INSURANCE

The City of Los Fresnos will be accepting proposals for **fully insured** group health and life insurance until 10:00 am on September 30, 2024. Alternate additional proposals for voluntary dental and vision coverage are requested. Sealed proposals should be delivered or mailed to Jacqueline Moya, City Secretary, 520 E Ocean Blvd., Los Fresnos, TX 78566. Current policy coverage is available for review at City Hall. Awarding of contract will be October 8, 2024 at 6:00 pm in City Hall. The City reserves the right to accept or reject any or all proposals.

CITY OF LOS FRESNOS

SPECIFICATIONS FOR GROUP HEALTH AND LIFE INSURANCE

INTRODUCTION

These specifications have been prepared for the solicitation of competitive proposals for the City of Los Fresnos' Group Health and Life Insurance. The City of Los Fresnos will also be referred to as the **"Entity."**

EFFECTIVE DATE

The effective date of the coverage will be December 1, 2024, at 12:01 A. M. Central Standard Time. The term of contract/agreement will be for one year with option by the Entity to extend to two, one year additional terms.

UNDERWRITING DATA

The Underwriting exposure and loss data included in these specifications have been assembled by the Entity. While every effort has been made to insure the accuracy of this information, it cannot be guaranteed. It shall be the responsibility of the successful broker and/or insurer (s) to review this information and work with the Entity on an ongoing basis to ensure that all data and exposures are included in the Entity's coverage.

If it becomes necessary to revise any part of this bid, a written addendum will be provided to all bidders. The Entity is not bound by any oral representations, clarifications, or changes made in the written specifications by the Entity's employees, unless such clarification or change is provided to bidders in written addendum from an authorized representative of the Entity.

AGENT/BROKER AND INSURER REQUIREMENTS

All agents/brokers and insurers involved must be authorized and/or licensed to operate in the State of Texas. Non-admitted or surplus lines carriers must be on the approval list of the Texas Insurance Department and any applicable taxes or fees must be fully disclosed. Insurers must have a rating in the current edition of Best's Insurance reports of at least an "A" or better or, if an intergovernmental pool, provide a copy of the most recent audited financial statements complete with auditor's notes.

COMPLIANCE WITH LAWS

All bidders involved shall observe and comply with all regulations, laws, ordinances, etc. of local, state, and federal governments as they may be applicable to this bidding process.

PROPOSAL RULES

1. **Proposals:** One (1) copy of sealed proposals must be submitted in writing (no facsimiles, please) on or before September 30, 2024 at 10:00 A.M., to Jacqueline Moya, City Secretary at the following address:

City of Los Fresnos
520 E. Ocean Blvd.
Los Fresnos, TX 78566

The sealed envelope must be clearly marked Group Health and Life Insurance Proposal and the date and time of the opening. Proposals will be approved at the Regular City Council Meeting on October 8, 2024 at 6:00 p.m.

All proposals will be reviewed by the City of Los Fresnos and a decision will be made within 30 days from date of receipt. Every effort will be made to compare proposals on an equitable basis; please be assured that your efforts will be well received and thoroughly considered. Our evaluation of the proposals will consider limits, terms, and conditions of the coverage provided, cost, and services available from the broker, insurer(s) and Pool(s), and the financial solvency of the carriers. The City of Los Fresnos reserves the right to accept or reject all or any part of any proposal based upon its own selection criteria.

MUST USE ENCLOSED HEALTH INSURANCE PROPOSAL FORM.

2. **Deviations from Specifications:** All deviations from these specifications must be clearly stated in your proposal. Any significant limitations of coverage, restrictive conditions, etc. should also be clearly described.

These specifications are not intended to be restrictive with respect to any innovative techniques for providing coverage, if a distinct advantage can be demonstrated. Proposals failing to meet all of the specifications will not necessarily be rejected, but deviations must be clearly noted to be considered.

3. **Coverage Quotations:** If the proposed coverage is contingent upon the City of Los Fresnos providing additional information, inspections, completed applications, or is subject to any conditions, such requirements must be stated clearly in the proposal.

4. **Loss Control Services:** Please provide a description of the specific loss control services that are available to the City of Los Fresnos from you and/or the insurer(s) and indicate any additional fees that will be charged for such services.

5. **Duration of Proposal:** We request that all proposals remain valid without material change for 30 days after due date noted in #1 above.

6. **Non-Compliance with Signed Proposal:** It is understood and agreed that, in the event that an insurance policy(ies) does not meet the terms and conditions agreed to in a signed proposal accepted by the City of Los Fresnos, then the City of Los Fresnos shall at its sole option have a right to:

a. Cancel the policy or policies on a pro-rata basis (not short rate); OR

b. Require the insurer or agent/broker to provide coverage as stated in the proposed premium.

7. **Indivisible Coverage:** The bidder must specify that coverage's which can only be written contingent upon receiving the bid for other coverage's. If no such indication is made, the City of Los Fresnos reserves the right to accept any part of the bid.

8. **Questions:** Any questions or requests for clarification on these specifications should be directed to:

Jacqueline Moya
City Secretary
City of Los Fresnos
520 E. Ocean Blvd.
Los Fresnos, TX 78566
(956) 233-5768
jmoya@citylf.us

CURRENT PLAN COSTS

The costs of the insurance provided for the employees of the City of Los Fresnos and their dependents for the twelve-month period to end November 30, 2024. The current plan is figured on composite rates.

UNITED HEALTHCARE:
1547193
Emp Only $599.46 / Emp+Sp $1268.94 / Emp+Chd $1266.06 / Emp+Fam $1935.53
[Dependent portion: Spouse=$669.48 / Chd=$666.60 / Family=$1336.07]

MUTUAL OF OMAHA:
G000C77D
Life Insurance
$0.15 per EE = $3.00
AD&D
$0.02 per EE = $0.40
[Total Life/AD&D = $3.40 per EE]

SPECIFICATIONS FOR GROUP HEALTH AND LIFE INSURANCE

GENERAL COVERAGE PROVISIONS

1. City of Los Fresnos proposals for Health and Life Insurance must contain the checklist provided in this package. Proposals received on other forms, other than those provided herein, will be considered non-responsive and will not be included for further evaluation. Forms, in addition to those provided, will be considered as clarification only, unless specified clearly on the provided forms.

2. All prices will be considered firm for acceptance for a December 1, 2024, effective date. Any exception to this must be so stated on the fact of the offer.

3. Inception Date: December 1, 2024, at 12:01 A.M. Central Standard Time for all policies.

4. City of Los Fresnos reserves the right to reject any or all offers or parts thereof and reserves the right to be sole judge of suitability of the proposals. Late responses will be un-opened.

5. Notice of Cancellation: All policies must be endorsed to require at least a 60-day written notice by the insurer of cancellation, non-renewal, or material policy change unless reason for such cancellation is non-payment of premium.

6. Premium Payment: All insurance companies must indicate whether monthly or quarterly payment of premiums is allowed, and the terms and conditions (including any and all finance charges of fees) under which such a plan would operate.

7. All proposals must be signed by hand by an authorized agent or broker.

8. Clarification of Objection to Proposal Specifications:

   If a bidder is in doubt as to the true meaning of the proposal specifications, or other proposal documents or any part thereof, he/she may submit to the City Secretary, at least five days prior to the proposal deadline, a request for clarification. All such requests for information shall be made in writing and the person submitting the request will be responsible for its prompt delivery. Any interpretation of the request for proposals, if made, will be made only by addendum duly issued. A copy of such Addendum will be mailed or delivered to each person receiving a set of bids. The City of Los Fresnos

will not be responsible for any other explanation or interpretation of the proposed bid made or given prior to the award of the proposal. Any objections to the specifications and requirements as set forth in this request for proposals must be filed in writing with the City of Los Fresnos City Secretary on or before five days prior to the scheduled opening.

SPECIFIC COVERAGE PROVISIONS

1. General: The City of Los Fresnos is seeking proposals this year for its Group Health and Life Insurance. The City desires each broker/insurer to draft proposals that provide the best possible health coverage at the least possible cost. We have provided what we currently provide our employees. The bottom line question is, "Can you do better?" If you have PPO's, HMO's, etc. established which would help restrain costs, please include them in your proposals. The City realizes that this request for Proposal is very "open-ended." It is incumbent upon each broker/insurer to provide a realistic and viable plan that is worthy of consideration. Obviously, a plan that asks for the City to double their health care costs will be rejected outright. The broker/insurer must understand that like most employers, the City is under budgetary constraints. Hopefully, the information provided in this packet will aid you in developing your proposals.

2. Coverage Eligibility: All full time employees and family members. The City will provide health and life insurance free of charge to the employee. Employees wishing to cover their family member(s) will be payroll deducted the additional cost.

3. Rate Guarantees: Rates quoted in the proposal shall be guaranteed for one year (December 1, 2024 through November 30, 2025) for health and life insurance provided that the actual census data does not deviate significantly from that furnished in the specifications.

4. Pre-Existing Conditions: The pre-existing is only applicable to Federal laws.

5. Coverage Effective Date: New employees will be insured thirty days after their date of employment. Family members will be insured on their same date as employee, provided they are enrolled prior to, or on the employee's eligibility date.

6. COBRA: Current COBRA participants will be included for coverage for health insurance only.

7. Employment Data: The average total employment for a year is 67 employees. For planning and comparison use 60 employees in your cost estimates.

8. References: Each proposal will include the name, address, and phone number, or a customer who utilizes the insurance proposed. References will be contacted to ascertain their satisfaction with coverage provided.

