

SERIAL 11001 RFP EMPLOYEE BENEFIT DENTAL SERVICES
Contract – CIGNA

DATE OF LAST REVISION: January 08, 2015 CONTRACT END DATE: June 30, 2018

CONTRACT PERIOD THROUGH JUNE 30, ~~2015~~ 2018

TO: All Departments
FROM: Office of Procurement Services
SUBJECT: Contract for **EMPLOYEE BENEFIT DENTAL SERVICES**

Attached to this letter is published an effective purchasing contract for products and/or services to be supplied to Maricopa County activities as awarded by Maricopa County on **October 19, 2011 (Eff. 07/01/12)**.

All purchases of products and/or services listed on the attached pages of this letter are to be obtained from the vendor holding the contract. Individuals are responsible to the vendor for purchases made outside of contracts. The contract period is indicated above.

Wes Baysinger, Chief Procurement Officer
Office of Procurement Services

SD/mm
Attach

Copy to: Office of Procurement Services
Chris Bradley, Department of Business Strategies and Health Care Programs

(Please remove Serial 04161-RFP from your contract notebooks)



CONTRACT PURSUANT TO 11001-RFP-CIGNA DENTAL

SERIAL 11001-RFP

This Contract is entered into this 19TH day of October 2011 by and between Maricopa County ("County"), a political subdivision of the State of Arizona, and CIGNA Dental Health Plan of Arizona, Inc., an Arizona corporation ("Contractor") for the purchase of Employee Dental Benefit Services Self Insured.

1.0 CONTRACT TERM:

- 1.1 This Contract is for a term of three (3) years, beginning on the 1st day of July 2012 and ending the 30th day of June, ~~2015~~ **2018**.
- 1.2 The County may, at its option and with the agreement of the Contractor, renew the term of this Contract for additional terms up to a maximum of three (3) years, (or at the County's sole discretion, extend the contract on a month-to-month bases for a maximum of six (6) months after expiration). The County shall notify the Contractor in writing of its intent to extend the Contract term at least thirty (30) calendar days prior to the expiration of the original contract term, or any additional term thereafter.

2.0 FEE ADJUSTMENTS:

Any request for fee adjustments must be submitted one hundred and eighty (180) days prior to the current Contract expiration date. Requests for adjustment in cost of labor and/or materials must be supported by appropriate documentation and not exceed the percentage cap in the Exhibit A. If the parties mutually agree to the adjusted fee, County shall issue written approval of the change.

3.0 PAYMENTS:

- 3.1 As consideration for performance of the duties described herein, County shall pay Contractor the sum(s) stated in Exhibit "A."
- 3.2 Payment shall be made upon the County's receipt of a properly completed invoice.

3.3 INVOICES:

3.3.1 The Contractor shall submit an electronic detailed invoice before payment(s) can be made. At a minimum, the invoice must provide the following information:

- Company name, address and contact
- County bill-to name and contact information
- Contract serial number
- Payment terms
- Date of service or delivery
- Quantity

- Contract Item number(s)
- Description of service provided
- Pricing per unit of service
- Extended price
- Total Amount Due

- 3.3.2 Problems regarding billing or invoicing shall be directed to the County as listed on the Purchase Order.
- 3.3.3 Payment shall be made to the Contractor by Accounts Payable through the Maricopa County Vendor Express Payment Program. This is an Electronic Funds Transfer (EFT) process. After Award the Contractor shall fill out an EFT Enrollment form located on the County Department of Finance Website as a fillable PDF document (www.maricopa.gov/finance/)
- 3.3.4 EFT payments to the routing and account numbers designated by the Contractor will include the details on the specific invoices that the payment covers. The Contractor is required to discuss remittance delivery capabilities with their designated financial institution for access to those details. Or the county will setup a sweep bank account in to be swept by the Contractor on a weekly bases.

4.0 AVAILABILITY OF FUNDS:

- 4.1 The provisions of this Contract relating to payment for services shall become effective when funds assigned for the purpose of compensating the Contractor as herein provided are actually available to County for disbursement. The County shall be the sole judge and authority in determining the availability of funds under this Contract. County shall keep the Contractor fully informed as to the availability of funds.
- 4.2 If any action is taken by any state agency, Federal department or any other agency or instrumentality to suspend, decrease, or terminates its fiscal obligations under, or in connection with, this Contract, County may amend, suspend, decrease, or terminate its obligations under, or in connection with, this Contract. In the event of termination, County shall be liable for payment only for services rendered prior to the effective date of the termination, provided that such services are performed in accordance with the provisions of this Contract. County shall give written notice of the effective date of any suspension, amendment, or termination under this Section, at least ten (10) days in advance.

5.0 DUTIES:

- 5.1 The Contractor shall perform all duties stated in Exhibit “B” Scope of Services, or Exhibit “B-1” ADMINISTRATIVE Service provided or as otherwise mutually agreed in writing by the parties.

6.0 TERMS and CONDITIONS:

6.1 INDEMNIFICATION:

- 6.1.1 To the fullest extent permitted by law, Contractor shall defend, indemnify, and hold harmless County, its agents, representatives, officers, directors, officials, and employees from and against all claims, damages, losses and expenses, including, but not limited to, attorney fees, court costs, expert witness fees, and the cost of appellate proceedings, relating to, arising out of, or alleged to have resulted from the negligent acts, errors, omissions, mistakes or malfeasance relating to the performance of this Contract. Contractor’s duty to defend, indemnify and hold harmless County, its agents, representatives, officers, directors, officials, and employees shall arise in connection with any claim, damage, loss or expense that is caused by any negligent acts, errors, omissions or mistakes in the performance of this Contract by the Contractor, as well as any person or entity for whose acts, errors, omissions, mistakes or malfeasance Contractor may be legally liable.

- 6.1.2 The amount and type of insurance coverage requirements set forth herein will in no way be construed as limiting the scope of the indemnity in this paragraph.
- 6.1.3 The scope of this indemnification does not extend to the gross negligence of County.

6.2 INSURANCE REQUIREMENTS:

- 6.2.1 **Contractor, at Contractor's own expense, shall purchase and maintain the herein stipulated minimum insurance from a company or companies duly licensed by the State of Arizona and possessing a current A.M. Best, Inc. rating of B++. In lieu of State of Arizona licensing, the stipulated insurance may be purchased from a company or companies, which are authorized to do business in the State of Arizona, provided that said insurance companies meet the approval of County. The form of any insurance policies and forms must be acceptable to County.**

Agreed. However, with respect to the County's right to approve Contractor's insurance carriers, due to the inherent nature of this request and potential changes in the insurance marketplace, Contractor is unable to comply with this request. It should be noted that some of Contractor's insurance coverages have been in place for 18+ consecutive years and Contractor reviews its insurance carriers' ratings at least annually and more frequently, if needed.

- 6.2.2 All insurance required herein shall be maintained in full force and effect until all work or service required to be performed under the terms of the Contract is satisfactorily completed and formally accepted. Failure to do so may, at the sole discretion of County, constitute a material breach of this Contract.
- 6.2.3 Contractor's insurance shall be primary insurance as respects County, and any insurance or self-insurance maintained by County shall not contribute to it.
- 6.2.4 Any failure to comply with the claim reporting provisions of the insurance policies or any breach of an insurance policy warranty shall not affect the County's right to coverage afforded under the insurance policies.
- 6.2.5 The insurance policies may provide coverage that contains deductibles or self-insured retentions. Such deductible and/or self-insured retentions shall not be applicable with respect to the coverage provided to County under such policies. Contractor shall be solely responsible for the deductible and/or self-insured retention and County, at its option, may require Contractor to secure payment of such deductibles or self-insured retentions by a surety bond or an irrevocable and unconditional letter of credit.
- 6.2.6 County reserves the right to request and to receive, within 10 working days, certified copies of any or all of the herein required insurance certificates. County shall not be obligated to review policies and/or endorsements or to advise Contractor of any deficiencies in such policies and endorsements, and such receipt shall not relieve Contractor from, or be deemed a waiver of County's right to insist on strict fulfillment of Contractor's obligations under this Contract.
- 6.2.7 The insurance policies required by this Contract, except Workers' Compensation, and Errors and Omissions, shall name County, its agents, representatives, officers, directors, officials and employees as Additional Insureds.

Agreed. However, please note that Contractor is able to grant "Additional Insured" status to its clients and business partners only under the following insurance policies and only if it is required by a written contract:

1. General Liability (Commercial General Liability)
2. Automobile Liability (Commercial Auto Liability or Business Auto Liability)
3. Umbrella / Excess Liability (Excess only to General & Auto Liability)

In accordance with standard and customary insurance industry practices coupled with the insurance marketplace, Contractor is unable to grant additional insured status on any other insurance policies.

- 6.2.8 The policies required hereunder, except Workers' Compensation, and Errors and Omissions, shall contain a waiver of transfer of rights of recovery (subrogation) against County, its agents, representatives, officers, directors, officials and employees for any claims arising out of Contractor's work or service.

- 6.2.9 Commercial General Liability.

Commercial General Liability insurance and, if necessary, Commercial Umbrella insurance with a limit of not less than \$2,000,000 for each occurrence, \$2,000,000 Products/Completed Operations Aggregate, and \$4,000,000 General Aggregate Limit. The policy shall include coverage for bodily injury, broad form property damage, personal injury, products and completed operations and blanket contractual coverage, and shall not contain any provision which would serve to limit third party action over claims. There shall be no endorsement or modification of the CGL limiting the scope of coverage for liability arising from explosion, collapse, or underground property damage.

- 6.2.10 Automobile Liability.

Commercial/Business Automobile Liability insurance and, if necessary, Commercial Umbrella insurance with a combined single limit for bodily injury and property damage of not less than \$2,000,000 each occurrence with respect to any of the Contractor's owned, hired, and non-owned vehicles assigned to or used in performance of the Contractor's work or services under this Contract.

- 6.2.11 Workers' Compensation.

6.2.11.1 **Workers' Compensation insurance to cover obligations imposed by federal and state statutes having jurisdiction of Contractor's employees engaged in the performance of the work or services under this Contract; and Employer's Liability insurance of not less than \$1,000,000 for each accident, \$1,000,000 disease for each employee, and \$1,000,000 disease policy limit.**

6.2.11.2 Contractor waives all rights against County and its agents, officers, directors and employees for recovery of damages to the extent these damages are covered by the Workers' Compensation and Employer's Liability or commercial umbrella liability insurance obtained by Contractor pursuant to this Contract.

- 6.2.12 **Errors and Omissions Insurance:**

Errors and Omissions insurance and, if necessary, Commercial Umbrella insurance, which will insure and provide coverage for errors or omissions of the Contractor, with limits of no less than \$1,000,000 for each claim.

- 6.2.13 Certificates of Insurance.

6.2.11.3 Prior to commencing work or services under this Contract, Contractor shall furnish the County with certificates of insurance, or formal endorsements as required by the Contract in the form provided by the County, issued by Contractor's insurer(s), as evidence that policies providing the required coverage, conditions and limits required by this Contract are in full force and effect. Such certificates shall identify this contract number and title.

6.2.11.4 **Prior to commencing work or services under this Contract, Contractor shall have insurance in effect as required by the Contract in the form provided by the County, issued by Contractor's insurer(s), as evidence that policies providing the required coverage, conditions and limits required by this Contract are in full force and effect. Such certificates shall be made available to the County upon ten (10) business days. BY SIGNING THE AGREEMENT PAGE THE CONTRACTOR AGREES TO THIS REQUIREMENT AND FAILURE TO MEET THIS REQUIREMENT WILL RESULT IN CANCELLATION OF CONTRACT. "Subject to a ninety (90) day period to cure any deficiencies after notification to contractor's risk management department"**

6.2.13.2.1 In the event any insurance policy (ies) required by this Contract is (are) written on a "claims made" basis, coverage shall extend for two (2) years past completion and acceptance of Contractor's work or services and as evidenced by annual Certificates of Insurance.

6.2.13.2.2 If a policy does expire during the life of the Contract, a renewal certificate must be sent to County fifteen (15) days prior to the expiration date.

~~6.2.14 Cancellation and Expiration Notice.~~

~~Insurance required herein shall not be permitted to expire, be canceled, or materially changed without notice to the County within thirty (30) days.~~

6.3 WARRANTY OF SERVICES:

6.3.1 The Contractor warrants that all services provided hereunder will conform to the requirements of the Contract, including all descriptions, specifications and attachments made a part of this Contract. County's acceptance of services or goods provided by the Contractor shall not relieve the Contractor from its obligations under this warranty.

6.3.2 In addition to its other remedies, County may, at the Contractor's expense, require prompt correction of any services failing to meet the Contractor's warranty herein. Services corrected by the Contractor shall be subject to all the provisions of this Contract in the manner and to the same extent as services originally furnished hereunder.

6.4 INSPECTION OF SERVICES:

6.4.1 The Contractor shall provide and maintain an inspection system acceptable to County covering the services under this Contract. Complete records of all inspection work performed by the Contractor shall be maintained and made available to County during contract performance and for as long afterwards as the Contract requires.

6.4.2 County has the right to inspect and test all services called for by the Contract, to the extent practicable at all times and places during the term of the Contract. County shall perform inspections and tests in a manner that will not unduly delay the work.

6.4.3 If any of the services do not conform with Contract requirements, County may require the Contractor to perform the services again in conformity with Contract requirements, at an increase in Contract amount. When the defects in services cannot be corrected by re-performance, County may:

6.4.3.1 Require the Contractor to take necessary action to ensure that future performance conforms to Contract requirements; and

6.4.3.2 Reduce the Contract price to reflect the reduced value of the services performed.

6.4.4 If the Contractor fails to promptly perform the services again or to take the necessary action to ensure future performance in conformity with Contract requirements, County may:

6.4.4.1 By Contract or otherwise, perform the services and charge to the Contractor any cost incurred by County that is directly related to the performance of such service; or

6.4.4.2 Terminate the Contract for default.

6.5 NOTICES:

All notices given pursuant to the terms of this Contract shall be addressed to:

For County:

Maricopa County
Office of Procurement Services
Attn: Director of Purchasing
320 West Lincoln Street
Phoenix, Arizona 85003-2494

For Contractor:
CIGNA Dental Health Plan of Arizona
Attn: Stephanie Gorman
900 Cottage Grove Road
Hartford CT. 06152

6.6 REQUIREMENTS CONTRACT:

Contractor signifies its understanding and agreement by signing this document that this Contract is a requirements contract. This Contract does not guarantee any purchases will be made (minimum or maximum). Orders will only be placed when County identifies a need and issues a purchase order or a written notice to proceed.

6.7 TERMINATION FOR CONVENIENCE:

The County reserves the right to terminate the Contract, in whole or in part at any time, when in the best interests of the County without penalty or recourse. Upon receipt of the written notice, the Contractor shall immediately stop all work, as directed in the notice, notify all subcontractors of the effective date of the termination and minimize all further costs to the County. In the event of termination under this paragraph, all documents, data and reports prepared by the Contractor under the Contract shall become the property of and be delivered to the County upon demand. The Contractor shall be entitled to receive just and equitable compensation for work in progress, work completed and materials accepted before the effective date of the termination.

6.8 TERMINATION FOR DEFAULT:

6.8.1 In addition to the rights reserved in the Contract, the County may terminate the Contract in whole or in part due to the failure of the Contractor to comply with any term or condition of the Contract, to acquire and maintain all required insurance policies, bonds, licenses and permits, or to make satisfactory progress in performing the Contract. The Procurement Officer shall provide written notice of the termination and the reasons for it to the Contractor.

6.8.2 Upon termination under this paragraph, all goods, materials, documents, data and reports prepared by the Contractor under the Contract shall become the property of and be delivered to the County on demand.

6.8.3 The County may, upon termination of this Contract, procure, on terms and in the manner that it deems appropriate, materials or services to replace those under this Contract. The Contractor shall be liable to the County for any excess costs incurred by the County in procuring materials or services in substitution for those due from the Contractor.

6.8.4 The Contractor shall continue to perform, in accordance with the requirements of the Contract, up to the date of termination, as directed in the termination notice.

6.9 STATUTORY RIGHT OF CANCELLATION FOR CONFLICT OF INTEREST:

Notice is given that pursuant to A.R.S. §38-511 the County may cancel this Contract without penalty or further obligation within three years after execution of the contract, if any person significantly involved in initiating, negotiating, securing, drafting or creating the contract on behalf of the County is at any time while the Contract or any extension of the Contract is in effect, an employee or agent of any other party to the Contract in any capacity or consultant to any other party of the Contract with respect to the subject matter of the Contract. Additionally, pursuant to A.R.S §38-511 the County may recoup any fee or commission paid or due to any person significantly involved in initiating, negotiating, securing, drafting or creating the contract on behalf of the County from any other party to the contract arising as the result of the Contract.

6.10 OFFSET FOR DAMAGES;

In addition to all other remedies at law or equity, the County may offset from any money due to the Contractor any amounts Contractor owes to the County for damages resulting from breach or deficiencies in performance under this contract.

6.11 ADDITIONS/DELETIONS OF SERVICE:

The County reserves the right to add and/or delete products and/or services provided under this Contract. If a requirement is deleted, payment to the Contractor will be reduced proportionately to the amount of service reduced in accordance with the proposal price. If additional services and/or products are required from this Contract, prices for such additions will be negotiated between the Contractor and the County.

6.12 RELATIONSHIPS:

In the performance of the services described herein, the Contractor shall act solely as an independent contractor, and nothing herein or implied herein shall at any time be construed as to create the relationship of employer and employee, partnership, principal and agent, or joint venture between the District and the Contractor.

6.13 SUBCONTRACTING:

The Contractor may not assign this Contract or subcontract to another party for performance of the terms and conditions hereof without the written consent of the County. All correspondence authorizing subcontracting must reference the Proposal Serial Number and identify the job project.

6.14 AMENDMENTS:

All amendments to this Contract shall be in writing and approved/signed by both parties. Maricopa County **Office of Procurement Services** shall be responsible for approving all amendments for Maricopa County.

6.15 ACCESS TO AND RETENTION OF RECORDS FOR THE PURPOSE OF AUDIT AND/OR OTHER REVIEW:

6.15.1 In accordance with section MCI 367 of the Maricopa County Procurement Code the Contractor agrees to retain all books, records, accounts, statements, reports, files, and other records and back-up documentation relevant to this Contract for six (6) years after

final payment or until after the resolution of any audit questions which could be more than six (6) years, whichever is latest. The County, Federal or State auditors and any other persons duly authorized by the Department shall have full access to, and the right to examine, copy and make use of, any and all said materials.

