ABA
Assured Benefits Administrators

Thursday, July 11, 2019

Assured Benefits Administrators is pleased to present a proposal for Third Party Administration of health benefits to the County of Upshur, Texas.

We have proudly served employers and plan sponsors for more than 30 years. In addition, ABA has all TPA licenses and insurance needed to do business with the City of Broken Arrow. And as an independently owned TPA with more than 200,000 covered lives and 180 million in revenue, ABA (part of a family of six companies) is uniquely positioned to meet and exceed the needs of the City.

We look forward to providing the County of Upshur, Texas with competitively priced and service-oriented healthcare administration.

Sincerely,
Trevor Pearson
Vice President, Sales
Assured Benefits Administration

FILED
TERRI ROSS
COUNTY CLERK
2019 JUL 15 PM 12:55
UPSHUR COUNTY, TX.
BY _____
DEPUTY

Toll Free: 800.247.7114 ext. 1219
8150 North Central Expressway
Suite 1750
Dallas, Texas 75206
www.abadmin.com

ABA
Assured Benefits Administrators

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Section I – Bid Costs and Fees

1. **Proposed TPA Fees**

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4. **Sample EOB**

Medical & Dental Administration - Proposed TPA Fees	
	Cost PEPM
Medical Claims Administration	$ 21.00
Network Access Fee	$ 11.75
Pre-Certification / UR	Included
Dental Administration	$ 1.90
COBRA & HIPAA Administration	Included
Total Administrative Costs	$ 34.65
Rate Guarantee	2 years
TPA Fee Abatement Available First Year	Available
Additional Costs	
Large Case Management Fee	$124/hour
Plan Management Fee	None
Initial or Renewal Set up fees	None
Miscellaneaous Printing Costs	None
Miscellaneaous or any other fees not mentioned	
IMS PPO Network (Optional)	$9.00 PEPM
My Telemed	$1.95 PEPM

RFP SUPPLIER RESPONSE TEMPLATE

NSTRUCTIONS AND ASSUMPTIONS				
Complete the blue-shaded cells and submit responses as the TPA Questionnaire				
FP #	2019-1001			
FP Title	ADMINISTRATIVE SERVICES ONLY (ASO) FOR MEDICAL, DENTAL, PPO NETWORK and COBRA/HIPPA SERVICES			
ECTION 1: GENERAL QUESTIONNAIRE (To be answered by all Proposers)				
escribe your Organization				
usiness Name:	Assured Benefit Administrators			
ontact Address:	8150 N. Central Expressway, Suite 1700, Dallas, TX 75206			
ontact Person:	Sandy Locke			
ontact Phone #:	(214) 878-5890			
ontact Email:	slocke@abadmin.com			
ear Founded:	1985			
urther Organization Description				
here is your company headquarters located?	8150.N. Central Expressway, Suite 1700, Dallas, TX 75206			
lease provide your most recent published financial statement and/or Best Insurance ating. (Please provide financial size category.)	ABA is a privately held company and does not audit nor disclose financial statements. The company is consistently profitable and without long term debt. ABA possesses adequate financial resources to provide Upshur County with superior			
ill there be an individual account manager dedicated to Upshur County, and if so, here will he/she be located? Please provide biographies of each individual.	An individual account manager will be assigned to Upshur County. He/she will be located in Dallas, TX. Their biograhy is attached.			
pshur County requires the right to approve any correspondence sent to our employees. o you agree to the prior approval agreement?	Yes			
ill any of your services be sub-contracted with outside vendors? (if yes, please describe ne services and with whom you sub-contract – i.e. ABC Company for ID card printing.)	No.			
ill you be willing to have representatives available at initial employee educational and nrollment meetings as well as future open enrollments, health fairs, and other special equirements?	Yes			
ow long has your organization been doing business in the state of Texas?	34			
ill your phone unit provide support to the initial and on-going future enrollments by nswering members' phone calls about benefits and networks, etc.	Yes			
rovide three Texas client references (preferably public sector clients).	Contact Name	Contact Title	Contact Phone	Contact E-mail
entral Retail Network Group	Elizabeth Brown	Vice President, Human Resou	(918) 770-9013	
atholic Diocese of Jackson	Julie Williams	Benefits Coordinator	(601) 960-8462	
one Star National Bank	Ruben Garza		(956) 984-2967	
ECTION 1: SELF-FUNDED MEDICAL QUESTIONNAIRE (To be answered by TPA's and oriers)				
lan Administration				
re customer service functions and claim payment performed in the same location?	Yes. These are located in El Paso, TX.			
ontractor will provide COBRA administration and the fee will be included in the ubmitted rate. The County will provide notification of termination to the Contractor who ill then be responsible for all other aspects of the process, including but not limited to ne following: employee notification for medical, drug, dental, and vision benefits; ertificate of coverage for HIPAA compliance; billing and premium collection for nedical, drug and dental benefits; mail identification cards and informational materials the subscriber home.	Agreed			
ontractor agrees to provide the County with the Summary of Benefits and Coverage otices prior to open enrollment for the County to distribute to employees.	Agreed			
ustomer Service				

