I. SOLICITATION RESPONSE INSTRUCTIONS

This section documents the requirements that should be met by bidders in preparing the Corporate Overview, Technical Response, and Cost Sheet. Bidders should identify the subdivisions of "Project Description and Scope of Work" clearly in their solicitation response; failure to do so may result in disqualification. Failure to respond to a specific requirement may be the basis for elimination from consideration during the State's comparative evaluation.

Solicitation responses are due by the opening date and time shown in the Schedule of Events. Content requirements for the Corporate Overview, Technical Response, and Cost Sheet are presented separately in the following subdivisions: format and order:

A. SOLICITATION RESPONSE SUBMISSION

1. CORPORATE OVERVIEW

The Corporate Overview section of the solicitation response should consist of the following subdivisions:

a. BIDDER IDENTIFICATION AND INFORMATION

The bidder should provide the full company or corporate name, address of the company's headquarters, entity organization (corporation, partnership, proprietorship), state in which the bidder is incorporated or otherwise organized to do business, year in which the bidder first organized to do business and whether the name and form of organization has changed since first organized.

UMR, Inc.
115 W. Wausau Ave.
Wausau, WI 54401-2875

Toll-Free: (866) 881-0800
Website: umr.com

UMR is the third-party administrator (TPA) line of business for UnitedHealthcare, a business unit of UnitedHealth Group. UnitedHealth Group is a diversified health and well-being company dedicated to making health care work better. Headquartered in Minnetonka, Minnesota, UnitedHealth Group offers a broad spectrum of products and services. Through its family of businesses, UnitedHealth Group serves 147 million individuals worldwide.

UMR's state of incorporation is Delaware.

UMR was formed in 2008 by integrating three market-leading TPAs with a combined history in the health care industry dating back as far as 1948.

The history of UMR and its predecessor companies includes several names/name changes:
- **UMR in May 2008**
- **Fiserv Health in January 2006**
- **United Medical Resources in 2005**
- **Midwest Security Administrators in 2002**
- **Wausau Benefits in June 2000**

b. FINANCIAL STATEMENTS

The bidder should provide financial statements applicable to the firm. If publicly held, the bidder should provide a copy of the corporation's most recent audited financial reports and statements, and the name, address, and telephone number of the fiscally responsible representative of the bidder's financial or banking organization.

If the bidder is not a publicly held corporation, either the reports and statements required of a publicly held corporation, or a description of the organization, including size, longevity, client

base, areas of specialization and expertise, and any other pertinent information, should be submitted in such a manner that solicitation evaluators may reasonably formulate a determination about the stability and financial strength of the organization. Additionally, a non-publicly held firm should provide a banking reference.

The bidder must disclose any and all judgments, pending or expected litigation, or other real or potential financial reversals, which might materially affect the viability or stability of the organization, or state that no such condition is known to exist.

The State may elect to use a third party to conduct credit checks as part of the corporate overview evaluation.

Please refer to UnitedHealth Group's most recent Form 10-K found at: https://www.unitedhealthgroup.com/Investors/financial-reports.html.

From time to time, UMR is named as a defendant in various civil matters during the ordinary course of business. None of such lawsuits, either individually or in the aggregate, have at any time, even if the outcome were to be unfavorable to UMR, been of such a nature to impact UMR operations, or our financial situation, materially or adversely. We are unable to disclose further information and related details, as they are deemed confidential.

c. CHANGE OF OWNERSHIP

If any change in ownership or control of the company is anticipated during the twelve (12) months following the solicitation response due date, the bidder should describe the circumstances of such change and indicate when the change will likely occur. Any change of ownership to an awarded bidder(s) will require notification to the State.

At this time, there are no pending agreements to sell UMR or merge with another organization.

d. OFFICE LOCATION

The bidder's office location responsible for performance pursuant to an award of a contract with the State of Nebraska should be identified.

Based on geography, time zone, plan complexity and plan type, we are proposing our Wausau, Wisconsin, service team.

e. RELATIONSHIPS WITH THE STATE

The bidder should describe any dealings with the State over the previous three (3) years. If the organization, its predecessor, or any Party named in the bidder's solicitation response has contracted with the State, the bidder should identify the contract number(s) and/or any other information available to identify such contract(s). If no such contracts exist, so declare.

Not applicable.

f. BIDDER'S EMPLOYEE RELATIONS TO STATE

If any Party named in the bidder's solicitation response is or was an employee of the State within the past six (6) months, identify the individual(s) by name, State agency with whom employed, job title or position held with the State, and separation date. If no such relationship exists or has existed, so declare.

If any employee of any agency of the State of Nebraska is employed by the bidder or is a subcontractor to the bidder, as of the due date for solicitation response submission, identify all such persons by name, position held with the bidder, and position held with the State (including job title and agency). Describe the responsibilities of such persons within the proposing organization. If, after review of this information by the State, it is determined that a conflict of

interest exists or may exist, the bidder may be disqualified from further consideration in this solicitation. If no such relationship exists, so declare.

Not applicable.

g. CONTRACT PERFORMANCE

If the bidder or any proposed subcontractor has had a contract terminated for default during the past three (3) years, all such instances must be described as required below. Termination for default is defined as a notice to stop performance delivery due to the bidder's non-performance or poor performance, and the issue was either not litigated due to inaction on the part of the bidder or litigated and such litigation determined the bidder to be in default.

It is mandatory that the bidder submit full details of all termination for default experienced during the past three (3) years, including the other Party's name, address, and telephone number. The response to this section must present the bidder's position on the matter. The State will evaluate the facts and will score the bidder's solicitation response accordingly. If no such termination for default has been experienced by the bidder in the past three (3) years, so declare.

If at any time during the past three (3) years, the bidder has had a contract terminated for convenience, non-performance, non-allocation of funds, or any other reason, describe fully all circumstances surrounding such termination, including the name and address of the other contracting Party.

Not applicable.

h. SUMMARY OF BIDDER'S CORPORATE EXPERIENCE

The bidder should provide a summary matrix listing the bidder's previous projects similar to this Solicitation in size, scope, and complexity. The State will use no more than three (3) narrative project descriptions submitted by the bidder during its evaluation of the solicitation response.

The bidder should address the following:

i. Provide narrative descriptions to highlight the similarities between the bidder's experience and this Solicitation. These descriptions should include:

- **a)** The time period of the project,
- **b)** The scheduled and actual completion dates,
- **c)** The bidder's responsibilities,
- **d)** For reference purposes, a customer name (including the name of a contact person, a current telephone number, a facsimile number, and e-mail address); and
- **e)** Each project description should identify whether the work was performed as the prime Vendor or as a subcontractor. If a bidder performed as the prime Vendor, the description should provide the originally scheduled completion date and budget, as well as the actual (or currently planned) completion date and actual (or currently planned) budget.

ii. Bidder and Subcontractor(s) experience should be listed separately. Narrative descriptions submitted for Subcontractors should be specifically identified as subcontractor projects.

iii. If the work was performed as a subcontractor, the narrative description should identify the same information as requested for the bidders above. In addition, subcontractors should identify what share of contract costs, project responsibilities, and time period were performed as a subcontractor.

UMR currently does not have a similar customer narrative to provide.

i. SUMMARY OF BIDDER'S PROPOSED PERSONNEL/MANAGEMENT APPROACH

The bidder should present a detailed description of its proposed approach to the management of the project.

The bidder should identify the specific professionals who will work on the State's project if their company is awarded the contract resulting from this Solicitation. The names and titles of the team proposed for assignment to the State project should be identified in full, with a description of the team leadership, interface, and support functions, and reporting relationships. The primary work assigned to each person should also be identified.

The bidder should provide resumes for all personnel proposed by the bidder to work on the project. The State will consider the resumes as a key indicator of the bidder's understanding of the skill mixes required to carry out the requirements of the Solicitation in addition to assessing the experience of specific individuals.

Resumes should not be longer than three (3) pages. Resumes should include, at a minimum, academic background and degrees, professional certifications, understanding of the process, and at least three (3) references (name, address, and telephone number) who can attest to the competence and skill level of the individual. Any changes in proposed personnel shall only be implemented after written approval from the State.

UMR has an experienced staff of strategic client executives (SCEs) located throughout the country. Our goal is to always maintain a local presence in the service of our customers, where possible. UMR SCEs average 12 years of experience in various facets of the health insurance industry. Your SCE will be assigned based on various factors such as proximity to your location, group size and current workloads.

UMR will appoint a designated SCE to NDCS upon being named a finalist.

j. SUBCONTRACTORS

If the bidder intends to subcontract any part of its performance hereunder, the bidder should provide:

i. name, address, and telephone number of the subcontractor(s),
ii. specific tasks for each subcontractor(s),
iii. percentage of performance hours intended for each subcontract; and
iv. total percentage of subcontractor(s) performance hours.

UMR is your single source third-party administrator. We provide most of our core services directly or through the UnitedHealth Group family of companies. This allows us to offer affordable solutions through integrated data elements and systems, streamlined implementations and unified account management support.

While most services are performed in-house or through sister companies, there are times when we partner with external vendors for certain services. We have programs in place to assure that these subcontractors meet relevant performance, operational, contractual/compliance and regulatory standards. In general, subcontractors are selected based on the strategic needs of our entire organization and dependent on the subcontractors' abilities to comply with our requirements.

REVISED ATTACHMENT A, BIDDER QUESTIONNAIRE
RFP 120174 O3
Third-party administrator to process payments for claims/ invoices for an incarcerated individual(s) healthcare services.

Bidder Name: _UMR, Inc._____

It is preferred that the bidder uses this template. Bidder must describe in detail solutions on how their response meets and/or exceed the requirements as outlined in the RFP. Bidder should use the RESPONSE box below for the detailed solution being proposed.

If the bidder choses to provide additional documents outside this template to aid in their response, for evaluation purposes, bidder must cross-reference which question in Attachment A the supplemental documents support.

Business Requirements	
C.1	No correspondence of any type is to be sent to the incarcerated individual(s). This includes, but is not limited to, explanation of benefits (EOB), checks, letters, brochures, billings, etc. Describe what methods are in place to ensure that communication is not sent to the incarcerated individual directly.
RESPONSE: Turning off all correspondence for members can be done with development.	

C.2	Rates for Medical/Dental Claims submitted: Nebraska Medicaid Rates or the negotiated PPO. Incarcerated Individuals and/or NDCS are not responsible for remaining balance due after Medicaid/PPO rates have been applied. a. Contractor is responsible for notifying member providers on remittance statements. No balance will be due after Medicaid or PPO rates are applied. ~~Rates for Medical/Dental Claims submitted: Nebraska Medicare Rates unless the negotiated PPO rate is lower. Incarcerated Individuals and/or NDCS are not responsible for remaining balance due after Medicare/PPO rates have been applied. Contractor is responsible for notifying member providers on remittance statements, no balance will be due after Medicare or PPO rates are applied~~. Describe the process of how the contractor will notify member providers on remittance statements ensuring no balance will be due after ~~Medicare~~ Medicaid or PPO rates are applied.
RESPONSE: Per Addendum Two (bidder Q&A responses) awarded bidders are permitted to pay provider claims in accordance with their contractor/provider agreement. UMR will be utilizing the UnitedHealthcare Choice Plus network. In accordance with our in-network provider contracts, balance billing is not permitted.	

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C.3	Bidder understands and acknowledges Nebraska Medicaid eligibility as defined by Nebraska Department of Health and Human Services (DHHS).	**Will comply**	**Will not comply**
RESPONSE: Will comply.		X	

C.4	Bidder understands that deductible, coinsurance, and/or copays do not apply.	**Will comply**	**Will not comply**
RESPONSE: Will comply.		X	

C.5	Bidder understands that the awarded contractor will accept claims as timely if filed within two (2) years of date of service pursuant to the State Contract Claims Act, see Neb. Rev. Stat. § 81-8,306.	**Will comply**	**Will not comply**
RESPONSE: Will comply.		X	

C.6	Bidder understands Claims maximums such as day, dollar, and lifetime maximums do not apply.	**Will comply**	**Will not comply**
RESPONSE: Will comply.		X	

C.7	Bidder understands that preauthorization is not applicable for emergency services or inpatient services. ~~For out-patient services, NDCS will provide a prior authorization number.~~	**Will comply**	**Will not comply**
RESPONSE: UMR will administer prior authorizations as directed by NDCS.		X	

C.8	The services below should **not** be paid by contractor. Describe what processes will be in place to ensure these services are not paid. ~~a. Claims billed by out-of-network providers. These claims should be sent to NDCS for consideration.~~ b. Medications for use after leaving medical provider. ~~c. Prosthetics/ Orthotics except for those off-site items issued at the time of surgery.~~ ~~i. Prosthetics/orthotics deemed necessary will need to be pre-approved by NDCS Medical Director or designee and billed directly to NDCS.~~

Bidder Name: _UMR, Inc._____

	d. Services covered by Medicaid. e. Newborn or childcare. f. Abortion. g. Caffeine-related disorders. h. Chiropractic care. i. Dental implants. ~~j. Dentures/Dental Laboratory Services,~~ ~~i. Claims deemed necessary will need to be pre-approved by NDCS Medical Director or designee and billed directly to NDCS.~~ k. Elective procedures. l. Erectile dysfunction. m. Factitious disorder. n. Learning disorder. o. Nicotine-related disorders. p. Other conditions/disorders/issues/procedures as determined by the Medical Director or designee for NDCS Health Services.
RESPONSE: We are able to code claims to automatically deny for services which are readily identifiable and are specifically excluded under the plan. We may not be able to code more complex claims involving multiple services and diagnoses to automatically deny. Complex details that cannot be coded to automatically deny will pend to the customer first representative (CFR) for review and determination. Wherever possible we code plans to automatically apply plan benefits and either pay or deny, as this improves efficiency and reduces the incidence of error. Our average plan automatic adjudication rate is 86.60%.	

C.9	In-State and Out-of-State Services: Only those services approved by the NDCS should be submitted to contractor for payment. If billed, the following services should be paid by contractor: a. Claims billed by out-of-network providers. These claims should be sent to NDCS for consideration. b. Prosthetics/ Orthotics except for those off-site items issued at the time of surgery. i. Prosthetics/orthotics deemed necessary will need to be pre-approved by NDCS Medical Director or designee and billed directly to NDCS. c. Dentures/Dental Laboratory Services, i. Claims deemed necessary will need to be pre-approved by NDCS Medical Director or designee and billed directly to NDCS.
RESPONSE: Will comply. UMR will process claims according to the submitted plan design.	

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C.10	Bidder understands that Contractor will not pay Workers' Compensation /Subrogation claims. The employer's workers' compensation insurer must cover the incarcerated individuals for all work-related claims.	**Will comply**	**Will not comply**
RESPONSE: NDCS can carve out subrogation and handle the process internally or through an external vendor. If you choose to do your own subrogation, all claims will be processed upon submission according to the plan. Claims will not be reviewed for subrogation identification. Our reporting team can create a report of paid claims which NDCS or their external vendor can use to identify claims with potential third-party liability and pursue accordingly.		X	

C.11	Billing received for transplant services must be pre-approved by the NDCS Medical Director or designee. Patient must also meet transplant criteria. NDCS will not pay for elective transplant procedures. Describe what processes will be in place to ensure that pre-approval is received prior to billing.
RESPONSE: Not applicable. Prior authorizations services would be provided by NDCS.	

C.12	Bidder understands Medicaid Claims are covered by Medicaid will not be paid by contractor. NDCS will notify contractor of any Medicaid service eligibility changes.	**Will comply**	**Will not comply**
RESPONSE: NDCS will be responsible for communicating eligibility information to UMR in a timely manner.		X	

Bidder Requirements			
E.7	Contractor network will include service providers for all NDCS facility locations. Provide listing of in-network providers in a sortable file by each Specialty ~~listed in Lincoln Physicians Directory~~ in following 5 cities in Nebraska: Omaha metro area, Lincoln, York, Tecumseh, and McCook.	**Will comply**	**Will not comply**
RESPONSE: Links to UnitedHealthcare Choice Plus provider directories are posted online at **umr.com**.			

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E.8	~~Describe the processes to ensure provider rates are not paid higher than the Nebraska Medicare rates.~~ Identify the processes to ensure provider rates are not paid higher than the Nebraska negotiated rates. What reports are available that compare provider and ~~Medicare~~ Medicaid rates to the corresponding claims paid.
RESPONSE: Not applicable. Per Addendum Two (bidder Q&A responses), awarded bidders are permitted to pay provider claims in accordance with their contractor/provider agreement.	

E.9	Include an outline of compliance management for claims processing in accordance with the RFP Scope of Work. ~~Describe the proposed utilization management of claims process. Including the ability and process to customize the utilization management of claims.~~
RESPONSE: Claims pass through our reimbursement policy editing software where they are reviewed for bundling/unbundling, duplication, exclusive services, modifiers, assistant surgeon, medical necessity of appropriateness of treatment and/or diagnosis, procedures and place of service, validation of age appropriateness and gender-specific procedures. If a claim edit is applied, additional review by our medical claim review (MCR) team is necessary.	

E.11	Provide a list of all network providers with response to the RFP.
RESPONSE: Links to UnitedHealthcare Choice Plus provider directories are posted online at **umr.com**.	

Contractor Requirements – General			
F.1.a	Contractor's network will include services for all NDCS facility locations	**Will comply**	**Will not comply**
RESPONSE: We are proposing our UnitedHealthcare Choice Plus network. Today, this network includes approximately seven out of every 10 available physicians and nine out of 10 hospitals nationwide. It currently consists of over 779,000 physicians and 6,000 hospitals. Customers will appreciate the vast reach of our network and the simplicity of one uniting administrative system.			

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F.1.b	Describe how valid patient care claims for State incarcerated individual(s) committed to NDCS will be processed.

RESPONSE:
For paper claims, UMR has partnered with Exela Technologies for mail room and data entry processes. Exela Technologies receives mail in their Salt Lake City, Utah, office where they open, sort, assign a claim control number (CCN) and scan claims. Exela Technologies handles our HCFAs based on the common Healthcare Procedure Coding System (HCPCS), dental and Universal Benefits (UB) claims. They send us data entered/repaired claims electronically.

For EDI claims (837), providers are able to submit claims electronically using the clearinghouse of their choice. All inbound clearinghouse claims are directed through Optum360 for delivery to UMR. A unique payer ID is provided.

If claims require certain manual interventions, they are sent to a claim processor to complete. Manual interventions may occur when a claim:
■ Pends during the front-end process, waiting for the claim information to be validated. This is prior to the claim being sent to a CFR for payment or denial.
■ Does not meet specific criteria (defined by business rules) and the claim must be entered into the system, field-by-field.

A claim processor works with a senior claim processor on any claim that requires investigation or further communication with the provider.

If a claim does not automatically adjudicate or does not need to be handled by a claims processor, it is sent to a CFR. The CFR reviews the claim and determines the appropriate action:
■ Pend for additional information
■ Pend to an internal support unit
■ Review for CARE program recommendations
■ Apply reasonable and customary (R&C)
■ Review for subrogation opportunities
■ Forward to the Prospective Fraud, Waste, and Abuse unit
■ Enter additional provider or process information that allows the claim system to determine eligibility, condition, provider and plan language requirements

After a claim has been processed through the system, our quality assurance team performs a quality review on approximately 2% of all claims. They verify claims were handled and processed according to plan benefits and processing guidelines.

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F.1.c	Describe how the contractor will ensure claims are paid properly and what measurements are in place to ensure ~~Nebraska Medicare~~ rates ~~are~~ do not exceed the negotiated rate.
RESPONSE: Not applicable. Per Addendum Two (bidder Q&A responses), awarded bidders are permitted to pay provider claims in accordance with their contractor/provider agreement.	

F.1.d	Claims to be paid by Nebraska Medicaid are to be denied. Describe what methodology is used to ensure this requirement will be met.
RESPONSE: Claims received by UMR are matched against plan and member information such as group number, name, DOB, and ID number, to ensure that the claim is for an eligible member. Claims for eligible members are then matched against eligibility information received by NDCS to confirm if the member has any other coverage such as Medicaid before the claim is sent for processing.	

F.1.e	Describe the ability to have the provider directory available via an electronic site. Including the process on how the directory is maintained by contractor to ensure accurate information.
RESPONSE: Links to provider directories are posted online at **umr.com**. The directories are updated regularly (the frequency of updates varies based on the network).	

Contractor Requirements - Reporting			
F.2.a	Contractor will provide NDCS Accounting with an automated denial report monthly (minimum).	**Will comply**	**Will not comply**
RESPONSE: Will comply.			

F.2.b	Provide an example of reporting that meets electronic reports requirements. Bidder may provide a narrative response expanding on reporting along with the samples. Provide the following electronic reports, upon request by NDCS, at no charge: Include a listing (title or topic) and provide a sample printout of all reports that are considered standard and included at no additional charge. Special reports of health care paid for an incarcerated individual within two (2) business days. Rejected claims and rationale for rejection. Breakout by specialty, i.e. physical therapy, dental, psychiatry, maternity, etc.

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	Report of charges of $20,000 or above per incarcerated individual, per diagnosis, and per off-site hospitalization per occurrence, or as requested.

RESPONSE:
Please see below for information regarding our reporting.

InfoPort
InfoPort, UMR's proprietary data analysis and reporting tool, offers users a proactive strategy to pinpoint potential issues before they have a negative impact on results. With our dynamic reporting tool, NDCS will have the option to create, customize and schedule reports or run reports on demand. InfoPort's flexibility offers a broad range of online reports that are accessible via a secure, password-protected website. With data available daily (lag of two business days), our reporting tool assists users with identifying emerging trends and reviewing alternative plan strategies.

The intuitive online reporting tool provides users with instant access to the following information:
- Paid claims
- Benefit utilization
- Claim lag
- Financial and plan cost activity
- Network performance
- Enrollment
- Adult preventive service activity
- Admission summary
- Top claimant paid activity

With the option to review reports to identify emerging trends and alternative strategies, InfoPort empowers users to:
- Monitor plan performance
- View incurred but not reported (IBNR) activity based on incurred/paid claims
- Identify trends and outliers by analyzing multiple years of UMR data (if available)
- Identify high-cost patient activity based on a user-defined dollar threshold
- Access transactional data
- Drill down to details (protected health information (PHI) authorized users only)
- Access various report designs
- Customize report criteria, allowing a myriad of report variations
- Save customized report templates
- Schedule recurring reports with dynamic dates
- Export to multiple formats such as Excel, PDF, Word and Rich Text
- Provide access to report data in both PHI and non-PHI versions

Please refer to **Exhibit A**, InfoPort Report Sample.

F.2.c	Bidder should provide an example of reporting that meets these requirements. Bidder may provide a narrative response expanding on reporting along with the samples. Contractor will provide a monthly listing in Excel format of all claims paid per incarcerated individual, identifying: Incarcerated individual committed name. NDCS Incarcerated individual identification number. Incarcerated individual age/ date of birth. Date of service (beginning and ending).

Bidder Name: _UMR, Inc._____

	Medical provider name and location. Place of service codes. Detailed billing including ALL diagnosis code(s) and each procedure code(s) (ICD10, CPT, modifiers, units, and NDCS number(s)). APR-DRG (Diagnose Related Group) + SOI (Severity of Illness) level determines reimbursement level. Prospective Payment System detail showing weight and rate of each APR-DRG for different clinics/hospitals/surgical centers. Total Gross charged amount. Total Net paid amount. Dates of claim submission to contractor. Dates of payment to providers.

RESPONSE:
InfoPort is UMR's proprietary data analysis and online secure reporting tool, providing authorized users with the option to create, customize by applying report data filters, schedule, and run on-demand reports. Report types include paid claims, benefit utilization, admission activity, financial activities, network performance, provider utilization, and enrollment activity. Data is updated daily with a lag of two business days.

F.2.d	Provide an example of the Service Organizational Control Report (SOC2) and provide the Service Organizational Control Type 2 certification if applicable.

RESPONSE:
Please see below for information regarding Health Information Trust Alliance (HITRUST).

What is HITRUST?
HITRUST was founded in 2007 to help organizations effectively manage data, information risk and compliance.

HITRUST certification by the HITRUST Alliance enables vendors and covered entities to demonstrate compliance with HIPAA requirements based on a standardized framework. It provides an option for the health care sector to address information risk management across a matrix of third-party assurance assessments, with the hope of consolidating, reducing, and in some cases, eliminating the need for multiple reports.

What is HITRUST Common Security Framework Certification?
Organizations that create, access, store or exchange sensitive information can use the HITRUST Common Security Framework (CSF) assessment as a roadmap to data security and compliance. The CSF is a certifiable (by security assessors) standard that provides organizations with the needed structure, detail and clarity relating to information protection. It was designed as a risk-based approach to organizational security–as opposed to a compliance-based approach. The HITRUST CSF assurance program combines aspects from common security frameworks like ISO, NIST, PCI and HIPAA.

With input from leading organizations, HITRUST identified a subset of the HITRUST CSF control requirements that an organization must meet to be HITRUST CSF certified. After meeting the requirements on more than 160 controls that deal with software, security, privacy and other regulatory requirements, HITRUST concluded that UMR's portal and support infrastructure meet the HITRUST CSF certification criteria.

Please refer to **Exhibit B** for a copy of UMR's HITRUST certification.

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Bidder Name: _UMR, Inc._____

Contractor Requirements – Electronic Dashboard	
E.10 **F.3.a**	Provide an example of an electronic dashboard meeting the RFP requirements. Describe what methodology will be used to establish an electronic dashboard meeting the minimum requirements as described in the RFP. hboard must provide a minimum of the following. Most expensive patients. Top diagnoses. Frequency of diagnoses. Year to date. Month to month. Specialists/category. Itemized billings for all patients. Files be protected to meet confidentiality standards. Prefer to have the capability to print off the file at NDCS. Contractor shall provide menu listing of industry standard services including Certification and Concurrent Review Requirements with applicable cost and bullet point Return on Investment (ROI) as options for NDCS to consider using: Pre-payment auditing cost. Concurrent review cost. Complex medical review cost.

RESPONSE:
InfoPort is UMR's proprietary data analysis and online secure reporting tool, providing authorized users with the option to create, customize by applying report data filters, schedule, and run on-demand reports. Report types include paid claims, benefit utilization, admission activity, financial activities, network performance, provider utilization, and enrollment activity. Data is updated daily with a lag of two business days.

F.3.b	Contractor will, to the best of their abilities, include additional analytics on the electronic dashboard as required by the NDCS Medical Director. It is preferred that the data on the electronic dashboard be easily customized to perform analysis.	**Will comply**	**Will not comply**

RESPONSE:
If you require customized, ad hoc reports that are not included in our standard offering, we will be happy to discuss in further detail. Turnaround time for ad hoc reports is under 10 days after receipt of final data requirements. This time frame may be adjusted depending on the complexity of the request or if programming support is required. Ad hoc report data is requested through, and delivered to you via your assigned strategic client executive (SCE). Ad hoc reports are available in the following formats:
- PDF
- Microsoft Excel
- Microsoft Excel Data-only

If a report cannot be produced by our ad hoc team, we will contact our IT department to discuss development options. Project timing and cost estimates are provided, and requirements discussed before beginning any work.

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Bidder Name: _UMR, Inc._____

Contractor Requirements – Claims			
F.4.a	When submitting claim inquiries to NDCS, contractor will provide details as described in the RFP. Incarcerated individual committed name and date of birth. NDCS five (5) or six (6) digits incarcerated individual identification number. Medical provider name and location and clinic/hospital/surgical center if applicable. Admit and Discharge Date. Total Charges. Detailed billing including ALL diagnosis code(s) and each procedure code(s) (ICD10, CPT, modifiers, units, and NDCS number(s)). APR-DRG (Diagnose Related Group) + SOI (Severity of Illness) level determines reimbursement level.	**Will comply**	**Will not comply**
RESPONSE: UMR can manually provide the above information to NDCS upon request if needed for a claim review decision.			

Contractor Requirements –Meetings			
F.5.a **F.5.b**	Contractor will attend quarterly meetings and an annual review of SOC2.	**Will comply**	**Will not comply**
RESPONSE: Will comply.			

PAYMENT SCHEDULE/DELIVERABLES			
J.1.a	Invoices shall include detailed itemized billing per patient including ALL diagnosis code(s) and each procedure code(s) (ICD10, CPT, modifiers, units, and NDCS number(s)).	**Will comply**	**Will not comply**
RESPONSE: Will comply.			

REVISED ATTACHMENT A, BIDDER QUESTIONNAIRE
RFP 120174 O3
Third-party administrator to process payments for claims/ invoices for an incarcerated individual(s) healthcare services.

Bidder Name: _UMR, Inc._____

J.2.a	If awarded at a fee per incarcerated individual, the formula used to calculate the monthly processing fee shall be "fee per incarcerated individual multiplied by the ADP."	**Will comply**	**Will not comply**
RESPONSE: Will comply.			

J.2.b	If awarded at a monthly flat rate, no formula will be required on invoices.	**Will comply**	**Will not comply**
RESPONSE: Will not comply.			

J.3	All recoupment requests to NDCS will be processed within 30 calendar days upon agreement.	**Will comply**	**Will not comply**
RESPONSE: Will comply.			

OPTIONAL SERVICES (NOT SCORED)	
K.1	Prior to claims being paid, a utilization review shall be completed to include but is not limited to reviewing claims for appropriate services, review procedures/documentations related to visit for appropriateness and review hospital stays for appropriate length of stay. Describe in detail the analytical capabilities and competency of providing a detailed, accurate and comprehensive utilization review.

RESPONSE:
Please see below for an overview of our Utilization Management program.

Ensuring Clinical Appropriateness
One of the greatest challenges for health care organizations today is to provide high-quality, cost-effective treatment for patients. UMR CARE supports health care organizations, customers and members by providing effective utilization management services. We base our URAC-accredited Utilization Management program on three concepts:
- Timely review and determination of medical necessity
- Determination of appropriate inpatient length of stay
- Identification of potential Complex Condition CARE or Ongoing Condition CARE referrals

REVISED ATTACHMENT A, BIDDER QUESTIONNAIRE
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Cost-Reducing Prior Authorization and Notification Services
It is a fact that early intervention can often lead to claim cost reduction. We work closely with our customers to understand their culture and benefit plan objectives. We have a recommended list of inpatient and outpatient procedures for prior authorization review, and allow our customers to customize this list, based on their requirements. Through our prior authorization and advanced notification process, we work to ensure procedures are medically appropriate.

Hospital admissions generally follow a consistent treatment course without the need for aggressive utilization management. UMR, however, monitors all cases, from initial notification through discharge. Our goal is to ensure these cases do not deviate from the expected treatment plan and become complicated and costly. By monitoring each case, we can gain early awareness of a case's financial implications. Cases that might be deemed high risk are forwarded to our Complex Condition CARE or Ongoing Condition CARE programs for further review. Triggers for analysis include ICD diagnosis codes, CPT procedure codes, length of stay criteria and claims dollar thresholds, as well as specific criteria requested by customers or stop loss carriers.

Thorough Inpatient Care Management and Concurrent Review
Our inpatient CARE nurses conduct concurrent review to determine which setting is most appropriate for hospitalized members who require additional care. We also check to ensure the length of stay is appropriate and observed. Our inpatient CARE nurses help with discharge planning to support the member going to the appropriate lower level of care once they are medically stable and ready for discharge.

A UMR medical director oversees complex cases to determine the best course of action and consults with the member's physician if necessary.

Transition Planning
Transition planning begins as early as the notification process and/or at the time of admission. We offer discharge planning assistance upon admission or when we are notified of the admission. During a concurrent review, the Utilization Management nurse ensures that transition planning is in place for discharge. UMR's goal is to intervene as early as possible to determine the resources needed to deliver quality clinical care at a reasonable expense.

K.2	Describe and/or provide examples of any other available analytical services, reports, quality assurance, auditing, tools etc., at no additional cost.

RESPONSE:
InfoPort is UMR's proprietary data analysis and reporting tool, which provides users with an option to create and customize reports. InfoPort is highly flexible and offers a broad range of online reports that are accessible via a secure, password-protected web environment. Reports can be run on demand or scheduled by the authorized user to run weekly, monthly, quarterly or annually. Transactional data is updated daily with a lag of two business days. Authorized users have the option to drill down to details within InfoPort reports and export data using multiple formats such as Excel, PDF, Rich Text and Word.

We also offer the following no-charge report packages:
- Plan activity and checkpoint evaluation – monthly
- Plan performance and analytic review – yearly

REVISED ATTACHMENT A, BIDDER QUESTIONNAIRE
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Bidder Name: _UMR, Inc._____

Plan Activity and Checkpoint Evaluation Report
The plan activity and checkpoint evaluation report is a comprehensive, PDF formatted, reporting package delivering data based on paid medical claims and eligibility activity administered by UMR during the customer's plan year. This summary-level report includes an enrollment versus cost trend, network utilization, and paid claims utilization activity by place of service, with benchmarks using UMR book of business activity. The year-over-year comparison assists with identifying plan cost breakouts by high-cost versus non-high-cost claimants and the number of readmissions based on inpatient claims activity.

Plan Performance and Analytic Review Report
The plan performance and analytic review report displays several data components including an executive summary of enrollment demographics, cost drivers, high cost claimant activity with top highest cost conditions, paid medical claims by on demand care and illness, acute clinical conditions paid, inpatient admissions, preventive screenings and well visits, emergency room service utilization, network performance, condition focused data, paid pharmacy claims (if available), UMR Clinical Advocacy Relationships to Empower (CARE) activity, and dental claims activity (if applicable) in a series of reports presented in a report package. A minimum of 12 months of incurred claims with three additional paid months of UMR medical claims data is required; two full years of data will provide a year-to-year comparison.
Plan performance and analytic review reporting is available in PDF or PowerPoint format and provided by the customer's SCE as part of an annual customer meeting. The report contains year-over-year customer comparisons for a 24-month period (if data is available), including the most recent customer year evaluated to benchmarks derived from the UMR book of business. Key findings related to the metrics are highlighted and opportunities with recommendations for program improvement are identified to assist the customer with strategic plan management.

Internal Claim Auditing
UMR has a group of dedicated individuals across multiple functions that serve as our Quality Alliance unit. This unit is comprised of five separate audit teams that were established to specifically meet our service expectations and our customers' needs.
■ **Internal Claim Review:** This team is responsible for the daily monitoring of processor quality on both an individual and customer basis. All automatically adjudicated claims in excess of $15,000 and manual claim payments in excess of $150,000 are reviewed for accuracy (unless a processor has a higher check limit). UMR also has these quality measures in place:
  ■ **Random Reviews:** Each week a stratified random claim sampling is selected for review. These include both claims released by a CFR and automatically adjudicated claims. A quality auditor analyzes these claims for coding, payment and procedural accuracy. If the auditor detects an error, he or she provides feedback to the appropriate CFR who then corrects the error.
  ■ **Special Case Reviews:** Unit supervisors review claims that exceed specific dollar values (e.g., over-check limit and large-dollar claims) as well as those that involve payment to a third party (other than the employee or provider).
  ■ **Targeted Reviews:** For quality improvement purposes, UMR conducts reviews on a pre-check basis which are focused on particular claim scenarios.
  ■ **Trainee Reviews:** All trainee claims are reviewed on a pre-check basis until the CFR has reached an acceptable quality performance level.
■ **Strategic Business Assessment:** This team serves as a corporate audit department and performs comprehensive reviews of each business unit for total operational, security and claim controls. The team also performs corporate claim audits on behalf of a number of existing customers and detailed focused audits on all new customers as they transition to UMR. The goal is to mirror an external audit in a more comprehensive manner.
■ **Ancillary Department Review:** This team is responsible for reviews of ancillary departments, including enrollment, provider, flexible spending account (FSA) and data entry.

REVISED ATTACHMENT A, BIDDER QUESTIONNAIRE
RFP 120174 O3
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■ **External and Regulatory Audit:** This team is responsible for the coordination of all external customer audit requests and regulatory audits in addition to SSAE 18 (SSAE 16/SAS 70) facilitation. They also perform special audits to monitor compliance for PPACA and health care reform (HCR).

K.3	Describe any additional like-services that are available which are not specifically mentioned in this RFP.

RESPONSE:
Our claims processing system was internally designed to meet the needs of a diverse customer base, as well as to accommodate changes in the benefits environment. It provides consistent administration for a wide variety of benefit plans and pricing arrangements. The system is flexible and is easily enhanced for new products and services.

This flexibility gives us the ability to administer all levels of fee schedules and PPO configurations. We can also administer conversion factor pricing, negotiated or fixed-fee schedules, provider discounts, reasonable and customary (R&C) fee administration, per diem rates or any combination of these elements.

Cost Proposal
RFP 120174 O3
Third-party administrator to process payments for claims/ invoices for an incarcerated individual(s) healthcare services.

Bidder Name: UMR, Inc.

All expenses associated with these services must be bid as all-inclusive. No other costs shall be billed. This is an estimated usage contract based on historical data and will fluctuate based on the average daily population (ADP). The bidder may use the ADP of 5872 and may refer to the historical information provided in the RFP to help aid in developing cost. This contract shall have no minimum/maximum ADP requirements.

The bidder shall provide two (2) cost solutions for the Medical and Dental payment processing fees. One (1) cost solution will be for a flat monthly rate and one (1) cost solution at a rate per incarcerated individual. The State will determine if the award will be based on the monthly flat rate or award at the rate per incarcerated individual, whichever is deemed in the best interest of the State.

1. Bidder shall:
    a. Provide a monthly flat rate for both the Medical Payment Processing Fee and the Dental Payment Processing Fee.

Monthly flat rate	Unit of Measure	ADP	Initial contract term cost per month	Renewal 1 (Optional)	Renewal 2 (Optional)
Medical payment processing fee	Per month	5872	Not applicable.	Not applicable.	Not applicable.
Dental payment processing fee	Per month	5872	Not applicable.	Not applicable.	Not applicable.

2. Bidder shall:
    a. Provide a rate per incarcerated individual for the Medical Payment Processing Fee and the Dental Payment Processing Fee.
        i. For billing purposes, the formula used to calculate the processing fee shall be “fee per incarcerated individual multiplied by the average daily population”, the formula used shall be on every monthly invoice.
            1. Example: “$19.50 (fee) x 5872 (ADP) = $114,504”.

Rate per incarcerated individual	Unit of Measure	ADP	Initial contract term cost per individual	Renewal 1 (Optional)	Renewal 2 (Optional)
Medical payment processing fee	Per person	5872	$18.50	$18.95	$19.40
Dental payment processing fee	Per person	5872	$1.22	$1.24	$1.27

Bidder Name: UMR, Inc.

3. OPTIONAL SERVICES, NOT REQUIRED.

   a. NDCS may consider awarding optional services as outlined in section V.K. at the time of award or after contract award, if deemed in the best interest of the State.
   b. If optional services are provided with the RFP response, the bidder must provide cost for optional services with the response.
   c. Bidder may add additional rows if needed.

Description of Optional Service	Unit of Measure	Initial contract term cost	Renewal 1 (Optional)	Renewal 2 (Optional)
Not applicable.	Not applicable.	Not applicable.	Not applicable.	Not applicable.

State of Nebraska Department of Correctional Services
REQUEST FOR PROPOSAL FOR SERVICES CONTRACT

SOLICITATION NUMBER	RELEASE DATE
120174 O3	November 01, 2024
OPENING DATE AND TIME	**PROCUREMENT CONTACT**
January 07, 2025, 2:00 p.m. Central Time	Julie Schiltz

PLEASE READ CAREFULLY!
SCOPE OF SERVICE

The State of Nebraska (State), Department of Correctional Services, is issuing this solicitation for a service contract for the purpose of selecting a qualified bidder to process payments for claims/ invoices for an incarcerated individual(s) healthcare services on behalf of NDCS. A more detailed description can be found in Section V. The resulting contract may not be an exclusive contract as the State reserves the right to contract for the same or similar services from other sources now or in the future.

The term of the contract will be four (4) years commencing upon notice to proceed. The Contract includes the option to renew for two (2) additional two (2) year periods upon mutual agreement of the Parties. The State reserves the right to extend the period of this contract beyond the termination date when mutually agreeable to the Parties.

In the event that a contract with the awarded bidder(s) is cancelled or in the event that the State needs additional Vendors to supply the solicited services, this solicitation may be used to procure the solicited services up to twenty-four (24) months from the date the Intent to Award is posted, provided that 1) the solicited goods or services will be provided by a bidder (or a successive owner) who submitted a response pursuant to this solicitation, 2) the bidder's solicitation response was evaluated, and 3) the bidder will honor the bidder's original solicitation response, including the proposed cost, allowing for any price increases that would have otherwise been allowed if the bidder would have received the initial award.

ALL INFORMATION PERTINENT TO THIS SOLICITATION CAN BE FOUND ON THE INTERNET AT: https://das.nebraska.gov/materiel/bidopps.html.

IMPORTANT NOTICE: Pursuant to Neb. Rev. Stat. § 84-602.04, State contracts in effect as of January 1, 2014, and contracts entered into thereafter, must be posted to a public website. The resulting contract, the Solicitation, and the awarded solicitation response will be posted to a public website managed by DAS, which can be found at http://statecontracts.nebraska.gov and https://www.nebraska.gov/das/materiel/purchasing/contract_search/index.php.

In addition and in furtherance of the State's public records Statute (Neb. Rev. Stat. § 84-712 et seq.), all responses received regarding this Solicitation will be posted to the State Purchasing Bureau public website.

These postings will include the entire solicitation response. Bidder must request that proprietary information be excluded from the posting. The bidder must identify the proprietary information, mark the proprietary information according to state law, and submit the proprietary information in a separate file named conspicuously as "PROPRIETARY INFORMATION". The bidder should submit a detailed written document showing that the release of the proprietary information would give a business advantage to named business competitor(s) and explain how the named business competitor(s) will gain an actual business advantage by disclosure of information. The mere assertion that information is proprietary or that a speculative business advantage might be gained is not sufficient. (See Attorney General Opinion No. 92068, April 27, 1992). **THE BIDDER MAY NOT ASSERT THAT THE ENTIRE SOLICITATION IS PROPRIETARY. COST SHEETS WILL NOT BE CONSIDERED PROPRIETARY AND ARE A PUBLIC RECORD IN THE STATE OF NEBRASKA.** The State will determine, in its sole discretion, if the disclosure of the information designated by the Bidder as proprietary would 1) give advantage to business competitors and 2) serve no public purpose. The Bidder will be notified of the State's decision. Absent a determination by the State that the information may be withheld pursuant to Neb. Rev. Stat. § 84-712.05, the State will consider all information a public record subject to disclosure.

If the State determines it is required to release withheld proprietary information, the bidder will be informed. It will be the bidder's responsibility to defend the bidder's asserted interest in non-disclosure.

To facilitate such public postings, with the exception of proprietary information, the State of Nebraska reserves a royalty-free, nonexclusive, and irrevocable right to copy, reproduce, publish, post to a website, or otherwise use any contract, or solicitation response for any purpose, and to authorize others to use the documents. Any individual or entity awarded a contract, or who submits a solicitation response, specifically waives any copyright or other protection the contract, or solicitation response may have; and acknowledges that they have the ability and authority to enter into such waiver. This reservation and waiver are a prerequisite for submitting a solicitation response, and award of a contract. Failure to agree to the reservation and waiver will result in the solicitation response being found non-responsive and rejected.

Any entity awarded a contract or submitting a solicitation response agrees not to sue, file a claim, or make a demand of any kind, and will indemnify and hold harmless the State and its employees, volunteers, agents, and its elected and appointed officials from and against

any and all claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses of every nature, including investigation costs and expenses, settlement costs, and attorney fees and expenses, sustained or asserted against the State, arising out of, resulting from, or attributable to the posting of the contract or solicitation response, awards, and other documents.

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GLOSSARY OF TERMS

Acceptance Test Procedure: Benchmarks and other performance criteria, developed by the State or other sources of testing standards, for measuring the effectiveness of products or goods and the means used for testing such performance.

Addendum: A written correction or alteration to a document during the solicitation process (e.g., Questions and Answers, Revised Schedule of Events, Addendum to Contract Award).

Agency: All officers of the state, departments, bureaus, boards, commissions, councils, and institutions receiving legislative appropriations.

Agent/Representative: A person authorized to act on behalf of another.

Amend: To alter or change by adding, subtracting, or substituting.

Amendment: A written correction or alteration to a document.

Appropriation: Legislative authorization to expend public funds for a specific purpose; money set apart for a specific use.

Automated Clearing House (ACH): Electronic network for financial transactions in the United States.

Award: All purchases, leases, or contracts which are based on competitive solicitations will be awarded according to the provisions in the solicitation.

Best and Final Offer (BAFO): In a competitive solicitation, the final offer submitted which contains Vendor's most favorable terms for price.

Bid: See Solicitation Response.

Bid Opening: The process of opening correctly submitted solicitation responses at the time and place specified in the written solicitation and in the presence of any bidder who wishes to attend.

Bidder: A Vendor who submits a Solicitation Response.

Breach: Violation of a contractual obligation by failing to perform or repudiation of one's own promise.

Business: Any corporation, partnership, individual, sole proprietorship, joint-stock company, joint venture, or any other private legal entity.

Business Day: Any weekday, except State-recognized holidays.

Calendar Day: Every day shown on the calendar including Saturdays, Sundays, and State/Federal holidays.

Cancellation: To call off or revoke a solicitation, purchase order, or contract without expectation of conducting or performing at a later time.

Catalog/Non-Core: A printed or electronic list of products a Vendor may provide at a discounted rate or discount off list price to the State. Initial contract award(s) is not based on Catalog/Non-Core items.

Central Processing Unit (CPU): Any computer or computer system that is used by the State to store, process, or retrieve data or perform other functions using Operating Systems and applications software.

Change Order: Document that provides amendments to an executed purchase order or contract.

Collusion: An agreement or cooperation between two or more persons or entities to accomplish a fraudulent, deceitful, or unlawful purpose.

Commodities: Any equipment, material, supply, or goods; anything movable or tangible that is provided or sold.

Commodities Description: Detailed descriptions of the items to be purchased; may include information necessary to obtain the desired quality, type, color, size, shape, or special characteristics necessary to perform the work intended to produce the desired results.

Community Standard Level of Care: Nebraska State Statute 83-4,154 (1) Community standard of health care means medical care of the type, quality, and amount that any individual residing within the community in question could expect to receive in that community; (2) Department means the Department of Correctional Services; (3) Health care services means all medical care provided by or on behalf of the department to inmates and includes the practice of medicine and surgery, the practice of pharmacy, nursing care, dental care, optometric care, audiological care, physical therapy, mental health care, and substance abuse counseling and treatment; (4) Inmate means an individual in the custody of the department; and (5) Medical doctor means a person licensed to practice medicine and surgery in this state.

Competition: The effort or action of two or more commercial interests to obtain the same business from third parties.

Confidential Information: See Proprietary Information.

Contract: An agreement between two or more parties creating obligations that are enforceable or otherwise recognizable at law; the writing that sets forth such an agreement.

Contract Administration: The management of the contract which includes and is not limited to contract signing, contract amendments and any necessary legal actions.

Contract Award: Document that officially awards a contract to a bidder(s) as the result of a competitive solicitation or a vendor(s) in a contract that qualifies for an exception or exemption from the competitive bidding requirements of the State Procurement Act.

Contract Management: The management of day-to-day activities at the agency which includes and is not limited to ensuring deliverables are received, specifications are met, handling meetings and making payments to the Vendor.

Contract Period: The duration of the contract.

Contractor: See Vendor.

Cooperative Purchasing: The combining of requirements of two or more political entities to obtain advantages of volume purchases, reduction in administrative expenses or other public benefits.

Copyright: A property right in an original work of authorship fixed in any tangible medium of expression, giving the holder the exclusive right to reproduce, adapt and distribute the work.

Cost Sheet: Commodities or Services specifically listed within the solicitation for evaluation.

Critical Program Error: Any Program Error, whether or not known to the State, which prohibits or significantly impairs use of the Licensed Software as set forth in the documentation and intended in the contract.

Customer Service: The process of ensuring customer satisfaction by providing assistance and advice on those commodities or services provided by a Vendor.

Default: The omission or failure to perform a contractual duty.

Deviation: Any proposed change(s) or alteration(s) to either the terms and conditions or deliverables within the scope of the written solicitation or contract.

Evaluation: The process of examining a solicitation response after opening to determine the bidder's responsibility, responsiveness to requirements, and to ascertain other characteristics of the solicitation response that relate to determination of the successful award.

Evaluation Committee: Individual(s) identified by the agency that leads the solicitation to evaluate solicitation responses.

Extension: Continuance of a contract for a specified duration upon the agreement of the parties beyond the original Contract Period; not to be confused with "Renewal Period".

Free on Board (F.O.B.) Destination: The delivery charges are included in the quoted price and prepaid by the Vendor. Vendor is responsible for all claims associated with damages during delivery of product.

Free on Board (F.O.B.) Point of Origin: The delivery charges are not included in the quoted price and are the responsibility of the agency. Agency is responsible for all claims associated with damages during delivery of product.

Foreign Corporation: A foreign corporation that was organized and chartered under the laws of another state, government, or country.

Goods: See Commodities.

Incarcerated Individual: an individual in the custody of the Department of Correctional Services.

In-patient: refers to a hospitalization that exceeds 24 hours, but excludes observation stays.

Installation Date: The date when the procedures described in “Installation by Vendor“ and “Installation by State” as found in the solicitation or contract are completed.

Interested Party: A person acting in their personal capacity or an entity entering into a contract or other agreement creating a legal interest therein.

Late Solicitation Response: A solicitation response received after the Opening Date and Time.

Licensed Software Documentation: The user manuals and any other materials in any form or medium customarily provided by the Vendor to the users of the Licensed Software which will provide the State with sufficient information to operate, diagnose, and maintain the Licensed Software properly, safely, and efficiently.

Mandatory: Required, compulsory, or obligatory.

May: Discretionary, permitted; used to express possibility.

Medicaid: Medical assistance provided under a state plan approved under title XIX of the Act.

Medicare: The health insurance program for the aged and disabled under title XVIII of the Act.

Medicare rates: Prevailing Medicare reimbursement rate at the time of the claim.

Module (see System): A collection of routines and data structures that perform a specific function of software.

Must: See Shall.

National Institute for Governmental Purchasing (NIGP): National Institute of Governmental Purchasing – Source used for assignment of universal commodity codes to goods and services.

Nebraska Medicaid eligibility: An inmate of a public institution, as defined by 42 Code of Federal Regulations (CFR) 435.1009, who meets inpatient status in a medical institution, as defined by 42 CFR 435.1010, and who is otherwise eligible may only receive payment for services received during his or her inpatient stay over 24 hours.

Non-core: See Catalog.

Non-Responsive Solicitation Response: Any solicitation response that does not comply with the requirements of the solicitation or cannot be evaluated against the other solicitation responses.

Nonnegotiable: These clauses are controlled by state law and are not subject to negotiation.

Opening Date and Time: Specified date and time for the opening of received, labeled, and sealed formal solicitation responses.

Operating System: The control program in a computer that provides the interface to the computer hardware and peripheral devices, and the usage and allocation of memory resources, processor resources, input/output resources, and security resources.

Out-patient: a patient who receives medical treatment without being admitted to a hospital.

Outsourcing: The contracting out of a business process that an organization may have previously performed internally or for which an organization has a new need to an independent organization from which the process is purchased back.

Payroll & Financial Center (PFC): Electronic procurement system of record.

Performance Bond: An insurance agreement accompanied by a monetary commitment by which a third party (the surety) accepts liability and guarantees that the Vendor fulfills any and all obligations under the contract.

Personal Property: See Commodities.

Pending Claims: For the purposes of this RFP, pending claims are applications that have not been yet submitted, approved, or denied.

Platform: A specific hardware and Operating System combination that is different from other hardware and Operating System combinations to the extent that a different version of the Licensed Software product is required to execute properly in the environment established by such hardware and Operating System combination.

Point of Contact (POC): The person designated to receive communications and to communicate.

Product: Something that is distributed commercially for use or consumption and that is usually (1) tangible personal property, (2) the result of fabrication or processing, and (3) an item that has passed through a chain of commercial distribution before ultimate use or consumption.

Program Error: Code in Licensed Software that produces unintended results or actions or that produces results or actions other than those described in the specifications. A program error includes, without limitation, any Critical Program Error.

Program Set: The group of programs and products, including the Licensed Software specified in the solicitation, plus any additional programs and products licensed by the State under the contract for use by the State.

Project: The total scheme, program, or method worked out for the accomplishment of an objective, including all documentation, commodities, and goods to be provided under the contract.

Proposal: See Solicitation Response.

Proprietary Information: Trade secrets, academic and scientific research work that is in progress and unpublished or other information that if released would give advantage to business competitors and service no public purpose. See Neb. Rev. Stat. § 84-712.05(3). In accordance with Attorney General Opinions 92068 and 97033, proof that information is proprietary requires identification of specific named competitor(s) advantaged by release of the information and the demonstrated advantage the named competitor(s) would gain by the release of information.

Protest/Grievance: A complaint about a governmental action or decision related to the solicitation or resultant contract under SPB's Protest Policy.

Quote: See Solicitation Response.

Recommended Hardware Configuration: The data processing hardware (including all terminals, auxiliary storage, communication, and other peripheral devices) to the extent used by the State as recommended by the Vendor.

Release Date: The date of public release of the solicitation.

Renewal Period: Optional contract periods subsequent to the original Contract Period for a specified duration with previously agreed to terms and conditions; not to be confused with "Extension".

Request for Proposal (RFP): See Solicitation.

Responsible Bidder: A Vendor who has the capability in all respects to perform fully and lawfully all requirements with integrity and reliability to assure good faith performance.

Responsive Bidder: A Vendor who has submitted a solicitation response which conforms to all requirements of the solicitation.

Shall: An order/command; mandatory.

Should: Expected; suggested, but not necessarily mandatory.

Software License: Legal instrument with or without printed material that governs the use or redistribution of licensed software.

Solicitation: A formal invitation to receive quotes in the form of a Request for Proposal or Invitation to Bid.

Solicitation Bond: An insurance agreement, accompanied by a monetary commitment, by which a third party (the surety) accepts liability and guarantees that the Vendor will not withdraw the solicitation response.

Solicitation Conference: A meeting scheduled for the purpose of clarifying a written solicitation and related expectations.

Solicitation Response: An offer, quote, bid, or proposal submitted by a Vendor in response to a Solicitation.

Specifications: The detailed statement, especially of the measurements, quality, materials, and functional characteristics, or other items to be provided under a contract.

Subcontractor: Individual or entity with whom the Vendor enters a contract to perform a portion of the work awarded to the Vendor.

System (see Module): Any collection or aggregation of two (2) or more Modules that is designed to function, or is represented by the Vendor as functioning or being capable of functioning, as an entity.

Termination: Occurs when either Party, under a power created by agreement or law, puts an end to the contract prior to the stated expiration date; all obligations that are still executory on both sides are discharged but any right based on prior breach or performance survives.

Third-Party: Any person or entity, including but not limited to fiduciaries, shareholders, owners, officers, managers, employees, legally disinterested persons, and subcontractors or agents, and their employees. It shall not include any entity or person who is an interested party to the contract or agreement.

Trade Secret: Information, including but not limited to, a drawing, formula, pattern, compilation, program, device, method, technique, code, or process that (a) derives independent economic value, actual or potential, from not being known to, and not being ascertainable by proper means by, other persons who can obtain economic value from its disclosure or use; and (b) is the subject of efforts that are reasonable under the circumstances to maintain its secrecy (see Neb. Rev. Stat. § 87-502(4)).

Trademark: A word, phrase, logo, or other graphic symbol used by a manufacturer or Vendor to distinguish its product from those of others, registered with the U.S. Patent and Trademark Office.

Upgrade: Any change that improves or alters the basic function of a product of service.

Vendor: An individual or entity lawfully conducting business with the State. or licensed to do so, who seeks to provide and contract for goods or services under the terms of a Solicitation and/or Contract.

Will: See Shall.

Work Day: See Business Day.