- 6.15.2 If the Contractor's books, records, accounts, statements, reports, files, and other records and back-up documentation relevant to this Contract are not sufficient to support and document that requested services were provided, the Contractor shall reimburse Maricopa County for the services not so adequately supported and documented.
- 6.15.3 **If at any time it is determined by the County that a cost for which payment has been made is a disallowed cost, the County shall notify the Contractor in writing of the disallowance. The course of action to address the disallowance shall be at sole discretion of the County, and may include either an adjustment to future claim submitted by the Contractor by the amount of the disallowance, or to require reimbursement forthwith of the disallowed amount by the Contractor by issuing a check payable to Maricopa County.**

6.16 AUDIT DISALLOWANCES:

If at any time, County determines that a cost for which payment has been made is a disallowed cost, such as overpayment, County shall notify the Contractor in writing of the disallowance. County shall also state the means of correction, which may be but shall not be limited to adjustment of any future claim submitted by the Contractor by the amount of the disallowance, or to require repayment of the disallowed amount by the Contractor.

- 6.16.1 The County reserves the right to audit the contractor's claims processing, payments and participant records, with reasonable notice.

The contractor, by submitting a proposal in response to these specifications, acknowledges the County's right to select the auditors, and further agrees to cooperate fully with such auditors and waive any and all fees associated with providing access to the County's claim records including use of the contractor's staff time to assist in the audit. The audits may include, but not be limited to:

- a. Determinations of any mathematical errors in computation.
- b. Determinations that only eligible insured's have had claims honored.
- c. Review of dental charges per service.
- d. Review of turnaround time in claim processing.
- e. Review of in-network and out-of-network claims payments.
- f. Review of claim denials and responses to claim appeals.

The audits may be conducted during the policy period and/or upon completion of the policy period and/or following submission of the final policy report by the contractor at the discretion of the County.

Additionally, the contractor may be requested to provide periodic eligibility lists or tapes to the County at no charge in order to reconcile participants' eligibility.

If, at any time, the County has a reasonable belief that it is being systematically overcharged or double-billed under the contract, or that any other significant accounting irregularities exist, the County may conduct or hire an agent to conduct an audit of the Contractor's books and records with respect to this Contract. Such audit shall be undertaken at contractor's expense.

- 6.16.2 Claim audits are permitted in accordance with the following terms:

Upon 45 days advance written request, and subject to confidentiality and proprietary concerns, documents relating to claims administration services provided pursuant to the contract (not a quality, financial or clinical audit) shall be made available to the County

for its audit or inspection during regular business hours, at a mutually agreeable date and time and at the place or places of business where it is maintained by CIGNA (the "Audit"). CIGNA shall also reasonably cooperate with audits other than the "Audit" subject to mutually agreed charges. With respect to the audit and any other audits, the scope may include types of claims prone to overpayments provided the types of claims prone to underpayments are equally included and will exclude electronic analysis. With respect to the Audit and any other audit, any claim adjustments will be based upon the actual claims reviewed and not upon statistical projections or extrapolations. All audits shall be conducted pursuant to an audit agreement in a form acceptable to CIGNA and executed by all parties. CIGNA shall be allowed to agree on an independent, third party auditor to conduct the audit. In addition, if the County has 5,000 or more employee Members, the County may conduct one such audit every Plan Year (but not within 6 months of a prior audit); otherwise, the County may conduct one such audit every two plan years (but not within 18 months of a prior audit). No audit shall review claims paid more than two years before the date of the audit. The County will remain responsible for all costs associated with an audit. The County may review payment documents relating to a random, statistically valid sample of 225 claims paid.

6.17 ALTERNATIVE DISPUTE RESOLUTION:

6.17.1 After the exhaustion of the administrative remedies provided in the Maricopa County Procurement Code, any contract dispute in this matter is subject to compulsory arbitration. Provided the parties participate in the arbitration in good faith, such arbitration is not binding and the parties are entitled to pursue the matter in state or federal court sitting in Maricopa County for a de novo determination on the law and facts. If the parties cannot agree on an arbitrator, each party will designate an arbitrator and those two arbitrators will agree on a third arbitrator. The three arbitrators will then serve as a panel to consider the arbitration. The parties will be equally responsible for the compensation for the arbitrator(s). The hearing, evidence, and procedure will be in accordance with Rule 74 of the Arizona Rules of Civil Procedure. Within ten (10) days of the completion of the hearing the arbitrator(s) shall:

6.17.1.1 Render a decision;

6.17.1.2 Notify the parties that the exhibits are available for retrieval; and

6.17.1.3 Notify the parties of the decision in writing (a letter to the parties or their counsel shall suffice).

6.17.2 Within ten (10) days of the notice of decision, either party may submit to the arbitrator(s) a proposed form of award or other final disposition, including any form of award for attorneys' fees and costs. Within five (5) days of receipt of the foregoing, the opposing party may file objections. Within ten (10) days of receipt of any objections, the arbitrator(s) shall pass upon the objections and prepare a signed award or other final disposition and mail copies to all parties or their counsel.

6.17.3 Any party which has appeared and participated in good faith in the arbitration proceedings may appeal from the award or other final disposition by filing an action in the state or federal court sitting in Maricopa County within twenty (20) days after date of the award or other final disposition. Unless such action is dismissed for failure to prosecute, such action will make the award or other final disposition of the arbitrator(s) a nullity.

6.18 SEVERABILITY:

The invalidity, in whole or in part, of any provision of this Contract shall not void or affect the validity of any other provision of this Contract.

6.19 VALIDITY:

The invalidity, in whole or in part, of any provision of the Contract shall not void or affect the validity of any other provision of the Contract

6.20 RIGHTS IN DATA:

The County shall own have the use of all data and reports resulting from this Contract without additional cost or other restriction except as provided by law. Each party shall supply to the other party, upon request, any available information that is relevant to this Contract and to the performance hereunder.

6.21 INTEGRATION:

This Contract represents the entire and integrated agreement between the parties and supersedes all prior negotiations, proposals, communications, understandings, representations, or agreements, whether oral or written, express or implied.

6.22 VERIFICATION REGARDING COMPLIANCE WITH ARIZONA REVISED STATUTES §41-4401 AND FEDERAL IMMIGRATION LAWS AND REGULATIONS:

6.22.1 By entering into the Contract, the Contractor warrants compliance with the Immigration and Nationality Act (INA using e-verify) and all other federal immigration laws and regulations related to the immigration status of its employees and A.R.S. §23-214(A). The contractor shall obtain statements from its subcontractors certifying compliance and shall furnish the statements to the Procurement Officer upon request. These warranties shall remain in effect through the term of the Contract. The Contractor and its subcontractors shall also maintain Employment Eligibility Verification forms (I-9) as required by the Immigration Reform and Control Act of 1986, as amended from time to time, for all employees performing work under the Contract and verify employee compliance using the E-verify system and shall keep a record of the verification for the duration of the employee's employment or at least three years, whichever is longer. I-9 forms are available for download at USCIS.GOV.

6.22.2 The County retains the legal right to inspect contractor and subcontractor employee documents performing work under this Contract to verify compliance with paragraph 6.21.1 of this Section. Contractor and subcontractor shall be given reasonable notice of the County's intent to inspect and shall make the documents available at the time and date specified. Should the County suspect or find that the Contractor or any of its subcontractors are not in compliance, the County will consider this a material breach of the contract and may pursue any and all remedies allowed by law, including, but not limited to: suspension of work, termination of the Contract for default, and suspension and/or department of the Contractor. All costs necessary to verify compliance are the responsibility of the Contractor.

~~6.23 VERIFICATION REGARDING COMPLIANCE WITH ARIZONA REVISED STATUTES §§35-391.06 AND 35-393.06 BUSINESS RELATIONS WITH SUDAN AND IRAN:~~

~~6.23.1 By entering into the Contract, the Contractor certifies it does not have scrutinized business operations in Sudan or Iran. The contractor shall obtain statements from its subcontractors certifying compliance and shall furnish the statements to the Procurement Officer upon request. These warranties shall remain in effect through the term of the Contract.~~

~~6.23.2 The County may request verification of compliance for any contractor or subcontractor performing work under the Contract. Should the County suspect or find that the Contractor or any of its subcontractors are not in compliance, the County may pursue any and all remedies allowed by law, including, but not limited to: suspension of work, termination of the Contract for default, and suspension and/or debarment of the Contractor. All costs necessary to verify compliance are the responsibility of the Contractor.~~

6.24 CONTRACTOR LICENSE REQUIREMENT:

6.24.1 The Respondent shall procure all permits, insurance, licenses and pay the charges and fees necessary and incidental to the lawful conduct of his/her business, and as necessary complete any required certification requirements, required by any and all governmental or non-governmental entities as mandated to maintain compliance with and in good standing for all permits and/or licenses. The Respondent shall keep fully informed of existing and future trade or industry requirements, Federal, State and Local laws, ordinances, and regulations which in any manner affect the fulfillment of a Contract and shall comply with the same. Contractor shall immediately notify both Office of Procurement Services and the using agency of any and all changes concerning permits, insurance or licenses.

6.25 CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

6.25.1 The undersigned (authorized official signing for the Contractor) certifies to the best of his or her knowledge and belief, that the Contractor, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

6.23.1.1 are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

6.23.1.2 have not within 3-year period preceding this Contract been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

6.23.1.3 are not presently indicted or otherwise criminally or civilly charged by a government entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (2) of this certification; and

6.23.1.4 have not within a 3-year period preceding this Contract had one or more public transaction (Federal, State or local) terminated for cause of default.

6.25.2 Should the Contractor not be able to provide this certification, an explanation as to why should be attached to the Contact.

6.25.3 The Contractor agrees to include, without modification, this clause in all lower tier covered transactions (i.e. transactions with subcontractors) and in all solicitations for lower tier covered transactions related to this Contract.

6.26 PRICES:

Contractor warrants that prices extended to County under this Contract are no higher than those paid by any other customer for these or similar services.

6.27 GOVERNING LAW:

This Contract shall be governed by the laws of the state of Arizona. Venue for any actions or lawsuits involving this Contract will be in Maricopa County Superior Court or in the United States District Court for the District of Arizona, sitting in Phoenix, Arizona

6.28 ORDER OF PRECEDENCE:

To the extent possible, the terms and conditions of this Agreement will be construed consistently. In the event of a conflict between the provisions of this Contract (including Exhibit B-3), and Exhibits B (Scope of ASO Services), B-1 (Administrative Services Provided), B-2 (Business Associate Agreement), and C (Sample Claims Audit Form), then the terms of this Contract shall prevail.

6.29 STRATEGIC ALLIANCE for VOLUME EXPENDITURES (\$AVE)

The County is a member of the \$AVE cooperative purchasing group. \$AVE includes the State of Arizona, many Phoenix metropolitan area municipalities, and many K-12 unified school districts. Under the \$AVE Cooperative Purchasing Agreement, and with the concurrence of the successful Respondent under this solicitation, a member of \$AVE may access a contract resulting from a solicitation issued by the County. If you do not want to grant such access to a member of \$AVE, please so state in your proposal. In the absence of a statement to the contrary, the County will assume that you do wish to grant access to any contract that may result from this Request for Proposal.

6.30 INTERGOVERNMENTAL COOPERATIVE PURCHASING AGREEMENTS (ICPA's)

County currently holds ICPA's with numerous governmental entities throughout the State of Arizona. These agreements allow those entities, with the approval of the Contractor, to purchase their requirements under the terms and conditions of the County Contract. Please indicate on Attachment A, your acceptance or rejection regarding such participation of other governmental entities. Your response will not be considered as an evaluation factor in awarding a contract.

6.31 PUBLIC RECORDS:

All Offers submitted and opened are public records and must be retained by the Records Manager at the Office of Procurement Services. Offers shall be open to public inspection after Contract award and execution, except for such Offers deemed to be confidential by the Office of Procurement Services. If an Offeror believes that information in its Offer should remain confidential, it shall indicate as confidential, the specific information and submit a statement with its offer detailing the reasons that the information should not be disclosed. Such reasons shall include the specific harm or prejudice which may arise. The Records Manager of the Office of Procurement Services shall determine whether the identified information is confidential pursuant to the Maricopa County Procurement Code.

6.32 INFLUENCE

As prescribed in MC1-1202 of the Maricopa County Procurement Code, any effort to influence an employee or agent to breach the Maricopa County Ethical Code of Conduct or any ethical conduct, may be grounds for Disbarment or Suspension under MC1-902.

An attempt to influence includes, but is not limited to:

- 6.32.1 A Person offering or providing a gratuity, gift, tip, present, donation, money, entertainment or educational passes or tickets, or any type valuable contribution or subsidy,
- 6.32.2 That is offered or given with the intent to influence a decision, obtain a contract, garner favorable treatment, or gain favorable consideration of any kind.

If a Person attempts to influence any employee or agent of Maricopa County, the Chief Procurement Officer, or his designee, reserves the right to seek any remedy provided by the Maricopa County Procurement Code, any remedy in equity or in the law, or any remedy provided by this contract.

6.33 INCORPORATION OF DOCUMENTS:

The following are to be attached to and made part of this Contract:

- 6.33.1 Exhibit A, Pricing;
- 6.33.2 Exhibit B, Scope of Services (ASO);
- 6.33.3 Exhibit B-1, Administrative Services Provided;
- 6.33.4 Exhibit B-2, Business Associate Agreement;
- 6.33.5 Exhibit B-3 Contractor Questionnaire Response;
- 6.33.6 Exhibit C Sample Claims Audit From;

IN WITNESS WHEREOF, this Contract is executed on the date set forth above.

CONTRACTOR

Stephanie C. Gorman
AUTHORIZED SIGNATURE

Stephanie C. Gorman, President and General Manager
PRINTED NAME AND TITLE

11001 N. Black Canyon Highway; Phoenix, AZ 85029
ADDRESS

10/17/11
DATE

MARICOPA COUNTY *[Signature]*

OCT 19 2011

CHAIRMAN, BOARD OF SUPERVISORS

DATE

ATTESTED:

[Signature]
CLERK OF THE BOARD

OCT 19 2011

DATE

APPROVED AS TO FORM:

[Signature]
LEGAL COUNSEL

Oct 20 2011
DATE

**EXHIBIT A
PRICING**

SERIAL 11001-RFP
PRICING SHEET 95348

BIDDER NAME:	CIGNA HealthCare	
F.I.D./VENDOR #:	W000003051	
BIDDER ADDRESS:	11001 N. Black Canyon Hwy., 3rd Floor, Phoenix, AZ 85029	
P.O. ADDRESS:		
BIDDER PHONE #:	602.861.8118	
BIDDER FAX #:	602.861.8187	
COMPANY WEB SITE:	www.cigna.com	
COMPANY CONTACT (REP):	Ray Brandenburg	Margot Ozyp Erica Emmons
E-MAIL ADDRESS (REP):	ray.brandenburg@cigna.com	Margot.Ozyp@Cigna.com erica.emmons@cigna.com

NET 30 X

1.0 PRICING:

**1.1 Dental Claim Administration:
Rate per month per employee:**

Rate Guarantee			Maximum Rate Increase (not to exceed rate)		
Year 7/1/2012 - 6/30/2013	Year 2 (7/1/2013 - 6/30/2014)	Year 3 (7/1/2014 - 6/30/2015)	Year 4 (7/1/2015 - 6/30/2016)	Year 5 (7/1/2016 - 6/30/2017)	Year 6 (7/1/2017 - 6/30/2018)

PRICING

1.1.1 ASO Fee (SELF INSURED)

4999 employees or less	\$ 2.23	\$ 2.23	\$ 2.23	3.00%	3.00%	3.00%
				2.42%	2.42%	2.42%
				3.00%	3.00%	3.00%
5000-6999 employees	\$ 2.14	\$ 2.14	\$ 2.14	3.00%	3.00%	3.00%
				2.33%	2.33%	2.33%
				3.00%	3.00%	3.00%
7000-8999 employees	\$ 2.05	\$ 2.05	\$ 2.05	3.00%	3.00%	3.00%
				2.24%	2.24%	2.24%
				3.00%	3.00%	3.00%
9000-1099 employees	\$ 1.96	\$ 1.96	\$ 1.96	3.00%	3.00%	3.00%
				2.14%	2.14%	2.14%
				3.00%	3.00%	3.00%
11000+ employees	\$ 1.87	\$ 1.87	\$ 1.87	3.00%	3.00%	3.00%
				2.05%	2.05%	2.05%
1.1.2 Network Access Fee	\$ 0.12	\$ 0.12	\$ 0.12	3.00%	3.00%	3.00%

What, if any, set-up fees are there in addition to the monthly ASO fees:

1.1.2.1 Guaranteed minimum network discounts from 10.32 and 10.33 ___34.3% General _____34.3% Specialist

Maximum Rate Increase will be calculated against prior year rate in effect.

1.1.4 Charge for drafting benefit document/booklet (If any)	0	0	0	0.00%	0.00%	0.00%
1.1.5 Charge for printing benefit document/booklet (assume initial order of 15,000 copies) if any	\$0.12	\$0.12	\$ 0.12	50.0%	50.0%	50.0%
				0.12%	0.12%	0.12%

EXHIBIT B
SCOPE OF SERVICES

1.0 Claim Administration

- 1.1 While this Contract (11001-RFP) is in effect, Connecticut General shall, consistent with the current claim administration procedures and practices currently applicable to its own health care plan administration business perform the following:
- 1.1.1 receive claims for Plan benefits and requests for Plan services, and expeditiously review such claims and requests to determine what amount, if any, is due, payable and/or allowable with respect thereto in accordance with the terms and conditions of the Plan;
 - 1.1.2 disburse or provide, to the person entitled thereto, benefit payments or authorization for services that it determines to be due in accordance with the provisions of the Plan; and
 - 1.1.3 provide to the claimant within the time limits then required by applicable law following receipt of a claim, written notification (a) as to the disposition of the claim, or (b) of an anticipated delay beyond such time limits in the disposition of the claim together with an explanation of the delay.
 - 1.1.4 Although ERISA is inapplicable to this governmental plan, ERISA will serve as guidance in construing the following requirement. Employer reserves the right to review and decide all final appeals with respect to each Pre-Service Claim, Post-Service Claim, and Concurrent Care Claim as those terms are defined under ERISA and shall notify the claimant of its decision on review. Employer acknowledges that this reservation of authority is reflected in its Plan Document. Connecticut General will decide all final appeals of Urgent Care Claims as that term is defined under ERISA.

