

EXHIBIT H
(Part 6)

- Amount of each individual deposit and a grand total per deposit type.

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- d) Ability to produce Member level detail when requested by the Plan.

Confirm Does Not Confirm

- 4) Daily NSF report listing all NSF for the previous months which includes:

- a) Subscriber number, if applicable.
- b) Provider information, if applicable.
- c) Date returned.
- d) Dollar amount.

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- 5) Monthly misapplied deposits and/or collections report (e.g., applied deposit to wrong Member or wrong client) which includes date originally deposited and how they were corrected.

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- 6) Weekly reporting package of claims and other disbursements by Product type, which includes, but is not limited to:

- a) Number of checks processed weekly.
- b) Number of EFTs processed weekly.
- c) Payment amount(s) by type e.g., claims refunds, adjustments, miscellaneous payments, voided checks, escheats, reissued checks, etc.
- d) Weekly total by type.
- e) Month to date total by type.
- f) Supporting documentation of all disbursements and an explanation of any adjustments and/or miscellaneous payments, e.g., check register, any system generated reports of check writes, etc.

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- 7) Monthly deposit reconciliation which includes, but is not limited to:

- a) Date of each daily deposit.
- b) Total amount of deposit for each day.
- c) Breakdown of amount by type of deposit, i.e., checks, wires, ACH (drafts).
- d) Monthly total of each type.

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- 8) Monthly reconciliation of claims and other disbursements which includes, but is not limited to:
- a) Daily transactions listed individually with a daily total as well as a summary total.
 - b) A breakout of ACH/EFT, voids, cancelled checks, manual checks, any adjustments, total net disbursement, refunds, and other disbursements.

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- 9) As applicable, escheats report of all warrants/checks to be escheated by state and Product type, which includes, but is not limited to:
- a) Final due date to escheat the warrants/checks.
 - b) Name of state and dormancy period for each state.
 - c) Number of warrants for each state and dollar amount.
 - d) Grand total of number of warrants, dollar amount by Product type and grand total dollar amount for all Product types.
 - e) Explanation of any special circumstances or issues.

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- 10) Monthly Summary of Billed Charges by State Fiscal Year which includes a summary of claims paid for the period which includes both medical and pharmacy claims.

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- 11) Monthly Statement of Account (SOA) which includes all charges including claims and administrative fees paid. It is a full picture of all income/expenses for the month.

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- x. Vendor will provide each of the following Financial Performance reports or reporting packages. The method for providing the report will be determined during implementation.

- 1) Performance Guarantees (PG), as outlined in Section 6.3, reports as follows:

- a) Monthly PG status report.
- b) Quarterly PG report cards.
- c) Annual PG report cards that include summary data and year end PG results.

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- 2) Monthly Performance Matrix reports as outlined in Exhibit 12, "Matrix Reports," and listed below:

- a) Reports 1 and 2: Charge Summary Paid and Incurred Reports.
- b) Reports 3 and 4: Charge Summary Trend Paid and Incurred.
- c) Reports 5 and 6: Coinsurance and Deductible, Full Population-Paid and Incurred.
- d) Reports 7 and 8: Coinsurance and Deductible, Closed Population-Paid and Incurred.
- e) Reports 9 and 10: Copay-Incurred and Paid.
- f) Report 11: Copay-Incurred (Claims Run out).

- g) Reports 12 and 13: Claims Experience Summary by Demographics, Paid/Incurred, Time, etc.
- h) Reports 14 and 15: Financial Summary-Paid and Incurred.
- i) Reports 16 and 17: Financial Reconciliation-Paid and Incurred.
- j) Report 19: Utilization and Cost-Share by Service Type-Paid Claims.

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3) Monthly Triangulations reports with the following stratifications:

- a) Service type to include Ancillary, Inpatient Facility, Inpatient Professional, Outpatient Facility, etc. and the individual plan options, including a summary based on total membership.
- b) Plan Design and/or Product, including a summary based on total membership.

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4) Monthly prompt payment interest claims report that includes, but are not limited to:

- a) Prompt pay for adjusted claims.
- b) Prompt pay for new claims.
- c) Claim count.
- d) Total interest paid.

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xi. Vendor will provide each of the following Claims and Appeals reports or reporting packages. The method for providing the report will be determined during implementation.

1) Monthly processed claims reports that include, but are not limited to:

- a) Claims type.
- b) Total claims billed.
- c) Total claims paid.

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2) Monthly Deductible and Out-of-Pocket reports, by Plan Design, by month.

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3) Monthly COB reports that identify savings associated with both Medicare and Commercial COB.

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4) Quarterly high claimant reports (dollar threshold will be determined during implementation) that include, but are not limited to:

- a) Denial reason.
- b) Number of claims for each denial reason.

c) Total charges for each denial reason.

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5) Quarterly high claimant reports that include, but are not limited to (the dollar threshold for including Members on the report will be determined during implementation):

- a) Member ID.
- b) Plan ID.
- c) Member age.
- d) Diagnosis.
- e) Service start date.
- f) Encounter service type.
- g) Place of service.
- h) Provider specialty description.
- i) Paid amount.

