Amendment 10
Contract Number 102894 O4

Service Contract

Between
The State of Nebraska Department of Health and Human Services
And
Nebraska Total Care Inc

THIS AMENDMENT is entered into by and between the State of Nebraska Department of Health and Human Services ("DHHS") and Nebraska Total Care Inc ("NTC").

WHEREAS, the DHHS has a contract with NTC identified as 102894 O4 for use by state agencies and other entities.

WHEREAS, the terms of the contract specifically state that the contract may be amended when mutually agreeable to NTC and the DHHS.

WHEREAS, This Amendment and any attachments hereto will become part of the Contract. Except as set forth in this Amendment, the Contract is unaffected and shall continue in full force and effect in accordance with its terms. If there is conflict between this Amendment and the Contract or any earlier amendment, the terms of this Amendment will prevail.

NOW, THEREFORE, it is agreed by the parties to amend the contract as follows:

I. **Additions:** The Parties hereto agree to add the following sections:

A. **GLOSSARY OF TERMS**
Certified Community Behavioral Health Clinics: A CCBHC is a healthcare provider who is certified by the Divisional of Behavioral Health and has met the SAMHSA requirements for eligible providers and the criteria to provide all required services. A CCBHC must provide service to any individual who presents in their clinic, regardless of ability to pay or insurance.

IServe: The State service delivery system for public benefits, accessible through a toll-free telephone number and website.

B. **ACRONYM AND INITIALISM LIST**

CCBHC: Certified Community Behavioral Health Clinic
DCO: Designated Collaborating Organization
HRSN: Health-related Social Needs
IEP: Individual Education Plan
MAT: Medication Assisted Treatment
SAMHSA: Substance Abuse and mental Health Services Administration
USPSTF: US Preventive Services Task Force

C. **Section V.E.35.a. - Certified Community Behavioral Health Clinics**
a. **Effective January 1, 2026**, CCBHCs will provide at a minimum the following community-based services either directly or indirectly through formal (DCO) referral relationships with other providers:
i. Outpatient mental health and substance use services;
ii. Crisis mental health services;
iii. Screening, assessment, and diagnosis, including risk assessments;
iv. Person-centered treatment planning;
v. Outpatient clinic primary care screening and monitoring of key health indicators and health risks;
vi. Targeted case management;
vii. Psychiatric rehabilitation services;

viii. Peer support and counselor services and family supports; and
ix. Community-based mental health care for members of the armed forces and veterans consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration.

D. Section V.I.9.f.
f. **Effective January 1, 2026,** MCOs must abide by the requirements outlined in 2025 Nebraska LB 198 (Neb. Rev. Stat. sections 44-4601, 44-4603, and 44-4610).

E. Section V.N.11.e
e. MCOs must have a documented program in place to monitor the appropriate use of antipsychotic medication by adults (over the age of 18) residing in institutional care settings (including nursing facilities, intermediate care facilities for individuals with intellectual disabilities, institutions for mental diseases, inpatient psychiatric hospitals, and other such institutional care settings.

F. Section V.N.11.f.
f. MCOs must have a documented program in place to monitor the appropriate use of antipsychotic medications by adults (over the age of 18) receiving home and community-based services (as defined in section 9817(a)(2)(B) of Public Law 117-2.)

G. Section V.N.19.
19. **Beginning January 1, 2026**, following each calendar year it has a contract with a State Medicaid agency, the MCO must report prior authorization data, excluding data on any and all drugs covered by the MCO at the plan level by March 31st. The MCO must make the following data from the previous calendar year publicly accessible by posting them on its website:
    a. A list of all items and services that require prior authorization.
    b. The percentage of standard prior authorization requests that were approved, aggregated for all items and services.
    c. The percentage of standard prior authorization requests that were denied, aggregated for all items and services.
    d. The percentage of standard prior authorization requests that were approved after appeal, aggregated for all items and services.
    e. The percentage of prior authorization requests for which the timeframe for review was extended, and the request was approved, aggregated for all items and services.
    f. The percentage of expedited prior authorization requests that were approved, aggregated for all items and services.
    g. The percentage of expedited prior authorization requests that were denied, aggregated for all items and services.
    h. The average and median time that elapsed between the submission of a request and a determination by the MCO, PIHP or PAHP, for standard prior authorizations, aggregated for all items and services.
    i. The average and median time that elapsed between the submission of a request and a decision by the MCO, PIHP or PAHP, for expedited prior authorizations, aggregated for all items and services.