2.0 Funding and Payment of Claims

- 2.1 Employer shall establish in its or its nominee's name, a benefit plan account ("Account") with a bank designated by Connecticut General, and shall maintain in the Account an amount which will be sufficient at all times to fund the checks written on it for payment of Plan benefits and such Plan-related expenses as set forth in Exhibit A. Charges to the Account may include capitation payments, which are contractually determined periodic payments to certain network providers based on the number of Plan participants entitled to receive services from that provider ("Capitation Payments"), in return for which such network providers furnish certain agreed-upon services to eligible participants. Charges may also include: (i) network access fees, as set forth in Exhibit A, which are paid to Connecticut General's healthplan affiliates for the establishment and maintenance of provider networks as set forth in Exhibit A (ii) expenses described in Section 6.3.3 and 6.3.4; and (iii) monies owed to Connecticut General by the Employer as a result of Connecticut General paying to Employer amounts not due by Connecticut General to Employer. In addition, there may also be payments to Connecticut General Affiliates or subcontractors for the provision of certain in- and out-of-network services. These charges and the services for which they pertain are itemized in Exhibits A and B-1.
- 2.2 Connecticut General, as agent for the Employer, shall issue checks from the Account for Plan benefits and Plan-related expenses in the amount Connecticut General determines to be proper under the Plan and/or under this Contract.
- In the event that sufficient funds are not available in the Account to pay all Plan benefits and Plan-related expenses when due, then Connecticut General shall cease to process claims (including runout claims, if applicable) under this Contract.
- 2.3 In the event Connecticut General pays any person less than the amount to which he is entitled under the Plan, Connecticut General will promptly adjust the underpayment by drawing the additional funds from the Employer's Account. In the event Connecticut General overpays any person entitled to benefits under the Plan, or pays benefits to any person not entitled to them, Connecticut General shall take all reasonable steps to recover the overpayment; however, Connecticut General shall not be required to initiate court, mediation, arbitration or other administrative proceedings to recover an overpayment. Connecticut General shall only be liable for overpayments to the extent set forth in Section 6.5. If the overpayment is a result of claims

incurred or charged through the date Connecticut General processes Employer's notice of a retroactive change or termination, or Employer's failure to provide timely and accurate eligibility information to Connecticut General, Employer shall be charged overpayment recovery fees as specified in Exhibit A.

- 2.4 Connecticut General shall indemnify and save the Employer harmless from any loss caused by criminal or intentionally wrongful acts by any employee of Connecticut General arising out of its use of the Account and the corollary check stock under its control. This indemnity shall survive the termination of this Contract. The Employer shall give Connecticut General prompt and timely notice of any fact or condition which comes to its attention which may give rise to a claim of indemnity under this paragraph.
- 2.5 Following termination of this Contract, the Employer shall remain liable for payment of all Plan benefits or fees due any provider or entity for services rendered prior to termination and for all reimbursements due any Plan Participant under the Plan. Employer shall reimburse Connecticut General to the extent Connecticut General makes any such payment. In no event shall any payment of Plan benefits or fees by Connecticut General be construed to oblige Connecticut General to assume any liability of the Employer for the payment of such benefits or fees. This provision shall survive the termination of this Contract.

3.0 Charges

- 3.1 Charges. Employer shall pay Connecticut General charges for services performed under this Contract in the amounts and according to the schedules listed in Exhibits A and B-1, or any other applicable exhibits, and any sales and use taxes, or any similar benefit- or plan-related charge, surcharge or assessment, however denominated, which may be imposed by any governmental authority (collectively referred to hereafter as "Charges".)
- 3.2 Monthly Statement. A monthly statement showing (i) charges determined in accordance with the schedule set forth in Exhibit A and B-1 except to the extent that such charges are processed through the Account, plus (ii) the fees for optional services, if any, identified in Exhibit B, plus (iii) the charges set forth in any other applicable Exhibit hereto, plus (iv) any sales or use taxes, or any similar benefit- or plan-related charge, surcharge or assessment, however denominated, which may be imposed by any governmental authority, shall be produced by Connecticut General. The Charges shall be computed by reference to the actual number of employees covered for such month (see Sections 3.5 and 3.6, below/)
- 3.3 Due Date: The charges shall be due in full on or before the last day of the month following the month of service.
- 3.4 Employee Charges – Additions and Terminations.
 - 3.4.1 Additions. If an employee becomes covered on or before the fifteenth (15th) day of the month, full Charges shall be due for that employee for that month. If coverage begins on any other day of the month, no Charges shall be due for that employee for that month.
 - 3.4.2 Terminations. If coverage ceases on or before the fifteenth (15th) day of the month for an employee, no Charges shall be due for that employee for that month. If coverage ceases on any other day of the month for an employee, full Charges are due for that employee for that month.
- 3.5 Retroactive Changes and Terminations. Employer shall remain responsible for all Charges and claims incurred or charged through the date Connecticut General processes Employer's notice of a retroactive change or termination. However, if the change or termination would work a reduction in fees, Connecticut General shall credit to Employer the reduction in network access fees, medical management fees and claim administration fees charged for the shorter of (a) the sixty (60) day period preceding the date Connecticut General processes the notice, or (b) the period from the date of the change or termination to the date Connecticut General processes the notice.
- 3.6 For purposes of this Contract:
 - 3.6.1 a "Claim Check Issued," if applicable, means any payment by Connecticut General to or on behalf of an individual under the Plan; and

3.6.2 "Service Line Processed", if applicable, means the line item created by Connecticut General's claim systems upon review of service/treatment codes submitted in accordance with the plan.

4.0 Enrollment and Determination of Eligibility

4.1 Employer shall:

- 4.1.1 respond to all routine inquiries from employees concerning enrollment in the Plan and its terms, conditions, and operations;
- 4.1.2 handle all enrollment activity including the transmission to employees and back to Connecticut General of employee documents necessary for HSA enrollment and account establishment; and
- 4.1.3 Notify Plan participants of their right to apply for benefits and supply them with claim forms (to be provided by Connecticut General) and claim filing instructions.

4.2 Eligibility Determinations and Eligibility Data. In determining any person's right to benefits under the Plan, Connecticut General shall rely upon eligibility information furnished by the Employer. It is mutually understood that the effective performance of this Contract by Connecticut General will require that it be advised on a timely basis by the Employer during the continuance of this Contract of the identity of individuals eligible for benefits under the Plan. Such information shall identify the effective date of eligibility and the termination date of eligibility and shall be provided promptly to Connecticut General in a form and with such other information as reasonably may be required by Connecticut General for the proper administration of the Plan. Employer represents and warrants that its eligibility determinations shall be in accordance with the terms of the Plan.

4.3 Release of Liability. Employer acknowledges that its prompt furnishing of complete and accurate eligibility and benefit information is essential to the timely and efficient administration by Connecticut General of claims for the Plan. If Employer, or any party designated by Employer, fails to provide Connecticut General with accurate eligibility information, benefit design requirements, or other agreed-upon data, including but not limited to electronic data, tapes, or software, in an accessible and readable format, and in the time frame and format prescribed by Connecticut General ("Required Data"), Connecticut General shall have no liability whatsoever under this Contract (specifically including but not limited to Section 6.5. herein) for any act or omission by Connecticut General, or its employees, affiliates, subcontractors, agents, or representatives, which is directly or indirectly caused by such failure.

Employer acknowledges further that its prompt furnishing of complete and accurate High Deductible Health Plan (HDHP) eligibility and benefit information, including prompt depositing of contributions, is essential to the timely and efficient administration of its employees' health savings accounts and impacts bank ability to respond to employee account withdrawals or payments.

4.4 Reconciliation of Eligibility Data. Connecticut General will periodically share potential discrepancies in eligibility data with Employer. Employer agrees to review such data and reconcile any discrepancies within thirty (30) days of receipt.

4.5 Default Terminations. If Employer does not reconcile within the timeframe specified in subparagraph 4.4 above, a participant who is listed as eligible in Connecticut General's eligibility data, but who is not listed as eligible in Employer's submitted eligibility data, Connecticut General will terminate coverage for said participant. It is understood and acknowledged that in the case of employees enrolled in an HSA, employee coverage terminations, including default terminations, could result in health savings account tax consequences for the employee and/or in interrupting the employee's eligibility to make health savings account contributions.

5.0 Plan Claim Audits, Record Retention and Review

5.1 The Employer has the right to perform a claim audit of Plan benefits administered by Connecticut General pursuant to the following terms. Upon forty-five (45) days' advance written request, all documents relating to the payment of claims shall be made available to the Employer for its audit or inspection during regular business hours at the place or places of business where it is maintained by Connecticut General. Any audit shall be conducted pursuant to the Claim Audit Contract attached as Exhibit C, limited to reviewing claims at most two years prior to the date of

the claim audit, and may be subject to a pre-determined charge. The Employer and Connecticut General must mutually agree upon any third-party auditor that the Employer retains to perform and audit. Employer shall be responsible for its Auditor's costs.

Audits may be permitted as follows:

Less than 5000 enrolled employees: One (1) audit every two (2) Plan years.

5000 or more enrolled employees: One (1) audit each Plan year.

Each audit permitted pursuant to this Section 5.1 shall be limited to a review of not more than 225 claims paid during the time frames identified above. Moreover, any additional audits or requests to review more than 225 claims during an audit will be subject to a charge mutually agreed upon by and between Employer and Connecticut General.

Any release of confidential records or information to the Employer or its designee shall be made subject to the Privacy Provisions attached hereto as Exhibit B-2.

Employer agrees that it shall ensure that any designee or other third party who will have access to such confidential records or information executes such documentation required by Connecticut General to effectuate the purpose of this section. No information shall be furnished in the absence of such documentation.

Upon termination of this Contract, claim information shall be furnished to Employer to the extent administratively feasible and to the extent that the parties negotiate a mutually agreeable charge.

If erroneous claim payments are identified in an audit, no adjustments or refunds shall be made based upon statistical projections or extrapolations of actual errors.

- 5.2 Employer shall have no interest in, nor shall Connecticut General have any obligation to provide to Employer, any claim or payment data recorded for or otherwise integrated into Connecticut General's data processing systems during the ordinary course of business (provided, however, that claim or payment data will be available to Employer pursuant to Section 5.1), any information which Connecticut General reasonably deems to be proprietary in nature or any information which Connecticut General reasonably believes it cannot divulge due to applicable state and/or federal privacy restrictions.
- 5.3 All data and records shall be maintained by Connecticut General for the same periods of time, in the same manner, and subject to the same privacy and confidentiality safeguards as similar data maintained by Connecticut General in connection with its own insurance business.
- 5.4 If, upon the written request by Employer, Connecticut General agrees to provide certain of its proprietary information including, but not limited to, information about Connecticut General's arrangements with health care providers ("Proprietary Information") to Employer's designee(s), Employer agrees that the Proprietary Information will be kept confidential and will be used solely for the purpose of satisfying Employer's responsibilities with respect to the administration of the Plan as identified in its request.
- 5.5 The obligations set forth in this section shall survive termination of the Contract.

6.0 Liability and Indemnity (In relation to Exhibit B, B-1)

- 6.1 In performing its obligations under this Contract, Connecticut General neither insures nor underwrites any liability of the Employer or the Plan and acts only as the provider of the services described in this Contract.
- 6.2 Connecticut General shall have no duty or obligation to defend against any action or proceeding brought to recover a claim for Plan benefits. Connecticut General shall, however, make available to the Employer and its counsel, such evidence relevant to such action or proceeding as Connecticut General may have as a result of its administration of the contested benefit determination.
- 6.3 Except as otherwise explicitly provided in this Contract, the Employer shall accept the tender of defense and retain the liability for all Plan benefit claims and all expenses incident to the Plan and agrees to indemnify Connecticut General for and hold it, its directors, officers, and employees, harmless from all amounts and expenses (including reasonable attorneys' fees and court costs) for which Connecticut General may become liable:

- 6.3.1 for any state premium, or similar tax, or any similar benefit- or plan-related charge, surcharge or assessment, however denominated, including any penalties and interest payable with respect thereto, assessed against Connecticut General on the basis of and/or measured by the amount of Plan benefits administered by Connecticut General pursuant to this Contract;
- 6.3.2 in consequence of any acts or omissions occurring during the operation of this Contract alleged to be a breach of fiduciary duty;
- 6.3.3 arising from any legal action or proceeding to recover benefits under the Plan;
- 6.3.4 arising from any claim, legal action or proceeding, whether made by or on behalf of any Plan participant or participants, any governmental body or bodies, or any other party, regarding unclaimed or abandoned property, or laws relating thereto, or any escheat obligations, as related to Plan benefits administered pursuant to this Contract, including any penalties and interest payable with respect thereto; and/or
- 6.3.5 resulting from any claim, legal action or proceeding arising directly or indirectly out of release of confidential information or protected health information to Employer, the Plan or a third party or arising out of the use of such information by the Plan, Employer or a third party or any violation of the terms of Exhibit B-2 ("Privacy Addendum") by the Plan or Employer.

This indemnity shall survive the termination of this Contract.

- 6.3.6 In the event litigation is instituted by a third party against the Employer and/or Connecticut General concerning any matter under the Plan, including a suit for Plan benefits, each party to this Contract shall have sole authority to select legal counsel of its choice.
- 6.3.7 Connecticut General shall use ordinary and reasonable care in the performance of its duties, but shall not be liable to the Employer for mistakes of judgment or other actions taken in good faith (including benefits erroneously overpaid). Connecticut General will indemnify and hold the Employer harmless from and against all extra-contractual (non-benefit) costs, damages, judgments, reasonable attorneys' fees, expenses, and liabilities of any kind or nature, including overpayments unrecovered pursuant to section 2.3, which occur as the result of:
- 6.3.8 Connecticut General's gross negligence or intentional wrongdoing with respect to the administration of claims under the Employer's Plan;
- 6.4 To avoid misunderstanding by third parties concerning the respective duties and liabilities hereunder, each party agrees not to use the other's name, logo, service marks, trademarks or other identifying information without the prior written approval of the other.
- 6.5 Upon termination of this Contract or of any individual Plan Participant hereunder, and except as otherwise explicitly provided in this Contract, Employer shall retain the liability for all reimbursement requests and all expenses incident to any FSA, HRA and/or DFSA and for any and all violations of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") and agrees to indemnify Connecticut General for and hold it, its directors, officers, and employees, harmless from all amounts and expenses (including reasonable attorneys' fees and court costs) in connection therewith for which Connecticut General may become liable.

7.0 Modification of Plan and Administrative Duties and Charges

- 7.1 Connecticut General shall have the right to revise any charge (i) on the Contract expiration date of June 30, 2015 in accordance with Section 2.0 (Fee Adjustments) of this Contract, (ii) upon any variation of plus or minus fifteen percent (15%) in the number of participants in Employer's Plan in relation to the number of participants used by Connecticut General in calculating the charge, and/or upon any change in law or regulation which materially impacts Connecticut General's liabilities and/or responsibilities under this Contract.
- 7.2 Modification or amendment of the Plan shall be communicated in writing by the Employer to Connecticut General. Implementation of the modification or amendment shall be mutually agreed upon by the Employer and Connecticut General subject to data processing systems changes,

retroactive effective dates, and other adjustments and procedure changes necessitated by the modification or amendment.

7.3 The term "Plan" as used in this Contract shall include each such modification or amendment as of the implementation date agreed upon by the parties.

7.4 Modification of the duties as described in Exhibit B-1 or other applicable exhibits shall be by mutual Contract of the Employer and Connecticut General. Any such modification (and the revised charge, if any, applicable thereto) shall be evidenced by letter Contract between the parties which, upon execution, shall become a part of this Contract.

8.0 Termination of Contract

This Contract shall terminate upon the earliest of the following dates:

8.1 The date specified in the Contract (June 30, 2015) per Section 1.0 (Contract Term) and 1.1 of this Contract.

8.2 The effective date of any state's or other jurisdiction's action which prohibits activities of the parties under this Contract.

8.3 At the option of Connecticut General, the date upon which the Employer fails to maintain the Account in a sufficient amount pursuant to Section 2.1 or fails to pay any charge as provided in Exhibit A Connecticut General shall immediately communicate its election of this option to Employer;

8.4 Following termination of this Contract for any reason other than as provided in Section 8.0, above, or upon termination of eligibility of a Plan participant(s), or upon termination of a benefit option, Connecticut General shall continue for a period of twelve (12) months to administer all claims for Dental PPO Plan participants that were incurred prior to termination. No additional charge shall be assessed for this service.

8.5 At the termination of the applicable run-out period, Connecticut General shall make all records relating to such claims in process reasonably available to the Employer With respect to all other claims, following termination of this Contract for any reason other than as provided in Section 8.0. above, or upon termination of eligibility of a Plan participant(s), or upon termination of a benefit option, Connecticut General shall cease the processing of all such claims then in its possession and make all records relating to claims in process reasonably available to the Employer. This obligation shall not require Connecticut General to provide to Employer or any other party proprietary information.

9.0 Third Party Beneficiaries

This Contract is for the benefit of Employer and Connecticut General and not for any other person. It shall not create any legal relationship between Connecticut General and any employee, beneficiary or any other party claiming any right, whether legal or equitable, under the terms of this Contract or of the Plan.

10.0 Waivers

No course of dealing or failure of either party to strictly enforce any term, right or condition of this Contract shall be construed as a general waiver or relinquishment of such term, right or condition. Waiver by either party of any default shall not be deemed a waiver of any other default.

11.0 Headings

Article, section, or paragraph headings contained in this Contract are for reference purposes only, and shall not affect the meaning or interpretation of this Contract (Exhibit B).

12.0 Survival

Provisions contained in this Exhibit B that by their sense and context are intended to survive completion of performance, termination or cancellation of this Contract shall so survive.

13.0 Force Majeure

Connecticut General shall not be liable for any failure to meet any of the obligations or provide any of the services and/or benefits specified or required under this Contract where such failure to perform is due to any contingency beyond the reasonable control of Connecticut General, its employees, officers, or

directors. Such contingencies include, but are not limited to, acts or omissions of any person or entity not employed or reasonably controlled by Connecticut General, its employees, officers, or directors, acts of God, fires, wars, accidents, labor disputes or shortages, and governmental laws, ordinances, rules or regulations, whether valid or invalid.

14.0 Identifying Information and Internet Usage

Except as necessary in the performance of their duties under this Contract, neither party may use the other's name, logo, service marks, trademarks or other identifying information nor shall Employer establish a link from any World Wide Web site to any Connecticut General World Wide Web site without the prior written permission of Connecticut General.

15.0 PLAN DOCUMENT

A Plan Booklet that includes Plan Benefits and Members' rights and responsibilities under the Plan will be provided by Employer to Connecticut General and attached hereto. If Employer has not provided Connecticut General with a copy of its finalized Plan Booklet by the time this Contract is effective, Connecticut General will administer the Plan in accordance with the medical management and claims administration policies and procedures and/or practices then applicable to its own health insurance business and the definitions and other language contained in the draft version of the Plan Booklet created when the Employer purchased services under this Contract. Connecticut General will continue to administer Employer's benefits in this manner until Connecticut General receives the finalized Plan Booklet and follows its preparation and review process. After that time, Connecticut General will use the finalized Plan Booklet to administer Plan.

EXHIBIT B-1
ADMINISTRATIVE SERVICES PROVIDED

(ALL FEES IN CONNECTION TO THIS EXHIBIT ARE IN EXHIBIT A).