ACRONYM LIST

ACH – Automated Clearing House

ADP – Average Daily Population

APR-DRG - Diagnose Related Group

ARO – After Receipt of Order

BAFO – Best and Final Offer

COI – Certificate of Insurance

CPU – Central Processing Unit

DAS – Department of Administrative Services

DHHS – Department of Health and Human Services

EOB - Explanation of Benefits

F.O.B. – Free on Board

NDCS – Nebraska Department of Correctional Services (NDCS/DCS)

PPO - Preferred provider organization

RFP – Request for Proposal

ROI – Return on Investment

SFTP - Secure file Transfer Protocol

SOC2 - Service Organizational Control Report

SOI - Severity of Illness

SPB – State Purchasing Bureau

I. PROCUREMENT PROCEDURE

A. GENERAL INFORMATION

This solicitation is designed to solicit responses from qualified bidders who will be responsible for process payments for claims/ invoices for an incarcerated individual(s) healthcare on behalf of NDCS at a competitive and reasonable cost.

Solicitation responses shall conform to all instructions, conditions, and requirements included in the solicitation. Prospective bidders are expected to carefully examine all documents, schedules, and requirements in this solicitation, and respond to each requirement in the format prescribed. Solicitation responses may be found non-responsive if they do not conform to the solicitation.

B. PROCURING OFFICE AND COMMUNICATION WITH STATE STAFF AND EVALUATORS

Procurement responsibilities related to this solicitation reside with the Department of Correctional Services. The point of contact (POC) for the procurement is as follows:

RFP Number:	120174 O3
Name:	Julie Schiltz, NDCS Assistant Materiel Administrator
Agency:	Nebraska Department of Correctional Services
Address:	801 W. Prospector Place, Bldg. #1
	Lincoln, NE 68522
Telephone:	402-479-5718
E-Mail:	julie.schiltz@nebraska.gov

From the date the solicitation is issued until the Intent to Award is issued, communication from the bidder is limited to the POC listed above. After the Intent to Award is issued, the bidder may communicate with individuals the State has designated as responsible for negotiating the contract on behalf of the State. No member of the State Government, employee of the State, or member of the Evaluation Committee is empowered to make binding statements regarding this solicitation. The POC will issue any answers, clarifications, or amendments regarding this solicitation in writing. Only the SPB or awarding agency can award a contract. Bidders shall not have any communication with or attempt to communicate or influence any evaluator involved in this solicitation.

The following exceptions to these restrictions are permitted:

1. Contact made pursuant to pre-existing contracts or obligations;

2. Contact required by the schedule of events or an event scheduled later by the POC; and

3. Contact required for negotiation and execution of the final contract.

The State reserves the right to reject a bidder's solicitation response, withdraw an Intent to Award, or terminate a contract if the State determines there has been a violation of these procurement procedures.

C. SCHEDULE OF EVENTS

The State expects to adhere to the procurement schedule shown below, but all dates are approximate and subject to change.

NOTE: All ShareFile links in the Schedule of Events below, are unique links for each schedule step. Please click the correct link for the upload step you are requesting.

Schedule of Events		
ACTIVITY		**DATE/TIME**
1.	Release solicitation	11/1/2024
2.	Last day to submit written questions. E-mail to dcs.purchasing@nebraska.gov clearly marked “RFP 120174 O3 Questions”.	11/22/2024
3.	State responds to written questions through solicitation “Addendum” to be posted to the Internet at: http://das.nebraska.gov/materiel/bidopps.html	12/09/2024
4.	Electronic Solicitation Opening – Online Via Webex IT IS THE BIDDER’S RESPONSIBILTY TO UPLOAD ELECTRONIC FILES BY OPENING DATE AND TIME. EXCEPTIONS WILL NOT BE MADE FOR TECHNOLOGY ISSUES. ShareFile Electronic Solicitation Submission Link: https://nebraska.sharefile.com/r-r7b4ab0735d3644aea876197a9a268dfb Join Webex Meeting https://sonvideo.webex.com/sonvideo/j.php?MTID=m2d29c2d13369a4c0b37aaf17b865c065	01/07/2025 2:00 PM Central Time
5.	Review for conformance to solicitation requirements	01/07/2025 – 01/10/2025
6.	Evaluation period	01/10/2025 – 02/12/2025
7.	“Vendor Demonstrations” (if required)	TBD
8.	Post “Notification of Intent to Award” to Internet at: https://das.nebraska.gov/materiel/bidopps.html	TBD
9.	Contract finalization period	TBD
10	Contract award	TBD
11	Vendor start date	TBD

D. WRITTEN QUESTIONS AND ANSWERS

Questions regarding the meaning or interpretation of any solicitation provision must be submitted via e-mail to dcs.purchasing@nebraska.gov clearly marked "RFP 120174 O3 Questions". The POC is not obligated to respond to questions that are received late per the Schedule of Events.

Bidders should submit questions for any items upon which assumptions may be made when preparing a response to the solicitation. Any solicitation response containing assumptions may be deemed non-responsive and may be rejected by the State. Solicitation responses will be evaluated without consideration of any known or unknown assumptions of a bidder. The contract will not incorporate any known or unknown assumptions of a bidder.

Questions should be uploaded using the ShareFile link provided in the solicitation Schedule of Events, Section I.C. It is recommended that bidders submit questions using the following format:

RFP Section Reference	RFP Page Number	Question

Written answers will be posted at https://das.nebraska.gov/materiel/bidopps.html per the Schedule of Events.

E. SECRETARY OF STATE/TAX COMMISSIONER REGISTRATION REQUIREMENTS (Nonnegotiable)

All bidders must be authorized to transact business in the State of Nebraska and comply with all Nebraska Secretary of State Registration requirements. The bidder who is the recipient of an Intent to Award may be required to certify that it has complied and produce a true and exact copy of its current (within ninety (90) calendar days of the intent to award) Certificate or Letter of Good Standing, or in the case of a sole proprietorship, provide written documentation of sole proprietorship and complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at: https://das.nebraska.gov/materiel/docs/pdf/Individual%20or%20Sole%20Proprietor%20United%20States%20Attestation%20Form%20English%20and%20Spanish.pdf This should be accomplished prior to execution of the contract.

F. ETHICS IN PUBLIC CONTRACTING

The State reserves the right to reject solicitation responses, withdraw an intent to award or award, or terminate a contract if an ethical violation has been committed, which includes, but is not limited to:

1. Offering or giving, directly or indirectly, a bribe, fee, commission, compensation, gift, gratuity, or anything of value to any person or entity in an attempt to influence the bidding process;
2. Utilizing the services of lobbyists, attorneys, political activists, or consultants to influence or subvert the bidding process;
3. Being considered for, presently being, or becoming debarred, suspended, ineligible, or excluded from contracting with any state or federal entity:
4. Submitting a solicitation response on behalf of another Party or entity; and
5. Colluding with any person or entity to influence the bidding process, submit sham solicitation responses, preclude bidding, fix pricing or costs, create an unfair advantage, subvert the solicitation response, or prejudice the State.

The bidder shall include this clause in any subcontract entered into for the exclusive purpose of performing this contract.

Bidder shall have an affirmative duty to report any violations of this clause by the bidder throughout the bidding process and throughout the term of this contract for the awarded bidder and their subcontractors.

G. DEVIATIONS FROM THE SOLICITATION

The requirements contained in the solicitation (Sections II thru VI) become a part of the terms and conditions of the contract resulting from this solicitation. Any deviations from the solicitation in Sections II thru VI must be clearly defined by the bidder in its solicitation response and, if accepted by the State, will become part of the contract. Any specifically defined deviations must not be in conflict with the basic nature of the solicitation, requirements, or applicable state or federal laws or statutes. "Deviation", for the purposes of this solicitation, means any proposed changes or alterations to either the contractual language or deliverables within the scope of this solicitation. The State discourages deviations and reserves the right to reject proposed deviations.

H. SUBMISSION OF SOLICITATION RESPONSES

The State is only accepting electronic responses submitted in accordance with this solicitation. The State will not accept solicitation responses by mail, email, voice, or telephone, unless otherwise explicitly stated in writing by the State.

Pages may be consecutively numbered for the entire solicitation response or may be numbered consecutively within sections. Figures and tables should be numbered and referenced in the text by that number. They should be placed as close as possible to the referencing text.

The Technical Responses should not contain any reference to dollar amounts. However, information such as data concerning labor hours and categories, materials, subcontracts and so forth, shall be considered in the Technical Response so that the bidder's understanding of the scope of work may be evaluated. The Technical Response shall disclose the bidder's technical requirements in as much detail as possible, including, but not limited to, the information required by the Technical Response instructions.

It is the bidder's responsibility to ensure the solicitation response is received electronically by the date and time indicated in the Schedule of Events. Solicitation Responses must be submitted via ShareFile by the date and time of the opening per the Schedule of Events. No late solicitation responses will be accepted.

It is the responsibility of the bidder to check the website for all information relevant to this solicitation to include addenda and/or amendments issued prior to the opening date. The website can be found here: https://das.nebraska.gov/materiel/bidopps.html.

Emphasis should be concentrated on conformance to the solicitation instructions, responsiveness to requirements, completeness, and clarity of content. If the solicitation response is presented in such a fashion that makes evaluation difficult or overly time consuming the State reserves the right to reject the solicitation response as non-conforming.

The ShareFile link for uploading Solicitation Response(s) is provided in the Schedule of Events, Section I.C.

*****UNLESS OTHERWISE NOTED, DO NOT SUBMIT DOCUMENTS THAT CAN ONLY BE ACCESSED WITH A PASSWORD*****

1. Bidders must submit responses via ShareFile using the solicitation submission link.
Note: Not all browsers are compatible with ShareFile. Currently Chrome, Internet Explorer and Firefox are compatible. After the bidder clicks the solicitation response submission link, the bidder will be prompted to enter contact information including an e-mail address. By entering an e-mail address, the bidder should receive a confirmation email confirming the successful upload directly from ShareFile.

ShareFile link for uploading solicitation response(s) provided in the Schedule of Events, Section I.C.

a. The Solicitation response and Proprietary information should be uploaded as separate and distinct files.

i. If duplicated responses are submitted, the State will retain only the most recently submitted response.
ii. If it is the bidder's intent to submit multiple responses, the bidder must clearly identify the separate submissions.
iii. It is the bidder's responsibility to allow time for electronic uploading. All file uploads must be completed by the Opening date and time per the Schedule of Events. No late responses will be accepted.

b. ELECTRONIC SOLICITATION RESPONSE FILE NAMES
The bidder should clearly identify the uploaded solicitation response files. To assist in identification the bidder should use the following naming convention:
i. 120174 O3, Company Name
If multiple files are submitted for one solicitation response, add number of files to file names:
120174 O3 Company Name File 1 of 2.
120174 O3 Company Name File 2 of 2.
ii. If multiple responses are submitted for the same solicitation, add the response number to the file names:
120174 O3 Company Name Response 1 File 1 of 2.

The "Contractual Agreement Form" must be signed manually in ink or by DocuSign and returned by the opening date and time along with the bidder's solicitation response and any other requirements as stated in this solicitation in order for the bidder's solicitation response to be evaluated.

By signing this Contractual Agreement Form, the bidder guarantees compliance with the provisions stated in this solicitation and agrees to the terms and conditions unless otherwise indicated in writing.

I. SOLICITATION PREPARATION COSTS

The State shall not incur any liability for any costs incurred by bidder's in replying to this solicitation, including any activity related to bidding on this solicitation.

J. FAILURE TO COMPLY WITH SOLICITATION

Violation of the terms and conditions contained in this solicitation or any resultant contract, at any time before or after the award, shall be grounds for action by the State which may include, but is not limited to, the following:

1. Rejection of a bidder's solicitation response,
2. Withdrawal of the Intent to Award,
3. Withdrawal of the Award,
4. Negative documentation regarding Vendor Performance,
5. Termination of the resulting contract,
6. Legal action; and
7. Suspension or Debarment of the bidder from further bidding with the State for the period of time relative to the seriousness of the violation. Such period to be within the sole discretion of the State.

K. SOLICITATION RESPONSE CORRECTIONS

A bidder may correct a mistake in an electronically submitted solicitation response prior to the time of opening by uploading a revised and completed solicitation response.

1. If a corrected electronic solicitation response is submitted, the file name(s) date/time stamped with latest date/time stamp will be accepted. The corrected solicitation response file name(s) should be identified as:

    a. Corrected 120174 O3 Company Name Response #1 File 1 of 2,
    b. Corrected 120174 O3 Company Name Response #2 File 2 of 2, etc.

Changing a solicitation response after opening may be permitted if the change is made to correct a minor error that does not affect price, quantity, quality, delivery, or contractual conditions. In case of a mathematical error in extension of price, unit price shall govern.

L. LATE SOLICITATION RESPONSES

Solicitation Responses received after the time and date of the opening will be considered late responses. Late responses will be considered non-responsive. The State is not responsible for responses that are late or lost regardless of cause or fault.

M. BID OPENING

The opening will consist of opening solicitation responses and announcing the names of bidders. Responses **WILL NOT** be available for viewing by those present at the opening. Responses will be posted to the State Purchasing Bureau website once an Intent to Award has been posted to the website. Once responses are opened, they become the property of the State of Nebraska and will not be returned.

N. SOLICITATION REQUIREMENTS

The solicitation responses will first be examined to determine if all requirements listed below have been addressed and whether further evaluation is warranted. Solicitation responses not meeting the requirements may be rejected as non-responsive. The requirements are as follows:

1. Original Contractual Agreement Form signed manually in ink or by DocuSign;
2. Clarity and responsiveness;
3. Completed Corporate Overview;
4. Completed Sections II thru VI;
5. Completed Attachment A, Bidder Questionnaire;
6. Completed Cost Proposal.

O. EVALUATION COMMITTEE

Solicitation Responses are evaluated by members of an Evaluation Committee(s). The Evaluation Committee(s) will consist of individuals selected at the discretion of the State. Names of the members of the Evaluation Committee(s) will not be published prior to the intent to award.

Any contact, attempted contact, or attempt to influence an evaluator that is involved with this Solicitation may result in the rejection of this response and further administrative actions.

P. EVALUATION OF SOLICITATION RESPONSES

All solicitation responses that are deemed responsive to the solicitation will be evaluated. Each evaluation category will have a maximum point potential. The State will conduct a fair, impartial, and comprehensive evaluation of all responses in accordance with the criteria set forth below. Areas that will be addressed and scored during the evaluation include:

1. Corporate Overview may include, but is not limited to:

- **a.** the ability, capacity, and skill of the bidder to deliver and implement the system or project that meets the requirements of the Solicitation;
- **b.** the character, integrity, reputation, judgment, experience, and efficiency of the bidder;
- **c.** whether the bidder can perform the contract within the specified time frame;
- **d.** the bidder's historical or current performance; and
- **e.** such other information that may be secured and that has a bearing on the decision to award the contract.

In evaluating the corporate overview, the State may consider, past experiences with the vendor, references, the State's record of the vendor which may include, but is not limited to Vendor Compliance Request, Contract Non-Compliance Notice, vendor performance reports, and any information related to the vendor's historical or current character, integrity, reputation, capability, or performance with the State or a third-party.

1. Attachment A Bidder Questionnaire and,
2. Cost Proposal.

Neb. Rev. Stat. § 73-808 allows the State to consider a variety of factors, including, but not limited to, the quality of performance of previous contracts to be considered when evaluating responses to competitive solicitations in determining a responsible bidder. Information obtained from any Contract Compliance Request or any Contract Non-Compliance Notice (See Terms & Conditions, Section H) may be used in evaluating responses to solicitations for goods and services to determine the best value for the State.

Neb. Rev. Stat. § 73-107 allows for a preference for a resident disabled veteran or business located in a designated enterprise zone. When a state contract is to be awarded to the lowest responsible bidder, a resident disabled veteran or a business located in a designated enterprise zone under the Enterprise Zone Act shall be allowed a preference over any other resident or nonresident bidder, if all other factors are equal.

Resident disabled veterans means any person (a) who resides in the State of Nebraska, who served in the United States Armed Forces, including any reserve component or the National Guard, who was discharged or otherwise separated with a characterization of honorable or general (under honorable conditions), and who possesses a disability rating letter issued by the United States Department of Veterans Affairs establishing a service-connected disability or a disability determination from the United States Department of Defense and (b)(i) who owns and controls a business or, in the case of a publicly owned business, more than fifty percent of the stock is owned by one or more persons described in (a) of this paragraph and (ii) the management and daily business operations of the business are controlled by one or more persons described in (a) of this paragraph. Any contract entered into without compliance with this section shall be null and void.

Therefore, if a resident disabled veteran or business located in a designated enterprise zone submits a solicitation response in accordance with Neb. Rev. Stat. § 73-107 and has so indicated on the Contractual Agreement Form under "Vendor must complete the following" requesting priority/preference to be considered in the award of this contract, the following will need to be submitted by the Vendor within ten (10) business days of request:

1. Documentation from the United States Armed Forces confirming service,
2. Documentation of discharge or otherwise separated characterization of honorable or general (under honorable conditions),
3. Disability rating letter issued by the United States Department of Veterans Affairs establishing a service-connected disability or a disability determination from the United States Department of Defense; and
4. Documentation which shows ownership and control of a business or, in the case of a publicly owned business, more than fifty percent of the stock is owned by one or more persons described in subdivision (a) of this subsection; and the management and daily business operations of the business are controlled by one or more persons described in subdivision (a) of this subsection.

Failure to submit the requested documentation within ten (10) business days of notice will disqualify the bidder from consideration of the preference.

Q. BEST AND FINAL OFFER

Each bidder should provide its best offer with their original solicitation response and should not expect the State to request a best and final offer (BAFO).

The State reserves the right to conduct more than one BAFO.. If requested by the State, the BAFO must be submitted on the BAFO Cost Sheet and in accordance with the State's instructions. Failure to submit a requested BAFO or failure to submit a BAFO in accordance with the State's instructions may result in rejection of the bidder's entire solicitation response. BAFOs may be scored and ranked by the Evaluation Committee.

R. REFERENCE AND CREDIT CHECKS

The State reserves the right to conduct and consider reference and credit checks. The State reserves the right to use third parties to conduct reference and credit checks. By submitting a solicitation response, the bidder grants to the State the right to contact or arrange a visit in person with any or all of the bidder's clients. Reference and credit checks may be grounds to reject a solicitation response, withdraw an intent to award, or rescind the award of a contract.

S. AWARD

The State reserves the right to evaluate solicitation responses and award contracts in a manner utilizing criteria selected at the State's discretion and in the State's best interest. After evaluation of the solicitation responses, or at any point in the Solicitation process, the State of Nebraska may take one or more of the following actions:

1. Amend the solicitation;
2. Extend the date and time of a solicitation;
3. Waive deviations or errors in the State's solicitation process and in bidder responses that are not material, do not compromise the solicitation process or a bidder's response, and do not improve a Vendor's competitive position;
4. Accept or reject a portion of or all of a solicitation response;
5. Accept or reject all responses;
6. Withdraw the solicitation;
7. Elect to re-release the solicitation;
8. Award single lines or multiple lines to one or more Vendors; or,
9. Award one or more all-inclusive contracts.

The State of Nebraska may consider, but is not limited to considering, one or more of the following award criteria:

1. Price,
2. Location,
3. Quality,
4. Delivery time,
5. Bidder qualifications and capabilities,
6. State contract management requirements and/or costs,
7. Attachment A Bidder Questionnaire.

The solicitation does not commit the State to award a contract. Once intent to award decision has been determined, it will be posted to the Internet at: https://das.nebraska.gov/materiel/bidopps.html

Any protests must be filed by a bidder within ten (10) business days after the intent to award decision is posted to the Internet. Grievance and protest procedure is available on the Internet at: https://das.nebraska.gov/materiel/docs/NE_DAS_Materiel_Purchasing_Agency-SPB_Policy_23_07_Protest_Policy.pdf

T. LUMP SUM OR "ALL OR NONE" SOLICITATION RESPONSES

The State reserves the right to purchase item-by-item, by groups or as a total when the State may benefit by so doing. Bidders may submit a response on an "all or none" or "lump sum" basis but should also submit a response on an item-by-item basis. The term "all or none" means a conditional response which requires the purchase of all items on which responses are offered and bidder declines to accept award on individual items; a "lump sum" response is one in which the bidder offers a lower price than the sum of the individual responses if all items are purchased but agrees to deliver individual items at the prices quoted.

"LUMP SUM" OR "ALL OR NONE" RESPONSES SHOULD BE CLEARLY IDENTIFIED ON THE FIRST PAGE OF THE SOLICITATION AND COST SHEET (IF APPLICABLE)

U. REJECTION OF SOLICITATION RESPONSES

The State reserves the right to reject any or all responses, wholly or in part, in the best interest of the State.

V. PRICES & COST CLARIFICATION

Discount and Price provisions are discussed in Sections III.F and III.G. The State reserves the right to review all aspects of cost for reasonableness and realism as those terms are defined in (Neb. Rev. Stat. § 73-810 (1) (a) and (b) The State may request clarification of any solicitation where the cost component indicates a significant and unsupported deviation from industry standards or in areas where detailed pricing is required. Under Neb. Rev. Stat. § 73-810 (2), the State may reject a bid if the price is not reasonable or realistic.

W. VENDOR DEMONSTRATIONS

The State may determine that oral interviews/presentations and/or demonstrations are required. Every bidder may not be given an opportunity to interview/present and/or give demonstrations; the State reserves the right, in its discretion, to select only the top scoring bidders to present/give oral interviews. The scores from the oral interviews/presentations and/or demonstrations will be added to the scores from the Technical Response and Cost Sheets. The presentation process will allow the bidders to demonstrate their solicitation response offering, explaining and/or clarifying any unusual or significant elements related to their solicitation responses. Bidders' key personnel, identified in their solicitation response, may be requested to participate in a structured interview to determine their understanding of the requirements of this solicitation response, their authority and reporting relationships within their firm, and their management style and philosophy. Only representatives of the State and the presenting bidder will be permitted to attend the oral interviews/presentations and/or demonstrations. A written copy or summary of the presentation, and demonstrative information (such as briefing charts, et cetera) may be offered by the bidder, but the State reserves the right to refuse or not consider the offered materials. Bidders shall not be allowed to alter or amend their solicitation responses.

Once the oral interviews/presentations and/or demonstrations have been completed, the State reserves the right to make an award without any further discussion with the bidders regarding the solicitation responses received.

Any cost incidental to the oral interviews/presentations and/or demonstrations shall be borne entirely by the bidder and will not be compensated by the State.

II. TERMS AND CONDITIONS

Bidder should read the Terms and Conditions within this section and must initial either "Accept All Terms and Conditions Within Section as Written" or "Exceptions Taken to Terms and Conditions Within Section as Written" in the table below. If the bidder takes any exceptions, they must provide the following within the "Exceptions" field of the table below (Bidder may provide responses in separate attachment if multiple exceptions are taken):

1. The specific clause, including section reference, to which an exception has been taken;
2. An explanation of why the bidder took exception to the clause; and
3. Provide alternative language to the specific clause within the solicitation response.

By signing the solicitation, bidder agrees to be legally bound by all the accepted terms and conditions, and any proposed alternative terms and conditions submitted with the solicitation response. The State reserves the right to negotiate rejected or proposed alternative language. If the State and bidder fail to agree on the final Terms and Conditions, the State reserves the right to reject the solicitation response. The State reserves the right to reject solicitation responses that attempt to substitute the bidder's commercial contracts and/or documents for this solicitation.

Accept All Terms and Conditions Within Section as Written (Initial)	**Exceptions Taken to Terms and Conditions Within Section as Written (Initial)**	**Exceptions:** (Bidder must note the specific clause, including section reference, to which an exception has been taken, an explanation of why the bidder took exception to the clause, and provide alternative language to the specific clause within the solicitation response.)
	X	Please refer to the State of NE DOC – Terms and Conditions – Exceptions to Terms PDF document provided with our response.

The bidders should submit with their solicitation response any license, user agreement, service level agreement, or similar documents that the bidder wants incorporated in the Contract. The State will not consider incorporation of any document not submitted with the solicitation response as the document will not have been included in the evaluation process. These documents shall be subject to negotiation and will be incorporated as addendums if agreed to by the Parties.

If a conflict or ambiguity arises after the Addendum to Contract Award has been negotiated and agreed to, the Addendum to Contract Award shall be interpreted as follows:

1. If only one (1) Party has a particular clause, then that clause shall control,
2. If both Parties have a similar clause, but the clauses do not conflict, the clauses shall be read together,
3. If both Parties have a similar clause, but the clauses conflict, the State's clause shall control.

A. GENERAL

1. The contract resulting from this Solicitation shall incorporate the following documents:

   a. Solicitation, including any attachments and addenda;
   b. Questions and Answers;
   c. Bidder's properly submitted solicitation response, including any terms and conditions or agreements submitted by the bidder;
   d. Addendum to Contract Award (if applicable);and
   e. Amendments to the Contract. (if applicable)

   These documents constitute the entirety of the contract.

   Unless otherwise specifically stated in a future contract amendment, in case of any conflict between the incorporated documents, the documents shall govern in the following order of preference with number one (1) receiving preference over all other documents and with each lower numbered document having preference over any higher numbered document: 1) Amendment to the executed Contract with the most recent dated amendment having the highest priority, 2) Executed Contract and any attached Addenda 3) Addendums to the solicitation and any Questions and Answers, 4) the original solicitation document and any Addenda or attachments, and 5) the Vendor's submitted solicitation response, including any terms and conditions or agreements that are accepted by the State.

Unless otherwise specifically agreed to in writing by the State, the State's standard terms and conditions, as executed by the State, shall always control over any terms and conditions or agreements submitted or included by the Vendor.

Any ambiguity or conflict in the contract discovered after its execution, not otherwise addressed herein, shall be resolved in accordance with the rules of contract interpretation as established in the State of Nebraska.

B. NOTIFICATION

Bidder and State shall identify the contract manager who shall serve as the point of contact for the executed contract.

Communications regarding the executed contract shall be in writing and shall be deemed to have been given if delivered personally; electronically, return receipt requested; or mailed, return receipt requested. All notices, requests, or communications shall be deemed effective upon receipt.

Either party may change its address for notification purposes by giving notice of the change and setting forth the new address and an effective date.

C. BUYER'S REPRESENTATIVE

The State reserves the right to appoint a Buyer's Representative to manage or assist the Buyer in managing the contract on behalf of the State. The Buyer's Representative will be appointed in writing, and the appointment document will specify the extent of the Buyer's Representative authority and responsibilities. If a Buyer's Representative is appointed, the bidder will be provided a copy of the appointment document and is expected to cooperate accordingly with the Buyer's Representative. The Buyer's Representative has no authority to bind the State to a contract, amendment, addendum, or other change or addition to the contract.

D. GOVERNING LAW (Nonnegotiable)

Notwithstanding any other provision of this contract, or any amendment or addendum(s) entered into contemporaneously or at a later time, the parties understand and agree that, (1) the State of Nebraska is a sovereign state and its authority to contract is therefore subject to limitation by the State's Constitution, statutes, common law, and regulation; (2) this contract will be interpreted and enforced under the laws of the State of Nebraska; (3) any action to enforce the provisions of this agreement must be brought in the State of Nebraska per state law; (4) the person signing this contract on behalf of the State of Nebraska does not have the authority to waive the State's sovereign immunity, statutes, common law, or regulations; (5) the indemnity, limitation of liability, remedy, and other similar provisions of the final contract, if any, are entered into subject to the State's Constitution, statutes, common law, regulations, and sovereign immunity; and, (6) all terms and conditions of the final contract, including but not limited to the clauses concerning third party use, licenses, warranties, limitations of liability, governing law and venue, usage verification, indemnity, liability, remedy or other similar provisions of the final contract are entered into specifically subject to the State's Constitution, statutes, common law, regulations, and sovereign immunity.

The Parties must comply with all applicable local, state, and federal laws, ordinances, rules, orders, and regulations.

E. BEGINNING OF WORK & SUSPENSION OF SERVICES

The bidder shall not commence any billable work until a valid contract has been fully executed by the State and the successful Vendor. The Vendor will be notified in writing when work may begin.

The State may, at any time and without advance notice, require the Vendor to suspend any or all performance or deliverables provided under this Contract. In the event of such suspension, the Contract Manager or POC, or their designee, will issue a written order to stop work. The written order will specify which activities are to be immediately suspended and the reason(s) for the suspension. Upon receipt of such order, the Vendor shall immediately comply with its terms and take all necessary steps to mitigate and eliminate the incurrence of costs allocable to the work affected by the order during the period of suspension. The suspended performance or deliverables may only resume when the State provides the Vendor with written notice that such performance or deliverables may resume, in whole or in part.

F. AMENDMENT

This Contract may be amended in writing, within scope, upon the agreement of both parties.

G. CHANGE ORDERS OR SUBSTITUTIONS

The State and the Vendor, upon the written agreement, may make changes to the contract within the general scope of the solicitation. Changes may involve specifications, the quantity of work, or such other items as the State may find necessary or desirable. Corrections of any deliverable, service, or work required pursuant to the contract shall not be deemed a change. The Vendor may not claim forfeiture of the contract by reasons of such changes.

The Vendor shall prepare a written description of the work required due to the change and an itemized cost sheet for the change. Changes in work and the amount of compensation to be paid to the Vendor shall be determined in

accordance with applicable unit prices if any, a pro-rated value, or through negotiations. The State shall not incur a price increase for changes that should have been included in the Vendor's solicitation response, were foreseeable, or result from difficulties with or failure of the Vendor's solicitation response or performance.

No change shall be implemented by the Vendor until approved by the State, and the Contract is amended to reflect the change and associated costs, if any. If there is a dispute regarding the cost, but both parties agree that immediate implementation is necessary, the change may be implemented, and cost negotiations may continue with both Parties retaining all remedies under the contract and law.

In the event any good or service is discontinued or replaced upon mutual consent during the contract period or prior to delivery, the State reserves the right to amend the contract to include the alternate product at the same price.

*****Vendor will not substitute any item that has been awarded without prior written approval of NDCS*****

H. RECORD OF VENDOR PERFORMANCE

The State may document the vendor's performance, which may include, but is not limited to, the customer service provided by the vendor, the ability of the vendor, the skill of the vendor, and any instance(s) of products or services delivered or performed which fail to meet the terms of the purchase order, contract, and/or specifications. In addition to other remedies and options available to the State, the State may issue one or more notices to the vendor outlining any issues the State has regarding the vendor's performance for a specific contract ("Contract Compliance Request"). The State may also document the Vendor's performance in a report, which may or may not be provided to the vendor ("Contract Non-Compliance Notice"). The Vendor shall respond to any Contract Compliance Request or Contract Non-Compliance Notice in accordance with such notice or request. At the sole discretion of the State, such Contract Compliance Requests and Contract Non-Compliance Notices may be placed in the State's records regarding the vendor and may be considered by the State and held against the vendor in any future contract or award opportunity. The record of vendor performance will be considered in any suspension or debarment action.

I. NOTICE OF POTENTIAL VENDOR BREACH

If Vendor breaches the contract or anticipates breaching the contract, the Vendor shall immediately give written notice to the State. The notice shall explain the breach or potential breach, a proposed cure, and may include a request for a waiver of the breach if so desired. The State may, in its discretion, temporarily or permanently waive the breach. By granting a waiver, the State does not forfeit any rights or remedies to which the State is entitled by law or equity, or pursuant to the provisions of the contract. Failure to give immediate notice, however, may be grounds for denial of any request for a waiver of a breach.

J. BREACH

Either Party may terminate the contract, in whole or in part, if the other Party breaches its duty to perform its obligations under the contract in a timely and proper manner. Termination requires written notice of default and a thirty (30) calendar day (or longer at the non-breaching Party's discretion considering the gravity and nature of the default) cure period. Said notice shall be delivered by email, delivery receipt requested; certified mail, return receipt requested; or in person with proof of delivery. Allowing time to cure a failure or breach of contract does not waive the right to immediately terminate the contract for the same or different contract breach which may occur at a different time.

The State's failure to make payment shall not be a breach, and the Vendor shall retain all available statutory remedies. (See Indemnity - Self-Insurance and Payment)

K. NON-WAIVER OF BREACH

The acceptance of late performance with or without objection or reservation by a Party shall not waive any rights of the Party nor constitute a waiver of the requirement of timely performance of any obligations remaining to be performed.

L. SEVERABILITY

If any term or condition of the contract is declared by a court of competent jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and conditions shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if the contract did not contain the provision held to be invalid or illegal.

M. INDEMNIFICATION

1. GENERAL

The Vendor agrees to defend, indemnify, and hold harmless the State and its employees, volunteers, agents, and its elected and appointed officials ("the indemnified parties") from and against any and all third party claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses of every nature, including investigation costs and expenses, settlement costs, and attorney fees and expenses ("the claims"), sustained or asserted against the State for personal injury, death, or property loss

or damage, arising out of, resulting from, or attributable to the willful misconduct, negligence, error, or omission of the Vendor, its employees, Subcontractors, consultants, representatives, and agents, resulting from this contract, except to the extent such Vendor liability is attenuated by any action of the State which directly and proximately contributed to the claims.

2. INTELLECTUAL PROPERTY

The Vendor agrees it will, at its sole cost and expense, defend, indemnify, and hold harmless the indemnified parties from and against any and all claims, to the extent such claims arise out of, result from, or are attributable to, the actual or alleged infringement or misappropriation of any patent, copyright, trade secret, trademark, or confidential information of any third party by the Vendor or its employees, Subcontractors, consultants, representatives, and agents; provided, however, the State gives the Vendor prompt notice in writing of the claim. The Vendor may not settle any infringement claim that will affect the State's use of the Licensed Software without the State's prior written consent, which consent may be withheld for any reason.

If a judgment or settlement is obtained or reasonably anticipated against the State's use of any intellectual property for which the Vendor has indemnified the State, the Vendor shall, at the Vendor's sole cost and expense, promptly modify the item or items which were determined to be infringing, acquire a license or licenses on the State's behalf to provide the necessary rights to the State to eliminate the infringement, or provide the State with a non-infringing substitute that provides the State the same functionality. At the State's election, the actual or anticipated judgment may be treated as a breach of warranty by the Vendor, and the State may receive the remedies provided under this Solicitation.

3. PERSONNEL

The Vendor shall, at its expense, indemnify and hold harmless the indemnified parties from and against any claim with respect to withholding taxes, worker's compensation, employee benefits, or any other claim, demand, liability, damage, or loss of any nature relating to any of the personnel, including subcontractor's and their employees, provided by the Vendor.

4. SELF-INSURANCE

The State of Nebraska is self-insured for any loss and purchases excess insurance coverage pursuant to Neb. Rev. Stat. § 81-8,239.01. If there is a presumed loss under the provisions of this agreement, Vendor may file a claim with the Office of Risk Management pursuant to Neb. Rev. Stat. §§ 81-8,239.01 to 81-8,306 for review by the State Claims Board. The State retains all rights and immunities under the State Miscellaneous (Neb. Rev. Stat. § 81-8,294), Tort (Neb. Rev. Stat. § 81-8,209), and Contract Claim Acts (Neb. Rev. Stat. § 81-8,302), as outlined in state law and accepts liability under this agreement only to the extent provided by law.

5. The Parties acknowledge that Attorney General for the State of Nebraska is required by statute to represent the legal interests of the State, and that any provision of this indemnity clause is subject to the statutory authority of the Attorney General.

N. PERFORMANCE BOND

The Awarded Bidder may be required to supply a bond executed by a corporation authorized to contract surety in the State of Nebraska, payable to the State of Nebraska, which shall be valid for the life of the contract to include any renewal and/or extension periods. The amount of the bond must be an established dollar amount $500,000. The bond, if required, will guarantee that the Awarded Bidder will faithfully perform all requirements, terms and conditions of the contract. Failure to comply shall be grounds for forfeiture of the bond as liquidated damages. Amount of forfeiture will be determined by the agency based on loss to the State. The bond will be returned when the contract has been satisfactorily completed as solely determined by the State, after termination or expiration of the contract.

O. ASSIGNMENT, SALE, OR MERGER

Either Party may assign the contract upon mutual written agreement of the other Party. Such agreement shall not be unreasonably withheld.

The Vendor retains the right to enter into a sale, merger, acquisition, internal reorganization, or similar transaction involving Vendor's business. Vendor agrees to cooperate with the State in executing amendments to the contract to allow for the transaction. If a third party or entity is involved in the transaction, the Vendor will remain responsible for performance of the contract until such time as the person or entity involved in the transaction agrees in writing to be contractually bound by this contract and perform all obligations of the contract.

P. CONTRACTING WITH OTHER NEBRASKA POLITICAL SUBDIVISIONS OF THE STATE OR ANOTHER STATE

The Vendor may, but shall not be required to, allow agencies, as defined in Neb. Rev. Stat. § 81-145(2), to use this contract. The terms and conditions, including price, of the contract may not be amended. The State shall not be

contractually obligated or liable for any contract entered into pursuant to this clause. A listing of Nebraska political subdivisions may be found at the website of the Nebraska Auditor of Public Accounts.

The Vendor may, but shall not be required to, allow other states, agencies or divisions of other states, or political subdivisions of other states to use this contract. The terms and conditions, including price, of this contract shall apply to any such contract, but may be amended upon mutual consent of the Parties. The State of Nebraska shall not be contractually or otherwise obligated or liable under any contract entered into pursuant to this clause. The State shall be notified if a contract is executed based upon this contract.

Q. FORCE MAJEURE

Neither Party shall be liable for any costs or damages, or for default resulting from its inability to perform any of its obligations under the contract due to a natural or manmade event outside the control and not the fault of the affected Party ("Force Majeure Event") that was not foreseeable at the time the Contract was executed. The Party so affected shall immediately make a written request for relief to the other Party and shall have the burden of proof to justify the request. The other Party may grant the relief requested; relief may not be unreasonably withheld. Labor disputes with the impacted Party's own employees will not be considered a Force Majeure Event.

R. CONFIDENTIALITY

All materials and information provided by the Parties or acquired by a Party on behalf of the other Party shall be regarded as confidential information. All materials and information provided or acquired shall be handled in accordance with federal and state law, and ethical standards. Should said confidentiality be breached by a Party, the Party shall notify the other Party immediately of said breach and take immediate corrective action.

It is incumbent upon the Parties to inform their officers and employees of the penalties for improper disclosure imposed by the Privacy Act of 1974, 5 U.S.C. 552a. Specifically, 5 U.S.C. 552a (i)(1), which is made applicable by 5 U.S.C. 552a (m)(1), provides that any officer or employee, who by virtue of his/her employment or official position has possession of or access to agency records which contain individually identifiable information, the disclosure of which is prohibited by the Privacy Act or regulations established thereunder, and who knowing that disclosure of the specific material is prohibited, willfully discloses the material in any manner to any person or agency not entitled to receive it, shall be guilty of a misdemeanor and fined not more than $5,000.

S. EARLY TERMINATION

The contract may be terminated as follows:

1. The State and the Vendor, by mutual written agreement, may terminate the contract, in whole or in part, at any time.

2. The State, in its sole discretion, may terminate the contract, in whole or in part, for any reason upon thirty (30) calendar day's written notice to the Vendor. Such termination shall not relieve the Vendor of warranty or other service obligations incurred under the terms of the contract. In the event of termination, the Vendor shall be entitled to payment, determined on a pro rata basis, for products or services satisfactorily performed or provided.

3. The State may terminate the contract, in whole or in part, immediately for the following reasons:

- **a.** if directed to do so by statute,
- **b.** Vendor has made an assignment for the benefit of creditors, has admitted in writing its inability to pay debts as they mature, or has ceased operating in the normal course of business,
- **c.** a trustee or receiver of the Vendor or of any substantial part of the Vendor's assets has been appointed by a court,
- **d.** fraud, misappropriation, embezzlement, malfeasance, misfeasance, or illegal conduct pertaining to performance under the contract by its Vendor, its employees, officers, directors, or shareholders,
- **e.** an involuntary proceeding has been commenced by any Party against the Vendor under any one of the chapters of Title 11 of the United States Code and (i) the proceeding has been pending for at least sixty (60) calendar days; or (ii) the Vendor has consented, either expressly or by operation of law, to the entry of an order for relief; or (iii) the Vendor has been decreed or adjudged a debtor,
- **f.** a voluntary petition has been filed by the Vendor under any of the chapters of Title 11 of the United States Code,
- **g.** Vendor intentionally discloses confidential information,
- **h.** Vendor has or announces it will discontinue support of the deliverable; and,
- **i.** In the event funding is no longer available.

T. CONTRACT CLOSEOUT

Upon termination of the contract for any reason the Vendor shall within thirty (30) days, unless stated otherwise herein:

1. Transfer all completed or partially completed deliverables to the State,
2. Transfer ownership and title to all completed or partially completed deliverables to the State,
3. Return to the State all information and data unless the Vendor is permitted to keep the information or data by contract or rule of law. Vendor may retain one copy of any information or data as required to comply with applicable work product documentation standards or as are automatically retained in the course of Vendor's routine back up procedures,
4. Cooperate with any successor Contactor, person, or entity in the assumption of any or all of the obligations of this contract,
5. Cooperate with any successor Contactor, person, or entity with the transfer of information or data related to this contract,
6. Return or vacate any state owned real or personal property; and,
7. Return all data in a mutually acceptable format and manner.

Nothing in this section should be construed to require the Vendor to surrender intellectual property, real or personal property, or information or data owned by the Vendor for which the State has no legal claim.

III. VENDOR DUTIES

Bidder should read the Vendor Duties within this section and must initial either "Accept All Terms and Conditions Within Section as Written" or "Exceptions Taken to Vendor Duties Within Section as Written" in the table below. If the bidder takes any exceptions, they must provide the following within the "Exceptions" field of the table below (Bidder may provide responses in separate attachment if multiple exceptions are taken):

1. The specific clause, including section reference, to which an exception has been taken;
2. An explanation of why the bidder took exception to the clause; and
3. Provide alternative language to the specific clause within the solicitation response.

By signing the solicitation, bidder agrees to be legally bound by all the accepted terms and conditions, and any proposed alternative terms and conditions submitted with the solicitation response. The State reserves the right to negotiate rejected or proposed alternative language. If the State and bidder fail to agree on the final Terms and Conditions, the State reserves the right to reject the solicitation response. The State reserves the right to reject solicitation responses that attempt to substitute the bidder's commercial contracts and/or documents for this solicitation.

Accept All Vendor Duties Within Section as Written (Initial)	**Exceptions Taken to Vendor Duties Within Section as Written (Initial)**	**Exceptions:** (Bidder must note the specific clause, including section reference, to which an exception has been taken, an explanation of why the bidder took exception to the clause, and provide alternative language to the specific clause within the solicitation response.)
	X	Please refer to the State of NE DOC – Terms and Conditions – Exceptions to Terms PDF document provided with our response.

A. INDEPENDENT VENDOR / OBLIGATIONS

It is agreed that the Vendor is an independent Vendor and that nothing contained herein is intended or should be construed as creating or establishing a relationship of employment, agency, or a partnership.

The Vendor is solely responsible for fulfilling the contract. The Vendor or the Vendor's representative shall be the sole point of contact regarding all contractual matters.

The Vendor shall secure, at its own expense, all personnel required to perform the services under the contract. The personnel the Vendor uses to fulfill the contract shall have no contractual or other legal relationship with the State; they shall not be considered employees of the State and shall not be entitled to any compensation, rights or benefits from the State, including but not limited to, tenure rights, medical and hospital care, sick and vacation leave, severance pay, or retirement benefits.

By-name personnel commitments made in the bidder's solicitation response shall not be changed without the prior written approval of the State. Replacement of these personnel, if approved by the State, shall be with personnel of equal or greater ability and qualifications.

All personnel assigned by the Vendor to the contract shall be employees of the Vendor or a subcontractor and shall be fully qualified to perform the work required herein. Personnel employed by the Vendor or a subcontractor to fulfill the terms of the contract shall remain under the sole direction and control of the Vendor or the subcontractor respectively.

With respect to its employees, the Vendor agrees to be solely responsible for the following:

1. Any and all pay, benefits, and employment taxes and/or other payroll withholding,
2. Any and all vehicles used by the Vendor's employees, including all insurance required by state law,
3. Damages incurred by Vendor's employees within the scope of their duties under the contract,
4. Maintaining Workers' Compensation and health insurance that complies with state and federal law and submitting any reports on such insurance to the extent required by governing law,
5. Determining the hours to be worked and the duties to be performed by the Vendor's employees; and,
6. All claims on behalf of any person arising out of employment or alleged employment (including without limit claims of discrimination alleged against the Vendor, its officers, agents, or subcontractors or subcontractor's employees).

If the Vendor intends to utilize any subcontractor, the subcontractor's level of effort, tasks, and time allocation should be clearly defined in the solicitation response. The Vendor shall agree that it will not utilize any subcontractors not specifically included in its solicitation response in the performance of the contract without the prior written authorization of the State. If the Vendor subcontracts any of the work, the Vendor agrees to pay any and all subcontractors in accordance with the Vendor's agreement with the respective subcontractor(s).

The State reserves the right to require the Vendor to reassign or remove from the project any Vendor or subcontractor employee.

Vendor shall insure that the terms and conditions contained in any contract with a subcontractor does not conflict with the terms and conditions of this contract.

The Vendor shall include a similar provision, for the protection of the State, in the contract with any Subcontractor engaged to perform work on this contract.

B. EMPLOYEE WORK ELIGIBILITY STATUS

The Vendor is required and hereby agrees to use a federal immigration verification system to determine the work eligibility status of employees physically performing services within the State of Nebraska. A federal immigration verification system means the electronic verification of the work authorization program authorized by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, 8 U.S.C. 1324a, known as the E-Verify Program, or an equivalent federal program designated by the United States Department of Homeland Security or other federal agency authorized to verify the work eligibility status of an employee.

If the Vendor is an individual or sole proprietorship, the following applies:

1. The Vendor must complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at https://das.nebraska.gov/materiel/docs/pdf/Individual%20or%20Sole%20Proprietor%20United%20States%20Attestation%20Form%20English%20and%20Spanish.pdf
2. The completed United States Attestation Form should be submitted with the Solicitation response.
3. If the Vendor indicates on such attestation form that he or she is a qualified alien, the Vendor agrees to provide the US Citizenship and Immigration Services documentation required to verify the Vendor's lawful presence in the United States using the Systematic Alien Verification for Entitlements (SAVE) Program.
4. The Vendor understands and agrees that lawful presence in the United States is required, and the Vendor may be disqualified or the contract terminated if such lawful presence cannot be verified as required by Neb. Rev. Stat. § 4-108.

C. COMPLIANCE WITH CIVIL RIGHTS LAWS AND EQUAL OPPORTUNITY EMPLOYMENT / NONDISCRIMINATION (Nonnegotiable)

The Vendor shall comply with all applicable local, state, and federal statutes and regulations regarding civil rights laws and equal opportunity employment. The Nebraska Fair Employment Practice Act prohibits Vendors of the State of Nebraska, and their Subcontractors, from discriminating against any employee or applicant for employment, with respect to hire, tenure, terms, conditions, compensation, or privileges of employment because of race, color, religion, sex, disability, marital status, or national origin (Neb. Rev. Stat. §§ 48-1101 to 48-1125). The Vendor guarantees compliance with the Nebraska Fair Employment Practice Act, and breach of this provision shall be regarded as a

material breach of contract. The Vendor shall insert a similar provision in all Subcontracts for goods and services to be covered by any contract resulting from this Solicitation.

D. COOPERATION WITH OTHER VENDORS

Vendor may be required to work with or in close proximity to other Vendors or individuals that may be working on same or different projects. The Vendor shall agree to cooperate with such other Vendors or individuals and shall not commit or permit any act which may interfere with the performance of work by any other Vendor or individual. Vendor is not required to compromise Vendor's intellectual property or proprietary information unless expressly required to do so by this contract.

E. DISCOUNTS

Prices quoted shall be inclusive of ALL trade discounts. Cash discount terms of less than thirty (30) days will not be considered as part of the solicitation response. Cash discount periods will be computed from the date of receipt of a properly executed claim voucher or the date of completion of delivery of all items in a satisfactory condition, whichever is later.

F. PRICES

Prices quoted shall be net, including transportation and delivery charges fully prepaid by the bidder, F.O.B. destination named in the Solicitation. No additional charges will be allowed for packing, packages, or partial delivery costs. When an arithmetic error has been made in the extended total, the unit price will govern.

Prices submitted on the cost sheet, once accepted by the State, shall remain fixed for the first four (4) years of the contract. Any request for a price increase subsequent to the initial term of the contract shall not exceed five percent (5%) of the price proposed for the period. Increases shall not be cumulative and will only apply to that period of the contract. The request for a price increase must be submitted in writing to the Department of Correctional Services a minimum of 120 days prior to the end of the current contract period. Documentation may be required by the State to support the price increase.

The State reserves the right to deny any requested price increase. No price increases are to be billed to any State Agencies prior to written amendment of the contract by the parties.

The State will be given full proportionate benefit of any decreases for the term of the contract.

G. PERMITS, REGULATIONS, LAWS

The contract price shall include the cost of all royalties, licenses, permits, and approvals, whether arising from patents, trademarks, copyrights or otherwise, that are in any way involved in the contract. The Vendor shall obtain and pay for all royalties, licenses, and permits, and approvals necessary for the execution of the contract. The Vendor must guarantee that it has the full legal right to the materials, supplies, equipment, software, and other items used to execute this contract.

H. OWNERSHIP OF INFORMATION AND DATA / DELIVERABLES

The State shall have the unlimited right to publish, duplicate, use, and disclose all information and data developed or obtained by the Vendor on behalf of the State pursuant to this contract.

The State shall own and hold exclusive title to any deliverable developed as a result of this contract. Vendor shall have no ownership interest or title, and shall not patent, license, or copyright, duplicate, transfer, sell, or exchange, the design, specifications, concept, or deliverable.

I. INSURANCE REQUIREMENTS

The Vendor shall throughout the term of the contract maintain insurance as specified herein and provide the State a current Certificate of Insurance/Acord Form (COI) verifying the coverage. The Vendor shall not commence work on the contract until the insurance is in place. If Vendor subcontracts any portion of the Contract the Vendor must, throughout the term of the contract, either:

1. Provide equivalent insurance for each subcontractor and provide a COI verifying the coverage for the subcontractor,
2. Require each subcontractor to have equivalent insurance and provide written notice to the State that the Vendor has verified that each subcontractor has the required coverage; or,
3. Provide the State with copies of each subcontractor's Certificate of Insurance evidencing the required coverage.

The Vendor shall not allow any Subcontractor to commence work until the Subcontractor has equivalent insurance. The failure of the State to require a COI, or the failure of the Vendor to provide a COI or require subcontractor insurance shall not limit, relieve, or decrease the liability of the Vendor hereunder.

In the event that any policy written on a claims-made basis terminates or is canceled during the term of the contract or within one (1) years of termination or expiration of the contract, the Vendor shall obtain an extended discovery or reporting period, or a new insurance policy, providing coverage required by this contract for the term of the contract and one (1) years following termination or expiration of the contract.

If by the terms of any insurance a mandatory deductible is required, or if the Vendor elects to increase the mandatory deductible amount, the Vendor shall be responsible for payment of the amount of the deductible in the event of a paid claim.

Notwithstanding any other clause in this Contract, the State may recover up to the liability limits of the insurance policies required herein.

1. WORKERS' COMPENSATION INSURANCE

The Vendor shall take out and maintain during the life of this contract the statutory Workers' Compensation and Employer's Liability Insurance for all of the contactors' employees to be engaged in work on the project under this contract and, in case any such work is sublet, the Vendor shall require the Subcontractor similarly to provide Worker's Compensation and Employer's Liability Insurance for all of the Subcontractor's employees to be engaged in such work. This policy shall be written to meet the statutory requirements for the state in which the work is to be performed, including Occupational Disease. **The policy shall include a waiver of subrogation in favor of the State. The COI shall contain the mandatory COI subrogation waiver language found hereinafter**. The amounts of such insurance shall not be less than the limits stated hereinafter. For employees working in the State of Nebraska, the policy must be written by an entity authorized by the State of Nebraska Department of Insurance to write Workers' Compensation and Employer's Liability Insurance for Nebraska employees.

2. COMMERCIAL GENERAL LIABILITY INSURANCE AND COMMERCIAL AUTOMOBILE LIABILITY INSURANCE

The Vendor shall take out and maintain during the life of this contract such Commercial General Liability Insurance and Commercial Automobile Liability Insurance as shall protect Vendor and any Subcontractor performing work covered by this contract from claims for damages for bodily injury, including death, as well as from claims for property damage, which may arise from operations under this contract, whether such operation be by the Vendor or by any Subcontractor or by anyone directly or indirectly employed by either of them, and the amounts of such insurance shall not be less than limits stated hereinafter.

The Commercial General Liability Insurance shall be written on an **occurrence basis**, and provide Premises/Operations, Products/Completed Operations, Independent Vendors, Personal Injury, and Contractual Liability coverage. **The policy shall include the State, and others as required by the contract documents, as Additional Insured(s). This policy shall be primary, and any insurance or self-insurance carried by the State shall be considered secondary and non-contributory**. **The COI shall contain the mandatory COI liability waiver language found hereinafter.** The Commercial Automobile Liability Insurance shall be written to cover all Owned, Non-owned, and Hired vehicles.

REQUIRED INSURANCE COVERAGE	
COMMERCIAL GENERAL LIABILITY	
General Aggregate	$2,000,000
Products/Completed Operations Aggregate	$2,000,000
Personal/Advertising Injury	$1,000,000 per occurrence
Medical Payments	$10,000 any one person
Contractual	Included
Independent Vendors	Included
Abuse & Molestation	Included
If higher limits are required, the Umbrella/Excess Liability limits are allowed to satisfy the higher limit.	
WORKER'S COMPENSATION	
Employers Liability Limits	$500K/$500K/$500K
Statutory Limits- All States	Statutory - State of Nebraska
Voluntary Compensation	Statutory
UMBRELLA/EXCESS LIABILITY	
Over Primary Insurance	$5,000,000 per occurrence
PROFESSIONAL LIABILITY	
All Other Professional Liability (Errors & Omissions)	$1,000,000 Per Claim / Aggregate
COMMERCIAL CRIME	
Crime/Employee Dishonesty Including 3rd Party Fidelity	$1,000,000
CYBER LIABILITY	
Breach of Privacy, Security Breach, Denial of Service, Remediation, Fines and Penalties	$5,000,000
MANDATORY COI SUBROGATION WAIVER LANGUAGE	
"Workers' Compensation policy shall include a waiver of subrogation in favor of the State of Nebraska."	
MANDATORY COI LIABILITY WAIVER LANGUAGE	
"Commercial General Liability & Commercial Automobile Liability policies shall name the State of Nebraska as an Additional Insured and the policies shall be primary and any insurance or self-insurance carried by the State shall be considered secondary and non-contributory as additionally insured."	

3. EVIDENCE OF COVERAGE

The Vendor shall furnish the Contract Manager, via email, with a certificate of insurance coverage complying with the above requirements prior to beginning work at:

RFP 120174 O3
Nebraska Department of Correctional Services
Attn: Julie Schiltz
dcs.purchasing@nebraska.gov

These certificates or the cover sheet shall reference the solicitation number, and the certificates shall include the name of the company, policy numbers, effective dates, dates of expiration, and amounts and types of coverage afforded. If the State is damaged by the failure of the Vendor to maintain such insurance, then the Vendor shall be responsible for all reasonable costs properly attributable thereto.

Reasonable notice of cancellation of any required insurance policy must be submitted to the contract manager as listed above when issued and a new coverage binder shall be submitted immediately to ensure no break in coverage.

4. DEVIATIONS

The insurance requirements are subject to limited negotiation. Negotiation typically includes, but is not necessarily limited to, the correct type of coverage, necessity for Workers' Compensation, and the type of automobile coverage carried by the Vendor.

J. ANTITRUST

The Vendor hereby assigns to the State any and all claims for overcharges as to goods and/or services provided in connection with this contract resulting from antitrust violations which arise under antitrust laws of the United States and the antitrust laws of the State.

K. CONFLICT OF INTEREST

By submitting a solicitation response, vendor certifies that no relationship exists between the vendor and any person or entity which either is, or gives the appearance of, a conflict of interest related to this solicitation or project.