H. Section V.N.20.a. - CCHBC Prior Authorization Requirement
    a. MCO will require prior authorization for any CCBHC services which would otherwise require prior authorization. If authorization is not obtained for any services that would trigger a PPS encounter, the PPS encounter would not be paid, and claim should be denied.

I. Section V.I.20.a-e. - CCBHC Contracting
    a. MCO must ensure the CCBHC is an enrolled Medicaid provider (via the Provider Master File) for the entire dates of service span of each claim. If not, the MCOs must reject the claim.
    b. MCO must ensure that all individual provider NPIs per service line are active providers within the CCBHC for the dates of service of the claim line. If not, MCO must reject the claim.
    c. MCO will not separately contract with CCBHC DCOs. DCO individual provider staff will contract with the CCBHC provider. A DCO billing provider will NOT complete a separate contract/provide agreement.
    d. MCO will ensure contracting/credentialing activities align with the Provider Master File. Each CCBHC must have an individual provider agreement per practice location (whether it is a

hub/main location or an ancillary/satellite location. The provider must bill using the NPI, taxonomy, and zip+4 associated with the provider agreement applicable to the location where services were utilized.

e. MCO must only contract with individual providers which are affiliated with each CCHBC provider/location.

J. Section V.Q.23.a.i-ii. - CCBHC Provider Reimbursement

i. The MCO must reimburse CCBHCs in accordance with the established cost-based reimbursement rates for each CCBHC (the same rate will apply per CCBHC for all of their enrolled/contracted locations.)

ii. The MCO must not enter into alternative reimbursement arrangements with CCBHCs without prior approval from MLTC.

II. Modifications: The Parties hereto agree to modify the following sections:

A. Attachment 13 – Reporting Requirements

B. Section V.B.1.a.

a. DHHS administers and manages eligibility for Medicaid and economic assistance programs through IServe in accordance with state and federal rules and regulations. Details on how individuals can apply for benefits are found on the IServe website, currently available at https://iserve.nebraska.gov/

C. Section V.B.4.c.i.-ii.

i. The MCO must notify MLTC via IServe, of any changes in contact information of living arraignments for families or individual members within five (5) business days of identification, including changes in mailing address, residential address, email address, and telephone number, in a manner and format required by MLTC.

ii. MCO must notify MLTC via IServe, of any other known changes in status, including but not limited to, death, entry into involuntary custody, or incarceration, in a manner and format required by MLTC.

D. Section V.F.9.e.ii.c)

c) Medicaid specific unique Bank Identification Number (BIN) and Processor Control Number (PCN) combination, with a group member identifier.

E. Section V.F.10.g.v.

v. A link to the Medicaid Eligibility website, currently https://iserve.nebraska.gov/ for questions about Medicaid eligibility; and

F. Section V.N.18.d.iii.b)-c)

iii. Informal Reconsideration

b) In a case involving an initial adverse determination, the MCO must provide the treating provider an opportunity to send in new clinical information to be reviewed (informal reconsideration process) and to discuss (peer-to-peer process) the decision with the physician or dentist or clinical peer making the adverse determination. This may or may not lead to a change in the initial determination, however this is not considered part of the formal appeal process.

c) Such processes should occur as soon as possible after the initial adverse determination is made. The informal reconsideration and peer-to-peer processes will in no way extend the thirty (30) calendar day requirement timeframe for a Notice of Appeal Resolution.

G. Section V.O.2.a. Recovery of Overpayments

a. Overpayments must be reported within thirty (30) calendar days of the identification of the overpayments. Information on recoveries is used for the setting of capitation rates.

III. **Deletions**: The Parties hereto agree to delete the following sections:

A. GLOSSARY OF TERMS
ACCESSNebraska: The State service delivery system for public benefits, accessible through a toll-free telephone number and website.