BANKING AND ADMINISTRATION		
All products <u>excluding</u> Health Savings Account		
1	Furnishing Connecticut General's standard bank account activity data reports to Employer as and when agreed upon. Connecticut General's administration of your plan does not include performing obligations, if any, under state escheat or unclaimed property laws. It is Employer's responsibility to determine the extent to which these laws may apply to the Plan and to comply with such laws.	All Dental Products
2	Reporting to Employer the claim payment information required in connection with Section 6041 of the Internal Revenue Code.	All Dental Products

CLAIM ADMINISTRATION		
All products <u>excluding</u> Health Savings Account		
1	Calculation of benefits, check preparation and communications through Connecticut General's standard processes.	All Dental Products
2	Preparation and delivery of Connecticut General's standard claim forms to Employer for issuance to Members.	All Dental Products
3	Investigation of claims, as necessary.	All Dental Products
4	Discussion of claims, where appropriate, with providers of health services.	All Dental Products
5	Performance of internal audits of Plan Benefit payments on a random sample basis.	All Dental Products
6	Application of claim control procedures.	All Dental Products
7	Response to Insurance Department complaints.	All Dental Products
8	Shared toll-free telephone service for Employer calls to Connecticut General Claim office.	All Dental Products
9	Member services and provider relations services.	All Dental Products
10	Explanation of Benefit ("EOB") statements when applicable.	All Dental Products
11	Notification to Members of denied Plan Benefit claims, the reason for the denial and appeal rights.	All Dental Products
12	Eligibility verification using monthly Member eligibility list updated by Employer.	All Dental Products

Dental Only		
1	Connecticut General's standard enrollment forms are prepared and delivered to Employer for distribution to individuals eligible to enroll in the Plan.	All Dental Products
2	Standard Dental predetermination of benefits for dental procedures.	All Dental Products
DOCUMENT PRODUCTION		
All products <u>excluding</u> Health Savings Account		
1	Preparation and delivery of Member benefit booklet drafts to Employer.	All Dental Products
UNDERWRITING SERVICES		
All products <u>excluding</u> Health Savings Account		
1	Provision of Connecticut General's standard annual year-end accounting summary of a) the number and amount of paid claims and b) fees paid.	All Dental Products
2	Connecticut General's standard Underwriting services: a) benefit design analysis, b) reserve analysis, c) projected cost analysis, and d) multi-divisional reports and disclosures.	All Dental Products
HIPAA INDIVIDUAL RIGHTS		
All products <u>excluding</u> Health Savings Account		
	Handling of requests from Members for access to, amendment and accounting of protected health information and requests for restrictions and alternative communications as required under federal HIPAA law and regulations, as set out in this Contract and its Exhibits.	All Dental Products
COST CONTAINMENT		
1	Delivery of information, as necessary, regarding standard application of non-duplication or coordination of benefits.	All Dental Products
2	Network Savings Program, a national vendor network that provides discounted rates when a Member accesses care through a Network Savings Program contracted provider.	All Dental Products
3	Annual reporting of Connecticut General's standard dental cost containment results upon Employer's request.	All Dental Products
CUSTOMER REPORTING		
1	Summary reports of dental cost and utilization experience available through CIGNA web site.	All Dental Products
2	Connecticut General's standard dental reporting package.	All Dental Products

NETWORK MANAGEMENT SERVICES		
	Connecticut General, and/or its affiliates shall:	
1	Provide or arrange access to the applicable network of Participating Providers to furnish health care services/products to Members at negotiated rates and methods of reimbursement (e.g. fee-for service, capitation, per diem charges, incentive bonuses, case rates, withholds etc.);	All Dental Products
2	Credential and re-credential Participating Providers in accordance with Connecticut General’s credentialing requirements and ensure that third-party network vendors credential/re-credential Participating providers in accordance with Connecticut General’s requirements;	All Dental Products
3	Review Participating Provider compliance with protocols and procedures for quality, participant satisfaction, and grievance resolution;	All Dental Products
4	Facilitate the identification of Participating Providers by Members; and	All Dental Products
5	Maintain Member services staff to respond to Member inquiries.	All Dental Products

EXHIBIT B-2
BUSINESS ASSOCIATE AGREEMENT

MARICOPA COUNTY
Health Insurance Portability and Accountability Act of 1996 (“HIPAA”)
Business Associate Provisions

This Attachment sets out the HIPAA-related responsibilities and obligations of Contractor pursuant to the Contract between Contractor and Department.

I. Definitions

- A. Applicable Law means any of the following items, including any amendments to any such item as such may become effective:
1. the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”);
 2. the federal regulations regarding privacy and promulgated with respect to HIPAA, found at 45 C.F.R. Parts 160 and 164 (the “Privacy Rule”);
 3. the federal regulations regarding electronic data interchange and promulgated with respect to HIPAA, found at 45 C.F.R. Parts 160 and 162 (the “Transaction Rule”);
 4. the federal regulations regarding security and promulgated with respect to HIPAA, found at 45 C.F.R. Parts 160 and 164 (the “Security Rule”); and
 5. the American Recovery and Reinvestment Act of 2009 (“ARRA”), §§ 13400-24, Public Law 111-5, 123 Stat 115 (Feb. 17, 2009), codified at 42 U.S.C. §§ 17921, 17931-40, 17951-53.
- B. Business Associate means an entity that performs or assists in the performance of a function on behalf of a Covered Entity, which involves the use or disclosure of Individually Identifiable Health Information as defined in 45 C.F.R. § 160.103. Contractor is a Business Associate of Department under this Contract, and for purposes of Contractor’s obligations under this Attachment, the terms “Business Associate” and “Contractor” are synonymous. Notwithstanding this definition, if Contractor does not have access to or create PHI under this Contract, Contractor is not a Business Associate, and the terms of this Attachment do not apply to Contractor.
- C. Contract means the entire agreement between the parties.
- D. Contractor for purposes of this Attachment means any party to this Contract, which is not a department of Maricopa County government.
- E. Covered Entity means a health plan, a health care clearinghouse, or a health care provider that transmits any health information in electronic form in connection with a transaction covered by HIPAA as defined in 45 C.F.R. § 160.103. Department or a part of Department, as designated by Maricopa County, is a Covered Entity under this Contract.
- F. Department means the party to this Contract that is part of Maricopa County government.
- G. ePHI means electronic protected health information within the meaning of 45 C.F.R. § 160.103, limited to the information created, received, maintained, or transmitted by Business Associate from or on behalf of Department.
- H. Individual means the person who is the subject of PHI.

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MARICOPA COUNTY
Health Insurance Portability and Accountability Act of 1996 (“HIPAA”)
Business Associate Provisions

- I. Protected Health Information (“PHI”) is health information that (1) is created or received by a Covered Entity, (2) relates to the physical condition, mental health or other health condition of an Individual, or to the provision of health care to the Individual (including but not limited to the payment for such health care), and (3) identifies or can be used to identify the Individual, as defined in 45 C.F.R. § 160.103.
- J. Secretary means the Secretary of the United States Department of Health and Human Services (“HHS”) and her designees.
- K. Security Breach means (1) unauthorized access to, or acquisition, use, disclosure, modification or destruction, of Department’s Unsecured PHI, whether in paper or electronic form, or (2) the successful interference with system operations in an information system containing Department’s PHI. The term does *not* include (1) disclosure of PHI to an unauthorized person in circumstances where that person would not reasonably have been able to retain the information, or (2) good faith unintentional access to, or acquisition or use of, PHI by Business Associate’s employees, agents or subcontractors in the course of such person’s performance of services authorized by the Contract provided that such PHI is not further accessed, acquired, used, or disclosed by any person.
- L. Unsecured PHI means all PHI, *except*: (1) PHI in electronic form that is encrypted consistent with regulations promulgated by HHS or has been subject to disposal in a manner that renders the information irretrievable, or (2) PHI in paper form that has been shredded, burned, or otherwise rendered irrecoverable.

II. Rights and Obligations of Business Associate

A. General Obligations

1. Compliance with Privacy Rule
- a. Business Associate shall not use or further disclose PHI other than as permitted or required by HIPAA, the Privacy Rule, and this Attachment.
 - b. Business Associate shall use appropriate safeguards to prevent use or disclosure of PHI other than as provided for by this Attachment.
 - c. Business Associate shall report to Department any use or disclosure of PHI, known to Business Associate, that is not permitted by this Attachment.
2. Compliance with Security Rule
- a. Business Associate shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of ePHI.
 - b. Business Associate shall report to Department any Security Breach of which Business Associate becomes aware.
3. Compliance with ARRA
- a. Business Associate shall comply with the Security Breach notice requirements provided in Section II.A.4 of this Attachment.

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BUSINESS ASSOCIATE AGREEMENT

MARICOPA COUNTY
Health Insurance Portability and Accountability Act of 1996 (“HIPAA”)
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- b. Business Associate shall not receive remuneration, either directly or indirectly, in exchange for PHI, except as may be permitted by 42 U.S.C. § 17935(d). [This paragraph shall be effective 180 days after issuance of final regulations implementing 42 U.S.C. § 17935]
- c. Pursuant to the Privacy Rule, made applicable to Business Associate by ARRA, Business Associate shall adopt, implement, and follow privacy policies and procedures in the same manner and to the same extent as if it were a Covered Entity.
- d. Pursuant to the Security Rule, made applicable to Business Associate by ARRA, Business Associate shall adopt, implement, and follow security policies and procedures in the same manner and to the same extent as if it were a Covered Entity.

4. **Notice of Security Breach**

- a. *Notice to Department.* Business Associate shall notify Department without unreasonable delay and within five (5) business days of Business Associate’s discovery of a Security Breach. The notice to Department shall include the identity of each Individual whose Unsecured PHI was involved in the Security Breach, a brief description of the Security Breach, and any mitigation efforts. To the extent that Business Associate does not know the identities of all affected Individuals when it is required to notify Department, Business Associate shall provide such additional information as soon as administratively practicable after such information becomes available. For purposes of this paragraph, a Security Breach shall be treated as discovered as of the first day on which the Security Breach is known or should reasonably have been known to Business Associate (including any person, other than the one committing the Security Breach, who is an employee, officer, or other agent of Business Associate).
- b. *Notice to Individuals.* On behalf of Department, Business Associate shall provide written notice of the Security Breach without unreasonable delay, but no later than sixty (60) calendar days following the date the Security Breach is discovered, or such later date as is authorized under 45 C.F.R. § 164.412, to each Individual whose Unsecured PHI has been, or is reasonably believed by Business Associate to have been, accessed, used, or disclosed as a result of the Security Breach. For purposes of this paragraph, a Security Breach shall be treated as discovered as of the first day on which the Security Breach is known or should reasonably have been known to Business Associate (including any person, other than the one committing the Security Breach, who is an employee, officer, or other agent of Business Associate).

The content, form, and delivery of such written notice shall comply in all respects with 45 C.F.R. § 164.404(c)-(d).

Business Associate and Department shall cooperate in all respects regarding the drafting and the content of the notice. To that end, before sending any notice to any Individual, Business Associate shall first provide a draft of the notice to

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Department. Department shall have five (5) business days (plus any reasonable extensions) to provide comments on Business Associate’s draft of the notice.

- c. *Notice to Media.* On behalf of Department, Business Associate shall provide written notice of a Security Breach to the media to the extent required under 45 C.F.R. § 164.406. Business Associate and Department shall cooperate in all respects regarding the drafting and the content of the notice. To that end, before sending any notice to the media, Business Associate shall first provide a draft of the notice to Department. Department shall have five (5) business days (plus any reasonable extensions) to provide comments on Business Associate’s draft of the notice.
- d. *Notice to Secretary.* On behalf of Department, Business Associate shall provide written notice of a Security Breach to the Secretary to the extent required under 45 C.F.R. § 164.408. Business Associate and Department shall cooperate in all respects regarding the drafting and the content of the notice. To that end, before sending any notice to the Secretary, Business Associate shall first provide a draft of the notice to Department. Department shall have five business days (plus any reasonable extensions) to provide comments on Business Associate’s draft of the notice.

If a Security Breach involves fewer than five hundred (500) Individuals, Business Associate shall maintain a log or other documentation of the Security Breach that contains such information as would be required to be included if the log were maintained by Department pursuant to 45 C.F.R. § 164.408, and provide such log to Department within five (5) business days of Department’s written request.

5. Subcontractors and Agents. Business Associate shall ensure that any agent, including a subcontractor, to whom it provides PHI agrees to the same restrictions and conditions that apply through this Attachment to Business Associate with respect to PHI.
6. Access to Books and Records by Secretary. Business Associate shall make its internal practices, books, and records relating to the use, disclosure, and security of PHI available to the Secretary for purposes of the Secretary determining Department’s and Business Associate’s compliance with HIPAA.
7. Mitigation. Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of (a) a use or disclosure of PHI by Business Associate in violation of the requirements of this Attachment, or (b) a Security Breach.

B. Obligations Relating to Individual Rights

1. Restrictions on Disclosures. Upon request by an Individual, Department shall determine whether the Individual shall be granted a restriction on disclosure of PHI pursuant to 45 C.F.R. § 164.522. Department shall not agree to any such restriction without the prior consent of Business associate if such restriction would affect Business Associate’s use or disclosure of PHI, *provided, however*, that Business Associate’s consent is not required for requests that must be granted under 42 U.S.C. § 17935(a). Department shall communicate any grant of a request to Business Associate. Business Associate shall restrict its disclosures of the Individual’s PHI in the same manner as would be required

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for Department. If Business Associate receives an Individual’s request for restrictions, Business Associate shall forward such request to Department within five (5) business days.

2. **Access to PHI.** Upon request by an Individual, Department shall determine whether an Individual is entitled to access his or her PHI pursuant to 45 C.F.R. § 164.524. If Department determines that an Individual is entitled to such access, and that such PHI is under the control of Business Associate, Department shall communicate the decision to Business Associate. Business Associate shall provide access to the PHI in the same manner as would be required for Department. If Business Associate receives an Individual’s request to access his or her PHI, Business Associate shall forward such request to Department within five (5) business days.
3. **Amendment of PHI.** Upon request by an Individual, Department shall determine whether the Individual is entitled to amend his or her PHI pursuant to 45 C.F.R. § 164.526. If Department determines that an Individual is entitled to such an amendment, and that such PHI is both in a designated record set and under the control of Business Associate, Department shall communicate the decision to Business Associate. Business Associate shall provide an opportunity to amend the PHI in the same manner as would be required for Department. If Business Associate receives an Individual’s request to amend his or her PHI, Business Associate shall forward such request to Department within five (5) business days.
4. **Accounting of Disclosures.** Upon request by an Individual, Department shall determine whether any Individual is entitled to an accounting pursuant to 45 C.F.R. § 164.528. If Department determines that an Individual is entitled to an accounting, Department shall communicate the decision to Business Associate. Business Associate shall provide information to Department that will enable Department to meet its accounting obligations. If Business Associate receives an Individual’s request for an accounting, Business Associate shall forward such request to Department within five (5) business days.

C. **Permitted Uses and Disclosures by Business Associate.** Except as otherwise limited in this Attachment or by Applicable Law, Business Associate may:

1. Use or disclose PHI to perform functions, activities, or services for or on behalf of Department, as specified in the Contract, *provided that* such use or disclosure (a) is consistent with Department’s Notice of Privacy Practices, and (b) would not violate Applicable Law if done by Department;
2. Use PHI for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate;
3. Disclose PHI for the proper management and administration of Business Associate, *provided that* (a) Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and be used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached, or (b) the disclosures are required by law; and

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4. Use PHI to provide Data Aggregation services to Department as permitted by 45 C.F.R. § 164.504(e)(2)(i)(B).

III. Rights and Obligations of Department

A. Privacy Practices and Restrictions

1. Upon request, Department shall provide Business Associate with the notice of privacy practices that Department produces in accordance with 45 C.F.R. § 164.520. If Department subsequently revises the notice, Department shall provide a copy of the revised notice to Business Associate.
2. Department shall notify Business Associate of any restriction to the use or disclosure of PHI that Department has agreed to in accordance with 45 C.F.R. § 164.522. Department shall provide Business Associate with any changes in, or revocation of, permission by an Individual to use or disclose PHI, if such changes affect Business Associate’s permitted or required uses and disclosures.

- B. Permissible Requests by Department.** Department shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by Department.

IV. Term and Termination

- A. Term.** This Attachment shall become effective upon execution by the Parties and shall supersede any existing Business Associate Agreement among the Parties. The requirements of this Attachment shall end upon the termination of the Contract or upon termination for cause as set forth in the following Section IV.B, whichever is earlier.

- B. Termination for Cause.** Upon any Party’s knowledge of a material breach of this Attachment by another Party, the nonbreaching Party shall have the following rights:

1. If the breach is curable, the nonbreaching Party may provide an opportunity for the other Party to cure the breach or end the violation. Alternatively, or if the other Party fails to cure the breach or end the violation, the nonbreaching Party may terminate this Contract.
2. If the breach is not curable, the nonbreaching Party may immediately terminate this Contract.
3. If termination is not feasible, the nonbreaching Party may report the problem to the Secretary.

C. Effect of Termination.

1. Except as provided in Section IV.C.2, upon termination of this Contract, for any reason, Business Associate shall return or destroy all PHI within its possession or control, and all PHI that is in the possession or control of Business Associate’s subcontractors or agents. Business Associate shall retain no copies of the PHI.
2. If Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall provide to Department notification of the conditions that make

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return or destruction infeasible. Business Associate shall extend the protections of this Attachment to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

V. Miscellaneous

- A. Electronic Health Records.** The Parties agree that Business Associate shall not maintain any “electronic health record” or “personal health record,” as those terms are defined in ARRA, for or on behalf of Department. As such, Business Associate has no obligation to document disclosures that are exempt from the accounting requirement under 45 C.F.R. § 164.528(1)(i)-(ix), and Department agrees not to include Business Associate on any list Department produces pursuant to 42 U.S.C. § 17935(c)(3).
- B. Regulatory References.** A reference in this Attachment to a section in any Applicable Law means the section in effect or as amended, and for which compliance is required.
- C. Amendment.** The Parties agree to take such action as is necessary to amend this Attachment from time to time as is necessary for Department to comply with the requirements of Applicable Law. All amendments to this Attachment, except those occurring by operation of law, shall be in writing and signed by both Parties.
- D. Survival.** The respective rights and obligations of Business Associate under Section IV.C. of this Attachment shall survive the term and termination of the Contract.
- E. Interpretation.** Any ambiguity in this Attachment shall be resolved in favor of a meaning that permits Department to comply with Applicable Law.
- F. No Third Party Beneficiaries.** Nothing express or implied in this Attachment is intended to confer, nor shall anything herein confer upon any person, other than Department, Business Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.
- G. Assignment.** No assignment of rights or obligations under this Attachment shall be made by either Party without the prior written consent of the other Party; provided however, that Business Associate may assign the rights and obligations under this Attachment to an affiliate.
- H. Effect on Agreement.** Except as specifically required to implement the purposes of this Attachment, or to the extent inconsistent with this Attachment, all other terms of the underlying Contract shall remain in force and effect.
- I. Counterparts.** This Attachment may be executed in counterparts, each of which may be deemed an original.

<u>CIGNA Dental Health Plan of Arizona, Inc.</u>	<u>Stephanie C Gorman</u>
FIRM NAME	SIGNATURE
<u>Stephanie C. Gorman</u>	<u>10/17/11</u>
PERSON SIGNING (PLEASE PRINT)	DATE

EXHIBIT B-3
CONTRACTOR QUESTIONNAIRE RESPONSE

2.0 **SCOPE OF SERVICES:**

2.1 **Program Outline**

2.1.1 **Eligibility:**

- A regular status employee scheduled to work at least 20 hours per week.
- Any existing retiree, who left County medical coverage, cannot enroll in dental coverage. For new retirees who enroll in a County retiree medical plan, the retiree has the option of electing dental coverage.