Vendor further certifies that vendor will not employ any individual known by vendor to have a conflict of interest nor shall vendor take any action or acquire any interest, either directly or indirectly, which will conflict in any manner or degree with the performance of its contractual obligations hereunder or which creates an actual or appearance of conflict of interest.

If there is an actual or perceived conflict of interest, vendor shall provide with its solicitation response a full disclosure of the facts describing such actual or perceived conflict of interest and a proposed mitigation plan for consideration. The State will then consider such disclosure and proposed mitigation plan and either approve or reject as part of the overall solicitation response evaluation.

L. SITE RULES AND REGULATIONS

The Vendor shall use its best efforts to ensure that its employees, agents, and Subcontractors comply with site rules and regulations while on State premises. If the Vendor must perform on-site work outside of the daily operational hours set forth by the State, it must make arrangements with the State to ensure access to the facility and the equipment has been arranged. No additional payment will be made by the State on the basis of lack of access, unless the State fails to provide access as agreed to in writing between the State and the Vendor.

M. NDCS SECURITY

1. Contractor's personnel shall be subject to NDCS background security checks prior to their arrival on site and will carry proper identification with them at all times while on facility grounds.

2. Contractor shall make its employees aware of the provisions of Neb. Rev. Stat. § 28-322.01, which state that a person commits the offense of sexual abuse of an inmate or parolee if such person subjects an inmate or parolee to sexual penetration or sexual contact, because an inmate or parolee is not legally capable of giving consent to any such relationship. Neb. Rev. Stat. § 28-322 states that individuals "working under contract with the department" are included in the list of persons prohibited from having sexual relations with one or more of NDCS' inmates. CONTRACTOR will promptly notify NDCS if allegations of sexual abuse or contact become known.

3. Contractor shall make his/her employees aware of the Nebraska Department of Correctional Services, Policy 112.31 (Code of Ethics and Conduct). CONTRACTOR may be required to sign and return documentation showing receipt of NDCS Policy 112.31 (Code of Ethics and Conduct).

4. Contractor shall inform his/her personnel of the Nebraska Department of Correctional Services Tobacco Policy, which states that tobacco and tobacco-related products are contraband and must not be carried into any NDCS-owned or controlled property. Such products must remain in CONTRACTOR'S locked vehicle while on NDCS-owned or controlled property.

5. Contractor and his/her personnel may be subject to pat searches and tool inventory upon arrival and departure from NDCS facilities.

Wireless devices and/or cellular phones are prohibited at NDCS facilities unless prior approval is given. Wireless devices include type smart watches or other electronic devices with internet connection. If wireless devices are necessary for use on site at NDCS, CONTRACTOR will seek prior approval to carry such devices by requesting the Cellular Device Institutional Use Report form. All persons are prohibited from providing a cellphone/electronic communication device to an inmate of any facility, per Policy104.05. Electronic Communication Devices.

N. ADVERTISING

The Vendor agrees not to refer to the contract award in advertising in such a manner as to state or imply that the company or its goods or services are endorsed or preferred by the State. Any publicity releases pertaining to the project shall not be issued without prior written approval from the State.

O. NEBRASKA TECHNOLOGY ACCESS STANDARDS (Nonnegotiable)

1. The State of Nebraska is committed to ensuring that all information and communication technology (ICT), developed, leased, or owned by the State of Nebraska, affords equivalent access to employees, program participants and members of the public with disabilities, as it affords to employees, program participants and members of the public who are not persons with disabilities.

2. By entering into this Contract, Vendor understands and agrees that if the Vendor is providing a product or service that contains ICT, as defined in subsection 3 (below) and such ICT is intended to be directly interacted with by the user or is public facing, such ICT must provide equivalent access, or be modified during implementation to afford equivalent access, to employees, program participants, and members of the public who have and who do not have disabilities. The Vendor may comply with this section by complying

with Section 508 of the Rehabilitation Act of 1973, as amended, and its implementing standards adopted and promulgated by the U.S. Access Board.

3. ICT means information technology and other equipment, systems, technologies, or processes, for which the principal function is the creation, manipulation, storage, display, receipt, or transmission of electronic data and information, as well as any associated content. Vendor hereby agrees ICT includes computers and peripheral equipment, information kiosks and transaction machines, telecommunications equipment, customer premises equipment, multifunction office machines, software, applications, web sites, videos, and electronic documents. For the purposes of these assurances, ICT does not include ICT that is used exclusively by a Vendor.

P. DISASTER RECOVERY/BACK UP PLAN

The Vendor shall have a disaster recovery and back-up plan, of which a copy should be provided upon request to the State, which includes, but is not limited to equipment, personnel, facilities, and transportation, in order to continue delivery of goods and services as specified under the specifications in the contract in the event of a disaster.

Q. DRUG POLICY

Vendor certifies it maintains a drug free workplace environment to ensure worker safety and workplace integrity. Vendor agrees to provide a copy of its drug free workplace policy at any time upon request by the State.

R. WARRANTY

Despite any clause to the contrary, the Vendor represents and warrants that its services hereunder shall be performed by competent personnel and shall be of professional quality consistent with generally accepted industry standards for the performance of such services and shall comply in all respects with the requirements of this Agreement. For any breach of this warranty, the Vendor shall, for a period of ninety (90) days from performance of the service, perform the services again, at no cost to the State, or if Vendor is unable to perform the services as warranted, Vendor shall reimburse the State all fees paid to Vendor for the unsatisfactory services. The rights and remedies of the parties under this warranty are in addition to any other rights and remedies of the parties provided by law or equity, including, without limitation actual damages, and, as applicable and awarded under the law, to a prevailing party, reasonable attorneys' fees and costs.

S. TIME IS OF THE ESSENCE

Time is of the essence with respect to Vendor's performance and deliverables pursuant to this Contract.

IV. PAYMENT

Bidder should read the Payment clauses within this section and must initial either "Accept All Terms and Conditions Within Section as Written" or "Exceptions Taken to Payment clauses Within Section as Written" in the table below. If the bidder takes any exceptions, they must provide the following within the "Exceptions" field of the table below (Bidder may provide responses in separate attachment if multiple exceptions are taken):

1. The specific clause, including section reference, to which an exception has been taken;
2. An explanation of why the bidder took exception to the clause; and
3. Provide alternative language to the specific clause within the solicitation response.

By signing the solicitation, bidder agrees to be legally bound by all the accepted terms and conditions, and any proposed alternative terms and conditions submitted with the solicitation response. The State reserves the right to negotiate rejected or proposed alternative language. If the State and bidder fail to agree on the final Terms and Conditions, the State reserves the right to reject the solicitation response. The State reserves the right to reject solicitation responses that attempt to substitute the bidder's commercial contracts and/or documents for this solicitation.

Accept All Payment Clauses Within Section as Written (Initial)	Exceptions Taken to Payment Clauses Within Section as Written (Initial)	**Exceptions:** (Bidder must note the specific clause, including section reference, to which an exception has been taken, an explanation of why the bidder took exception to the clause, and provide alternative language to the specific clause within the solicitation response.)
	X	Please refer to the State of NE DOC – Terms and Conditions – Exceptions to Terms PDF document provided with our response.

A. PROHIBITION AGAINST ADVANCE PAYMENT (Nonnegotiable)

Pursuant to Neb. Rev. Stat. § 81-2403, "[n]o goods or services shall be deemed to be received by an agency until all such goods or services are completely delivered and finally accepted by the agency."

B. TAXES (Nonnegotiable)

The State is not required to pay taxes and assumes no such liability as a result of this Solicitation. The Vendor may request a copy of the Nebraska Department of Revenue, Nebraska Resale or Exempt Sale Certificate for Sales Tax Exemption, Form 13 for their records. Any property tax payable on the Vendor's equipment which may be installed in a state-owned facility is the responsibility of the Vendor.

C. INVOICES

Invoices for payments must be submitted by the Vendor to the agency requesting the services with sufficient detail to support payment.

Invoices shall include detailed itemized billing per patient including ALL diagnosis code(s) and each procedure code(s) (ICD10, CPT, modifiers, units, and NDCS number(s)).

The terms and conditions included in the Vendor's invoice shall be deemed to be solely for the convenience of the parties. No terms or conditions of any such invoice shall be binding upon the State, and no action by the State, including without limitation the payment of any such invoice in whole or in part, shall be construed as binding or estopping the State with respect to any such term or condition, unless the invoice term or condition has been previously agreed to by the State as an amendment to the contract. **The State shall have forty-five (45) calendar days to pay after a valid and accurate invoice is received by the State.**

D. INSPECTION AND APPROVAL

Final inspection and approval of all work required under the contract shall be performed by the designated State officials.

The State and/or its authorized representatives shall have the right to enter any premises where the Vendor or Subcontractor duties under the contract are being performed, and to inspect, monitor or otherwise evaluate the work being performed. All inspections and evaluations shall be at reasonable times and in a manner that will not unreasonably delay work.

E. PAYMENT (Nonnegotiable)

Payment will be made by the responsible agency in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. § 81-2403). The State may require the Vendor to accept payment by electronic means such as ACH deposit. In no event shall the State be responsible or liable to pay for any goods and services provided by the Vendor prior to the Effective Date of the contract, and the Vendor hereby waives any claim or cause of action for any such goods or services.

F. LATE PAYMENT (Nonnegotiable)

The Vendor may charge the responsible agency interest for late payment in compliance with the State of Nebraska Prompt Payment Act (See Neb. Rev. Stat. §§ 81-2401 through 81-2408).

G. SUBJECT TO FUNDING/FUNDING OUT CLAUSE FOR LOSS OF APPROPRIATIONS (Nonnegotiable)

The State's obligation to pay amounts due on the Contract for fiscal years following the current fiscal year is contingent upon legislative appropriation of funds. Should said funds not be appropriated, the State may terminate the contract with respect to those payments for the fiscal year(s) for which such funds are not appropriated. The State will give the Vendor written notice thirty (30) calendar days prior to the effective date of termination. All obligations of the State to make payments after the termination date will cease. The Vendor shall be entitled to receive just and equitable compensation for any authorized work which has been satisfactorily completed as of the termination date. In no event shall the Vendor be paid for a loss of anticipated profit.

H. RIGHT TO AUDIT (First Paragraph is Nonnegotiable)

The State shall have the right to audit the Vendor's performance of this contract upon a thirty (30) days' written notice. Vendor shall utilize generally accepted accounting principles, and shall maintain the accounting records, and other records and information relevant to the contract (Information) to enable the State to audit the contract. (Neb. Rev. Stat. § 84-304 et seq.) The State may audit, and the Vendor shall maintain, the Information during the term of the contract and for a period of five (5) years after the completion of this contract or until all issues or litigation are resolved, whichever is later. The Vendor shall make the Information available to the State at Vendor's place of business or a location acceptable to both Parties during normal business hours. If this is not practical or the Vendor so elects, the Vendor may provide electronic or paper copies of the Information. The State reserves the right to examine, make copies of, and take notes on any Information relevant to this contract, regardless of the form or the Information, how it is stored, or who possesses the Information. Under no circumstance will the Vendor be required to create or maintain documents not kept in the ordinary course of Vendor's business operations, nor will Vendor be required to disclose any information, including but not limited to product cost data, which is confidential or proprietary to Vendor.

The Parties shall pay their own costs of the audit unless the audit finds a previously undisclosed overpayment by the State. If a previously undisclosed overpayment exceeds one half of one percent (0.05%) of the total contract billings, or if fraud, material misrepresentations, or non-performance is discovered on the part of the Vendor, the Vendor shall reimburse the State for the total costs of the audit. Overpayments and audit costs owed to the State shall be paid within ninety (90) days of written notice of the claim. The Vendor agrees to correct any material weaknesses or condition found as a result of the audit.

V. PROJECT DESCRIPTION AND SCOPE OF WORK

The bidder should provide the following information in response to this Solicitation.

A. PROJECT OVERVIEW

This solicitation is solicit a response from a qualified bidder which can provide a solution to process payments for claims/ invoices for an incarcerated individual(s) healthcare services on behalf of NDCS.

In accordance with Nebraska State Statute 83-4,154, NDCS is required to provide a Community Standard Level of Care to all incarcerated individuals. Services provided to the incarcerated individuals are provided both off-site and on-site.

Payment processing services will apply Nebraska Medicare Rates, unless the negotiated Preferred Provider Organization (PPO) rate is lower within the contractor's network of providers and/or a non-network provider under contract NDCS.

Medical expenses for individuals on parole or individuals in the custody of NDCS on behalf of a county jail are not included in this service.

B. SCOPE OF WORK

Minimum scope of work provided by contractor will include the following:

1. Healthcare providers will bill contractor directly for NDCS incarcerated individuals' healthcare provided off-site or on-site of a NDCS facility. NDCS will notify contractor if services are to be billed as an exception to the contract, i.e., Medicaid, NDCS direct billing; such claim exceptions will not be processed and will be rejected by the contractor.
2. Individuals on parole or individuals in the custody of NDCS on behalf of a county jail will not be factored into the average daily population (ADP) and at this time are considered outside the scope of services.
3. Pay networked provider claims in accordance with contractor's internal network provider agreement.
4. NDCS approved dental services.
5. Pregnancy care: This will include prenatal and postnatal care for the mother only not covered by Medicaid.
6. Prosthetics/Orthotics when placed at the time of surgery.
7. Other Specialty Out-Patient Services.

C. BUSINESS REQUIREMENTS

Minimum requirements shall include the following:

1. Claim Correspondence: No correspondence of any type is to be sent to the incarcerated individual(s) or entities other than NDCS. This includes, but is not limited to, explanation of benefits (EOB), checks, letters, brochures, billings, etc.
2. Rates for Medical/Dental Claims submitted: Nebraska Medicare Rates unless the negotiated PPO rate is lower. Incarcerated Individuals and/or NDCS are not responsible for remaining balance due after Medicare/PPO rates have been applied.
   - **a.** Contractor is responsible for notifying member providers on remittance statements. No balance will be due after Medicare or PPO rates are applied.
3. Nebraska Medicaid eligibility as defined by Nebraska Department of Health and Human Services (DHHS):
   - **a.** Reference is 477 NAC 11-003.01(A) INSTITUTIONALIZED INDIVIDUALS. An inmate of a public institution, as defined by 42 Code of Federal Regulations (CFR) 435.1009, who meets inpatient status in a medical institution, as defined by 42 CFR 435.1010, and who is otherwise eligible may only receive payment for services received during his or her inpatient stay over 24 hours.
     - **i.** Chapter 11-003.01(A) at https://rules.nebraska.gov/rules?agencyId=37&titleId=232
4. Deductible, Coinsurance or Copays: Do not apply.
5. Claims Timeframe: Contractor will accept claims as timely if filed within two (2) years of date of service pursuant to the State Contract Claims Act, see Neb. Rev. Stat. § 81-8,306.
6. Claims Maximums: Claims maximums such as day, dollar, and lifetime maximums do not apply.
7. Preauthorization: Not applicable for emergency services or inpatient services. For out-patient services, NDCS will provide a prior authorization number.
8. In-State and Out-of-State Services: Only those services approved by the NDCS should be submitted to contractor for payment. However, if billed, the following services should not be paid by contractor:
   - **a.** Claims billed by out-of-network providers. These claims should be sent to NDCS for consideration.
   - **b.** Medications for use after leaving medical provider.
   - **c.** Prosthetics/ Orthotics except for those off-site items issued at the time of surgery.
     - **i.** Prosthetics/orthotics deemed necessary will need to be pre-approved by NDCS Medical Director or designee and billed directly to NDCS.
   - **d.** Services covered by Medicaid.

e. Newborn or childcare.
f. Abortion.
g. Caffeine-related disorders.
h. Chiropractic care.
i. Dental implants.
j. Dentures/Dental Laboratory Services,
  i. Claims deemed necessary will need to be pre-approved by NDCS Medical Director or designee and billed directly to NDCS.
k. Elective procedures.
l. Erectile dysfunction.
m. Factitious disorder.
n. Learning disorder.
o. Nicotine-related disorders.
p. Other conditions/disorders/issues/procedures as determined by the Medical Director or designee for NDCS Health Services.

9. Workers' Compensation/Subrogation: Contractor will not pay these claims. The employer's workers' compensation insurer must cover the incarcerated individuals for all work-related claims.
10. Transplants: Billing received for transplant services must be pre-approved by the NDCS Medical Director or designee. Patient must also meet transplant criteria. NDCS will not pay for elective transplant procedures.
11. Medicaid Claims: Services covered by Medicaid will not be paid by contractor. NDCS will notify contractor of any Medicaid service eligibility changes.
12. Most-used hospital(s) include but are not limited to the following.
  a. Nebraska Medicine, CHI Health, Bryan Health, Johnson County Hospital, York General Hospital and McCook Community Hospital.

D. HISTORICAL INFORMATION

The information below provides historical information on past use of such services and is intended to aid bidder(s) in developing their response to this RFP.

1. The ADP since 2023 has been 5692 people.
2. NDCS Fiscal Year '24, Quarter 4 (April – June 2024) the ADP was 5872 people.
  a. NDCS fiscal year runs July 1 through June 30.
  b. Additional historical reports may be found at https://www.corrections.nebraska.gov/public-information/statistics-reports/ndcs-reports
3. Fiscal year 2023 Medical and Dental claims
  a. Medical
    i. 23,418 claims
    ii. $18,104,303.51 dollars paid.
    iii. 261 providers
  b. Dental
    i. 113 claims
    ii. $34,351.10 dollars paid.
4. Fiscal year 2024 Medical and Dental claims
  a. Medical
    i. 24,704 claims paid.
    ii. $15,649,991.34 dollars paid.
    iii. 252 providers
  b. Dental
    i. 250 claims paid.
    ii. $51,454.21 dollars paid.
    iii. 3 Unique Providers.
5. Inpatient facility claims paid from June 2023 to July 2024 (see table 1).
  a. This does not include professional claims related to an inpatient stay.
  b. The following were excluded from the counts below:
    i. Claims that were paid and later reversed.
    ii. Reversal claims.
    iii. Claim Adjustments.

Service Year	IP Claim Count	IP Claimant Count
2022	5	5
2023	84	71
2024	36	36

Table 1

E. BIDDER REQUIREMENTS

The bidder shall provide a minimum of the following in the response to the RFP.

1. Original Contractual Agreement Form signed manually in ink or by DocuSign;
2. Clarity and responsiveness;
3. Completed Corporate Overview;
4. Completed Sections II thru VI;
5. Completed Attachment A, Bidder Questionnaire;
6. Completed Cost Proposal.
7. Provide listing of in-network Providers, that is sortable by each specialty in following 5 cities: Omaha metro area, Lincoln, York, Tecumseh, and McCook.
8. Identify the processes to ensure provider rates are not paid higher than the Nebraska Medicare rates, to include applicable reports that compare provider and Medicare rates to the corresponding claims paid.
9. Outline of the utilization management of claims process and potential to customize.
10. Example of standard analytical dashboard.
11. A list of all network providers.

F. CONTRACTOR REQUIREMENTS

While maintaining the minimum business requirements, service provided by contractor shall include the following minimum requirements.

1. General

- **a.** Contractor network will include service providers for all NDCS facility locations.
- **b.** Process valid patient care claims for State incarcerated individual(s) committed to NDCS or other NDCS approved incarcerated individuals.
- **c.** Will pay provider claims in accordance with the contractor/provider agreement but are not to exceed Nebraska Medicare rates.
- **d.** Will deny any of those claims to be paid by Nebraska Medicaid.
- **e.** An updated provider directory will be available via an electronic site maintained by contractor.

2. Reporting

- **a.** Provide NDCS a minimum of a monthly report outlining claims that have been denied and a detailed reason for denial.
- **b.** Shall provide the following electronic reports, upon request by NDCS, at no charge:
  - **i.** Include a listing (title or topic) and provide a sample printout of all reports that are considered standard and included at no additional charge.
  - **ii.** Special reports of health care paid for an incarcerated individual within two (2) business days.
  - **iii.** Rejected claims and rationale for rejection.
  - **iv.** Breakout by specialty, i.e. physical therapy, dental, psychiatry, maternity, etc.
  - **v.** Report of charges of $20,000 or above per incarcerated individual, per diagnosis, and per off-site hospitalization per occurrence, or as requested.
- **c.** Provide a weekly and monthly listing in Excel or CSV format of all claims paid per incarcerated individual, identifying:
  - **i.** Incarcerated individual committed name.
  - **ii.** NDCS Incarcerated individual identification number.
  - **iii.** Incarcerated individual age/ date of birth.
  - **iv.** Date of service (beginning and ending).
  - **v.** Medical provider name and location.
  - **vi.** Place of service codes.
  - **vii.** Detailed billing including ALL diagnosis code(s) and each procedure code(s) (ICD10, CPT, modifiers, units, and NDCS number(s)).
  - **viii.** APR-DRG (Diagnose Related Group) + SOI (Severity of Illness) level determines reimbursement level.
  - **ix.** Prospective Payment System detail showing weight and rate of each APR-DRG for different clinics/hospitals/surgical centers.
  - **x.** Total Gross charged amount.
  - **xi.** Total Net paid amount.
  - **xii.** Dates of claim submission to contractor.
  - **xiii.** Dates of payment to providers.
- **d.** Provide Service Organizational Control Report (SOC2) document annually or the latest SOC2 upon NDCS request.

3. Electronic dashboard

Contractors' website or other electronic source that shows real time data for inpatient stay/outpatient visit.

- **a.** The dashboard must provide a minimum of the following.
  - **i.** Most expensive patients.
  - **ii.** Top diagnoses.

iii. Frequency of diagnoses.
iv. Year to date.
v. Month to month.
vi. Specialists/category.
vii. Itemized billings for all patients.
viii. Files be protected to meet all applicable state and federal confidentiality standards.
a) Prefer to have the capability to print off the file at NDCS.
ix. Contractor shall provide menu listing of industry standard services including Certification and Concurrent Review Requirements with applicable cost and bullet point Return on Investment (ROI) as options for NDCS to consider using:
a) Pre-payment auditing cost.
b) Concurrent review cost.
c) Complex medical review cost.

b. Medical Director may require additional analytics on the electronic dashboard. It is preferred that the data on the electronic dashboard be easily configured to perform analysis.

4. Claims

a. When submitting an inquiry to the NDCS regarding a claim, the Contractor shall include:
i. Incarcerated individual committed name and date of birth.
ii. NDCS five (5) or six (6) digits incarcerated individual identification number.
iii. Medical provider name and location and clinic/hospital/surgical center if applicable.
iv. Admit and Discharge Date.
v. Total Charges.
vi. Detailed billing including ALL diagnosis code(s) and each procedure code(s) (ICD10, CPT, modifiers, units, and NDCS number(s)).
vii. Diagnose Related Group (APR-DRG) + Severity of Illness (SOI) level determines reimbursement level.

5. Meetings

a. Must attend meetings to ensure a successful process flow.
b. Annual review of SOC2.

G. NDCS REQUIREMENTS

1. NDCS will provide an electronic listing of all incarcerated individual(s) to be covered by this service, including assigned identification numbers, appropriate demographics, and facility location.
   a. This listing will be updated each workday via the Secure file Transfer Protocol (SFTP).
   b. File format and specifications will be agreed upon in advance between the contractor and NDCS.
2. Provide the contractor with the previous quarterly ADP report. The contractor shall calculate the monthly processing fee based upon the most recent ADP report provided.
3. NDCS Accounting will contact the providers who are incorrectly billing and/or submitting ineligible claims NDCS and advise them of the appropriate billing procedures for their services.
4. Provide contractor with a list of Nebraska Medicaid eligible and pending applications. This list will be provided at a reasonable timeframe mutually agreed upon.
5. NDCS will reimburse the contractor on a twice monthly basis for paid claims. In addition, NDCS will process payment to Contractor on a monthly basis for any fee other than claims paid.
6. Meetings NDCS Health Services will:
   a. Administer quarterly meetings to ensure a successful process flow.
   b. Schedule reoccurring meetings with stakeholders.
   c. Provide meeting agenda prior to meeting date.
   d. Provide meeting minutes to stakeholders.
      i. Stakeholders may include but are not limited to contractor, hospitals, providers, billing groups, NDCS, and/or other state agencies.

H. NDCS FACILITY LOCATIONS

Current facilities are listed below. Locations may be added/removed as needed.

1. Community Corrections Center Lincoln (CCCL) Lincoln
2. Community Corrections Center Omaha – (CCCO) Omaha
3. Reception and Treatment Center (RTC)- Lincoln
4. Nebraska Correctional Center for Women (NCCW) York
5. Nebraska Correctional Youth Facility (NCYF) Omaha
6. Nebraska State Penitentiary (NSP) Lincoln
7. Omaha Correctional Center (OCC) Omaha
8. Work Ethic Camp (WEC) McCook
9. Tecumseh State Correctional Institution (TSCI) Tecumseh

I. NDCS CONTACTS

A list of current NDCS contacts will be provided upon contract award. The contacts may be subject to change during the life of the contract. Contractor will be notified of any changes.

J. PAYMENT SCHEDULE/DELIVERABLES

Invoices will not be processed for payment unless the associated requirements have been met, refer to Section IV.C. Reimbursement will be based upon the following payment schedule and processing fees outside of claims paid.

Contractor must provide:

1. Detailed billing summary at the time of payment reimbursement request.
   - **a.** Invoices shall include detailed itemized billing per patient including ALL diagnosis code(s) and each procedure code(s) (ICD10, CPT, modifiers, units, and NDCS number(s)).
2. Award options:
   - **a.** If awarded at a fee per incarcerated individual.
     - **i.** The formula used to calculate the monthly processing fee shall be "fee per incarcerated individual multiplied by the ADP."
       - **a)** Monthly invoices shall include the payment processing fee and the ADP number to determine the monthly fee.
         Example: Medical payment processing fee = $19.50 and ADP = 5872.
         The invoice would reflect "$19.50 (fee) x 5872 (ADP) = $114,504.00".
   - **b.** If awarded at a monthly flat rate, no formula will be required on invoices.
3. All recoupment requests to NDCS will be processed within 30 calendar days upon agreement.

K. OPTIONAL SERVICES

Optional services may be provided in the response to the RFP. These services may be considered and awarded if deemed within the best interest of the State. Any costs associated with optional services shall be provided under "Optional Services" within the Cost Proposal.

1. Prior to claims being paid, Utilization Review should include but not be limited to:
   - **a.** Review claims for appropriate level of service.
   - **b.** Review procedures/documentation related to visit for appropriateness.
   - **c.** Review hospital stays for appropriate length of stay.
2. Any other analytical services, reports, quality assurance, auditing, tools etc., available that would be provided to NDCS at no additional cost.
3. Additional like-services that are available which are not specifically mentioned in this RFP.

VI. SOLICITATION RESPONSE INSTRUCTIONS

This section documents the requirements that should be met by bidders in preparing the Corporate Overview, Technical Response, and Cost Sheet. Bidders should identify the subdivisions of "Project Description and Scope of Work" clearly in their solicitation response; failure to do so may result in disqualification. Failure to respond to a specific requirement may be the basis for elimination from consideration during the State's comparative evaluation.

Solicitation responses are due by the opening date and time shown in the Schedule of Events. Content requirements for the Corporate Overview, Technical Response, and Cost Sheet are presented separately in the following subdivisions: format and order:

A. SOLICITATION RESPONSE SUBMISSION

1. CORPORATE OVERVIEW

The Corporate Overview section of the solicitation response should consist of the following subdivisions:

a. BIDDER IDENTIFICATION AND INFORMATION

The bidder should provide the full company or corporate name, address of the company's headquarters, entity organization (corporation, partnership, proprietorship), state in which the bidder is incorporated or otherwise organized to do business, year in which the bidder first organized to do business and whether the name and form of organization has changed since first organized.

b. FINANCIAL STATEMENTS

The bidder should provide financial statements applicable to the firm. If publicly held, the bidder should provide a copy of the corporation's most recent audited financial reports and statements, and the name, address, and telephone number of the fiscally responsible representative of the bidder's financial or banking organization.

If the bidder is not a publicly held corporation, either the reports and statements required of a publicly held corporation, or a description of the organization, including size, longevity, client base, areas of specialization and expertise, and any other pertinent information, should be submitted in such a manner that solicitation evaluators may reasonably formulate a determination about the stability and financial strength of the organization. Additionally, a non-publicly held firm should provide a banking reference.

The bidder must disclose any and all judgments, pending or expected litigation, or other real or potential financial reversals, which might materially affect the viability or stability of the organization, or state that no such condition is known to exist.

The State may elect to use a third party to conduct credit checks as part of the corporate overview evaluation.

c. CHANGE OF OWNERSHIP

If any change in ownership or control of the company is anticipated during the twelve (12) months following the solicitation response due date, the bidder should describe the circumstances of such change and indicate when the change will likely occur. Any change of ownership to an awarded bidder(s) will require notification to the State.

d. OFFICE LOCATION

The bidder's office location responsible for performance pursuant to an award of a contract with the State of Nebraska should be identified.

e. RELATIONSHIPS WITH THE STATE

The bidder should describe any dealings with the State over the previous three (3) years. If the organization, its predecessor, or any Party named in the bidder's solicitation response has contracted with the State, the bidder should identify the contract number(s) and/or any other information available to identify such contract(s). If no such contracts exist, so declare.

f. BIDDER'S EMPLOYEE RELATIONS TO STATE

If any Party named in the bidder's solicitation response is or was an employee of the State within the past six (6) months, identify the individual(s) by name, State agency with whom employed, job title or position held with the State, and separation date. If no such relationship exists or has existed, so declare.

If any employee of any agency of the State of Nebraska is employed by the bidder or is a subcontractor to the bidder, as of the due date for solicitation response submission, identify all such persons by name, position held with the bidder, and position held with the State (including job title and agency). Describe the responsibilities of such persons within the proposing organization. If, after review of this information by the State, it is determined that a conflict of interest exists or may exist, the bidder may be disqualified from further consideration in this solicitation. If no such relationship exists, so declare.

g. CONTRACT PERFORMANCE

If the bidder or any proposed subcontractor has had a contract terminated for default during the past three (3) years, all such instances must be described as required below. Termination for default is defined as a notice to stop performance delivery due to the bidder's non-performance or poor performance, and the issue was either not litigated due to inaction on the part of the bidder or litigated and such litigation determined the bidder to be in default.

It is mandatory that the bidder submit full details of all termination for default experienced during the past three (3) years, including the other Party's name, address, and telephone number. The response to this section must present the bidder's position on the matter. The State will evaluate the facts and will score the bidder's solicitation response accordingly. If no such termination for default has been experienced by the bidder in the past three (3) years, so declare.

If at any time during the past three (3) years, the bidder has had a contract terminated for convenience, non-performance, non-allocation of funds, or any other reason, describe fully all circumstances surrounding such termination, including the name and address of the other contracting Party.

h. SUMMARY OF BIDDER'S CORPORATE EXPERIENCE

The bidder should provide a summary matrix listing the bidder's previous projects similar to this Solicitation in size, scope, and complexity. The State will use no more than three (3) narrative project descriptions submitted by the bidder during its evaluation of the solicitation response.

The bidder should address the following:

i. Provide narrative descriptions to highlight the similarities between the bidder's experience and this Solicitation. These descriptions should include:

- **a)** The time period of the project,
- **b)** The scheduled and actual completion dates,
- **c)** The bidder's responsibilities,
- **d)** For reference purposes, a customer name (including the name of a contact person, a current telephone number, a facsimile number, and e-mail address); and
- **e)** Each project description should identify whether the work was performed as the prime Vendor or as a subcontractor. If a bidder performed as the prime Vendor, the description should provide the originally scheduled completion date and budget, as well as the actual (or currently planned) completion date and actual (or currently planned) budget.

ii. Bidder and Subcontractor(s) experience should be listed separately. Narrative descriptions submitted for Subcontractors should be specifically identified as subcontractor projects.

iii. If the work was performed as a subcontractor, the narrative description should identify the same information as requested for the bidders above. In addition, subcontractors should identify what share of contract costs, project responsibilities, and time period were performed as a subcontractor.

i. SUMMARY OF BIDDER'S PROPOSED PERSONNEL/MANAGEMENT APPROACH

The bidder should present a detailed description of its proposed approach to the management of the project.

The bidder should identify the specific professionals who will work on the State's project if their company is awarded the contract resulting from this Solicitation. The names and titles of the team proposed for assignment to the State project should be identified in full, with a description of the

team leadership, interface, and support functions, and reporting relationships. The primary work assigned to each person should also be identified.

The bidder should provide resumes for all personnel proposed by the bidder to work on the project. The State will consider the resumes as a key indicator of the bidder's understanding of the skill mixes required to carry out the requirements of the Solicitation in addition to assessing the experience of specific individuals.

Resumes should not be longer than three (3) pages. Resumes should include, at a minimum, academic background and degrees, professional certifications, understanding of the process, and at least three (3) references (name, address, and telephone number) who can attest to the competence and skill level of the individual. Any changes in proposed personnel shall only be implemented after written approval from the State.

j. SUBCONTRACTORS

If the bidder intends to subcontract any part of its performance hereunder, the bidder should provide:

i. name, address, and telephone number of the subcontractor(s),
ii. specific tasks for each subcontractor(s),
iii. percentage of performance hours intended for each subcontract; and
iv. total percentage of subcontractor(s) performance hours.

2. TECHNICAL RESPONSE

The Technical Response section of the solicitation response should consist of the following subsections:

a. Understanding of the project requirements;
b. Proposed development approach;
c. Attachment A, Bidder Questionnaire requirements;
d. Detailed project work plan; and
e. Deliverables and due dates.

CONTRACTUAL AGREEMENT FORM

BIDDER MUST COMPLETE THE FOLLOWING

By signing this Contractual Agreement Form, the bidder guarantees compliance with the provisions stated in this solicitation and agrees to the terms and conditions unless otherwise indicated in writing and certifies that bidder is not owned by the Chinese Communist Party.

Per Nebraska's Transparency in Government Procurement Act, Neb. Rev Stat § 73-603, DAS is required to collect statistical information regarding the number of contracts awarded to Nebraska Vendors. This information is for statistical purposes only and will not be considered for contract award purposes.

_____ NEBRASKA VENDOR AFFIDAVIT: Bidder hereby attests that bidder is a Nebraska Vendor. "Nebraska Vendor" shall mean any bidder who has maintained a bona fide place of business and at least one employee within this state for at least the six (6) months immediately preceding the posting date of this Solicitation. All vendors who are not a Nebraska Vendor are considered Foreign Vendors under Neb. Rev Stat § 73-603 (c).

_____ I hereby certify that I am a Resident disabled veteran or business located in a designated enterprise zone in accordance with Neb. Rev. Stat. § 73-107 and wish to have preference, if applicable, considered in the award of this contract.

_____ I hereby certify that I am a blind person licensed by the Commission for the Blind & Visually Impaired in accordance with Neb. Rev. Stat. § 71-8611 and wish to have preference considered in the award of this contract.

FORM MUST BE SIGNED MANUALLY IN INK OR BY DOCUSIGN

BIDDER:	**UMR, Inc.**
COMPLETE ADDRESS:	**115 West Wausau Avenue** **Wausau, WI 54401**
TELEPHONE NUMBER:	**866-881-0800**
FAX NUMBER:	
DATE:	**01/21/2025**
SIGNATURE:	Scott Hogan
TYPED NAME & TITLE OF SIGNER:	**President & CEO**

NEBRASKA DEPARTMENT OF CORRECTIONAL SERVICES
SUPPLEMENTAL INFORMATION
SOLICITATION NUMBER 120174 O3

The Nebraska Department of Correctional Services (NDCS) is committed to the open and fair process for selection of contractual services; additionally, we are committed to upholding the laws of the State of Nebraska, the NDCS Code of Ethics and Conduct, and internal recommendations for improving best business practices.

Please complete the questions below and submit with your bid documents. Responding "yes" to any question will not disqualify you from consideration but may necessitate a follow-up information request.

Company Name: UMR, Inc. _____

PO Box Address: _____

Physical Address: 115 West Wausau Avenue _____

City/State/Zip: Wausau, WI 54401 _____

Phone Number: 866-881-0800 _____

Name/Title of Contact: Tim Moore _____

		YES	NO
1.	To your knowledge do you have any relatives, employees, contractors, sub-contractors, or a personal relationship with anyone who is currently employed by the Nebraska Department of Correctional Services?		**X**
	If yes, who?		
2.	Has an employee of the Department of Correctional Services performed work for you under your current contract with the NDCS?		**X**
	If yes, who, how long, and in what capacity?		
3.	Does an employee of the Department of Correctional Services (past or present) hold any corporate position in your company?		**X**
	If yes, who and what position?		
4.	Incorporated companies, please provide the following information: Name of Corporate Entity: United Healthcare Services, Inc. Principle Office Address: 9700 Health Care Lane, Minnetonka, MN 55343 Registered Agent and Office Address: Tim Moore 2717 N. 118th Street, Suite 300, Omaha, NE 68164		
5.	Non-Incorporated Companies please provide the following information: Owner: _____		

By my signature below, I attest that neither I, nor my company, nor any primary officer or employee in my company has a known conflict of interest with the Nebraska Department of Correctional Services.

Scott Hogan

01/21/2025

Company President Signature Date

InfoPort℠

Report Samples

V3.3

UMR℠

A UnitedHealthcare Company

UMR's InfoPort reporting tool supports business intelligence in a web-based application for delivery of data to run reports in a secure environment. Create and customize reports with an on-demand or schedule feature and view data at a summary or detail level based on activity administered by UMR.

Information in this document provides a summary of report content available within InfoPort. Hyperlinks are accessible in the electronic version of the document, providing an option to find a specific report. This document is also posted within InfoPort's Information Center. *Note:* Availability of specific reports within InfoPort may vary based on a client's line(s) of coverage with UMR; the client's plan representative authorizes report access levels.

Report Type	Description
Admission Summary	The Admission Summary Report, available in a standard or expanded format, summarizes medical claim dollars by inpatient hospital admissions. Report data includes the number of patients/admissions, length of stay, and average length of stay, with the option to filter by plan account structure and summarize by admission type.
Adult Screening	The Adult Screening Report displays members age 18 and over based on service/report date with medical claims by preventive care activity (e.g., cholesterol, colorectal cancer screen, breast cancer screen, cervical cancer screen, prostate cancer screen, and flu vaccination).
Adult Wellness Exam	The Adult Wellness Exam Report displays members age 18 and over based on service/report date with medical claims by preventive care visits (e.g., annual well visit/preventive visit/well visit/routine visit).
CARE Savings Summary [3]	The CARE Savings Summary Report provides an overview of potential savings for Utilization Management (pre-certification/concurrent and retrospective review of patient services) and Case Management (support of catastrophic or complex condition patients) when services are administered by UMR.
Claim Comparison	The Claim Comparison Report compares financial and enrollment data for multiple periods of time, provides a paid PMPM, and can be run with a user defined date range for time period comparison, including options to filter data and display activity by claim expenses or benefit type.
Claim Detail	The Claim Detail Report is a claim-by-claim list displaying a summary of paid claims activity and claim-level dollar totals. By setting the report criteria, report data can be narrowed down to claims expenses required for analysis, with the option to suppress PHI.
Claim Distribution	The Claim Distribution Report provides a view of patient and claim totals for a select time period, categorized by a user selection of financial ranges distributed by claims or by patients.
Claim Lag [1]	The Claim Lag Report displays the lag time between when services are performed and when the claim is paid over the course of a 12 or 24-month period.
Claim Summary [1]	The Claim Summary Report displays claim counts and dollars summarized by the dimensions selected (up to four filters). Choose from a myriad of summary fields (including account structure, claim category, network designation and patient attributes) to customize the report's claims data output view.

Report Type	Description
Claim Summary by Member	The Claim Summary by Member Report summarizes claim information by patient or family. This report can be used to answer member questions on claim payment, determine utilization, or identify patients/families with the highest paid costs in claims.
Claim Summary by Network	The Claim Summary by Network Report assists with evaluating the financial benefit of the plan's network arrangements. The report displays summary claim information and discount percent by network.
Claim Summary by Provider	The Claim Summary by Provider Report summarizes claim information by the individual provider or by the provider's Tax Identification Number and displays key provider data on paid claims activity.
Claim Summary Service Level	The Claim Summary Service Level Report, like the Claim Summary Report, displays claim counts and dollars summarized by dimensions (filters) selected, with a focus on the claim service line-level attributes such as procedure and diagnosis. Report data can be run to view patient utilization of services and includes the option to filter or summarize the report by a Telehealth or Telemedicine vendor indicator (if applicable to the plan).
Claims and Enrollment by Month	The Claims and Enrollment by Month Report provides totals by month for the patient's paid claims activity, including a summary of billed, covered, allowed, and paid amounts, and paid PMPM.
Enrollment Census	The Enrollment Census Report is a listing of plan membership, displaying both demographic and enrollment information. It can be used to audit active plan enrollment at various points in time, or to identify new or terminating enrollees and under/over age dependent children.
Enrollment Summary[1]	The Enrollment Summary Report displays counts of enrollees summarized by the dimensions (filters) selected on the report. Choose from enrollment fields and account structure to summarize the report to assist with analyzing the plan's enrollment data.
Enrollment Summary by Month	The Enrollment Summary by Month Report provides counts of members by month summarized by the dimensions (filters) selected. Choose enrollment fields and plan account structure cuts of data to assist with analyzing the plan's enrollment data.
Extract – Claim Level	The Extract – Claim Level Report provides unformatted claim-level data suitable for downloading into a local application such as MS Excel; the paid claims layout contains a volume of data elements and can be used for claim analysis.
Extract – Claim Service Level	The Extract – Claim Service Level Report provides unformatted claim service line-level data suitable for download; the paid claims layout contains a volume of data elements including a Telehealth or Telemedicine vendor indicator (if applicable to the plan). Report data can be used for claim analysis at a service line-level.

Report Type	Description
Extract – Enrollment Census	The Extract – Enrollment Census provides unformatted member demographic and enrollment data suitable for download; layout contains a volume of data elements and can be used for review of the plan's enrollment activity.
HRA Utilization Detail [3]	The HRA Utilization Detail Report provides a view of the member's contribution based on reporting month and can be filtered by account structure and subscriber to customize data. The report includes rollover dollars, incentive contribution (if applicable), initial balance, remaining balance, and payment year-to-date. The report provides data each month based on the prior month activity.
HRA Utilization Summary [3]	The HRA Utilization Summary Report provides member count and payment year-to-date based on reporting month and can be filtered by account structure and subscriber to customize data. The summary report offers an option to run in two separate formats to include the initial and remaining HRA dollars balance, with additional fields including new contributions, rollover, and incentive contributions (if applicable). The report provides data each month based on the prior month activity.
Incurred But Not Reported (IBNR) [1]	The IBNR Report provides an estimate (based on UMR's book of business completion factors, non-certified) of the amount a group may want to have on reserve to budget for claims incurred but not yet reported and paid. The report uses claims for the last 24 rolling months (if available) of incurred/paid claims split by benefit type applicable to the plan.
Performance Indicators	The Performance Indicators Report provides a presentation style report of plan payment activity with a prior and current year comparison. Data can be utilized to monitor key measures and costs including inpatient, outpatient, physician, and ancillary paid and compared to a UMR normative value, top 10 clinical conditions driving costs, and breakout of high cost versus non-high cost claimants.
Plan Cost Summary [1]	The Plan Cost Summary Report provides a 12-service month view of plan payments (medical, dental, vision), plan expenses (including stop loss premiums, and various fees), and plan recoveries (stop loss reimbursements-if applicable) for benefits and services administered by UMR. Also included are enrollment counts and a claim summary comparison of billed, not covered, covered, discount, allowed, deductible, patient out of pocket, and plan paid amounts.
Rx Extract	The Rx Extract Report provides a volume of data fields in an unformatted file that can be downloaded. Based on detail reporting, *UMR clients must have pharmacy claim detail data sent by their PBM vendor to UMR for reporting to view report data.*
Rx Summary	The Rx Summary Report provides an option to filter and summarize data. The report includes a count of PBM paid claims, prescription count, generic count, patient responsibility, and plan paid amount. *UMR clients must have pharmacy claim detail data sent by their PBM vendor to UMR for reporting to view report data.*

Report Type	Description
Stop Loss 50 Percent [2]	The Stop Loss 50 Percent Report displays members who have reached 50 percent or more of their specific stop loss deductible during the current stop loss period for the plan. Report data is refreshed on a monthly basis, based on year-to-date activity. The data provides current contract terms and is specific to each individual stop loss contract supported by UMR. This is a static report.
Stop Loss Aggregate [2]	The Stop Loss Aggregate Report displays a year-to-date view of paid claims and contract adjustments that relate to the aggregate stop loss contract. The report is based on the S/L plan year and contract type for benefits covered under the aggregate contract. The summary and detail report provides updates on year-to-date Aggregate Stop Loss Contract results. This is a static report.
Stop Loss Member Monitor (PHI and Non-PHI Versions) [2]	The Stop Loss Member Monitor Report displays an inventory of members who have hit criteria based on plan set up for stop loss monitoring. Report activity is based on date parameters aligned with the stop loss contract period for the plan. Criteria can include a trigger diagnosis and/or clinical note entered by a UMR clinical staff member (PHI version). This is a static report.
Stop Loss Reimbursement [2]	The Stop Loss Reimbursement Report displays member claims for a specific group submitted to the Stop Loss Carrier for reimbursement after stop loss plan criteria has been met based on paid claims administered by UMR. This is a static report.
Top Claimant	The Top Claimant Report provides paid claims activity by member for the top 1 – 100 patients based on total combined paid by the plan. An option for the report user to select the number of members to display and top 1-10 paid claim records per patient is available. Report data includes paid medical claims and paid dental, paid prescription drug claims (if available) for the selected report time frame with an option to suppress Protected Health Information (PHI). Report data can be used to view high-cost claims contributing to plan expense by diagnosis and the type of service under each member.

[1] Available for InfoPort's restricted users without PHI or drill-in; can include limited selection of filters.
[2] This report is generated and placed within InfoPort's My Files section by UMR for eligible users.
[3] This report is only available to UMR clients with activity administered by UMR.

Admission Summary

The Admission Summary Report is available in either a standard or expanded version and summarizes medical claim dollars by inpatient hospital admissions.

Inpatient hospital admissions are defined as episodes of care involving an overnight stay in a hospital or other inpatient facility with room and board charges. The admissions capture all services associated with the hospitalization (inpatient facility, physician charges, lab, radiology, ancillary).

Admission Types available on this report:

- Inpatient Hospital
- Inpatient Skilled Nursing Unit (SNF)
- Inpatient Detoxification
- Inpatient Maternity
- Inpatient Rehab Facility– Med/Physical
- Inpatient Psychiatric Facility
- Facility Special Charges

Report Parameters/Customization (available options):

- Date Range
- Filters
- Summarize by
- Display Options
- Schedule Options
- Report Format

The summary dimension report parameter fields available for selection provide the option to filter data (up to four filters). The following data elements are provided under a standard or expanded report format:

Standard Report Content

- (Number of) Patients
- Admits (hyperlink; drills into claim profile)
- (Length of Stay) LOS
- Billed
- Allowed
- Paid

Expanded Report Content

- (Number of) Patients
- (Number of) Services
- Admits (hyperlink; drills into claim profile)
- (Length of Stay) LOS
- (Average Length of Stay) Avg. LOS
- Inpatient Billed Amount
- Inpatient Allowed Amount
- Inpatient Paid Amount
- Billed
- Allowed
- Paid

The Inpatient Billed, Inpatient Allowed, and Inpatient Paid Amounts represent facility charges.

The Billed, Allowed, and Paid Amounts represent all services associated with the hospitalization.

View next page for report samples.

Return to Report Content

Standard Format

ABC COMPANY (76888888)
Admission Summary

Admission Dates: All
Paid Dates: 09/01/20xx - 10/01/20xx

Click hyperlink to drill into inpatient claim profile

		Patients	Admits	LOS	Billed	Allowed	Paid
ABC COMPANY		9	9	33	$128,964.80	$30,488.03	$24,041.04
REPORT TOTALS:	**1 Distinct Group:**	**9**	**9**	**33**	**$128,964.80**	**$30,488.03**	**$24,041.04**

CRITERIA: Admission Summary (Standard) **Group:** ABC Company
Date Range: Admission Dates: All; Paid Dates: 09/01/20xx - 10/01/20xx
Filters: None
Summarize By: None

Admission data valued as of 10/16/20xx.

Drill in Profile

ABC COMPANY (76888888)
Admission Summary
Drilled into Admission Detail

Admit Type	Member Id	Patient Name	Facility Name	Admission Date	Facility Date Paid	LOS	Tot Billed	Tot Allowed	Tot Paid
INPATIENT HOSPITAL	XXXXXXXXX	XXXX, XXXX	Facility	09/30/20XX	10/15/20XX	2	$20,203.63	$4,681.16	$3,744.89
INPATIENT MATERNITY	XXXXXXXXX	XXXX, XXXX	Facility	10/16/20XX	01/10/20XX	1	$17,883.00	$6,964.23	$5,784.23
INPATIENT HOSPITAL	XXXXXXXXX	XXXX, XXXX	Facility	07/26/20XX	10/15/20XX	1	$8,511.45	$5,151.27	$5,151.27
INPATIENT REHAB	XXXXXXXXX	XXXX, XXXX	Facility	02/08/20XX	08/27/20XX	2	$50,665.88	$41,654.88	$4,839.03
INPATIENT FACILITY	XXXXXXXXX	XXXX, XXXX	Facility	07/09/20XX	08/27/20XX	14	$86,856.04	$18,380.76	$16,704.05
REPORT TOTALS:					9 Admits:	33	$1,018,332.90	$240,197.61	$187,984.85

Expanded Format

ABC COMPANY (76888888)
Admission Summary by Admission Type

Admission Dates: All
Paid Dates: 09/01/20xx - 10/01/20xx

Click hyperlink to drill into inpatient claim profile

Admission Type	Patients	Services	Admits	LOS	Avg. LOS	Inp Billed	Inp Allowed	Inp Paid	Billed	Allowed	Paid
Admission Type: ### - INPATIENT HOSPITAL	4	88	4	14	3.50	$738,863.32	$132,488.77	$129,328.73	$100,803.55	$21,466.47	$16,868.59
Admission Type: ### - INPATIENT MATERNITY	5	75	5	6	1.20	$103,589.28	$60,167.91	$24,320.22	$49,462.40	$8,083.06	$6,040.43
Admission Type: ### - INPATIENT FACILITY	1	7	1	14	14.00	$72,420.04	$14,105.00	$14,105.00	$3,426.00	$938.50	$1,132.02
REPORT TOTALS: **3 Distinct Groups:**	**10**	**170**	**10**	**34**	**3.40**	**$914,852.64**	**$206,761.68**	**$167,753.95**	**$153,691.95**	**$30,488.03**	**$24,041.04**

CRITERIA: Admission Summary (Expanded) **Group:** ABC Company
Date Range: Admission Dates: All; Paid Dates: 09/01/20xx - 10/01/20xx
Filters: None
Summarize By: 1. Admission Type

Admission data valued as of 10/23/20xx.

Return to Report Content

Adult Screening

The Adult Screening Report displays paid medical claim dollars by preventive care activity for employees, spouses, domestic partners, and qualifying dependents (age 18 or older at the time of visit) based on service dates. Additional age parameters are used for the screenings as noted below:

- Cholesterol– members age 40 to 75
- Diabetes – members age 18 and over
- Colorectal cancer screening – members age 18 and over
- Prostate cancer screening – members age 40 and over, gender specific
- Breast cancer screening – members age 18 and over
- Cervical cancer screening – members age 18 and over, gender specific
- Flu Vaccinations – members age 18 and over

With this report, there are options for summarizing by the plan's account structure and screening type, including suppression of PHI.

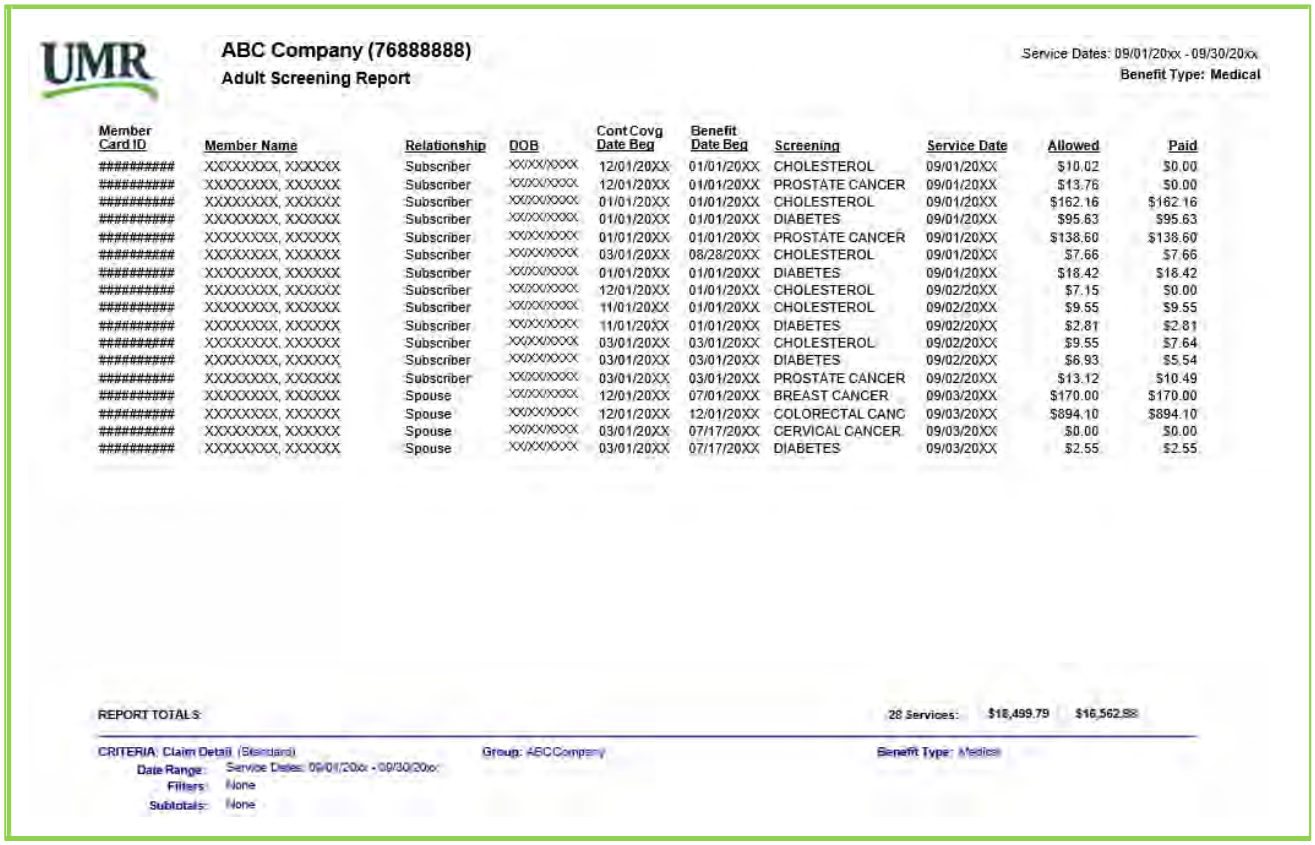
Report Parameters/ Customization (available options)

- Benefit Type *[Medical only]*
- Date Range
- Filters
- Subtotals
- Display Options
- Schedule Options
- Report Format

Standard Report Content

- Member Card ID
- Member Name
- Relationship
- Date of Birth (DOB)
- Cont Covg Date Beg*
- Benefit Date Beg**
- Screening
- Service Date
- Allowed
- Paid

Report



UMR

ABC Company (76888888)

Adult Screening Report

Service Dates: 09/01/20xx - 09/30/20xx

Benefit Type: Medical

Member Card ID	Member Name	Relationship	DOB	Cont Covg Date Beg	Benefit Date Beg	Screening	Service Date	Allowed	Paid
##########	XXXXXXXX, XXXXXX	Subscriber	XX/XX/XXXX	12/01/20XX	01/01/20XX	CHOLESTEROL	09/01/20XX	$10.02	$0.00
##########	XXXXXXXX, XXXXXX	Subscriber	XX/XX/XXXX	12/01/20XX	01/01/20XX	PROSTATE CANCER	09/01/20XX	$13.76	$0.00
##########	XXXXXXXX, XXXXXX	Subscriber	XX/XX/XXXX	01/01/20XX	01/01/20XX	CHOLESTEROL	09/01/20XX	$162.16	$162.16
##########	XXXXXXXX, XXXXXX	Subscriber	XX/XX/XXXX	01/01/20XX	01/01/20XX	DIABETES	09/01/20XX	$95.63	$95.63
##########	XXXXXXXX, XXXXXX	Subscriber	XX/XX/XXXX	01/01/20XX	01/01/20XX	PROSTATE CANCER	09/01/20XX	$138.60	$138.60
##########	XXXXXXXX, XXXXXX	Subscriber	XX/XX/XXXX	03/01/20XX	08/28/20XX	CHOLESTEROL	09/01/20XX	$7.66	$7.66
##########	XXXXXXXX, XXXXXX	Subscriber	XX/XX/XXXX	01/01/20XX	01/01/20XX	DIABETES	09/01/20XX	$18.42	$18.42
##########	XXXXXXXX, XXXXXX	Subscriber	XX/XX/XXXX	12/01/20XX	01/01/20XX	CHOLESTEROL	09/02/20XX	$7.15	$0.00
##########	XXXXXXXX, XXXXXX	Subscriber	XX/XX/XXXX	11/01/20XX	01/01/20XX	CHOLESTEROL	09/02/20XX	$9.55	$9.55
##########	XXXXXXXX, XXXXXX	Subscriber	XX/XX/XXXX	11/01/20XX	01/01/20XX	DIABETES	09/02/20XX	$2.81	$2.81
##########	XXXXXXXX, XXXXXX	Subscriber	XX/XX/XXXX	03/01/20XX	03/01/20XX	CHOLESTEROL	09/02/20XX	$9.55	$7.64
##########	XXXXXXXX, XXXXXX	Subscriber	XX/XX/XXXX	03/01/20XX	03/01/20XX	DIABETES	09/02/20XX	$6.93	$5.54
##########	XXXXXXXX, XXXXXX	Subscriber	XX/XX/XXXX	03/01/20XX	03/01/20XX	PROSTATE CANCER	09/02/20XX	$13.12	$10.49
##########	XXXXXXXX, XXXXXX	Spouse	XX/XX/XXXX	12/01/20XX	07/01/20XX	BREAST CANCER	09/03/20XX	$170.00	$170.00
##########	XXXXXXXX, XXXXXX	Spouse	XX/XX/XXXX	12/01/20XX	12/01/20XX	COLORECTAL CANC	09/03/20XX	$894.10	$894.10
##########	XXXXXXXX, XXXXXX	Spouse	XX/XX/XXXX	03/01/20XX	07/17/20XX	CERVICAL CANCER	09/03/20XX	$0.00	$0.00
##########	XXXXXXXX, XXXXXX	Spouse	XX/XX/XXXX	03/01/20XX	07/17/20XX	DIABETES	09/03/20XX	$2.55	$2.55

REPORT TOTALS: 28 Services: $18,499.79 $16,562.88

CRITERIA: Claim Detail (Standard) Group: ABCCompany Benefit Type: Medical

Date Range: Service Dates: 09/01/20xx - 09/30/20xx

Filters: None

Subtotals: None

** Continuous Coverage Date Begin: Beginning date of uninterrupted health insurance coverage.*

*** Benefit Date Begin: Date the reported benefits began for a member.*

**** Standard coding for these services are subject to change as new recommendations and guidelines for preventive services are issued. UMR will implement the required changes to standard coding across our reports, including industry code effective dates.*

Return to Report Content

Adult Wellness Exam

The Adult Wellness Exam Report displays paid medical claim dollars by standard preventive care visits for employees, spouses, domestic partners, and qualifying dependents (age 18 or older at the time of visit) based on service dates. The report includes services and examinations available through paid claims data (by procedure code): Annual routine visit, wellness visit, preventive visit, and routine visit.