Attachments:

The following attachments, as amended (if applicable), are attached hereto and hereby incorporated into this Amendment:

1. AMENDED Attachment 13 - Contract 102894 O4_ Effective 1-1-2025

IN WITNESS WHEREOF, the parties have executed this amendment as of the effective date by both parties below.

FOR DHHS:		FOR CONTRACTOR:	
By:	Signed by: Drew Gonshorowski 06E4C348F9184A5...	By:	Signed by: Adam Proctor AC913FACE283442...
Name:	Drew Gonshorowski	Name:	Adam Proctor
Title:	Director, Division of Medicaid & Long-Term Care	Title:	CEO
Date:	9/17/2025 | 09:48:45 CDT	Date:	8/25/2025 | 10:42:21 CDT

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Attachment 13 – Reporting Requirements Effective January 1, 2025

Bi-Weekly	**B1** submission reporting period – **1st-15th**. **B2** submission reporting period – **16th- last day of the month.** Submissions are due three (3) business days after the reporting period.
Monthly Deliverables	Due on the 15th day of the following calendar month unless otherwise noted in the RFP or agreed to in writing by the MCO and MLTC.
Quarterly Deliverables	Due 45 calendar days after the end of the most recent quarter unless otherwise noted in the RFP or agreed to in writing by the MCO and MLTC.
Semi-Annual Deliverables	Due as specified in this attachment.
Annual Deliverables	Reports, files, and other deliverables due annually must be submitted within 45 calendar days following the 12th month of the contract year, except those reports that are specifically exempted from the 45-calendar day deadline by this RFP or by written agreement between MLTC and the MCO.
Ad Hoc Deliverables	Ad hoc reports must be submitted within five business days from the date of request, unless otherwise specified by MLTC.

- **If a due date falls on a weekend or State-recognized holiday, the deliverable is due the next business day.**
- **All reports must be submitted in an MLTC provided template or in a format approved by MLTC.**

Ad Hoc Deliverables	Description	Due Date
Vetting Report	Form, template, and field definitions used to respond to NMPI or MFPAU requests for provider history and detailed claims information.	Ad Hoc (5 Business Days to respond)
Bi-Weekly Deliverables	**Description**	**Due Date**
Bi-Weekly Tips	Pursuant to V.O, The MCO must notify MLTC if it identifies patterns of provider billing anomalies and/or the safety of Nebraska Medicaid members (42 CFR 455.15). **Reporting Critical Incidents**: actual events or situations that cause serious harm to the health or welfare of a person or negatively impacts the physical and/or mental health of a person or creates a situation of significant risk for serious harm.	**B1** submission reporting period – **1st-15th**. **B2** submission reporting period – **16th- last day of the month.** Submissions are due three (3) business days after the reporting period.
Monthly Deliverables	**Description**	**Due Date**
Third Party Resource – Health Coverage	Data on instances of MCO identified TPR	Monthly; No later than the 15th
Call Center Report	Pursuant to Section V.F, data summarizing relevant call center operations.	Monthly; No later than the 15th
Death Notifications	Data reporting MCO notification of member deaths to IServe.	Monthly; No later than the 15th

EVV KPI – Home Health	Summary key performance indicators for home health claims and visits for electronic visit verification, as required by the 21st Century Cures Act.	Monthly; No later than the 15th
Executive Dashboard	Summary operations, communications, financial, claims, and care management data for leadership meetings.	Monthly

Monthly Claims Report	Segmented data on all non-pharmacy claims volume, adjudication status, and payment timeliness.	Monthly; No later than the 15th
Monthly FWA Detection Effort Report	Summary of the MCO's fraud prevention efforts as described in Section V.O - Program Integrity.	Monthly; No later than the 15th
Monthly FWA Report	Summary of investigations as described in Section V.O – Program Integrity.	Monthly; No later than the 15th
Pharmacy Claims Report	Data on Pharmacy claims volume, adjudication status, and payment timeliness	Monthly; No later than the 15th
Pharmacy Prior Authorization Report	Summary of prior authorizations, peer review, and peer-to-peer consultation statistics; also includes special categories of drug prior authorizations.	Monthly; No later than the 15th
Provider Network Changes	Data and metrics summarizing any change to the MCO's network.	Monthly; No later than the 15th
Supplemental Member Care Report	Contains supplemental information related to member care and case management and member outreach.	Monthly; No later than the 15th
Care Management Log	Data of member assessment and their care management.	Monthly; No later than the 15th
Grievance Log	Data regarding the grievances received by the MCOs.	Monthly; No later than the 15th
Appeals Log	Data regarding the appeals received by the MCOs.	Monthly; No later than the 15th
State Fair Hearing Log	Data regarding the state fair hearings.	Monthly; No later than the 15th
Out of Network Referrals	Data regarding out of network provider authorization requests.	Monthly; No later than the 15th
Quarterly Deliverables	**Description**	**Due Date**
Geographic Access Standards	Details of the MCO's network, including GeoAccess reports, as described in Section V.I – Provider Network Requirements and Attachment 14 – Access Standards.	Quarterly