9. **Alternate Bid: The City of Los Fresnos request that an Alternate Bid be prepared for voluntary Dental Coverage and Vision Coverage.**

CITY OF LOS FRESNOS
HEALTH INSURANCE PROPOSAL FORM
2024-2025

IN NETWORK BENEFITS	
Deductible - Calendar Year	
Coinsurance	
Annual Coinsurance limit (single/family)	
Annual Out-of-Pocket Maximum (single/family)	
Office Visit Copay	
Includes same day lab & x-ray if billed	
by attending physician	
Professional Services: In-Patient	
Also includes surgery, anesthesia, x-ray,	
lab and imaging	
Preventive Care	
Babies/children: exam, immunization	
and necessary lab work	
Adults: rountine pap smears & mammograms	
for women and routine PSA's for men	
Maternity	
Home Health Care Services	
Spinal Manipulation Therapy	
Emergency Room Care	
Prescription Drug Benefit	
Serious Mental Illness	
*required for Public Entities *	
OUT OF NETWORK BENEFITS	

Deductible - Calendar Year	
Coinsurance	
Annual coinsurance limit (single/family)	
Professional Services: In-Patient	
Lifetime Maximum	

COST OF INSURANCE:	
Employee Only	
Employee + Spouse	
Employee + Children	
Employee + Family	
If age-rated premiums attach list	
Company:	
Name:	
Address:	
Contact Number:	

City of Los Fresnos

	Gender	DOB	Medical	Vision	Dental	Zip code
Employee 1	M	8/22/1990	EO	n/a	EC	78520
Employee 2	M	11/22/1996	EO	EO	EO	78566
Employee 3	M	12/2/1983	EO	EF	EF	78586
Employee 4	M	1/27/2000	EO	n/a	EO	78521
Employee 5	M	9/19/1997	EO	EF	EF	78566
Employee 6	F	9/21/1985	EO	n/a		78566
Employee 7	M	4/2/1969	EO	n/a		78566
Employee 8	M	3/23/1991	EO	n/a		78566
Employee 9	F	4/7/1996	EO	EO	EO	78552
Employee 10	M	2/28/1997	EO	EO	EO	78566
Employee 11	M	9/29/1997	EO	n/a		78520
Employee 12	F	1/8/2003	EO	n/a		78566
Employee 13	F	11/29/2000	EO	EO	EO	78566
Employee 14	F	10/28/1962	EO	EO	EO	78578
Employee 15	F	8/19/1990	EO	EO	ES	78566
Employee 16	M	1/16/1978	EO	EO	EO	78566
Employee 17	F	6/29/1962	EO	EO	EO	78566
Employee 18	F	11/24/1985	EO	n/a	EO	78566
Employee 19	M	11/14/1953	EO	ES	ES	78550
Employee 20	F	1/4/1997	EO	n/a		78520
Employee 21	M	12/21/1980	EO	EC		78520
Employee 22	M	3/13/1995	EO	n/a		78566
Employee 23	F	12/9/1986	EO	EO	ES	78566
Employee 24	M	9/5/2000	EO	EO	ES	78566
Employee 25	M	8/12/2002	EO	EO	EO	78566
Employee 26	M	10/20/1993	EO	EO	EO	78520
Employee 27	M	1/20/1958	EO	n/a		78566
Employee 28	F	9/10/1983	EO	n/a		78578
Employee 29	F	9/22/1984	EO	n/a		78521
Employee 30	M	6/27/1991	EC	EC	EC	78566
Employee 31	M	1/21/1963	EO	n/a		78566
Employee 32	M	3/5/1962	EO	n/a		78566
Employee 33	F	9/29/1960	EO	n/a	EO	78566
Employee 34	F	5/18/1977	EO	n/a	EO	78566
Employee 35	F	9/2/1990	EO	n/a	ES	78566
Employee 36	M	12/5/1970	EO	EO	EC	78578
Employee 37	F	3/19/1980	EO	EF	EF	78566
Employee 38	M	1/9/2000	EO	EO	EO	78521
Employee 39	M	7/1/1961	EO	ES	ES	78566
Employee 40	M	10/30/1962	EO	EO		78566
Employee 41	F	2/13/1984	EO	EF	EF	78566
Employee 42	F	10/16/1993	EO	EO		78521
Employee 43	M	10/4/2004	EO	n/a		78566
Employee 44	M	5/25/1999	EO	n/a	EO	78566
Employee 45	M	11/14/1983	EO	ES	ES	78520
Employee 46	F	1/7/1995	EO	EC	EC	78566
Employee 47	M	6/22/1965	EO	n/a		78566
Employee 48	F	1/22/1984	EO	n/a		78521
Employee 49	M	11/26/1982	EO	EO	EO	78566
Employee 50	M	1/12/1972	EO	EC	EC	78566
Employee 51	M	2/21/1996	EO	n/a	EO	78520
Employee 52	M	4/3/1968	EO	ES		78566
Employee 53	M	11/4/1957	EO	n/a	EO	78566
Employee 54	M	4/9/1994	EO	EO		78566
Employee 55	M	7/30/1961	EO	n/a		78566
Employee 56	M	6/30/1958	EO	n/a		78586
Employee 57	M	7/18/1976	EO	n/a		78526
Employee 58	M	8/2/1969	EO	n/a		78566
Employee 59	M	3/21/2003	EO			78583
Employee 60	F	12/14/1976	EO	EC	EC	78550

UnitedHealthcare Insurance Choice Plus BCX4 / G58Y

Coverage For: Family | Plan Type: PS1

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-866-633-2446 or visit welcometouhc.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$500** Individual / **$1,000** Family Out-of-Network: **$5,000** Individual / **$10,000** Family Per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive Care Services and categories with a copay are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network: **$2,000** Individual / **$4,000** Family Out-of-Network: **$10,000** Individual / **$20,000** Family Per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover and penalties for failure to obtain preauthorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.myuhc.com or call 1-866-633-2446 for a list of network providers.	You will pay the least if you use a provider in the Designated Network. You pay more if you use a provider in the Network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay per visit, deductible does not apply	30% coinsurance	Under age 19 - Network visits are covered at No Charge. Virtual Visits - No Charge by a Designated Virtual Network Provider. If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
	Specialist visit	Designated Network: $25 copay per visit, deductible does not apply Network: $50 copay per visit, deductible does not apply	30% coinsurance	If you receive services in addition to office visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
	Preventive care/ screening/ immunization	No Charge	\30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. *Deductible/coinsurance may not apply to certain services.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	30% coinsurance	Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount or $500, whichever is less.
	Imaging (CT/PET scans, MRIs)	0% coinsurance	30% coinsurance	Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount or $500, whichever is less.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at welcometouhc.com	Tier 1 - Your Lowest Cost Option	Retail: $10 copay, deductible does not apply. Mail-Order: $25 copay, deductible does not apply. Specialty Retail: $10 copay, deductible does not apply.	Retail: $10 copay, deductible does not apply. Specialty Retail: $10 copay, deductible does not apply.	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Up to a 90 day supply or Preferred 90 Day Retail Network Pharmacy. Specialty drugs are not covered through mail order. You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a preauthorization requirement or may result in a higher cost. If you use an out-of-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount. Certain preventive medications (including certain contraceptives) and the List of Zero Cost Share Medications are covered at No Charge. See the website listed for information on drugs covered by your plan. Not all drugs are covered. You may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs.
	Tier 2 - Your Mid-Range Cost Option	Retail: $45 copay, deductible does not apply. Mail-Order: $112.50 copay, deductible does not apply. Specialty Retail: $150 copay, deductible does not apply.	Retail: $45 copay, deductible does not apply. Specialty Retail: $150 copay, deductible does not apply.	
	Tier 3 - Your Mid-Range Cost Option	Retail: $80 copay, deductible does not apply. Mail-Order: $200 copay, deductible does not apply. Specialty Retail: $500 copay, deductible does not apply.	Retail: $80 copay, deductible does not apply. Specialty Retail: $500 copay, deductible does not apply.	
	Tier 4 - Your Highest Cost Option	Not Applicable	Not Applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	30% coinsurance	Preauthorization is required out-of-network for certain services or benefit reduces to 50% of allowed amount or $500, whichever is less.
	Physician/ surgeon fees	0% coinsurance	30% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$300 copay per visit, deductible does not apply	$300 copay per visit, deductible does not apply	None
	Emergency medical transportation	0% coinsurance	*0% coinsurance	*Network deductible applies.
	Urgent Care	$75 copay per visit, deductible does not apply	30% coinsurance	Virtual Visits - No Charge by a Designated Virtual Network Provider. If you receive services in addition to Urgent care visit, additional copays, deductibles or coinsurance may apply e.g. surgery.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	30% coinsurance	Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount or $500, whichever is less.
	Physician/ surgeon fees	0% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay per visit, deductible does not apply	30% coinsurance	Network Partial hospitalization/intensive outpatient treatment: 0% coinsurance See your policy or plan document for additional information about EAP benefits.
	Inpatient services	0% coinsurance	30% coinsurance	Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount or $500, whichever is less. See your policy or plan document for additional information about EAP benefits.
If you are pregnant	Office Visits	No Charge	30% coinsurance	Cost sharing does not apply for preventive services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	0% coinsurance	30% coinsurance	Depending on the type of service a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	0% coinsurance	30% coinsurance	Inpatient Preauthorization applies out-of-network if stay exceeds 48 hours (C-Section: 96 hours) or benefit reduces to 50% of allowed amount or $500, whichever is less.
If you need help recovering or have other special health needs	Home health care	0% coinsurance	30% coinsurance	Limited to 60 visits per calendar year. Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount or $500, whichever is less.
	Rehabilitation services	$25 copay per visit, deductible does not apply	30% coinsurance	Limits per calendar year: Physical, Occupational, Speech, Pulmonary: 20 visits each; Cardiac: 36 visits.
	Habilitative services	$25 copay per visit, deductible does not apply	30% coinsurance	Services are provided under and limits are combined with Rehabilitation Services above. No limits apply for treatment of autism or early childhood intervention.
	Skilled nursing care	0% coinsurance	30% coinsurance	Limited to 60 days per calendar year, combined with inpatient rehabilitation. Preauthorization is required out-of-network or benefit reduces to 50% of allowed amount or $500, whichever is less.
	Durable medical equipment	0% coinsurance	30% coinsurance	Covers 1 per type of DME (including repair/replacement) every 3 years. Preauthorization is required out-of-network for DME over $1,000 or benefit reduces to 50% of allowed amount or $500, whichever is less.
	Hospice services	0% coinsurance	30% coinsurance	Preauthorization is required out-of-network before admission for an Inpatient Stay in a hospice facility or benefit reduces to 50% of allowed amount or $500, whichever is less.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	No coverage for Children's eye exams.
	Children's glasses	Not Covered	Not Covered	No coverage for Children's glasses.
	Children's dental check-up	Not Covered	Not Covered	No coverage for Children's dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic Surgery
- Dental Care
- Glasses
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside - the US
- Private duty nursing
- Routine Eye Care
- Routine foot care - Except as covered for Diabetes
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic (manipulative) care - 20 visits per calendar year
- Hearing aids

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you, too including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Member Service number listed on the back of your ID card or myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa/healthreform or Texas Department of Insurance at 1-800-252-3439 or tdi.texas.gov.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-633-2446.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-633-2446.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-633-2446.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-633-2446.