With this report, there are options for summarizing by the plan's account structure, including suppression of PHI.

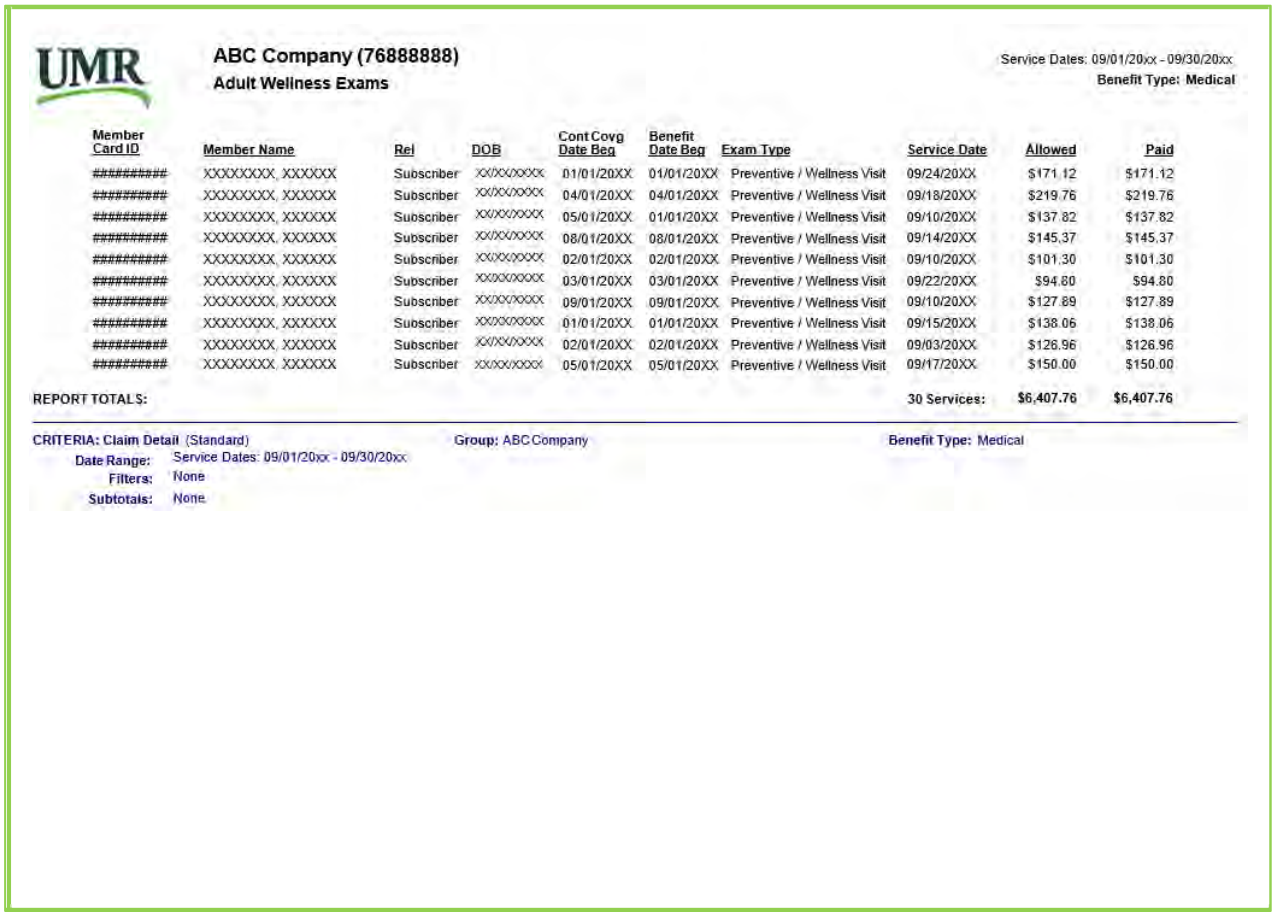
Report Parameters/ Customization (available options)

- Benefit Type *[Medical only]*
- Date Range
- Filters
- Subtotals
- Display Options
- Schedule Options

Standard Report Content

- Member Card ID
- Member Name
- Relationship
- Date of Birth (DOB)
- Cont Covg Date Beg*
- Benefit Date Beg **
- Exam Type
- Service Date
- Allowed
- Paid

Report



UMR

ABC Company (76888888)
Adult Wellness Exams

Service Dates: 09/01/20xx - 09/30/20xx
Benefit Type: Medical

Member Card ID	Member Name	Rel	DOB	Cont Covg Date Beg	Benefit Date Beg	Exam Type	Service Date	Allowed	Paid
##########	XXXXXXXX, XXXXXX	Subscriber	XX/XX/XXXX	01/01/20XX	01/01/20XX	Preventive / Wellness Visit	09/24/20XX	$171.12	$171.12
##########	XXXXXXXX, XXXXXX	Subscriber	XX/XX/XXXX	04/01/20XX	04/01/20XX	Preventive / Wellness Visit	09/18/20XX	$219.76	$219.76
##########	XXXXXXXX, XXXXXX	Subscriber	XX/XX/XXXX	05/01/20XX	01/01/20XX	Preventive / Wellness Visit	09/10/20XX	$137.82	$137.82
##########	XXXXXXXX, XXXXXX	Subscriber	XX/XX/XXXX	08/01/20XX	08/01/20XX	Preventive / Wellness Visit	09/14/20XX	$145.37	$145.37
##########	XXXXXXXX, XXXXXX	Subscriber	XX/XX/XXXX	02/01/20XX	02/01/20XX	Preventive / Wellness Visit	09/10/20XX	$101.30	$101.30
##########	XXXXXXXX, XXXXXX	Subscriber	XX/XX/XXXX	03/01/20XX	03/01/20XX	Preventive / Wellness Visit	09/22/20XX	$94.80	$94.80
##########	XXXXXXXX, XXXXXX	Subscriber	XX/XX/XXXX	09/01/20XX	09/01/20XX	Preventive / Wellness Visit	09/10/20XX	$127.89	$127.89
##########	XXXXXXXX, XXXXXX	Subscriber	XX/XX/XXXX	01/01/20XX	01/01/20XX	Preventive / Wellness Visit	09/15/20XX	$138.06	$138.06
##########	XXXXXXXX, XXXXXX	Subscriber	XX/XX/XXXX	02/01/20XX	02/01/20XX	Preventive / Wellness Visit	09/03/20XX	$126.96	$126.96
##########	XXXXXXXX, XXXXXX	Subscriber	XX/XX/XXXX	05/01/20XX	05/01/20XX	Preventive / Wellness Visit	09/17/20XX	$150.00	$150.00
REPORT TOTALS:							30 Services:	$6,407.76	$6,407.76

CRITERIA: Claim Detail (Standard) Group: ABC Company Benefit Type: Medical
Date Range: Service Dates: 09/01/20xx - 09/30/20xx
Filters: None
Subtotals: None

** Continuous Coverage Date Begin: Beginning date of uninterrupted health insurance coverage.*

*** Benefit Date Begin: Date the reported benefits began for a member.*

**** Standard coding for these services are subject to change as new recommendations and guidelines for preventive services are issued. UMR will implement the required changes to standard coding across our reports, including industry code effective dates.*

Return to Report Content

CARE Savings Summary*

The CARE Savings Summary Report provides an overview of potential savings for Utilization Management (pre-certification/concurrent and retrospective review of patient services) and Complex Condition Care (case management - support of catastrophic or complex condition patients throughout treatment) when services are administered by UMR. The report provides a summary of activity by program and includes the number of units saved compared to the requested/approved units. There is an option to filter and subtotal data by plan account structure and schedule the report. The report provides data updated each month, based on the plan's current and prior year (previous 12 months of activity if available), and is available in a standard format.

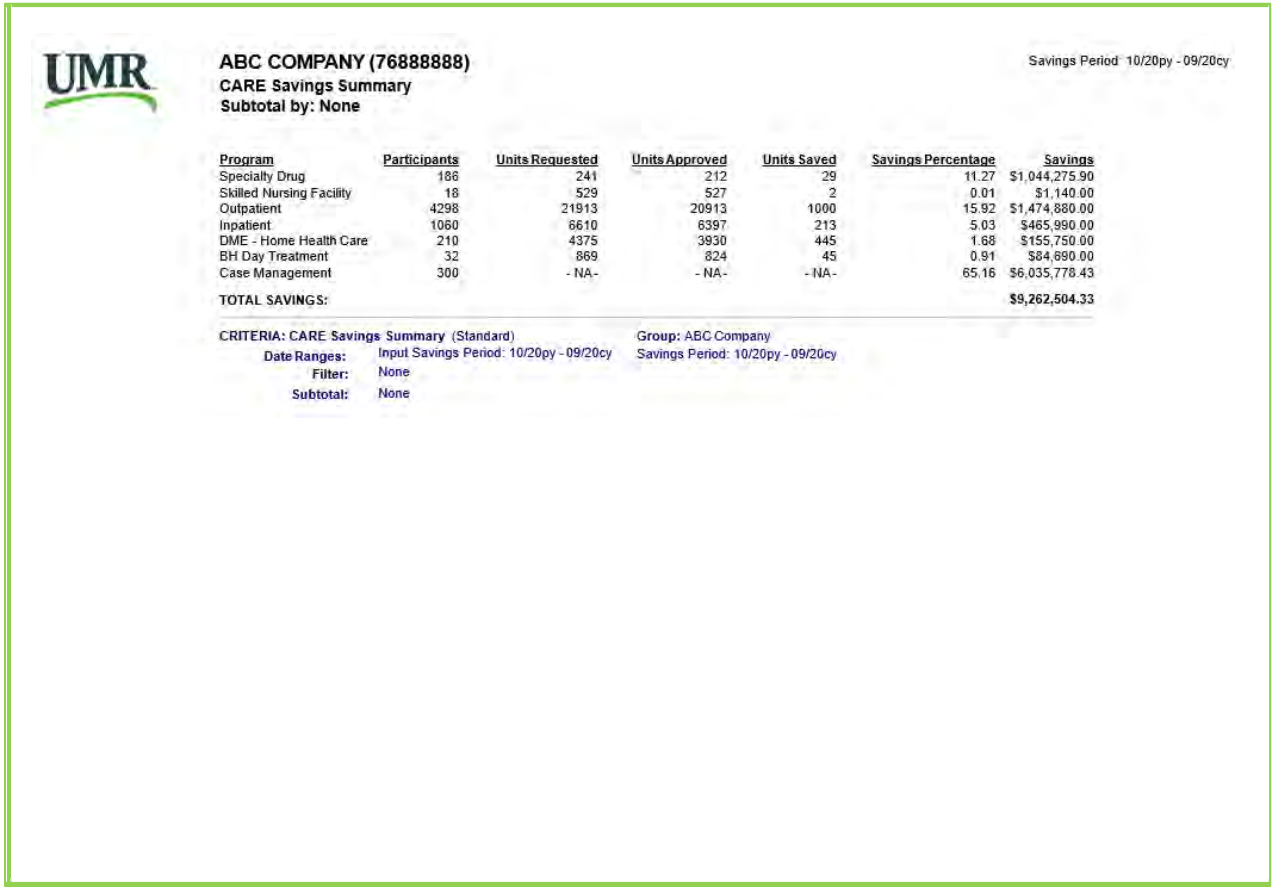
Report Parameters/ Customization (available options)

- Benefit Type *[Medical only]*
- Date Range
- Filters
- Subtotals
- Schedule Options

Standard Report Content

- Program
- Participants
- Units Requested
- Units Approved
- Units Saved
- Savings Percentage
- Savings

Report



UMR

ABC COMPANY (76888888)
CARE Savings Summary
Subtotal by: None

Savings Period 10/20py - 09/20cy

Program	Participants	Units Requested	Units Approved	Units Saved	Savings Percentage	Savings
Specialty Drug	186	241	212	29	11.27	$1,044,275.90
Skilled Nursing Facility	18	529	527	2	0.01	$1,140.00
Outpatient	4298	21913	20913	1000	15.92	$1,474,880.00
Inpatient	1060	6610	6397	213	5.03	$465,990.00
DME - Home Health Care	210	4375	3930	445	1.68	$155,750.00
BH Day Treatment	32	869	824	45	0.91	$84,690.00
Case Management	300	- NA-	- NA-	- NA-	65.16	$6,035,778.43
TOTAL SAVINGS:						**$9,262,504.33**

CRITERIA: CARE Savings Summary (Standard)
Date Ranges: Input Savings Period: 10/20py - 09/20cy
Filter: None
Subtotal: None

Group: ABC Company
Savings Period: 10/20py - 09/20cy

This report is available for UMR clients with CARE Utilization and Complex Condition Care (case management) activity administered by UMR.

[Return to Report Content]

Claim Comparison

The Claim Comparison Report, available in standard and expanded version, compares financial and enrollment data for multiple periods of time and can be run with various date ranges, filters, summarize by, and display options.

Report Parameters/Customization (available options):

- Benefit Type
- Date Range
- Filters
- Summarize By
- Display Options
- Schedule Options
- Report Format

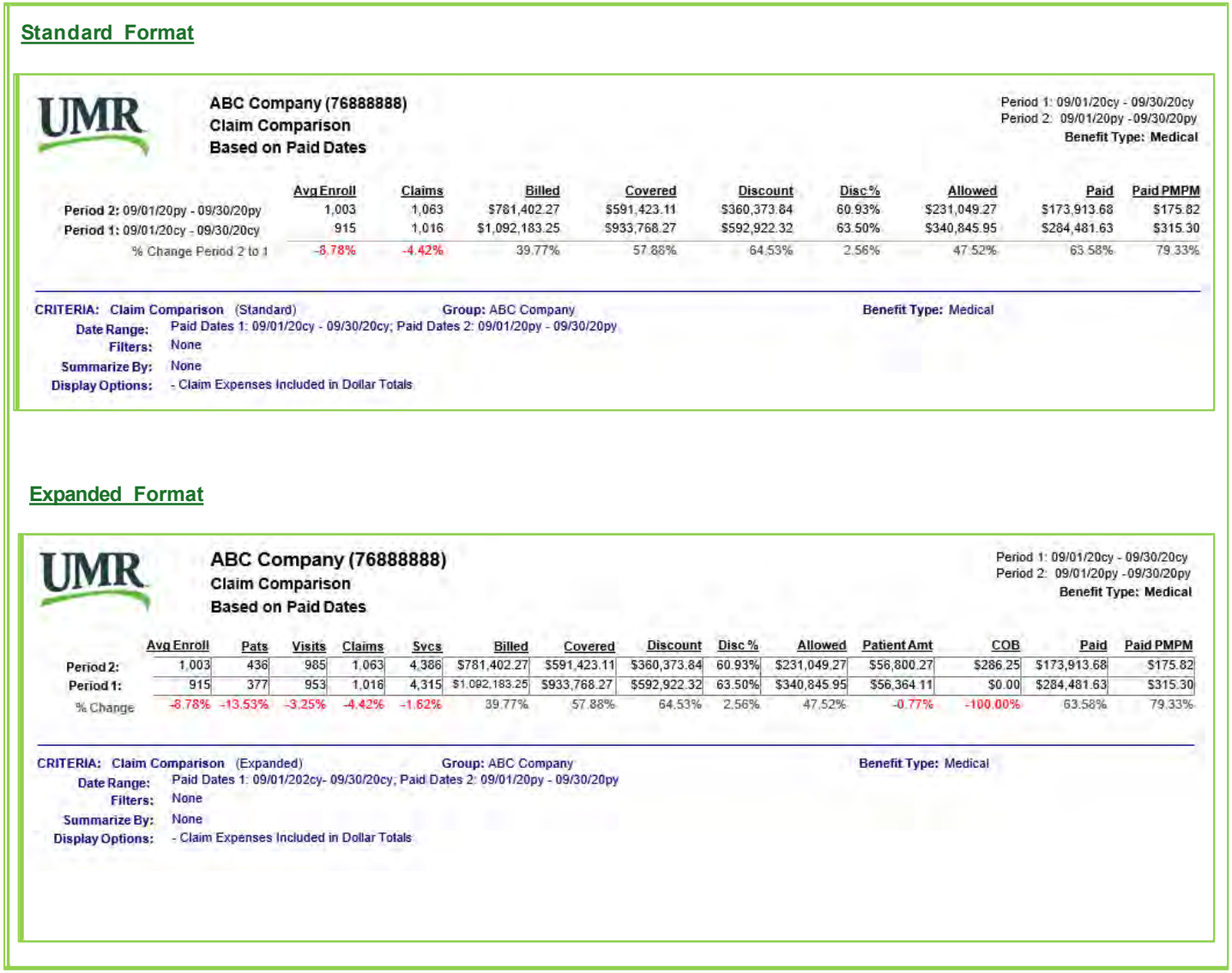
Standard Report Content:

- (Average Enrollment) Avg Enroll
- (Number of) Claims
- Billed
- Covered
- Discount
- Disc %
- Allowed
- Paid
- Paid PMPM

Expanded Report Content:

- (Average Enrollment) Avg Enroll
- (Number of Patients) Pats
- Visits
- (Number of) Claims
- (Number of Services) Svcs
- Billed
- Covered
- Discount
- Disc %
- Allowed
- Patient Amt
- (Coordination of Benefits) COB
- Paid
- Paid PMPM

Standard Format



UMR

ABC Company (76888888)
Claim Comparison
Based on Paid Dates

Period 1: 09/01/20cy - 09/30/20cy
Period 2: 09/01/20py - 09/30/20py
Benefit Type: Medical

	Avg Enroll	Claims	Billed	Covered	Discount	Disc %	Allowed	Paid	Paid PMPM
Period 2: 09/01/20py - 09/30/20py	1,003	1,063	$781,402.27	$591,423.11	$360,373.84	60.93%	$231,049.27	$173,913.68	$175.82
Period 1: 09/01/20cy - 09/30/20cy	915	1,016	$1,092,183.25	$933,768.27	$592,922.32	63.50%	$340,845.95	$284,481.63	$315.30
% Change Period 2 to 1	-8.78%	-4.42%	39.77%	57.88%	64.53%	2.56%	47.52%	63.58%	79.33%

CRITERIA: Claim Comparison (Standard) **Group:** ABC Company **Benefit Type:** Medical
Date Range: Paid Dates 1: 09/01/20cy - 09/30/20cy; Paid Dates 2: 09/01/20py - 09/30/20py
Filters: None
Summarize By: None
Display Options: - Claim Expenses Included in Dollar Totals

Expanded Format

UMR

ABC Company (76888888)
Claim Comparison
Based on Paid Dates

Period 1: 09/01/20cy - 09/30/20cy
Period 2: 09/01/20py - 09/30/20py
Benefit Type: Medical

	Avg Enroll	Pats	Visits	Claims	Svcs	Billed	Covered	Discount	Disc %	Allowed	Patient Amt	COB	Paid	Paid PMPM
Period 2:	1,003	436	985	1,063	4,386	$781,402.27	$591,423.11	$360,373.84	60.93%	$231,049.27	$56,800.27	$286.25	$173,913.68	$175.82
Period 1:	915	377	953	1,016	4,315	$1,092,183.25	$933,768.27	$592,922.32	63.50%	$340,845.95	$56,364.11	$0.00	$284,481.63	$315.30
% Change	-8.78%	-13.53%	-3.25%	-4.42%	-1.62%	39.77%	57.88%	64.53%	2.56%	47.52%	-0.77%	-100.00%	63.58%	79.33%

CRITERIA: Claim Comparison (Expanded) **Group:** ABC Company **Benefit Type:** Medical
Date Range: Paid Dates 1: 09/01/202cy- 09/30/20cy; Paid Dates 2: 09/01/20py - 09/30/20py
Filters: None
Summarize By: None
Display Options: - Claim Expenses Included in Dollar Totals

[Return to Report Content](#)

Claim Detail

The Claim Detail Report is a claim-by-claim list that can be used to narrow down to a specific set of paid claims for review. The report displays key information common to the entire claim (service dates, patient, and provider) and claim-level dollars, providing a summarization of services on a paid claim. The online report provides an option to drill into each claim number to view the service line detail and adjustment history, providing data to quickly pinpoint information and answer member questions related to claim payment.

Another common use of this report is to review large dollar claims paid by the plan. Apply report thresholds to generate a Top 10 Claims report or to identify all claims above an allowed, billed, or paid dollar value.

The report illustrates key elements associated with the claim paid date or dates of service for a user specified time period. The report is a high-level summary of claims at the claim header level. InfoPort will search for the paid claims data at the claim level versus the service line level.

The report has the capacity to display up to 2,500 claims. It is recommended that report criteria is considered when filtering data, including limiting the report's time frame to just those claims that are required for review. If analysis involves a large volume of claims, consider running one of InfoPort's claim summary reports and drilling into the detail using a report's hyperlink as required. The Extract-Claim Level report also provides an option to generate an unformatted detail of paid claims and download the report's results.

Report Parameters/Customization (available options)

- Benefit Type
- Date Range
- Filters
- Subtotals
- Thresholds
- Display Options
- Schedule Options
- Report Format

Standard Report Content:

- Claim ID (hyperlink drills into claim profile)
- Member ID
- Patient Name
- Provider Name-(billing provider)
- Date Serv (Service) From
- Date Paid Through
- Services
- Billed
- Paid

Expanded Report Content

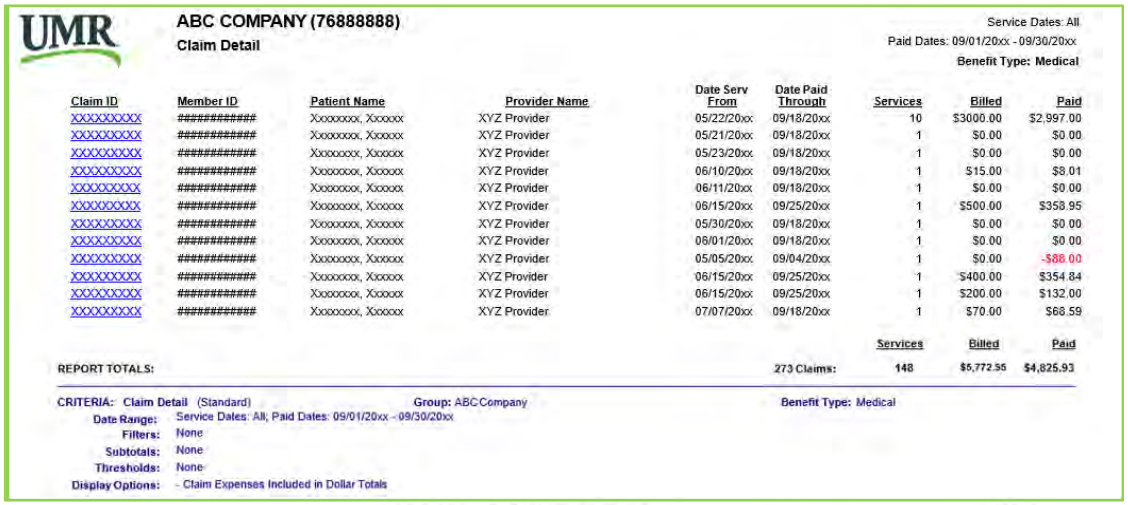
- Claim ID (hyperlink; drills into claim profile)
- Member ID
- Patient Name
- Relationship (Patient)
- DOB (Date of Birth)
- Gender (Patient)
- Contract
- Benefit Plan
- Class
- Location
- Provider Name-(billing provider)
- Provider TIN
- Network Indicator
- Service Dates
- Paid Initial
- Paid Thru
- Services
- Billed
- Paid

View next page for report samples.

Return to Report Content

Standard Format

Click hyperlink to drill into claim profile



UMR

ABC COMPANY (76888888)

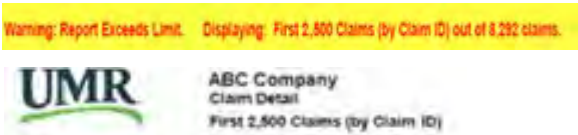
Claim Detail

Service Dates: All
Paid Dates: 09/01/20xx - 09/30/20xx
Benefit Type: Medical

Claim ID	Member ID	Patient Name	Provider Name	Date Serv From	Date Paid Through	Services	Billed	Paid
XXXXXXXXX	###########	Xxxxxxx, Xxxxx	XYZ Provider	05/22/20xx	09/18/20xx	10	$3000.00	$2,997.00
XXXXXXXXX	###########	Xxxxxxx, Xxxxx	XYZ Provider	05/21/20xx	09/18/20xx	1	$0.00	$0.00
XXXXXXXXX	###########	Xxxxxxx, Xxxxx	XYZ Provider	05/23/20xx	09/18/20xx	1	$0.00	$0.00
XXXXXXXXX	###########	Xxxxxxx, Xxxxx	XYZ Provider	06/10/20xx	09/18/20xx	1	$15.00	$8.01
XXXXXXXXX	###########	Xxxxxxx, Xxxxx	XYZ Provider	06/11/20xx	09/18/20xx	1	$0.00	$0.00
XXXXXXXXX	###########	Xxxxxxx, Xxxxx	XYZ Provider	06/15/20xx	09/25/20xx	1	$500.00	$358.95
XXXXXXXXX	###########	Xxxxxxx, Xxxxx	XYZ Provider	05/30/20xx	09/18/20xx	1	$0.00	$0.00
XXXXXXXXX	###########	Xxxxxxx, Xxxxx	XYZ Provider	06/01/20xx	09/18/20xx	1	$0.00	$0.00
XXXXXXXXX	###########	Xxxxxxx, Xxxxx	XYZ Provider	05/05/20xx	09/04/20xx	1	$0.00	-$88.00
XXXXXXXXX	###########	Xxxxxxx, Xxxxx	XYZ Provider	06/15/20xx	09/25/20xx	1	$400.00	$354.84
XXXXXXXXX	###########	Xxxxxxx, Xxxxx	XYZ Provider	06/15/20xx	09/25/20xx	1	$200.00	$132.00
XXXXXXXXX	###########	Xxxxxxx, Xxxxx	XYZ Provider	07/07/20xx	09/18/20xx	1	$70.00	$68.59
						Services	**Billed**	**Paid**
REPORT TOTALS:					**273 Claims:**	**148**	**$5,772.55**	**$4,825.93**

CRITERIA: Claim Detail (Standard) **Group:** ABC Company **Benefit Type:** Medical
Date Range: Service Dates: All; Paid Dates: 09/01/20xx - 09/30/20xx
Filters: None
Subtotals: None
Thresholds: None
Display Options: - Claim Expenses Included in Dollar Totals

Message when report exceeds 2,500 claims

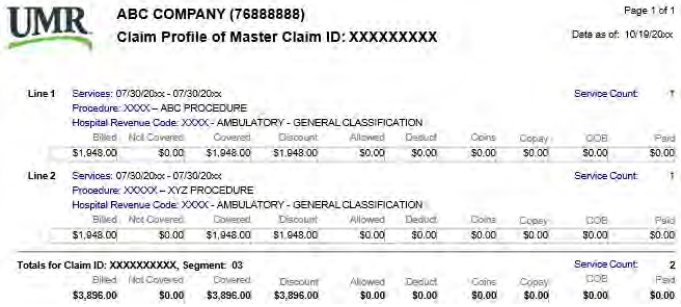


Warning: Report Exceeds Limit. Displaying: First 2,500 Claims (by Claim ID) out of 8,292 claims.

UMR

ABC Company
Claim Detail
First 2,500 Claims (by Claim ID)

Drill in Profile



UMR

ABC COMPANY (76888888)

Claim Profile of Master Claim ID: XXXXXXXXX

Page 1 of 1
Data as of: 10/19/20xx

Line 1 Services: 07/30/20xx - 07/30/20xx — Service Count: 1
Procedure: XXXX – ABC PROCEDURE
Hospital Revenue Code: XXXX - AMBULATORY - GENERAL CLASSIFICATION

Billed	Not Covered	Covered	Discount	Allowed	Deduct	Coins	Copay	COB	Paid
$1,948.00	$0.00	$1,948.00	$1,948.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Line 2 Services: 07/30/20xx - 07/30/20xx — Service Count: 1
Procedure: XXXX – XYZ PROCEDURE
Hospital Revenue Code: XXXX - AMBULATORY - GENERAL CLASSIFICATION

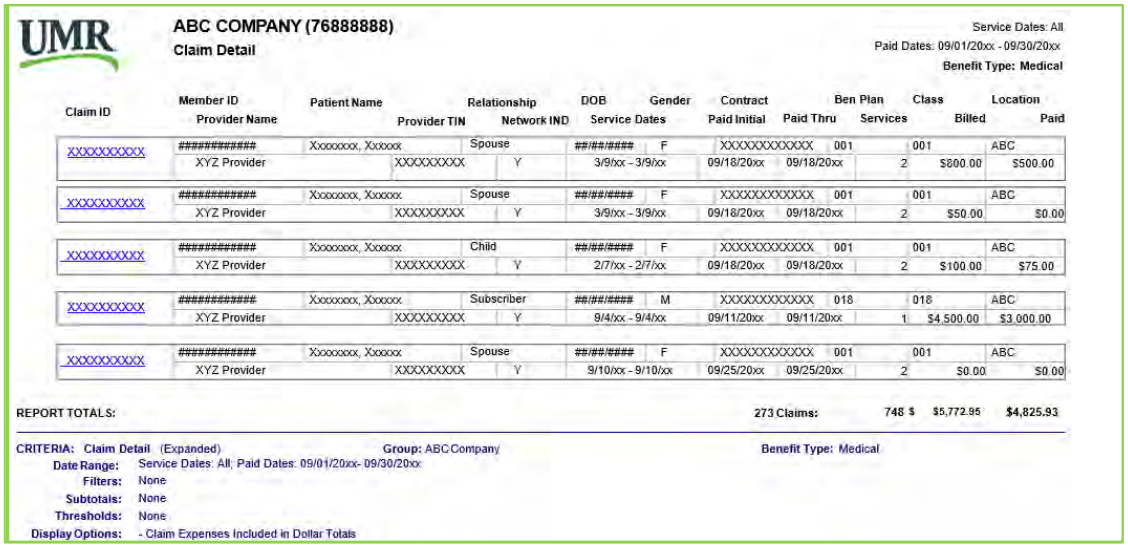
Billed	Not Covered	Covered	Discount	Allowed	Deduct	Coins	Copay	COB	Paid
$1,948.00	$0.00	$1,948.00	$1,948.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Totals for Claim ID: XXXXXXXXX, Segment: 03 — Service Count: 2

Billed	Not Covered	Covered	Discount	Allowed	Deduct	Coins	Copay	COB	Paid
$3,896.00	$0.00	$3,896.00	$3,896.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Expanded Format

Click hyperlink to drill into claim profile



UMR

ABC COMPANY (76888888)

Claim Detail

Service Dates: All
Paid Dates: 09/01/20xx - 09/30/20xx
Benefit Type: Medical

Claim ID	Member ID / Provider Name	Patient Name / Provider TIN	Relationship / Network IND	DOB / Service Dates	Gender	Contract / Paid Initial	Ben Plan / Paid Thru	Class / Services	Location / Billed	Paid
XXXXXXXXX	###########	Xxxxxxx, Xxxxx	Spouse	##########	F	XXXXXXXXXXX	001	001	ABC	
	XYZ Provider	XXXXXXXXX	Y	3/9/xx - 3/9/xx		09/18/20xx	09/18/20xx	2	$800.00	$500.00
XXXXXXXXX	###########	Xxxxxxx, Xxxxx	Spouse	##########	F	XXXXXXXXXXX	001	001	ABC	
	XYZ Provider	XXXXXXXXX	Y	3/9/xx - 3/9/xx		09/18/20xx	09/18/20xx	2	$50.00	$0.00
XXXXXXXXX	###########	Xxxxxxx, Xxxxx	Child	##########	F	XXXXXXXXXXX	001	001	ABC	
	XYZ Provider	XXXXXXXXX	Y	2/7/xx - 2/7/xx		09/18/20xx	09/18/20xx	2	$100.00	$75.00
XXXXXXXXX	###########	Xxxxxxx, Xxxxx	Subscriber	##########	M	XXXXXXXXXXX	018	018	ABC	
	XYZ Provider	XXXXXXXXX	Y	9/4/xx - 9/4/xx		09/11/20xx	09/11/20xx	1	$4,500.00	$3,000.00
XXXXXXXXX	###########	Xxxxxxx, Xxxxx	Spouse	##########	F	XXXXXXXXXXX	001	001	ABC	
	XYZ Provider	XXXXXXXXX	Y	9/10/xx - 9/10/xx		09/25/20xx	09/25/20xx	2	$0.00	$0.00
REPORT TOTALS:					**273 Claims:**			**748 $**	**$5,772.95**	**$4,825.93**

CRITERIA: Claim Detail (Expanded) **Group:** ABC Company **Benefit Type:** Medical
Date Range: Service Dates: All; Paid Dates: 09/01/20xx- 09/30/20xx
Filters: None
Subtotals: None
Thresholds: None
Display Options: - Claim Expenses Included in Dollar Totals

[Return to Report Content]

Claim Distribution

The Claim Distribution Report provides a view of patient and claim totals for a selected period of time, broken down into various financial ranges. With this report, there are options to filter by the plan's account structure. The report also offers the option to summarize data by a selection, suppress PHI, and show the distribution of paid claims dollars based on billed, allowed, covered, paid amount, or specific dollar ranges.

Report Parameters/Customization (available options)

- Benefit Type
- Date Range
- Filters
- Summarize By
- Distribution
- Display Options
- Schedule Options

Standard Report Content

- Claim Amount Range (user select distribution by: Billed, Allowed, Covered, or Paid)
- Patients
- Claims (hyperlink drills into Claim profile)
- Services
- Avg per Claim (by Billed, Allowed, Covered, or Paid)
- Amount (by Billed, Allowed, Covered, or Paid)
- % Amt Range v. Total ((by Billed, Allowed, Covered, or Paid)

Additional Information based on Distribution Selected

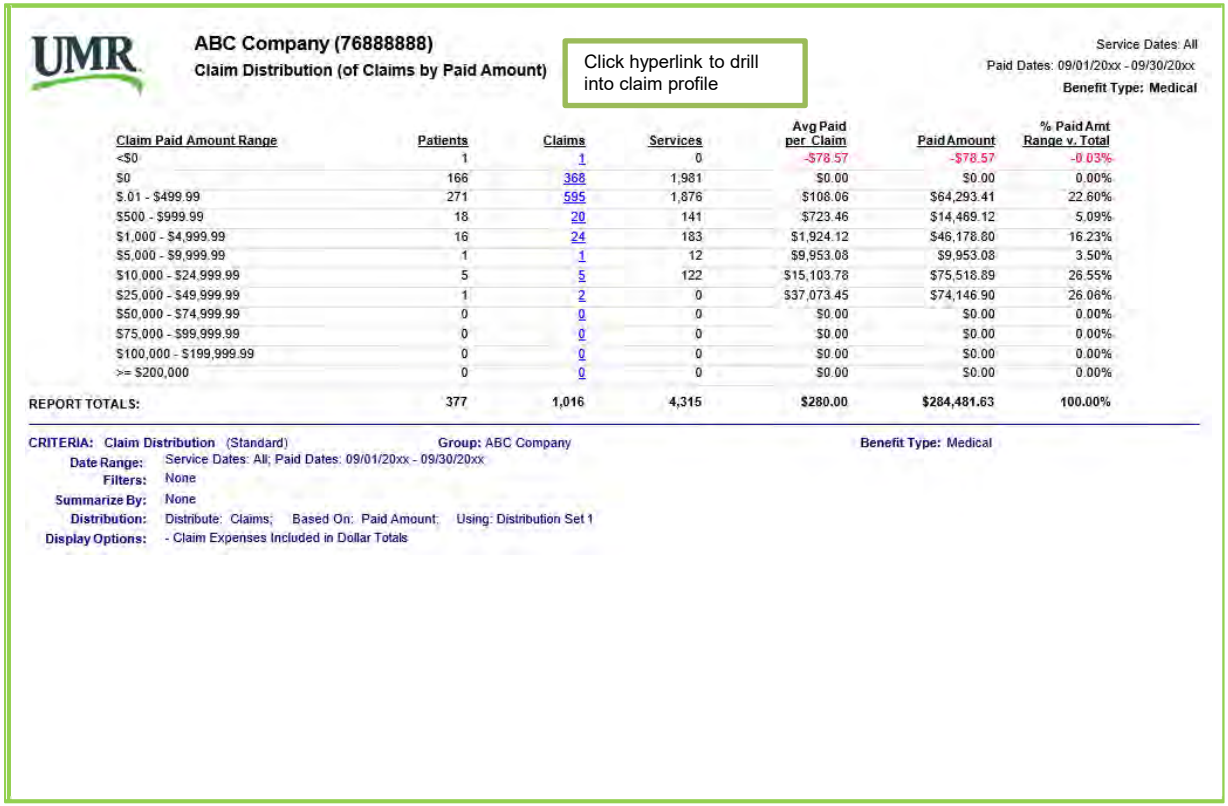
For Reports distributed by Claims:

- Avg * per Claim (* = Per selection can be Billed, Allowed, Covered, or Paid)
- % * Amt Range v. Total (* = Per selection can be Billed, Allowed, Covered, or Paid)

For Reports distributed by Patients:

- Avg * per Patient (* = Per selection can be Billed, Allowed, Covered, or Paid)
- % * Amt Range v. Total (* = Per selection can be Billed, Allowed, Covered, or Paid)

Report



UMR

ABC Company (76888888)
Claim Distribution (of Claims by Paid Amount)

Click hyperlink to drill into claim profile

Service Dates: All
Paid Dates: 09/01/20xx - 09/30/20xx
Benefit Type: Medical

Claim Paid Amount Range	Patients	Claims	Services	Avg Paid per Claim	Paid Amount	% Paid Amt Range v. Total
<$0	1	1	0	-$78.57	-$78.57	-0.03%
$0	166	368	1,981	$0.00	$0.00	0.00%
$.01 - $499.99	271	595	1,876	$108.06	$64,293.41	22.60%
$500 - $999.99	18	20	141	$723.46	$14,469.12	5.09%
$1,000 - $4,999.99	16	24	183	$1,924.12	$46,178.80	16.23%
$5,000 - $9,999.99	1	1	12	$9,953.08	$9,953.08	3.50%
$10,000 - $24,999.99	5	5	122	$15,103.78	$75,518.89	26.55%
$25,000 - $49,999.99	1	2	0	$37,073.45	$74,146.90	26.06%
$50,000 - $74,999.99	0	0	0	$0.00	$0.00	0.00%
$75,000 - $99,999.99	0	0	0	$0.00	$0.00	0.00%
$100,000 - $199,999.99	0	0	0	$0.00	$0.00	0.00%
>= $200,000	0	0	0	$0.00	$0.00	0.00%
REPORT TOTALS:	377	1,016	4,315	$280.00	$284,481.63	100.00%

CRITERIA: Claim Distribution (Standard) Group: ABC Company Benefit Type: Medical
Date Range: Service Dates: All; Paid Dates: 09/01/20xx - 09/30/20xx
Filters: None
Summarize By: None
Distribution: Distribute: Claims; Based On: Paid Amount; Using: Distribution Set 1
Display Options: - Claim Expenses Included in Dollar Totals

Drill in Profile

UMR

ABC Company (76888888)
Claim Distribution (of Claims by Paid Amount)
Drilled into Claim Detail

Service Dates: All
Paid Dates: 09/01/20xx - 09/30/20xx
Benefit Type: Medical

Claim ID	Member Id	Patient Name	Provider Name	Date Serv From	Date Paid Through	Services	Billed	Paid
Med XXXXXXXXX	XXXXXXXXXX	XXXXX XXX X	ABC Provider	08/27/20xx	09/17/20xx	0	$0.00	-$78.57
REPORT TOTALS:					1 Claim:	0	$0.00	-$78.57

Source Report: Claim Distribution 10/21/20xx Benefit Type: Medical
Date Range: Service Dates: All; Paid Dates: 09/01/20xx - 09/30/20xx
Filters: None
Display Options: - Claim Expenses Included in Dollar Totals
Drilled into: - Claim Paid Amount: <$0

Return to Report Content

Claim Lag[1]

The Claim Lag Report displays lag time between when services are performed and when the claim is paid over the course of a 12 or *24-month period. Results are presented in a grid, typically forming a triangular pattern. The report can be viewed to determine lag factors used for calculating the volume of claims incurred but not yet submitted and processed for payment. This report can provide results in two different formats: Paid Lag Months (excludes paid 24-month period) or Paid Calendar Months.

- Paid Lag Months: This format displays the Service Month (YYYY-MM) as the Y (vertical) axis and the Lag Months (0-11) as the X (horizontal) axis. Each row represents the paid dollar amount for the given service month, where each column is the number of months removed from the service month (0 lag months equal dollars paid the same month as the service month; 1 lag month equals dollars paid one month after the service month, etc.). The paid 24-month period cannot be selected utilizing this format.

- Paid Calendar Months: This format displays the Service Month (YYYY-MM) as the Y (vertical) axis and the Paid Month (YYYY-MM) as the X (horizontal) axis. Each row represents the paid dollar amount for the given service month, and each column represents the paid dollar amount for the given paid month.

Report Parameters/Customization (available options)

- Benefit Type
- Date Range (includes 24-month period/paid months)
- Filters
- Display Options
- Schedule Options

Report Content

Paid Months are Lag Months (0-11)

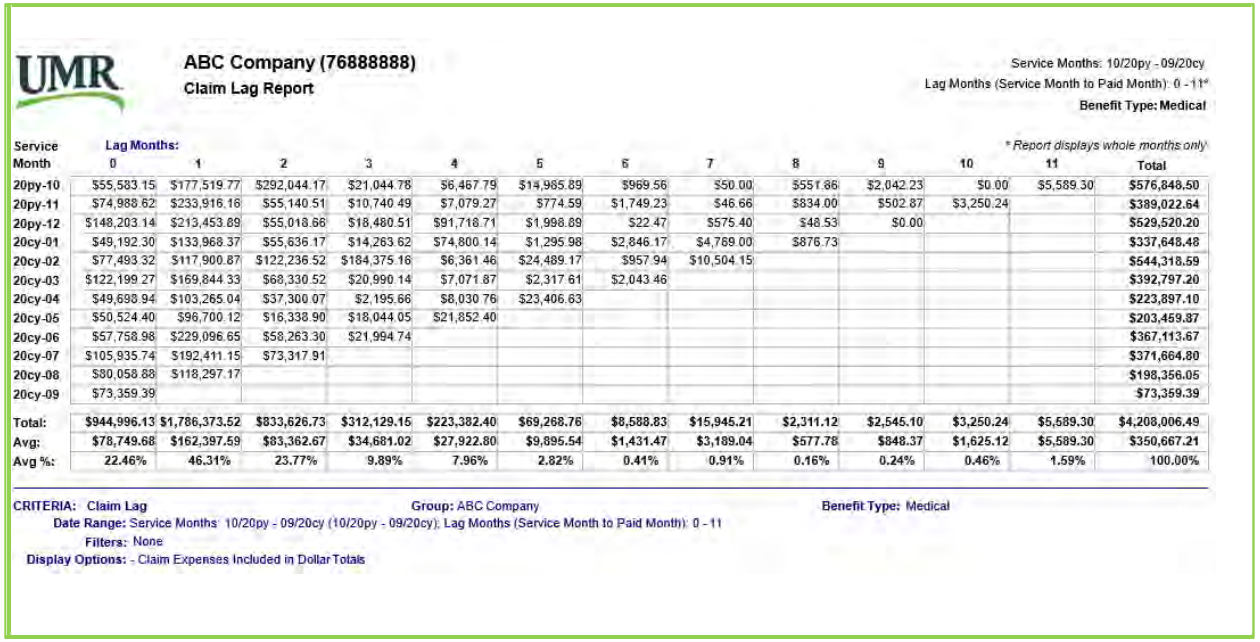
- Service Month: Month when service was performed.
- Lag Months: Number of months between service month and paid month.
- Total: Total paid dollars for rows and columns.
- Average: Average paid dollars for each Lag Month.
- Average %: Percent of average dollars paid for each Lag Month, indicates % of claims paid by month.

– Or –

Paid Months are Calendar Months

- Service Month: Month when service was performed.
- Paid Months: The 12 or 24 paid months for each service month.
- Total: Total paid dollars for rows and columns.

Paid Lag Months



UMR

ABC Company (76888888)
Claim Lag Report

Service Months: 10/20py - 09/20cy
Lag Months (Service Month to Paid Month): 0 - 11*
Benefit Type: Medical

*Report displays whole months only

Service Month	Lag Months: 0	1	2	3	4	5	6	7	8	9	10	11	Total
20py-10	$55,583.15	$177,519.77	$292,044.17	$21,044.78	$6,467.79	$14,985.89	$969.56	$50.00	$551.86	$2,042.23	$0.00	$5,589.30	$576,848.50
20py-11	$74,988.62	$233,916.16	$55,140.51	$10,740.49	$7,079.27	$774.59	$1,749.23	$46.66	$834.00	$502.87	$3,250.24		$389,022.64
20py-12	$148,203.14	$213,453.89	$55,018.66	$18,480.51	$91,718.71	$1,998.89	$22.47	$575.40	$48.53	$0.00			$529,520.20
20cy-01	$49,192.30	$133,968.37	$55,636.17	$14,263.62	$74,800.14	$1,295.98	$2,846.17	$4,769.00	$876.73				$337,648.48
20cy-02	$77,493.32	$117,900.87	$122,236.52	$184,375.16	$6,361.46	$24,489.17	$957.94	$10,504.15					$544,318.59
20cy-03	$122,199.27	$169,844.33	$68,330.52	$20,990.14	$7,071.87	$2,317.61	$2,043.46						$392,797.20
20cy-04	$49,698.94	$103,265.04	$37,300.07	$2,195.66	$8,030.76	$23,406.63							$223,897.10
20cy-05	$50,524.40	$96,700.12	$16,338.90	$18,044.05	$21,852.40								$203,459.87
20cy-06	$57,758.98	$229,096.65	$58,263.30	$21,994.74									$367,113.67
20cy-07	$105,935.74	$192,411.15	$73,317.91										$371,664.80
20cy-08	$80,058.88	$118,297.17											$198,356.05
20cy-09	$73,359.39												$73,359.39
Total:	$944,996.13	$1,786,373.52	$833,626.73	$312,129.15	$223,382.40	$69,268.76	$8,588.83	$15,945.21	$2,311.12	$2,545.10	$3,250.24	$5,589.30	$4,208,006.49
Avg:	$78,749.68	$162,397.59	$83,362.67	$34,681.02	$27,922.80	$9,895.54	$1,431.47	$3,189.04	$577.78	$848.37	$1,625.12	$5,589.30	$350,667.21
Avg %:	22.46%	46.31%	23.77%	9.89%	7.96%	2.82%	0.41%	0.91%	0.16%	0.24%	0.46%	1.59%	100.00%

CRITERIA: Claim Lag
Group: ABC Company
Benefit Type: Medical
Date Range: Service Months: 10/20py - 09/20cy (10/20py - 09/20cy); Lag Months (Service Month to Paid Month): 0 - 11
Filters: None
Display Options: - Claim Expenses Included in Dollar Totals

Note: This report is available for InfoPort's restricted (no-PHI) users.

[Return to Report Content](#)

View next page for additional report samples.