ontractor will develop, print, and distribute a customized, lay language, Summary Plan ocument (SPD) booklets to be made available in electronic format or be mailed to the ubscriber's home address at the time of initial enrollment and thereafter for new hires or ther new subscribers? SPD shall be reviewed and approved by the County. The SPD ill be developed and submitted to each subscriber not later than April of each year nless another date has been agreed upon by the County.	Agreed
ligibility	
an you accept enrollment, maintenance, and termination data from the County nline?	Yes.
enrollment available with electronic data feed capabilities?	Yes.
etwork	
o you currently offer any hospital tiered benefit arrangements (Accountable Care rganizations or EPO) in the East Texas area?	IMS Select is the premier RGV PPO network with deeply discounted, Medicare-based fixed fee facility and professional contracts. Our cost containment strategy includes narrow networks (EPOs) targeting the highest incident cost of medical
re you anticipating any material changes in network size (for either hospitals or roviders) in the network area serving the County during the next 24 months?	No.
hat is the Contractor's standard process and advance notification timeframe to notify ie County and its subscribers of network changes?	Notification will be made when a major event occurs, e.g. the addition or termination of an area hospital or large provider group. Our provider lists are updated weekly.
escribe the Contractor's transition process for handling patients that are currently ceiving care in a non-network hospital as well as those currently receiving outpatient ervices at time of contract implementations.	Current UR inpatient and outpatient reports should be obtained form the current TPA/UR Vendor and then ABA will see that MedWatch takes of and contacts the facilities and makes sure that the care meets the URAC guidelines for medical necessity and appropriate care.
e any parts of the Contactor's networks leased?	No, IMS primary PPO is an affiliated company of ABA with discounts that meet or exceed the discounts obtained through
yes, identify owner of the network and the geographic service area.	Not applicable.
your designated network separate or a subset of your large network?	Our designated network is a subset of IMS's large network.
laims Payment Processing	
ontractor will furnish Explanation of Benefit (EOB) payment statements to subscribers ter a claim has been received and payment issued or rejected. A sample copy of EOB included.	Please find attached.
r those claims that require additional information before processing can continue, is a otice sent to the provider and/or subscriber advising them of this fact?	Yes
ow much of a delay generates such notice?	All claims pended for additional information generate a notice.
escribe the process for obtaining medical consultation needed for claims payment etermination.	Peer review organizations are utilized.
hat qualifications do the Contractor's medical consultant(s) possess?	MD
ow often do the Contractor's medical consultant(s) meet to review claims?	As needed.
ease indicate your process for handling subrogation claims	A senior claims examiner researches the claim and gathers information from the provider, the claimant and also from public
plain the current procedure for identifying and processing claims for Coordination of enefits.	When a member is a dependent or has a dependent, ABA administers a COB questionnaire to determine if the member has other coverage. Any members older than 65 are also required to document their Medicare status. ABA has long experience
escribe the appeal process of a contested claim.	ABA adheres to the plan document. Members and providers may request an appeal in writing. ABA will gather and review
oes your claim system check for duplicate charges? What are the criteria used?	Yes, matching member and provider name, DOB, ID number, DOS, Claims type, POS and dollar amount of claim.
oes your system check for bundling/ unbundling of claims? What are the criteria used?	Yes, the WLT claims system includes proprietary code bundling software.
ease provide a copy of your Standard Performance Guarantees.	Please find attached.
edical Management	
Hospital Pre-Certification and Large Case Management	
efly describe your case management and utilization review functions. Provide an timate of savings associated with these programs.	ABA proposes MedWatch, an URAC accredited UR and case management company affiliated with Harvard Pilgrim. UR and case management fees are listedseparately with the proposal.
escribe the process and criteria for identifying subscribers in need of large case anagement, including those with large outpatient expenses without having an patient stay.	Care coordinators, case managers and disease managers work in conjunction with ABA/IMS managed care specialists to regularly review high dollar treatments and claims. Patients are steered to more cost-effective forms of treatments and facilities, matching members with best practices to deliver cost savings and improved outcomes.
Centers of Excellence	
oes the Contractor have a network of "Centers of Excellence"? If so, Describe how cilities are selected.	Yes Medwatch the UR and Case Management partner of ABA has many options for Cancer, Transplant and Cardio programs - information regardign the programs are attached.
efine experimental treatment and the process for evaluating new treatments.	

'hat is the policy on experimental and catastrophic procedures such as organ or tissue ansplants and new technologies?	
escribe the selection criteria or prior authorization process to gain access to the centers.	The member is contacted by a Nurse from Medwatch and is informed of the Centers after Medwatch receives the pre-certification call regarding one of the conditions.
escribe how case management is provided for subscribers who access Centers of cellence (i.e., are they handled in a unit separate from other catastrophic cases)?	Casemanagement foolows the members care throught the care by coordinating with with Care Mnanagmeent at the Center until the member is released.
anking Arrangements	
re checks issued on the employer's or carrier's stock?	Checks can be issued on either.
o you require a minimum balance to be maintained or can the County use a zero alance account?	A zero balance is acceptable so long as funding is timely.
Cards	
e ID cards customizable?	Yes
ease describe ID card distribution.	Assured Benefit Administrators will mail employee ID cards, Employee Benefit Book and other related materials be mailed to
urse Line & Patient Engagement	
a nurse advisory toll free number available? Is there any associated cost?	My Telemed is available for $1.95 PEPM.
ovide your definition of patient engagement? Explain how your levels of engagement e changing behavior. What percent of your engagement activity is telephonic versus ail based?	Web based disease management programs have a very low adoption rate, for this reason MedWatch does not put emphasis on our member portal. It is proven that the truly successful programs for lifestyle and behavior modification programs occur when meaningful real time 2-way communication occurs between the member and the coach and when
op Loss Integration	
your system set up to automatically pend stop loss claims, so an audit can be erformed prior to issuing the check? What is the turnaround time for this to happen?	Yes, generally within 30 days.
ease describe the stop loss filing process that will be used for the County.	After claim is processed it is filed with the stop loss carrier along with all documentation, updated LCM reports, notes,
pharmacy benefits are provided through a third-party, are you able to integrate edical and pharmacy cost data into one combined summary to provide to the stop ss carrier?	Yes.
udits	
'hat is the frequency of your internal audits?	15% of random claims
'hat is the frequency of your external audits?	Audit Frequency varies based on the requirements of clients and stop loss carriers.
'ho performs external audits?	External Audits are primarily performed by stop loss carriers.
ould you be willing to pay for an outside audit?	No
what trigger point do you conduct/require hospital claims audit?	All specific stop loss claims require a full audit.
eporting / Access to Claims Data	
hen are your monthly aggregate reports released?	Reports will be produced by the 8th calendar day of each month.
ill the County have access to a reporting site with raw Medical and RX claims data?	The asigned HR person at the Coutny can be setup with access to our Plan Watch reporting system
o you have a dedicated reporting department? If so, please provide names and titles.	Yes

ABA BIOS

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TODD E. ARCHER

Chief Marketing Officer & Executive Vice President, Sales and Marketing

Todd Archer serves as Chief Marketing Officer & Executive Vice President, Sales & Marketing for Assured Benefits Administrators. With over 35 years' experience, Todd has a rich history of success in the third party administration of health benefits. Prior to joining ABA, Todd was with Mutual Assurance Administrators/HealthSmart for 26 years, where he served in various executive management roles.

Todd earned a Bachelor of Science degree in Business Administration from the University of Tennessee, Knoxville. He is involved in numerous industry and community leadership boards and activities including: Healthcare Administrators Association (HCAA) – Past President; Self Insurance Institute of America (SIIA) – SIPAC Trustee; QUBIC, Inc. – Past Board Member; Rebuilding Together OKC – Past Board President and Current Advisory Board Member.

ANGIE CARRASCO

Vice President, Operations

Angie Carrasco serves as Vice President of Operations for ABA. She is a strongly focused professional with over 36 years' experience in third party administration. Her duties include managing and over seeing all aspects of claims processing and customer service, as well as auditing and file transfers for ABA's El Paso claims processing location.

RICHARD LACKEY

Chief Information Officer & Senior Vice President

Richard Lackey serves as ABA's CIO and Senior Vice President with full responsibility for all information systems and processes. He has over 20 years of technology experience within the global healthcare industry, starting his career as a systems engineer/solutions architect and developer and moving on to consulting roles. Richard then expanded into leadership as Director of IT, General Manager and Director of Strategic Initiatives for Global Excel Management.

Richard obtained his Master's degree in Healthcare Administration from Florida Atlantic University and holds a BS in Biology and Chemistry from Bluefield State College. He's a Six Sigma Greenbelt in Healthcare, is a Certified Change Professional (PROSCI), and holds several certifications, including ITIL, MCDBA, Advanced Project Management, and Systems Engineering in EDS.