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$500**
- **Specialist copay** **$25**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Specialist office visits *(pre-natal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	**$500**
Copayments	**$10**
Coinsurance	**$0**
What isn't covered	
Limits or exclusions	**$60**
The total Peg would pay is	**$570**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$500**
- **Specialist copay** **$25**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	**$200**
Copayments	**$400**
Coinsurance	**$0**
What isn't covered	
Limits or exclusions	**$0**
The total Joe would pay is	**$600**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$500**
- **Specialist copay** **$25**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	**$500**
Copayments	**$500**
Coinsurance	**$0**
What isn't covered	
Limits or exclusions	**$0**
The total Mia would pay is	**$1,000**

The plan would be responsible for the other costs of these EXAMPLE covered services.

We do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.
Online: UHC_Civil_Rights@uhc.com
Mail: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608 Salt Lake City, UTAH 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again.
If you need help with your complaint, please call the toll-free number listed within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human Services.
Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the number contained within this Summary of Benefits and Coverage (SBC) , TTY 711, Monday through Friday, 8 a.m. to 8 p.m.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número gratuito que aparece en este Resumen de Beneficios y Cobertura (Summary of Benefits and Coverage, SBC).

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請撥打本福利和承保摘要(Summary of Benefits and Coverage, SBC) 內所列的免付費電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ghi trong bản Tóm lược về quyền lợi và đài thọ bảo hiểm (Summary of Benefits and Coverage, SBC) này.

알림: 한국어**(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 본 혜택 및 보장 요약서(Summary of Benefits and Coverage, SBC)에 기재된 무료전화번호로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numerong nakalista sa Buod na ito ng Mga Benepisyo at Saklaw (Summary of Benefits and Coverage o SBC).

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному в данном «Обзоре льгот и покрытия» (Summary of Benefits and Coverage, SBC).

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. يُرجى الاتصال برقم الهاتف المجاني المدرج بداخل مخلص المزايا والتغطية (Summary of Benefits and Coverage، SBC) هذا.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki nan Rezime avantaj ak pwoteksyon sa a (Summary of Benefits and Coverage, SBC).

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro sans frais figurant dans ce Sommaire des prestations et de la couverture (Summary of Benefits and Coverage, SBC).

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer podany w niniejszym Zestawieniu świadczeń i refundacji (Summary of Benefits and Coverage, SBC).

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para o número gratuito listado neste Resumo de Benefícios e Cobertura (Summary of Benefits and Coverage - SBC).

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Chiamate il numero verde indicato all'interno di questo Sommario dei Benefit e della Copertura (Summary of Benefits and Coverage, SBC).

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die in dieser Zusammenfassung der Leistungen und Kostenübernahmen (Summary of Benefits and Coverage, SBC) angegebene gebührenfreie Rufnummer an.

注意事項：**日本語 (Japanese)** を話される場合、無料の言語支援サービスをご利用いただけます。
本「保障および給付の概要」(Summary of Benefits and Coverage, SBC) に記載されているフリー
ダイヤルにてお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به‌طور رایگان در اختیار شما می باشد. لطفاً با شماره تلفن رایگان ذکر شده در این خلاصه مزایا و پوشش (Summary of Benefits and Coverage، SBC) تماس بگیرید.

ध्यान दें: यदि आप **हिंदी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। लाभ और कवरेज (Summary of Benefits and Coverage, SBC) के इस सारांश के भीतर सूचीबद्ध टोल फ्री नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu dawb teev muaj nyob ntawm Tsab Ntawv Nthuav Qhia Cov Txiaj Ntsim Zoo thiab Kev Kam Them Nqi (Summary of Benefits and Coverage, SBC) no.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយ**ភាសាខ្មែរ (Khmer)** សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។
សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមានកត់នៅក្នុង សេចក្តីសង្ខេបអត្ថប្រយោជន៍ និងការគ្របដណ្តប់ (Summary of Benefits and Coverage, SBC) នេះ។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan ti awan bayad na nu tawagan nga numero nga nakalista iti uneg na daytoy nga Dagup dagiti Benipisyo ken Pannakasakup (Summary of Benefits and Coverage, SBC).

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí Naaltsoos Bee 'Aa'áhayání dóó Bee 'Ak'é'asti' Bee Baa Hane'í (Summary of Benefits and Coverage, SBC) biyi' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka bilaashka ah ee ku yaalla Soo-koobitaanka Dheefaha iyo Caymiska (Summary of Benefits and Coverage, SBC).

GREER & ASSOCIATES, INC.
A Spire Risk Management Company SPIRE

Mutual of Omaha

United of Omaha Life Insurance Company
A Mutual of Omaha Company

LOS FRESNOS - TEXAS -
COMMUNITY WITH OPPORTUNITY

Term Life Insurance

Help Protect What Matters – You, Your Family & Your Future

We understand you've worked hard to get where you are today. Ensuring your loved ones can maintain financial stability if an unexpected death should occur is something to consider when planning for the future.

We've Got You Covered

As an active employee of City of Los Fresnos, you have access to a life insurance policy from United of Omaha Life Insurance Company.

It replaces the income you would have provided, and helps pay funeral costs, manage debt and cover ongoing expenses.

How much insurance is enough?

When determining how much life insurance you need, think about the expenses you may encounter now and through every stage of your life.

Coverage guidelines and benefits are outlined in the chart below.

ELIGIBILITY - ALL ELIGIBLE EMPLOYEES	
Eligibility Requirement	You must be actively working a minimum of 30 hours per week to be eligible for coverage.
Premium Payment	The premiums for this insurance are paid in full by the policyholder. There is no cost to you for this insurance.
Life Insurance Benefit Amount	For You: $20,000 In the event of death, the benefit paid will be equal to the benefit amount after any age reductions less any living care/accelerated death benefits previously paid under this plan.
Accidental Death & Dismemberment (AD&D) Benefit Amount	For You: The Principal Sum amount is equal to the amount of your life insurance benefit.
FEATURES	
Living Care/ Accelerated Death Benefit	80% of the amount of the life insurance benefit is available to you if terminally ill, not to exceed $16,000.

Waiver of Premium	If it is determined that you are totally disabled, your life insurance benefit will continue without payment of premium, subject to certain conditions.
Additional AD&D Benefits	In addition to basic AD&D benefits, you are protected by the following benefits: - Seat Belt - Airbag - Common Carrier - Paralysis
Conversion	If your employment ends, you may apply for an individual life insurance policy from Mutual of Omaha without having to provide evidence of insurability (information about your health). You will be responsible for the premium for the coverage.
SERVICES	
Travel Assistance	The Travel Assistance program is an added benefit that provides assistance for your travels over 100 miles away from home or outside the country.
Employee Assistance Program (EAP)	Mutual of Omaha's team of master's level EAP professionals are available 24/7/365 to provide you and your loved ones resources for assistance with personal and workplace issues. Access to EAP services is obtained by calling 1-800-316-2796 or by using an online submission form for employee convenience at www.mutualofomaha.com/eap. Online are valuable resources and links for additional assistance, including current events, family and relationships, emotional well-being, financial wellness, substance abuse and addiction, legal assistance and work and career.
Hearing Discount Program	The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.
Will Prep Services	We work with Epoq, Inc. to offer employees online will prep tools. In just a few clicks you can complete a basic will or other documents to protect your family and property. To get started visit www.willprepservices.com.

AGE REDUCTIONS AND EXCLUSIONS

Insurance benefits and guarantee issue amounts are subject to age reductions:

- At age 65, amounts reduce to 65%
- At age 70, amounts reduce to 50%

Information about the AD&D exclusions for this plan will be included in the summary of coverage, which you will receive after enrolling.

Please contact your employer if you have questions prior to enrolling.

Frequently Asked Questions

Who is eligible for this insurance?

You must be actively working (performing all normal duties of your job) at least 30 hours per week.

What is Guarantee Issue?

The amount of insurance applied for without answering any health questions (or which does not require evidence of insurability). Coverage amounts over the Guarantee Issue Amount will require evidence of insurability.

What is Evidence of Insurability?

Evidence of Insurability or proof of good health – may be required if you are a late entrant and/or you request any additional coverage above your guarantee issue amount.

Can I take this insurance with me if I change jobs/am no longer a member of this group?

In the event this insurance ends due to a change in your employment/membership status with the group, or for certain other reasons, you may have the right to continue this insurance under the Conversion provision, subject to certain conditions.

Are there any limitations, reductions or exclusions?

The benefits payable are based on the following:

- Insurance benefits and guarantee issue amounts are subject to age reductions:
  - At age 65, amounts reduce to 65%
  - At age 70, amounts reduce to 50%
- Information about the AD&D exclusions for this plan will be included in the summary of coverage, which you will receive after enrolling.