Paid Calendar Months–12 paid month period

ABC Company (76888888)
Claim Lag Report

Service Months: 10/20py - 09/20cy
Paid Months: 10/20py - 09/20cy
Benefit Type: Medical

Service Month	Paid Months: 20py-10	20py-11	20py-12	20cy-01	20cy-02	20cy-03	20cy-04	20cy-05	20cy-06	20cy-07	20cy-08	20cy-09	Total
20py-10	$55,583.15	$177,519.77	$292,044.17	$21,044.78	$6,467.79	$14,985.89	$969.56	$50.00	$551.86	$2,042.23	$0.00	$5,589.30	**$576,848.50**
20py-11		$74,988.62	$233,916.16	$55,140.51	$10,740.49	$7,079.27	$774.59	$1,749.23	$46.66	$834.00	$502.87	$3,250.24	**$389,022.64**
20py-12			$148,203.14	$213,453.89	$55,018.66	$18,480.51	$91,718.71	$1,998.89	$22.47	$575.40	$48.53	$0.00	**$529,520.20**
20cy-01				$49,192.30	$133,968.37	$55,636.17	$14,263.62	$74,800.14	$1,295.98	$2,846.17	$4,769.00	$876.73	**$337,648.48**
20cy-02					$77,493.32	$117,900.87	$122,236.52	$184,375.16	$6,361.46	$24,489.17	$957.94	$10,504.15	**$544,318.59**
20cy-03						$122,199.27	$169,844.33	$68,330.52	$20,990.14	$7,071.87	$2,317.61	$2,043.46	**$392,797.20**
20cy-04							$49,698.94	$103,265.04	$37,300.07	$2,195.66	$8,030.76	$23,406.63	**$223,897.10**
20cy-05								$50,524.40	$96,700.12	$16,338.90	$18,044.05	$21,852.40	**$203,459.87**
20cy-06									$57,758.98	$229,096.65	$58,263.30	$21,994.74	**$367,113.67**
20cy-07										$105,935.74	$192,411.15	$73,317.91	**$371,664.80**
20cy-08											$80,058.88	$118,297.17	**$198,356.05**
20cy-09												$73,359.39	**$73,359.39**
Total:	**$55,583.15**	**$252,508.39**	**$674,163.47**	**$338,831.48**	**$283,688.63**	**$336,281.98**	**$449,506.27**	**$485,093.38**	**$221,027.74**	**$391,425.79**	**$365,404.09**	**$354,492.12**	**$4,208,006.49**

CRITERIA: Claim Lag **Group:** ABC Company **Benefit Type:** Medical
Date Range: Service Months: 10/20py - 09/20cy (10/20py - 09/20cy); Paid Months: 10/20py - 09/20cy
Filters: None
Display Options: - Claim Expenses Included in Dollar Totals

Paid Calendar Months–24 paid month period

Data only format

ABC Company (76888888) Claim Lag Report Service Months: 02/201x - 01/20cy Paid Months: 02/201x - 01/20cyBenefit Type: Medical, Vision

Service Month	Paid Months:	201x-02	201x-03	201x-04	201x-05	201x-06	201x-07	201x-08	201x-09	201x-10	201x-11	201x-12	20py-01	20py-02	20py-03	20py-04	20py-05	20py-06	20py-07	20py-08	20py-09	20py-10	20py-11	20py-12	20cy-01	Total
201x-02		$41,427.87	$124,265.35	$67,250.17	$20,104.24	$151,072.00	$8,607.57	$17,402.78	$2,203.31	$564.82	$5,848.40	$36.00	$1,522.75	$400.96	$421.64	$-107.50	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$112.28	$0.00	$0.00	$441,132.64
201x-03			$70,207.99	$132,200.79	$64,044.32	$19,156.05	$8,374.61	$53,208.92	$6,673.33	$1,323.19	$200.73	$354.26	$32.00	$511.41	$5,713.56	$45.87	$1,043.65	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$-120.90	$0.00	$362,969.78
201x-04				$45,011.50	$140,213.78	$85,158.79	$28,918.91	$47,387.74	$7,294.00	$6,808.71	$3,752.11	$128.96	$5,066.74	$205.11	$7,101.61	$-205.11	$538.33	$0.00	$0.00	$0.00	$0.00	$2,247.67	$0.00	$-1,398.88	$0.00	$378,223.97
201x-05					$89,649.24	$94,636.20	$43,625.98	$7,067.29	$33,076.28	$8,048.84	$4,536.56	$268.61	$3,050.98	$1,841.40	$3,497.13	$72.07	$384.07	$-47.16	$0.00	$0.00	$0.00	$-209.63	$0.00	$0.00	$0.00	$289,497.86
201x-06						$84,640.69	$108,647.41	$81,764.97	$20,323.10	$6,883.63	$35,530.19	$83,249.44	$1,808.37	$672.23	$186.90	$3,939.72	$480.49	$0.00	$0.00	$0.00	$145.20	$0.00	$0.00	$0.00	$0.00	$428,672.34
201x-07							$55,142.63	$212,116.38	$149,216.36	$22,806.01	$23,326.25	$1,041.46	$664.58	$2,786.94	$2,320.24	$1,568.09	$2,322.32	$0.00	$0.00	$0.00	$0.00	$95.00	$0.00	$0.00	$0.00	$473,406.26
201x-08								$124,934.42	$319,245.53	$34,636.14	$33,489.69	$67,667.56	$15,491.17	$539.84	$11,444.71	$4,806.72	$35,180.34	$14,545.60	$9,372.35	$80.37	$188.61	$352.08	$0.00	$14.60	$0.00	$731,989.73
201x-09									$77,726.53	$150,165.70	$73,172.61	$83,102.86	$3,899.04	$2,096.21	$11,965.43	$1,988.63	$1,897.00	$-349.01	$100.00	$0.00	$0.00	$128.55	$45.00	$-323.28	$252.62	$405,868.09
201x-10										$55,583.15	$177,519.77	$232,044.17	$21,044.78	$6,467.79	$14,985.89	$969.56	$50.00	$551.86	$2,042.23	$0.00	$5,589.30	$115.98	$590.75	$816.44	$0.00	$578,371.67
201x-11											$74,988.62	$233,916.16	$55,140.51	$10,740.49	$7,079.27	$774.59	$1,749.23	$46.66	$834.00	$502.87	$3,250.24	$144.09	$5,473.47	$724.33	$0.00	$395,364.53
201x-12												$148,203.14	$213,453.89	$55,018.66	$18,480.51	$91,718.71	$1,998.89	$22.47	$575.40	$48.53	$0.00	$-1,055.41	$115.98	$-282.83	$-36.84	$528,261.10
20py-01													$49,192.30	$133,968.37	$55,636.17	$14,263.62	$74,800.14	$1,295.98	$2,846.17	$4,769.00	$876.73	$301.93	$203.99	$304.54	$585.13	$339,044.07
20py-02														$77,493.32	$117,900.87	$122,236.52	$184,375.16	$6,361.46	$24,489.17	$957.94	$10,504.15	$3,276.81	$-954.89	$-50.95	$50.82	$546,740.38
20py-03															$122,199.27	$169,844.33	$68,330.52	$20,990.14	$7,071.87	$2,317.61	$2,043.46	$593.73	$1,105.06	$103.47	$0.00	$394,599.46
20py-04																$49,698.94	$103,265.04	$37,300.07	$2,195.66	$8,030.76	$23,406.63	$1,464.38	$4,563.41	$-2,956.45	$260.00	$227,228.44
20py-05																	$50,524.40	$96,700.12	$16,338.90	$18,044.05	$21,852.40	$4,288.84	$185.44	$-16,725.99	$1,920.06	$193,128.22
20py-06																		$57,758.98	$229,096.65	$58,263.30	$21,994.74	$32,508.16	$-307.60	$33,095.25	$732.48	$433,141.96
20py-07																			$105,935.74	$192,411.15	$73,317.91	$67,333.59	$1,861.84	$993.01	$1,589.72	$443,442.96
20py-08																				$80,058.88	$118,297.17	$104,241.56	$188,802.31	$4,150.74	$653.44	$496,204.10
20py-09																					$73,359.39	$373,449.44	$204,604.56	$6,557.59	$960.49	$658,931.47
20py-10																						$141,633.72	$209,573.22	$60,263.48	$14,294.81	$425,765.23
20py-11																							$109,034.46	$247,967.79	$43,984.72	$406,986.97
20py-12																								$141,192.69	$204,583.27	$345,775.96
20cy-01																									$88,657.08	$88,657.08
Total:		$41,427.87	$194,473.34	$244,462.46	$314,011.58	$434,663.73	$253,317.11	$543,882.50	$616,358.44	$286,620.19	$492,364.93	$910,012.62	$370,367.11	$292,742.73	$378,933.20	$461,614.96	$526,939.58	$235,177.17	$400,898.14	$365,484.46	$354,825.93	$730,910.43	$725,009.28	$474,324.65	$364,587.80	$10,013,410.27
Avg:		$41,427.87	$97,236.67	$81,487.49	$78,502.90	$86,932.75	$42,219.52	$77,697.50	$77,044.81	$31,846.69	$49,236.49	$82,728.42	$30,863.93	$22,518.67	$27,066.66	$30,774.33	$32,933.72	$13,833.95	$22,272.12	$19,236.02	$17,741.30	$34,805.26	$32,954.97	$20,622.81	$15,191.16	$10,013,410.27
Avg %:		0.41%	0.97%	0.81%	0.78%	0.87%	0.42%	0.78%	0.77%	0.32%	0.49%	0.83%	0.31%	0.22%	0.27%	0.31%	0.33%	0.14%	0.22%	0.19%	0.18%	0.35%	0.33%	0.21%	0.15%	100.00%

Return to Report Content

Claim Summary[1]

The Claim Summary Report is one of the most flexible reports in the InfoPort suite. This report is ideal for analyzing large volumes of paid claims data; the online report provides the ability to drill into the claim profile using a report hyperlink. Data can be summarized by claim count and claim dollars, with up to four dimensions available. The report provides an option to analyze paid claims to desired data specifications and create a customized summary report. The available summary fields cover attributes of a variety of categories, including:

- Plan Account Structure
- Claim Category (inpatient, outpatient, physician, dental, etc.)
- Patient name, age, gender, relationship, gender, network
- Subscriber ID, name, state

Report Parameters/Customization (available options):

- BenefitType
- DateRange
- Filters
- Summarize by
- Thresholds
- Display Options
- Schedule Options
- Report Format

Standard Report Content

- Patients
- Claims (hyperlink; drills into claim profile)
- Services
- Billed
- Allowed
- Paid

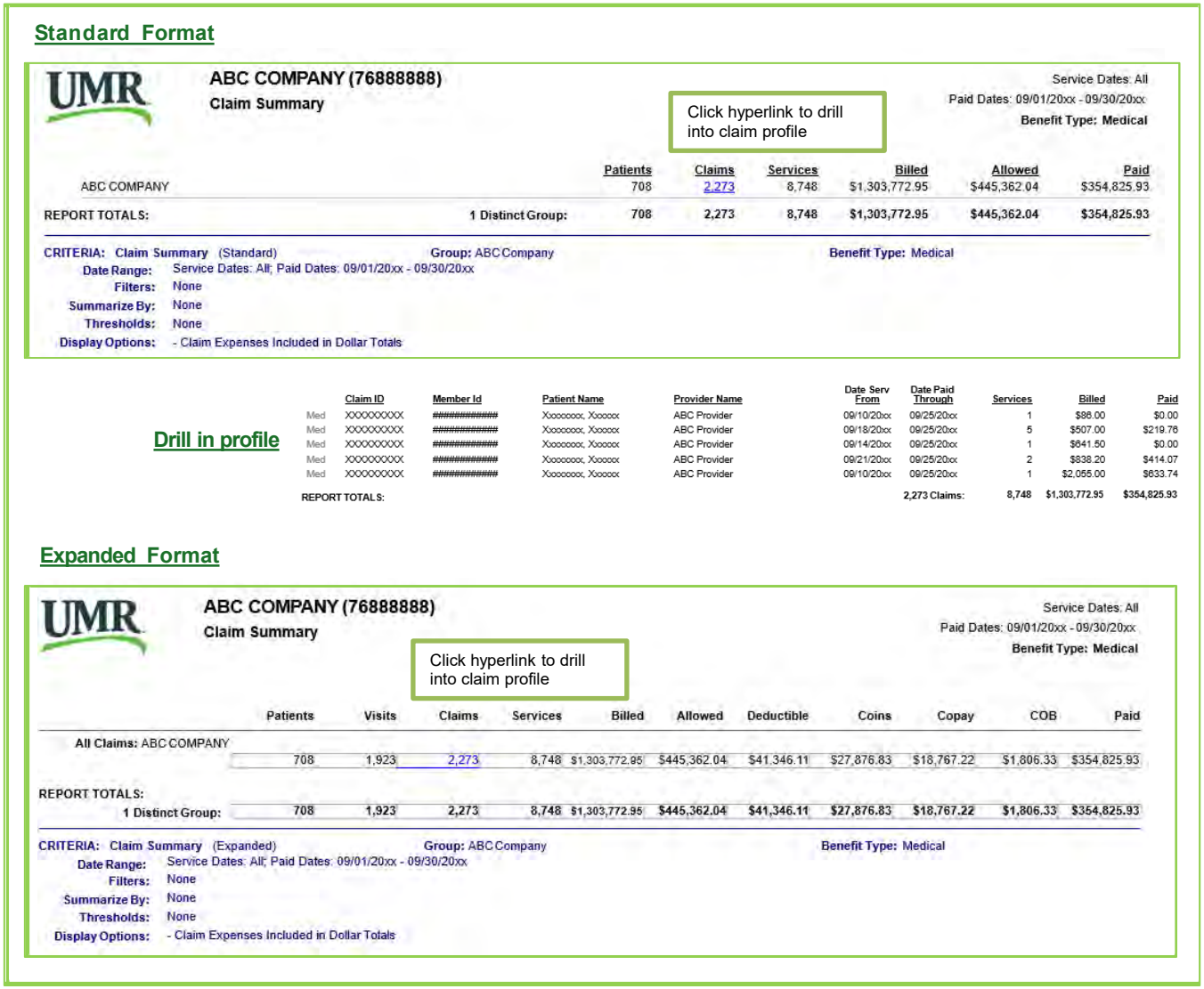
Expanded Report Content

- Patients
- Visits
- Claims (hyperlink; drills into claim profile)
- Services
- Billed
- Allowed
- Deductible
- Coinsurance
- Copay
- COB (Coordination of Benefits)
- Paid

Note: This report is available for restricted (no-PHI) users; no drill-in capability. Restricted users will have limited filter/summarize by options.

Return to Report Content

Standard Format



Expanded Format

Claim Summary by Member

The Claim Summary by Member Report provides summary claim information displayed by individual patient or grouped by the patient's family and displays key demographic information. The report can be used to answer member questions regarding claim payment, determine utilization, or identify patients/families with the highest claim costs based on a user defined dollar threshold. To complete analysis, the online report provides a hyperlink to drill into the claim detail. The standard format displays basic member data and costs. The expanded format increases financial fields. When the Family display option is selected, the data and dimensions are at the subscriber level.

Report Parameters/Customization (available options):

- Benefit Type
- Date Range
- Filters
- Subtotals
- Thresholds
- Display Options
- Schedule Options
- Report Format

Standard Report Content

Patient Level:

- Member Name
- Member ID
- Relationship
- Sex
- Age
- Claims (hyperlink)
- Services
- Billed
- Covered
- Allowed
- Paid

Family Level

- Subscriber Name
- Subscriber ID (hyperlink)
- Coverage Tier
- Patients
- Claims (hyperlink)
- Services
- Billed
- Covered
- Allowed
- Paid

Expanded Report Content

Patient Level:

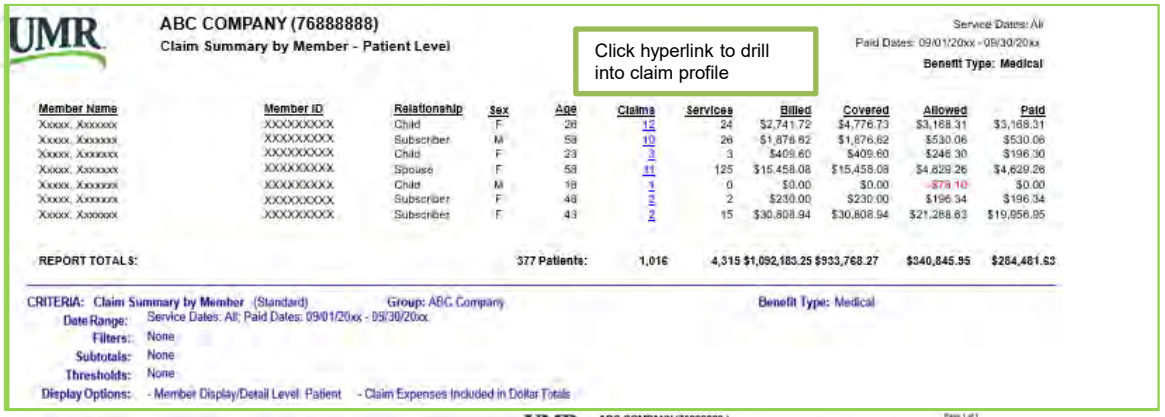
- Member Name
- Member ID
- Relationship
- Sex / Age / State / Zip
- Patients / Visits
- Claims (hyperlink)
- Svcs (Services)
- Billed
- Not Covered / Covered
- Discount / Allowed
- Deductible / Coins
- Copayment / COB
- Paid

Family Level

- Subscriber Name
- Subscriber ID (hyperlink)
- Coverage Tier
- State / Zip
- Patients / Visits
- Claims (hyperlink)
- Svcs (Services)
- Billed
- Not Covered / Covered
- Discount / Allowed
- Deductible / Coins
- Copayment / COB
- Paid

Return to Report Content

Standard Format – Patient Level



Drill in profile – subscriber ID

Expanded Format – Family Level

Claim Summary by Network

The Claim Summary by Network Report assists with evaluating financial benefit of the plan's network arrangements. The report displays summary claim information by network. By applying filters, subtotals, and thresholds, custom data analysis can occur. The online report provides a hyperlink to drill into the claim profile. Report data can be split on separate reports in two different views:

- Claim Network: This method summarizes paid claims based on the specific network that applied the discount, including travel and wrap networks. The report provides information on savings the plan is receiving by network and assists with analyzing network utilization.
- Member Network: This method summarizes paid claims based on the primary network of the individual member. If the plan offers multiple network arrangements, using this option can assist with evaluating overall network strategy.

Report Parameters/ Customization (available options):

- Benefit Type
- Date Range
- Filters
- Subtotals
- Thresholds
- Display Options
- Schedule Options
- Report Format

Standard Report Content

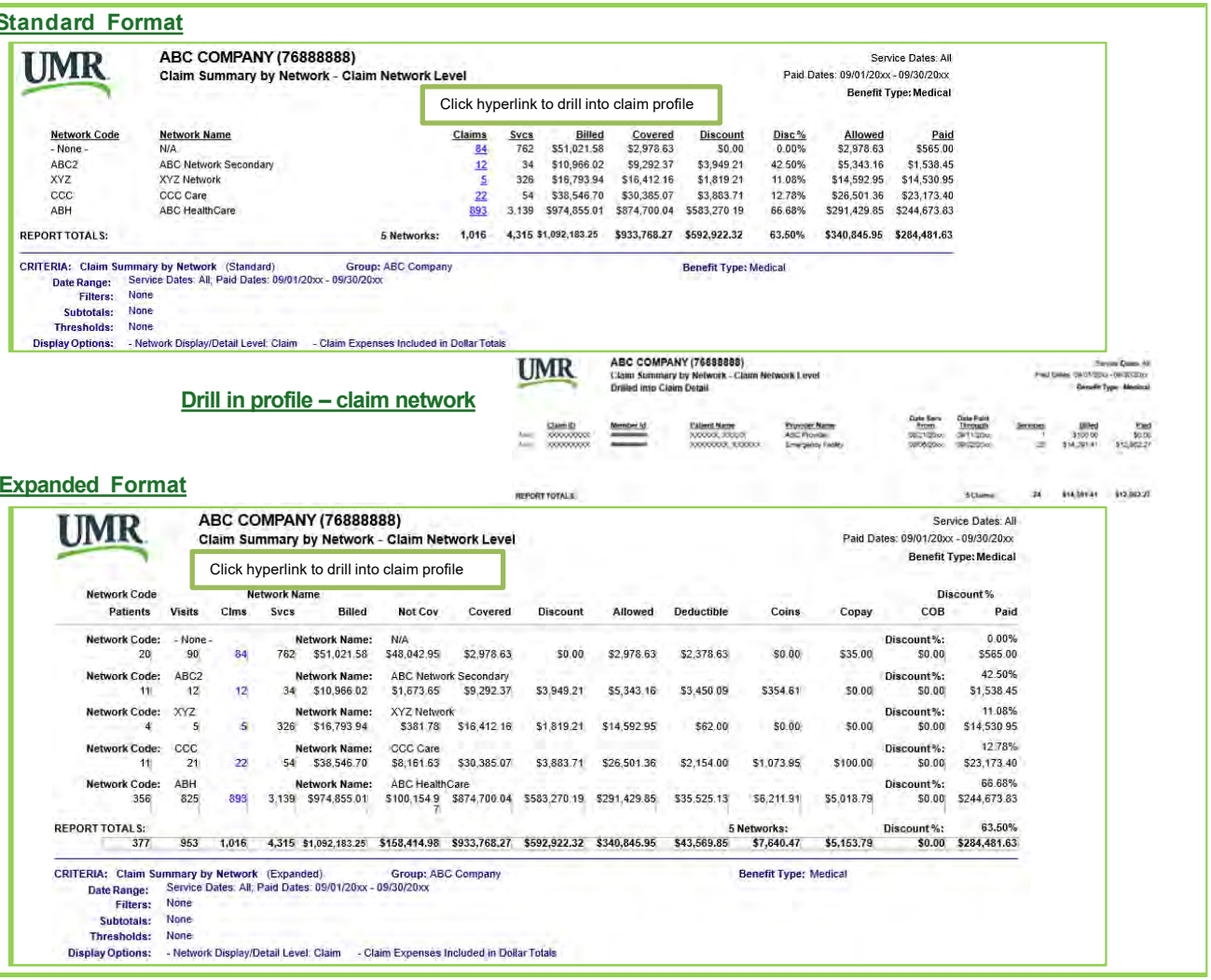
- Network Code
- Network Name
- Claims (hyperlink; drills into claim profile)
- Svcs (Services)
- Billed
- Covered
- Discount
- Discount Percent
- Allowed
- Paid

Expanded Report Content

- Network Code
- Network Name
- Patients
- Visits
- Claims (hyperlink)
- Svcs (Services)
- Billed
- Not Covered
- Covered
- Discount
- Allowed
- Deductible
- Coins
- Copay
- Discount Percent
- COB (Coordination of Benefits)
- Paid

Return to Report Content

Standard Format



UMR

ABC COMPANY (76888888)
Claim Summary by Network - Claim Network Level

Service Dates: All
Paid Dates: 09/01/20xx - 09/30/20xx
Benefit Type: Medical

Click hyperlink to drill into claim profile

Network Code	Network Name	Claims	Svcs	Billed	Covered	Discount	Disc %	Allowed	Paid
- None -	N/A	84	762	$51,021.58	$2,978.63	$0.00	0.00%	$2,978.63	$565.00
ABC2	ABC Network Secondary	12	34	$10,966.02	$9,292.37	$3,949.21	42.50%	$5,343.16	$1,538.45
XYZ	XYZ Network	5	326	$16,793.94	$16,412.16	$1,819.21	11.08%	$14,592.95	$14,530.95
CCC	CCC Care	22	54	$38,546.70	$30,385.07	$3,883.71	12.78%	$26,501.36	$23,173.40
ABH	ABC HealthCare	893	3,139	$974,855.01	$874,700.04	$583,270.19	66.68%	$291,429.85	$244,673.83
REPORT TOTALS:	5 Networks:	1,016	4,315	$1,092,183.25	$933,768.27	$592,922.32	63.50%	$340,845.95	$284,481.63

CRITERIA: Claim Summary by Network (Standard) Group: ABC Company Benefit Type: Medical
Date Range: Service Dates: All; Paid Dates: 09/01/20xx - 09/30/20xx
Filters: None
Subtotals: None
Thresholds: None
Display Options: - Network Display/Detail Level: Claim - Claim Expenses Included in Dollar Totals

Drill in profile – claim network

UMR

ABC COMPANY (76888888)
Claim Summary by Network - Claim Network Level
Drilled into Claim Detail

Expanded Format

UMR

ABC COMPANY (76888888)
Claim Summary by Network - Claim Network Level

Service Dates: All
Paid Dates: 09/01/20xx - 09/30/20xx
Benefit Type: Medical

Click hyperlink to drill into claim profile

Network Code / Patients	Visits	Clms	Svcs	Billed	Not Cov	Covered	Discount	Allowed	Deductible	Coins	Copay	Discount % COB	Paid
Network Code: - None - Network Name: N/A												Discount %:	0.00%
20	90	84	762	$51,021.58	$48,042.95	$2,978.63	$0.00	$2,978.63	$2,378.63	$0.00	$35.00	$0.00	$565.00
Network Code: ABC2 Network Name: ABC Network Secondary												Discount %:	42.50%
11	12	12	34	$10,966.02	$1,673.65	$9,292.37	$3,949.21	$5,343.16	$3,450.09	$354.61	$0.00	$0.00	$1,538.45
Network Code: XYZ Network Name: XYZ Network												Discount %:	11.08%
4	5	5	326	$16,793.94	$381.78	$16,412.16	$1,819.21	$14,592.95	$62.00	$0.00	$0.00	$0.00	$14,530.95
Network Code: CCC Network Name: CCC Care												Discount %:	12.78%
11	21	22	54	$38,546.70	$8,161.63	$30,385.07	$3,883.71	$26,501.36	$2,154.00	$1,073.95	$100.00	$0.00	$23,173.40
Network Code: ABH Network Name: ABC HealthCare												Discount %:	66.68%
356	825	893	3,139	$974,855.01	$100,154.97	$874,700.04	$583,270.19	$291,429.85	$35,525.13	$6,211.91	$5,018.79	$0.00	$244,673.83
REPORT TOTALS: 5 Networks:												Discount %:	63.50%
377	953	1,016	4,315	$1,092,183.25	$158,414.98	$933,768.27	$592,922.32	$340,845.95	$43,569.85	$7,640.47	$5,153.79	$0.00	$284,481.63

CRITERIA: Claim Summary by Network (Expanded) Group: ABC Company Benefit Type: Medical
Date Range: Service Dates: All; Paid Dates: 09/01/20xx - 09/30/20xx
Filters: None
Subtotals: None
Thresholds: None
Display Options: - Network Display/Detail Level: Claim - Claim Expenses Included in Dollar Totals

Claim Summary by Provider

The Claim Summary by Provider Report provides a summary of claim information by the provider to display at two levels on separate reports: **Individual Provider Level**, or by **Provider Tax Identification Number** (providers with the same TIN are grouped together). Report data can be used to answer member questions regarding claim payment, determine which providers/facilities are the frequently utilized, and analyze provider utilization patterns. The report format provides basic provider and cost information. The online report also supports a hyperlink to drill into the claim profile.

Report Parameters/ Customization (available options):

- Benefit Type
- Date Range
- Filters
- Subtotals
- Thresholds
- Display Options
- Schedule Options
- Report Format

Report Content

By provider:

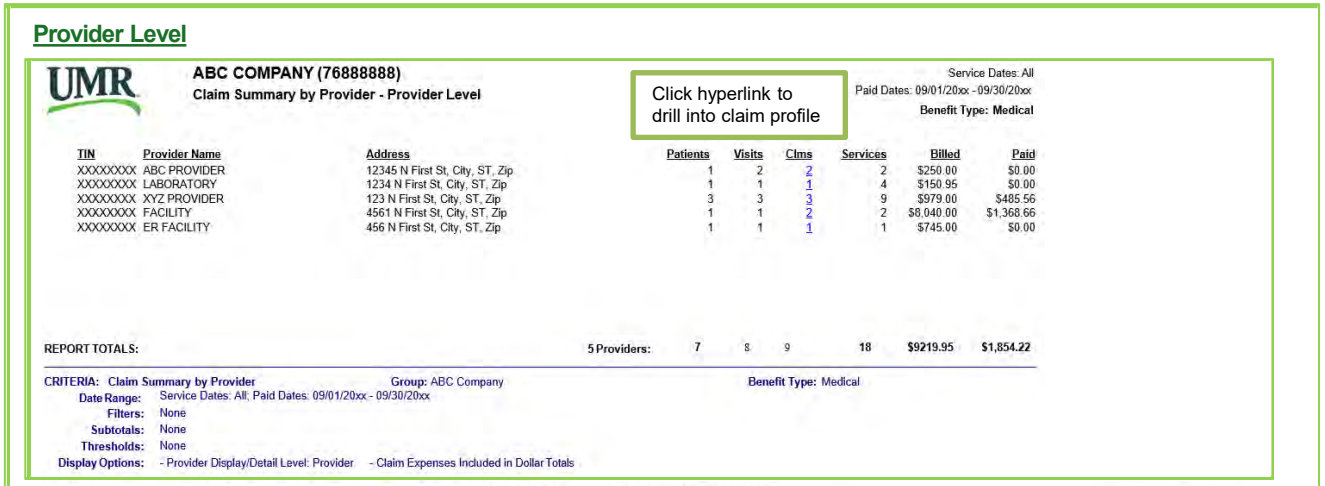
- TIN (Provider Tax Identification Number)
- Provider Name-(billing provider)
- Address (Provider Full Address)
- Patients
- Visits
- Claims (hyperlink; drills into claim profile)
- Services
- Billed
- Paid

By TIN:

- TIN (Provider Tax Identification Number)
- Provider Name-(billing provider)
- Patients
- Visits
- Claims (hyperlink; drills into claim profile)
- Services
- Billed
- Paid

Report

Provider Level



UMR

ABC COMPANY (76888888)
Claim Summary by Provider - Provider Level

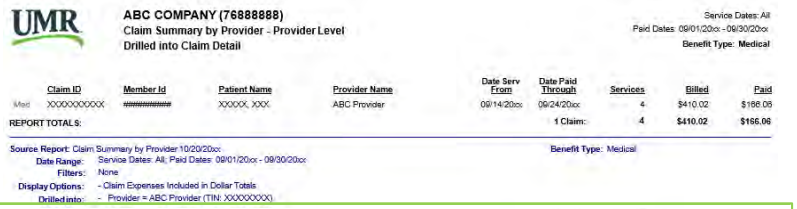
Click hyperlink to drill into claim profile

Service Dates: All
Paid Dates: 09/01/20xx - 09/30/20xx
Benefit Type: Medical

TIN	Provider Name	Address	Patients	Visits	Clms	Services	Billed	Paid
XXXXXXXX	ABC PROVIDER	12345 N First St, City, ST, Zip	1	2	2	2	$250.00	$0.00
XXXXXXXX	LABORATORY	1234 N First St, City, ST, Zip	1	1	1	4	$150.95	$0.00
XXXXXXXX	XYZ PROVIDER	123 N First St, City, ST, Zip	3	3	3	9	$979.00	$485.56
XXXXXXXX	FACILITY	4561 N First St, City, ST, Zip	1	1	2	2	$8,040.00	$1,368.66
XXXXXXXX	ER FACILITY	456 N First St, City, ST, Zip	1	1	1	1	$745.00	$0.00
REPORT TOTALS:			5 Providers:	7	8	9	18	$9219.95	$1,854.22

CRITERIA: Claim Summary by Provider Group: ABC Company Benefit Type: Medical
Date Range: Service Dates: All; Paid Dates: 09/01/20xx - 09/30/20xx
Filters: None
Subtotals: None
Thresholds: None
Display Options: - Provider Display/Detail Level: Provider - Claim Expenses Included in Dollar Totals

Drill in profile



UMR

ABC COMPANY (76888888)
Claim Summary by Provider - Provider Level
Drilled into Claim Detail

Service Dates: All
Paid Dates: 09/01/20xx - 09/30/20xx
Benefit Type: Medical

Claim ID	Member Id	Patient Name	Provider Name	Date Serv From	Date Paid Through	Services	Billed	Paid
Med XXXXXXXXXX	##########	XXXXX, XXX	ABC Provider	09/14/20xx	09/24/20xx	4	$410.02	$166.06
REPORT TOTALS:					1 Claim:	4	$410.02	$166.06

Source Report: Claim Summary by Provider 10/20/20xx
Date Range: Service Dates: All; Paid Dates: 09/01/20xx - 09/30/20xx
Filters: None
Display Options: - Claim Expenses Included in Dollar Totals
Drilled into: - Provider = ABC Provider (TIN: XXXXXXXX)
Benefit Type: Medical

TIN Level

UMR

ABC COMPANY (76888888)
Claim Summary by Provider – TIN Level

Click hyperlink to drill into claim profile

Service Dates: All
Paid Dates: 09/01/20xx - 09/30/20xx
Benefit Type: Medical

TIN	Provider Name	Patients	Visits	Clms	Services	Billed	Paid
XXXXXXXX	1 Provider: ABC PROVIDER	1	2	2	2	$250.00	$0.00
XXXXXXXX	1 Providers: LABORATORY	1	1	1	4	$150.95	$0.00
XXXXXXXX	3 Providers: XYZ PROVIDER	3	1	3	9	$979.00	$485.56
XXXXXXXX	1 Provider: FACILITY	1	2	2	2	$8,040.00	$1,368.66
XXXXXXXX	1 Provider: ER FACILITY	1	1	1	1	$745.00	$0.00
REPORT TOTALS:		350 TINs:	377	953	1,016	4,315	$92,183.25	$84,481.63

CRITERIA: Claim Summary by Provider Group: ABC Company Benefit Type: Medical
Date Range: Service Dates: All; Paid Dates: 09/01/20xx - 09/30/20xx
Filters: None
Subtotals: None
Thresholds: None
Display Options: - Provider Display/Detail Level: Provider TIN - Claim Expenses Included in Dollar Totals

Return to Report Content

Claim Summary Service Level

Similar to the Claim Summary Report, the Claim Summary Service Level Report provides an option to summarize claim counts and claim dollars by up to four dimensions. The report's focus, however, is on the claim service line attributes, which are not available on the Claim Summary Report. This report provides an option to filter on and produce report summaries by type of service, diagnosis, procedure, telehealth/telemedicine indicator (if applicable), claim category, etc., providing a source to analyze member utilization and cost by condition or treatment. Summarize report data by *service category sub 2* to view patient utilization by services.

Note: The Claim Summary Service Level Report does not have all claim-level field options as the Claim Summary Report; this report does not provide claim drill-in. The Claim Summary Report can be utilized for analysis of the plan above the service line level.

Report Parameters/ Customization (available options)

- Benefit Type
- Date Range
- Filters
- Summarize by
- Thresholds
- Display Options
- Schedule Options
- Report Format

Report Content

- Patients
- Visits
- Claims
- Services
- Billed
- Paid

Report

UMR

ABC COMPANY (76888888)
Claim Summary Service Level

Service Dates: All
Paid Dates: 09/01/20xx - 09/30/20xx
Benefit Type: Medical

		Patients	Visits	Claims	Services	Billed	Paid
ABC COMPANY		708	1,923	2,273	8,748	$1,303,772.95	$354,825.93
REPORT TOTALS:	**1 Distinct Group:**	**708**	**1,923**	**2,273**	**8,748**	**$1,303,772.95**	**$354,825.93**

CRITERIA: Claim Summary Service Level **Group:** ABC Company **Benefit Type:** Medical
Date Range: Service Dates: All; Paid Dates: 09/01/20xx - 09/30/20xx
Filters: None
Summarize By: None
Thresholds: None
Display Options: - Claim Expenses Included in Dollar Totals

Report summarized by Service Category Sub 2

UMR

ABC COMPANY (76888888)
Claim Summary Service Level by Service Category Sub 2

Service Dates: All
Paid Dates: 09/01/20xx - 09/30/20xx
Benefit Type: Medical

Serv Category Sub 2		Patients	Visits	Claims	Services	Billed	Paid
### - EYEGLASSES		2	2	3	4	$157.00	$0.00
### - PRESCRIPTION ITEMS		36	48	49	125	$23,467.60	$7,086.88
### - INPATIENT FACILITY		1	1	3	3	$13,608.45	$0.00
### - INPATIENT PHYSICIAN		1	1	3	3	$300.00	$59.00
### - ER FACILITY		3	13	22	88	$1,889.34	$0.00
### - SUPPLIES		1	1	1	180	$2,052.00	$613.44
XXX - OTHER		75	88	90	234	$14,922.75	$5,062.84
REPORT TOTALS:	**43 Distinct Groups:**	**708**	**1,923**	**2,273**	**8,748**	**$1,303,772.95**	**$354,825.93**

CRITERIA: Claim Summary Service Level **Group:** ABC Company **Benefit Type:** Medical
Date Range: Service Dates: All; Paid Dates: 09/01/20xx - 09/30/20xx
Filters: None
Summarize By: 1. Service Category Sub 2
Thresholds: None
Display Options: - Claim Expenses Included in Dollar Totals

Return to Report Content

Claims and Enrollment by Month

The Claims and Enrollment by Month Report provides totals by month for member and claim information, including a comparison of billed, covered, allowed, and paid amounts including a paid PMPM. This report offers hyperlinks for drill in on member detail or claims profile which provide corresponding details. The report is available in a standard or expanded version.

Report Parameters/ Customization (available options)

- Benefit Type
- Date Range
- Filters
- Summarize By
- Display Options
- Schedule Options
- Report Format

Standard Report Content

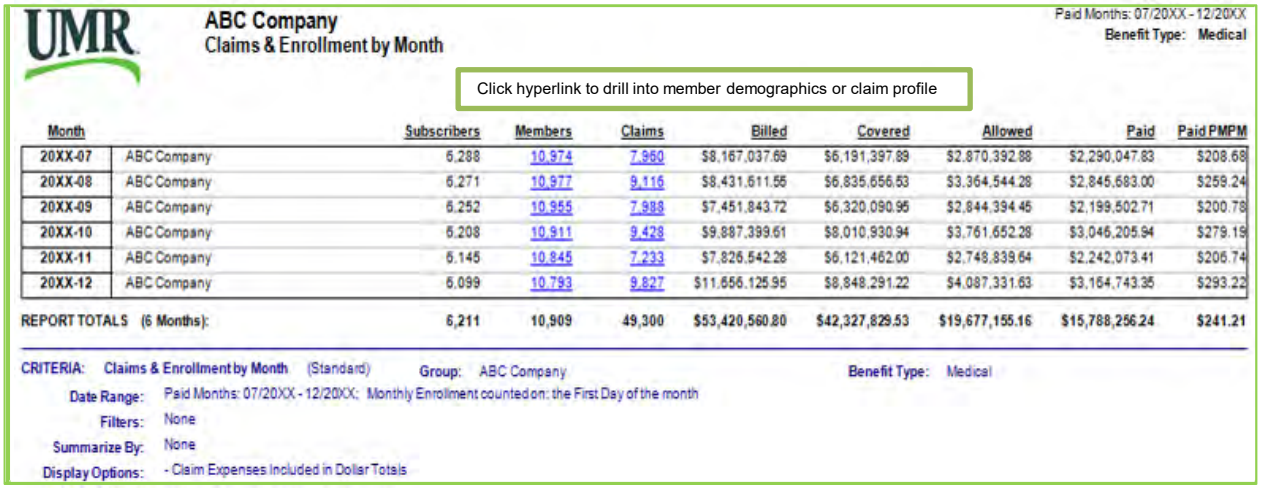
- Month
- Client Name
- Subscribers
- Members (hyperlink; drills into member demographics)
- Claims (hyperlink; drills into claim profile)
- Billed
- Covered
- Allowed
- Paid
- Paid PMPM

Expanded Report Content

- Month
- Subs (Subscribers)
- Mems (Members-hyperlink)
- Claims (hyperlink)
- Billed
- Not Cov
- Covered
- Discount
- Allowed
- Patient Amt
- COB (Coord of Bnfts)
- Paid
- Paid PMPM

Return to Report Content

Standard Format



UMR

ABC Company
Claims & Enrollment by Month

Paid Months: 07/20XX - 12/20XX
Benefit Type: Medical

Click hyperlink to drill into member demographics or claim profile

Month		Subscribers	Members	Claims	Billed	Covered	Allowed	Paid	Paid PMPM
20XX-07	ABC Company	6,288	10,974	7,960	$8,167,037.69	$6,191,397.89	$2,870,392.88	$2,290,047.83	$208.68
20XX-08	ABC Company	6,271	10,977	9,116	$8,431,611.55	$6,835,656.53	$3,364,544.28	$2,845,683.00	$259.24
20XX-09	ABC Company	6,252	10,955	7,988	$7,451,843.72	$6,320,090.95	$2,844,394.45	$2,199,502.71	$200.78
20XX-10	ABC Company	6,208	10,911	9,428	$9,887,399.61	$8,010,930.94	$3,761,652.28	$3,046,205.94	$279.19
20XX-11	ABC Company	6,145	10,845	7,233	$7,826,542.28	$6,121,462.00	$2,748,839.64	$2,242,073.41	$206.74
20XX-12	ABC Company	6,099	10,793	9,827	$11,656,125.95	$8,848,291.22	$4,087,331.63	$3,164,743.35	$293.22
REPORT TOTALS (6 Months):		6,211	10,909	49,300	$53,420,560.80	$42,327,829.53	$19,677,155.16	$15,788,256.24	$241.21

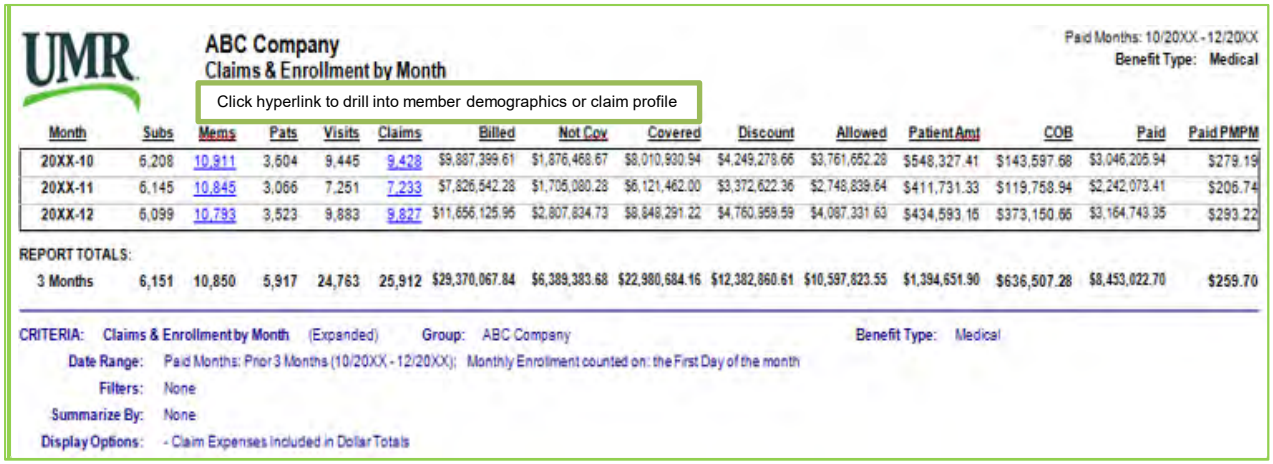
CRITERIA: Claims & Enrollment by Month (Standard) Group: ABC Company Benefit Type: Medical
Date Range: Paid Months: 07/20XX - 12/20XX; Monthly Enrollment counted on: the First Day of the month
Filters: None
Summarize By: None
Display Options: - Claim Expenses Included in Dollar Totals

Drill in profile

ID Card	Member ID	Member Name	Relationship	DOB	Age	Sex	Ben Beg	Ben End	Coverage Tier	Ntwk Code
XXXXXXX	##########	XXXXX, XXXXX X	Subscriber	09/30/19XX	##	F	05/01/20XX		Sub and Children	00
XXXXXXX	##########	XXXXX, XXXXX X	Child	01/01/20XX	##	M	01/01/20XX		Sub and Family	00
XXXXXXX	##########	XXXXX, XXXXX X	Subscriber	03/26/19XX	##	F	01/01/20XX		Sub Only	AL
XXXXXXX	##########	XXXXX, XXXXX X	Subscriber	08/13/19XX	##	M	01/01/20XX		Sub Only	LL
XXXXXXX	##########	XXXXX, XXXXX X	Child	10/23/19XX	##	M	01/01/20XX		Sub and Family	LL

REPORT TOTALS: Subscribers: 46 Dependents: 45 Total Members: 91

Expanded Format



UMR

ABC Company
Claims & Enrollment by Month

Paid Months: 10/20XX - 12/20XX
Benefit Type: Medical

Click hyperlink to drill into member demographics or claim profile

Month	Subs	Mems	Pats	Visits	Claims	Billed	Not Cov	Covered	Discount	Allowed	Patient Amt	COB	Paid	Paid PMPM
20XX-10	6,208	10,911	3,604	9,445	9,428	$9,887,399.61	$1,876,468.67	$8,010,930.94	$4,249,278.66	$3,761,652.28	$548,327.41	$143,597.68	$3,046,205.94	$279.19
20XX-11	6,145	10,845	3,066	7,251	7,233	$7,826,542.28	$1,705,080.28	$6,121,462.00	$3,372,622.36	$2,748,839.64	$411,731.33	$119,758.94	$2,242,073.41	$206.74
20XX-12	6,099	10,793	3,523	9,883	9,827	$11,656,125.95	$2,807,834.73	$8,848,291.22	$4,760,959.59	$4,087,331.63	$434,593.16	$373,150.66	$3,164,743.35	$293.22
REPORT TOTALS:														
3 Months	6,151	10,850	5,917	24,763	25,912	$29,370,067.84	$6,389,383.68	$22,980,684.16	$12,382,860.61	$10,597,823.55	$1,394,651.90	$636,507.28	$8,453,022.70	$259.70

CRITERIA: Claims & Enrollment by Month (Expanded) Group: ABC Company Benefit Type: Medical
Date Range: Paid Months: Prior 3 Months (10/20XX - 12/20XX); Monthly Enrollment counted on: the First Day of the month
Filters: None
Summarize By: None
Display Options: - Claim Expenses Included in Dollar Totals

Enrollment Census

The Enrollment Census Report provides a list of members enrolled in the plan. The report contains information about each subscriber and dependent (including name, relationship, age, and benefit begin date) as well as data related to coverage (coverage tier and primary network code). The report can be filtered by a selection of demographic and plan-related dimensions, providing a report view of plan membership in several different cuts of data.

Active members can be included on the report as of a specific census date; the report also provides an option to include enrollment activity within a user-defined date range. Report data can be used to identify members who either began or terminated coverage over the prior month or view a dependent child over or under a specific age. By setting the report's Valuation Date, member data can be viewed as of a specific point in time in history to track and monitor changes.

Report Parameters/ Customization (available options)

- Benefit Type
- Date Range
- Filters
- Subtotals
- Schedule Options
- Report Format

Standard Report Content

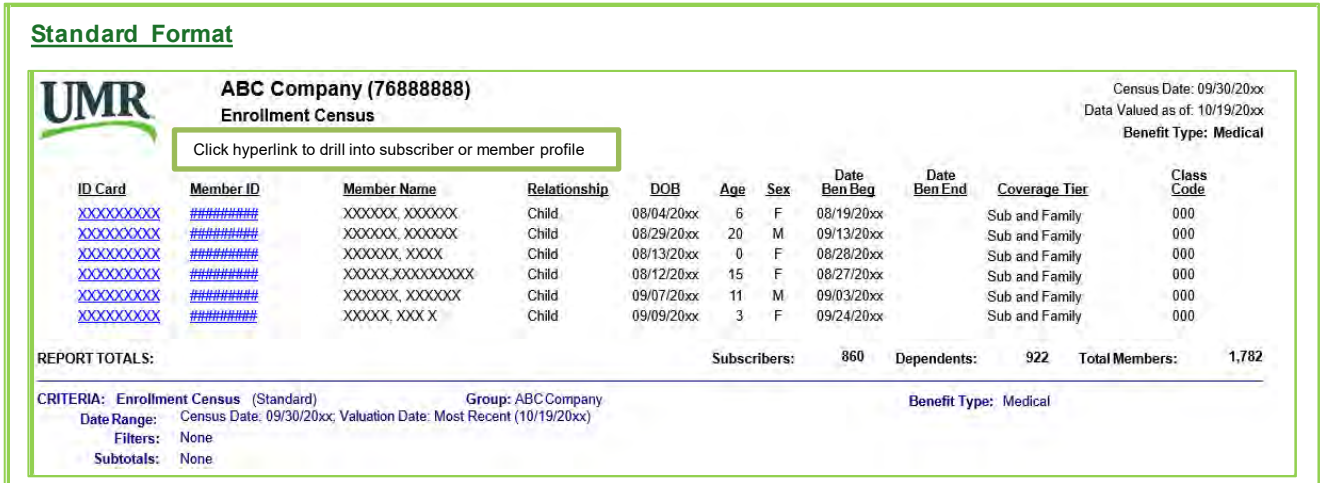
- ID Card (hyperlink; drills into subscriber profile)
- Member ID (hyperlink; drills into member profile)
- Member Name
- Relationship
- DOB (Member Date of Birth)
- Age (Member)
- Sex (Member)
- Date Benefit Begin
- Date Benefit End
- Coverage Tier
- Class Code

Expanded Report Content

- Member ID (hyperlink)
- Member Name
- Relationship
- ID Card (hyperlink)
- Subscriber Name
- Coverage Tier
- Date Benefit Begin
- Date Benefit End
- DOB (Member)
- Age (Member)
- Sex (Member)
- Primary Network
- City
- State
- Zip
- Benefit Plan
- Class
- Location

Return to Report Content

Standard Format



UMR

ABC Company (76888888)
Enrollment Census

Census Date: 09/30/20xx
Data Valued as of: 10/19/20xx
Benefit Type: Medical

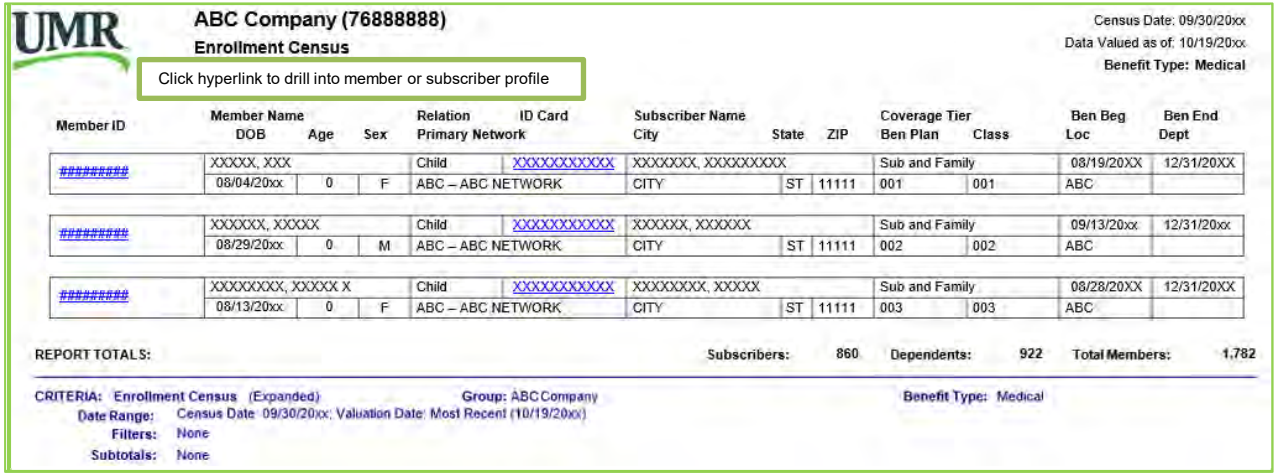
Click hyperlink to drill into subscriber or member profile

ID Card	Member ID	Member Name	Relationship	DOB	Age	Sex	Date Ben Beg	Date Ben End	Coverage Tier	Class Code
XXXXXXXXX	#########	XXXXX, XXXXXX	Child	08/04/20xx	6	F	08/19/20xx		Sub and Family	000
XXXXXXXXX	#########	XXXXX, XXXXXX	Child	08/29/20xx	20	M	09/13/20xx		Sub and Family	000
XXXXXXXXX	#########	XXXXX, XXXX	Child	08/13/20xx	0	F	08/28/20xx		Sub and Family	000
XXXXXXXXX	#########	XXXXX,XXXXXXXXX	Child	08/12/20xx	15	F	08/27/20xx		Sub and Family	000
XXXXXXXXX	#########	XXXXX, XXXXXX	Child	09/07/20xx	11	M	09/03/20xx		Sub and Family	000
XXXXXXXXX	#########	XXXXX, XXX X	Child	09/09/20xx	3	F	09/24/20xx		Sub and Family	000

REPORT TOTALS: Subscribers: 860 Dependents: 922 Total Members: 1,782

CRITERIA: Enrollment Census (Standard) Group: ABC Company Benefit Type: Medical
Date Range: Census Date: 09/30/20xx; Valuation Date: Most Recent (10/19/20xx)
Filters: None
Subtotals: None

Expanded Format



UMR

ABC Company (76888888)
Enrollment Census

Census Date: 09/30/20xx
Data Valued as of: 10/19/20xx
Benefit Type: Medical

Click hyperlink to drill into member or subscriber profile

Member ID	Member Name / DOB	Age	Sex	Relation / Primary Network	ID Card	Subscriber Name / City	State	ZIP	Coverage Tier / Ben Plan	Class	Ben Beg / Loc	Ben End / Dept
#########	XXXXX, XXX			Child	XXXXXXXXXX	XXXXXXX, XXXXXXXXX			Sub and Family		08/19/20XX	12/31/20XX
	08/04/20xx	0	F	ABC – ABC NETWORK		CITY	ST	11111	001	001	ABC	
#########	XXXXXX, XXXXX			Child	XXXXXXXXXX	XXXXXX, XXXXXX			Sub and Family		09/13/20xx	12/31/20xx
	08/29/20xx	0	M	ABC – ABC NETWORK		CITY	ST	11111	002	002	ABC	
#########	XXXXXXXX, XXXXX X			Child	XXXXXXXXXX	XXXXXXXX, XXXXX			Sub and Family		08/28/20XX	12/31/20XX
	08/13/20xx	0	F	ABC – ABC NETWORK		CITY	ST	11111	003	003	ABC	

REPORT TOTALS: Subscribers: 860 Dependents: 922 Total Members: 1,782

CRITERIA: Enrollment Census (Expanded) Group: ABC Company Benefit Type: Medical
Date Range: Census Date: 09/30/20xx; Valuation Date: Most Recent (10/19/20xx)
Filters: None
Subtotals: None

Enrollment Summary[1]

The Enrollment Summary Report provides an option to analyze or track plan enrollment without the full detail that is included in the Enrollment Census Report. This report provides an option to summarize enrollment counts by up to four dimensions. There are a variety of plan account structure and member summary fields to select, providing the flexibility to stratify plan membership in a variety of cuts of data, and to answer common enrollment questions. The online report also provides the option to drill in from the summary into the member detail. View plan membership as of a specific census date, or view enrollment activity within a date range (benefit begin and/or end date, continuous enrollment, coverage tier, network code).

Report Parameters/ Customization (available options)

- Benefit Type
- Date Range
- Filters
- Summarize By
- Schedule Options

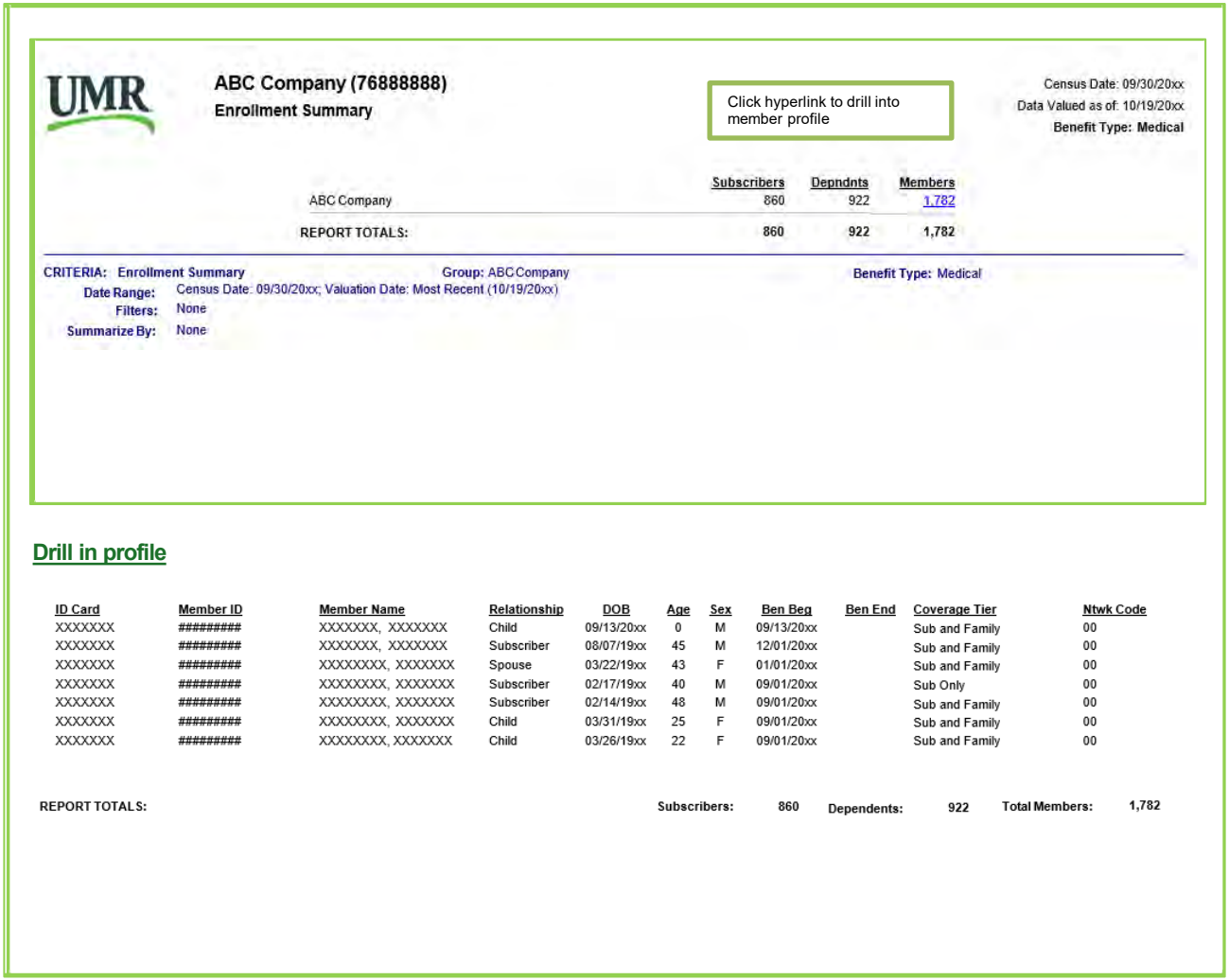
Report Content

- Company Name
- Subscribers (Number)
- Dependents (Number)
- Members (total membership-hyperlink; drills into member profile)

Note: This report is available for restricted (no-PHI) users; no drill-in capability.

Restricted users will have limited filter and summarize by options.

Report



UMR

ABC Company (76888888)
Enrollment Summary

Click hyperlink to drill into member profile

Census Date: 09/30/20xx
Data Valued as of: 10/19/20xx
Benefit Type: Medical

	Subscribers	Depndnts	Members
ABC Company	860	922	1,782
REPORT TOTALS:	860	922	1,782

CRITERIA: Enrollment Summary Group: ABC Company Benefit Type: Medical
Date Range: Census Date: 09/30/20xx; Valuation Date: Most Recent (10/19/20xx)
Filters: None
Summarize By: None

Drill in profile

ID Card	Member ID	Member Name	Relationship	DOB	Age	Sex	Ben Beg	Ben End	Coverage Tier	Ntwk Code
XXXXXXX	#########	XXXXXXX, XXXXXXX	Child	09/13/20xx	0	M	09/13/20xx		Sub and Family	00
XXXXXXX	#########	XXXXXXX, XXXXXXX	Subscriber	08/07/19xx	45	M	12/01/20xx		Sub and Family	00
XXXXXXX	#########	XXXXXXXX, XXXXXXX	Spouse	03/22/19xx	43	F	01/01/20xx		Sub and Family	00
XXXXXXX	#########	XXXXXXXX, XXXXXXX	Subscriber	02/17/19xx	40	M	09/01/20xx		Sub Only	00
XXXXXXX	#########	XXXXXXXX, XXXXXXX	Subscriber	02/14/19xx	48	M	09/01/20xx		Sub and Family	00
XXXXXXX	#########	XXXXXXXX, XXXXXXX	Child	03/31/19xx	25	F	09/01/20xx		Sub and Family	00
XXXXXXX	#########	XXXXXXXX, XXXXXXX	Child	03/26/19xx	22	F	09/01/20xx		Sub and Family	00

REPORT TOTALS: Subscribers: 860 Dependents: 922 Total Members: 1,782

Return to Report Content

Enrollment Summary by Month

The Enrollment Summary by Month Report provides counts of members by month summarized by the dimensions selected (up to four). There are a variety of fields to summarize data by, providing the flexibility to stratify plan membership using different cuts of data to answer enrollment questions. This report offers a hyperlink to member fields which provide the ability to drill into the corresponding member profile. The report can also be summarized by different member age bands.