SANDY LOCKE

Vice President, Client Management

As ABA's Vice President of Client Management, Sandy Locke is responsible for meeting and exceeding our clients' needs and expectations. She has more than 35 years' experience in third party administration and self-funding.

Sandy's experience includes serving as President of Mutual Assurance Administrators – Texas Division & Senior Account Executive for HealthSmart Benefit Solutions. Her experience encompasses virtually every phase of self-funding, including stop loss, claims resolutions, provider/vendor integration and plan design.

ABA BIOS

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ERNESTO OLGUIN
Senior Account Manager

As a Senior Account manager, Ernesto Olguin is responsible for several high profile accounts. He has more than 18 years' experience in healthcare administration. With expertise in developing and maintaining strong client relationships, Ernesto is also an experienced management professional with strong leadership skills.

Ernesto is also skilled at negotiating with stop loss carriers for better terms and rates at renewal time. He uses operational systems and industry knowledge to solve problems that arise for clients or members, including claims, administrative issues and other concerns.

DEBORAH E. VASQUEZ
Claims Manager

Deborah Vasquez serves as ABA's Claims Manager. She has more than 26 years' experience in healthcare administration. She is highly flexible and adaptable with an ability to work with people in a variety of fields. Deborah's duties at ABA include working with the Case management and reviewing case management reports, processing claims and managing FSA/HRA accounts, just to name a few.

Assured Benefit Administrators
PO BOX 211517
EAGAN MN 55121-2717

Explanation of Payments

RETAIN FOR TAX PURPOSES
THIS IS NOT A BILL

Forwarding Service Requested

JBA1 24,566

John Doe
701 SANTA Deer Drive
Fawn TX 78575

Customer Service Information

For questions regarding this claim, please contact us at (800) 247-7114 or (915) 532-2100.

Date: 11/09/2018
Group #: 00231
Group Name: ABC Group

Going Green

ABA has gone green. You can access all your EOBs online at www.abadmin.com

Provider: COLUMBIA VALLEY HEALTHCARE SYSTEM
Claim#: 2018-311000452-0000
PPO Network:

Patient: John Doe **Patient #:** 2018382049
Insured: John Doe **Insured #:** 042440001300

Dates of Service	Type of Service	Total Charge	Discount or Penalty	Not Covered	Eligible Expense	Rmk Code	Co-Pay	Deductible Applied	Paid %	Benefits Paid
11/01-11/01/2018	OUT PT HOSPITAL	$3,308.00	$2,183.28	$0.00	$1,124.72	13 1	$0.00	$1,124.72	100%	$0.00
11/01-11/01/2018	OUT PT HOSPITAL	$964.00	$636.24	$0.00	$327.76	13 1	$0.00	$327.76	100%	$0.00
	Claim Totals:	**$4,272.00**	**$2,819.52**	**$0.00**	**$1,452.48**		**$0.00**	**$1,452.48**		**$0.00**

Patient Responsibility: $1,452.48

Total Amount Covered	**$1,452.48**
Paid by Other Insurance Company	**$0.00**
Total Paid by Plan	**$0.00**

Plan Status

Description	Remaining
Deductible Remaining - Out of Network	$6,000.00
Out of Pocket Deductible Remaining - Out of Network	$9,000.00
Out of Pocket Deductible Remaining - In Network	$2,027.52
Deductible Remaining - In Network	$1,547.52

Statement Totals

# of Claims	Total Charge	Discount or Penalty	Not Covered	Co-pay	Deductible Applied	Co-insurance	Benefits Paid	Patient Responsibility
1	$4,272.00	$2,819.52	$0.00	$0.00	$1,452.48	$0.00	$0.00	$1,452.48

Remark Code Messages

1 APPLIED TO DEDUCTIBLE
13 PPO DISCOUNT APPLIED

Additional Information

To request a review of a claim that has been denied in whole or in part, please complete the appeal filing form and follow the instructions on the form.

Additional Important Information about Your Appeal Rights

What if I need help understanding this denial? Contact us at (800) 247-7114 or (915) 532-2100 if you need assistance understanding this notice or our decision to deny you a service or coverage.

What if I don't agree with this decision? You have a right to appeal any decision not to provide you or pay for an item or service (in whole or in part).

How do I file an appeal? Complete and detach the bottom of this page and send this document to P.O. Box 211517 Eagan, MN 55121 ***within 180 days from receipt of this notification. Must submit a statement in clear and concise terms as to why you disagree with the denial of benefits.*** See also the "Other resources to help you" section of this form for assistance filing a request for an appeal.

What if my situation is urgent? If your situation meets the definition of urgent under the law, your review will generally be conducted within 72 hours. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an expedited appeal by following the instructions above for filing an internal appeal and also by faxing at (915) 532-0159.

Who may file an appeal? You or someone you name to act for you (your authorized representative) may file an appeal.

Can I provide additional information about my claim? Yes, you may supply additional information.

Can I request copies of information relevant to my claim? Yes, you may request copies (free of charge). If you think a coding error may have caused this claim to be denied, you have the right to have billing and diagnosis codes sent to you, as well. You can request copies of this information by contacting us at (800) 247-7114 or (915) 532-2100 .

What happens next? If you appeal, we will review our decision and provide you with a written determination. If we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision.

Other resources to help you: For questions about your rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). Additionally, a consumer assistance program can help you file your appeal. One way to locate an office of health insurance consumer assistance or ombudsmen is to contact your local U.S. Department of Labor Office and/or your State insurance regulatory agency. The U.S. Department of Labor has a website that identifies states that have established a consumer assistance program. For an up to date listing of each state with a consumer assistance program visit www.dol.gov/ebsa/ healthreform/ or contact us at the customer service number located on the front of this notice.

Appeal Filing Form

NAME OF PERSON FILING APPEAL: _____
Circle one: ☐Covered person ☐ Patient ☐ Authorized Representative
Contact information of person filing appeal (if different from patient)
Address: _____ **Daytime phone:** _____ **Email:** _____

If person filing appeal is other than patient, patient must indicate authorization by signing here:

_____

Are you requesting an urgent appeal? ☐Yes ☐ No

Briefly describe why you disagree with this decision (you may attach additional information, such as a physician's letter, bills, medical records, or other documents to support your claim):

_____

_____

Send this form and your denial notice to: Assured Benefits Administrators P.O. Box 211517 Eagan, MN 55121
Be certain to keep copies of this form, your denial notice, and all documents and correspondence related to this claim.

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Assured Benefits Administrators

Section II – Requested Forms

1. Deviations Form
2. Submission Form Performance Commitments and Penalties
3. ABA Performance Guarantees
4. Summary Conditions & Specifications
5. Conflict of Interest Questionnaire
6. Certificate of Interested Parties Form 1295
7. HB 89 Verification

DEVIATIONS FROM SPECIFICATIONS

1. Does your organization agree to the Specifications as outlined in the RFP?

   Assured Benefit Administrators agrees to the Specifications outlined in the RFP.