Confirmed

2.1.2 **Eligibility period/Enrollment Effective Date:**

- Coverage begins the first day of the month following date of hire for active employees. Benefit deductions begin the first day of the pay period in which the coverage begins date falls.
- For new retirees who enroll in a County retiree medical plan, the effective date is the beginning of the pay period in which retirement occurred so there is no break in coverage.

Confirmed

2.2 **MANDATORY CONTRACTOR'S QUALIFICATIONS:**

2.2.1 **Contractor shall have (on award) and maintain a office in Arizona.**

Agree

2.2.1.1 **Contractor shall have and operate their own provider network. Sub-contracting to a separate network is not acceptable.**

Agree

2.2.2 **Contractor shall receive eligibility data at least weekly in HIPAA compliant format from ADP.**

Agree

2.2.3 **Contractor shall apply data received electronically from ADP to their system within 48 hours of receipt and will generate an electronic exception report for ADP within five working days from applying the data from each file.**

Agree

2.2.4 **Contractor must accept subscriber identification number as defined by the County. A subscriber identification number could be either: an employee identification number, social security number or an alternative identification number.**

Agree

2.2.5 **Contractor shall maintain and update electronic database of all participants including but not limited to participants name, subscriber identification number as defined in 2.2.3, addresses, etc., needed to administer the claim payments, maintain complete history, and report to the County, Federal and State regulatory bodies as may be necessary or required**

Agree

- 2.2.6 **Contractor shall maintain and update procedures and computer software needed to receive and process all benefit claims according to the Plan and all current and future regulations.**

Agree

- 2.2.7 **Contractor shall maintain claim processing procedures and software needed to screen claims for duplicate payments, overpayments, underpayments and non-payments. Contractor shall have a process in place to recoup overpayments.**

Agree

- 2.2.8 **Contractor shall administer for the plan participants electing to continue their dental plans under COBRA, through a COBRA plan administrator, currently ADP, as determined by County.**

Agree

- 2.2.9 **Contractor shall provide secure online access/self-service capabilities indicating where the participating employee can inquire about his/her account. Current provider directories that are updated at least every 30 calendar days shall be available on-line.**

Agree

- 2.2.10 **Contractor shall provide online access capabilities where the employer can inquire about eligibility, review claims status, enroll a participating employee in an emergency situation, and generate reports through a secured Web site.**

Agree

- 2.2.11 **Contractor shall provided claims forms and processing instructions online to contractor's Web site. Claim forms must clearly state the mailing address and customer service telephone number, and clear and complete processing instructions.**

Agree

- 2.2.12 **Contractor shall set up the account structure for eligibility and reporting as defined by employer**

Confirmed.

- 2.2.13 **Contractor shall provide an electronic invoice in Excel-compatible format to the County. Such invoice must contain detail of employees included on the invoice and their coverage level.**

Agree

- 2.2.14 **Contractor shall provide initial ID cards for newly eligible employees and their covered dependents, and replacement ID cards within, five (5) working days of receipt of the eligibility file or request from the participant. Please indicate if replacement ID cards can be ordered online and if there is an additional cost for new and replacement ID cards.**

Nearly 99 percent of ID cards are mailed within 10 business days after the ID card vendor receives clean and accurate eligibility from CIGNA.

Identification cards with the client's account information are bulk-shipped to the location specified by the client, at no charge. The cards are printed with the company name, account number, claim office information, and phone number for our automated Dental Office Locator. A space is provided for the employee to insert their name. Members can also print ID cards instantly on myCIGNA.com.

- 2.2.15 **Contractor shall process adjustments/corrections to the contractor's eligibility data within five working days following response from the County to contractor's reconciliation/exception report.**

Agree

- 2.2.16 **Contractor shall conduct an annual Maricopa County specific customer service satisfaction survey and provide the County with results and an action plan to improve any unsatisfactory results.**

Confirmed.

- 2.2.17 **Contractor will properly adjudicate and pay county-specific claims based on the following standards: a) payment of 90% or more of all clean claims within 10 working days of receipt; b) financial accuracy rate of 99%; and c) procedural accuracy rate of at least 96%. Contractor shall notify the participant via an Explanation of Benefits (EOB) within one claims cycle or two weeks, whichever less is of approved or denied status of claims. Contractor shall notify the participant in writing of claims pending a determination over 30 calendar days and the reason for the delay in processing the claim. Contractor shall allow the county or their designee to conduct an audit of claims activity to determine if standards were achieved. Contractor will provide a response and action plan where the standard criteria have not been achieved.**

Confirmed

- 2.2.18 **The Contractor shall provide a customer service program description that includes, the number and availability of customer service representatives to assist participants with questions regarding their claims; business hours including weekend and after hours availability, number of Bilingual staff (English/Spanish); description of how calls received in other languages are handled (e.g., Vietnamese), description of the customer service training program; telephone call documentation requirements, and telephone metrics of less than 30 seconds average speed of answer and less than 5% abandonment rate. Customer service representatives must have the ability to view information regarding eligibility, claims status, and must be trained to explain claims denials, pending status, reason for pending status, and claims payment results to employees who contact them. Include a sample copy of your customer service program in your response.**

Confirmed.

- 2.2.19 **Contractor shall provide a provider relations program description that includes a process for dispute resolution between the participant and the provider when a quality of care or quality of service issue arises.**

Agree

- 2.2.20 **Contractor shall provide a toll free telephone number to customer service.**

Confirmed

- 2.2.21 **Contractor shall provide a quality program description that addresses how quality of care is assured to the participants. The program description should include the**

goals, objectives, planned activities, and a description of quality assurance initiatives.

Confirmed.

- 2.2.22 **Contractor shall provide fully trained staff to participate during the County's Open Enrollment including scheduled benefit fairs and presentations, monthly New Employee Orientation presentations, specific County Departmental Meetings and provide ongoing support according to a predefined service schedule.**

Confirmed.

- 2.2.23 **Contractor shall provide the first and second level claims appeal process for the ASO product and the full claims appeal process for the fully insured product. Include a copy of the appeal process in your response.**

Confirmed.

- 2.2.24 **Contractor shall produce and distribute all collateral materials in both English and Spanish for the fully insured product and provide the plan description and benefit summary documents electronically in English and Spanish to the County for the ASO product.**

Confirmed.

- 2.2.25 **Contractor will conduct an initial audit for the purpose of assessing system set-up within the first 90 days of the plan and provide a report to the County within 30 calendar days following the audit.**

Confirmed.

- 2.2.26 **Contractor shall have an annual SAS70 audit of their claims processing system. Results of the audit and corrective action plan shall be provided to the County within 30 calendar days of the audit completion.**

Confirmed.

- 2.2.27 **To ensure the confidentiality of Protected Health Insurance (PHI), contractor shall be fully compliant, through automation and manual processes, with the Health Insurance Portability Accountability Act (HIPAA) and will sign a Business Associate Agreement with the County.**

Agreed, for the self-insured arrangement. For our fully insured arrangement, Contractor is considered the insurer and covered entity.

- 2.2.28 **Contractor shall participate in joint operations meeting with other external vendors, and will share data according to mutually agree upon guidelines and confidentiality agreements.**

Confirmed.

- 2.2.29 **Contractor shall provide run-out of claims administration for one year, should the County terminate services with the Contractor.**

Confirmed.

- 2.2.30 **Contractor shall allow for the County to self-bill based on their eligibility data.**

Confirmed.

2.2.31 **Contractor shall follow the County's requirements for banking and funding an ASO arrangement.**

2.2.31.1 **Claims will be paid electronically on a daily basis.**

2.2.31.2 **ASO fee's will be invoiced and paid in arrears on a monthly basis.**

Confirmed all above.

2.3 **Implementation and Ongoing Requirements**

To properly implement the plan, the successful Contractor will be required to devote staff attention to the following implementation and ongoing activities. Please include samples where appropriate.

2.3.1 **Implementation Team as defined by the Contractor shall have expertise in Project Management and Issue Resolution Management.**

2.3.2 **Set-up client account according to a comprehensive time line, which will identify tasks, dates, and responsible parties.**

2.3.3 **Establish banking and/or payment arrangements. Please include a copy of your banking process overview, funding and account monitoring options and cash management program reports.**

2.3.4 **Provide implementation and ongoing educational materials describing the Contractor and their services electronically on an ongoing basis.**

2.3.5 **Attend open enrollment meetings including scheduled benefits' fairs and presentations, new employee orientations, departmental meetings, and provide ongoing support according to a predetermined schedule at contractor's expense as scheduled by Benefits personnel.**

Confirmed all above.

2.4 **Reporting Requirements (minimum)**

All reports listed below are due by the 15th calendar day following the reporting period and are County specific. Please include a sample copy of each report.

2.4.1 **Include a copy of your standard reporting package**

2.4.2 **Monthly number of claims received and/or processed**

2.4.3 **Weekly exceptions to the contractor's eligibility files.**

2.4.4 **Monthly paid check listing.**

2.4.5 **Monthly outstanding checks listing.**

2.4.6 **Monthly fund transfer dates and amounts.**

2.4.7 **Monthly claims payment, enrollment and fees paid report.**

2.4.8 **Quarterly financial and procedural accuracy claims report**

2.4.9 **Quarterly claims processing turn around time reports.**

2.4.10 **Quarterly number of appeals, reasons and outcomes.**

2.4.11 **Quarterly claims quality results.**

2.4.12 **Quarterly reporting of the number of dental plan participants who have met their annual calendar year maximum and lifetime orthodontia maximum.**

2.4.13 **Monthly average speed of answer by Customer Service Representatives.**

2.4.14 **Monthly average abandonment rate of calls received by Customer Service Representatives.**

2.4.15 **Quarterly cumulative claims lag schedules (claims paid amount by paid date and incurred date).**

2.4.16 **Quarterly count and total billed amounts for claims received but not yet paid with an estimation of the amounts to be paid (RBUC).**

Confirmed all above

2.5 **County Rights and Obligations**

- 2.5.1 **The County, upon awarding a contract, assumes responsibility for the following actions:**
- 2.5.1.1 **Distribute announcement of new contractor, plan design and administrative requirements.**
 - 2.5.1.2 **Review and approve all communications materials to employees including but not limited to benefit summaries, forms, booklets, newsletters, letters, and any other employee communication material prior to its printing and distribution.**
- 2.5.2 **The County Benefits Office must approve all on-site visits by the Contractor's personnel to any County department or location prior to the scheduled visit.**
- 2.5.3 **The County will allow the Contractor to audit the County's records for valid business reasons to verify accounting of fee payments with proper notification.**

Confirmed all above

2.6 **UNDERWRITING REQUIREMENTS:**

Your proposal should take into account the following:

- 2.6.1 **Not to exceed renewal rate caps will be due 360 days prior to the contract renewal dates for years four, five and six. Final rates will be due 180 days prior to the contract renewal date.**

Confirmed.

- 2.6.2 **The County will self-administer the payment of fees. All fees will be paid based upon the County's total enrollment count on the first enrollment file at the beginning of each month. Monthly COBRA and leave of absence counts will also be provided.**

Confirmed.

- 2.6.3 **Regardless of which pricing scenario is chosen, claims experience will need to be tracked and reported based upon the separate entities (The County Administration and Non-Payroll Groups) and their respective sub-groups.**

Confirmed.

- 2.6.4 **The County may correct legitimate administrative errors and is the final determinant of when such errors have occurred. The County shall be the final determinant for all eligibility issues and claims determination for the ASO product.**

Agreed

- 2.6.5 **In determining any person's rights to benefits under the Plan, contractor shall rely upon eligibility information furnished by the employer.**

The policy's or contract's rate change date and anniversary will fall on July 1st. The County reserves the right to annually negotiate benefit modifications it considers in its best interest. Rates may be modified for such changes subject to mutual good faith negotiation on the value of such changes. By mutual agreement of the parties, the anniversary date of the contract may be changed to coincide with the County's fiscal year.

Agreed.

- 2.6.6 **The County maintains the right to accept, reject, or cancel the contract of a contractor at any time following 30 days written notice, if there is a significant change, in the County's opinion, in the contractor's operation of the plan, including but not limited to, satisfaction with customer service, quality of care or service of the plan, satisfaction by the County's employees, and adequacy of the provider network.**

Agreed

- 2.6.7 **The contractor shall have the capability to accept electronic transfer of funds.**

Confirmed

- 2.6.8 **The contractor shall be responsible for drafting (for ASO and fully insured product), producing and distributing (for fully insured product), subject to County review and approval, all communication materials and administrative forms in both English and Spanish. Such services may be subcontracted. Such documents shall be available electronically.**

Confirmed.

- 2.6.9 **Successful contractor will implement Maricopa County in a timely fashion and accomplish the following tasks:**

- 2.6.9.1 **Setting up eligibility data (subscriber, dependents, correct plans, effective dates, etc.)**
- 2.6.9.2 **Setting up the account structure and corresponding subgroups**
- 2.6.9.3 **Setting up the plan design in-network and out-of-network along with plan limitations and exclusions.**
- 2.6.9.4 **Setting up the dental provider contracts, terms and network relationships**
- 2.6.9.5 **Providing a network comparison of the current network with the contractor's network.**
- 2.6.9.6 **Identifying services that need to be pre-determined**
- 2.6.9.7 **Establishing the claims edits and/or business rules**
- 2.6.9.8 **Implement a transition-related coordination of care and services process**
- 2.6.9.9 **Identify other insurance for coordination of benefits**
- 2.6.9.10 **Pay in-network and out-of-network claims according to the Plan Description**
- 2.6.9.11 **Provide timely ID cards to participants**
- 2.6.9.12 **Provide accurate participant correspondence and reporting**

Confirmed all above

2.7 **INVOICES AND PAYMENTS:**

- 2.7.1 **The Respondent shall submit two (2) legible copies of their detailed invoice before payment(s) can be made. At a minimum, the invoice must provide the following information:**

- **Company name, address and contact** -- CIGNA Invoice includes Company name, Address and Contact person.
- **County bill-to name and contact information** -If multiple invoices then multiple contacts can be accommodated
- **Contract Serial Number** - CIGNA assigns a unique account number and client ID
- **County purchase order number** - can not accommodate
- **Invoice number and date** - CIGNA's invoice does include an invoice number and print date
- **Payment terms** - The invoice does reflect the 1st of the month due date but we do allow payment thru month end.

- **Date of service or delivery** -CIGNA's invoice does reflect the coverage period
- **Quantity**
- **Contract Item number(s)**
- **Description of Purchase (services)** - CIGNA's invoice includes type of product/benefit
- **Pricing per unit of service** - CIGNA's invoice reflects billing on a PEPM basis by product/benefit
- **Extended price**
- **Total Amount Due** - CIGNA's invoice reflects Total Amount Due

2.7.2 **Problems regarding billing or invoicing shall be directed to the using agency as listed on the Purchase Order**

Agreed

2.7.3 **Payment shall be made to the Contractor by Accounts Payable through the Maricopa County Vendor Express Payment Program. This is an Electronic Funds Transfer (EFT) process. After Contract Award the Contractor shall complete the Vendor Registration Form located on the County Department of Finance Vendor Registration Web Site (www.maricopa.gov/finance/vendors).**

Agreed.

2.7.4 **EFT payments to the routing and account numbers designated by the Contractor will include the details on the specific invoices that the payment covers. The Contractor is required to discuss remittance delivery capabilities with their designated financial institution for access to those details.**

Agreed

2.8 **TAX: (SERVICES)**

No tax shall be levied against labor. It is the responsibility of the Contractor to determine any and all taxes and include the same in proposal price.

Confirmed.

QUESTIONNAIRE:

Please complete each item completely and in the order shown. Clear reference to readily accessible back-up material (e.g., plan documents, reports, charts, etc.) is acceptable. Incomplete or inaccurate answers may result in the disqualification of the proposal. Answers should be inserted directly below question.

1.0 **Ownership**

- 1.1 **Who is the owner (sponsor) of the plan (e.g., commercial carrier, dental group, etc.)?**
Connecticut General Life Insurance Company (CGLIC) is the owner of this plan. CGLIC is an insurance carrier authorized in all states as well as other jurisdictions. CGLIC is an indirect, wholly owned subsidiary of CIGNA Corporation.
- 1.2 **Do you have any plans to merge, sell, or otherwise change (e.g., change management contracts or personnel) your current organization structure?**
Proprietary and confidentiality concerns preclude any comment on planned activity, if any. However, CIGNA would take steps to ensure the continued, uninterrupted service to our customers if another merger or acquisition were to occur.
- 1.3 **If you do plan to merge, sell or otherwise change your current organization structure please explain.**

This question is not applicable.

- 1.4 **Provide your two most recent audited financial reports that are usually given to stockholders. These reports should include a Balance Sheet, Income Statement, and Statement of Changes in Financial Position, along with any auditor's notes.**

We have included the requested audited financial statements in the Exhibits section of this proposal.

2.0 **Account Management**

- 2.1 **Provide a biography of the account manager who would be the primary contact for the County's Benefits staff. Provide biographies of any other members who will have routine interaction with the County's Benefits staff.**

See attached in the Qualifications section of this binder.

- 2.2 **Please describe an ideal mix of skills between the County and your organization that will ensure a successful implementation and ongoing account management.**

CIGNA has a long history working with Maricopa County. Most of CIGNA's employees who currently work with the County, have been doing so for more than 5 years. As a result, CIGNA understands the County's specific needs and expectations. To ensure ongoing stability, the current Dental Implementation, Service and Client Management team will continue to work with the County.

3.0 **Technology**

- 3.1 **What is the name of your dental claims payor system?**

The name of our dental claim system is DentaCom.

- 3.2 **Is your system fully integrated? Please provide a high level schematic of your dental claims payor system.**

Yes. CIGNA's DentaCom claim system was developed in-house in the early 1990s based upon our vast experience in the dental industry and the needs of our customers. It uses an IBM 9021.900 mainframe computer and is run under CICS (Version 4.1) with both macro and command level using VSAM file access. In 1996, when the CIGNA Dental PPO plan was introduced, enhancements were made to support the processing of a DPPO plan. Major upgrades, since then, include the integration of data entry and auto-adjudication functions into an integrated health care systems environment; a central repository of eligibility and benefit/structure-related data; Cobol II upgrades; automated orthodontia payments; and a new explanation of benefits (EOB) system. Our system is updated with new CDT codes as well as HIPAA compliance enhancements.

Dental logic prevents payment of duplicate submissions, assists with coding accuracy, and automates plan design features. The logic stores claim-adjusting parameters (guidelines based on dentistry standards), coverage exclusions and limitations, procedure frequencies, and individual dental plan information. This enables us to detect unbundled procedures and appropriate codes for payment and flags procedures needing further review.