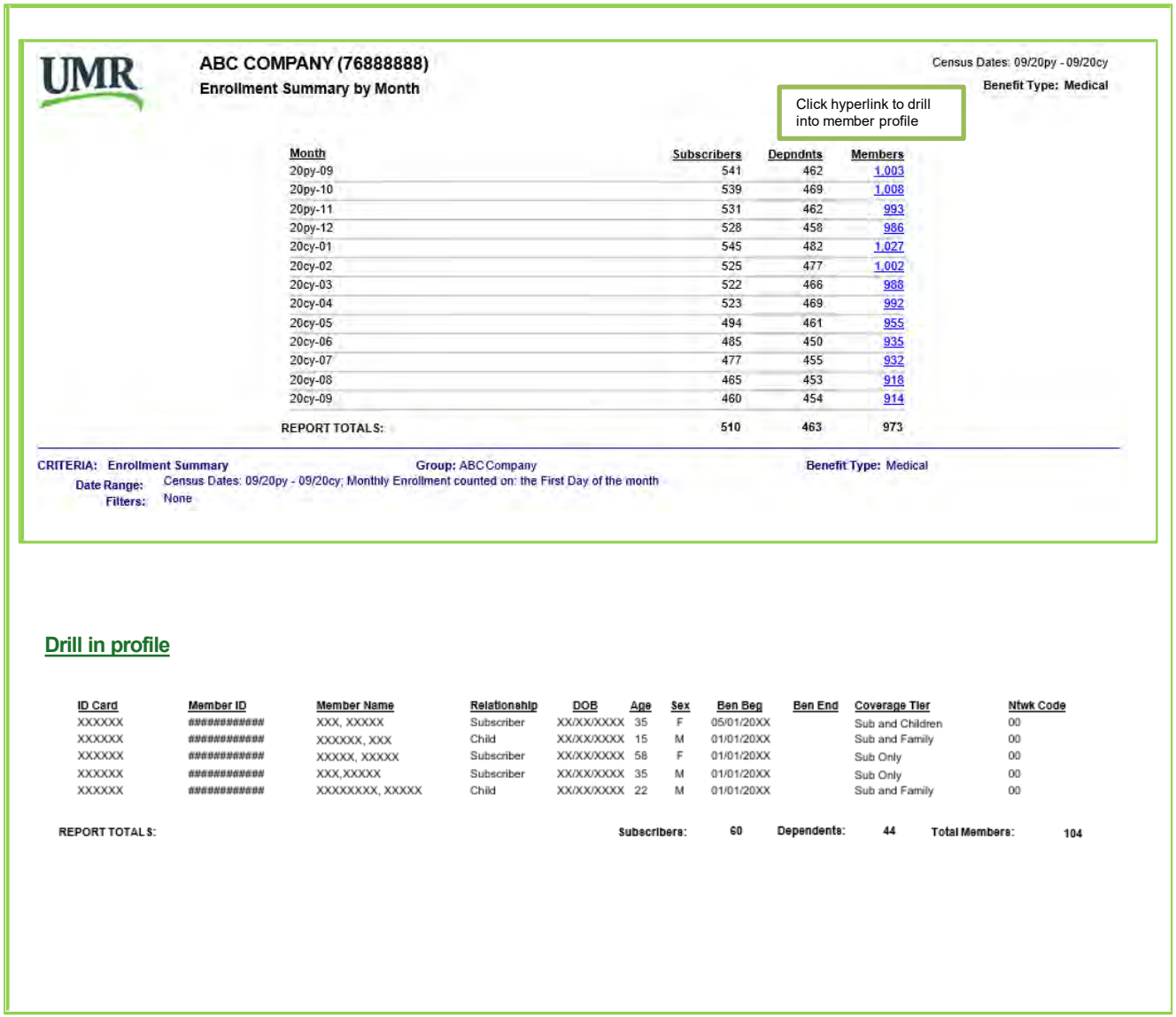
Report Parameters/ Customization (available options)

- Benefit Type
- Date Range
- Filters
- Summarize By
- Schedule Options

Report Content

- Month
- Subscribers (Number)
- Dependents (Number)
- Members (Number) (hyperlink; drills into member profile)

Report



UMR

ABC COMPANY (76888888)

Enrollment Summary by Month

Census Dates: 09/20py - 09/20cy

Benefit Type: Medical

Click hyperlink to drill into member profile

Month	Subscribers	Depndnts	Members
20py-09	541	462	1,003
20py-10	539	469	1,008
20py-11	531	462	993
20py-12	528	458	986
20cy-01	545	482	1,027
20cy-02	525	477	1,002
20cy-03	522	466	988
20cy-04	523	469	992
20cy-05	494	461	955
20cy-06	485	450	935
20cy-07	477	455	932
20cy-08	465	453	918
20cy-09	460	454	914
REPORT TOTALS:	510	463	973

CRITERIA: Enrollment Summary Group: ABC Company Benefit Type: Medical

Date Range: Census Dates: 09/20py - 09/20cy; Monthly Enrollment counted on: the First Day of the month

Filters: None

Drill in profile

ID Card	Member ID	Member Name	Relationship	DOB	Age	Sex	Ben Beg	Ben End	Coverage Tier	Ntwk Code
XXXXXX	##########	XXX, XXXXX	Subscriber	XX/XX/XXXX	35	F	05/01/20XX		Sub and Children	00
XXXXXX	##########	XXXXXX, XXX	Child	XX/XX/XXXX	15	M	01/01/20XX		Sub and Family	00
XXXXXX	##########	XXXXX, XXXXX	Subscriber	XX/XX/XXXX	58	F	01/01/20XX		Sub Only	00
XXXXXX	##########	XXX,XXXXX	Subscriber	XX/XX/XXXX	35	M	01/01/20XX		Sub Only	00
XXXXXX	##########	XXXXXXXX, XXXXX	Child	XX/XX/XXXX	22	M	01/01/20XX		Sub and Family	00

REPORT TOTALS: Subscribers: 60 Dependents: 44 Total Members: 104

Return to Report Content

Extract – Claim Level

While all the reports in InfoPort have the option to export the report data, the extract reports are specifically designed for this purpose. Each extract report provides a volume of data fields in an unformatted file that can be downloaded locally for plan analysis. The downloaded data can be utilized to create pivots and graphs or merge with other data.

The Extract – Claim Level Report provides claim-level data elements. Each row represents a claim, and the data includes dimension fields applicable to the entire claim (service dates, plan account structure data, patient and provider data, in or out of network benefit level). The report includes a range of claim-level dollar fields that summarize the services on a paid claim.

The extract reports have the capacity to support a large volume of data; download times are dependent on the user's internet browser connection. Contact the plan's designated UMR Strategic Account Executive or InfoPort Solutions if a data file with additional fields or on a frequent basis is required outside of InfoPort. The extract reports are specifically set up for data-only exporting; it is highly recommended that you do not print the report based on file size.

Report Parameters/ Customization (available options)

- Benefit Type
- Date Range
- Filters
- Schedule

Extract – Claim Level Data Elements listed alphabetically):

1	Adjusted Ind (Y or N)	16	Date Paid Through	31	Patient Acct Nbr	46	Sbscr Addr 1
2	Ben Level Code (In or Out)	17	Date Recvd	32	Patient Age	47	Sbscr Addr 2
3	Ben Plan Code	18	Date Serv From	33	Patient Last Name	48	Sbscr City
4	Ben Plan Desc	19	Date Serv Through	34	Patient Name	49	Sbscr Last Name
5	Ben Type	20	Location Code	35	Patient Sex	50	Sbscr State
6	Billed Amt	21	Location Desc	36	Provider Name-(billing provider)	51	Sbscr ZIP
7	Claim ID	22	Mem Network 1 Code	37	Provider TIN	52	Self Pay Ind
8	Class Code	23	Mem Network 1 Desc	38	Prvd Addr1	53	Serv Category
9	Class Desc	24	Member Card ID	39	Prvd Addr2	54	Service Count
10	COB Type	25	Member ID	40	Prvd City	55	Subscriber ID
11	Contract	26	Network Code	41	Prvd Specialty	56	Subscriber Name
12	Coverage Tier	27	Network Desc	42	Prvd State		
13	Customer	28	Network Ind	43	Prvd Type		
14	Customer ID	29	Network Tier	44	Prvd ZIP		
15	Date Paid Initial	30	Paid Amt	45	Relationship		

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View next page for report extract sample.

InfoPort's Data Extract Reports can be exported onto the user's local drive, providing the option to customize the report view, filter, sort and organize the data, create a pivot table or graphs, and review any data field based on individual requirements.

The image below provides an example of how data exported from InfoPort's extract reports are viewed on a spreadsheet (not an all-inclusive field list).

This report is specifically formatted for **Data-Only Exporting**. It is not recommended for other export formats.
It is highly recommended that you do not print this report.

Customer	Customer ID	Contract	Class Code	Class Code Descr	Ben Type	Subscriber ID	Coverage Tier	Subscriber Last	Patient Name	Relation	Provider Name	Date Serv From	Date Serv To	Date Paid Through	Billed Amt	Paid Amt	Ben Level
ABC COMPANY	#########	XXXXXXXXXXX	A00	ACT EES	MED	XXXXXXXXX	SUBFAM	XXXXXX	XXXXXX	SUB	ABC PROVIDER	5/8/20XX	5/8/20XX	9/17/20XX	125.00	0.00	In
ABC COMPANY	#########	XXXXXXXXXXX	A01	ACT EES	MED	XXXXXXXXX	SUBOLY	XXXXXX	XXXXXX	SUB	ABC PROVIDER	9/23/20XX	9/23/20XX	9/30/20XX	165.00	103.77	In
ABC COMPANY	#########	XXXXXXXXXXX	A02	ACT EES W HDHP	MED	XXXXXXXXX	SUBFAM	XXXXXX	XXXXXX	SUB	ABC PROVIDER	9/10/20XX	9/10/20XX	9/24/20XX	200.00	0.00	Out
ABC COMPANY	#########	XXXXXXXXXXX	A03	ACT EES PPO	MED	XXXXXXXXX	SUBOLY	XXXXXX	XXXXXX	SUB	ABC PROVIDER	9/3/20XX	9/3/20XX	9/17/20XX	150.00	25.92	In
ABC COMPANY	#########	XXXXXXXXXXX	A04	ACT EES PPO	MED	XXXXXXXXX	SUBFAM	XXXXXX	XXXXXX	SUB	ABC PROVIDER	9/9/20XX	9/9/20XX	9/24/20XX	230.00	51.29	In
ABC COMPANY	#########	XXXXXXXXXXX	A05	ACT EES PPO	MED	XXXXXXXXX	SUBOLY	XXXXXX	XXXXXX	SUB	ABC PROVIDER	7/29/20XX	7/29/20XX	9/30/20XX	7,185.21	1,581.34	In
ABC COMPANY	#########	XXXXXXXXXXX	A06	ACT EES W HDHP	MED	XXXXXXXXX	SUBOLY	XXXXXX	XXXXXX	SUB	ABC PROVIDER	8/25/20XX	8/25/20XX	9/3/20XX	222.00	120.43	In
ABC COMPANY	#########	XXXXXXXXXXX	A07	ACT EES W HDHP	MED	XXXXXXXXX	SUBFAM	XXXXXX	XXXXXX	SPS	ABC PROVIDER	8/5/20XX	8/5/20XX	9/17/20XX	1,316.28	1,184.65	In
ABC COMPANY	#########	XXXXXXXXXXX	A08	ACT EES PPO	MED	XXXXXXXXX	SUBOLY	XXXXXX	XXXXXX	SUB	ABC PROVIDER	4/20/20XX	4/20/20XX	9/17/20XX	107.00	64.06	In
ABC COMPANY	#########	XXXXXXXXXXX	A09	ACT EES PPO	MED	XXXXXXXXX	SUBOLY	XXXXXX	XXXXXX	SUB	ABC PROVIDER	8/21/20XX	8/21/20XX	9/3/20XX	193.00	152.10	In

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Extract – Claim Service Level

While all the reports in InfoPort have the option to export the report data, the extract reports are specifically designed for this purpose. Each extract report provides a volume of data fields in an unformatted file that can be downloaded locally for plan analysis. The downloaded data can be utilized to create pivots and graphs or merge with other data.

The Extract – Claim Service Level Report provides claim service line-level data elements. Each row represents paid claim line-level dollar amounts. The data includes dimension fields applicable to a claim service line (service dates, plan account structure data, patient and provider data, in or out of network indicator, type of service, place of service, procedure, diagnosis codes 1 and 2). The report includes a Telehealth/Telemedicine vendor indicator (if applicable), and a wide range of claim service line dollar fields that display services on a paid claim.

The extract reports have the capacity to support a large volume of data; download times are dependent on the user's internet browser connection. Contact the plan's designated UMR Strategic Account Executive or InfoPort Solutions if a data file with additional fields or on a frequent basis is required outside of InfoPort. The extract reports are specifically set up for data-only exporting; it is highly recommended that you do not print the report based on file size.

Report Parameters/ Customization (available options)

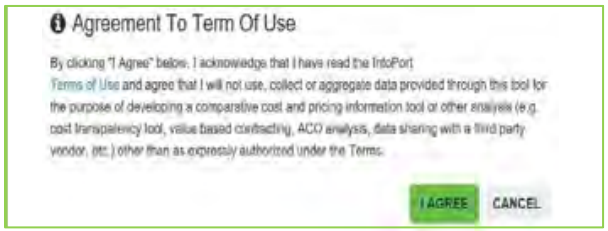
- Benefit Type
- Date Range
- Filters
- Display Options
- Schedule

Terms of Use Agreement

Due to the level of detail contained in this extract report, generating report data requires the individual authorized user to acknowledge an ***Agreement To Term of Use***.

When an InfoPort user agrees to the Terms of Use, the user is indicating that they will abide by the content outlined within the Agreement To Term of Use.

When the Extract– Claim Service Level Report is selected, the user will be prompted with the dialog box displayed at the right.



- Click the **Terms of Use hyperlink** within the message for a detailed review.
- Select 'I Agree' to proceed with setting options and generating the extract report.
- Select Cancel to return to InfoPort's Home screen.

View next page for report data elements.

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Extract – Claim Service Level (continued)

Extract - Claim Service Level Data Elements (listed alphabetically):

1	Adjust Reason Code	19	Date Serv From	37	Network Tier	55	Provider ZIP
2	Adjust Reason Desc	20	Date Serv Through	38	Not Covered Code	56	Relationship
3	Ben Level Code	21	Diagnosis 1 Code	39	Not Covered Desc	57	Reversal Reason Code
4	Ben Plan Code	22	Diagnosis 1 Desc	40	Paid Amt	58	Reversal Reason Desc
5	Ben Type	23	Diagnosis 2 Code	41	Patient Age	59	Subscriber City
6	Bill Type Code	24	Diagnosis 2 Desc	42	Patient Last Name	60	Subscriber Last Name
7	Billed Amt	25	Hospital Rev Code	43	Patient Name (full)	61	Subscriber State
8	Claim ID	26	Hospital Rev Description	44	Patient Sex	62	Subscriber ZIP
9	Claim Segment	27	Location Code	45	Place of Service Code	63	Self Pay Ind
10	Claim Service Number	28	MDC Code	46	Place of Service Desc	64	Service Category
11	Class Code	29	MDC Desc	47	Procedure Code	65	Service Count
12	COB Type	30	Mem Network 1 Code	48	Procedure Desc	66	Servicing Provider Name
13	Contract	31	Mem Network 1 Desc	49	Provider Name-(billing provider)	67	Subscriber ID
14	Coverage Tier	32	Member Card ID	50	Provider Specialty Code	68	Subscriber Name
15	Customer	33	Member ID	51	Provider Specialty Description	69	Telehealth Indicator
16	Customer ID	34	Network Code	52	Provider TIN	70	Telemedicine Ven Ind
17	Date Paid	35	Network Desc	53	Provider City	71	Type of Service Code
18	Date Recvd	36	Network Ind	54	Provider State	72	Type of Service Desc

Click here to view an example of the InfoPort data view when exported into a spreadsheet (refer to page 27)

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Extract – Enrollment Census

While all the reports in InfoPort have the option to export the report data, the extract reports are specifically designed for this purpose. Each extract report provides a volume of data fields in an unformatted file that can be downloaded locally for plan analysis. The downloaded data can be utilized to create pivots and graphs or merge with other data.

The Extract – Enrollment Census Report provides plan enrollment data elements. Each row of data includes subscriber and member demographic information, as well as data related to their coverage. The report includes an option to view the plan's active enrollment as of a specific day, or report on enrollment activity within a user defined date range.

The extract reports have the capacity to support a large volume of data; download times are dependent on the user's internet browser connection. Contact the plan's designated UMR Strategic Account Executive or InfoPort Solutions if a data file with additional fields or on a frequent basis is required outside of InfoPort. The extract reports are specifically set up for data-only exporting; it is highly recommended that you do not print the report based on file size.

Report Parameters/ Customization (available options)

- Benefit Type
- Date Range
- Filters
- Schedule Options

Extract – Enrollment Census Content (listed alphabetically):

1	Ben Plan Code	16	Continuous Covg Date Beg	31	Member Card ID	46	Subscriber Addr 1
2	Ben Plan Desc	17	Continuous Covg Date End	32	Member Cust ID	47	Subscriber Addr 2
3	Ben Status From	18	Contract	33	Member DOB	48	Subscriber City
4	Ben Status Through	19	Coverage Tier	34	Member ID	49	Subscriber First Name
5	Ben Type	20	Customer	35	Member Name	50	Subscriber Hire Date
6	Class Code	21	Customer ID	36	Member Seq	51	Subscriber Last Name
7	Class Desc	22	Disabled Ind	37	Member Sex	52	Subscriber Marital Status
8	Class Grp 1 Code	23	Location Code	38	Relationship	53	Subscriber Work State
9	Class Grp 1 Desc	24	Location Desc	39	Rpt Group 1	54	Subscriber ZIP
10	Class Grp 2 Code	25	Mem First Name	40	Rpt Group 2	55	Subscriber ZIP Ext
11	Class Grp 2 Desc	26	Mem Last Name	41	Rpt Group 3	56	Student Date End
12	Class Grp 3 Code	27	Mem Network 1 Code	42	Rpt Group 4	57	Student Ind
13	Class Grp 3 Desc	28	Mem Network 1 Desc	43	Rpt Group 5	58	Subscriber ID
14	Cobra Date Beg	29	Mem Network 2 Code	44	Rpt Group 6	59	Subscriber Name
15	Cobra Ind	30	Mem Network 2 Desc	45	Rpt Group 7	60	Valuation Date

Click here to view an example of the InfoPort data view when exported into a spreadsheet (refer to page 27)

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HRA Utilization Detail *

The HRA Utilization Detail Report provides a view of subscribers who have contributed to the plan's HRA account in a year-to-date period by reporting month. The report can be produced utilizing up to four different dimensions by the plan's account structure or subscriber. There is an option to subtotal data by different dimensions, providing the flexibility to view HRA activity by the plan's account structure or subscribers to answer HRA dollar questions. The report provides data each month based on the prior month activity.

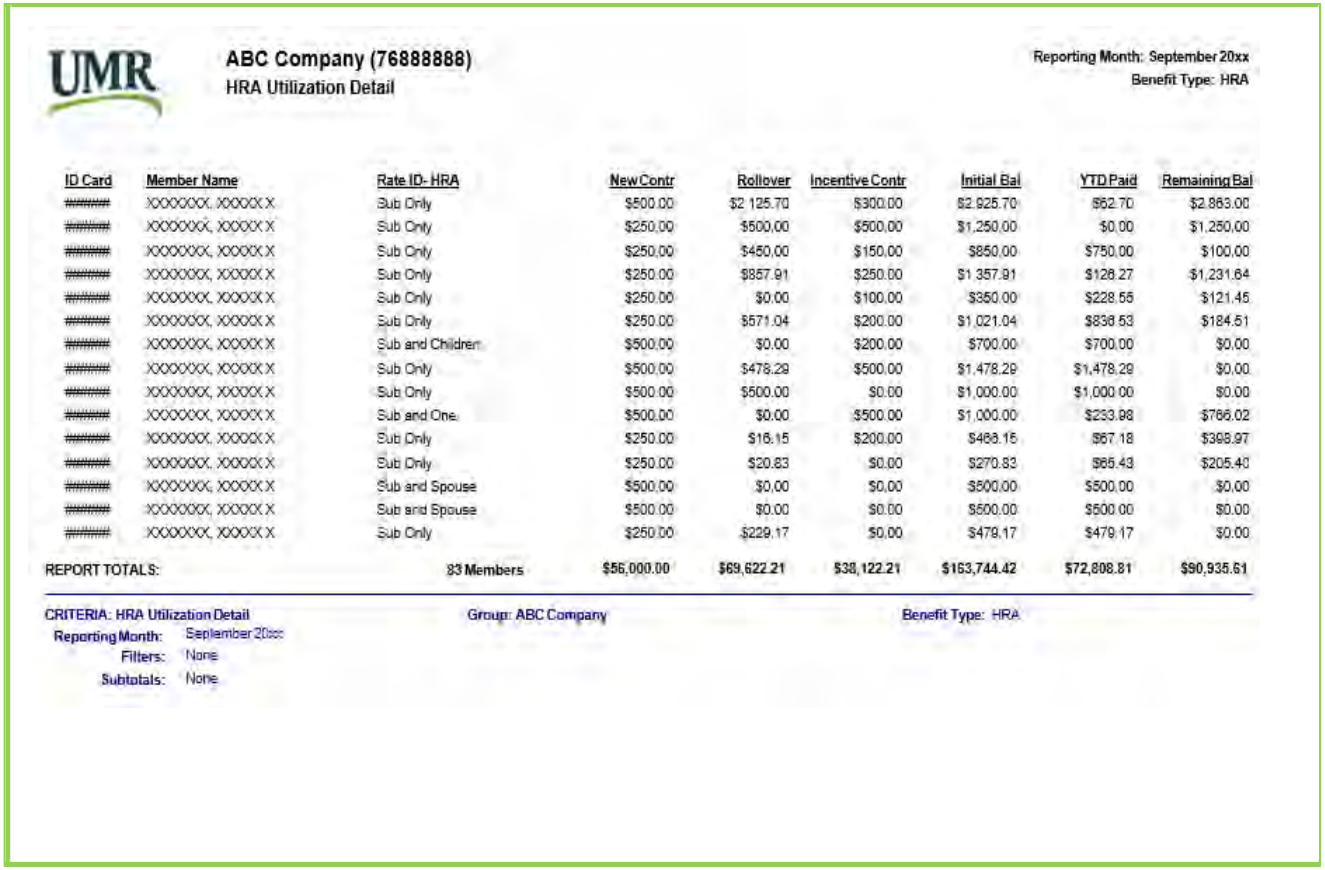
Report Parameters/Customization (available options)

- Filters
- Subtotals
- Display Options
- Schedule Options

Report Content

- ID Card
- Member Name
- Rate ID - HRA
- New Contribution
- Rollover
- Incentive Contribution
- Initial Balance
- YTD Paid
- Remaining Balance

Report



UMR

ABC Company (76888888)
HRA Utilization Detail

Reporting Month: September 20xx
Benefit Type: HRA

ID Card	Member Name	Rate ID- HRA	New Contr	Rollover	Incentive Contr	Initial Bal	YTD Paid	Remaining Bal
#######	XXXXXXX, XXXXX X	Sub Only	$500.00	$2,125.70	$300.00	$2,925.70	$62.70	$2,863.00
#######	XXXXXXX, XXXXX X	Sub Only	$250.00	$500.00	$500.00	$1,250.00	$0.00	$1,250.00
#######	XXXXXXX, XXXXX X	Sub Only	$250.00	$450.00	$150.00	$850.00	$750.00	$100.00
#######	XXXXXXX, XXXXX X	Sub Only	$250.00	$857.91	$250.00	$1,357.91	$126.27	$1,231.64
#######	XXXXXXX, XXXXX X	Sub Only	$250.00	$0.00	$100.00	$350.00	$228.55	$121.45
#######	XXXXXXX, XXXXX X	Sub Only	$250.00	$571.04	$200.00	$1,021.04	$836.53	$184.51
#######	XXXXXXX, XXXXX X	Sub and Children	$500.00	$0.00	$200.00	$700.00	$700.00	$0.00
#######	XXXXXXX, XXXXX X	Sub Only	$500.00	$478.29	$500.00	$1,478.29	$1,478.29	$0.00
#######	XXXXXXX, XXXXX X	Sub Only	$500.00	$500.00	$0.00	$1,000.00	$1,000.00	$0.00
#######	XXXXXXX, XXXXX X	Sub and One	$500.00	$0.00	$500.00	$1,000.00	$233.98	$766.02
#######	XXXXXXX, XXXXX X	Sub Only	$250.00	$16.15	$200.00	$466.15	$67.18	$398.97
#######	XXXXXXX, XXXXX X	Sub Only	$250.00	$20.83	$0.00	$270.83	$65.43	$205.40
#######	XXXXXXX, XXXXX X	Sub and Spouse	$500.00	$0.00	$0.00	$500.00	$500.00	$0.00
#######	XXXXXXX, XXXXX X	Sub and Spouse	$500.00	$0.00	$0.00	$500.00	$500.00	$0.00
#######	XXXXXXX, XXXXX X	Sub Only	$250.00	$229.17	$0.00	$479.17	$479.17	$0.00
REPORT TOTALS:		83 Members	$56,000.00	$69,622.21	$38,122.21	$163,744.42	$72,808.81	$90,935.61

CRITERIA: HRA Utilization Detail
Reporting Month: September 20xx
Filters: None
Subtotals: None
Group: ABC Company
Benefit Type: HRA

This report is available for UMR clients with HRA activity administered on the UMR processing platform.

[Return to Report Content](#)

HRA Utilization Summary*

The HRA Utilization Summary Report provides a count of the number of subscribers who have contributed to the plan's HRA account in a year-to-date period by reporting month. The report can be produced utilizing up to four different dimensions by the plan's account structure or subscriber. There is an option to subtotal data by different dimensions, providing the flexibility to view HRA activity by the plan's account structure or individual subscriber to answer HRA dollar questions at a summary level. The report provides data each month based on the prior month activity and is available in a standard or expanded format.

Report Parameters/ Customization (available options)

- Filters
- Summarize By
- Display Options
- Schedule Options

Standard Report Content

- Member Count
- Initial Bal
- YTD Paid
- Remaining Balance

Expanded Report Content

- Member Count
- New Contribution
- Rollover
- Incentive Contribution
- Initial Bal
- YTD Paid
- Remaining Balance

This report is available for UMR clients with HRA activity administered on the UMR processing platform.

Standard Format

UMR

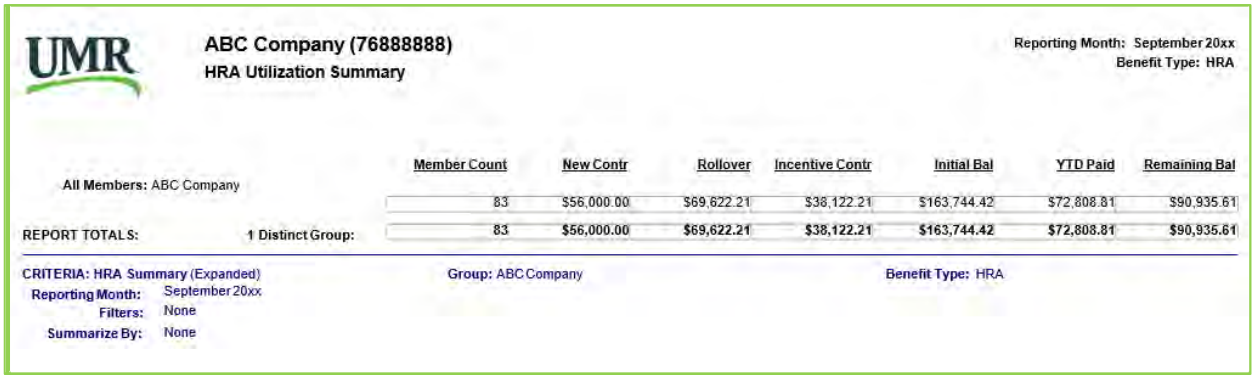
ABC Company (76888888)
HRA Utilization Summary

Reporting Month: September 20xx
Benefit Type: HRA

		Member Count	Initial Bal	YTD Paid	Remaining Bal
ABC Company		83	$163,744.42	$72,808.81	$90,935.61
REPORT TOTALS:	1 Distinct Group:	83	$163,744.42	$72,808.81	$90,935.61

CRITERIA: HRA Summary (Standard) Group: ABC Company Benefit Type: HRA
Reporting Month: September 20xx
Filters: None
Summarize By: None

Expanded Format



UMR

ABC Company (76888888)
HRA Utilization Summary

Reporting Month: September 20xx
Benefit Type: HRA

		Member Count	New Contr	Rollover	Incentive Contr	Initial Bal	YTD Paid	Remaining Bal
All Members: ABC Company		83	$56,000.00	$69,622.21	$38,122.21	$163,744.42	$72,808.81	$90,935.61
REPORT TOTALS:	1 Distinct Group:	83	$56,000.00	$69,622.21	$38,122.21	$163,744.42	$72,808.81	$90,935.61

CRITERIA: HRA Summary (Expanded) Group: ABC Company Benefit Type: HRA
Reporting Month: September 20xx
Filters: None
Summarize By: None

Return to Report Content

Incurred But Not Reported (IBNR) [1]

The Incurred but not Reported (IBNR) Report provides an estimate (based on UMR's book of business completion factors) of the amount a group may want to have on reserve to budget for claims incurred but not yet reported and paid. The **non-certified** report is available in a standard format.

Clients with 24 months (or more) of UMR paid claims activity:
The IBNR Report uses paid claims activity for the last 24 rolling months of incurred and paid claims, split by benefit type, to estimate the liability based on the UMR book of business completion factors. While this report has not been actuarially certified, it is calculated using typical actuarial principles. Please note that administration fees and pended claims are excluded from this report; the report has not been adjusted for high-cost claimants.

Clients with Less Than 24 months of UMR paid claims:
The IBNR Report uses paid claims activity for the last 24 rolling months of incurred and paid claims, split by benefit type, to estimate the liability based on the UMR book of business completion factors. While this report has not been actuarially certified, it is calculated using typical actuarial principles. Report results can vary if immature claim experience (less than 24 months) is used. Please note that administration fees and pended claims are excluded from this report; the report has not been adjusted for high-cost claimants. When less than 24 months of data is available for reporting, the IBNR Report will display the following warning message: ***Report results can vary if immature claim experience (less than 24 months) is used.***

The report provides an option to filter by one of the following dimensions: Claim category, benefit plan, class, contract, or location.

Report Formula
The IBNR Report utilizes the following formula for each service month:

- Total Paid (IBNR Adjusted) = IBNR Factor x Total Payment Amount
- Reserve Estimate = Total Paid (IBNR Adjusted) – Total Payment Amount

IBNR factors used for this report *are **updated monthly** by the 10th workday*. If scheduling: Recommendation is to schedule this report to run post the monthly update-use a frequency of Monthly *or* Quarterly and select "…***as soon as the data has been updated for the month***".
***Running this report before the IBNR factors have been updated will result in an incomplete display of claims paid through last month.*

Report Parameters/ Customization (available options)
- Date Range
- Filters
- Schedule

Report Content
- Service Month
- IBNR Factor
- Total Payment Amount
- Total Paid (IBNR Adjusted)
- Reserve Estimate

The Service Month includes healthcare claims incurred within the listed service month and paid from the service month through the report's paid time frame.

Note: This report is available for InfoPort's restricted users.

View next page for report samples.

Return to Report Content

Report: ***Group with at least 24 months of UMR paid claims***

ABC COMPANY
Incurred But Not Reported

Service Months: 02/20XX - 01/20ZZ
Paid Months: 02/20XX - 01/20ZZ
Benefit Type: Medical

Service Month	IBNR Factor	Total Payment Amount	Total Paid (IBNR Adjusted)	Reserve Estimate
20XX-02	0.99999248	$42,992.40	$42,992.08	-$0.32
20XX-03	0.99991697	$75,590.96	$75,584.68	-$6.28
20XX-04	0.99978780	$127,345.74	$127,318.72	-$27.02
20XX-05	0.99983160	$49,063.88	$49,055.62	-$8.26
20XX-06	0.99990232	$40,627.57	$40,623.60	-$3.97
20XX-07	0.99990065	$245,816.01	$245,791.59	-$24.42
20XX-08	1.00021352	$73,465.19	$73,480.88	$15.69
20XX-09	1.00045148	$20,387.93	$20,397.13	$9.20
20XX-10	1.00094949	$77,294.47	$77,367.86	$73.39
20XX-11	1.00141294	$17,419.30	$17,443.91	$24.61
20XX-12	1.00208060	$114,404.97	$114,643.00	$238.03
20YY-01	1.00321245	$112,395.93	$112,757.00	$361.07
20YY-02	1.00501110	$44,953.37	$45,178.64	$225.27
20YY-03	1.00730762	$47,570.62	$47,918.25	$347.63
20YY-04	1.01091462	$77,028.72	$77,869.46	$840.74
20YY-05	1.01557883	$94,295.27	$95,764.28	$1,469.01
20YY-06	1.02123158	$43,153.58	$44,069.80	$916.22
20YY-07	1.03063555	$68,311.92	$70,404.69	$2,092.77
20YY-08	1.04540046	$38,841.55	$40,604.97	$1,763.42
20YY-09	1.06980623	$62,454.24	$66,813.94	$4,359.70
20YY-10	1.11578568	$73,098.27	$81,562.00	$8,463.73
20YY-11	1.21909576	$40,175.66	$48,977.98	$8,802.32
20YY-12	1.57398432	$96,671.73	$152,159.79	$55,488.06
20ZZ-01	6.29067819	$17,756.07	$111,697.72	$93,941.65
	Total:	$1,701,115.35	$1,880,477.59	$179,362.24

The IBNR report uses claim activity for the last 24 rolling months of incurred and paid claims, split by benefit type, to estimate the liability based on UMR book of business completion factors. While this report has not been actuarially certified, it has been calculated using typica actuarial principles. Please note that admin fees and pended claims are excluded from this report, and the report has not been adjusted for high cost claimants.

CRITERIA: Incurred But Not Reported Group: ABC Company Benefit Type: Medical
Date Range: Service Months: Prior 24 Months (02/20XX - 01/20ZZ) Paid Months: Prior 24 Months (02/20XX - 01/20ZZ)
Filters: None

Report: ***Group with less than 24 months of UMR paid claims***

ABC COMPANY
Incurred But Not Reported

Service Months: 03/20XX - 02/20ZZ
Paid Months: 03/20XX - 02/20ZZ
Benefit Type: Medical

Service Month	IBNR Factor	Total Payment Amount	Total Paid (IBNR Adjusted)	Reserve Estimate
20XX-03	0.99982112	$0.00	$0.00	$0.00
20XX-04	0.99967025	$0.00	$0.00	$0.00
20XX-05	1.00001348	$0.00	$0.00	$0.00
20XX-06	1.00039557	$0.00	$0.00	$0.00
20XX-07	1.00082285	$46,415.68	$46,453.87	$38.19
20XX-08	1.00152351	$60,468.46	$60,560.58	$92.12
20YY-12	1.22224954	$44,302.40	$54,148.59	$9,846.19
20ZZ-01	1.57414618	$69,148.48	$108,849.82	$39,701.34
20ZZ-02	6.84832034	$26,163.06	$179,173.02	$153,009.96
	Total:	$911,860.28	$1,139,956.50	$228,096.22

Report results can vary if immature claim experience (less than 24 months) is used.

The IBNR report uses claim activity for the last 24 rolling months of incurred and paid claims, split by benefit type, to estimate the liability based on UMR book of business completion factors. While this report has not been actuarially certified, it has been calculated using typica actuarial principles. Please note that admin fees and pended claims are excluded from this report, and the report has not been adjusted for high cost claimants.

CRITERIA: Incurred But Not Reported Group: ABC Company Benefit Type: Medical
Date Range: Service Months: Prior 24 Months (03/20XX - 02/20ZZ) Paid Months: Prior 24 Months (03/20XX - 02/20ZZ)
Filters: None

[Return to Report Content](#)

Performance Indicators Report

The Performance Indicators Report is available in a Standard format and provides a compare of prior/current year plan payment activity in a dashboard style report. Data includes a summary of key indicator metrics, top 10 clinical conditions ranked by highest total paid amount, payment by core claim categories including a PMPM measure and UMR normative value compare, and cost breakout between high cost and non-high cost claimants.

Report Parameters/ Customization (available options): Paid Date Range and Schedule Option

Report Content

Key Indicators: Prior/Current Year To Date Compare / % Change

Metric
- Admissions per 1000
- Paid per Admission
- ER Visits per 1000
- Paid per ER Visit

Cost Breakout - High Cost versus Non-High Cost Claimants: Prior/Current Year To Date Compare / % Change

Paid PMPM - Med & RX (RX paid if detail is available)
- High Cost Claimants 50K+
- Non-High Cost
- All Members

Chart displays prior compared to current year paid dollars for the report date range, categorized by high cost and non-high cost claimants.

Calendar YTD Clinical Conditions with Highest Total Paid:
- Rank (1-10 based on total paid)
- Clinical Conditions
- Member Count
- Total Paid

Payment by Claim Category: Prior/Current Year To Date Compare

Claim Category	Data Fields
Inpatient	Total Paid
Outpatient	Paid PMPM
Physician	% of Total
Ancillary	% Change Paid PMPM
Total Med (medical)	UMR Norm
Rx (if available)	
Med & Rx (Rx paid if available)	

Arrow color coordination:

Green: Decrease in the current year data metric based on comparison of prior year data.

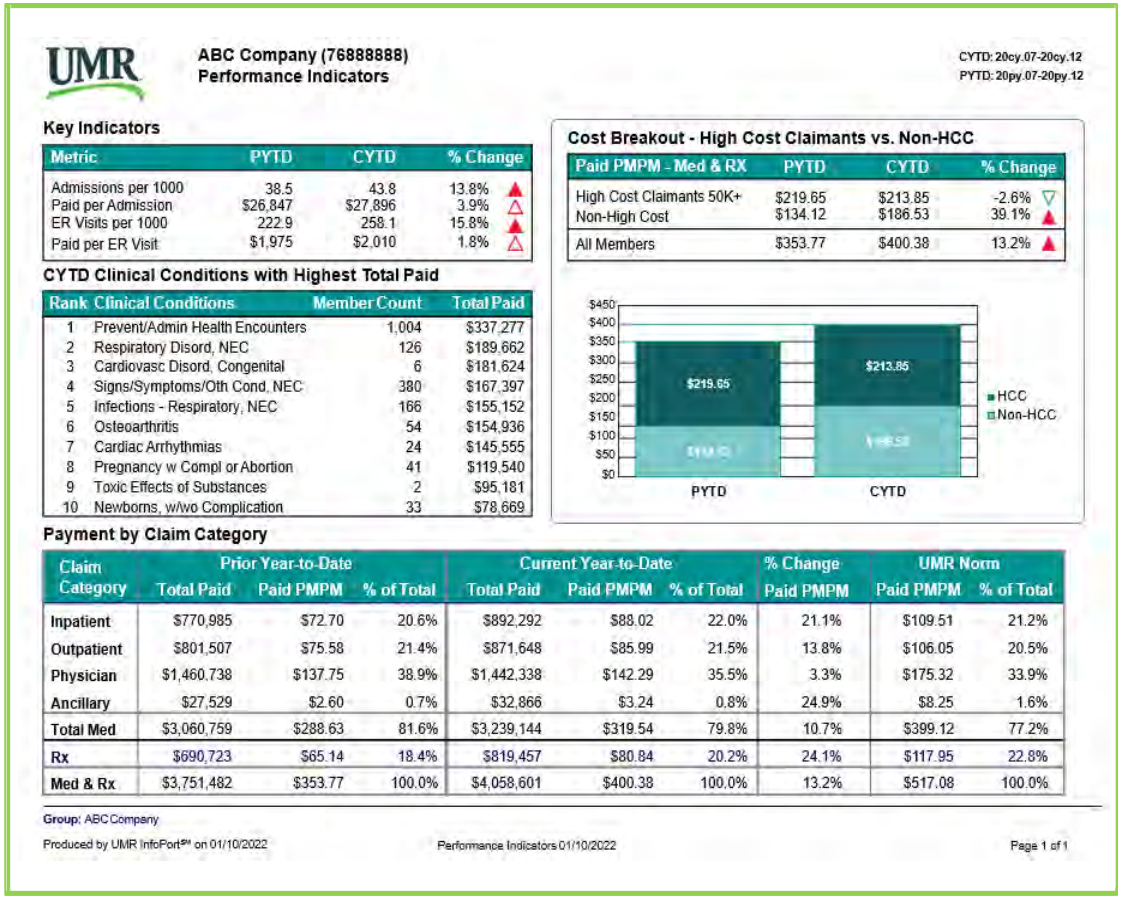
Red: Increase in the current year data metric based on comparison of prior year data.

Black: Metric changes cannot be determined without more data.

Note: Directional arrows assist with identifying report data changes based on a current/prior year comparison.

Up arrow indicates the current year metric increased; down arrow indicates the current year metric decreased; solid arrow indicates a notable change; arrow outline indicates a slight change.

Report



UMR

ABC Company (76888888)
Performance Indicators

CYTD: 20cy.07-20cy.12
PYTD: 20py.07-20py.12

Key Indicators

Metric	PYTD	CYTD	% Change
Admissions per 1000	38.5	43.8	13.8% ▲
Paid per Admission	$26,847	$27,896	3.9% △
ER Visits per 1000	222.9	258.1	15.8% ▲
Paid per ER Visit	$1,975	$2,010	1.8% △

Cost Breakout - High Cost Claimants vs. Non-HCC

Paid PMPM - Med & RX	PYTD	CYTD	% Change
High Cost Claimants 50K+	$219.65	$213.85	-2.6% ▽
Non-High Cost	$134.12	$186.53	39.1% ▲
All Members	$353.77	$400.38	13.2% ▲

CYTD Clinical Conditions with Highest Total Paid

Rank	Clinical Conditions	Member Count	Total Paid
1	Prevent/Admin Health Encounters	1,004	$337,277
2	Respiratory Disord, NEC	126	$189,662
3	Cardiovasc Disord, Congenital	6	$181,624
4	Signs/Symptoms/Oth Cond, NEC	380	$167,397
5	Infections - Respiratory, NEC	166	$155,152
6	Osteoarthritis	54	$154,936
7	Cardiac Arrhythmias	24	$145,555
8	Pregnancy w Compl or Abortion	41	$119,540
9	Toxic Effects of Substances	2	$95,181
10	Newborns, w/wo Complication	33	$78,669

Payment by Claim Category

Claim Category	Prior Year-to-Date			Current Year-to-Date			% Change	UMR Norm	
	Total Paid	Paid PMPM	% of Total	Total Paid	Paid PMPM	% of Total	Paid PMPM	Paid PMPM	% of Total
Inpatient	$770,985	$72.70	20.6%	$892,292	$88.02	22.0%	21.1%	$109.51	21.2%
Outpatient	$801,507	$75.58	21.4%	$871,648	$85.99	21.5%	13.8%	$106.05	20.5%
Physician	$1,460,738	$137.75	38.9%	$1,442,338	$142.29	35.5%	3.3%	$175.32	33.9%
Ancillary	$27,529	$2.60	0.7%	$32,866	$3.24	0.8%	24.9%	$8.25	1.6%
Total Med	$3,060,759	$288.63	81.6%	$3,239,144	$319.54	79.8%	10.7%	$399.12	77.2%
Rx	$690,723	$65.14	18.4%	$819,457	$80.84	20.2%	24.1%	$117.95	22.8%
Med & Rx	$3,751,482	$353.77	100.0%	$4,058,601	$400.38	100.0%	13.2%	$517.08	100.0%

Group: ABC Company

Produced by UMR InfoPort℠ on 01/10/2022 Performance Indicators 01/10/2022 Page 1 of 1

Return to Report Content

Plan Cost Summary[1]

The Plan Cost Summary Report is available in a Standard format, provides a 12-month view of plan *payments* (medical, dental, vision), plan *expenses* (including stop loss premiums, and various fees), and plan *recoveries* (stop loss reimbursements) for benefits and services administered by UMR. Additional data includes enrollment counts and a comparison of billed, not covered, covered, discount, allowed, patient out of pocket dollars, and paid amount. Note that the report is not suitable for budgeting or other financial controls reporting due to the many variables that can impact the monthly displayed dollar amounts.

Report Parameters/ Customization (available options): Date Range and Schedule Option

Report Content

- Paid 12 Months
- Average Total
- Billed
- Not Covered
- Covered
- Discount Amt
- Allowed
- Deductible
- Coinsurance
- Copay
- COB
- Claims paid by Employee, Spouse, Dep
- Total Paid
- Paid % of Charges
- Stop Loss Reimburse
- Net Paid
- Enrollment Count
- Claims Cost
- Other Fees
- Rx Invoice (if avail)
- Admin Fees
- SL Premium
- Opt Fees
- Ancillary Costs
- Total Plan Cost
- Plan Cost Per Employee
- Plan Cost Per Member

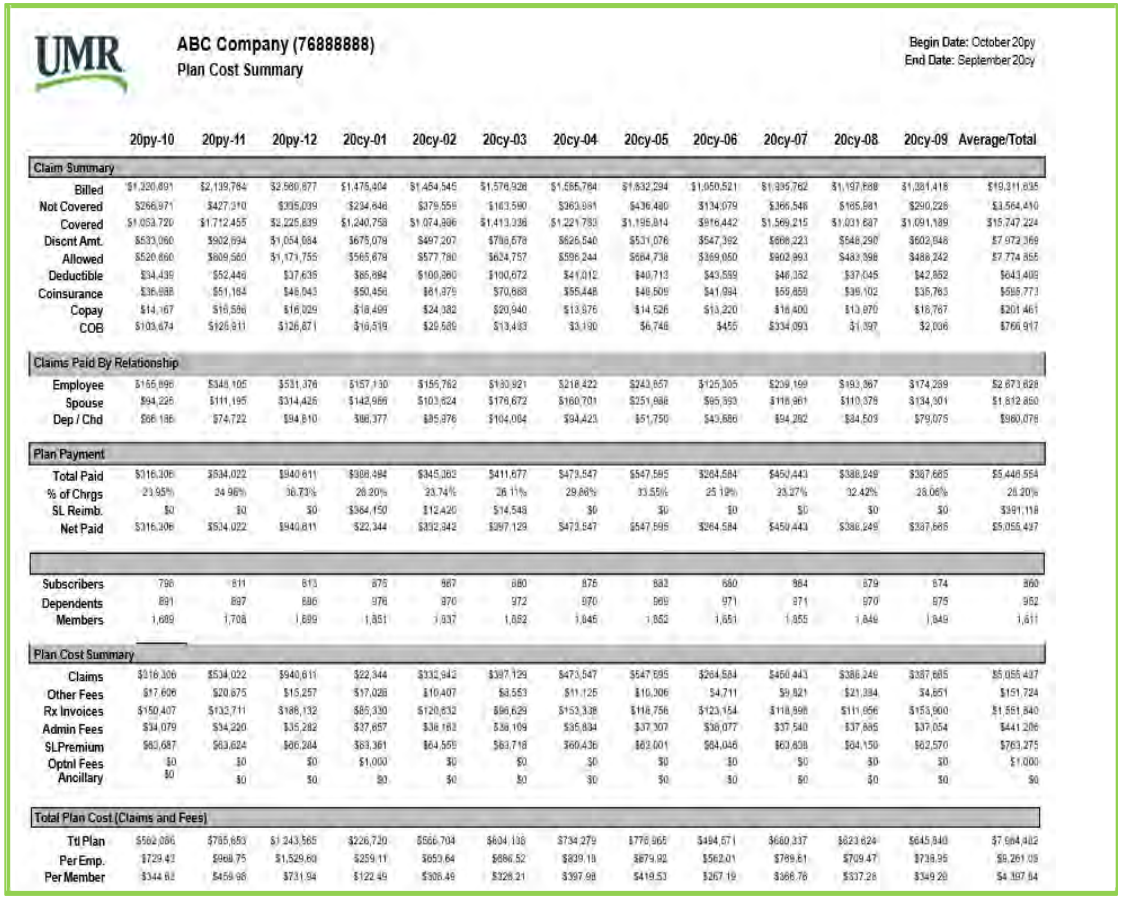
Fees used for the report are *updated monthly by the 5th workday*. Schedule: Recommend using a *Frequency* of Monthly *or* Quarterly, and "…*as soon as the data has been updated for the month*".

Notes:

- Dollars within the Claim Summary section are also found on the expanded view of InfoPort's claim summary reports.
- Enrollment counts represent the total number of active unique members across medical, dental, and vision plans as of the beginning of the month.
- *Payment* totals from the monthly financial reports available on umr.com will match the *Total Paid*, *Rx Invoices* (Rx amounts invoiced by UMR), and *Admin Fees* amounts on the report.
- UMR administered Stop Loss: *SL Reimb* reflects reimbursements issued by carrier for report month.
- Monthly total balance due on Invoice Inquiry (umr.com) will match a combination of stop loss premiums, admin/optional fees, ancillary fees on this report.

Note: This report is available for InfoPort's restricted (no-PHI) users.

Report



UMR

ABC Company (76888888)
Plan Cost Summary

Begin Date: October 20py
End Date: September 20cy

	20py-10	20py-11	20py-12	20cy-01	20cy-02	20cy-03	20cy-04	20cy-05	20cy-06	20cy-07	20cy-08	20cy-09	Average/Total
Claim Summary													
Billed	$1,220,691	$2,139,784	$2,580,877	$1,475,404	$1,454,545	$1,576,928	$1,585,764	$1,832,294	$1,950,521	$1,935,762	$1,197,888	$1,381,418	$19,311,835
Not Covered	$266,971	$427,310	$395,039	$234,646	$379,559	$163,590	$360,991	$436,480	$134,079	$366,546	$165,581	$290,228	$3,564,410
Covered	$1,053,720	$1,712,455	$2,225,839	$1,240,758	$1,074,986	$1,413,338	$1,221,783	$1,195,814	$816,442	$1,569,215	$1,031,687	$1,091,189	$15,747,224
Discnt Amt.	$533,060	$902,894	$1,054,684	$675,079	$497,207	$786,678	$626,540	$531,076	$547,392	$688,223	$548,290	$602,848	$7,972,369
Allowed	$520,660	$809,560	$1,171,155	$565,679	$577,780	$624,757	$596,244	$664,738	$269,050	$902,993	$483,398	$488,242	$7,774,855
Deductible	$34,439	$52,446	$37,635	$85,884	$100,860	$100,672	$41,012	$48,713	$43,589	$46,352	$37,045	$42,852	$643,409
Coinsurance	$36,688	$51,184	$46,043	$50,456	$61,879	$70,688	$55,448	$48,509	$41,094	$59,658	$39,102	$35,763	$598,773
Copay	$14,167	$16,586	$16,029	$18,499	$24,382	$20,940	$13,976	$14,526	$13,220	$16,400	$13,970	$16,767	$201,461
COB	$103,674	$126,911	$126,871	$19,519	$29,589	$13,483	$3,190	$6,746	$455	$334,093	$1,397	$2,096	$766,917
Claims Paid By Relationship													
Employee	$155,996	$348,105	$531,376	$157,130	$156,762	$180,921	$218,422	$243,857	$125,305	$239,199	$193,867	$174,289	$2,673,828
Spouse	$94,226	$111,195	$314,426	$142,986	$103,624	$176,672	$160,701	$251,988	$95,393	$118,961	$110,378	$134,301	$1,812,850
Dep / Chd	$66,186	$74,722	$94,810	$86,377	$85,876	$104,084	$94,423	$51,750	$43,686	$94,282	$84,509	$79,075	$960,078
Plan Payment													
Total Paid	$316,308	$534,022	$940,611	$308,494	$345,262	$411,677	$473,547	$547,595	$264,584	$450,443	$388,249	$387,665	$5,446,554
% of Chrgs	21.95%	24.96%	36.73%	26.20%	23.74%	26.11%	29.86%	33.55%	25.19%	23.27%	32.42%	28.06%	28.20%
SL Reimb.	$0	$0	$0	$364,150	$112,420	$14,548	$0	$0	$0	$0	$0	$0	$391,118
Net Paid	$316,308	$534,022	$940,611	$22,344	$332,842	$397,129	$473,547	$547,595	$264,584	$450,443	$388,249	$387,665	$5,055,437
Subscribers	796	811	813	875	867	880	876	882	880	884	879	874	860
Dependents	891	897	886	976	970	972	970	969	971	971	970	975	952
Members	1,689	1,708	1,699	1,851	1,837	1,852	1,846	1,852	1,851	1,855	1,849	1,849	1,811
Plan Cost Summary													
Claims	$316,308	$534,022	$940,611	$22,344	$332,842	$397,129	$473,547	$547,595	$264,584	$450,443	$388,249	$387,665	$5,055,437
Other Fees	$17,606	$20,675	$15,257	$17,028	$10,407	$8,553	$11,125	$10,306	$4,711	$9,821	$21,384	$4,851	$151,724
Rx Invoices	$150,407	$132,711	$186,132	$85,330	$120,632	$96,629	$153,338	$118,756	$123,154	$118,998	$111,956	$153,900	$1,551,840
Admin Fees	$34,079	$34,220	$35,282	$37,657	$38,183	$38,109	$35,834	$37,307	$36,077	$37,540	$37,885	$37,054	$441,206
SLPremium	$83,687	$83,624	$86,284	$83,361	$84,559	$83,718	$69,436	$82,001	$84,046	$83,638	$84,150	$82,570	$763,275
Optnl Fees	$0	$0	$0	$1,000	$0	$0	$0	$0	$0	$0	$0	$0	$1,000
Ancillary	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Plan Cost (Claims and Fees)													
Ttl Plan	$592,086	$785,653	$1,243,565	$226,720	$566,704	$634,138	$734,279	$776,965	$494,671	$660,337	$623,624	$645,840	$7,984,482
Per Emp.	$729.43	$968.75	$1,529.60	$259.11	$653.64	$886.52	$839.19	$879.92	$562.01	$789.61	$709.47	$738.95	$9,261.09
Per Member	$344.82	$459.98	$731.94	$122.49	$308.49	$328.21	$397.98	$419.53	$267.19	$366.76	$337.28	$349.29	$4,397.64

[Return to Report Content](#)

Rx Extract

UMR clients must have pharmacy claim detail data sent by their PBM vendor to UMR for reporting to view data on this report.

While all the reports in InfoPort have the option to export the report data, the extract reports are specifically designed for this purpose. Each extract report provides a volume of data fields in an unformatted file that can be downloaded locally for plan analysis. The downloaded data can be utilized to create pivots and graphs or merge with other data.

The Rx Extract provides paid PBM activity at the claim-level. Each report row represents a prescription drug claim and data includes fields that are applicable to the Rx claim based on paid claims activity submitted by the PBM (service dates, drug name, days supply, additional pharmacy data and associated patient). The report includes a range of claim-level dollar fields which summarize all services on the PBM data claim.