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6) Monthly medical and pharmacy appeals reports that include, but are not limited to:

- a) Number of first level appeals received.
- b) Number of first level appeals approved.
- c) Number of first level appeals denied.
- d) Number of second level appeals received.
- e) Number of second level appeals approved.
- f) Number of second level appeals denied.
- g) Statistics on types of appeals received, approved, and denied at both first and second level.

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7) A Monthly pharmacy appeals received detail report that includes, but is not limited to, the following:

- a) Member ID.
- b) Member First Name.
- c) Member Last Name.
- d) Type of Appeal Review Decision.
- e) Type of Appeal Category.
- f) Date Appeal Initiated.
- g) Final Written Date.
- h) Appeal Decision Description.
- i) Medication Name, Strength, and Dosage.
- j) Method Appeal Received.
- k) Appeal Origin.

- I) Drug Class.
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- xii. Vendor will provide the following Network report or reporting packages. The method for providing the report will be determined during implementation.
 - 1) Quarterly GeoAccess report. If multiple networks are utilized, a separate report will be required for each one.
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- xiii. Vendor will provide each of the following Medical Management reports or reporting packages. The method for providing the report will be determined during implementation.
 - 1) Quarterly Medical Cost and Clinical Outcomes reports across diagnosis categories, highly prevalent, costly, and/or determined by the Plan to be clinically significant, to include HEDIS measures, and state, national, and book-of-business data segregated by Plan Designs (70/30, 80/20, HDHP,) Medicare and Non-Medicare primary status, and by Group.
Confirm Does Not Confirm
 - 2) Quarterly Case Management Clinical Outcomes.
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 - 3) Quarterly Preventive Care Service Utilization.
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- xiv. Vendor will provide each of the following Utilization Management reports or reporting packages. The method for providing the report will be determined during implementation.
 - 1) Quarterly Utilization Management Cause, Cost and Clinical Outcomes, including, but not limited to, inpatient admissions, readmissions, emergency department visits, urgent care visits, outpatient services, behavioral health services, ambulance services, private duty nursing, pharmacy services and polypharmacy, primary care physician visits, specialist visits, prior authorizations and approvals, and high cost claims and claimants across Plan Products (70/30, 80/20, HDHP, non-Medicare) and Employing Units.
Confirm Does Not Confirm
 - 2) Annual Utilization Management Interventions: Interventions and outcomes of efforts to address ineffective utilization of services.
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- xv. Vendor will provide the following specialty pharmacy management report or reporting package. The method for providing the report will be determined during implementation.
 - 1) A quarterly utilization report detailing specialty pharmacy Rebates.
Confirm Does Not Confirm
- xvi. Vendor will provide each of the following Customer Experience reports or reporting packages. The method for providing the report will be determined during implementation.
 - 1) The Weekly Operations Dashboard of Key Performance Indicators (KPI), including, but not limited to, the following:

- a) Total Member calls received.
- b) Weekly ASA rate for Member calls.
- c) Weekly first contact resolution rate.
- d) Weekly second contact resolution rate.
- e) Turnaround Time (TAT) for processing all enrollment data files received from Plan's EES Vendor.
- f) TAT for completing manual enrollment updates.
- g) Enrollment accuracy rate for the current month.
- h) Number and percentage of clean claims processed ≤ 30 days.
- i) Number and percentage of claims processed > 30 days.
- j) Number and percentage of claims processed > 60 days.
- k) Number and percentage of claims processed > 90 days.

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- 2) A Quarterly Web Trends Report that provides statistics on Plan Members transaction history compared to Vendors' Book of Business data.

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xvii. Vendor will provide each of the following Recovery and Special Investigation reports or reporting packages. The method for providing the report will be determined during implementation.

- 1) Monthly recovery reporting package that includes, but it not limited to the following:
 - a) Recovery or pre-prepayment claim types (Examples: COB, Duplicate Claims, Pricing, etc.).
 - b) Total requested or saved, by recovery type and recovery subcontractor.
 - c) Total received, by recovery type and recovery subcontractor included Plan recovery Vendors. (Example: The Plan's Subrogation Vendor's results included in reporting package alongside Vendor's other recovery results.)
 - d) Total by subcontractor, including Plan recovery Vendors.
 - e) Quarter and year to date results.
 - f) Trends.
 - g) If available, benchmark data.

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- 2) Monthly Plan specific investigation reports that include, but are not limited to, the following data:

- a) Name of provider.
- b) Number of Members impacted.

- c) Date case opened.
- d) Basis for review.
- e) Summary of case.
- f) Status of the case.
- g) Total projected Plan claims dollars associated with the case.
- h) Upon final resolution, dollars to be recovered and any projected savings from future avoidance of similar claims.

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3) A quarterly medical audit repayment report that includes, but is not limited to, the following data:

- a) Date of Service.
- b) Member Name.
- c) Subscriber Number.
- d) Claim Number.
- e) Original Paid Amount.
- f) Appropriate Paid Amount.
- g) Overpayment Amount.
- h) Amount Repaid to the Plan.
- i) Total Amount Repaid to Plan from all Claims Across All Members for Quarter.
- j) Cumulative Amount Repaid to Plan from all Claims Across All Members for YTD.

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