Dental history maintains the experience of each member to identify duplicate claims, deductibles, and maximum accumulators, and ensures that the status of the definition is accurate and current.

Repetitive orthodontic payments are calculated quarterly and automatically sent without additional adjuster intervention until the maximum benefits are paid.

Combined dentist checks/itemized explanation of benefits (EOBs) is calculated for payments being made to specific dentists on a given day.

Flexible plan designs are administered based on usual and customary charges, percent off billed charges, or scheduled benefits. The alternate benefit provision allows for consideration of what is commonly performed for that condition whether it is less costly or more costly.

Accumulators by plan year, calendar year, and lifetime maximums ensure that the correct amount of benefits is paid. Deductibles and out-of-pocket maximums are also tracked.

- 3.3 **Do you plan any revisions in your claims systems or system hardware or software?**

Yes.

3.4 **If you plan any revisions in your claims systems or system hardware or software when do you plan to make the changes and to what extent?**

The modules or subsystems are updated from an applications perspective in response to business requirements and enhancements throughout the year as needed.

Specifically, there are major releases three to four times a year and smaller releases monthly. Should a production issue arise, processes are in place to take immediate and appropriate action in addition to the release schedule.

Hardware capacity is reviewed on an ongoing basis and adjusted as necessary to meet database and CPU requirements.

System software (database, operating system, tools) are updated as vendors provide upgrades and adequate testing has taken place.

Some additional enhancements planned for our claim system in 2011 include:

- **Revisions to all electronic transactions:** to comply with federal regulations and new 5010 format
- **Increase mailroom automation:** in conjunction with the above, material changes to systems supporting the business process changes with our electronic mailroom

3.5 **What initiatives have you implemented to ensure your dental claims payor system is HIPAA compliant?**

Member privacy and confidentiality will be protected in accordance with HIPAA privacy regulations. We have made a significant investment in HIPAA-related activities and plan to continue this investment. In terms of the privacy regulations, we implemented necessary changes to support compliance with HIPAA and HITECH including the following:

- named a privacy officer, privacy office lead and implemented a privacy office which has responsibility for oversight and compliance with the HIPAA privacy rule, HITECH and state privacy regulations
- drafted and continue to execute agreements with business associates to ensure that they handle our members' protected health information in a manner consistent with HIPAA and HITECH requirements
- prepared and continue to distribute a Privacy Notice or Privacy Notice reminder to our members describing how their health information is used or disclosed in the course of provision of services to them
- implemented system changes and developed detailed processes designed to ensure quick response to requests from individuals for access to their health care information and other individual rights requests
- reinforced internal rules that allow only those employees with a "need to know" access to identifiable health information, and then only the limited amount of information needed
- trained workforce on the HIPAA privacy rule and CIGNA's privacy policies and procedures

3.6 **Do you have a SAS 70 audit of your claims payment system? If so, how frequently is the audit completed? What were the results of your latest audit?**

Yes. CIGNA conducts two Type II CIGNA SAS 70 audits every year. The periods under review are October 1 through March 31 and April 1 through September 30. The last completed CIGNA SAS 70 was for April 1, 2010 through September 30, 2010.

The April 2010 report received a "clean" opinion from PricewaterhouseCoopers.

3.7 **Eligibility data will be transmitted from ADP in a HIPAA compliant format. Confirm that your system can accept this file automatically. Is there a fee associated with setting this process up?**

Agreed

3.8 **How many other employer groups submit their eligibility to your organization using data provided by ADP?**

We currently have over 450 other automated clients that use ADP.

4.0 **Customer Service**

4.1 **What is the location of the customer service center that would handle our account being located?**

Customer service for your employees will be provided by the Denison service center, located at:
4616 US Highway 75 South
Denison, TX 75020

- 4.2 **What are the hours of operation of the customer service center?**
CIGNA chose to be the only national health service company to expand our customer service hours to include the weekends, holidays, and overnight hours. Our toll-free customer service number, 1.800.CIGNA24, is staffed 24 hours a day, 7 days a week to answer questions regarding benefits, claims, procedures, or any other concerns.
- 4.3 **What is your staffing ratio of customer service representative to members?**
In 2010, the customer service representative ratio to members was 1:48,377 (total membership).
- 4.4 **How many members does the customer service center currently service?**
In 2010, our representatives serviced 8,876,960 members.
- 4.5 **Will additional staff be added to the customer service center to accommodate our account?**
No, additional staff are not necessary to accommodate your account. In all of our customer service claim centers, we use a phone and claim (PAC) strategy. The PAC strategy refers to several customer service associates and claim processors who have been cross-trained in each location. They ensure, during times of either high absenteeism or higher than planned claim or call volume, that the PAC strategy is implemented and that our customers and members receive no disruption of service.
- 4.6 **Describe how telephone calls from non-English speaking members are handled in your customer service department.**
When calling the toll-free customer service line, callers are given the option to continue in English or Spanish. Callers requesting to continue in Spanish can speak to or leave a message for a Spanish-speaking customer service associate (CSA). We also utilize Language LineSM, an over-the-phone interpretation service that provides access to translation for over 170 languages.
- 4.7 **Describe the structure of your organization (include customer services, claims processing, provider relations, eligibility, account management, billing).**
CIGNA will perform all administrative, underwriting, and network management services. Supporting the account service team are service representatives from each of the following: claim, eligibility, billing, local health plans, contracts and compliance, banking, underwriting, and reporting.
- 4.8 **List the specific functions of the customer service department.**
Customer service associates (CSAs) receive all initial calls from your employees. Online tools give CSAs access to a variety of information to quickly and efficiently respond to questions and resolve concerns.
- 4.9 **Will you provide a dedicated customer service team to handle inquiries related to the County's plans?**
No. Due to our extensive phone technology and interactive voice response systems, we do not specify dedicated customer service associates (CSAs). We can provide the best service to your employees using all of our available CSAs and phone lines.
- 4.10 **Describe your customer service call recording system, inquiry tracking system and reporting capabilities**
All member inquiries are tracked in a call tracking database by our customer service department. Reports are available that document the volume, reason, and resolution type which can be used for analysis, education, and to ensure we meet member expectations through appropriate and timely resolution.
CIGNA dental's call tracking system includes:
- date of call.
 - real-time documentation.
 - representative who handled call.

- call status as “open” or “closed.”
- where call was referred, if applicable.
- category indicating reason/type.
- notation fields to document response.

A call remains “open” until the issue is resolved. Managers review open call reports to determine the progress of resolution. Reports can be run daily, weekly, monthly, quarterly, or annually.

The majority of all inquiries are resolved during the first call, meeting our “same day closure” standard of 90 percent; with most of the remaining calls resolved within 48 hours. Open calls that are not resolved within 48 hours generally involve retrieval and review of member dental records by our clinical staff of dental directors.

4.11 Provide sample client-specific reports generated from your customer service inquiry tracking system.

See sample reports located on the CD provided in the back of the binder.

4.12 Does your organization perform customer satisfaction surveys on a continuing basis?

Yes.

4.13 If your organization does perform customer satisfaction surveys, how often are surveys conducted?

We use a third-party research firm on an ongoing basis to survey a representative sampling of members to determine satisfaction with the service provided by their network dentists (approximately 11,000 DPPO surveys annually).

4.14 Are customer satisfaction survey results available by client?

Yes.

4.15 Provide a copy of your most recent customer satisfaction survey instrument and the results.

We have included our most recent survey and results in the Exhibits section of this proposal.

4.16 Provide examples of three recent changes implemented as a result of customer satisfaction surveys. Explain how the outcome has changed?

Our main priority at CIGNA is to provide the best access to dental care and service. We place great value on any input we receive from our members and providers. As a result, we look very closely at our survey results.

Based on the input that we receive from our surveys, we look at the amount of time that our members are sitting in the dentists’ waiting rooms. Though the patient wait times as reported by our surveys are very low, we feel that receiving attention as close to the scheduled appointment time as possible is essential to providing maximum patient satisfaction.

The second issue that we assess is members’ perception that treatment they receive is appropriate to their needs. Again, our performance in this category is very strong, but we want to continue to ensure that our members are receiving the best possible dental care.

Finally, we address that members are made aware of the cost of dental work prior to starting treatment.

To address each of these issues, we established an initiative to improve communication with network providers. An example is the expansion of our provider performance monitoring program and our provider scorecard. Provider performance monitoring reports are run on a regular basis to determine the performance of individual dental offices. The information that is gathered is used to determine which dental offices are performing very well, and which offices need some improvement. The information is then put onto a provider scorecard that shows where each dental office is excelling and needs improvement. Offices that need improvement are then contacted by CIGNA and counseled on how they can improve their performance. Some of the metrics on the provider scorecard include wait time, member transfers, member complaints, treatment mix, and on-site audits.

4.17 On average, how long does it take for members to move through your menu selections and speak directly with a customer services representative?

Using toll-free numbers for access, callers are routed to an integrated voice response system (IVR). Following various menu options and the input of an ID and date of birth, callers can

complete their call in the IVR, or opt out to a customer service associate (CSA) based on the appropriate product. Timing is dependent upon which option the caller chooses.

4.18 **What is your 2010 year-to-date call abandonment rate at the customer service center?**
In 2010, the abandonment rate was 1.4 percent.

4.19 **Please provide your customer service center metrics for the last three months?**
We have included our customer service statistics for the last three months in the table below.

Month	Average Speed of Answer	Abandonment Rate
December	21	0.9%
January	20	0.9%
February	30	1.4%

4.20 **Please describe your service guarantees.**
Please see the attached performance guarantee.

4.21 **Do you have an employer portal? If so, please describe the extent of data available for review by the employer including enrollment, claims payments, customer contacts and appeals and grievances.**
Yes. CIGNAaccess.com provides tools and information to support employers in the following key areas:

Feature	Capabilities
Claim Inquiry	View paid claim information at the member level. Clients can also view deductible and lifetime maximum accumulation data at the member level. (The client must be a recipient of Protected Health Information per HIPAA).
Eligibility and Benefit Inquiry	View eligibility and benefit information at the member level. Clients can also print temporary ID cards. (This feature does not require the client to be a recipient of Protected Health Information).
Automated Eligibility Management and Reporting Tool	Clients that submit eligibility via our automated eligibility process can access and download fallout reports. You can review key file processing metrics that provide a historical view of file processing results, including file processing timeliness, member defect rates and error resolution cycle times.
Employee Enrollment and Maintenance	Enroll and maintain benefit elections and demographics for their employees and dependents. Transactions are posted immediately to the internal eligibility system. Clients can: <ul style="list-style-type: none"> • add/delete a dependent • terminate employee coverage • reinstate employee/dependent • process life status changes
Eligibility Reports and Statistics	Create and download eligibility reports that include membership listings and census reports. Customers can tailor the reports to meet their needs. Data is available in real-time as it appears in our eligibility system at the time of the request. If clients submit electronic eligibility files, they can also use the Automated Eligibility Management and Reporting Tool to access and download user-friendly fallout reports and key file processing metrics.
Premium/Fee Invoices	Electronic versions (PDF) of the CARBS premium/fee invoices are available. <ul style="list-style-type: none"> • system generated notification when the invoice is ready • clients retrieve, view, save or print the invoices at their convenience

Feature	Capabilities
Financial Reports	Review standard financial reports which include monthly experience reports (excluding premium) and lag reports. Reports are posted to the Web by the 10 th calendar day of the month.
Banking Reports and Statistics	View current banking reports based on a pre-selected request (daily, weekly, or monthly depending on the report type). Reports include worksheets, issued check register, cleared check register, and claim refunds. Monthly reports are available by the 10 th business day of the following month; weekly reports are available the 1 st business day of the following week; daily issued reports are available the next business day. Daily cleared reports are available two business days later. <u>Note:</u> Timing for reports is dependent upon the successful transmission from the source systems.

Clients control access to sensitive plan data for different employees based on their specific job position.

5.0 **Billing Process**

5.1 **Describe your billing process (frequency, due dates, grace period, late payment procedures, interest penalties, etc.) and system for premiums or fees and/or claims reimbursement.**

Monthly invoices are automatically generated based on eligibility data provided by Maricopa County and maintained in our central eligibility database (CED). Our CIGNA accounts receivable and billing system (CARBS) is fully integrated with our CED system. As eligibility related changes are processed in CED, they are systematically generated to CARBS throughout the business day. Maricopa County’s billing representative will be able to view a pending version of your next invoice containing these changes to effectively respond to any billing questions you may have. Rate and structure changes are updated using the same approach.

Our customers are able to receive a single, system-generated, eligibility-based invoice for all products offered by CIGNA on an insured, minimum premium, and/or ASO basis.

There is flexibility in the date that bills can be produced and mailed. Dates available for bill productions are determined on a client-specific basis, based on the products selected and Maricopa County’s timing preference.

Bill timing options include:

- **Prior Bill:** produce bills prior to the month of service (standard)
- **Current Bill:** produce bills during the month of service

Bills can be produced between the 2nd and the 28th of the month. Customers may select one of the following calendar dates for bill production:

- **Prior Bill:** recommended calendar date is between the 10th and 26th
- **Current Bill:** recommended calendar date is between the 2nd and 10th

A case installation specialist will work with Maricopa County to determine the billing date and timing that best meets your needs. The bill will be produced each month on the calendar date that is selected.

The bill reflects eligibility data in our system as of the close of business day the bill is produced. Additions, changes, and terminations processed through the date will be reflected on the bill. Eligibility changes processed after the bill is produced will be reflected on the next month’s bill.

The monthly billing package provides a summary page detailing the total amount to be remitted. The total amount includes charges for current month of service, retroactive adjustments, and any unpaid amounts from prior bills. Eligibility updates that were not processed in time for the current month’s bill will be reflected on the next bill.

Premiums and fees are due as of the first day of the coverage month and are considered delinquent if payment is not received by the last day of the month.

5.2 **Provide a sample monthly invoice.**

We have included a sample invoice in the Exhibits section of this proposal.

5.3 **Describe your self-billed process.**

CIGNA will continue to work with the existing billing process used by the County today.

5.4 **Describe your banking arrangements.**

Fully Insured

The proposed plan is fully insured; banking will be administered by CIGNA.

ASO

Citibank administers our ASO banking arrangements. However, Maricopa County may select any bank to fund their program account. We issue claim checks through our claim administration process with several controls in place.

As checks are issued, the daily issue data is sent to Citibank. Checks are paid through the central disbursing account for all ASO accounts. This is an unfunded, zero-balance account, so when checks are paid, it becomes momentarily overdrawn. There is an estimated 3- to 4-day float for single payment checks and a 5- to 7-day float for bulk payment checks.

Paid checks are matched against the outstanding issue file and immediately transferred to the account from which they were drawn. This ensures that your account is not debited unless the paid and outstanding checks match in the issue file. Your account is then debited, and the central disbursing account is credited, bringing the latter to its proper zero-balance.

You have a choice of daily or weekly funding for your account. The required imprest amount for an ASO account is the greater of 3-days' average claim activity or \$10,000 if funded daily, or the greater of 7-days' average claim activity or \$10,000 if funded weekly. If you choose daily funding, Citibank will wire request funds from your bank daily for the aggregate amount of checks cleared the night before. If you choose weekly funding, they will wire request funds from your local bank on the first business day of each week for the aggregate amount of checks cleared the prior week. Your local bank must honor the request for funds via Fed Wire transfer the same day to immediately restore your account to the imprest balance. Funding arrangements can be made utilizing the Automated Clearing House (ACH), which requires an additional day's imprest whether funding daily or weekly.

We provide daily, weekly, or monthly registers of checks issued or cleared and a monthly ASO worksheet summarizing claim activity. Citibank supplies us with a detailed monthly statement and reconciliation. All paid checks are microfilmed and kept in the financial services unit as proof of payment.

6.0 **Benefit Provisions**

6.1 **Can you administer the current benefit plan without modification?**

Yes.

6.2 **If you cannot administer the current benefit plan, explain the changes you would require and the reason for them.**

Not applicable.

6.3 **Include a detailed description of any services or materials which would be excluded under your program.**

CIGNA matched our current benefit plan in place.

6.4 **State your willingness to offer your plan in conjunction with another carrier's dental HMO and/or PPO plan.**

Agree

6.5 **Do you offer pre-determination of benefits?**

Yes.

6.6 **If yes, is the pre-determination of benefits mandatory or optional?**

Optional.

6.7 **Please describe the pre-determination of benefits process.**

Predetermination of benefits is a voluntary review of a dentist's proposed treatment plan and expected charges. The treatment plan should include supporting pre-operative X-rays and other diagnostic materials as requested by a CIGNA dental consultant. If there is a change in the treatment plan, a revised plan should be submitted.

We will determine covered dental expenses for the proposed treatment plan. If there is no predetermination of benefits, we will determine covered dental expenses when we receive a claim. Predetermination of benefits is not a guarantee of a set payment. Payment is based on the services that are actually delivered and the coverage in force at the time services are completed. Predeterminations are valid for 12 months from the date of issuance. After the expiration date the predetermination is automatically purged from our system.

6.8 Describe in detail how you will handle dental treatment already in process. Include orthodontia coverage in your response.

Inlays, onlays, crowns, bridges, partial and full dentures, and root canals initiated prior to changing to CIGNA must be completed under the terms of the previous carrier.

In-Network

If a member chooses an in-network orthodontist, we will initiate payments for the number of months remaining in the member's orthodontic case based on the DPPO contracted amount. We will pay up to the benefit maximum for the member's plan for the number of months remaining, and retention if any maximum dollars are left.

Out-of-Network

If a member chooses an out-of-network dentist, we will initiate payments for the number of months remaining in the member's orthodontic case based the member's benefit plan and the individual dentist's charges. We will pay up to the benefit maximum for the number of months remaining and retention if any maximum dollars are left.

6.9 Describe any pre-existing condition limitations in your plan.

Replacement of bridges, crowns, or dentures within five years of the date of installation (on some plans within two or three years) will not be covered unless:

- replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth after existing prosthetic was installed
- bridge, crown or denture, while in the mouth, is damaged beyond repair as a result of injury

6.10 Does your plan charge for a dentist's sterilization fee?

No

6.11 Do you have an online tool where the County can review the benefit set up?

Yes, personalized benefit information is available through myCIGNA.com.

6.12 Indicate all benefit limitations and/or exclusions in your contract proposal.

Please see the list of benefit limitations and/or exclusions attached in the proposal binder.

6.13 Explain continuity of care arrangements for procedures started but not completed at the beginning and end of the contract.

Coverage for a dental procedure that was started before disenrollment from the plan (crowns, root canal treatment, bridges, dentures, and partials if the teeth were fully prepared or the final impressions), will be extended for 90 days after disenrollment unless it was due to non-payment of premiums.

Coverage for orthodontic treatment which was started before disenrollment from the dental plan will be extended to the end of the quarter or for 60 days after disenrollment, unless it was due to non-payment of premiums.

Our standard extension of benefits is 90 days; however, other arrangements can be made.

7.0 Implementation/Enrollments

7.1 Do you require the County to sign a copy of your Service Agreement/Contract?

Yes.