The extract reports have the capacity to support a large volume of data; download times are dependent on the user's internet browser connection. Contact the plan's designated UMR Strategic Account Executive or InfoPort Solutions if a data file with additional fields or on a frequent basis is required outside of InfoPort. The extract reports are specifically set up for data-only exporting; it is highly recommended that you do not print the report based on file size.

Report Criteria Options / Customization (available options):

- Date Range
- Filters
- Schedule

Rx Extract - Data Elements (listed alphabetically):

1 Admin Expense	18 Date Recvd	35 Member Card ID	52 Rx Count
2 Allowed Amt	19 Date Serv From	36 Member ID	53 Sales Tax
3 Ben Plan Code	20 Date Serv Through	37 NDC Brand Name	54 Sbscr Add 1
4 Ben Plan Desc	21 DAW Code	38 NDC Code	55 Sbscr Add 2
5 Ben Type	22 DAW Desc	39 NDC Generic Name	56 Sbscr City
6 Billed Amt	23 Days Supply	40 Paid Amt	57 Sbscr Last Name
7 Claim ID	24 Deductible Amt	41 Patient Age	58 Sbscr State
8 Claim Status Code	25 Dispensing Fee	42 Patient Last Name	59 Sbscr ZIP
9 Claim Status Desc	26 Drug Name	43 Patient Name	60 Subscriber ID
10 Class Code	27 Formulary	44 Patient Resp	61 Subscriber Name
11 Class Desc	28 Generic	45 Patient Sex	62 Therapeutic Class Code - Spec
12 Contract	29 Ingredient Cost	46 PBM Code	63 Therapeutic Class Code - Std
13 Copay Amt	30 Location Code	47 PBM Name	64 Therapeutic Class Desc - Spec
14 Coverage Tier	31 Location Desc	48 Prescriber First Name	65 Therapeutic Class Desc - Std
15 Customer	32 Mail Order	49 Prescriber Last Name	66 Units Dispensed
16 Customer ID	33 Mem Network 1 Code	50 Refill Count	
17 Date Paid	34 Mem Network 1 Desc	51 Relationship	

Click here to view an example of the InfoPort data view when exported into a spreadsheet (refer to page 27)

Return to Report Content

Rx Summary

UMR clients must have pharmacy claim detail data sent by their PBM vendor to UMR for reporting/to view data on this report.

The Rx Summary Report provides an option to summarize prescription drug claims by up to four dimensions. The report can aggregate paid pharmacy data based on user requirements, provide prescribed drug utilization, and display the plan paid amount at a summary level with an option to suppress PHI. The online report provides an option to drill into the PBM claim profile (if detail is available).

The available filters provide an option to summarize data by:

- Plan Account Structure
- Claim Data (Paid Month, Drug Name, Therapeutic Class, Generic, Brand)
- Patient (Patient Gender, Patient Age Range, Relationship)
- Pharmacy (Pharmacy Name, Pharmacy TIN, Pharmacy ZIP Code)
- Subscriber (Subscriber ID, Subscriber State/Zip Code)

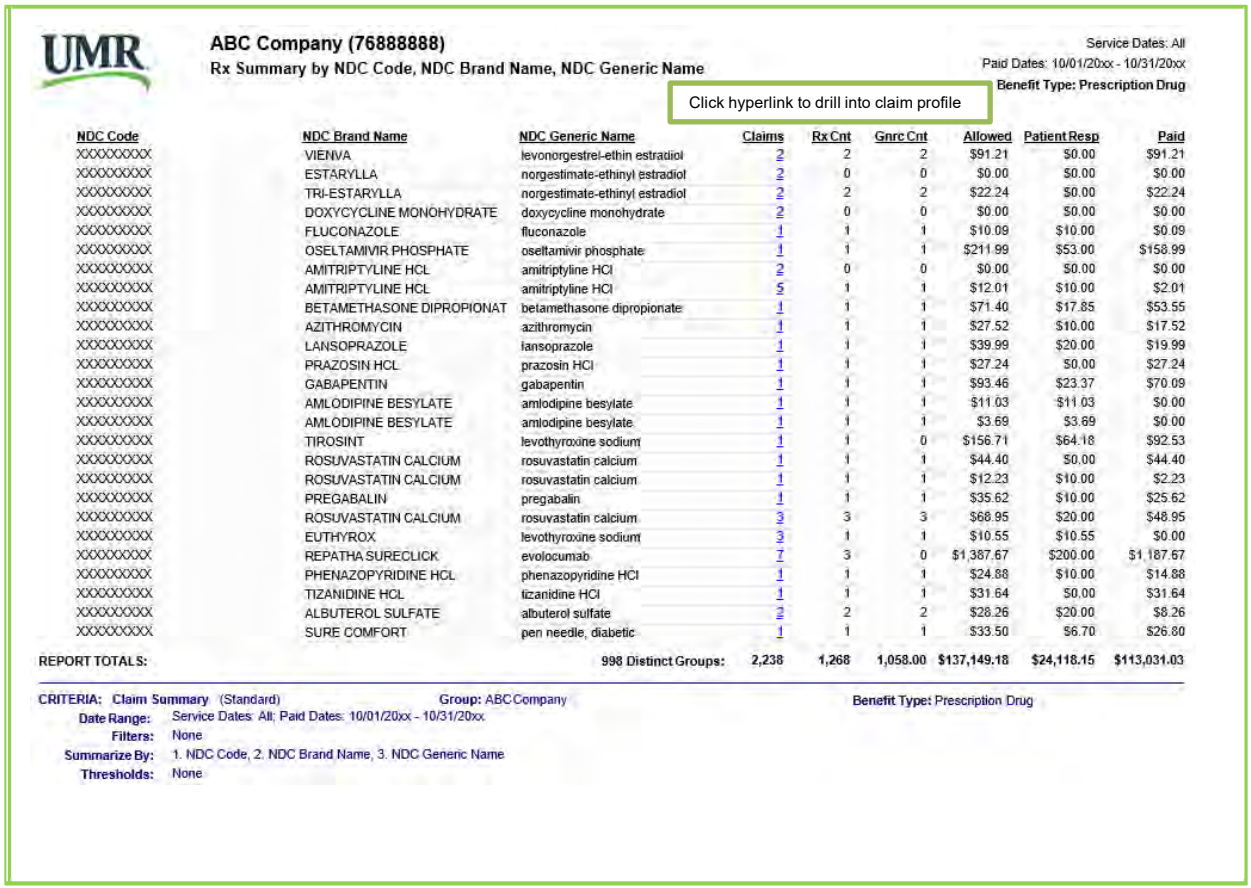
Report Parameters/ Customization (available options)

- Date Range
- Filters
- Summarize by
- Thresholds
- Display Options
- Schedule Options

Report Content

- Claims (hyperlink; drills into claim profile)
- Rx Count
- Generic Count
- Allowed
- Patient Responsibility
- Paid

Report summarized by NDC



UMR

ABC Company (76888888)

Rx Summary by NDC Code, NDC Brand Name, NDC Generic Name

Service Dates: All
Paid Dates: 10/01/20xx - 10/31/20xx
Benefit Type: Prescription Drug

Click hyperlink to drill into claim profile

NDC Code	NDC Brand Name	NDC Generic Name	Claims	Rx Cnt	Gnrc Cnt	Allowed	Patient Resp	Paid
XXXXXXXXX	VIENVA	levonorgestrel-ethin estradiol	2	2	2	$91.21	$0.00	$91.21
XXXXXXXXX	ESTARYLLA	norgestimate-ethinyl estradiol	2	0	0	$0.00	$0.00	$0.00
XXXXXXXXX	TRI-ESTARYLLA	norgestimate-ethinyl estradiol	2	2	2	$22.24	$0.00	$22.24
XXXXXXXXX	DOXYCYCLINE MONOHYDRATE	doxycycline monohydrate	2	0	0	$0.00	$0.00	$0.00
XXXXXXXXX	FLUCONAZOLE	fluconazole	1	1	1	$10.09	$10.00	$0.09
XXXXXXXXX	OSELTAMIVIR PHOSPHATE	oseltamivir phosphate	1	1	1	$211.99	$53.00	$158.99
XXXXXXXXX	AMITRIPTYLINE HCL	amitriptyline HCl	2	0	0	$0.00	$0.00	$0.00
XXXXXXXXX	AMITRIPTYLINE HCL	amitriptyline HCl	5	1	1	$12.01	$10.00	$2.01
XXXXXXXXX	BETAMETHASONE DIPROPIONAT	betamethasone dipropionate	1	1	1	$71.40	$17.85	$53.55
XXXXXXXXX	AZITHROMYCIN	azithromycin	1	1	1	$27.52	$10.00	$17.52
XXXXXXXXX	LANSOPRAZOLE	lansoprazole	1	1	1	$39.99	$20.00	$19.99
XXXXXXXXX	PRAZOSIN HCL	prazosin HCl	1	1	1	$27.24	$0.00	$27.24
XXXXXXXXX	GABAPENTIN	gabapentin	1	1	1	$93.46	$23.37	$70.09
XXXXXXXXX	AMLODIPINE BESYLATE	amlodipine besylate	1	1	1	$11.03	$11.03	$0.00
XXXXXXXXX	AMLODIPINE BESYLATE	amlodipine besylate	1	1	1	$3.69	$3.69	$0.00
XXXXXXXXX	TIROSINT	levothyroxine sodium	1	1	0	$156.71	$64.18	$92.53
XXXXXXXXX	ROSUVASTATIN CALCIUM	rosuvastatin calcium	1	1	1	$44.40	$0.00	$44.40
XXXXXXXXX	ROSUVASTATIN CALCIUM	rosuvastatin calcium	1	1	1	$12.23	$10.00	$2.23
XXXXXXXXX	PREGABALIN	pregabalin	1	1	1	$35.62	$10.00	$25.62
XXXXXXXXX	ROSUVASTATIN CALCIUM	rosuvastatin calcium	3	3	3	$68.95	$20.00	$48.95
XXXXXXXXX	EUTHYROX	levothyroxine sodium	3	1	1	$10.55	$10.55	$0.00
XXXXXXXXX	REPATHA SURECLICK	evolocumab	7	3	0	$1,387.67	$200.00	$1,187.67
XXXXXXXXX	PHENAZOPYRIDINE HCL	phenazopyridine HCl	1	1	1	$24.88	$10.00	$14.88
XXXXXXXXX	TIZANIDINE HCL	tizanidine HCl	1	1	1	$31.64	$0.00	$31.64
XXXXXXXXX	ALBUTEROL SULFATE	albuterol sulfate	2	2	2	$28.26	$20.00	$8.26
XXXXXXXXX	SURE COMFORT	pen needle, diabetic	1	1	1	$33.50	$6.70	$26.80
REPORT TOTALS:		**998 Distinct Groups:**	**2,238**	**1,268**	**1,058.00**	**$137,149.18**	**$24,118.15**	**$113,031.03**

CRITERIA: Claim Summary (Standard) **Group:** ABC Company **Benefit Type:** Prescription Drug
Date Range: Service Dates: All; Paid Dates: 10/01/20xx - 10/31/20xx
Filters: None
Summarize By: 1. NDC Code, 2. NDC Brand Name, 3. NDC Generic Name
Thresholds: None

[Return to Report Content](#)

Stop Loss 50 Percent [2]

The Stop Loss 50 Percent Report displays members who have reached 50 percent or more of their specific stop loss deductible during the current stop loss period. The static report is refreshed on a monthly basis and is based on year-to-date information. Information about the current stop loss contract is in the right-hand corner of the report. The data provides current contract terms and is specific to each individual stop loss contract.

Report Content

Member Number: The unique member ID from each member's plan ID card.

Rel Code: The relationship code of the member to the employee. Relationship codes include:

- CH (Child)
- EE (Employee)
- SP (Spouse)
- OT (Other)

Age: The age of the member.

Gender: The gender of the member.

Laser Ind: An L in this column indicates that the member has a different specific stop loss deductible than the other members. If no L exists, the member has the same specific stop loss deductible as referenced in the right-hand corner of the report, Specific Deductible.

Pct of Deduct: The ratio; a percent of total claims processed to the plan deductible amount.

Total Medical Paid: Total medical paid dollars for the member.

Total Rx Paid: Total Rx paid dollars for the member (if available).

Total Paid: The total medical and Rx paid dollars for the member.

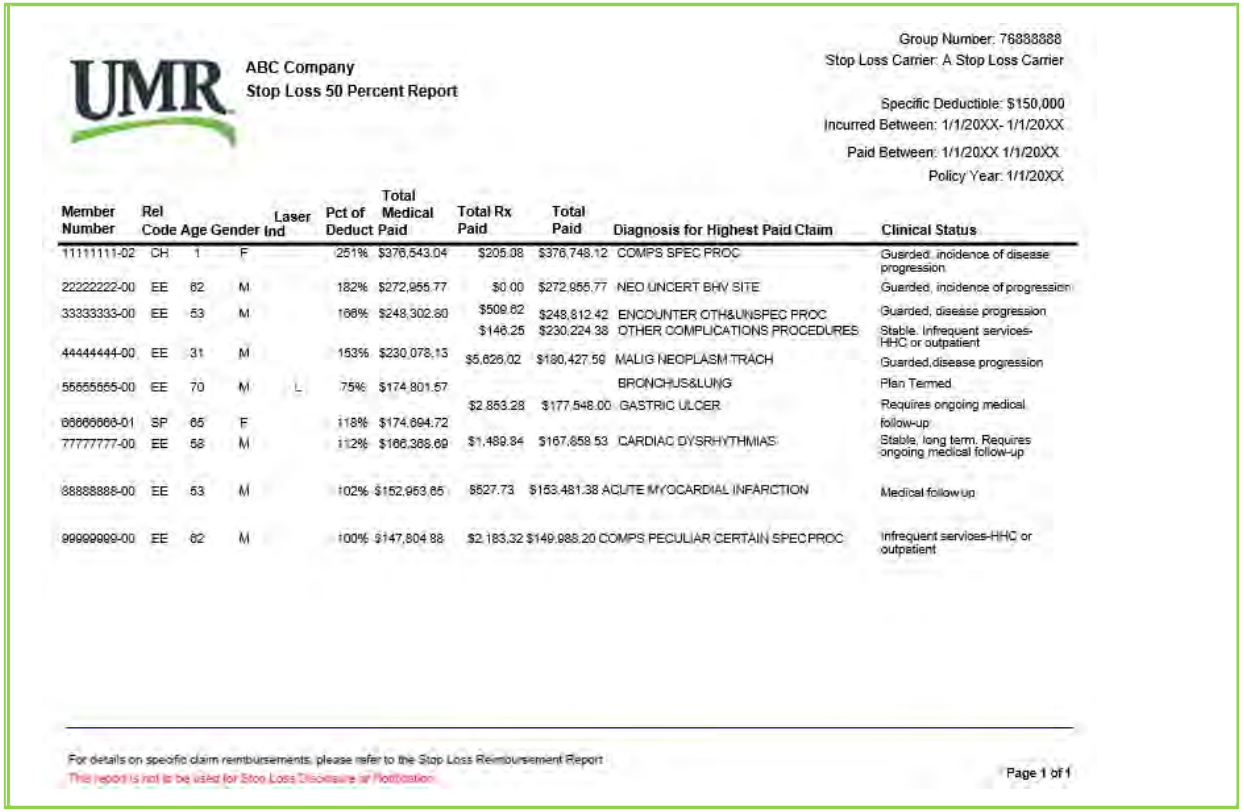
Diagnosis for Highest Paid Claim: Diagnosis description associated with the single highest paid claim.

This report is available for UMR clients with Stop Loss services supported by UMR.

Clinical Status: Displays the values provided after UMR clinical case review (if applicable). Values can include:

- Guarded high incidence of relapse or disease progression: The member is at high-risk for future incidences.
- Stable, episodic, infrequent services-HHC or outpatient: The member's condition has improved but may need outpatient follow-up care.
- Plan Termed: The member is no longer covered under the plan.
- Patient Expired: The member is deceased.
- Stable, Long Term: The member's condition has improved and there is a low likelihood of relapse.
- Does not meet UMR Case Management criteria: Cases that have not been transferred for clinical review.

Report



UMR

ABC Company
Stop Loss 50 Percent Report

Group Number: 76888888
Stop Loss Carrier: A Stop Loss Carrier

Specific Deductible: $150,000
Incurred Between: 1/1/20XX- 1/1/20XX
Paid Between: 1/1/20XX 1/1/20XX
Policy Year: 1/1/20XX

Member Number	Rel Code	Age	Gender	Laser Ind	Pct of Deduct	Total Medical Paid	Total Rx Paid	Total Paid	Diagnosis for Highest Paid Claim	Clinical Status
11111111-02	CH	1	F		251%	$376,543.04	$205.08	$376,748.12	COMPS SPEC PROC	Guarded, incidence of disease progression
22222222-00	EE	62	M		182%	$272,955.77	$0.00	$272,955.77	NEO UNCERT BHV SITE	Guarded, incidence of progression
33333333-00	EE	53	M		166%	$248,302.60	$509.62	$248,812.42	ENCOUNTER OTH&UNSPEC PROC	Guarded, disease progression
							$146.25	$230,224.38	OTHER COMPLICATIONS PROCEDURES	Stable, Infrequent services-HHC or outpatient
44444444-00	EE	31	M		153%	$230,078.13	$5,626.02	$180,427.59	MALIG NEOPLASM TRACH	Guarded,disease progression
55555555-00	EE	70	M	L	75%	$174,801.57			BRONCHUS&LUNG	Plan Termed
							$2,853.28	$177,548.00	GASTRIC ULCER	Requires ongoing medical follow-up
66666666-01	SP	65	F		118%	$174,694.72				
77777777-00	EE	58	M		112%	$166,368.69	$1,489.84	$167,858.53	CARDIAC DYSRHYTHMIAS	Stable, long term, Requires ongoing medical follow-up
88888888-00	EE	53	M		102%	$152,953.85	$527.73	$153,481.38	ACUTE MYOCARDIAL INFARCTION	Medical follow up
99999999-00	EE	62	M		100%	$147,804.88	$2,183.32	$149,988.20	COMPS PECULIAR CERTAIN SPEC PROC	Infrequent services-HHC or outpatient

For details on specific claim reimbursements, please refer to the Stop Loss Reimbursement Report
This report is not to be used for Stop Loss Disclosure or Notification

Page 1 of 1

[Return to Report Content](#)

Stop Loss Aggregate [2]

The Stop Loss Aggregate Report displays a year-to-date view of paid claims and contract adjustments that relate to the aggregate stop loss contract. The report is based on the S/L plan year and contract type for benefits covered under the aggregate contract (i.e., paid basis, 12/15 etc.). The purpose of the report is to provide updates on year-to-date Aggregate Stop Loss Contract results. **Note:** This report is audited only after the close of contract review and is not suitable for budgeting or other financial controls reporting due to the many Stop Loss contract variables that impact the displayed dollar amounts.

Summary Report Tab Information

- *Minimum Attachment Point Percent*: % used to calculate the minimum attachment point.
- *Aggregate Attachment Point*: Contracted aggregate liability. This is determined by the Stop Loss carrier's initial annual aggregate attachment.
- *Monthly Aggregate Attachment*: The number of covered units for that month times the applicable monthly factor(s). Aggregate Factors: Single, family. Aggregate factors are determined by the Stop Loss carrier. These factors, when multiplied by the monthly enrollment, will equal the Maximum Aggregate Liability for the group.
- *Coverages Included*: Lines of coverage under the aggregate stop loss contract (i.e., medical, Rx).
- *Single EE Count*: Number of employees that have single coverage based on census provided as of the 1st of the month.
- *Family EE Count*: Number of employees that have family coverage based on census provided as of the 1st of the month.

Note: Enrollment is restated based on late additions and terminations, limited to 6 months per administrative standard.

- *Actual Attachment Point Calc*: Calculated by adding the sum of the single attachment factor times the single ee count and the sum of the family attachment factor times the family ee count.
- *Other Eligible Claims*: Eligible fees, surcharges or other benefits included in the aggregate contract and are paid within the aggregate contract period
- *Total Monthly Claims*: The dollar sum of each coverage line included in the aggregate coverage (i.e., medical, pharmacy).
- *Total Exclusions*: Sum of any type of operating expenses or non-covered exception payments.
- *Specific Claims Requested*: Sum of all claims filed for reimbursement under specific stop loss coverage.
- *Monthly Eligible Stop Loss Claims*: Monthly eligible stop loss claims minus total exclusions and specific claims requested.
- *YTD Eligible Stop Loss Claims*: Running total of Monthly Eligible stop loss claims.
- *Specific Claims Received*: Number of reimbursements received from the Stop Loss carrier.

Detail Report Tab Information

- *Trans Date*: Month in which data is represented.
- *Med EE Single / Med Family*: Number of employees that have single or family coverage based on census provided as of the 1st of the month.
- *Medical Claims*: Medical claim payments for benefits that apply to the stop loss contract. Claims paid outside of the stop loss contract will not be included in the aggregate report.
- *Medical Prior TPA*: Unaudited eligible medical paid claim data for services administered by prior administrator within aggregate contract period.
- *Pharmacy Claims*: Rx payments for benefits that apply to the stop loss contract based on the billed or invoice date. **Note**: Will not match the check register as services are based on the billed or invoice date. The check register is based on the paid date.
- *Fees*: Eligible fees, surcharges or other product lines included in the aggregate contract and are paid within the aggregate contract period.
  Total Monthly Claims: Sum of Medical Paid Claims, Drug Vendor Payments, and Access Fees.
- *Spec Reimb Req Amt*: Total specific dollars requested from the stop loss carrier within that month.
- *Exception Claims*: Medical claim payments excluded from the aggregate contract. (i.e., services administered outside of the plan provisions).
- *Spec Reimb Received*: Amount of reimbursement received from the stop loss carrier within that month.
- *Adjusted Claims*: Claim payment adjustment.

This report is available for UMR clients with Stop Loss services supported by UMR.

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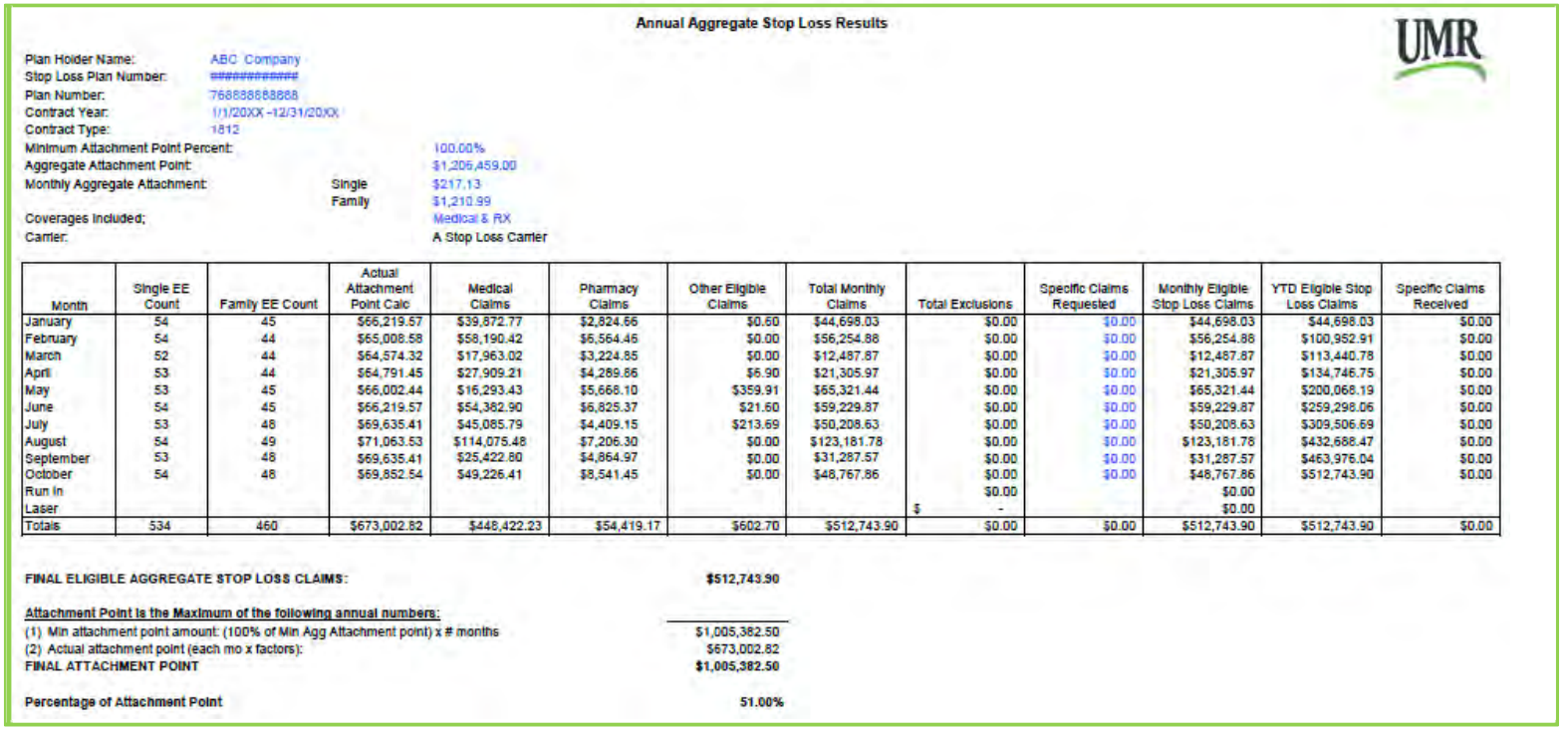
View next page for report samples.

Report Aggregate Summary:



Annual Aggregate Stop Loss Results

UMR

Plan Holder Name: ABC Company
Stop Loss Plan Number: ##########
Plan Number: 768888888888
Contract Year: 1/1/20XX -12/31/20XX
Contract Type: 1812
Minimum Attachment Point Percent: 100.00%
Aggregate Attachment Point: $1,206,459.00
Monthly Aggregate Attachment: Single $217.13
Family $1,210.99
Coverages Included: Medical & RX
Carrier: A Stop Loss Carrier

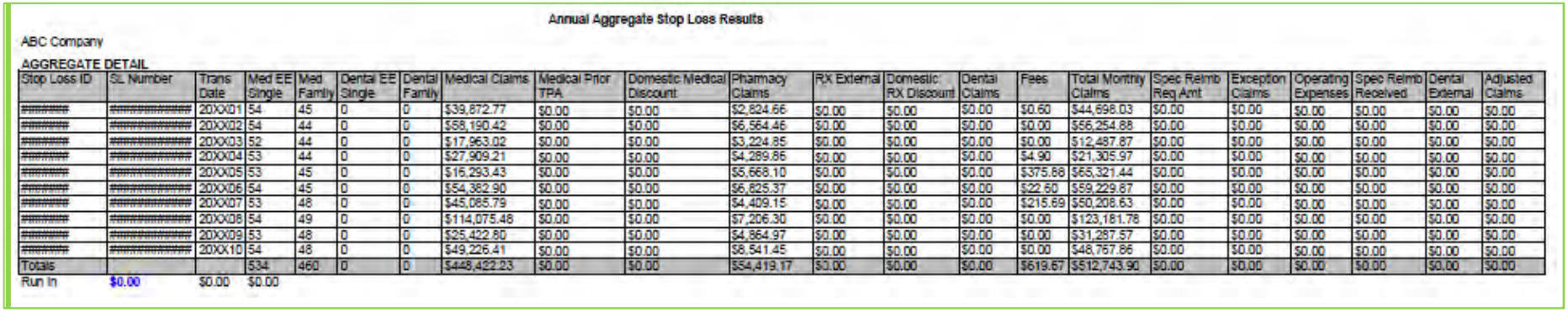
Month	Single EE Count	Family EE Count	Actual Attachment Point Calc	Medical Claims	Pharmacy Claims	Other Eligible Claims	Total Monthly Claims	Total Exclusions	Specific Claims Requested	Monthly Eligible Stop Loss Claims	YTD Eligible Stop Loss Claims	Specific Claims Received
January	54	45	$66,219.57	$39,872.77	$2,824.66	$0.60	$44,698.03	$0.00	$0.00	$44,698.03	$44,698.03	$0.00
February	54	44	$65,008.58	$58,190.42	$6,564.46	$0.00	$56,254.88	$0.00	$0.00	$56,254.88	$100,952.91	$0.00
March	52	44	$64,574.32	$17,963.02	$3,224.85	$0.00	$12,487.87	$0.00	$0.00	$12,487.87	$113,440.78	$0.00
April	53	44	$64,791.45	$27,909.21	$4,289.86	$5.90	$21,305.97	$0.00	$0.00	$21,305.97	$134,746.75	$0.00
May	53	45	$66,002.44	$16,293.43	$5,668.10	$359.91	$65,321.44	$0.00	$0.00	$65,321.44	$200,068.19	$0.00
June	54	45	$66,219.57	$54,382.90	$6,825.37	$21.60	$59,229.87	$0.00	$0.00	$59,229.87	$259,298.06	$0.00
July	53	48	$69,635.41	$45,085.79	$4,409.15	$213.69	$50,208.63	$0.00	$0.00	$50,208.63	$309,506.69	$0.00
August	54	49	$71,063.53	$114,075.48	$7,206.30	$0.00	$123,181.78	$0.00	$0.00	$123,181.78	$432,688.47	$0.00
September	53	48	$69,635.41	$25,422.80	$4,864.97	$0.00	$31,287.57	$0.00	$0.00	$31,287.57	$463,976.04	$0.00
October	54	48	$69,852.54	$49,226.41	$8,541.45	$0.00	$48,767.86	$0.00	$0.00	$48,767.86	$512,743.90	$0.00
Run In								$0.00		$0.00		
Laser								$ -		$0.00		
Totals	534	460	$673,002.82	$448,422.23	$54,419.17	$602.70	$512,743.90	$0.00	$0.00	$512,743.90	$512,743.90	$0.00

FINAL ELIGIBLE AGGREGATE STOP LOSS CLAIMS: **$512,743.90**

Attachment Point is the Maximum of the following annual numbers:
(1) Min attachment point amount: (100% of Min Agg Attachment point) x # months $1,005,382.50
(2) Actual attachment point (each mo x factors): $673,002.82
FINAL ATTACHMENT POINT **$1,005,382.50**

Percentage of Attachment Point **51.00%**

Report Aggregate Detail:



Annual Aggregate Stop Loss Results

ABC Company

AGGREGATE DETAIL

Stop Loss ID	SL Number	Trans Date	Med EE Single	Med Family	Dental EE Single	Dental Family	Medical Claims	Medical Prior TPA	Domestic Medical Discount	Pharmacy Claims	RX External	Domestic RX Discount	Dental Claims	Fees	Total Monthly Claims	Spec Reimb Req Amt	Exception Claims	Operating Expenses	Spec Reimb Received	Dental External	Adjusted Claims
########	##########	20XX01	54	45	0	0	$39,872.77	$0.00	$0.00	$2,824.66	$0.00	$0.00	$0.00	$0.60	$44,698.03	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
########	##########	20XX02	54	44	0	0	$58,190.42	$0.00	$0.00	$6,564.46	$0.00	$0.00	$0.00	$0.00	$56,254.88	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
########	##########	20XX03	52	44	0	0	$17,963.02	$0.00	$0.00	$3,224.85	$0.00	$0.00	$0.00	$0.00	$12,487.87	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
########	##########	20XX04	53	44	0	0	$27,909.21	$0.00	$0.00	$4,289.86	$0.00	$0.00	$0.00	$4.90	$21,305.97	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
########	##########	20XX05	53	45	0	0	$16,293.43	$0.00	$0.00	$5,668.10	$0.00	$0.00	$0.00	$375.66	$65,321.44	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
########	##########	20XX06	54	45	0	0	$54,382.90	$0.00	$0.00	$6,825.37	$0.00	$0.00	$0.00	$22.50	$59,229.87	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
########	##########	20XX07	53	48	0	0	$45,085.79	$0.00	$0.00	$4,409.15	$0.00	$0.00	$0.00	$215.69	$50,208.63	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
########	##########	20XX08	54	49	0	0	$114,075.48	$0.00	$0.00	$7,206.30	$0.00	$0.00	$0.00	$0.00	$123,181.78	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
########	##########	20XX09	53	48	0	0	$25,422.80	$0.00	$0.00	$4,864.97	$0.00	$0.00	$0.00	$0.00	$31,287.57	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
########	##########	20XX10	54	48	0	0	$49,226.41	$0.00	$0.00	$8,541.45	$0.00	$0.00	$0.00	$0.00	$48,767.86	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Totals			534	460	0	0	$448,422.23	$0.00	$0.00	$54,419.17	$0.00	$0.00	$0.00	$619.67	$512,743.90	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Run In	$0.00	$0.00	$0.00																		

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Stop Loss Member Monitor (PHI & No-PHI Versions) [2]

The PHI Member Monitor Stop Loss Report displays an inventory of members who have hit criteria for stop loss monitoring. It is based on date parameters aligned with the stop loss contract period. Criteria can include a trigger diagnosis and/or clinical note entered by a UMR clinical staff member. Please note that updates can be prompted by the member beginning UMR Case Management, or a carrier/broker requested a clinical review.

The PHI Member Monitor Report display is limited to members that are at 25% or more of their specific stop loss deductible; no percent of specific stop loss deductible applies if members meet Case Management or clinical criteria.
Note: If Rx dollars are not available on this report, this means that UMR is not receiving paid pharmacy details from the client's pharmacy vendor. However, it does not imply that Rx claims are not part of the Stop Loss contract.

Member and Claim Information

Specific Deductible: Amount of specific deductible for the member based on S/L contract.
Member Name: The name of the member being reported in the data. (PHI version)
Member DOB: The date of birth of the member. (PHI version)
Gender: The gender of the member. (PHI version)
Relationship: The relationship of the member to the employee. (PHI version)
Member ID: The internal unique member ID. (PHI version)
Term Date: The date after which services incurred for this member, are no longer considered for payment.
Employee Name: The name of the employee enrolled in the plan. (PHI version)
UMR ID: The unique member ID from each member's plan and ID card. (PHI version)
Location: The location of the member as provided to UMR. (PHI version)
Class: The benefit class the member is enrolled in. (PHI version)
Last Svc Date: The most recent date of medical service processed for this member.
Pended Claims: The sum of the billed amounts on claims received that have not been processed. The actual amount that will be paid will depend on benefit plan provisions.
Medical Paid Claims: The total medical paid dollars for the member.
RX Paid Claims: The total Rx paid dollars for the member (if available).
Paid Claims: The total medical and Rx paid dollars for the member.
% of Ded: The ratio, expressed as a percent, of the total claims processed to the plan deductible amount.
Largest ICD: The diagnosis code and description with the largest number of claims processed for the current year.
Largest ICD Pd Amt: The total amount processed in the current year for the diagnosis code with the largest number of claims processed.

Clinical Note Information

Review Date: The date clinical review was completed.
Reviewed by: The clinician involved with the Case Management review.
Clinical Update: A free form text field available at the time of clinical review to state the condition of the claimant.
Other Comments: A free form text field available at the time of clinical review. For Case Management cases, the field will reflect case related questions and answers. For notes added by a nurse from a Stop Loss carrier/broker inquiry, the field will state any other relevant comments concerning the member or the claim.

This report is available for UMR clients with Stop Loss services supported by UMR.

View next page for report samples.

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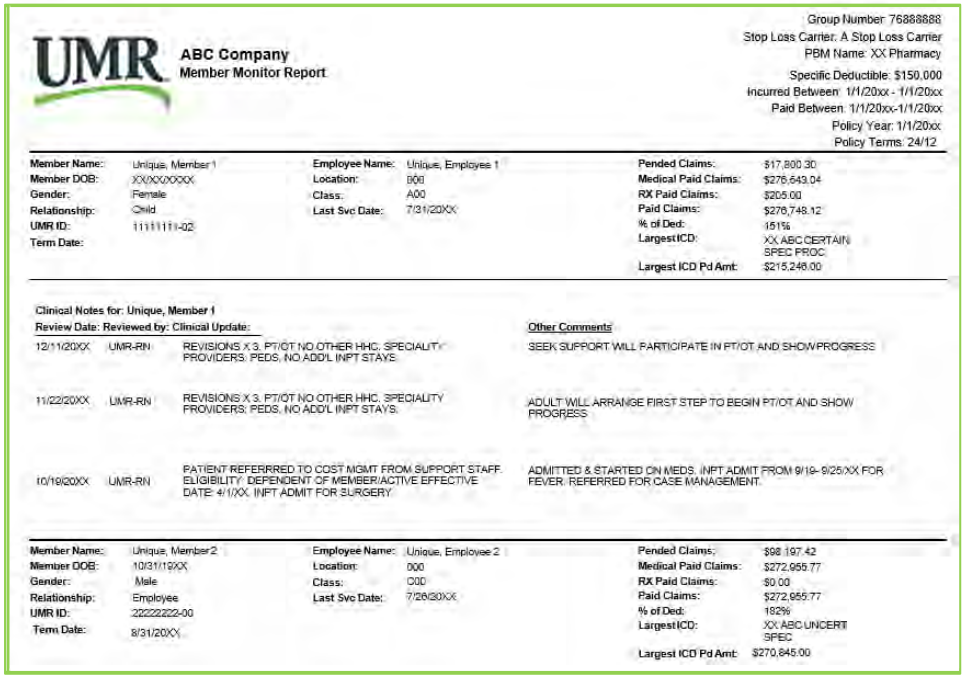
PHI Version:



UMR

ABC Company
Member Monitor Report

Group Number: 76888888
Stop Loss Carrier: A Stop Loss Carrier
PBM Name: XX Pharmacy
Specific Deductible: $150,000
Incurred Between: 1/1/20xx - 1/1/20xx
Paid Between: 1/1/20xx-1/1/20xx
Policy Year: 1/1/20xx
Policy Terms: 24/12

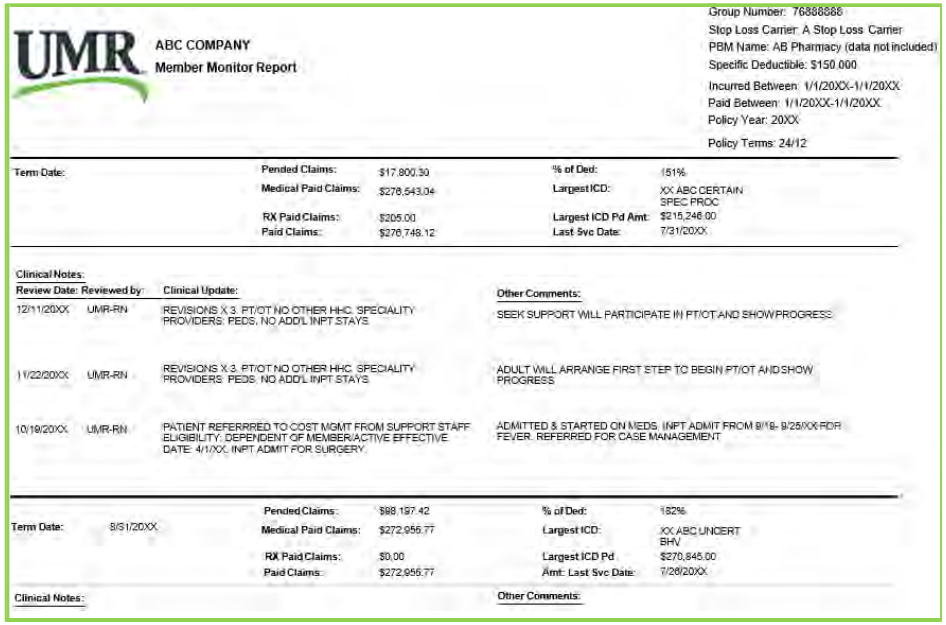
Member Name:	Unique, Member 1	Employee Name:	Unique, Employee 1	Pended Claims:	$17,800.30
Member DOB:	XX/XX/XXXX	Location:	000	Medical Paid Claims:	$276,643.04
Gender:	Female	Class:	A00	RX Paid Claims:	$205.00
Relationship:	Child	Last Svc Date:	7/31/20XX	Paid Claims:	$276,748.12
UMR ID:	11111111-02			% of Ded:	151%
Term Date:				Largest ICD:	XX ABC CERTAIN SPEC PROC
				Largest ICD Pd Amt:	$215,246.00

Clinical Notes for: Unique, Member 1

Review Date:	Reviewed by:	Clinical Update:	Other Comments
12/11/20XX	UMR-RN	REVISIONS X 3. PT/OT NO OTHER HHC. SPECIALITY PROVIDERS: PEDS, NO ADD'L INPT STAYS.	SEEK SUPPORT WILL PARTICIPATE IN PT/OT AND SHOW PROGRESS
11/22/20XX	UMR-RN	REVISIONS X 3. PT/OT NO OTHER HHC. SPECIALITY PROVIDERS: PEDS, NO ADD'L INPT STAYS.	ADULT WILL ARRANGE FIRST STEP TO BEGIN PT/OT AND SHOW PROGRESS
10/19/20XX	UMR-RN	PATIENT REFERRRED TO COST MGMT FROM SUPPORT STAFF. ELIGIBILITY: DEPENDENT OF MEMBER/ACTIVE EFFECTIVE DATE: 4/1/XX. INPT ADMIT FOR SURGERY.	ADMITTED & STARTED ON MEDS. INPT ADMIT FROM 9/18- 9/25/XX FOR FEVER. REFERRED FOR CASE MANAGEMENT.

Member Name:	Unique, Member 2	Employee Name:	Unique, Employee 2	Pended Claims:	$98,197.42
Member DOB:	10/31/19XX	Location:	000	Medical Paid Claims:	$272,955.77
Gender:	Male	Class:	C0D	RX Paid Claims:	$0.00
Relationship:	Employee	Last Svc Date:	7/26/20XX	Paid Claims:	$272,955.77
UMR ID:	22222222-00			% of Ded:	182%
Term Date:	8/31/20XX			Largest ICD:	XX ABC UNCERT SPEC
				Largest ICD Pd Amt:	$270,845.00

No-PHI Version:



UMR

ABC COMPANY
Member Monitor Report

Group Number: 76888888
Stop Loss Carrier: A Stop Loss Carrier
PBM Name: AB Pharmacy (data not included)
Specific Deductible: $150,000
Incurred Between: 1/1/20XX-1/1/20XX
Paid Between: 1/1/20XX-1/1/20XX
Policy Year: 20XX
Policy Terms: 24/12

Term Date:		Pended Claims:	$17,800.30	% of Ded:	151%
		Medical Paid Claims:	$276,643.04	Largest ICD:	XX ABC CERTAIN SPEC PROC
		RX Paid Claims:	$205.00	Largest ICD Pd Amt:	$215,246.00
		Paid Claims:	$276,748.12	Last Svc Date:	7/31/20XX

Clinical Notes:

Review Date:	Reviewed by:	Clinical Update:	Other Comments:
12/11/20XX	UMR-RN	REVISIONS X 3. PT/OT NO OTHER HHC. SPECIALITY PROVIDERS: PEDS, NO ADD'L INPT STAYS.	SEEK SUPPORT WILL PARTICIPATE IN PT/OT AND SHOW PROGRESS
11/22/20XX	UMR-RN	REVISIONS X 3. PT/OT NO OTHER HHC. SPECIALITY PROVIDERS: PEDS, NO ADD'L INPT STAYS.	ADULT WILL ARRANGE FIRST STEP TO BEGIN PT/OT AND SHOW PROGRESS
10/19/20XX	UMR-RN	PATIENT REFERRRED TO COST MGMT FROM SUPPORT STAFF. ELIGIBILITY: DEPENDENT OF MEMBER/ACTIVE EFFECTIVE DATE: 4/1/XX. INPT ADMIT FOR SURGERY.	ADMITTED & STARTED ON MEDS. INPT ADMIT FROM 9/18- 9/25/XX FOR FEVER. REFERRED FOR CASE MANAGEMENT

Term Date:	8/31/20XX	Pended Claims:	$98,197.42	% of Ded:	182%
		Medical Paid Claims:	$272,955.77	Largest ICD:	XX ABC UNCERT BHV
		RX Paid Claims:	$0.00	Largest ICD Pd Amt:	$270,845.00
		Paid Claims:	$272,955.77	Last Svc Date:	7/26/20XX

Clinical Notes: Other Comments:

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Stop Loss Reimbursement [2]

The Stop Loss Reimbursement Documentation displays all member claims, for a specific group, that have been submitted to the Stop Loss carrier for reimbursement. This display is refreshed on a monthly basis and is a cumulative report based on stop loss contract year-to-date information.

The Stop Loss report includes information about the current stop loss contract in the right-hand corner of the document. This information specifies the current contract terms and is specific to each individual stop loss contract.

Report Content

Location: The location of the member as provided to UMR.

Member Name: The name of the member being reported in the data.

Reimb Request Date: Date the claim was submitted to the Stop Loss carrier for reimbursement.

Reimb Request Amount: Dollar amount being requested.

Reimb Received Amount: Dollar amount that was received from the carrier.

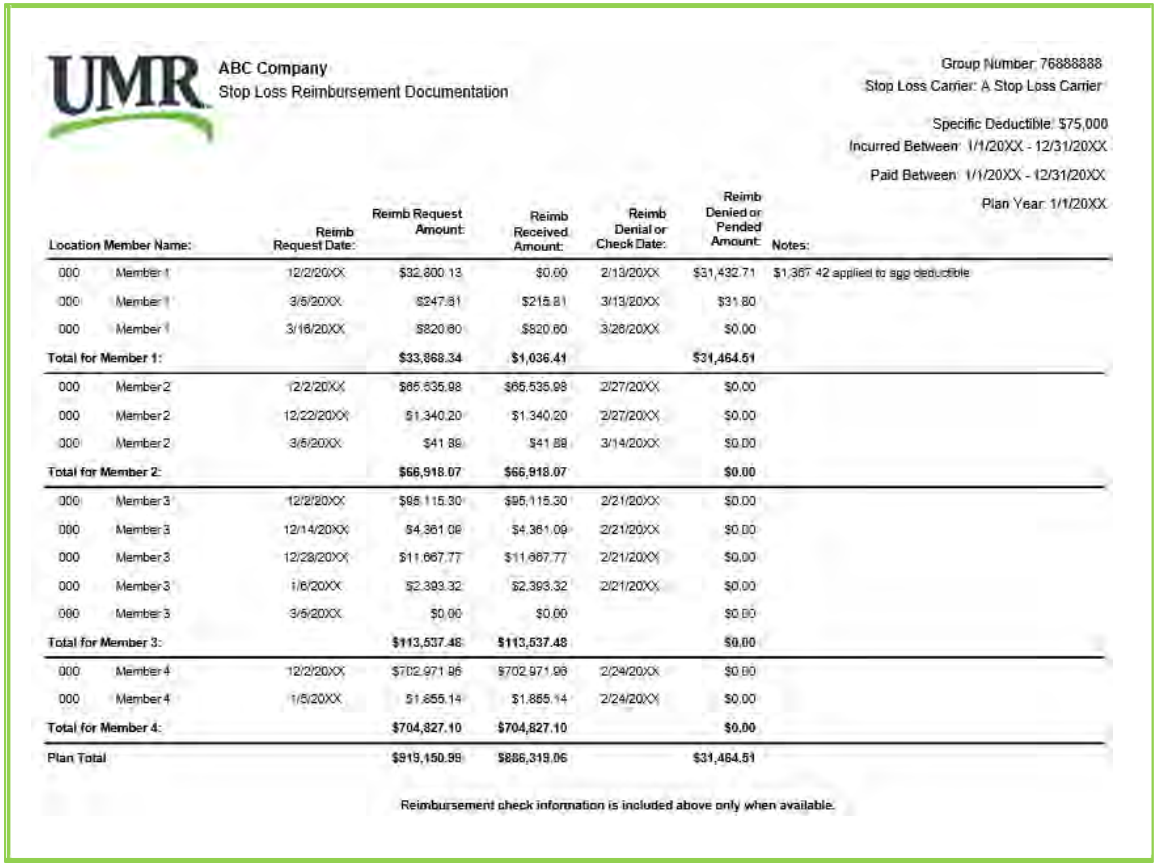
Reimb Denial or Check Date: Date the reimbursement was denied or date the reimbursement check was received from the Stop Loss carrier.

Reimb Denied or Pended Amount: The reimbursement dollar amount that was denied or the reimbursement pended amount.

Notes: Specifies additional information about reimbursement requests that are denied or pended.

Plan Total: Total of the report's dollar columns.

Report



UMR

ABC Company
Stop Loss Reimbursement Documentation

Group Number: 76888888
Stop Loss Carrier: A Stop Loss Carrier
Specific Deductible: $75,000
Incurred Between: 1/1/20XX - 12/31/20XX
Paid Between: 1/1/20XX - 12/31/20XX
Plan Year: 1/1/20XX

Location	Member Name:	Reimb Request Date:	Reimb Request Amount:	Reimb Received Amount:	Reimb Denial or Check Date:	Reimb Denied or Pended Amount:	Notes:
000	Member 1	12/2/20XX	$32,800.13	$0.00	2/13/20XX	$31,432.71	$1,367.42 applied to agg deductible
000	Member 1	3/5/20XX	$247.81	$215.81	3/13/20XX	$31.80	
000	Member 1	3/16/20XX	$820.60	$820.60	3/28/20XX	$0.00	
Total for Member 1:			**$33,868.34**	**$1,036.41**		**$31,464.51**	
000	Member 2	12/2/20XX	$65,535.99	$65,535.99	2/27/20XX	$0.00	
000	Member 2	12/22/20XX	$1,340.20	$1,340.20	2/27/20XX	$0.00	
000	Member 2	3/5/20XX	$41.88	$41.88	3/14/20XX	$0.00	
Total for Member 2:			**$66,918.07**	**$66,918.07**		**$0.00**	
000	Member 3	12/2/20XX	$95,115.30	$95,115.30	2/21/20XX	$0.00	
000	Member 3	12/14/20XX	$4,361.09	$4,361.09	2/21/20XX	$0.00	
000	Member 3	12/28/20XX	$11,667.77	$11,667.77	2/21/20XX	$0.00	
000	Member 3	1/6/20XX	$2,393.32	$2,393.32	2/21/20XX	$0.00	
000	Member 3	3/5/20XX	$0.00	$0.00		$0.00	
Total for Member 3:			**$113,537.48**	**$113,537.48**		**$0.00**	
000	Member 4	12/2/20XX	$702,971.96	$702,971.96	2/24/20XX	$0.00	
000	Member 4	1/5/20XX	$1,855.14	$1,855.14	2/24/20XX	$0.00	
Total for Member 4:			**$704,827.10**	**$704,827.10**		**$0.00**	
Plan Total			**$919,150.99**	**$886,319.06**		**$31,464.51**	

Reimbursement check information is included above only when available.

The monthly report represents data at the time of report creation.

Authorized users can access My Stop Loss Center for the most current Stop Loss reimbursement information.

This report is available for UMR clients with Stop Loss services supported by UMR.

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Top Claimant

The Top Claimant Report provides an overview of high-cost claims by member, with an option to suppress PHI. The report displays paid claims by member (patient) based on the top total combined paid activity with a user option to select the number of members to display and top 1-10 paid claim records per patient. Report data includes paid medical claims and paid dental, paid prescription drug claims (if available) for the selected time frame. Data can be used to review high-cost claims by patient contributing to plan expense including the paid diagnosis and type of service driving costs.

Report Parameters/ Customization (available options)

- Benefit Type
- Date Range
- Filters
- Thresholds
- Display Options
- Schedule

Display Options

Protected Health Information:

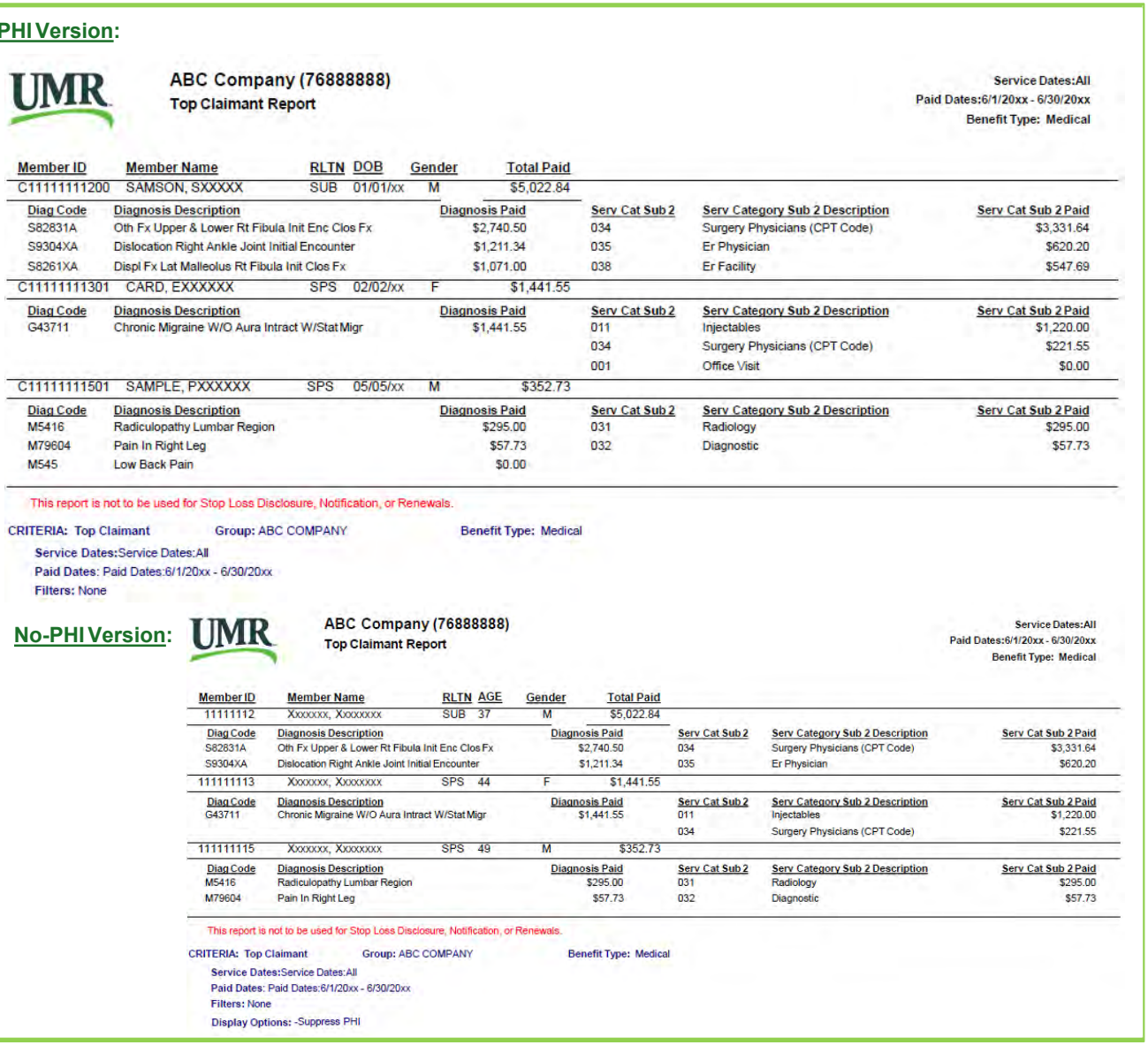
- Suppress PHI (Individual Identifiers)
- Number of claim records to display per patient (between 1 and 10)

Report Content (PHI version)

- Member ID
- Member Name
- Relationship
- DOB (Member Date of Birth)
- Gender (Member)
- Total Paid
- Medical Paid
- RX Paid (if available)
- Dental Paid (if available)
- Diagnosis Code
- Diagnosis Description
- Diagnosis Paid
- Serv Cat Sub 2 (internal service type code)
- Serv Category Sub 2 Description (type of service description)
- Serv Cat Sub 2 Paid (amount paid under the type of service)

Report

PHI Version:



ABC Company (76888888)
Top Claimant Report

Service Dates:All
Paid Dates:6/1/20xx - 6/30/20xx
Benefit Type: Medical

Member ID	Member Name	RLTN	DOB	Gender	Total Paid
C11111111200	SAMSON, SXXXXX	SUB	01/01/xx	M	$5,022.84

Diag Code	Diagnosis Description	Diagnosis Paid	Serv Cat Sub 2	Serv Category Sub 2 Description	Serv Cat Sub 2 Paid
S82831A	Oth Fx Upper & Lower Rt Fibula Init Enc Clos Fx	$2,740.50	034	Surgery Physicians (CPT Code)	$3,331.64
S9304XA	Dislocation Right Ankle Joint Initial Encounter	$1,211.34	035	Er Physician	$620.20
S8261XA	Displ Fx Lat Malleolus Rt Fibula Init Clos Fx	$1,071.00	038	Er Facility	$547.69

Member ID	Member Name	RLTN	DOB	Gender	Total Paid
C11111111301	CARD, EXXXXXX	SPS	02/02/xx	F	$1,441.55

Diag Code	Diagnosis Description	Diagnosis Paid	Serv Cat Sub 2	Serv Category Sub 2 Description	Serv Cat Sub 2 Paid
G43711	Chronic Migraine W/O Aura Intract W/Stat Migr	$1,441.55	011	Injectables	$1,220.00
			034	Surgery Physicians (CPT Code)	$221.55
			001	Office Visit	$0.00

Member ID	Member Name	RLTN	DOB	Gender	Total Paid
C11111111501	SAMPLE, PXXXXXX	SPS	05/05/xx	M	$352.73

Diag Code	Diagnosis Description	Diagnosis Paid	Serv Cat Sub 2	Serv Category Sub 2 Description	Serv Cat Sub 2 Paid
M5416	Radiculopathy Lumbar Region	$295.00	031	Radiology	$295.00
M79604	Pain In Right Leg	$57.73	032	Diagnostic	$57.73
M545	Low Back Pain	$0.00			

This report is not to be used for Stop Loss Disclosure, Notification, or Renewals.