All exclusions may not be applicable, or may be adjusted, as required by state regulations.

UnitedHealthcare

TEXAS - MANDATED REPORTING FOR INSURED BUSINESS

Texas insurance code[1] sets forth specific requirements for the release of claims information by Health insurance issuers upon written request of a plan, plan administrator, or plan sponsor. The information presented within this report is provided in accordance with Texas insurance code.

Section I:

- For claims that are not part of this report, the number of pre-certification requests for hospital stays of 5 days or longer that were made during the 30-day period preceding this report.

Section II:

- Monthly aggregate Premium and Paid Claims
- Total covered Employees by Coverage Tier, on a monthly basis

Section III:

- Individual Claimants[2] with paid amounts of $15,000 in the most current 12-month period

The following Additional Information [2] is available upon request, subject to Conditions for Release:

Large Claim Information	Conditions for Release
Additional Information[2], including prognosis or recovery case, management information, future expected cost and treatment plans that relate to the claims for those individuals whose total paid claims exceeded $15,000 during the preceding 12 month period.	In accordance with provisions of the state statute, a request for Additional Information may be made subsequent to the receipt of Individual Claimant (section III) information. The written request must come from the plan, plan administrator, or plan sponsor, and be received by the insurer no later than the 10th day following receipt of the initial Individual Claimant information.

[1] Texas insurance code: Section 1. Subtitle A, Title 8, Chapter 1215. Enacted Sep 1, 2007, compliance date Jan 1, 2008.

[2] A plan sponsor is entitled to receive protected health information under Subsections C (5) and (6) and Section 1215.04 only after an appropriately authorized representative of the plan sponsor makes to the health insurance issuer a certification. PLEASE CONTACT your UnitedHealthcare account representative for additional information on an acceptable Certification.

UnitedHealthcare
EMPLOYER & INDIVIDUAL

TEXAS - MANDATED REPORTING FOR INSURED BUSINESS

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

Customer Name: CITY OF LOS FRESNOS
Policy Number: 1547193
Reporting Period
Processed (paid) Dates: 08/01/2021-06/30/2024
Service (incurred) Dates: ALL

Date of Information Request:	7/24/24
Receipt Date of Information Request:	7/24/24
Receipt Date of HIPAA Certification:	7/24/24
Date of Report Production:	7/25/24

Section I:

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

Section II:

Bill / Book Year / Month	Restated Billed Premium	Total Payments	Single Subscribers	Subscribers plus Spouse	Subscribers plus Child/Children	Subscribers plus Family	Total Subscribers	Positively Enrolled Dependents	Total Members
202406	$ 36,634	$ 44,447	59	0	1	0	60	2	62
202405	$ 36,035	$ 25,151	58	0	1	0	59	2	61
202404	$ 36,634	$ 16,195	59	0	1	0	60	2	62
202403	$ 36,035	$ 33,554	58	0	1	0	59	2	61
202402	$ 34,836	$ 54,936	56	0	1	0	57	1	58
202401	$ 35,435	$ 24,166	57	0	1	0	58	1	59
202312	$ 34,836	$ 43,319	56	0	1	0	57	1	58
202311	$ 29,781	$ 30,649	58	0	1	0	59	1	60
202310	$ 29,781	$ 46,237	58	0	1	0	59	1	60
202309	$ 27,799	$ 12,793	54	0	1	0	55	1	56
202308	$ 25,322	$ 23,719	49	0	1	0	50	1	51
202307	$ 27,304	$ 30,371	53	0	1	0	54	1	55
202306	$ 27,304	$ 34,380	53	0	1	0	54	1	55
202305	$ 28,294	$ 41,108	55	0	1	0	56	1	57
202304	$ 28,294	$ 198,333	55	0	1	0	56	1	57
202303	$ 29,285	$ 173,896	57	0	1	0	58	1	59
202302	$ 29,285	$ 35,700	57	0	1	0	58	1	59
202301	$ 29,781	$ 14,035	58	0	1	0	59	1	60
202212	$ 29,781	$ 11,627	58	0	1	0	59	1	60
202211	$ 27,116	$ 43,431	57	0	1	0	58	1	59
202210	$ 26,657	$ 9,150	56	0	1	0	57	2	59
202209	$ 26,198	$ 15,656	55	0	1	0	56	1	57
202208	$ 27,116	$ 33,690	57	0	1	0	58	1	59
202207	$ 26,657	$ 9,842	56	0	1	0	57	1	58
202206	$ 27,575	$ 36,044	58	0	1	0	59	1	60
202205	$ 27,626	$ 28,288	56	0	2	0	58	4	62
202204	$ 27,626	$ 10,361	56	0	2	0	58	3	61
202203	$ 27,167	$ 24,516	55	0	2	0	57	3	60
202202	$ 27,626	$ 4,359	56	0	2	0	58	3	61
202201	$ 27,626	$ 9,094	56	0	2	0	58	3	61
202112	$ 27,626	$ 32,527	56	0	2	0	58	3	61
202111	$ 24,508	$ 12,255	53	0	2	0	55	3	58
202110	$ 24,508	$ 7,439	53	0	2	0	55	3	58
202109	$ 22,795	$ 24,784	49	0	2	0	51	3	54
202108	$ 22,367	$ 11,814	48	0	2	0	50	3	53
TOTAL	$ 1,013,250	$ 1,207,866	1945	0	45	0	1990	61	2051

TEXAS - MANDATED REPORTING FOR INSURED BUSINESS

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

Customer Name: CITY OF LOS FRESNOS
Policy Number: 1547193
Reporting Period
Processed (paid) Dates: 07/01/2023-06/30/2024
Service (incurred) Dates: ALL

Notification of Withheld Information and Confidentiality Statement

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

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

Claimant ID	1	Amount Paid	$ 87,123

One or more of the following Diagnosis, Procedure, and Service Dates were indicated for this claimant during the reporting period. Diagnosis and Procedure information is listed in ascending order based on Code. Service Date information is listed chronologically.

Diagnosis		Procedure		
Code	Description	Code	Description	Service Date
B351	TINEA UNGUIUM	2022F	DILATED RETINAL EXAM W/EVIDENCE OF RETINOPATHY	01/22/2024
E1122	TYPE 2 DM W/DIABETIC CKD	3074F	MOST RECENT SYSTOLIC BLOOD PRESSURE <130 MM HG	01/23/2024
E113393	TYPE 2 DM MOD NPDR W/O MAC ED BILAT	3075F	MOST RECENT SYSTOLIC BLOOD PRESS 130-139MM HG	02/15/2024
E782	MIXED HYPERLIPIDEMIA	3077F	MOST RECENT SYSTOLIC BLOOD PRES>= 140 MM HG	03/11/2024
E785	HYPERLIPIDEMIA UNSPECIFIED	3078F	MOST RECENT DIASTOLIC BLOOD PRESSURE < 80 MM HG	03/14/2024
I10	ESSENTIAL PRIMARY HYPERTENSION	3079F	MOST RECENT DIASTOLIC BLOOD PRESSURE 80-89 MM HG	03/25/2024
I959	HYPOTENSION UNSPECIFIED	3080F	MOST RECENT DIASTOL BLOOD PRES >= 90 MM HG	04/03/2024
J028	AC PHARYNGIT D/T OTH SPEC ORGANISMS	36415	COLLECTION VENOUS BLOOD VENIPUNCTURE	04/15/2024
L400	PSORIASIS VULGARIS	71046	RADIOLOGIC EXAM CHEST 2 VIEWS	04/18/2024
M542	CERVICALGIA	72040	RADEX SPINE CERVICAL 2 OR 3 VIEWS	04/22/2024
R051	ACUTE COUGH	74177	CT ABDOMEN & PELVIS W/CONTRAST MATERIAL	06/21/2024
R079	CHEST PAIN UNSPECIFIED	78452	MYOCARDIAL SPECT MULTIPLE STUDIES	06/24/2024
R1012	LEFT UPPER QUADRANT PAIN	80050	GENERAL HEALTH PANEL	08/04/2023
R809	PROTEINURIA UNSPECIFIED	80053	COMPREHENSIVE METABOLIC PANEL	08/15/2023

Claimant ID	1	Amount Paid	$ 87,123

One or more of the following Diagnosis, Procedure, and Service Dates were indicated for this claimant during the reporting period. Diagnosis and Procedure information is listed in ascending order based on Code. Service Date information is listed chronologically.

Diagnosis		Procedure		
Code	Description	Code	Description	Service Date
Z0001	ENC GEN ADULT EXAM W/ABNORMAL FIND	80061	LIPID PANEL	08/23/2023
Z041	ENC EXAM&OBSERV FLW TRANSPORT ACC	81002	URNLS DIP STICK/TABLET RGNT NON-AUTO W/O MICRSCP	09/06/2023
		82043	URINE ALBUMIN QUANTITATIVE	09/08/2023
		82306	25 HYDROXY INCLUDES FRACTIONS IF PERFORMED	09/11/2023
		82550	CREATINE KINASE TOTAL	11/28/2023
		82570	CREATININE OTHER SOURCE	12/12/2023
		83036	HEMOGLOBIN GLYCOSYLATED A1C	
		83540	ASSAY OF IRON	
		83690	ASSAY OF LIPASE	
		84550	ASSAY OF BLOOD/URIC ACID	
		85025	BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC	
		85027	BLOOD COUNT COMPLETE AUTOMATED	
		86480	TB CELL MEDIATED ANTIGN RESPNSE GAMMA INTERFERON	
		87426	IAAD IA SEVERE AQT RESPIR SYND CORONAVIRUS	
		87804	IAADIADOO INFLUENZA	
		87880	IAADIADOO STREPTOCOCCUS GROUP A	
		90471	IM ADM PRQ ID SUBQ/IM NJXS 1 VACCINE	
		90688	IIV4 VACC SPLIT VIRUS 0.5 ML DOS FOR IM USE	
		92014	OPH SVCS MEDICAL XM&EVAL COMPRE EST PT 1/>VST	
		92250	FUNDUS PHOTOGRAPHY W/INTERPRETATION & REPORT	
		93000	ECG ROUTINE ECG W/LEAST 12 LDS W/I&R	
		93005	ECG ROUTINE ECG W/LEAST 12 LDS TRCG ONLY W/O I&R	
		93010	ECG ROUTINE ECG W/LEAST 12 LDS I&R ONLY	
		93306	ECHO TTHRC R-T 2D W/WOM-MODE COMPL SPEC&COLR D	
		93922	NON-INVAS PHYSIOLOGIC STD EXTREMITY ART 2 LEVEL	
		94760	NONINVASIVE EAR/PULSE OXIMETRY SINGLE DETER	
		96372	THERAPEUTIC PROPHYLACTIC/DX INJECTION SUBQ/IM	
		99204	OFFICE/OUTPATIENT NEW MODERATE MDM 45 MINUTES	
		99213	OFFICE/OUTPATIENT ESTABLISHED LOW MDM 20 MIN	
		99214	OFFICE/OUTPATIENT ESTABLISHED MOD MDM 30 MIN	

Claimant ID	1	Amount Paid	$ 87,123

One or more of the following Diagnosis, Procedure, and Service Dates were indicated for this claimant during the reporting period. Diagnosis and Procedure information is listed in ascending order based on Code. Service Date information is listed chronologically.