7.2 If you do require the County to sign a copy of your Service Agreement/Contract please provide a copy for their review.

We have included our sample contract in the Exhibits section of this proposal.

- 7.3 **Provide a detailed implementation work plan with timeline outlining tasks, dates, roles and responsibilities assuming a July 1, 2012 effective date.**
We have included a sample implementation schedule in the Exhibits section of this proposal.
- 7.4 **Describe the members of your team who will be involved in the implementation prior to July 1, 2012.**
Please see the attached contact list
- 7.5 **Include brief biographies on these members of your team who will be involved in the implementation which reflect the expertise they bring to the implementation.**
Please see the attached contact list
- 7.6 **Indicate if there are any additional implementation costs not already included in your fees.**
Fees are comprehensive and include implementation.
- 7.7 **Describe your preferred method of communicating the new plan to our employees.**
Recent studies show that only 36 percent of employers believe their employees understand the true value and cost of the benefits they provide. We want to help Maricopa County with that. CIGNA believes that employee education is critical, and higher participation in value-added benefits equals higher employee retention and the ability to attract new employees.
Standard communication materials are included in the cost of the program. These are simple, easy-to-understand brochures that explain our products and services. If Maricopa County would like additional custom materials, we have communication experts that will work with you to develop a custom communication strategy. Most of these materials can be provided electronically at no additional charge (email templates to forward to your employees, flyers to post to your internal site, posters to hang in high traffic areas, newsletter articles, etc). Messaging may focus on benefit savings, prevention, or using in-network dentists. These messages will be customized based on your specific needs. There may be an additional charge for high volume printing or direct mailing. We also recommend you schedule benefit enrollment meetings in your larger locations to communicate your CIGNA plan options. Our experience has shown that employees benefit the most when they receive information directly from CIGNA representatives. We will provide pre-enrollment event communications to generate excitement, as well as materials for your on-site event. This could include interactive games, quizzes, or presentations to help your employees understand their benefit choices.
- 7.8 **Include sample communication materials.**
We have included our sample communication materials in the Exhibits section of this proposal.
- 7.9 **Will you do a direct mailing to employees' homes?**
All materials will be delivered to Maricopa County's main group location. Materials can also be mailed directly to employees' homes for an additional charge.
- 7.10 **If you will not provide direct mailing to employees' homes, how will communication materials be distributed?**
All materials will be delivered to Maricopa County's main group location.
- 7.11 **Confirm that the cost of printing and distributing communication materials is included in your quoted rates.**
We have shown an additional \$0.12 per employee per month to cover the cost of printing and distribution of communication materials.
- 7.12 **To what extent can your communication materials be customized?**
We will be happy to discuss customized materials with you. This may include adding your logo or including specific messaging that is important to your employees, or the plans you are offering.
- 7.13 **Confirm that the cost of customization of communication materials is included in your quoted rates.**
Confirmed

- 7.14 **Provide a copy of enrollment materials that the County would be able to include on their benefits Web site.**
We have included our sample enrollment material in the Exhibits section of this proposal.
- 7.15 **Will you provide a representative for the initial enrollment meetings this year and for each annual open enrollment meeting thereafter?**
Yes.
- 7.16 **Confirm that the cost of providing a representative each year at annual enrollments has been included in your quoted rates.**
Confirmed.
- 7.17 **Will you provide a representative for monthly new employee orientation, and ongoing service according to a predetermined schedule?**
Yes.
- 7.18 **Confirm that the cost of providing a representative for new employee orientation, and ongoing service has been included in your quoted rates?**
Confirmed.
- 7.19 **Confirm that you will provide draft plan documents and/or evidence of coverage booklets to the County in electronic format**
Confirmed.

Fully Insured

As a fully insured client, Maricopa County will receive a copy of the certificate of coverage (COC) electronically via PDF file at no additional cost. However, there may be additional fees for the client if numerous non-standard modifications are requested. The copy contains federal and state requirements that are needed for insured accounts.

We contract with an outside print vendor to handle the printing and distribution of certificates at no additional cost to the employer. However, additional fees may apply for shipping to multiple locations or individual members.

ASO

CIGNA prepares and provides a draft of the SPD at no additional cost to Maricopa County. The draft contains federal and possibly state requirements that are needed for ASO accounts. Drafts are provided electronically via PDF file. The draft may be adequate to serve as Maricopa County's SPD; however, the ASO employer is responsible for creating the final document that is tailored to the benefits they are offering to their employees, and for ensuring compliance with ERISA and all other applicable federal and state requirements.

We contract with an outside print vendor to supply printed copies of the booklet or SPD. However, additional fees apply based on coverage and services provided.

- 7.20 **If you will agree to provide draft plan documents and/or evidence of coverage booklets to the County will there be any charge to the County for these documents (describe).**
No.
- 8.0 **References from clients who have/had dental coverage with your company**
- 8.1 **How many employer groups and members are enrolled with your plan in Arizona?**
These numbers are based on the entire State of AZ; 1,096 groups and 202,804 total members
- 8.2 **How many public sector employer groups and members are enrolled with your plan in Arizona?**
State of AZ; 1,096 groups and 202,804 total members
- 8.3 **Provide a representative list of at least five current Arizona clients (Attachment C) for which you provide dental coverage and ASO and/or fully insured dental claims administration/payment, the number of covered employees, length of time that they have**

been contracted, and a contact name and phone number. Provide three employer groups who have terminated within the last 2 years.

Please see the attached list of references

8.4 Indicate the number of clients you have in the following categories which are administered in the same geographic location as would be used by the County:

8.4.1 **Less than 1,000 employees - 979**

8.4.2 **1,000 – 5,000 employees - 12**

8.4.3 **5,000 or more employees - 12**

9.0 Performance Guarantees

9.1 **Are you willing to negotiate and implement performance guarantees?** Yes

9.2 **Do you have a standard performance guarantee agreement?** Yes

9.3 **Provide a copy of your standard performance agreement, if any.** See Attached

9.4 **Are you willing to deviate from the standard performance agreement?** Yes

9.5 **Describe any areas in which you are unwilling to deviate from your standard performance agreement.**

N/A

10.0 Network (Mandatory – Network shall be owned by proposer)

10.1 Provide a brief overview of your network.

The CIGNA Dental Core PPO network is a single, seamless national network. All participating dental offices have gone through the same careful selection process and have met our criteria. Credentialing, utilization management, and network management are consistent regardless of location. Your employees can transfer between various locations and be confident that quality care will be available to their families. While CIGNA directly contracts with individual or group private dental practices for the vast majority of its PPO network, CIGNA's Dental PPO network includes additional dental providers contracted with an affiliated network. CIGNA monitors and reviews key data related to the vendor providers to ensure they also meet our key criteria's for participation in the network.

10.2 How long has the network been operational?

The DPPO product was introduced in July 1996 and licensed at varying times in states throughout the nation.

10.3 Was the network developed entirely by you?

CIGNA's national dental network was developed internally.

10.4 Where is your network currently operational?

CIGNA's group of operating subsidiaries is licensed to transact the business of insurance by the insurance departments in each of the 50 states, the District of Columbia, and Puerto Rico. The CIGNA Dental PPO (DPPO) plan is approved in 46 states (all states except Nebraska, Iowa, West Virginia, and Idaho). CIGNA is subject to regulation in each jurisdiction within the scope of applicable law.

10.5 Do you have providers available in the event of an emergency, after hours and on weekends?

Yes. Our agreements with dentists require them to provide or arrange for emergency care 24 hours a day, 7 days a week, and to provide emergency attention within 24 hours of requests.

10.6 Do you have a national network?

Yes.

10.7 Is your national network part of your proposal to the County making the national network available to all County employees?

Yes.

- 10.8 **Provide a listing of dentists (by specialty) currently under contract.**
We have included the requested information in the Exhibits section of this proposal.
- 10.9 **If you are provided a listing of the current provider network, are you willing and able to compare your network with the current network?**
Yes.
- 10.10 **Are there any restrictions on provider access (e.g., limitation on new patients for certain providers)?**
No.
- 10.11 **If there are restrictions on provider access note each individual provider currently under such restrictions.**
Members in the plan are free to visit any network or non-network specialist or general dentist.
- 10.12 **What is your current capacity to enroll new members with the current provider base?**
CIGNA Dental PPO network dentists do not cap or close their offices. Members are not required to select a primary network dental office.
- 10.13 **What criteria do you use for the selection/credentialing of providers, if any?**
In order to participate in our networks, each potential dentist must go through a rigorous and selective screening process to ensure that they are licensed practitioners and that their certifications and credentials meet our highest standards. The following review is completed by our network managers/credentialing department to help ensure that members receive the best care:
- dentists must be licensed in the state where they are providing services
 - specialty training verification (if applicable)
 - current malpractice insurance and state license information is kept on file for each dentist
 - history of conviction for fraud or felony, disciplinary action or litigation
 - graduation from accredited dental school
 - compliance with Occupational Safety and Hazard Association (OSHA) and the Center for Disease Control (CDC)
 - specific office standards are met
 - general office and dentist data is collected
- We re-verify the credentials of each participating dentist every three years.
- 10.14 **Please describe any special training dentists receive from you, if any.**
Dentists accepted into the CIGNA Dental PPO network will receive the *CIGNA Dental PPO Office Reference Guide*. This streamlined procedure manual provides education and training on our policies, procedures and processes.
In addition, our convenient Internet-based portal allows dentists the ability to conduct transactions over a secure website directly linked to CIGNA. This portal provides one-stop online access to information including all reference materials and forms needed to administer the CIGNA Dental PPO plans.
- 10.15 **How many members do you currently service under your network program in Arizona? What is your provider to member ratio?**
We currently provide DPPO services to 202,751 members in Arizona. Members are not assigned to a specific provider; therefore, we are unable to provide the provider to member ratio.
- 10.16 **What are your network development plans in Maricopa County and/or Arizona for 2011 and 2012**
The 2011 growth goals set for core based statistical areas (CBSA's) in Arizona for the core PPO network include:
- Phoenix – Mesa – Glendale, AZ: 46
 - Tucson, AZ: 30
 - Yuma, AZ: 4
- The 2012 growth strategy is still in development.

10.17 **Describe the nature and length of the contract between your providers and your organization.**

The CIGNA Dental PPO network consists of contracted individual or group private dental practices. Our provider contracts are not based on exclusive arrangements.

Network dentists agree to accept discounted fees for their services. These fees are based on average fees in a particular geographic area, less a certain percentage. Network dentists and specialists are also asked to provide a 20 percent discount (depending on state regulations) off their usual fees for any service not included in the fee schedule.

All CIGNA provider agreements expire on December 31st, of each year and are automatically renewed, unless the dentist or we terminate the contract. The contract may be terminated by either party with 60 or 90 days (according to state regulations) written notice anytime throughout the year.

Dentists leaving the program for any reason are contractually obligated to complete dental procedures in process. For services requiring multiple visits, the network dentist is contractually obligated to complete all services under the applicable fee schedule, within 90 days from the date of termination.

Network dentists contractually agree to participate in our quality management and utilization management programs. We have a 20 percent overlap in our DHMO and DPPO networks; therefore, those network dentist offices are visited annually when we conduct on-site reviews of the CIGNA Dental Care network. If there are quality issues, we reserve the right to perform on-site examinations of any CIGNA Dental PPO network office.

10.18 **If network gaps exist in areas where employees are concentrated, how would your firm propose to extend the network?**

For those areas where access is limited, we will work with Maricopa County to contact your employees' highly utilized dentists for possible recruitment into our network. Our field-based network managers will develop a targeted plan based on your needs.

10.19 **Describe your willingness to target particular non-contracting providers upon request from the County.**

We are continuously expanding our network to meet the needs of current and potential clients. While most of your employees have convenient access to network dentists, we are committed to expanding our network according to our clients' needs.

We offer three standard networks to provide a balance between network access and dentist discounts that best meets the needs of Maricopa County and your employees.

While the availability of dentists receptive to managed care is critical, our competitive compensation structure and reputation for fast, accurate claim payment has resulted in successful recruitment campaigns for clients like you.

In addition, members are welcome to suggest dental offices for inclusion in the CIGNA dental networks. We will make every effort to contract nominated dentists once they've passed our credentialing requirements.

10.20 **Describe how your firm would handle a case where a network provider refuses to give agreed-upon discounts or attempts to balance bill.**

Balance billing beyond the contract fee is not permitted for any service provided to the member.

In the case of CIGNA owned networks, balance billing for covered procedures is strictly prohibited. We will counsel network dentists who do not comply, and continued balance billing may cause the network dentist's file to be referred to our credentialing Committee for review of future participation in the network.

For leased networks, CIGNA would address any balance billing with the dentist or our affiliated network partner(s). In the case of dentist contracted with an affiliated network, the affiliated network contract would apply.

10.21 **Do your provider contracts support audit activities, including:**

10.21.1 **Audits conducted by your organization**

10.21.2 **Audits conducted by a third party**

As appropriate, CIGNA conducts focused audits if a network dentist has a significant number of complaints or other issues involving quality of care. We contractually retain

the right to perform on-site reviews if network dentist offices exhibit unusual utilization patterns, have a high percentage of participant grievances, or if those grievances are serious in nature.

A trained, experienced dental professional is responsible for performing the audit when an on-site review is warranted for existing network offices. This audit might include a chart review which investigates treatment planning, quality and quantity of radiographs, evidence of proper diagnosis, and appropriate treatment of disease. The audit must show adequate application of all available preventive and diagnostic measures. Network management staff and dental directors counsel dentists as part of this focused audit.

10.22 Describe your quality assurance and utilization review procedure in terms of provider networks, specifically:

10.22.1 Who is responsible for quality assurance?

The national dental director along with his clinical staff is responsible for quality and utilization management, including oversight of utilization review/management policies and guidelines. They report to the vice president of specialty solutions, who maintains oversight of the network management and network strategy staff for all CIGNA dental plans.

The clinical unit has responsibility for developing and maintaining policy guidelines used by the claim staff in processing claims. When revised guidelines are developed, drafts are distributed to the claim staff for input. When guidelines are finalized, an implementation plan is created, which includes agreed upon effective dates, training, and post-implementation feedback. This process creates the opportunity for our claim staff to understand clinical policy, and encourages communication between the two departments.

10.22.2 How often does this staff meet?

The quality management committee meets at least once per quarter.

10.23 Identify the provider appeal process that you use to respond to network disputes for both plan participants and providers of care (e.g., participant disputes, pre-determinations, or lack of pre-determinations, etc.).

The following dentist appeal process applies to all CIGNA initiated terminations. It may also apply when states require appeals for other reasons, such as network participation denials.

- We will provide notice to the dentist of the reason for termination and the right to appeal the termination.
- If the dentist wishes to appeal a termination, he or she must notify CIGNA within 30 calendar days from the receipt of the notice of termination. The appeal should be scheduled at a convenient date for both CIGNA and the dentist (if the dentist is planning to attend) and at a date that allows the dentist a reasonable amount of time to prepare information in support of his or her appeal.
- The appeal will generally be heard and a decision rendered prior to the effective date of the termination and prior to any notice to the members regarding the termination. This will not apply in those circumstances where the cause for termination is one for which an appeal can not reasonably be held prior to the effective date of the termination, such as loss of licensure.
- The dentist is given the opportunity to present information in support of the appeal. Information may be presented in writing and/or the dentist may elect to personally appear at the appeal or participate via conference call. The dentist may participate with his or her counsel provided that 3 business days advance notice is given to CIGNA.
- A panel of at least two CIGNA dentists and 1 regional vice president who were not involved in the original decision will hear the appeal of the termination. One member of the panel will be designated as the chair and will be the individual to whom any questions by the dentist or the dentist's counsel will be directed.
- If the termination decision is upheld, the dentist will be given the right to appeal to the National Provider Appeals Council. However, the termination will not be stayed pending that appeal.
- The National Provider Appeals Council includes three CIGNA dentists (including the national dental director) and a regional vice president who were not involved in the original decision or first level appeal. The dentist and/or representative do not participate in this level of appeal.

10.24 **Provide a geoaccess report of your network using the census provided and use the criteria of 2 dentists within 10 miles of home zip code. (Attachment E)**

We have included the requested GeoAccess report in the Exhibits section of this proposal.

10.25 **Provide your provider turnover rates in Maricopa County for each of the last 3 years: 2008, 2009, 2010.**

The turnover rate was 5.1 percent in 2008, 4.2 percent in 2009, and 3.4 percent in 2010.

10.26 **Indicate the reason for the terminations, if any, for each of the last 3 years: 2008, 2009, 2010.**

The majority of dentists who leave the plan are associates (non-owners) who move from practice to practice with some degree of regularity. We expect to retain 96% of network dentists each year.

10.27 **Provide your unduplicated total network size in Maricopa County for each of the last 3 years: 2008, 2009, 2010.**

Our DPPO Core network consisted of 1,166 unique providers in 2008, 1,322 unique providers in 2009, and 1,571 unique providers in 2010.

10.28 **Have any dentists been terminated for quality of care issues in the last 3 years: 2008, 2009, 2010? Please describe the top three quality of care issues in the last 3 years?**

Dentist termination is tracked using the following three categories:

- state board action (loss of licensure due to action or non-renewal, etc.)
- malpractice history or other quality of care issues
- other

The majority of dentist terminations are based on board action, because in many cases, states have already taken action by the time we find out about a quality of care violation.

DPPO Terminations

Reason for Termination	2010	2009	2008
State Board (BODEX), Medicare, Medicaid, or other sanctions	2	3	17
malpractice history or other quality of care issues	4	2	3
other	53	8	26

10.29 **What is the termination clause for dentists in your network?**

Generally, our network dentist agreements require 60 or 90 days (as required by law) advance notice for termination of the contract by the dentist or CIGNA. Immediate termination may be initiated by CIGNA in certain situations. CIGNA or the dentist may terminate the agreement for a variety of reasons including:

- failure to perform in accordance with the terms of the contract
- disqualification from practicing dentistry in the dentist's her licensed state
- activity that conflicts with the terms of the agreement or causes the dentist's license to be revoked or denied
- falsification of information on the dentist's application
- termination from another CIGNA Dental network
- activity that becomes the focus of a quality of care issue that is grounds for termination

Termination occurs only after a full investigation by the credentialing committee.

10.30 **Address the number of days for notification that a dentist is required to give prior to termination.**

Our network dentist agreements generally require 60 or 90 days (as required by law) advance notice for termination of the contract.

10.31 **Describe a terminating dentist's obligation for treatment-in-progress. Include orthodontia work in your response.**

For services requiring multiple visits, the network dentist is contractually obligated to complete all services under the applicable fee schedule, within 90 days from the date of termination.

If a claim is submitted and the dentist withdraws from the network during the processing of the claim, it will be paid if approved, incorporating applicable plan discounts. The claim will be paid because the dentist was a participating network dentist at the time service was rendered and/or initiated.

10.32 In Maricopa County, what is the average discount for your contracted general dentists?

The average discount in Maricopa County (zip code 850) is 34.3 percent.