CRITERIA: Top Claimant Group: ABC COMPANY Benefit Type: Medical
Service Dates:Service Dates:All
Paid Dates: Paid Dates:6/1/20xx - 6/30/20xx
Filters: None

No-PHI Version:

ABC Company (76888888)
Top Claimant Report

Service Dates:All
Paid Dates:6/1/20xx - 6/30/20xx
Benefit Type: Medical

Member ID	Member Name	RLTN	AGE	Gender	Total Paid
11111112	Xxxxxxx, Xxxxxxxx	SUB	37	M	$5,022.84

Diag Code	Diagnosis Description	Diagnosis Paid	Serv Cat Sub 2	Serv Category Sub 2 Description	Serv Cat Sub 2 Paid
S82831A	Oth Fx Upper & Lower Rt Fibula Init Enc Clos Fx	$2,740.50	034	Surgery Physicians (CPT Code)	$3,331.64
S9304XA	Dislocation Right Ankle Joint Initial Encounter	$1,211.34	035	Er Physician	$620.20

Member ID	Member Name	RLTN	AGE	Gender	Total Paid
111111113	Xxxxxxx, Xxxxxxxx	SPS	44	F	$1,441.55

Diag Code	Diagnosis Description	Diagnosis Paid	Serv Cat Sub 2	Serv Category Sub 2 Description	Serv Cat Sub 2 Paid
G43711	Chronic Migraine W/O Aura Intract W/Stat Migr	$1,441.55	011	Injectables	$1,220.00
			034	Surgery Physicians (CPT Code)	$221.55

Member ID	Member Name	RLTN	AGE	Gender	Total Paid
111111115	Xxxxxxx, Xxxxxxxx	SPS	49	M	$352.73

Diag Code	Diagnosis Description	Diagnosis Paid	Serv Cat Sub 2	Serv Category Sub 2 Description	Serv Cat Sub 2 Paid
M5416	Radiculopathy Lumbar Region	$295.00	031	Radiology	$295.00
M79604	Pain In Right Leg	$57.73	032	Diagnostic	$57.73

This report is not to be used for Stop Loss Disclosure, Notification, or Renewals.

CRITERIA: Top Claimant Group: ABC COMPANY Benefit Type: Medical
Service Dates:Service Dates:All
Paid Dates: Paid Dates:6/1/20xx - 6/30/20xx
Filters: None
Display Options: -Suppress PHI

Return to Report Content

State of Nebraska Department of Corrections—UMR RFP—Deviations Log (Terms and Conditions)

II. Terms and Conditions

Section	Term/Provision as Written	Requested Revision	Explanation
II (A)	**GENERAL** The contract resulting from this Solicitation shall incorporate the following documents: a. Solicitation, including any attachments and addenda; b. Questions and Answers; c. Bidder's properly submitted solicitation response, including any terms and conditions or agreements submitted by the bidder; d. Addendum to Contract Award (if applicable); and e. Amendments to the Contract (if applicable) These documents constitute the entirety of the contract. Unless otherwise specifically stated in a future contract amendment, in case of any conflict between the incorporated documents, the documents shall govern in the following order of preference with number one (1) receiving preference over all other documents and with each lower numbered document having preference over any higher numbered document: 1) Amendment to the executed Contract with the most recent dated amendment having the highest priority, 2) Executed Contract and any attached Addenda 3) Addendums to the solicitation and any Questions and Answers, 4) the original solicitation document and any Addenda or attachments, and 5) the Vendor's submitted solicitation response, including any terms and conditions or agreements that are accepted by the State.	**GENERAL** The contract resulting from this Solicitation shall incorporate the following documents: a. State Terms and Conditions~~Solicitation, including any attachments and addenda~~; b. Administrative Services Agreement Exhibit/Attachment~~Questions and Answers~~; ~~c. Bidder's properly submitted solicitation response, including any terms and conditions or agreements submitted by the bidder;~~ ~~d. Addendum to Contract Award (if applicable); and~~ ~~e.~~c. Amendments to the Contract (if applicable) These documents constitute the entirety of the contract. ~~Unless otherwise specifically stated in a future contract amendment, in case of any conflict between the incorporated documents, the documents shall govern in the following order of preference with number one (1) receiving preference over all other documents and with each lower numbered document having preference over any higher numbered document: 1) Amendment to the executed Contract with the most recent dated amendment having the highest priority, 2) Executed Contract and any attached Addenda 3) Addendums to the solicitation and any Questions and Answers, 4) the original solicitation document and any Addenda or attachments, and 5) the Vendor's submitted solicitation response, including any terms and conditions or agreements that are accepted by the State.~~	See the last line of this log for a description of the UMR exhibit/attachment that will contain necessary terms and provisions from our Administrative Services Agreement that are not addressed by the State's T&C, as well as fees and PGs. We are happy to discuss format and the order of precedence between the T&C and the ASA exhibit/attachment, but anticipate that the contract to be entered into between the parties shall reflect the material terms of the proposal and the final understanding and agreement between the parties. Negotiation of the final contract always aims to align the terms and conditions of the parties, to remove redundancies and conflicts.
II (E)	**BEGINNING OF WORK & SUSPENSION OF SERVICES** The bidder shall not commence any billable work until a valid contract has been fully executed by the State and the successful Vendor. The Vendor will be notified in writing when work may begin. The State may, at any time and without advance notice, require the Vendor to suspend any or all performance or deliverables provided under this Contract. In the event of such suspension, the Contract Manager or POC, or their designee, will issue a	**BEGINNING OF WORK & SUSPENSION OF SERVICES** ~~The bidder shall not commence any billable work until a valid contract has been fully executed by the State and the successful Vendor. The Vendor will be notified in writing when work may begin.~~ ~~The State may, at any time and without advance notice, require the Vendor to suspend any or all performance or deliverables provided under this Contract. In the event of such suspension, the Contract Manager or POC, or their designee, will issue a~~	We request to strike this if the contract is not signed by 10.1.2025, the current anticipated Effective Date. It is common, if not the norm, in our industry for services to begin prior to contract signature. We have quite a bit of time before 10.1.2025, so this may not be an issue. If the contract is signed on or before the intended commencement of services, we can leave this provision in the final contract if the State requires. We request to remove as this is applicable more to a goods contract, and does not align with our services, which are

	written order to stop work. The written order will specify which activities are to be immediately suspended and the reason(s) for the suspension. Upon receipt of such order, the Vendor shall immediately comply with its terms and take all necessary steps to mitigate and eliminate the incurrence of costs allocable to the work affected by the order during the period of suspension. The suspended performance or deliverables may only resume when the State provides the Vendor with written notice that such performance or deliverables may resume, in whole or in part.	~~written order to stop work. The written order will specify which activities are to be immediately suspended and the reason(s) for the suspension. Upon receipt of such order, the Vendor shall immediately comply with its terms and take all necessary steps to mitigate and eliminate the incurrence of costs allocable to the work affected by the order during the period of suspension. The suspended performance or deliverables may only resume when the State provides the Vendor with written notice that such performance or deliverables may resume, in whole or in part.~~	ongoing, or with regulatory requirements for processing claims.
II (G)	**CHANGE ORDERS OR SUBSTITUTIONS** The State and the Vendor, upon the written agreement, may make changes to the contract within the general scope of the solicitation. Changes may involve specifications, the quantity of work, or such other items as the State may find necessary or desirable. Corrections of any deliverable, service, or work required pursuant to the contract shall not be deemed a change. The Vendor may not claim forfeiture of the contract by reasons of such changes. The Vendor shall prepare a written description of the work required due to the change and an itemized cost sheet for the change. Changes in work and the amount of compensation to be paid to the Vendor shall be determined in accordance with applicable unit prices if any, a pro-rated value, or through negotiations. The State shall not incur a price increase for changes that should have been included in the Vendor's solicitation response, were foreseeable, or result from difficulties with or failure of the Vendor's solicitation response or performance. No change shall be implemented by the Vendor until approved by the State, and the Contract is amended to reflect the change and associated costs, if any. If there is a dispute regarding the cost, but both parties agree that immediate implementation is necessary, the change may be implemented, and cost negotiations may continue with both Parties retaining all remedies under the contract and law. In the event any good or service is discontinued or replaced upon mutual consent during the contract period or prior to delivery, the State reserves the right to amend the contract to include the alternate product at the same price. *****Vendor will not substitute any item that has been awarded without prior written approval of NDCS*****	**CHANGE ORDERS OR SUBSTITUTIONS** The State and the Vendor, upon ~~the~~ written agreement of the Parties, may amend~~make changes to~~ the contract within the general scope of the solicitation. Changes may involve specifications, the quantity of work, or such other items as the State may find necessary or desirable. Corrections of any deliverable, service, or work required pursuant to the contract shall not be deemed a change. The Vendor may not claim forfeiture of the contract by reasons of such changes. ~~The Vendor shall prepare a written description of the work required due to the change and an itemized cost sheet for the change. Changes in work and the amount of compensation to be paid to the Vendor shall be determined in accordance with applicable unit prices if any, a pro-rated value, or through negotiations. The State shall not incur a price increase for changes that should have been included in the Vendor's solicitation response, were foreseeable, or result from difficulties with or failure of the Vendor's solicitation response or performance.~~ ~~No change shall be implemented by the Vendor until approved by the State, and the Contract is amended to reflect the change and associated costs, if any. If there is a dispute regarding the cost, but both parties agree that immediate implementation is necessary, the change may be implemented, and cost negotiations may continue with both Parties retaining all remedies under the contract and law.~~ ~~In the event any good or service is discontinued or replaced upon mutual consent during the contract period or prior to delivery, the State reserves the right to amend the contract to include the alternate product at the same price.~~ ~~*****Vendor will not substitute any item that has been awarded without prior written approval of NDCS*****~~	We agree to work with the State to effect agreed changes to services, fees, etc. but request to strike parts of this section as it is more applicable to general goods/services contracts. Please see our comments under III (F)—Prices, where we have added provisions specific to our services around fee/service changes.
II (H)	**RECORD OF VENDOR PERFORMANCE** . . . . In addition to other remedies and options available to the State, the State may issue one or more notices to the vendor outlining any issues the State has regarding the vendor's performance for	**RECORD OF VENDOR PERFORMANCE** . . . . In addition to other remedies and options available to the State, the State may issue one or more notices to the vendor outlining any issues the State has regarding the vendor's performance for	We would require an opportunity to cure any alleged breach of the Agreement. We have added general language to this effect but can discuss with the State to arrive at final language.

	a specific contract ("Contract Compliance Request"). The State may also document the Vendor's performance in a report, which may or may not be provided to the vendor ("Contract Non-Compliance Notice"). The Vendor shall respond to any Contract Compliance Request or Contract Non-Compliance Notice in accordance with such notice or request.	a specific contract ("Contract Compliance Request"), and Vendor shall be provided an opportunity to respond and to cure the alleged non-compliance or breach within a reasonable agreed period of time. The State may also document the Vendor's performance in a report, which may or may not be provided to the vendor ("Contract Non-Compliance Notice"). The Vendor shall respond to any Contract Compliance Request or Contract Non-Compliance Notice in accordance with such notice or request.	
II (I)	**NOTICE OF POTENTIAL VENDOR BREACH** If Vendor breaches the contract or anticipates breaching the contract, the Vendor shall immediately give written notice to the State.	**NOTICE OF POTENTIAL VENDOR BREACH** If Vendor becomes aware that it has breached the contract or anticipates breaching the contract, the Vendor shall immediately give written notice to the State.	Revised to reflect that UMR would need to be aware of the breach.
II (J)	**BREACH** Either Party may terminate the contract, in whole or in part, if the other Party breaches its duty to perform its obligations under the contract in a timely and proper manner. Termination requires written notice of default and a thirty (30) calendar day (or longer at the non-breaching Party's discretion considering the gravity and nature of the default) cure period. Said notice shall be delivered by email, delivery receipt requested; certified mail, return receipt requested; or in person with proof of delivery. Allowing time to cure a failure or breach of contract does not waive the right to immediately terminate the contract for the same or different contract breach which may occur at a different time. The State's failure to make payment shall not be a breach, and the Vendor shall retain all available statutory remedies. (See Indemnity - Self-Insurance and Payment).	**BREACH** Either Party may terminate the contract, in whole or in part, if the other Party materially breaches its duty to perform its obligations under the contract in a timely and proper manner. Other than breach for non-payment of fees owed by the State or the funding of Plan benefits, tTermination for breach requires written notice of default and a thirty (30) calendar day (or longer at the non-breaching Party's discretion considering the gravity and nature of the default) cure period. Said notice shall be delivered by email, delivery receipt requested; certified mail, return receipt requested; or in person with proof of delivery. Allowing time to cure a failure or breach of contract does not waive the right to immediately terminate the contract for the same or different contract breach which may occur at a different time. The State's failure to make payment shall not be a breach, and the Vendor shall retain all available statutory remedies. (See Indemnity - Self-Insurance and Payment).	We request a consistent 30-day cure period for breach termination by either Party, and request that termination provisions be placed in the same section of the Contract (see comment under II(S)—Early Termination). We cannot agree that non-payment of required Fees or failure to fund the claims Bank Account would not be a breach, as this is the State's primary obligation to UMR under the Contract.
II (M)(1)	**INDEMNIFICATION—GENERAL** The Vendor agrees to defend, indemnify, and hold harmless the State and its employees, volunteers, agents, and its elected and appointed officials ("the indemnified parties") from and against any and all third party claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses of every nature, including investigation costs and expenses, settlement costs and attorney fees and expenses ("the claims"), sustained or asserted against the State for personal injury, death, or property loss or damage, arising out of, resulting from, or attributable to the willful misconduct, negligence, error, or omission of the Vendor, its employees, Subcontractors, consultants, representatives, and agents, resulting from this contract, except to the extent such Vendor liability is attenuated by any action of the State which directly and proximately contributed to the claims.	**INDEMNIFICATION—GENERAL** The Vendor agrees to defend, indemnify, and hold harmless the State and its employees, volunteers, agents, and its elected and appointed officials ("the indemnified parties") from and against any and all third party claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses of every nature, including investigation costs and expenses, reasonable settlement costs and attorney fees and expenses ("the claims"), sustained or asserted against the State for (1) personal injury, death, or property loss or damage unrelated to the provision of health care, arising out of, resulting from, or attributable to the willful misconduct, negligence, error, or omission of the Vendor, its employees, Subcontractors, consultants, representatives, and agents, resulting from this contract, except to the extent such Vendor liability is attenuated by any action of the State which directly and proximately contributed to the claims; and (2) Vendor's material breach of this Contract or that of its subcontractors.	We do not indemnify for demands or merely asserted claims; rather, for breach of the Agreement. We request mutual indemnification to the extent allowed under NE law. We are agreeable to this provided we carve out health care, as UMR is not a provider.

		To the extent allowed by Nebraska law, the State shall defend, indemnify, and hold harmless Vendor for any and all third party claims, liens, losses, liabilities, penalties, fines, costs, damages, judgments, and expenses Vendor incurs, including reasonable attorneys' fees and costs, to the extent arising out of one or more of the following: (i) the State's material breach of this Contract; (ii) the State's design and governance of the Plan; and (iii) a breach by a third party of any agreements Vendor enters into with third parties on the State's request. The provisions of this paragraph do not constitute a waiver of any applicable local, State and federal rules and laws, including Sovereign Immunity, Chapter *(Citation Placeholder).* The State remains responsible for payment of all Plan benefits and other Plan expenses and fees.	We request indemnification for the State's design and governance of the Plan to the extent allowed under NE law, as these are always the Plan's responsibility.
II (M)(2)	**INDEMNIFICATION—INTELLECTUAL PROPERTY** The Vendor agrees it will, at its sole cost and expense, defend, indemnify, and hold harmless the indemnified parties from and against any and all claims, to the extent such claims arise out of, result from, or are attributable to, the actual or alleged infringement or misappropriation of any patent, copyright, trade secret, trademark, or confidential information of any third party by the Vendor or its employees, Subcontractors, consultants, representatives, and agents; provided, however, the State gives the Vendor prompt notice in writing of the claim. The Vendor may not settle any infringement claim that will affect the State's use of the Licensed Software without the State's prior written consent, which consent may be withheld for any reason.	**INDEMNIFICATION—INTELLECTUAL PROPERTY** The Vendor agrees it will, at its sole cost and expense, defend, indemnify, and hold harmless the indemnified parties from and against any and all claims, to the extent such claims arise out of, result from, or are attributable to, the actual or alleged infringement or misappropriation of any patent, copyright, trade secret, trademark, or confidential information of any third party by the Vendor or its employees, Subcontractors, consultants, representatives, and agents; provided, however, the State gives the Vendor prompt notice in writing of the claim. ~~The Vendor may not settle any infringement claim that will affect the State's use of the Licensed Software without the State's prior written consent, which consent may be withheld for any reason.~~	Request to strike—in this situation we could not feasibly seek individual customers' consent.
II (O)	**ASSIGNMENT, SALE, OR MERGER** The Vendor retains the right to enter into a sale, merger, acquisition, internal reorganization, or similar transaction involving Vendor's business. Vendor agrees to cooperate with the State in executing amendments to the contract to allow for the transaction. If a third party or entity is involved in the transaction, the Vendor will remain responsible for performance of the contract until such time as the person or entity involved in the transaction agrees in writing to be contractually bound by this contract and perform all obligations of the contract.	**ASSIGNMENT, SALE, OR MERGER** Notwithstanding the foregoing, t~~T~~he Vendor retains the right to enter into a sale, merger, acquisition, internal reorganization, or similar transaction involving Vendor's business, and to assign this Contract to Vendor's affiliates or a purchaser of all or substantially all of Vendor's assets, and Vendor will provide notice to the State of the assignment. Vendor agrees to cooperate with the State in executing amendments to the contract to allow for the transaction. If a third party or entity is involved in the transaction, the Vendor will remain responsible for performance of the contract for the State until such time as the third party~~person~~ or entity involved in the transaction agrees in writing to be contractually bound by this contract and perform all obligations of the contract.	We require the ability to assign with notice as an assignment would occur across our book of business and we would not be able to seek individual customers' consent. We can agree to provide Services to the State until such time the third party/entity has agreed in writing to be bound by the Contract.
II (Q)	**FORCE MAJEURE** Neither Party shall be liable for any costs or damages, or for default resulting from its inability to perform any of its obligations under the contract due to a natural or manmade event outside the control and not the fault of the affected Party ("Force Majeure Event") that was not foreseeable at the time the Contract was executed.	**FORCE MAJEURE** Except for a failure to meet funding requirements under the Contract, n~~N~~either Party shall be liable for any costs or damages, or for default resulting from its inability to perform any of its obligations under the contract due to a natural or manmade event outside the control and not the fault of the	Funding requirements for the bank account established for funding claims would have to be met in order to have continuity of service, as UMR is not legally permitted to underwrite benefit payments for a self-insured plan.

		affected Party ("Force Majeure Event") that was not foreseeable at the time the Contract was executed.	
II (R)	**CONFIDENTIALITY** All materials and information provided by the Parties or acquired by a Party on behalf of the other Party shall be regarded as confidential information. All materials and information provided or acquired shall be handled in accordance with federal and state law, and ethical standards. Should said confidentiality be breached by a Party, the Party shall notify the other Party immediately of said breach and take immediate corrective action.	**CONFIDENTIALITY** All materials and information provided by the Parties or acquired by a Party on behalf of the other Party shall be regarded as C~~c~~onfidential I~~i~~nformation. Confidential Information shall include information disclosed or made available by a Party in connection with this Contract, including without limitation the following, regardless of form or the manner in which it is furnished: (a) pricing, discounts, reimbursement terms, payment methodologies and payment processes, compensation arrangements, and any similar commercial information, and (b) data, information, statistics, trade secrets, and any information about business, costs, operations, techniques, know-how, or intellectual property. Any material that is derived from or developed from Confidential Information will be deemed Confidential Information for purposes of this Contract, regardless of the person creating, disclosing, or making available such material. Any Confidential Information included in preparations, proposals, scope documents, discussions, findings, summaries, reports, and conclusions remain Confidential Information. Confidential Information does not include: (a) information that is or becomes generally available to the public other than as a result of a disclosure by a receiving Party in violation of this Contract or other agreement between the Parties, (b) information either obtained from a third party or already in a receiving Party's possession before receipt from the other Party, if the receiving Party can demonstrate such information was lawfully obtained and not subject to another obligation of confidentiality, and (c) information independently developed without reference to Confidential Information, if the receiving Party can demonstrate such independence through contemporaneous written records. All materials and information provided or acquired shall be handled in accordance with federal and state law, and ethical standards. Should said confidentiality be breached by a Party, the Party shall notify the other Party immediately of said breach and take immediate corrective action. Neither Party will disclose the other's Confidential Information to any person or entity other than to the receiving Party's employees and Business Associates needing access to such information to administer the Plan, to perform under this Contract, or as otherwise permitted under this Agreement. Notwithstanding the foregoing, (i) Vendor may disclose Customer Confidential Information to its affiliates and subcontractors as needed for those entities to provide Services under this Contract, (ii) Customer will not be prohibited from	We can discuss as needed but request to add these provisions, which are standardly included in our contracts. These provisions reflect our particular services and the types of confidential information, and the uses thereof, that are typically encountered in our customer relationships. We can discuss and negotiate these provisions and agree that no Contract provisions will prevent the State from meeting public records requirements.

		providing provider-specific cost or quality of care information or data, through a consumer engagement tool or any other means, to referring providers, the Plan Sponsor, Participants, or individuals eligible to become Participants of the Plan, to the extent required by Law, (iii) the State may only use Vendor's Confidential Information for Plan administration purposes, and (iv) before Vendor's Confidential Information can be disclosed, Vendor may require a mutually agreed upon confidentiality agreement consistent with Law. Neither party may a) sell, license, or grant any other rights to the other Party's Confidential Information, (b) use the other Party's Confidential Information for the creation, operation or improvement of any product, service or database for external or commercial use, or c) use the other Party's Confidential Information to contract with or manage healthcare or pharmacy providers, coalitions or networks. If a Party is requested or required to disclose Confidential Information by subpoena, legal process, or Law, including public records acts, such Party shall (to the extent permitted by Law) provide the other Party with immediate written notice of that request or requirement. Such Party shall reasonably cooperate in any efforts by the other Party to seek an appropriate protective order or other remedy or otherwise challenge or narrow the scope of that disclosure request or requirement. If a protective order or other remedy is not obtained, such Party shall furnish only that portion of the Confidential Information that is legally required. If the State requests that Vendor provide information about the Plan that is in Vendor's possession after the Contract terminates and any applicable runout period has expired, then Vendor may, in its discretion, provide such information subject to a Fee.	

II (S)	**EARLY TERMINATION** The contract may be terminated as follows: 1. The State and the Vendor, by mutual written agreement, may terminate the contract, in whole or in part, at any time. 2. The State, in its sole discretion, may terminate the contract, in whole or in part, for any reason upon thirty (30) calendar day's written notice to the Vendor. Such termination shall not relieve the Vendor of warranty or other service obligations incurred under the terms of the contract. In the event of termination, the Vendor shall be entitled to payment, determined on a pro rata basis, for products or services satisfactorily performed or provided. 3. The State may terminate the contract, in whole or in part, immediately for the following reasons: a. If directed to by statute, b. Vendor has made an assignment for the benefit of creditors, has admitted in writing its inability to pay debts as they mature, or has ceased operating in the normal course of business, c. A trustee or receiver of the Vendor or of any substantial part of the Vendor's assets has been appointed by a court, d. Fraud, misappropriation, embezzlement, malfeasance, misfeasance, or illegal conduct pertaining to performance under the contract by its Vendor, its employees, officers, directors, or shareholders, e. An involuntary proceeding has been commenced by any Party against the Vendor under any of the chapters of Title 11 of the United States Code and (i) the proceeding has been pending for at least sixty (60) calendar days; or (ii) the Vendor has consented, either expressly or by operation of law, to the entry of an order for relief; or (iii) the Vendor has been decreed or adjudged a debtor,	**EARLY TERMINATION** The contract may be terminated as follows: 1. The State and the Vendor, by mutual written agreement, may terminate the contract, in whole or in part, at any time. 2. Either Party~~The State, in its sole discretion,~~ may terminate the contract, in whole or in part, for any reason upon ninety (90)~~thirty (30)~~ calendar day's written notice to the other Party~~Vendor~~. Such termination shall not relieve the Vendor of warranty or other service obligations incurred under the terms of the contract. ~~In the event of termination, the Vendor shall be entitled to payment, determined on a pro rata basis, for products or services satisfactorily performed or provided~~. 3. The State may terminate the contract, in whole or in part, immediately for the following reasons: a. If directed to by statute, b. A Party~~Vendor~~ has made an assignment for the benefit of creditors, has admitted in writing its inability to pay debts as they mature, or has ceased operating in the normal course of business, c. A trustee or receiver of a~~the~~ Party~~Vendor~~ or of any substantial part of the Party's~~Vendor's~~ assets has been appointed by a court, d. Fraud, misappropriation, embezzlement, malfeasance, misfeasance, or illegal conduct pertaining to performance under the contract by a Party's~~its Vendor~~subcontractor~~, its employees, officers, directors, or shareholders~~, e. An involuntary proceeding has been commenced ~~by any Party~~ against a Party~~the Vendor~~ under any of the chapters of Title 11 of the United States Code and (i) the proceeding has been pending for at least sixty (60) calendar days; or (ii) the Party~~Vendor~~ has consented, either expressly or by operation of law, to the entry of an order	We require mutual termination rights and ninety-day notice for either Party for no-cause termination. Payment would be required for services performed throughout any agreed runout period. These services would be invoiced per the terms of the Agreement. By operation of law, this would include subcontractor employees, officers, and directors. We feel shareholders is too attenuated but can discuss if you have concerns.

	f. A voluntary petition has been filed by the Vendor under any of the chapters of Title 11 of the United States Code, g. Vendor intentionally discloses confidential information, h. Vendor has or announces it will discontinue support of the deliverable; and i. In the event funding is no longer available.	for relief; or (iii) the Party~~Vendor~~ has been decreed or adjudged a debtor, f. A voluntary petition has been filed by a Party~~the Vendor~~ under any of the chapters of Title 11 of the United States Code, g. A Party~~Vendor~~ intentionally discloses confidential information in violation of applicable Law or the Contract, or ~~h. Vendor has or announces it will discontinue support of the deliverable; and~~ ~~i.~~h. In the event funding is no longer available. 4. The Contract will terminate when Vendor gives the State notice of termination because the State did not pay the undisputed Fees or other amounts the State owed Vendor when due under the terms of the Contract; or when Vendor gives the State notice of termination because the State failed to provide the required funds for payment of benefits under the terms of the Contract.	We ask to strike this as too vague. Is this meant to cover a situation where United discontinues Services (we would agree to that)? We can discuss if needed. These deadlines are addressed in Exh A, Sections 3 and 4 of the ASA (see our sample ASA provided with our responses). We require addition of these terms as UMR is not permitted by law to insure benefit payments; we require funding of the claims account and payment of fees for services performed.
II (T)	**CONTRACT CLOSEOUT** Upon termination of the contract for any reason the Vendor shall within thirty (30) days, unless stated otherwise herein: 1. Transfer all completed or partially completed deliverables to the State, 2. Transfer ownership and title to all completed or partially completed deliverables to the State	**CONFIDENTIALITY** Upon termination of the contract for any reason the Vendor shall within thirty (30) days, unless stated otherwise herein: ~~1. Transfer all completed or partially completed deliverables to the State,~~ ~~2.~~1. ~~Transfer ownership and title to all completed or partially completed deliverables to the State~~	We request to strike as this aligns with goods, not our services. Post-termination, UMR will continue to perform all contractual duties applying to the agreed runout period. We retain records as required by law but maintain all legal and contractual protections and restrictions on that information as long as it is retained.
III (A)	**INDEPENDENT VENDOR/OBLIGATIONS** . . . . The Vendor shall secure, at its own expense, all personnel required to perform the services under the contract. The personnel the Vendor uses to fulfill the contract shall have no contractual or other legal relationship with the State; they shall not be considered employees of the State and shall not be entitled to any compensation, rights or benefits from the State, including but not limited to, tenure rights, medical and hospital care, sick and vacation leave, severance pay, or retirement benefits. . . . . If the Vendor intends to utilize any subcontractor, the subcontractor's level of effort, tasks, and time allocation should	**INDEPENDENT VENDOR/OBLIGATIONS** . . . . The Vendor shall secure, at its own expense, all personnel required to perform the services under the contract. The UMR personnel the Vendor ~~uses to fulfill the contract~~ assigns to the State's account to perform Services under the Contract shall have no contractual or other legal relationship with the State; they shall not be considered employees of the State and shall not be entitled to any compensation, rights or benefits from the State, including but not limited to, tenure rights, medical and hospital care, sick and vacation leave, severance pay, or retirement benefits. . . . . ~~If the Vendor intends to utilize any subcontractor, the subcontractor's level of effort, tasks, and time allocation should~~	With regard to a conflict of interest, we would agree to this as it relates to the UMR employees assigned to the account, but are not able to make such a warranty for each and every person, or subcontractor employees, that could possibly touch the account at some point. We can discuss if this is a concern.

	be clearly defined in the solicitation response. The Vendor shall agree that it will not utilize any subcontractors not specifically included in its solicitation response in the performance of the contract without the prior written authorization of the State. If the Vendor subcontracts any of the work, the Vendor agrees to pay any and all subcontractors in accordance with the respective subcontractor(s). The State reserves the right to require the Vendor to reassign or remove from the project any Vendor or subcontractor employee. . . . . The Vendor shall include a similar provision, for the protection of the State, in the contract with any Subcontractor engaged to perform work on this contract.	~~be clearly defined in the solicitation response.~~ Vendor may use its affiliates or subcontractors to perform Vendor's Services under this Contract. Vendor will be responsible for those Services to the same extent that United would have been had it performed those Services without the use of an affiliate or subcontractor. ~~The Vendor shall agree that it will not utilize any subcontractors not specifically included in its solicitation response in the performance of the contract without the prior written authorization of the State~~. If the Vendor subcontracts any of the work, the Vendor agrees to pay any and all subcontractors in accordance with the respective subcontractor(s). The State reserves the right to request~~require~~ the Vendor to reassign or remove from the project any Vendor or subcontractor employee. . . . . ~~The Vendor shall include a similar provision, for the protection of the State, in the contract with any Subcontractor engaged to perform work on this contract.~~	Our delegation to a subcontractor is made on behalf of our entire book of business. We therefore cannot allow one customer consent rights. Regardless of who performs the services (UHC or a subcontractor) we are responsible for the performance of those services under the agreement. This would be something we would want to discuss with you, as it could affect services (e.g., if we are not engaged with another subcontractor that could step in). Our subcontractors are used across our book of business so we would not be able to customize those contracts for individual customers. However, we take responsibility/liability for our subcontractors and their contracts are consistent with the requirements of our customer agreements.
III (D)	**COOPERATION WITH OTHER VENDORS** Vendor may be required to work with or in close proximity to other Vendors or individuals that may be working on same or different projects. The Vendor shall agree to cooperate with such other Vendors or individuals and shall not commit or permit any act which may interfere with the performance of work by any other Vendor or individual. Vendor is not required to compromise Vendor's intellectual property or proprietary information unless expressly required to do so by this contract.	**COOPERATION WITH OTHER VENDORS** Vendor may be requested~~required~~ to work with or in close proximity to other Vendors or individuals that may be working on same or different projects. Upon mutual agreement of the Parties, ~~The~~ Vendor shall ~~agree to~~ cooperate with such other Vendors or individuals and shall not commit or permit any act which may interfere with the performance of work by any other Vendor or individual. Vendor is not required to compromise Vendor's intellectual property or proprietary information unless expressly required to do so by this contract.	This would be handled case by case—we would want to discuss and agree based on what is being requested and what we are able to do. However, we would reasonably work with the State to meet its needs.
III (E)	**DISCOUNTS** Prices quoted shall be inclusive of ALL trade discounts. Cash discount terms of less than thirty (30) days will not be considered as part of the solicitation response. Cash discount periods will be computed from the date of receipt of a properly executed claim voucher or the date of completion of delivery of all items in a satisfactory condition, whichever is later.	**DISCOUNTS** ~~Prices quoted shall be inclusive of ALL trade discounts. Cash discount terms of less than thirty (30) days will not be considered as part of the solicitation response. Cash discount periods will be computed from the date of receipt of a properly executed claim voucher or the date of completion of delivery of all items in a satisfactory condition, whichever is later.~~	We request to strike as inapplicable to our services (it aligns more with general sale of goods).
III (F)	**PRICES** Prices quoted shall be net, including transportation and delivery charges fully prepaid by the bidder, F.O.B. destination named in the Solicitation. No additional charges will be allowed for packing, packages, or partial delivery costs. When an arithmetic error has been made in the extended total, the unit price will govern.	**PRICES** ~~Prices quoted shall be net, including transportation and delivery charges fully prepaid by the bidder, F.O.B. destination named in the Solicitation. No additional charges will be allowed for packing, packages, or partial delivery costs. When an arithmetic error has been made in the extended total, the unit price will govern.~~	We request the addition of our fee change provisions as they are specific to our services and used across our book of business. We are happy to discuss and negotiate these terms, including notice periods.

	Prices submitted on the cost sheet, once accepted by the State, shall remain fixed for the first four (4) years of the contract. Any request for a price increase subsequent to the initial term of the contract shall not exceed five percent (5%) of the price proposed for the period. Increases shall not be cumulative and will only apply to that period of the contract. The request for a price increase must be submitted in writing to the Department of Correctional Services a minimum of 120 days prior to the end of the current contract period. Documentation may be required by the State to support the price increase. **The State reserves the right to deny any requested price increase. No price increases are to be billed to any State Agencies prior to written amendment of the contract by the parties.** **The State will be given full proportionate benefit of any decreases for the term of the contract.**	~~Prices submitted on the cost sheet, once accepted by the State, shall remain fixed for the first four (4) years of the contract. Any request for a price increase subsequent to the initial term of the contract shall not exceed five percent (5%) of the price proposed for the period. Increases shall not be cumulative and will only apply to that period of the contract. The request for a price increase must be submitted in writing to the Department of Correctional Services a minimum of 120 days prior to the end of the current contract period. Documentation may be required by the State to support the price increase.~~ ~~**The State reserves the right to deny any requested price increase. No price increases are to be billed to any State Agencies prior to written amendment of the contract by the parties.**~~ ~~**The State will be given full proportionate benefit of any decreases for the term of the contract.**~~ **Changes in Fees.** Vendor may change the Fees on the latter of the expiration of: (1) a Renewal Term, or (2) any applicable multi-year Fee term as set forth in Exhibit D – Fees to Attachment A. Vendor will provide the State with 30 days prior written notice of the revised Fees for each Renewal Term, and such Fees will be effective the first day of such Renewal Term. Vendor will provide the State with a new fee exhibit that will replace the existing fee exhibit in the Contract. Vendor may also change the Fees: (1) any time there are changes made to this Contract or the Plan which affect the Fees, (2) any time there are changes in Law which affect the Services Vendor is providing, or will be required to provide, under this Contract, (3) if the number of Employees covered by the Plan or any Plan option changes (i) by 15% or more, or (ii) the enrollment band, or (4) if the total number of enrolled Participants divided by the total number of enrolled Employees, ("Average Contract Size"), varies by 15% or more from the assumed average contract size. Any new Fee will be effective as of the date the change is applicable, even if that date is retroactive.	This refers to the Administrative Services Agreement provisions that will be included in the Contract as an Exhibit/Attachment (see last entry in this log, below).

		If the State does not agree to any change in Fees, the State may terminate this Contract after the State receives written notice of the new Fees. The State must still pay any amounts due for the periods during which the Contract is in effect.	
III (H)	**OWNERSHIP OF INFORMATION AND DATA/DELIVERABLES** The State shall have the unlimited right to publish, duplicate, use, and disclose all information and data developed or obtained by the Vendor on behalf of the State pursuant to this contract. The State shall own and hold exclusive title to any deliverable developed as a result of this contract. Vendor shall have no ownership interest or title, and shall not patent, license, or copyright, duplicate, transfer, sell, or exchange, the design, specifications, concept, or deliverable.	**OWNERSHIP OF INFORMATION AND ~~DATA/~~DELIVERABLES** The State shall have the unlimited right to publish, duplicate, use, and disclose deliverables ~~all information and data~~ developed or obtained by the Vendor solely on behalf of the State pursuant to this contract. The State shall own and hold exclusive title to any deliverable developed solely for the State as a result of this contract. Vendor shall have no ownership interest or title, and shall not patent, license, or copyright, duplicate, transfer, sell, or exchange, the design, specifications, concept, or deliverable.	Our contracts and services do not contemplate the creation of IP, but we agree that were any developed specifically for the State in performing under the Contract, the State would own it.
III (I)	**INSURANCE REQUIREMENTS** . . . . If Vendor subcontracts any portion of the Contract the Vendor must, throughout the terms of the contract, either: 1. Provide equivalent insurance for each subcontractor and provide a COI verifying the coverage for the subcontractor, 2. Require each subcontractor to have equivalent insurance and provide written notice to the State that the Vendor has verified that each subcontractor has the required coverage; or 3. Provide the State with copies of each subcontractor's Certificate of Insurance evidencing the required coverage. The Vendor shall not allow any Subcontractor to commence work until the Subcontractor has equivalent insurance. The failure of the State to require a COI, or the failure of the Vendor to provide a COI or require subcontractor insurance shall not limit, relieve, or decrease the liability of the Vendor hereunder. . . . . 1. WORKER'S COMPENSATION INSURANCE …. The COI shall contain the mandatory COI subrogation waiver language found hereafter.	**INSURANCE REQUIREMENTS** **. . . .** ~~If Vendor subcontracts any portion of the Contract the Vendor must, throughout the terms of the contract, either:~~ ~~1. Provide equivalent insurance for each subcontractor and provide a COI verifying the coverage for the subcontractor,~~ ~~2. Require each subcontractor to have equivalent insurance and provide written notice to the State that the Vendor has verified that each subcontractor has the required coverage; or~~ ~~3. Provide the State with copies of each subcontractor's Certificate of Insurance evidencing the required coverage.~~ ~~The Vendor shall not allow any Subcontractor to commence work until the Subcontractor has equivalent insurance. The failure of the State to require a COI, or the failure of the Vendor to provide a COI or require subcontractor insurance shall not limit, relieve, or decrease the liability of the Vendor hereunder.~~ . . . . 1. WORKER'S COMPENSATION INSURANCE ….The COI shall contain the mandatory COI subrogation waiver language found hereafter.	Our contracts provide that we are responsible for our subcontractors' services as if we performed them ourselves, but we do not reach into subcontractors' insurance as these provisions would require. We agree to provide WOS language on the certificate. It will be our standard language.

	2. COMMERCIAL GENERAL LIABILITY INSURANCE AND COMMERCIAL AUTOMOBILE LIABILITY INSURANCE The Vendor shall take out and maintain during the life of this contract such Commercial General Liability Insurance and Commercial Automobile Liability Insurance as shall protect Vendor and any Subcontractor performing work covered by this contract from claims for damages for bodily injury, including death, as well as from claims for property damage, which may arise from operations under this contract, whether such operation be by the Vendor or by any Subcontractor or by anyone directly or indirectly employed by either of them, and the amounts of such insurance shall not be less than limits stated hereinafter. . . . . The Commercial General Liability Insurance shall be written on an occurrence basis, and provide Premises/Operations, Products/Completed Operations, Independent Vendors, Personal Injury, and Contractual Liability coverage. . . . The COI shall contain the mandatory COI liability waiver language found hereinafter. **REQUIRED INSURANCE COVERAGE** Independent Vendors--Included **MANDATORY COI LIABILITY WAIVER LANGUAGE** "Commercial General Liability & Commercial Automobile Liability policies shall name the State of Nebraska as an Additional Insured and the policies shall be primary and any insurance or self-insurance carried by the State shall be considered secondary and non-contributory as additionally insured." **EVIDENCE OF COVERAGE** . . . . Reasonable notice of cancellation of any required insurance policy must be submitted to the contract manager as listed above when issued and a new coverage binder shall be submitted immediately to ensure no break in coverage.	2. COMMERCIAL GENERAL LIABILITY INSURANCE AND COMMERCIAL AUTOMOBILE LIABILITY INSURANCE The Vendor shall take out and maintain during the life of this contract such Commercial General Liability Insurance and Commercial Automobile Liability Insurance as shall protect Vendor ~~and any Subcontractor performing work covered by this contract~~ from claims for damages for bodily injury, including death, as well as from claims for property damage, which may arise from operations under this contract, whether such operation be by the Vendor or by any Subcontractor or by anyone directly or indirectly employed by either of them, and the amounts of such insurance shall not be less than limits stated hereinafter. . . . . The Commercial General Liability Insurance shall be written on an occurrence basis, and provide Premises/Operations, Products/Completed Operations, ~~Independent Vendors,~~ Personal Injury, and Contractual Liability coverage. . . . The COI shall contain the mandatory COI liability waiver language found hereinafter. **REQUIRED INSURANCE COVERAGE** ~~Independent Vendors--Included~~ (no change) **EVIDENCE OF COVERAGE** . . . . Reasonable notice of cancellation of any required insurance policy must be submitted to the contract manager as listed above when issued and a new coverage binder shall be submitted immediately to ensure no break in coverage if Vendor is unable to comply with the requirements herein.	Vicarious liability only—we do not insure subcontractors under our policies. We agree to evidence on the COI. It will be our standard language. We agree to evidence our standard language. We agree to provide notice of cancellation if we are unable to procure replacement coverage.
III (J)	**ANTITRUST** The Vendor hereby assigns to the State any and all claims for overcharges as to goods and/or services provided in connection with this contract resulting from antitrust violations which arise	**ANTITRUST** ~~The Vendor hereby assigns to the State any and all claims for overcharges as to goods and/or services provided in connection with this contract resulting from antitrust violations which arise~~	We can discuss the State's intent or needs with this provision, but as written we could not agree to assign such claims.

	under antitrust laws of the United States and the antitrust laws of the State.	~~under antitrust laws of the United States and the antitrust laws of the State.~~	
III (K)	**CONFLICT OF INTEREST** . . . . Vendor further certifies that vendor will not employ any individual known by vendor to have a conflict of interest nor shall vendor take any action or acquire any interest, either directly or indirectly, which will conflict in any manner or degree with the performance of its contractual obligations hereunder or which creates an actual or appearance of conflict of interest.	**CONFLICT OF INTEREST** . . . . Vendor further certifies that vendor will not employ on the State's account any individual known by vendor to have a conflict of interest nor shall vendor take any action or acquire any interest, either directly or indirectly, which will conflict in any manner or degree with the performance of its contractual obligations hereunder or which creates an actual or appearance of conflict of interest.	We could not conduct this investigation with regard to all of UMR's employees but can agree that anyone with a conflict of interest would not be assigned to manage the State's account.
III (P)	**DISASTER RECOVERY/BACK UP PLAN** The Vendor shall have a disaster recovery and back-up plan, of which a copy should be provided upon request to the State, which includes, but is not limited to equipment, personnel, facilities, and transportation, in order to continue delivery of goods and services as specified under the specifications in the contract in the event of a disaster.	**DISASTER RECOVERY/BACK UP PLAN** (no change)	We can provide a copy once the ASA is signed, however an NDA may also be needed.
III (R)	**WARRANTY** Despite any clause to the contrary, the Vendor represents and warrants that its services hereunder shall be performed by competent personnel and shall be of professional quality consistent with generally accepted industry standards for the performance of such services and shall comply in all respects with the requirements of this Agreement. For any breach of this warranty, the Vendor shall, for a period of ninety (90) days from performance of the service, perform the services again, at no cost to the State, or if Vendor is unable to perform the services as warranted, Vendor shall reimburse the State all fees paid to Vendor for the unsatisfactory services. The rights and remedies of the parties under this warranty are in addition to any other rights and remedies of the parties provided by law or equity, including, without limitation actual damages, and, as applicable and awarded under the law, to a prevailing party, reasonable attorneys' fees and costs.	**WARRANTY** Despite any clause to the contrary, the Vendor represents and warrants that its services hereunder shall be performed by competent personnel and shall be of professional quality consistent with generally accepted industry standards for the performance of such services and shall comply in all respects with the requirements of this Agreement. ~~For any breach of this warranty, the Vendor shall, for a period of ninety (90) days from performance of the service, perform the services again, at no cost to the State, or if Vendor is unable to perform the services as warranted, Vendor shall reimburse the State all fees paid to Vendor for the unsatisfactory services.~~ The rights and remedies of the parties under this warranty are in addition to any other rights and remedies of the parties provided by law or equity, including, without limitation actual damages, and, as applicable and awarded under the law, to a prevailing party, reasonable attorneys' fees and costs.	Our services are not able to be re-performed. We will routinely work with our customers to address any shortcomings in services, or errors, including a fee dispute process. However, we do not offset or waive fees for services performed.

IV(C)	**INVOICES** Invoices for payments must be submitted by the Vendor to the agency requesting the services with sufficient detail to support payment. Invoices shall include detailed itemized billing per patient including ALL diagnosis code(s) and each procedure code(s) (ICD10, CPT, modifiers, units, and NDCS number(s)). The terms and conditions included in the Vendor's invoice shall be deemed to be solely for the convenience of the parties. No terms or conditions of any such invoice shall be binding upon the State, and no action by the State, including without limitation the payment of any such invoice in whole or in part, shall be construed as binding or estopping the State with respect to any such term or condition, unless the invoice term or condition has been previously agreed to by the State as an amendment to the contract. **The State shall have forty-five (45) calendar days to pay after a valid and accurate invoice is received by the State.**	**INVOICES** Invoices for payments must be submitted by the Vendor to the agency requesting the services with sufficient detail to support payment. ~~Invoices shall include detailed itemized billing per patient including ALL diagnosis code(s) and each procedure code(s) (ICD10, CPT, modifiers, units, and NDCS number(s)).~~ Vendor will provide the State with an on-line invoice in advance of the first of each month and the due date for payment is on the first day of such month ("Due Date"). Invoices are generated using monthly enrollment provided by the State. If the State has elected to self-bill, monthly enrollment shall be measured based off the eligibility information of the Employees on the first of the month. The terms and conditions included in the Vendor's invoice shall be deemed to be solely for the convenience of the parties. No terms or conditions of any such invoice shall be binding upon the State, and no action by the State, including without limitation the payment of any such invoice in whole or in part, shall be construed as binding or estopping the State with respect to any such term or condition, unless the invoice term or condition has been previously agreed to by the State as an amendment to the contract. ~~**The State shall have forty-five (45) calendar days to pay after a valid and accurate invoice is received by the State**~~. If undisputed amounts owed are not paid within 30 days after their Due Date, the State will pay Vendor interest on these amounts at the interest rate that Vendor charges to its self-funded customers. The State shall reimburse Vendor for any costs that Vendor incurs to collect these amounts.	We request the addition of our invoicing/payment terms as they are specific to our services and established processes across our book of business. We cannot agree to additional payment time beyond the allowed Due Date.
IV (D)	**INSPECTION AND APPROVAL** Final inspection and approval of all work required under the contract shall be performed by the designated State officials. The State and/or its authorized representatives shall have the right to enter any premises where the Vendor or Subcontractor duties under the contract are being performed, and to inspect, monitor or otherwise evaluate the work being performed. All inspections and evaluations shall be at reasonable times and in a manner that will not unreasonably delay work.	~~**INSPECTION AND APPROVAL**~~ ~~Final inspection and approval of all work required under the contract shall be performed by the designated State officials.~~ ~~The State and/or its authorized representatives shall have the right to enter any premises where the Vendor or Subcontractor duties under the contract are being performed, and to inspect, monitor or otherwise evaluate the work being performed. All inspections and evaluations shall be at reasonable times and in a manner that will not unreasonably delay work.~~	We request to remove as this does not align with our services.
IV(H)	**RIGHT TO AUDIT (First Paragraph is Nonnegotiable)** The State shall have the right to audit the Vendor's performance of this contract upon a thirty (30) days' written notice. Vendor shall utilize generally accepted accounting principles, and shall maintain the accounting records, and other records and	~~**RIGHT TO AUDIT (First Paragraph is Nonnegotiable)**~~ ~~The State shall have the right to audit the Vendor's performance of this contract upon a thirty (30) days' written notice. Vendor shall utilize generally accepted accounting principles, and shall maintain the accounting records, and other records and~~	We request this section to be replaced with our medical claims audit provisions, which reflect the audits we offer to customers and their parameters. We can negotiate this language to an extent but are requesting to start from our provisions as our audit processes are used across our book of business.

	information relevant to the contract (Information) to enable the State to audit the contract. (Neb. Rev. Stat. § 84-304 et seq.) The State may audit, and the Vendor shall maintain, the Information during the term of the contract and for a period of five (5) years after the completion of this contract or until all issues or litigation are resolved, whichever is later. The Vendor shall make the Information available to the State at Vendor's place of business or a location acceptable to both Parties during normal business hours. If this is not practical or the Vendor so elects, the Vendor may provide electronic or paper copies of the Information. The State reserves the right to examine, make copies of, and take notes on any Information relevant to this contract, regardless of the form or the Information, how it is stored, or who possesses the Information. Under no circumstance will the Vendor be required to create or maintain documents not kept in the ordinary course of Vendor's business operations, nor will Vendor be required to disclose any information, including but not limited to product cost data, which is confidential or proprietary to Vendor. The Parties shall pay their own costs of the audit unless the audit finds a previously undisclosed overpayment by the State. If a previously undisclosed overpayment exceeds one half of one percent (0.05%) of the total contract billings, or if fraud, material misrepresentations, or non-performance is discovered on the part of the Vendor, the Vendor shall reimburse the State for the total costs of the audit. Overpayments and audit costs owed to the State shall be paid within ninety (90) days of written notice of the claim. The Vendor agrees to correct any material weaknesses or condition found as a result of the audit.	~~information relevant to the contract (Information) to enable the State to audit the contract. (Neb. Rev. Stat. § 84-304 et seq.) The State may audit, and the Vendor shall maintain, the Information during the term of the contract and for a period of five (5) years after the completion of this contract or until all issues or litigation are resolved, whichever is later. The Vendor shall make the Information available to the State at Vendor's place of business or a location acceptable to both Parties during normal business hours. If this is not practical or the Vendor so elects, the Vendor may provide electronic or paper copies of the Information. The State reserves the right to examine, make copies of, and take notes on any Information relevant to this contract, regardless of the form or the Information, how it is stored, or who possesses the Information. Under no circumstance will the Vendor be required to create or maintain documents not kept in the ordinary course of Vendor's business operations, nor will Vendor be required to disclose any information, including but not limited to product cost data, which is confidential or proprietary to Vendor.~~ ~~The Parties shall pay their own costs of the audit unless the audit finds a previously undisclosed overpayment by the State. If a previously undisclosed overpayment exceeds one half of one percent (0.05%) of the total contract billings, or if fraud, material misrepresentations, or non-performance is discovered on the part of the Vendor, the Vendor shall reimburse the State for the total costs of the audit. Overpayments and audit costs owed to the State shall be paid within ninety (90) days of written notice of the claim. The Vendor agrees to correct any material weaknesses or condition found as a result of the audit.~~ **Medical Audits** Once each calendar year during the term of the Contract or any applicable run-out period, a mutually agreeable entity, on the State's behalf, may conduct a medical claims audit for purposes of determining if Vendor is administering its claims transactional Services in accordance with Plan provisions. Prior to the commencement of this audit, a signed, mutually agreeable confidentiality agreement with Vendor is required. The State must notify Vendor in writing of its intent to audit. The place, time, type, and duration of all audits must be reasonable and agreed to by Vendor. All audits will be limited to information relating to the calendar year in which the audit is conducted, and the immediately preceding calendar year (up to an 18 month look back). The audit scope and methodology for a medical claim audit will be consistent with generally acceptable auditing standards,	

		including a statistically valid random sample (not to exceed 300 transactions, less any transactions for targeted audits) as approved by Vendor ("Scope"). Vendor will not support any audits a) where the audit firm is paid on a contingency basis, or b) that do not use a statistically valid random selection methodology (other than as provided for in this Section); this includes electronic and data mining audits that are used for purposes of recovery discovery. As part of the medical claims audit, Vendor will also support a small, targeted audit of either member appeals, member calls, or clinical transactions (not to exceed 25 transactions). The State will pay any expenses that it incurs in connection with the audit. The State will be charged a reasonable per claim charge and a per day charge for any audit where the claim review portion and remote system access is not completed within 5 business days or for approved sample sizes exceeding the Scope specified above. The State will be charged a reasonable Fee for samples or audit days that exceed the agreed audit parameters. The State will also pay any extraordinary expenses Vendor incurs due to a State request related to the audit, such Fees to be reviewed and approved by the State in advance. The State will provide Vendor with copies of any audit reports within 30 days after the State receives the audit report(s) from the auditor.	

To Be Added to Contract	**Exhibit/Attachment – To Contain Statement of Work** **(Special Provisions Regarding Plan-Related Services)** The State's standard terms and conditions forms a good basis for establishing numerous legal terms, but since it is a general consulting/services-based contract for the State, it does not address a number of critical elements regarding plan and claim administration and who is responsible for that administration, nor does it provide the clear delegations necessary to perform certain services on behalf of the Plan. UMR's Sample Contract, which contains such terms, has been submitted with our bid response for reference. A State-specific Schedule of Services will be created based on the unique set of services elected by the State. For example, the terms and conditions do not describe how to establish and fund a bank account for the payment of plan benefits; do not set forth how claims will be processed and appeals handled; do not address additional product and service offerings such as transplant management, care management, network management; and do not describe who will create SPDs, etc. UMR proposes to add terms unique to claims administration, such as: • UMR's network access, management and administration • claim and appeal procedures • The State's responsibilities regarding the plan, • UMR's claim recovery, subrogation, and fraud services • rebate payments for medical, (and if applicable, pharmacy) • establishment of a bank account for the payment of claims and its funding • systems access for receipt of electronic reports • plan benefit litigation • audits • transfer of Plan information • fees, performance guarantees, credits, and pharmacy (if applicable) UMR's suggested language can be referenced in the sample Administrative Services Agreement submitted with UMR's RFP response.

UnitedHealthcare

January 2025

A solution for State of Nebraska Department of Correctional Services

Presented by Tim Moore

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TRADEMARKS AND SERVICE MARKS