Diagnosis		Procedure		
Code	Description	Code	Description	Service Date
		99284	EMERGENCY DEPARTMENT VISIT MODERATE MDM	
		99396	PERIODIC PREVENTIVE MED EST PATIENT 40-64YRS	
		A9500	TECHNETIUM TC-99M SESTAMIBI DX PER STUDY DOSE	
		G8418	BMI DOC BLW NML PARAM & A F/U PLAN IS DOCUMENTED	
		G8419	BMI DOC OUT NML PARAM NO F/U PLN DOC NO RSN GVN	
		G8420	BMI DOC W/I NORMAL PARAM & NO F/U PLAN REQUIRED	
		G8783	NORMAL BLOOD PRESS READING DOC F/U NOT REQUIRED	
		J0696	INJECTION CEFTRIAXONE SODIUM PER 250 MG	
		J1245	INJECTION DIPYRIDAMOLE PER 10 MG	
		UNKN	UNKNOWN	

UnitedHealthcare
EMPLOYER & INDIVIDUAL

TEXAS - MANDATED REPORTING FOR INSURED BUSINESS

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

Customer Name:	CITY OF LOS FRESNOS
Policy Number:	1547193
Reporting Period	
Processed (paid) Dates:	07/01/2023-06/30/2024
Service (incurred) Dates:	ALL

Notification of Withheld Information and Confidentiality Statement

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

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

Claimant ID	2	Amount Paid	$ 37,134

One or more of the following Diagnosis, Procedure, and Service Dates were indicated for this claimant during the reporting period. Diagnosis and Procedure information is listed in ascending order based on Code. Service Date information is listed chronologically.

Diagnosis		Procedure		
Code	Description	Code	Description	Service Date
B349	VIRAL INFECTION UNSPECIFIED	71045	RADIOLOGIC EXAM CHEST SINGLE VIEW	01/07/2024
999999	OTHER DIAGNOSIS	71046	RADIOLOGIC EXAM CHEST 2 VIEWS	01/08/2024
I071	RHEUMATIC TRICUSPID INSUFFICIENCY	74176	CT ABDOMEN & PELVIS W/O CONTRAST MATERIAL	10/17/2023
I21A1	MYOCARDIAL INFARCTION TYPE 2	74181	MRI ABDOMEN W/O CONTRAST MATERIAL	10/18/2023
K219	GERD WITHOUT ESOPHAGITIS	76376	3D RENDERING W/INTERP & POSTPROCESS SUPERVISION	10/19/2023
K8590	ACUTE PANCREATITIS WO NECRS/INF UNS	76705	US ABDOMINAL REAL TIME W/IMAGE LIMITED	10/20/2023
N179	ACUTE KIDNEY FAILURE UNSPECIFIED	80048	BASIC METABOLIC PANEL CALCIUM TOTAL	10/21/2023
R059	COUGH, UNSPECIFIED	80053	COMPREHENSIVE METABOLIC PANEL	11/09/2023
R0689	OTHER ABNORMALITIES OF BREATHING	80076	HEPATIC FUNCTION PANEL	
R0789	OTHER CHEST PAIN	80305	DRUG TEST PRSMV READ DIRECT OPTICAL OBS PR DATE	
R079	CHEST PAIN UNSPECIFIED	80320	DRUG SCREEN QUANTITATIVE ALCOHOLS	
R109	UNSPECIFIED ABDOMINAL PAIN	80329	DRUG SCREEN ANALGESICS NON-OPIOID 1 OR 2	
R161	SPLENOMEGALY NEC	82150	ASSAY OF AMYLASE	
		82570	CREATININE OTHER SOURCE	
		82607	CYANOCOBALAMIN VITAMIN B-12	
		82746	ASSAY OF FOLIC ACID SERUM	

Claimant ID	2	Amount Paid	$ 37,134

One or more of the following Diagnosis, Procedure, and Service Dates were indicated for this claimant during the reporting period. Diagnosis and Procedure information is listed in ascending order based on Code. Service Date information is listed chronologically.

Diagnosis		Procedure		
Code	Description	Code	Description	Service Date
		82784	ASSAY OF GAMMAGLOBULIN IGA IGD IGG IGM EACH	
		82805	GASES BLOOD PH DIRECT MEAS XCPT PULSE OXIMITRY	
		83036	HEMOGLOBIN GLYCOSYLATED A1C	
		83540	ASSAY OF IRON	
		83605	ASSAY OF LACTATE	
		83615	LACTATE DEHYDROGENASE LDH	
		83690	ASSAY OF LIPASE	
		83735	ASSAY OF MAGNESIUM	
		83880	NATRIURETIC PEPTIDE	
		84300	ASSAY OF URINE SODIUM	
		84478	ASSAY OF TRIGLYCERIDES	
		84484	ASSAY OF TROPONIN QUANTITATIVE	
		85027	BLOOD COUNT COMPLETE AUTOMATED	
		85610	PROTHROMBIN TIME	
		85651	SEDIMENTATION RATE RBC NON-AUTOMATED	
		85730	THROMBOPLASTIN TIME PARTIAL PLASMA/WHOLE BLOOD	
		86039	ANTINUCLEAR ANTIBODIES ANA TITER	
		86140	C-REACTIVE PROTEIN	
		86703	ANTIBODY HIV-1&HIV-2 SINGLE RESULT	
		87040	CULTURE BACTERIAL BLOOD AEROBIC W/ID ISOLATES	
		87088	CULTURE BCT ISOL&PRSMPTV ID ISOLATE EA URINE	
		87205	SMR PRIM SRC GRAM/GIEMSA STAIN BCT FUNGI/CELL	
		87390	IAAD IA HIV-1	
		93005	ECG ROUTINE ECG W/LEAST 12 LDS TRCG ONLY W/O I&R	
		93308	ECHO TRANSTHORC R-T 2D W/WO M-MODE REC F-UP/LMTD	
		93321	DOP ECHOCARD PULSE WAVE W/SPECTRAL F-UP/LMTD STD	
		93325	DOP ECHOCARD COLOR FLOW VELOCITY MAPPING	
		96361	IV INFUSION HYDRATION EACH ADDITIONAL HOUR	
		96374	THER PROPH/DX NJX IV PUSH SINGLE/1ST SBST/DRUG	
		96375	THERAPEUTIC INJECTION IV PUSH EACH NEW DRUG	
		99053	SERVICES PROVIDED BTW 10 PM&8 AM AT 24-HR FACI	
		99223	1ST HOSPITAL IP/OBS CARE HIGH MDM 75 MINUTES	
		99232	SBSQ HOSPITAL IP/OBS CARE MOD MDM 35 MINUTES	

Claimant ID	2	Amount Paid	$ 37,134

One or more of the following Diagnosis, Procedure, and Service Dates were indicated for this claimant during the reporting period. Diagnosis and Procedure information is listed in ascending order based on Code. Service Date information is listed chronologically.

Diagnosis		Procedure		
Code	Description	Code	Description	Service Date
		99233	SBSQ HOSPITAL IP/OBS CARE HIGH MDM 50 MINUTES	
		99239	HOSPITAL IP/OBS DISCHARGE DAY MGMT > 30 MIN	
		99284	EMERGENCY DEPARTMENT VISIT MODERATE MDM	
		99285	EMERGENCY DEPARTMENT VISIT HIGH MDM	
		99291	CRITICAL CARE ILL/INJURED PATIENT INIT 30-74 MIN	
		A0382	BLS ROUTINE DISPOSABLE SUPPLIES	
		A0398	ALS ROUTINE DISPOSABLE SUPPLIES	
		A0425	GROUND MILEAGE PER STATUTE MILE	
		A0427	AMB SERVICE ALS EMERGENCY TRANSPORT LEVEL 1	
		A0429	AMBULANCE SERVICE BLS EMERGENCY TRANSPORT	
		G8427	ELIG CLIN ATTSTS DOC M REC OBTD UPD/REV PT MEDS	
		UNKN	UNKNOWN	

UnitedHealthcare
EMPLOYER & INDIVIDUAL

TEXAS - MANDATED REPORTING FOR INSURED BUSINESS

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

Customer Name: CITY OF LOS FRESNOS
Policy Number: 1547193
Reporting Period
Processed (paid) Dates: 07/01/2023-06/30/2024
Service (incurred) Dates: ALL

Notification of Withheld Information and Confidentiality Statement

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

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

Claimant ID	3	Amount Paid	$ 29,680

One or more of the following Diagnosis, Procedure, and Service Dates were indicated for this claimant during the reporting period. Diagnosis and Procedure information is listed in ascending order based on Code. Service Date information is listed chronologically.