2. Describe, in detail, any deviations from the specifications.

   None.

Assured Benefit Administrators
Name of Organization

Sandy Forbe
Signature of Officer

SUBMISSION FORM PERFORMANCE COMMITMENTS AND PENALTIES

CARRIER PROPOSAL

Please give "at risk" amounts in percentages or dollars (whichever applies) for each of the below commitment categories and list the parameters surrounding the guarantee for each category:

Please find attached Performance Guarantees.

1. Claim Time-to-Process
2. Call Center
3. Account Management
4. Network Discount
5. Claim Target Turn-Around Time
6. Clinical Management
7. Implementation

The guarantees included above are based upon the current plan of benefits.

Assured Benefit Administrators

Name of Organization

Sandy Locke

Signature of Officer

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Assured Benefits Administrators

STANDARD PERFORMANCE GUARANTEE

Performance Service Area	Target	Administrative Fees at Risk	Measurement Frequency
Financial Accuracy (Total dollars paid correctly divided by the total dollars paid in the claims sample, expressed as a percentage. The financial accuracy is calculated by subtracting the total dollars paid in error, overpayments plus underpayments, from the total dollars paid).	99%	2%	Annual Evaluation to be finalized within 90 days of the close of the plan year.
Claims Processing Accuracy (The number of claims processed with no errors [payment or non-payment errors] divided by the number of claims in the example).	97%	2%	Annual Evaluation to be finalized within 90 days of the close of the plan year.
Claims Turnaround Time (Average number of calendar days utilized to process a claim payment, pended claim or denial, measured from receipt of the claim at the claims office).	99% within 30 calendar days	2%	Annual Evaluation to be finalized within 90 days of the close of the plan year.
Member Customer Service Abandoned calls Wait time in Queue	<4% <35 seconds	2%	Annual Evaluation of Member calls to be finalized within 90 days of the close of the plan year.
TOTAL ADMINISTRATIVE FEES AT RISK		10%	

SUMMARY CONDITIONS & SPECIFICATIONS

In submitting this proposal, the respondent agrees and certifies to the following conditions:

1. Non-Inducement Statement: The respondent certifies that no employee, representative or agent of the firm offered or gave gratuities in any form (gifts, entertainment, etc) to any County employee or elected or appointed County official in order to secure favorable treatment or consideration in awarding, negotiating, amending or concluding a final agreement for this proposal.

2. Non-Debarment Statement: The respondent hereby certifies that he/she is not included on the U.S. Comptroller General's Consolidated List of Persons or Firms currently debarred for violations of various contracts incorporating labor standard/provisions.

3. Validity Statement: If this proposal is accepted and a firm contract is entered, the undersigned offers and agrees, within one-hundred twenty (120) calendar days from the proposal date, to supply any or all items/services upon which prices are offered at the designated point and within the time specified.

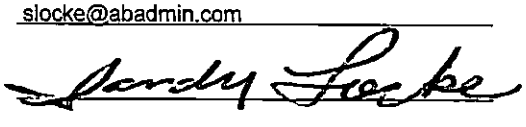
4. Non-Collusion Statement: The respondent hereby certifies that he/she has made this quote independently, without consultation, communication or agreement, for the purpose of restricting competition as to any matter relating to this proposal, with any other respondent or with any other competitor.

5. Conflict of Interest Statement: The respondent agrees that and warrants that no employee, official, or member of the County Commissioners Court is, or will be, peculiarly benefited, directly or indirectly, in this proposal or any ensuing contract that may follow.

6. Conduct Statement: The respondent certifies by signing below that all of the above statements are true, and he/she has read the entire proposal document and agrees to abide by the terms, certifications and conditions outlined.

7. Ethics Form: Form 1295, CIQ, HB 89 and SB 252.

Company Name: Assured Benefit Administrators
Printed Name of Officer: Sandy Locke
Title: Vice President, Client Management
Email Address: slocke@abadmin.com

Signature of Officer: 

CONFLICT OF INTEREST QUESTIONNAIRE

FORM CIQ

For vendor doing business with local governmental entity

This questionnaire reflects changes made to the law by H.B. 23, 84th Leg., Regular Session.

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

By law this questionnaire must be filed with the records administrator of the local governmental entity not later than the 7th business day after the date the vendor becomes aware of facts that require the statement to be filed. *See* Section 176.006(a-1), Local Government Code.

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

OFFICE USE ONLY

Date Received

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

Assured Benefit Administrators

2 ☐ **Check this box if you are filing an update to a previously filed questionnaire.** (The law requires that you file an updated completed questionnaire with the appropriate filing authority not later than the 7th business day after the date on which you became aware that the originally filed questionnaire was incomplete or inaccurate.)

3 **Name of local government officer about whom the information is being disclosed.**

None

Name of Officer

4 **Describe each employment or other business relationship with the local government officer, or a family member of the officer, as described by Section 176.003(a)(2)(A). Also describe any family relationship with the local government officer. Complete subparts A and B for each employment or business relationship described. Attach additional pages to this Form CIQ as necessary.**

A. Is the local government officer or a family member of the officer receiving or likely to receive taxable income, other than investment income, from the vendor?

☐ Yes ☒ No

B. Is the vendor receiving or likely to receive taxable income, other than investment income, from or at the direction of the local government officer or a family member of the officer AND the taxable income is not received from the local governmental entity?

☐ Yes ☒ No

5 **Describe each employment or business relationship that the vendor named in Section 1 maintains with a corporation or other business entity with respect to which the local government officer serves as an officer or director, or holds an ownership interest of one percent or more.**

6 ☐ Check this box if the vendor has given the local government officer or a family member of the officer one or more gifts as described in Section 176.003(a)(2)(B), excluding gifts described in Section 176.003(a-1).

7 Sandy Locke

Signature of vendor doing business with the governmental entity

July 10, 2019

Date

CONFLICT OF INTEREST QUESTIONNAIRE
For vendor doing business with local governmental entity

A complete copy of Chapter 176 of the Local Government Code may be found at http://www.statutes.legis.state.tx.us/Docs/LG/htm/LG.176.htm. For easy reference, below are some of the sections cited on this form.

Local Government Code § 176.001(1-a): "Business relationship" means a connection between two or more parties based on commercial activity of one of the parties. The term does not include a connection based on:

(A) a transaction that is subject to rate or fee regulation by a federal, state, or local governmental entity or an agency of a federal, state, or local governmental entity;

(B) a transaction conducted at a price and subject to terms available to the public; or

(C) a purchase or lease of goods or services from a person that is chartered by a state or federal agency and that is subject to regular examination by, and reporting to, that agency.