SUD IMD Stays Report	SUD-related inpatient residential stays for Medicaid beneficiaries ages 21-64 in IMDs (over 16 beds primarily engaged in behavioral health treatment) from 07/01/2019 to the end of the reporting period.	Quarterly; due 10 calendar days after the end of the reporting period.
Insure Kids Now (IKN) Report	MCO must submit a file (or multiple files) to the federal government that contains information, specified in Attachment 5 – Insure Kids Now, about the Medicaid and CHIP providers in the state that provide dental care to children.	Quarterly; The MCO must submit these no later than: Feb 4th (FFY Q1 (Oct-Dec)); May 4th (FFY Q2 (Jan-Mar)); Aug 4th (FFY Q3 (Apr-Jun); Nov 4th (FFY Q4 (July-Sept))
Insure Kids Now (IKN) – MLTC Notification	MCOs must provide MLTC the **"Data File Submission and Validation Receipt", with Examination Results of "Accepted" or "Accepted with rejected rows."** If IKN does not accept it, then the MCO must work with IKN technical team for technical revisions until it is accepted by IKN. MLTC will reject the receipt and direct the MCO to revise and resubmit both the report to IKN and subsequent receipt with IKN approval to MLTC. Report accuracy and timeliness for this reporting deliverable reflect MCO contractual compliance.	Quarterly; Feb 15th; May 15th; August 15th; Nov 15th
Language Availability Report	Summary data and metrics on language availability access as determined by MLTC.	Quarterly
LB1063_68-2004 Children's Health and Treatment Act	Data related to youth Medicaid mental health authorization requests for all children ages 0-19.	Quarterly; Due 45 days after the most recent calendar quarter.
MCO Financial Report	Financial Reporting Template that allows the state to measure all financial key performance indicators related to Heritage Health Managed Care, to include but not limited to costs, utilization, enrollment and revenue. Summary of value-added services (paid as claims and outside of claims payment systems) as agreed upon by the MCO and MLTC.	Quarterly; Due 45 calendar days after the end of the reported period.
NEMT Quarterly Report	Data regarding non-emergency transportation.	Quarterly

NF Skilled Stay Authorizations	Report the NF skilled stays authorized by the MCO. The report must include accurate information for the following: Provider Name, Provider NPI, Provider Medicaid ID, authorized date, start date for the skilled stay, last date paid for the skilled stay (in MMIS this is known as the end date for the stay), Member Medicaid ID, and Member first and last name. In addition, provide the determination/completion date for the most current PASRR completed as of the start date for the skilled stay. Also, provide the type of PASRR (Level I, Level II, or one of the following categorical exemptions: 7 day emergency, 30 day hospital exempt, 30 day respite, serious medical, dementia categorical for individuals with intellectual disability or related condition, or 60 day convalescent).	Quarterly
Pharmacy Call Center Report	Data summarizing relevant pharmacy call center operations.	Quarterly
Pharmacy DUR Report	DUR statistics to support preparation of MLTC's annual CMS DUR report.	Quarterly
Provider Appointment Availability Access	Summary data and metrics on provider network appointment access as determined by MLTC and described in Attachment 14 – Access Standards.	Quarterly
Psychotropic Medication for Youth Report	Summary of prior authorization and utilization relating to clinical edits.	Quarterly
Quarterly FWA Trending Reports	Summary data and narrative regarding FWA trends.	Quarterly
Service Verification	Service verification summary as described in Section V.O – Program Integrity, Section V.S – Claims Management, and Section V. T – Reporting and Deliverables.	Quarterly
Dental QAPI Committee Report	Narrative of the activities of the MCO's Dental QAPI Committee as described in Section V.M.8.g. – Dental QAPI Committee Responsibilities.	Quarterly
Semi-Annual Deliverables	**Description**	**Due Date**
Member Advisory Committee Report	Narrative of the activities of the MCO's Member Advisory Committee as described in Section V.M - Quality Management.	June 30 and December 31
Annual Deliverables	**Description**	**Due Date**
Adult Core Measures	Adult Core Measures results.	Annually by September 30
Annual Program Integrity Confirmation	Signed form acknowledging responsibilities related to the receipt of State and federal funds as described in Section V.O - Program Integrity.	Annually; No later than December 31st
Annual Systems Refresh Plan	Plan must outline how IS within the MCO's control will be systematically assessed to determine the need to modify, upgrade, or replace application	Annually; No later than December 31st