Diagnosis		Procedure		
Code	Description	Code	Description	Service Date
G44209	TENSION-TYP HEADACHE UNS NOT INTRCT	1126F	PAIN SEVERITY QUANTIFIED NO PAIN PRESENT	01/12/2024
H04123	DRY EYE SYNDROME BIL LACRIML GLANDS	1159F	MEDICATION LIST DOCUMENTED IN MEDICAL RECORD	01/17/2023
H6693	OTITIS MEDIA UNSPECIFIED BILATERAL	1160F	RVW ALL MEDS BY RXNG PRCTIONR OR CLIN RPH DOCD	01/19/2023
I10	ESSENTIAL PRIMARY HYPERTENSION	3077F	MOST RECENT SYSTOLIC BLOOD PRES>= 140 MM HG	02/02/2024
I2510	ASHD NATIVE CA W/O ANGINA PECTORIS	3079F	MOST RECENT DIASTOLIC BLOOD PRESSURE 80-89 MM HG	02/04/2024
I25119	ASHD NATIV CA W/UNS ANGINA PECTORIS	36415	COLLECTION VENOUS BLOOD VENIPUNCTURE	02/06/2024
I739	PERIPHERAL VASCULAR DISEASE UNS	70450	CT HEAD/BRAIN W/O CONTRAST MATERIAL	02/08/2024
I880	NONSPEC MESENTERIC LYMPHADENITIS	70480	CT ORBIT SELLA/POST FOSSA/EAR W/O CONTRAST MATRL	02/14/2024
J020	STREPTOCOCCAL PHARYNGITIS	70496	CT ANGIOGRAPHY HEAD W/CONTRAST/NONCONTRAST	02/20/2024
J029	ACUTE PHARYNGITIS UNSPECIFIED	70498	CT ANGIOGRAPHY NECK W/CONTRAST/NONCONTRAST	02/21/2024
J302	OTHER SEASONAL ALLERGIC RHINITIS	71045	RADIOLOGIC EXAM CHEST SINGLE VIEW	03/13/2024
J309	ALLERGIC RHINITIS UNSPECIFIED	72100	RADEX SPINE LUMBOSACRAL 2/3 VIEWS	03/20/2024
J328	OTHER CHRONIC SINUSITIS	74176	CT ABDOMEN & PELVIS W/O CONTRAST MATERIAL	03/21/2024

Claimant ID	3	Amount Paid	$ 29,680

One or more of the following Diagnosis, Procedure, and Service Dates were indicated for this claimant during the reporting period. Diagnosis and Procedure information is listed in ascending order based on Code. Service Date information is listed chronologically.

Diagnosis		Procedure		
Code	Description	Code	Description	Service Date
K5790	DVRTCLOS PRT UNS NO PERF/ABSC NO BL	76513	DX OPHTHALMIC US ANT SEGMENT IMMERSION UNI/BI	03/26/2024
M5440	LUMBAGO WITH SCIATICA UNS SIDE	78452	MYOCARDIAL SPECT MULTIPLE STUDIES	04/03/2024
N200	CALCULUS OF KIDNEY	80048	BASIC METABOLIC PANEL CALCIUM TOTAL	04/05/2024
R059	COUGH, UNSPECIFIED	80050	GENERAL HEALTH PANEL	04/17/2024
R0789	OTHER CHEST PAIN	80051	ELECTROLYTE PANEL	04/18/2024
R079	CHEST PAIN UNSPECIFIED	80053	COMPREHENSIVE METABOLIC PANEL	05/02/2024
R0981	NASAL CONGESTION	80061	LIPID PANEL	05/04/2024
R109	UNSPECIFIED ABDOMINAL PAIN	80076	HEPATIC FUNCTION PANEL	05/09/2024
R42	DIZZINESS AND GIDDINESS	80305	DRUG TEST PRSMV READ DIRECT OPTICAL OBS PR DATE	05/11/2024
R519	HEADACHE UNSPECIFIED	80307	DRUG TST PRSMV INSTRMNT CHEM ANALYZERS PR DATE	05/13/2024
U071	COVID-19	81002	URNLS DIP STICK/TABLET RGNT NON-AUTO W/O MICRSCP	05/18/2024
Z0000	ENC GEN ADULT EXAM W/O ABNORM FIND	81003	URNLS DIP STICK/TABLET RGNT AUTO W/O MICROSCOPY	05/30/2023
Z1152	ENCOUNT FOR SCREENING FOR COVID-19	81412	ASHKENAZI JEWISH ASSOC DSRDRS GEN SEQ ANAL 9 GEN	06/01/2024
Z131	ENCOUNTER FOR SCREENING FOR DM	82040	ALBUMIN SERUM PLASMA/WHOLE BLOOD	07/17/2023
Z1379	ENC OTH SCR GENETIC CHROMOSM ANOMAL	82043	URINE ALBUMIN QUANTITATIVE	08/02/2023
Z20828	CONTCT EXPS OTH VIRL COMMUNICABL DZ	82150	ASSAY OF AMYLASE	08/25/2023
Z712	PERS CNSLT EXPLANATN EXAM/TEST FIND	82172	APOLIPOPROTEIN EACH	08/31/2023
Z79899	OTH LONG TERM CURRENT DRUG THERAPY	82247	BILIRUBIN TOTAL	10/17/2023
		82306	25 HYDROXY INCLUDES FRACTIONS IF PERFORMED	10/18/2023
		82330	CALCIUM IONIZED	10/19/2022
		82374	CARBON DIOXIDE BICARBONATE	12/15/2023
		82550	CREATINE KINASE TOTAL	12/19/2022
		82565	CREATININE BLOOD	
		82570	CREATININE OTHER SOURCE	
		82607	CYANOCOBALAMIN VITAMIN B-12	
		82746	ASSAY OF FOLIC ACID SERUM	
		82947	GLUCOSE QUANTITATIVE BLOOD XCPT REAGENT STRIP	
		82977	ASSAY OF GLUTAMYLTRASE GAMMA	
		83036	HEMOGLOBIN GLYCOSYLATED A1C	
		83090	ASSAY OF HOMOCYSTEINE	
		83525	ASSAY OF INSULIN TOTAL	
		83615	LACTATE DEHYDROGENASE LDH	
		83690	ASSAY OF LIPASE	
		83718	LIPOPROTEIN DIR MEAS HIGH DENSITY CHOLESTEROL	
		83721	LIPOPROTEIN DIRECT MEASUREMENT LDL CHOLESTEROL	
		83735	ASSAY OF MAGNESIUM	

Claimant ID	3	Amount Paid	$ 29,680

One or more of the following Diagnosis, Procedure, and Service Dates were indicated for this claimant during the reporting period. Diagnosis and Procedure information is listed in ascending order based on Code. Service Date information is listed chronologically.

Diagnosis		Procedure		
Code	Description	Code	Description	Service Date
		83880	NATRIURETIC PEPTIDE	
		84075	ASSAY OF PHOSPHATASE ALKALINE	
		84100	ASSAY OF PHOSPHORUS INORGANIC	
		84132	POTASSIUM SERUM PLASMA/WHOLE BLOOD	
		84155	PROTEIN XCPT REFRACTOMETRY SERUM PLASMA/WHL BLD	
		84295	SODIUM SERUM PLASMA OR WHOLE BLOOD	
		84436	ASSAY OF THYROXINE TOTAL	
		84439	ASSAY OF FREE THYROXINE	
		84443	ASSAY OF THYROID STIMULATING HORMONE TSH	
		84450	TRANSFERASE ASPARTATE AMINO AST SGOT	
		84460	TRANSFERASE ALANINE AMINO ALT SGPT	
		84478	ASSAY OF TRIGLYCERIDES	
		84479	THYROID HORM UPTK/THYROID HORMONE BINDING RATIO	
		84484	ASSAY OF TROPONIN QUANTITATIVE	
		84520	ASSAY OF UREA NITROGEN QUANTITATIVE	
		85025	BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC	
		85610	PROTHROMBIN TIME	
		85730	THROMBOPLASTIN TIME PARTIAL PLASMA/WHOLE BLOOD	
		86141	C-REACTIVE PROTEIN HIGH SENSITIVITY	
		87015	CONCENTRATION INFECTIOUS AGENTS	
		87426	IAAD IA SEVERE AQT RESPIR SYND CORONAVIRUS	
		87428	IAAD IA SARSCOV & INFLUENZA VIRUS TYPES A&B	
		87481	IADNA CANDIDA SPECIES AMPLIFIED PROBE TQ	
		87491	IADNA CHLAMYDIA TRACHOMATIS AMPLIFIED PROBE TQ	
		87496	IADNA CYTOMEGALOVIRUS AMPLIFIED PROBE TQ	
		87498	IADNA ENTEROVIRUS AMPLIF PROBE & REVRSE TRNSCRIP	
		87529	IADNA HERPES SOMPLX VIRUS AMPLIFIED PROBE TQ	
		87591	IADNA NEISSERIA GONORRHOEAE AMPLIFIED PROBE TQ	
		87635	IADNA SARS-COV-2 COVID-19 AMPLIFIED PROBE TQ	
		87640	IADNA S AUREUS AMPLIFIED PROBE TQ	

Claimant ID	3	Amount Paid	$ 29,680

One or more of the following Diagnosis, Procedure, and Service Dates were indicated for this claimant during the reporting period. Diagnosis and Procedure information is listed in ascending order based on Code. Service Date information is listed chronologically.