Local Government Code § 176.003(a)(2)(A) and (B):

(a) A local government officer shall file a conflicts disclosure statement with respect to a vendor if:

***

(2) the vendor:

(A) has an employment or other business relationship with the local government officer or a family member of the officer that results in the officer or family member receiving taxable income, other than investment income, that exceeds $2,500 during the 12-month period preceding the date that the officer becomes aware that

(i) a contract between the local governmental entity and vendor has been executed; or

(ii) the local governmental entity is considering entering into a contract with the vendor;

(B) has given to the local government officer or a family member of the officer one or more gifts that have an aggregate value of more than $100 in the 12-month period preceding the date the officer becomes aware that:

(i) a contract between the local governmental entity and vendor has been executed; or

(ii) the local governmental entity is considering entering into a contract with the vendor.

Local Government Code § 176.006(a) and (a-1)

(a) A vendor shall file a completed conflict of interest questionnaire if the vendor has a business relationship with a local governmental entity and:

(1) has an employment or other business relationship with a local government officer of that local governmental entity, or a family member of the officer, described by Section 176.003(a)(2)(A);

(2) has given a local government officer of that local governmental entity, or a family member of the officer, one or more gifts with the aggregate value specified by Section 176.003(a)(2)(B), excluding any gift described by Section 176.003(a-1); or

(3) has a family relationship with a local government officer of that local governmental entity.

(a-1) The completed conflict of interest questionnaire must be filed with the appropriate records administrator not later than the seventh business day after the later of:

(1) the date that the vendor:

(A) begins discussions or negotiations to enter into a contract with the local governmental entity; or

(B) submits to the local governmental entity an application, response to a request for proposals or bids, correspondence, or another writing related to a potential contract with the local governmental entity; or

(2) the date the vendor becomes aware:

(A) of an employment or other business relationship with a local government officer, or a family member of the officer, described by Subsection (a);

(B) that the vendor has given one or more gifts described by Subsection (a); or

(C) of a family relationship with a local government officer.

CERTIFICATE OF INTERESTED PARTIES

FORM 1295

Complete Nos. 1 - 4 and 6 if there are interested parties.
Complete Nos. 1, 2, 3, 5, and 6 if there are no interested parties.

OFFICE USE ONLY
CERTIFICATION OF FILING

Certificate Number:
2019-514769

Date Filed:
07/10/2019

Date Acknowledged:

1 Name of business entity filing form, and the city, state and country of the business entity's place of business.

Assured Benefits Administrators, Inc
Dallas , TX United States

2 Name of governmental entity or state agency that is a party to the contract for which the form is being filed.

County of Upshur, Texas

3 Provide the identification number used by the governmental entity or state agency to track or identify the contract, and provide a description of the services, goods, or other property to be provided under the contract.

Proposal Number: #2019-1001
Request for Proposal for TPA Services

4 Name of Interested Party	City, State, Country (place of business)	Nature of interest (check applicable)	
		Controlling	Intermediary

5 Check only if there is NO Interested Party. [X]

6 UNSWORN DECLARATION

My name is Sandy Locke, and my date of birth is 05/19/1952.

My address is 8150 N. Central Expwy, Suite 1700 (street), Dallas (city), TX (state), 75206 (zip code), USA (country).

I declare under penalty of perjury that the foregoing is true and correct.

Executed in Dallas County, State of Texas, on the 10 day of July (month), 20 19 (year).

Sandy Locke
Signature of authorized agent of contracting business entity
(Declarant)

HOUSE BILL 89 VERIFICATION

I, Sandy Locke, the undersigned representative of Assured Benefit Administrators hereafter referred to as "Company"; being an adult over the age of eighteen (18) years of age, do hereby depose and verify under oath that the company named above under the provisions of Subtitle F, Title 10, Government Code Chapter 2270:

1. Does not boycott Israel currently; and
2. Will not boycott Israel during the term of this contract.

Pursuant to Section 2270.0014, Texas Government Code:

1. "Boycott Israel" means refusing to deal with, terminating business activities with, or otherwise taking any action that is intended to penalize, inflict economic hart on or limit commercial relations specifically with Israel, or with a person or entity doing business in Israel or in an Israeli-controlled territory, but does not include an action made for ordinary business purposes; and
2. "Company" means a for-profit sole proprietorship, organization, association, corporation, partnership, joint venture, limited partnership, limited liability partnership, or any limited liability company, including a wholly-owned subsidiary, majority-owned subsidiary, parent company or affiliate of those entities or business associations that exist to make a profit.

Sandy Locke

Signature of Company Officer

July 10, 2019

Date

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Section III – Additional Information

1. Information on Payor Compass Services

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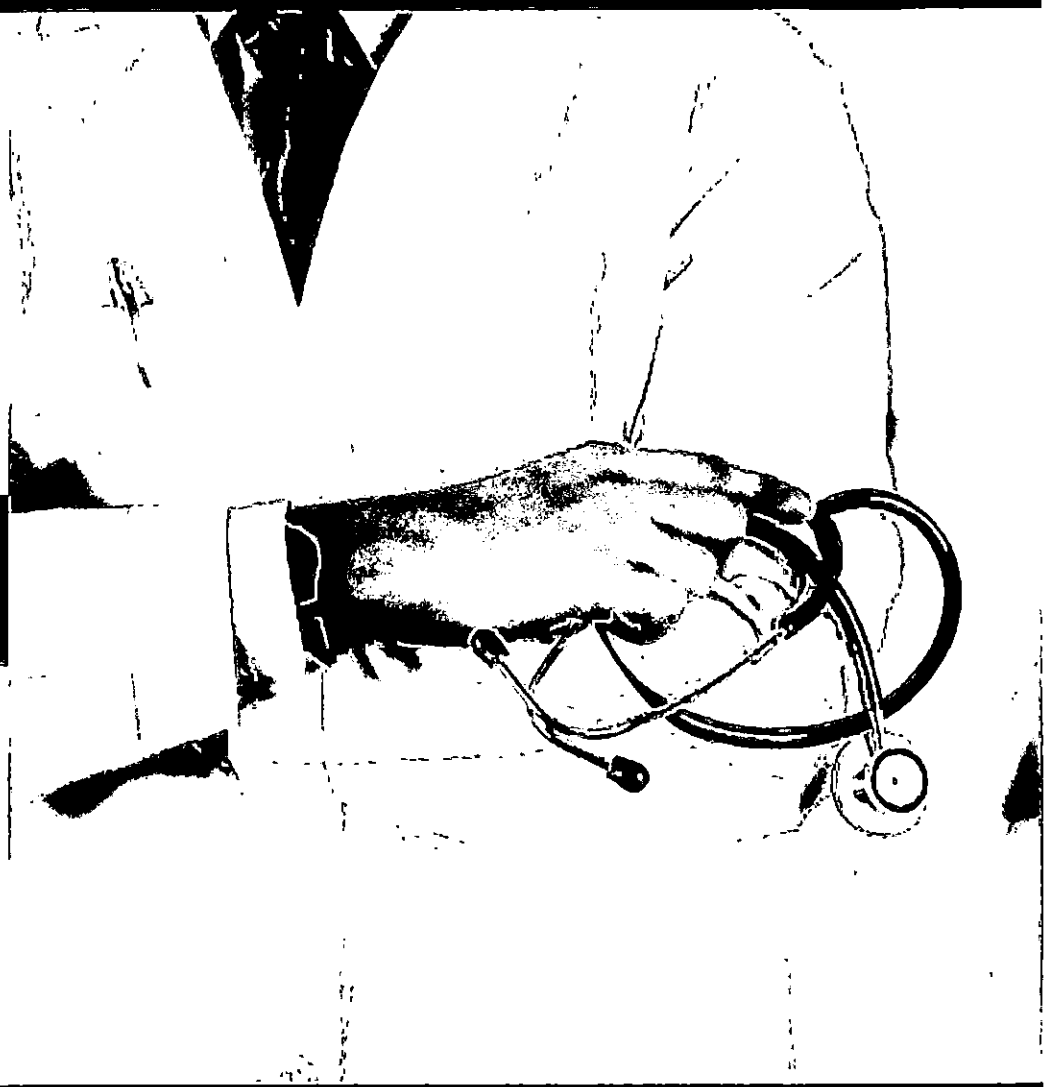
Powered by
PayerCompass