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Attachment 13 – Reporting Requirements Effective January 1, 2025

	software, operating hardware and software, telecommunications capabilities, or information management policies and procedures in response to changes in business requirements, technology obsolescence, staff turnover, or any other relevant issues. Section V.R.4.	
CAP – MCO Providers	Results and status of all corrective action plans by provider type.	Annually; No later than Jan 31st
Child Core Measures	Child Core Measures results.	Annually by September 30
Clinical Advisory Committee Plan	Plan describing the development of the Clinical Advisory Committee	Annually; No later than January 15th
Clinical Practice Guidelines	Using information acquired through its Quality Assurance and Process Improvement (QAPI) and UM activities, the MCO must submit to MLTC annually the implementation of the clinical practice guidelines, including compliance and outcomes measures and a process to integrate these practice guidelines into care and case management and UR activities.	Annually; No later than February 15th
Direct Medical Education/Indirect Medical Education Verification – In accordance with 471 NAC	For the state fiscal year, financial information on direct and indirect medical education costs as required by MLTC in accordance with 471 NAC.	Annually; No later than October 31st; State initiates the request
Electronic Attestation Acknowledgement	42 CFR 438.606; The MCO must submit certification (attestation) concurrently with the certified data and documents.	Annually, No later than Feb 1st
Fraud, Waste, Abuse, and Erroneous Payments Annual Plan	Compliance plan addressing requirements outlined in Section V.O - Program Integrity and 42 CFR 438.608	Annually; No later than Feb 15th
HEDIS Report	HEDIS results.	Annually by June 30th
LB 1160 Legislative Report	Number of state wards receiving behavioral health services from July 1 through June 30 immediately preceding the date of the current report; percentage of children denied Medicaid reimbursed services and the level of placement requested; and children in residential treatment.	Annually; No later than July 5th
CAHPS --Adult	Data regarding the annual member satisfaction survey for the listed population and supplement.	Annually; No later than September 30th
CAHPS –Child with CCC	Data regarding the annual member satisfaction survey for the listed population and supplement.	Annually; No later than September 30th
CAHPS – CHIP with CCC	Data regarding the annual member satisfaction survey for the listed population and supplement.	Annually; No later than September 30th
CAHPS –Dental Survey (Adult)	Data regarding the annual member satisfaction survey for the listed population and supplement.	Annually; No later than September 30th