Diagnosis		Procedure		
Code	Description	Code	Description	Service Date
		87651	IADNA STREPTOCOCCUS GROUP A AMPLIFIED PROBE TQ	
		87653	IADNA STREPTOCOCCUS GROUP B AMPLIFIED PROBE TQ	
		87798	IADNA NOS AMPLIFIED PROBE TQ EACH ORGANISM	
		87804	IAADIADOO INFLUENZA	
		87811	IAADIADOO SEVERE AQT RESPIR SYND CORONAVIRUS	
		87880	IAADIADOO STREPTOCOCCUS GROUP A	
		87899	IAADIADOO NOT OTHERWISE SPECIFIED	
		92014	OPH SVCS MEDICAL XM&EVAL COMPRE EST PT 1/>VST	
		92015	DETERMINATION REFRACTIVE STATE	
		92083	EXTENDED VISUAL FIELD XM UNI/BI I&R	
		92250	FUNDUS PHOTOGRAPHY W/INTERPRETATION & REPORT	
		92557	COMPRE AUDIOMETRY THRESHOLD EVAL SP RECOGNIJ	
		92567	TYMPANOMETRY	
		93000	ECG ROUTINE ECG W/LEAST 12 LDS W/I&R	
		93005	ECG ROUTINE ECG W/LEAST 12 LDS TRCG ONLY W/O I&R	
		93010	ECG ROUTINE ECG W/LEAST 12 LDS I&R ONLY	
		93015	CV STRS TST XERS&/OR RX CONT ECG W/SI&R	
		93306	ECHO TTHRC R-T 2D W/WOM-MODE COMPL SPEC&COLR D	
		93925	DUP-SCAN LXTR ART/ARTL BPGS COMPL BI STUDY	
		95004	PERCUTANEOUS TESTS W/ALLERGENIC EXTRACTS	
		95165	PREPJ& ALLERGEN IMMUNOTHERAPY 1/MLT ANTIGEN	
		96127	BEHAV ASSMT W/SCORE & DOCD/STAND INSTRUMENT	
		96361	IV INFUSION HYDRATION EACH ADDITIONAL HOUR	
		96365	IV INFUSION THERAPY/PROPHYLAXIS /DX 1ST TO 1 HR	
		96367	IV INFUSION THER PROPH ADDL SEQUENTIAL TO 1 HR	
		96372	THERAPEUTIC PROPHYLACTIC/DX INJECTION SUBQ/IM	
		96375	THERAPEUTIC INJECTION IV PUSH EACH NEW DRUG	
		99000	HANDLG&/OR CONVEY OF SPEC FOR TR OFFICE TO LAB	

Claimant ID	3	Amount Paid	$ 29,680

One or more of the following Diagnosis, Procedure, and Service Dates were indicated for this claimant during the reporting period. Diagnosis and Procedure information is listed in ascending order based on Code. Service Date information is listed chronologically.

Diagnosis		Procedure		
Code	Description	Code	Description	Service Date
		99053	SERVICES PROVIDED BTW 10 PM&8 AM AT 24-HR FACI	
		99212	OFFICE/OUTPATIENT ESTABLISHED SF MDM 10 MIN	
		99213	OFFICE/OUTPATIENT ESTABLISHED LOW MDM 20 MIN	
		99214	OFFICE/OUTPATIENT ESTABLISHED MOD MDM 30 MIN	
		99283	EMERGENCY DEPARTMENT VISIT LOW MDM	
		99284	EMERGENCY DEPARTMENT VISIT MODERATE MDM	
		99285	EMERGENCY DEPARTMENT VISIT HIGH MDM	
		99386	INITIAL PREVENTIVE MEDICINE NEW PATIENT 40-64YRS	
		99396	PERIODIC PREVENTIVE MED EST PATIENT 40-64YRS	
		A4208	SYRINGE WITH NEEDLE STERILE 3 CC EACH	
		A4209	SYRINGE WITH NEEDLE STERILE 5 CC OR GREATER EACH	
		A4216	STERIL WATER SALINE & OR DXT DILUENT/FLUSH 10 ML	
		A4649	SURGICAL SUPPLY; MISCELLANEOUS	
		A9500	TECHNETIUM TC-99M SESTAMIBI DX PER STUDY DOSE	
		G0447	FACE--FACE BEHAVIORAL COUNSELING OBESITY 15 MIN	
		J0696	INJECTION CEFTRIAXONE SODIUM PER 250 MG	
		J0744	INJECTION CIPROFLOXACIN INTRAVENOUS INFUS 200 MG	
		J1100	INJECTION DEXAMETHOSONE SODIUM PHOSPHATE 1 MG	
		J1836	INJECTION METRONIDAZOLE 10 MG	
		J1885	INJECTION KETOROLAC TROMETHAMINE PER 15 MG	
		J7030	INFUSION NORMAL SALINE SOLUTION 1000 CC	
		S1015	IV TUBING EXTENSION SET	
		S8301	INFECTION CONTROL SUPPLIES NOS	
		S9088	SERVICES PROVIDED IN AN URGENT CARE CENTER	
		U0002	2019-NCOV CORONAVIRUS SARS-COV-2/2019-NCOV	
		UNKN	UNKNOWN	

UnitedHealthcare
EMPLOYER & INDIVIDUAL

TEXAS - MANDATED REPORTING FOR INSURED BUSINESS

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

Customer Name: CITY OF LOS FRESNOS
Policy Number: 1547193
Reporting Period
Processed (paid) Dates: 07/01/2023-06/30/2024
Service (incurred) Dates: ALL

Notification of Withheld Information and Confidentiality Statement

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

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

Claimant ID	4	Amount Paid	$ 25,353

One or more of the following Diagnosis, Procedure, and Service Dates were indicated for this claimant during the reporting period. Diagnosis and Procedure information is listed in ascending order based on Code. Service Date information is listed chronologically.

Diagnosis		Procedure		
Code	Description	Code	Description	Service Date
E113293	TYPE 2 DM MILD NPDR W/O MAC ED BIL	1159F	MEDICATION LIST DOCUMENTED IN MEDICAL RECORD	01/31/2024
E119	TYPE 2 DM WITHOUT COMPLICATIONS	1160F	RVW ALL MEDS BY RXNG PRCTIONR OR CLIN RPH DOCD	02/08/2024
E559	VITAMIN D DEFICIENCY UNSPECIFIED	1170F	FUNCTIONAL STATUS ASSESSED	03/06/2024
E782	MIXED HYPERLIPIDEMIA	3074F	MOST RECENT SYSTOLIC BLOOD PRESSURE <130 MM HG	05/21/2024
E785	HYPERLIPIDEMIA UNSPECIFIED	3075F	MOST RECENT SYSTOLIC BLOOD PRESS 130-139MM HG	06/03/2024
I083	COMB RHEUMAT D/O MITRL AORTC TRICSP	3078F	MOST RECENT DIASTOLIC BLOOD PRESSURE < 80 MM HG	06/05/2024
I10	ESSENTIAL PRIMARY HYPERTENSION	3079F	MOST RECENT DIASTOLIC BLOOD PRESSURE 80-89 MM HG	06/06/2024
I209	ANGINA PECTORIS UNSPECIFIED	36415	COLLECTION VENOUS BLOOD VENIPUNCTURE	06/17/2024
I350	NONRHEUMATIC AORTIC VALVE STENOSIS	71045	RADIOLOGIC EXAM CHEST SINGLE VIEW	06/18/2024
I872	VENOUS INSUFF CHRONIC PERIPHERAL	71046	RADIOLOGIC EXAM CHEST 2 VIEWS	07/15/2023
J069	ACUTE UP RESPIRATORY INFECTION UNS	78000	THYROID UPTAKE SINGLE DETERMINATION	07/17/2023
J9811	ATELECTASIS	78452	MYOCARDIAL SPECT MULTIPLE STUDIES	07/27/2023
R071	CHEST PAIN ON BREATHING	80048	BASIC METABOLIC PANEL CALCIUM TOTAL	08/16/2023

Claimant ID	4	Amount Paid	$ 25,353

One or more of the following Diagnosis, Procedure, and Service Dates were indicated for this claimant during the reporting period. Diagnosis and Procedure information is listed in ascending order based on Code. Service Date information is listed chronologically.

Diagnosis		Procedure		
Code	Description	Code	Description	Service Date
R079	CHEST PAIN UNSPECIFIED	80050	GENERAL HEALTH PANEL	08/29/2023
R0989	OTH SPEC SX SIGNS INVLV CIRC RS	80053	COMPREHENSIVE METABOLIC PANEL	10/28/2023
R931	ABNORMAL FIND DX IMAG HRT COR CIRC	80061	LIPID PANEL	10/31/2023
U071	COVID-19	81001	URNLS DIP STICK/TABLET REAGENT AUTO MICROSCOPY	11/16/2023
Z01818	ENCOUNTER OTHER PREPROCEDURAL EXAM	82043	URINE ALBUMIN QUANTITATIVE	11/17/2023
		82044	URINE ALBUMIN SEMIQUANTITATIVE	12/05/2023
		82570	CREATININE OTHER SOURCE	12/06/2023
		82948	GLUCOSE BLOOD REAGENT STRIP	
		83036	HEMOGLOBIN GLYCOSYLATED A1C	
		83718	LIPOPROTEIN DIR MEAS HIGH DENSITY CHOLESTEROL	
		83721	LIPOPROTEIN DIRECT MEASUREMENT LDL CHOLESTEROL	
		84153	ASSAY OF PROSTATE SPECIFIC ANTIGEN TOTAL	
		84478	ASSAY OF TRIGLYCERIDES	
		85025	BLOOD COUNT COMPLETE AUTO&AUTO DIFRNTL WBC	
		85610	PROTHROMBIN TIME	
		85730	THROMBOPLASTIN TIME PARTIAL PLASMA/WHOLE BLOOD	
		87635	IADNA SARS-COV-2 COVID-19 AMPLIFIED PROBE TQ	
		87804	IAADIADOO INFLUENZA	
		87880	IAADIADOO STREPTOCOCCUS GROUP A	
		91000	ESOPHAGEAL INTUBATION	
		92014	OPH SVCS MEDICAL XM&EVAL COMPRE EST PT 1/>VST	
		93005	ECG ROUTINE ECG W/LEAST 12 LDS TRCG ONLY W/O I&R	
		93016	CV STRS TST XERS&/OR RX CONT ECG W/O I&R	
		93018	CV STRS TST XERS&/OR RX CONT ECG I&R ONLY	
		93306	ECHO TTHRC R-T 2D W/WOM-MODE COMPL SPEC&COLR D	
		93312	ECHO TRANSESOPHAG R-T 2D W/PRB IMG ACQUISJ I&R	
		93325	DOP ECHOCARD COLOR FLOW VELOCITY MAPPING	
		93456	CATH PLMT R HRT & ARTS W/NJX & ANGIO IMG S&I	
		99205	OFFICE/OUTPATIENT NEW HIGH MDM 60 MINUTES	
		99213	OFFICE/OUTPATIENT ESTABLISHED LOW MDM 20 MIN	
		99214	OFFICE/OUTPATIENT ESTABLISHED MOD MDM 30 MIN	

Claimant ID	4	Amount Paid	$ 25,353

One or more of the following Diagnosis, Procedure, and Service Dates were indicated for this claimant during the reporting period. Diagnosis and Procedure information is listed in ascending order based on Code. Service Date information is listed chronologically.