YOUR SOURCE FOR
REFERENCE BASED PRICING



Overview

- The evolution of reference based pricing (RBP)
- The three pillars of our RBP program
  - Claim pricing
  - Patient advocacy / balance billing support
  - Legal defense
- The next step: setting up a win-win relationship

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Evolution of Healthcare Reimbursement

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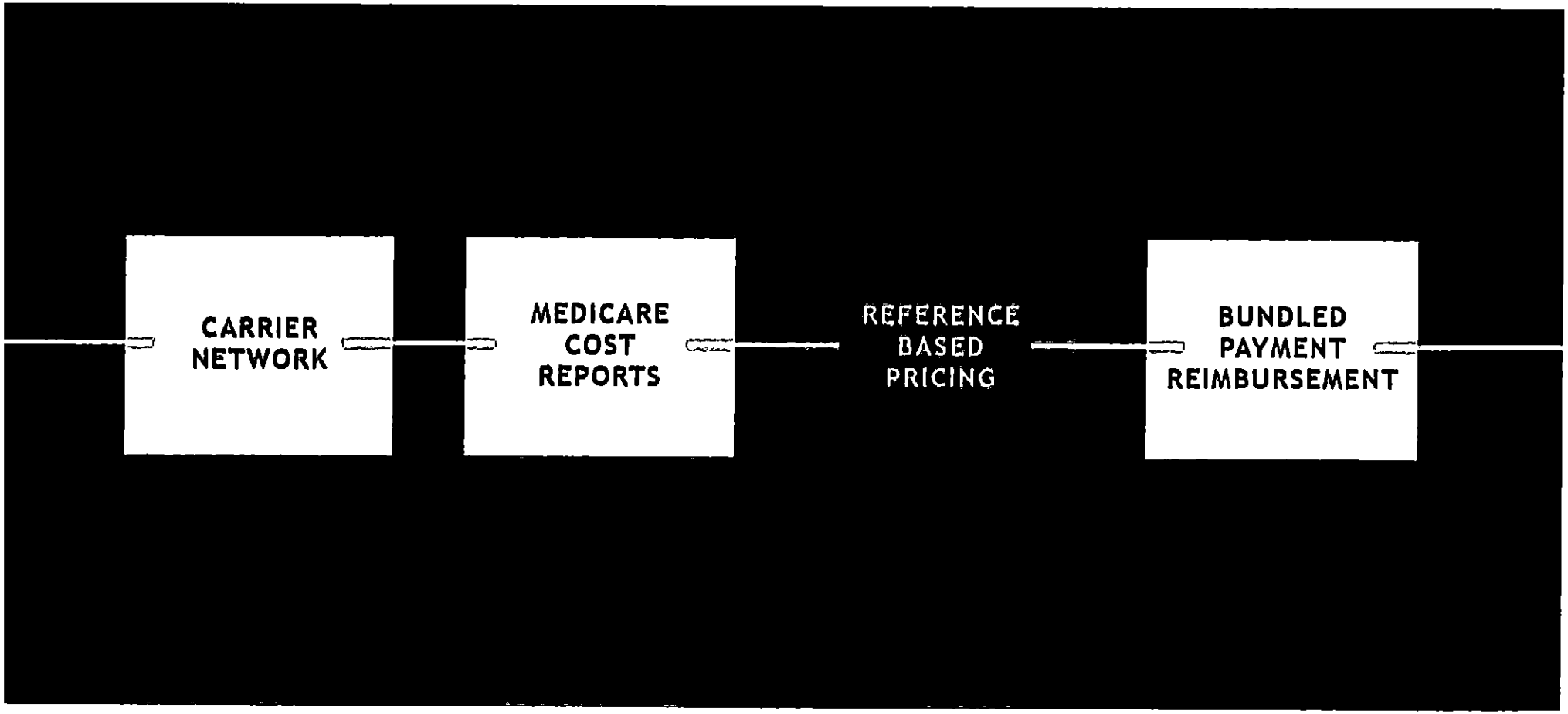

Why Medicare Plus A Percentage?

- Standard payment systems for all providers
- Most providers already accept Medicare
- Based on cost
- Still gives providers a margin
- Noted as reasonable pricing by statutes, regulations, and the courts

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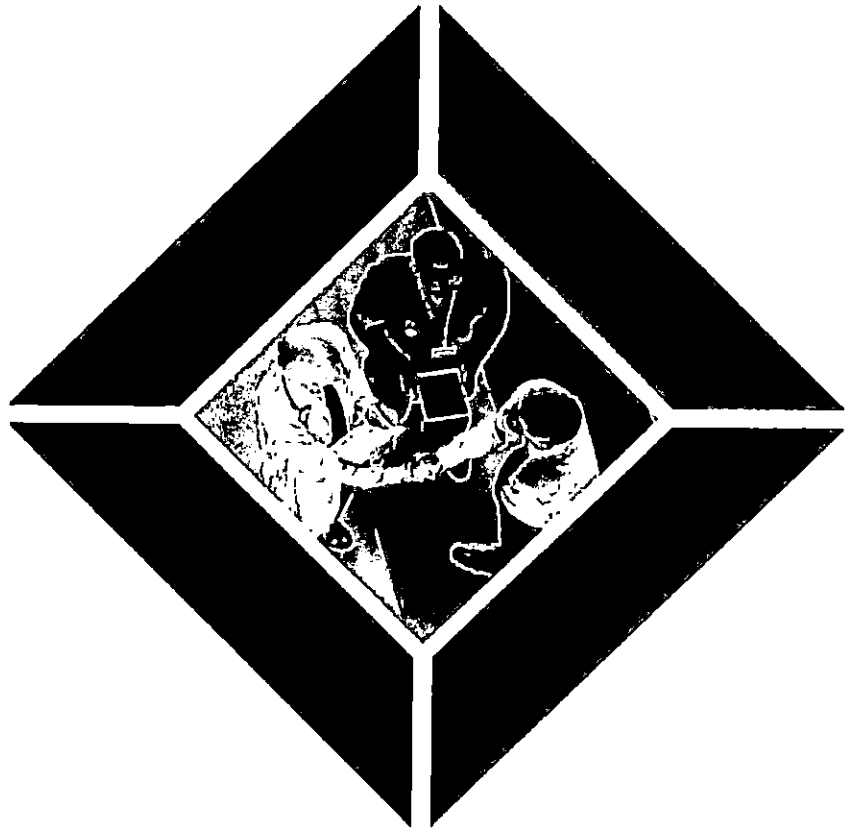