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Dental Survey (Child)	Data regarding the annual member satisfaction survey for the listed population and supplement	Annually; No later than September 30th
Marketing Plan	Plan detailing the marketing activities it will undertake and materials it will create during the contract period.	Annually; Must submit a minimum of one hundred and fifty (150) calendar days before intended implementation of the marketing activity
Member Advisory Committee Plan	Plan describing the draft goals and planned schedule for the Member Advisory Committee	Annually; No later than January 15th
Mental Health & Substance Use Disorder Parity Report	Pursuant to Section V.E.3 The MCO will report on the design and application of managed care practices such as prior authorization, reimbursement rate setting, and network design.	Annually; No later than July 1st
Network Development Management Plan & Network Development Plan Template	Details of the MCO's network adequacy, including attestation, GeoAccess reports, and a discussion of any provider network gaps and the MCO's remediation plans, as described in Section V.I – Provider Network Requirements.	Annually. No later than November 1st
Ownership Disclosure	Federal law requires full disclosure of ownership, management, and control of an MCO (42 CFR § 455.100-455.106). This information must be provided during the readiness review, annually thereafter for each contract year, and within 30 (thirty) calendar days of any change in the MCO's management, ownership or control. Section V.T.2.	Annually; No later than March 1st and when changes are made.
Prior Authorization Report	Data summarizing prior authorizations for MCPAR report (for CMS) for the previous calendar year.	Annually; No later than May 1st
Provider Satisfaction Survey - Medical and Behavioral Health Providers	The MCO must submit an annual provider satisfaction survey report that summarizes the survey methods and findings and provides an analysis of opportunities for improvement and action plans derived from survey results.	Annually; No later than Feb 15th
Provider Satisfaction Survey – Dental Providers	The MCO must submit an annual provider satisfaction survey report that summarizes the survey methods and findings and provides an analysis of opportunities for improvement and action plans derived from survey results.	Annually; No later than Feb 15th
QAPI Program Description and Work Plan	Discussion of the MCO's QAPI goals, objectives and accountabilities, including definition of the scope of the program; work plan to include timeline for the coming year and all planned QAPI activities. All as described in Section V.M – Quality Management.	Annually; No later than Feb 15th

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Attachment 13 – Reporting Requirements Effective January 1, 2025

QAPI Program Evaluation	Statistical analysis of the data a descriptive summary of findings from the annual QAPI Work Plan. All as described in Section V.M – Quality Management.	Annually; No later than April 30th
Dental QAPI Program Description and Work Plan	Discussion of the MCO's Dental QAPI goals, objectives and accountabilities, including definition of the scope of the program; work plan to include timeline for the coming year and all planned QAPI activities. All as described in Section V.M – Quality Management.	Annually; No later than Feb 15th
Dental QAPI Program Evaluation	Statistical analysis of the data a descriptive summary of findings from the annual Dental QAPI Work Plan. All as described in Section V.M – Quality Management.	Annually; No later than April 30th
UM Program Description	Outlines UM structure and accountability mechanisms per contract section V.N.2.	Annually; No later than Feb. 15th
UM Program Evaluation	Statistical analysis of the data and descriptive summary of findings from the annual UM Program description. All as described in Section V.N.2. UM Program Description.	Annually; No later than April 30th
Department of Insurance Financial Report	Copy of annual audited financial statement	Annually; No later than June 1 and upon request of MLTC;
SOC 1 Audit Reports and Bridge Letters	SOC 1 Audit reports (and applicable Bridge Letters) for IT and business process controls. Applicable to MCOs and any subcontractors, such as PBMs processing claims.	Annually for each state fiscal year, upon request from MLTC

Certificate Of Completion

Envelope Id: A7B2FAD6-30E4-412C-9035-1FB44D8CB4F1
Status: Completed
Subject: Complete with Docusign: 102894-O4 Nebraska Total Care Amendment 10 CLMS 2260.pdf
Envelope Type: Contract
Envelope Name: 102894-O4 Nebraska Total Care Amendment 10 CLMS 2260
Divison:
DHHS Sender: DHHS.Procurement@nebraska.gov
DHHS Sharepoint ID:
FFATA Reporting Required:
Source Envelope:
Document Pages: 11
Signatures: 2
Certificate Pages: 5
Initials: 0
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dhhs.procurement@nebraska.gov
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Location: Docusign

Signer Events	Signature	Timestamp
Adam Proctor Adam.Proctor@NebraskaTotalCare.com CEO Security Level: Email, Account Authentication (None)	Signed by: Adam Proctor AC913FACE283442... Signature Adoption: Pre-selected Style Using IP Address: 165.225.58.22	Sent: 8/8/2025 1:36:54 PM Resent: 8/8/2025 3:56:14 PM Resent: 8/11/2025 4:08:58 PM Resent: 8/12/2025 10:39:37 AM Resent: 8/13/2025 9:43:03 AM Resent: 8/14/2025 2:27:33 PM Resent: 8/18/2025 9:26:53 AM Resent: 8/19/2025 9:22:27 AM Resent: 8/20/2025 8:59:22 AM Resent: 8/21/2025 1:31:59 PM Resent: 8/22/2025 8:32:11 AM Resent: 8/25/2025 10:14:26 AM Viewed: 8/25/2025 10:42:06 AM Signed: 8/25/2025 10:42:21 AM