Diagnosis		Procedure		
Code	Description	Code	Description	Service Date
		99441	PHYS/QHP TELEPHONE EVALUATION 5-10 MIN	
		C1760	CLOSURE DEVICE VASCULAR	
		C1894	INTRDUCR/SHEATH NOT GUID INTRACARD EP NON-LASR	
		J1644	INJECTION HEPARIN SODIUM PER 1000 UNITS	
		J2250	INJECTION MIDAZOLAM HCL PER 1 MG	
		J3010	INJECTION FENTANYL CITRATE 0.1 MG	
		Q9967	LOCM 300-399 MG/ML IODINE CONCENTRATION PER ML	
		UNKN	UNKNOWN	

UnitedHealthcare
EMPLOYER & INDIVIDUAL

TEXAS - MANDATED REPORTING FOR INSURED BUSINESS

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

Customer Name:	CITY OF LOS FRESNOS
Policy Number:	1547193
Reporting Period	
Processed (paid) Dates:	07/01/2023-06/30/2024
Service (incurred) Dates:	ALL

Notification of Withheld Information and Confidentiality Statement

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

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

Claimant ID	5	Amount Paid	$ 19,572

One or more of the following Diagnosis, Procedure, and Service Dates were indicated for this claimant during the reporting period. Diagnosis and Procedure information is listed in ascending order based on Code. Service Date information is listed chronologically.

Diagnosis		Procedure		
Code	Description	Code	Description	Service Date
J209	ACUTE BRONCHITIS UNSPECIFIED	01830	ANES ARTHRS/ENDSCPY DSTL RADIUS ULNA/WRIST/HAND	06/19/2023
L03011	CELLULITIS OF RIGHT FINGER	11042	DEBRIDEMENT SUBCUTANEOUS TISSUE 1ST 20 SQ CM/<	07/03/2023
M86641	OTHER CHRONIC OSTEOMYELITIS RT HAND	1111F	DISCHRG MEDS RECONCILED W/CURRENT MED LIST	07/10/2023
M868X4	OTHER OSTEOMYELITIS HAND	1126F	PAIN SEVERITY QUANTIFIED NO PAIN PRESENT	07/17/2023
M869	OSTEOMYELITIS UNSPECIFIED	1159F	MEDICATION LIST DOCUMENTED IN MEDICAL RECORD	07/24/2023
R609	EDEMA UNSPECIFIED	1160F	RVW ALL MEDS BY RXNG PRCTIONR OR CLIN RPH DOCD	07/31/2023
S61200A	UNS OPN WND RT IF W/O DMG NAIL INIT	26951	AMP F/TH 1/2 JT/PHALANX W/NEURECT W/DIR CLSR	08/07/2023
S61200D	UNS OPN WND RT IF W/O DMG NAIL SUB	64415	INJECTION AA&/STRD BRACHIAL PLEXUS W/IMG GDN	08/14/2023
S61209A	UNS OPN WND UNS FNGR NO DMG NL INIT	73140	RADEX FINGR MINIMUM 2 VIEWS	08/21/2023
Z89029	ACQUIRED ABSENCE UNSPEC FINGERS	73218	MRI UPPER EXTREMITY OTH THAN JT W/O CONTR MATRL	08/28/2023
		99213	OFFICE/OUTPATIENT ESTABLISHED LOW MDM 20 MIN	09/11/2023
		99222	1ST HOSPITAL IP/OBS CARE MODERATE MDM 55 MINUTES	09/18/2023
		99223	1ST HOSPITAL IP/OBS CARE HIGH MDM 75 MINUTES	09/21/2023

Claimant ID	5	Amount Paid	$ 19,572

One or more of the following Diagnosis, Procedure, and Service Dates were indicated for this claimant during the reporting period. Diagnosis and Procedure information is listed in ascending order based on Code. Service Date information is listed chronologically.

Diagnosis		Procedure		
Code	Description	Code	Description	Service Date
		99232	SBSQ HOSPITAL IP/OBS CARE MOD MDM 35 MINUTES	09/25/2023
		99233	SBSQ HOSPITAL IP/OBS CARE HIGH MDM 50 MINUTES	09/27/2023
		99239	HOSPITAL IP/OBS DISCHARGE DAY MGMT > 30 MIN	09/28/2023
		UNKN	UNKNOWN	09/29/2023
				09/30/2023
				10/02/2023

TEXAS - MANDATED REPORTING FOR INSURED BUSINESS

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

Customer Name:	CITY OF LOS FRESNOS
Policy Number:	1547193
Reporting Period	
Processed (paid) Dates:	07/01/2023-06/30/2024
Service (incurred) Dates:	ALL

Notification of Withheld Information and Confidentiality Statement

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

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

Claimant ID	6	Amount Paid	$ 16,300

One or more of the following Diagnosis, Procedure, and Service Dates were indicated for this claimant during the reporting period. Diagnosis and Procedure information is listed in ascending order based on Code. Service Date information is listed chronologically.

Diagnosis		Procedure		
Code	Description	Code	Description	Service Date
D122	BENIGN NEOPLASM OF ASCENDING COLON	00812	ANESTHESIA LOWER INTST ENDOSCOPIC PX SCR COLSC	04/30/2024
D126	BENIGN NEOPLASM COLON UNSPECIFIED	3074F	MOST RECENT SYSTOLIC BLOOD PRESSURE <130 MM HG	06/20/2023
E113299	TYPE 2 DM MILD NPDR W/O ME UNS EYE	3075F	MOST RECENT SYSTOLIC BLOOD PRESS 130-139MM HG	07/19/2023
E1139	TYP 2 DM W/DIABETIC OPHTH COMP	3078F	MOST RECENT DIASTOLIC BLOOD PRESSURE < 80 MM HG	07/27/2023
E119	TYPE 2 DM WITHOUT COMPLICATIONS	36415	COLLECTION VENOUS BLOOD VENIPUNCTURE	08/09/2023
E785	HYPERLIPIDEMIA UNSPECIFIED	45380	COLONOSCOPY W/BIOPSY SINGLE/MULTIPLE	08/10/2023
I10	ESSENTIAL PRIMARY HYPERTENSION	71046	RADIOLOGIC EXAM CHEST 2 VIEWS	11/07/2023
J069	ACUTE UP RESPIRATORY INFECTION UNS	80050	GENERAL HEALTH PANEL	12/19/2023
J111	FLU D/T UNIDENT FLU VIR RESP MANIF	80061	LIPID PANEL	
J209	ACUTE BRONCHITIS UNSPECIFIED	81003	URNLS DIP STICK/TABLET RGNT AUTO W/O MICROSCOPY	
R059	COUGH, UNSPECIFIED	82043	URINE ALBUMIN QUANTITATIVE	
Z6830	BODY MASS INDEX BMI 30.0-30.9 ADULT	82044	URINE ALBUMIN SEMIQUANTITATIVE	
Z85038	PERS HX OTH MALIG NEOPLSM LG INTEST	82570	CREATININE OTHER SOURCE	
		83036	HEMOGLOBIN GLYCOSYLATED A1C	

Claimant ID	6	Amount Paid	$ 16,300

One or more of the following Diagnosis, Procedure, and Service Dates were indicated for this claimant during the reporting period. Diagnosis and Procedure information is listed in ascending order based on Code. Service Date information is listed chronologically.

Diagnosis		Procedure		
Code	Description	Code	Description	Service Date
		87635	IADNA SARS-COV-2 COVID-19 AMPLIFIED PROBE TQ	
		87804	IAADIADOO INFLUENZA	
		87880	IAADIADOO STREPTOCOCCUS GROUP A	
		88305	LEVEL IV SURG PATHOLOGY GROSS&MICROSCOPIC EXAM	
		92014	OPH SVCS MEDICAL XM&EVAL COMPRE EST PT 1/>VST	
		92015	DETERMINATION REFRACTIVE STATE	
		92134	COMPUTERIZED OPHTHALMIC IMAGING RETINA	
		93922	NON-INVAS PHYSIOLOGIC STD EXTREMITY ART 2 LEVEL	
		96372	THERAPEUTIC PROPHYLACTIC/DX INJECTION SUBQ/IM	
		99203	OFFICE/OUTPATIENT NEW LOW MDM 30 MINUTES	
		99213	OFFICE/OUTPATIENT ESTABLISHED LOW MDM 20 MIN	
		99214	OFFICE/OUTPATIENT ESTABLISHED MOD MDM 30 MIN	
		G8510	SCREENING DEPRESSION DOC NEG A F/U PLAN NOT RQR	
		UNKN	UNKNOWN	

TEXAS HOUSE BILL 2015 DATA DICTIONARY

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

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

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

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