Program Components

- Payer Compass
  Claim pricing, editing, and filling Medicare's gaps
- CareValent
  Patient advocacy, balance billing support, and care management
- The Phia Group
  Plan harmonization, escalated balance billing avoidance, and PACE

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Pricing Technology

Powered by Payer Compass

- Software as a service with no installation or maintenance required
- Extensive industry and compliance expertise
  - 20 years of repricing Medicare/Medicare Plus claims with United, Humana, Cigna, and Blue Cross subsidiaries
  - Type 1 compliance with SOC 2 Trust Services
- Serves numerous markets and clients
  - Medicare Advantage, reference-based pricing programs, Medicaid HMOs, PACE programs, Medicaid dual eligibles, indigent care programs, federal and state prisons, and MLR for Native American tribes
- Focus on customer service
  - Strategic guidance for pricing and plan design and ongoing client support
  - Complete, customizable Medicare/Medicaid based service

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Technology Platform

Powered by Payer Compass

- Medicare payment systems

  All systems beyond just fee schedules are supported, and real-time claim viewing and compliance updates help keep up with the systems' constant changes.

- System integration

  Integrate EDI, web services, manual entry, and edit/reason/error codes.

- Analytics

  Receive data analyses on historical performance versus Medicare as well as on national Medicare data.

- Gap filling

  The platform supports approximation, equivalency, crosswalk and MOI pricing in addition to commercial pricing methods.

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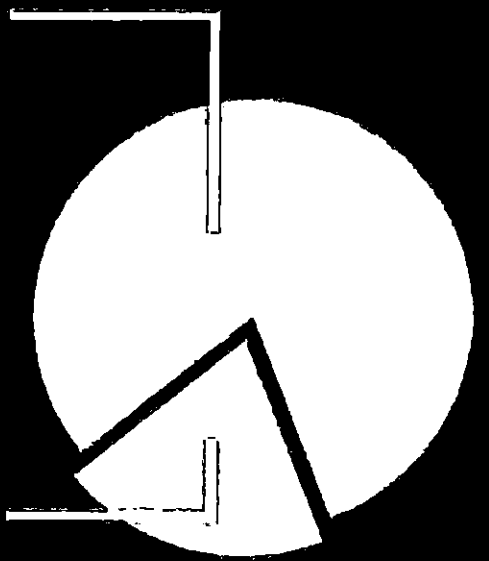
Using Medicare for a Commercial Population

80% OF THE SOLUTION

PRICING ALL MEDICARE SERVICES
6,000+ facilities
3,000,000+ physicians
Ancillary facilities



20% OF THE SOLUTION

MEDICARE EQUIVALENCY TOOL
Prices items Medicare doesn't

MEDICARE APPROXIMATION TOOL
Prices non-Medicare facilities

MEDICARE CARE CROSSWALK TOOL
Prices care in alternative settings

CUSTOMIZATION OF CMS OPPS EDITS

CCI EDITS FOR PHYSICIANS

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PAYER COMPASS

CAREVALENT

RBP

THE PHIA GROUP

Advocacy & Care

Powered by CareValent

- Patient advocacy and care management services
- Extensive industry and compliance expertise
  - 30+ years of experience in healthcare and medical risk industries
  - URAC accredited committee member and liaison to the URAC health standards committee
- Serves numerous markets and clients
  - Reference-based pricing (RBP) programs, out-of-network balance bill support, fully insured and self-funded plans, transplant carve-out programs, second opinion program
- Focus on customer service
  - Strategic guidance, education, and support for clients, groups, and members
  - Complete, customizable medical management and patient advocacy services

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Advocacy & Support

Powered by CareValent

- Patient advocacy and balance billing support
- Plan education
  Members and providers are engaged in plan education.
- Plan acceptance and rate negotiation
  Members can gain plan acceptance or have rates negotiated in advance by their patient advocates.
- Safe harbor list
  A safe harbor list containing providers in a member's locale who accept RBP is developed and maintained.

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Advocacy: Results

Powered by CareValent

- Greater member satisfaction
- Reduced negative feedback to client
- Increased provider acceptance
- Significant decrease in balance bills

LESS THAN 1%
of total processed claims
generates a balance bill

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Care Management

Powered by CareValent

- Utilization review
- Courtesy reviews
- Unsurpassed client and member service
- Case management
- Claim appeals
- Stop loss reports

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Legal Resources

Powered by The Phia Group

- Legal support with flexible timeframes and expedited turnaround times when needed
- Extensive industry and compliance expertise
  - 18 years as an industry leader in multiple areas
- Serves numerous markets and clients
  - Subrogation, plan document drafting, claim negotiation, reference-based pricing and balance billing support, one-off or subscription-based consulting services, legal compliance, and fiduciary transfer options
- Focus on customer service
  - Legal and consulting teams provide members with guidance on tough issues
  - Full-service resource for health plans, TPAs, brokers, MGUs, stop loss carriers, and more

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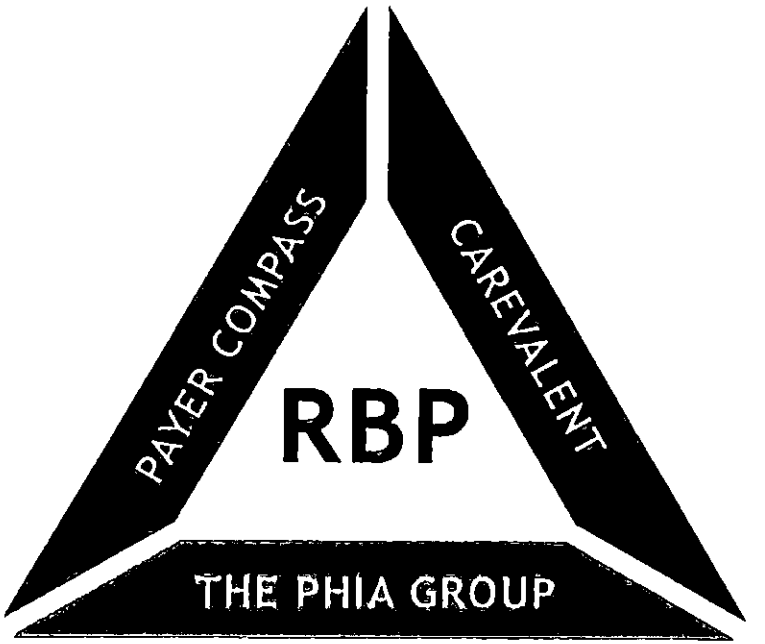

Legal Defense

Powered by The Phia Group

- Plan harmonization, escalated BB support, and PACE
- Plan documents
  Plan documents are reviewed for harmonization.
- ID card design
  The assignment of benefits (AOB) language is developed, and the maximum allowable charge is reviewed.
- Key EOB provisions
  Ensure that the AOB serves as payment in full and that accurate remark codes are utilized.
- PACE
  PACE makes the final appeals determination, and The Phia Group acts as the plan's fiduciary.