Electronic Record and Signature Disclosure:
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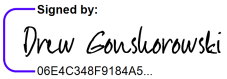
Signer Events	Signature	Timestamp
Drew Gonshorowski drew.gonshorowski@nebraska.gov Director of Medicaid and Long-term Care Security Level: Email, Account Authentication (None)	Signed by:  06E4C348F9184A5... Signature Adoption: Pre-selected Style Using IP Address: 164.119.5.218	Sent: 8/25/2025 10:42:23 AM Resent: 8/26/2025 11:54:17 AM Resent: 8/27/2025 2:44:36 PM Resent: 8/28/2025 10:07:13 AM Resent: 8/29/2025 8:25:13 AM Resent: 9/2/2025 12:08:30 PM Resent: 9/3/2025 8:49:59 AM Resent: 9/4/2025 11:03:25 AM Resent: 9/5/2025 8:27:42 AM Resent: 9/8/2025 9:45:21 AM Resent: 9/16/2025 12:19:58 PM Resent: 9/17/2025 9:41:16 AM Viewed: 9/17/2025 9:48:38 AM Signed: 9/17/2025 9:48:45 AM
Electronic Record and Signature Disclosure: Accepted: 9/17/2025 9:48:38 AM ID: 12117b3c-1472-4c3e-9417-40251f847689		

In Person Signer Events	Signature	Timestamp

Editor Delivery Events	Status	Timestamp

Agent Delivery Events	Status	Timestamp

Intermediary Delivery Events	Status	Timestamp

Certified Delivery Events	Status	Timestamp

Carbon Copy Events	Status	Timestamp
Kristine Radke Kristine.Radke@nebraska.gov Security Level: Email, Account Authentication (None) **Electronic Record and Signature Disclosure:** Accepted: 6/24/2025 8:26:55 AM ID: 18af51c9-148a-404a-9568-30e6e254dad8	COPIED	Sent: 8/8/2025 1:36:54 PM Viewed: 8/8/2025 2:17:13 PM
Kendra Wiebe Kendra.Wiebe@nebraska.gov Security Level: Email, Account Authentication (None) **Electronic Record and Signature Disclosure:** Not Offered via Docusign	COPIED	Sent: 8/25/2025 10:42:22 AM

Witness Events	Signature	Timestamp

Notary Events	Signature	Timestamp

Envelope Summary Events	Status	Timestamps
Envelope Sent	Hashed/Encrypted	8/8/2025 1:36:54 PM
Certified Delivered	Security Checked	9/17/2025 9:48:38 AM
Signing Complete	Security Checked	9/17/2025 9:48:45 AM
Completed	Security Checked	9/17/2025 9:48:45 AM

Payment Events	Status	Timestamps

Electronic Record and Signature Disclosure

CONSUMER DISCLOSURE

From time to time, Nebraska Department of Health & Human Services (we, us or Company) may be required by law to provide to you certain written notices or disclosures. Described below are the terms and conditions for providing to you such notices and disclosures electronically through the DocuSign, Inc. (DocuSign) electronic signing system. Please read the information below carefully and thoroughly, and if you can access this information electronically to your satisfaction and agree to these terms and conditions, please confirm your agreement by clicking the 'I agree' button at the bottom of this document.

Getting paper copies

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Withdrawing your consent

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To contact us by email send messages to: john.canfield@nebraska.gov

To advise Nebraska Department of Health & Human Services of your new e-mail address

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Required hardware and software

Operating Systems:	Windows® 2000, Windows® XP, Windows Vista®; Mac OS® X
Browsers:	Final release versions of Internet Explorer® 6.0 or above (Windows only); Mozilla Firefox 2.0 or above (Windows and Mac); Safari™ 3.0 or above (Mac only)
PDF Reader:	Acrobat® or similar software may be required to view and print PDF files
Screen Resolution:	800 x 600 minimum

Enabled Security Settings:	Allow per session cookies

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