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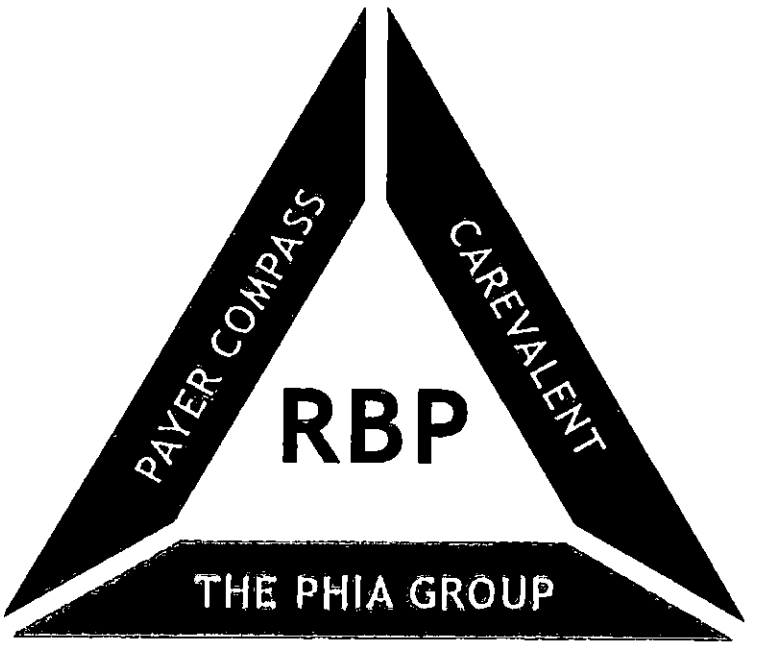
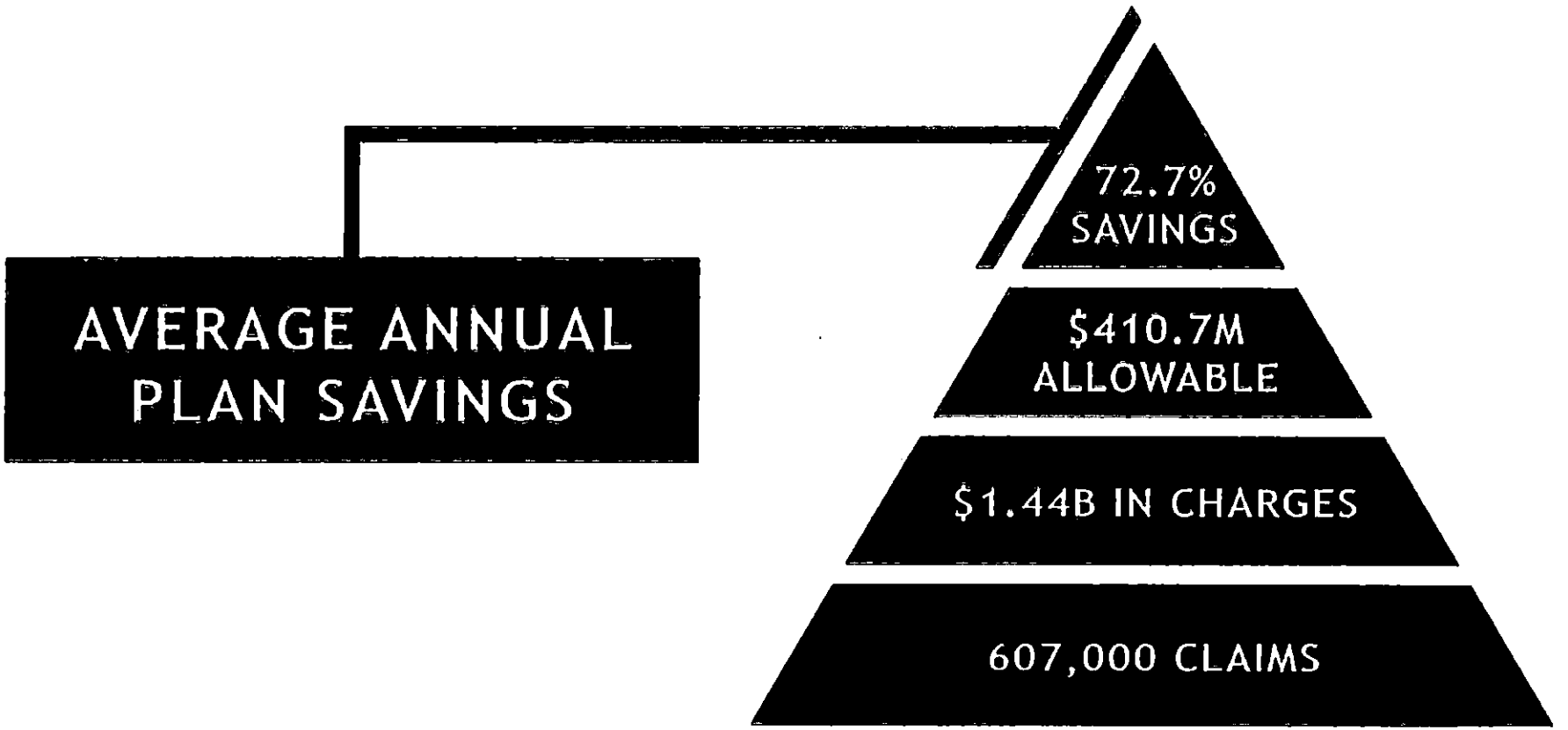


RBP National Savings



The Cost of RBP

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PER-EMPLOYEE-PER-MONTH (PEPM)
Our Model
Assuming 250 employees at one month

TOTAL CHARGES	$90,865.00
ALLOWABLE AT 150% OF MEDICARE	$13,566.00
OUR FEES	**$3,187.50/MONTH**
EFFECTIVE MEDICARE RATE	151.7%
(Includes our fees)	

PERCENT OF CHARGES
Other Vendors
Representative of one individual claim

TOTAL CHARGES	$90,865.00
ALLOWABLE AT 110% OF MEDICARE	$9,948.00
THEIR FEES	**$10,903.80 (12% of charges)**
EFFECTIVE MEDICARE RATE	230.6%

3+ MONTHS OF OUR FEES TO PROCESS
MULTIPLE CLAIMS
=
COMPETITOR'S FEES TO PROCESS **1 CLAIM**

FILED
TERRI ROSS
COUNTY CLERK