10.33 In Maricopa County, what is the average discount for your contracted dental specialists?

The average discount in Maricopa County (zip code 850) is 34.3 percent.

10.34 Is your discount calculated from billed charges or R&C?

Network negotiated fees are set at a discount off of the average charges in the 3-digit zip code.

10.35 If your discount is R&C, what is your data source and what percentile do you use?

We use data from the Prevailing Healthcare Charges System published by Fair Health to determine the standard maximum reimbursable charge (MRC). This data is considered statistically valid if there are nine or more occurrences of a procedure code in a geographical area. If there are fewer than nine, we use CIGNA's database to update MRC files. When both files contain less than nine, we utilize the CIGNA MRC amount prior to the update.

CIGNA's standard MRC allowance for out-of-network DPPO claims payments, except for orthodontic procedures, is the 80th percentile of submitted charges for a given area.

10.36 Do you have an online tool where the County can verify the payment terms of a dental contract, or contract status of a dental provider?

Yes. The following member self-service functions are available through myCIGNA.com:

- personalized benefits information
- claim status inquiry
- deductible and lifetime maximum accumulation data
- network dentist search with maps and directions
- claim forms and information on where to submit forms
- explanation of benefits (EOBs)
- dental prevention and wellness information, including WebMD articles
- glossary of dental terms
- print ID cards
- dental and claim office phone numbers and addresses
- list of frequently asked questions
- periodontal gum disease risk assessment quiz
- dental Treatment Cost Estimator
- dental Cavity Risk Assessment tool
- information about our Healthy Rewards® discount program

The following provides a brief overview of consumer tools available:

Treatment Cost Estimator (TCE)

Customers will have access to our consumer-driven tool, the dental Treatment Cost Estimator (TCE). The TCE is a user-friendly, comprehensive web-based tool that allows customers enrolled in any CIGNA dental plan to estimate and plan for their dental care costs, both on a procedure code level and a treatment level. The TCE uses a large national utilization database to provide geographically based dental fee estimates that, among other things, enables our customers to estimate their out-of-pocket costs, view what their savings would be with CIGNA for treatments and procedures, and displays what the treatment or procedure would cost without insurance.

Cavity Risk Assessment Tool (CRA)

Customers can also access our dental Cavity Risk Assessment tool which measures the risk of tooth decay for customers and their family members, and helps dentists identify their risk of getting a cavity. The assessment consists of 12 questions for adults and 16 questions for children under the age of 12.

Periodontal Risk Assessment Tool (PRA)

Our Periodontal Risk Assessment tool allows customers to assess their risk for periodontal disease in minutes by answering 20 simple questions. Available in both English and Spanish, this online quiz provides the user with a score that helps forecast their risk for having gum disease. Users can print the results to share with their dentist at the next visit.

CIGNA Dental Oral Cancer Awareness Quiz

This ten-question quiz is designed to help customers test their knowledge about the basics of oral cancer: where it can occur, warning signs, common risk factors, and what customers can do to help reduce their own risk. Please note, *this quiz does not score customer responses or evaluate risk* as the PRA and CRA do; instead, this quiz is a fast, easy and fun educational tool. Customers can take what they learn and ask questions at their next dental check-up.

To take a tour of myCIGNA.com, go to: <http://www.cigna.com/mycignademo>. The user ID is "mycigna" and the password is "preview" (case sensitive). Then choose the dental version.

- 10.37 Give the total number of providers currently employed in Maricopa County by location in the following categories and the rate of turnover during the last 12 months.

	Number by Location	Annual Rate of Turnover	% Closed Practices
Dentists	1,153	3.2%	0%
Orthodontists	168	1.1%	0%
Specialists	362	5.0%	0%
Dental Hygienists	N/A	N/A	N/A

- 10.38 Please complete the following table for R&C and PPO discounted fees. If you have individual contracts/files fees for participating dentists, then report the medium filed fee/contract in the PPO column. Base your fees on Maricopa County only.

We have included information based upon zip code 850 in the table below.

Class	Dental Procedure	90 th Percentile R&C Charge	80 th Percentile R&C Charge	PPO Contracted Fee
I	0120	\$54	\$50	\$28
	0150	\$87	\$84	\$41
	0210	\$136	\$122	\$78
	0272	\$47	\$42	\$23
	0274	\$65	\$60	\$35
	0330	\$120	\$114	\$62
	1110	\$94	\$89	\$59
	1120	\$70	\$66	\$42
	4910	\$147	\$137	\$96
II	2140	\$185	\$171	\$58
	2150	\$227	\$215	\$79
	2160	\$285	\$265	\$93
	2330	\$177	\$163	\$82
	2331	\$209	\$195	\$105
	2335	\$303	\$277	\$132
	3310	\$810	\$729	\$416
	3320	\$885	\$849	\$498
	3330	\$1,100	\$1,075	\$724
	4260	\$1,500	\$1,200	\$651
	4341	\$264	\$250	\$129
	7110	\$178	\$155	\$76
	7210	\$286	\$266	\$144
	7230	\$384	\$350	\$240
	7240	\$450	\$418	\$284

Class	Dental Procedure	90 th Percentile R&C Charge	80 th Percentile R&C Charge	PPO Contracted Fee
III	2750	\$1,068	\$1,019	\$672
	2751	\$1,054	\$1,000	\$540
	2752	\$1,064	\$975	\$610
	2790	\$1,122	\$1,050	\$625
	2792	\$1,181	\$1,095	\$530
	5110	\$1,783	\$1,566	\$806
	5214	\$1,862	\$1,666	\$912
	6240	\$1,112	\$1,037	\$649
	6750	\$1,112	\$1,037	\$631
	6752	\$1,103	\$1,005	\$631
Ortho	<=18	Reimbursements for orthodontic procedures are determined on a case-by-case basis.		
	18+			

Indicate date fee schedules last updated: There are no provisions in network dentist contracts concerning fee schedule increases. Dentists’ fees are reviewed at request of the dentist but no sooner than annually. We do expect to increase fee schedules at a rate no greater than dental consumer price index CPI⁽¹⁾ in order to maintain the size and integrity of the network.

Indicate planned date of next increase: (1)The 2010/2011 dental CPI is 2.7 percent.

- 10.39 **How and how often do you inform plan participants of changes in your provider network?**
 Since there is no need for members to select a primary care dentist we do not notify members if a dentist leaves the network. Members can verify the status of a dentist by calling our toll-free number, 1.800.CIGNA24, or visiting our website at www.CIGNA.com.
- 10.40 **If a participant is having difficulty scheduling an appointment, what type of assistance does your company provide?**
 We do not set the office hour requirements for network dentists; however, our *Dental Office Reference Guide* outlines expectations regarding the scheduling of dental appointments. Our target is for appointments to be provided at the same level as they would be for fee-for-service patients and that members should be able to receive an appointment for routine care within four weeks of calling the office. Dentist contracts require dentists to provide or arrange for emergency care 24 hours a day, 7 days a week and to provide emergency appointments within 24 hours of requests. All inquiries regarding excessive wait time are investigated, and corrective action is taken if we determine that timely and efficient dental care was available and not provided. In addition, if we determine that excessive wait time was the result of insufficient patient capacity, we initiate actions to expand the dentist’s capacity or recruit additional dentists in that particular area.
- 10.41 **What are your requirements of the contracted general dentists when requesting authorization from your company, or anyone else, before they can refer a patient to a specialist?**
 There is no need for a referral by a primary care dentist to obtain services from a specialist with the CIGNA Dental PPO plan. Members may choose to seek service from any in- or out-of-network specialist or general dentist at any time. Of course, network dentists have agreed to our reduced fee schedules, which lower out-of-pocket expenses.
- 10.42 **Describe how you monitor quality patient care with your providers, and how often is this done?**
 We are committed to delivering the highest quality of dental care. Trends and patterns for such metrics as member complaints, dental utilization, member satisfaction, and members’ access to care are routinely analyzed. Action plans are created to correct or improve the trends identified. Additionally, individual practice patterns and procedures are routinely monitored for appropriateness of treatment. Any abnormal patterns are followed up by phone. Dental office policies, procedures, and patient charts may be examined by a regional dental director. Upon further review, an office inspection may be necessary. Findings are evaluated by the regional

dental director and/or the grievance committee. If the results are unsatisfactory, the dentist will be referred to the credentialing committee for possible termination from the network.

11.0 Claims Processing

11.1 At what geographic location will claims be processed?

Claims will be processed by the Denison service center, located at:
4616 US Highway 75 South
Denison, Texas 75020

11.2 What is your targeted turnaround time for processing a clean claim from the time that it is received in your mailroom?

Our standards require that 92 percent of all claims received are processed within 10 working days and 98 percent are processed within 15 working days.
When measuring turnaround time we do not distinguish between types of claims (i.e., clean claims, COB claims).

11.3 What is your actual average turnaround time in the claims processing center that will process the County's claims?

In 2010, 96.6 percent of claims were processed in 10 days and 99.2 percent in 15 days.

11.4 Describe your claims facilities and procedures, including:

11.4.1 The percentage of dental claims undergoing review prior to payment and subsequent to payment.

We randomly select 2 percent of processed claims. We guarantee 60 audits per quarter per processor. These claims are reviewed daily for accuracy and are measured based on payment accuracy, financial accuracy, and overall claim processing accuracy.

11.4.1 Measures taken to prevent fraud by your own employees related to claims processing and claim/draft control.

Edits built into our system identify inappropriate or unnecessary treatment. The tracking of procedures (and the teeth they were performed on) serves as a basis for determining the appropriateness of each claim. The system automatically flags inconsistencies for further investigation by a dental reviewer. Dental consultants handle more complicated claims that require a greater level of dental expertise.

Potential fraudulent employee claim processing is prevented by various methods:

- employees cannot have both eligibility and claim processing IDs
- our daily audit programs randomly select claims from each processor and eligibility technician

Our special investigations unit (SIU) may also identify fraud as a part of their routine review of payment activity. Claims are reviewed for unusual activity, repetition of services, or pattern of treatment. They investigate the extent and scope of the fraudulent activity and collect supporting documentation. If the fraud is substantiated, the evidence is shared with the appropriate authorities. In the case of dentist fraud, evidence is referred to a law enforcement agency or the State Insurance Fraud Bureau.

Once potential fraud has been identified or suspected, the dentist is flagged in our claim system so that future claim submissions are reviewed by the fraud coordinator and/or the special investigations unit (SIU) before payment is issued.

11.4.2 Measures taken to prevent fraud by providers.

CIGNA requires that dentist claims state the actual services to the patient. When reasonable evidence reveals that this is not the case, we ensure that reimbursement is based on the actual services rendered to the patient.

CIGNA claim systems controls reduce the risk of loss through re-bundling fragmented claims, reasonable and customary guidelines, duplicate payment edits, and allowing for pre-payment audits of specific procedure codes.

Claim processors and customer service representatives are trained on identifying red flags of potential fraud. We have a formal focused review program and referral guidelines for

claim processors to ensure that potential suspect claims are surfaced and forwarded to the special investigations unit (SIU).

Published guidelines list circumstances under which a dentist's claim should be audited prior to payment, in order to verify services were provided.

Claims fitting specific fraud criteria are referred directly to SIU staff for investigation. Investigations consist of both retrospective and prospective reviews of paid claims and current claim submissions. Retrospective reviews may entail requesting supporting documents from the dentist and verification from the members that the services billed were provided. Prospective reviews involve "flagging" of dentist numbers in the respective claim systems. Flagging a dentist number can have many protocols, either to request additional documentation from the dentist and/or a survey to the member. The flagging field within the claim systems is protected, and only SIU and dentist data control representatives have authorization to access the flag field.

11.4.3 Your guidelines with respect to detection of and action on overcharges, unnecessary dental procedures, multiple procedures to the same tooth and other cost control programs you may utilize. What is the dental consultant's role in reviewing these claims?

Our dental consultants use a uniform set of written guidelines to review claims. These standards make sure that all review decisions are consistent. Our "dental advisory" is a document developed for internal use that contains the American Dental Associations' (ADAs') description of every ADA code (with their permission to facilitate claim payment). Included in the "dental advisory" are guidelines for payment based upon our standard book of business. This document also contains what can be reviewed by our dental reviewers as opposed to what must be reviewed by our dental consultants, and what is needed for review such as periodontal charting, full mouth x-rays, etc.

11.4.4 Your procedures for detecting duplicate payments and recovering such amounts from providers or employees.

The system verifies that any claim being considered in the claim processing process does not resemble a claim previously submitted for that patient. If duplication is suspected, a message is instantly sent to the claim processor and the system displays the suspected duplicate charge. The claim processor can then verify whether it is a duplicate. The duplicate claim edit procedure applies to the same date of service, tooth number, and procedure code.

11.4.5 The procedures in place to verify the continued eligibility of certain types of employees or dependents with respect to limiting ages, COBRA eligibility and survivor eligibility?

The accuracy of eligibility data plays a crucial role in our members obtaining benefit services, prescription drugs, and timely claim processing.

For automated processing, we adhere to a 99 percent accuracy rate. Our eligibility system uses a built-in edit process that compares the records received against the system and identifies the records that will fall out if the file is updated. If fallout is less than 2 percent, the file is updated. In every instance, error reports are generated for failed records and sent to the client or third-party administrator (TPA) for research and correction. For automated processing standards, open enrollment and renewal files are processed within five days; regular maintenance files are updated within two days.

For manual processing, we have the following standards:

- ninety-seven percent accuracy for in-house processing
- ninety-eight percent accuracy for vendor processing
- maintenance submissions via email processed in forty-eight hours and paper/maintenance sent via standard USPS mail processed in four days
- urgent updates processed in four hours; immediate access to care received via email processed within one hour
- new enrollment processed within four days
- re-enrollment processed within four days
- audit reports processed within ten days

- 11.4.6 **Your procedures and timeline for handling claim inquiries from employees.**
 All member inquiries are tracked in a call tracking database by our customer service department. Reports are available that document the volume, reason, and resolution type which can be used for analysis, education, and to ensure we meet member expectations through appropriate and timely resolution.
 A call remains “open” until the issue is resolved. Managers review open call reports to determine the progress of resolution. Reports can be run daily, weekly, monthly, quarterly, or annually.
 The majority of all inquiries are resolved during the first call, meeting our “same day closure” standard of 90 percent; with most of the remaining calls resolved within 48 hours. Our year-to-date result is a same-day closure rate of **97.3** percent. Open calls that are not resolved within 48 hours generally involve retrieval and review of member dental records by our clinical staff of dental directors.
- 11.4.7 **Your procedures and timeline for handling claim inquiries from the County**
 All member inquiries are tracked in a call tracking database by our customer service department. A call remains “open” until the issue is resolved. The majority of all calls are resolved during the first call, meeting our “same-day closure” standard of 90 percent.
- 11.4.8 **Your procedures and timeline for handling haste enrollment requests from ADP.**
 Urgent updates are processed in four hours; immediate access to care received via email is processed within one hour.
- 11.4.9 **How dental pre-determinations are handled in your system to ensure claims where a predetermination was approved are paid accordingly?**
 Predetermination of benefits is a voluntary review of a dentist’s proposed treatment plan and expected charges. The treatment plan should include supporting pre-operative x-rays and other diagnostic materials as requested by a CIGNA dental consultant. If there is a change in the treatment plan, a revised plan should be submitted.
 We will determine covered dental expenses for the proposed treatment plan. If there is no predetermination of benefits, we will determine covered dental expenses when we receive a claim.
 Predetermination of benefits is not a guarantee of a set payment. Payment is based on the services that are actually delivered and the coverage in force at the time services are completed.
 Predeterminations are valid for 12 months from the date of issuance. After the expiration date the predetermination is automatically purged from our system.
- 11.5 **Are you willing to provide documentation of all case specific internal audit results to the County?**
 Yes
- 11.6 **If you will provide documentation of all case specific internal audits to the County, how often will this documentation be provided?**
 As needed
- 11.7 **Please state your definition of a claim transaction.**
 A claim transaction as a single payment transaction identified by an explanation of benefits (EOB), which is a document furnished to an employee describing the action taken on related bills submitted by, or on behalf of, the employee. An EOB is provided even if the claim charges are not covered.
- 11.8 **Based on the definition given in 11.7, what is your average in-house service time, expressed in business days, for processing a transaction during the last 3 months?**
 We have included our claim statistics for the last three months in the table below.

Month	Time To Pay 10 Bus Days	Time To Pay 15 Bus Days	Financial Accuracy	Payment Accuracy	Processing Accuracy
December	98.1%	99.4%	99.3%	98.6%	96.5%

Month	Time To Pay 10 Bus Days	Time To Pay 15 Bus Days	Financial Accuracy	Payment Accuracy	Processing Accuracy
January	97.3%	98.1%	99.1%	98.5%	96.8%
February	96.9%	99.2%	99.2%	98.3%	96.7%

11.9 **Describe your administration of maximum allowable charges including:**

11.9.1 **How do you define/determine the maximum allowable charge for an out-of-network provider?**

When determining the maximum reimbursable charge (MRC), careful consideration is given to the nature and severity of the condition being treated, as well as to any complications or unusual circumstances that require additional time, skill or experience. To establish MRC information, data is based on procedure code, zip code, date of service, and charge amount.

11.9.2 **If your reimbursement methodology differs from usual, reasonable and customary, fully describe your methodology and answer all remaining questions appropriately for the process you have described.**

11.9.2.1 **Describe the data used to develop reasonable and customary rates.**

We use data from the Prevailing Healthcare Charges System published by Fair Health to determine the maximum reimbursable charge (MRC). This data is considered statistically valid if there are nine or more occurrences of a procedure code in a geographical area. If there are fewer than nine, we use CIGNA's database to update MRC files. When both files contain less than nine, we utilize the CIGNA MRC amount prior to the update.

11.9.2.2 **At what percentile do you consider charges reasonable and customary?**

CIGNA's standard maximum reimbursable charge (MRC) allowance for out-of-network DPPO claims payments is the 80th percentile of submitted charges for a given area.

11.9.2.3 **How many different geographic area rates do you maintain?**

To achieve the best discounts nationwide, we offer 271 standard schedules which are assigned by 3-digit zip code and/or the provider level. In addition, we have the capability to assign custom schedules at the provider level.

11.9.2.4 **What procedures, if any, are excluded from your reasonable and customary rates?**

Orthodontic procedures are excluded from our standard maximum reimbursable charge (MRC).

11.9.2.5 **Does your plan allow for balance billing to patients?**

Balance billing beyond the contract fee is not permitted for any service provided to the member.

In the case of CIGNA owned networks, balance billing for covered procedures is strictly prohibited. We will counsel network dentists who do not comply, and continued balance billing may cause the network dentist's file to be referred to our credentialing committee for review of future participation in the network.

CIGNA's network dentists' contracts include language to assure that members are only charged in accordance with the contracted fee schedule amounts. They are prohibited from balance billing patients. Network fee schedules apply for covered services even after members have reached their annual maximums or exceeded frequency limitations, or if missing tooth limitations or other similar limitations are imposed by the applicable dental plan. For non-covered services, members are responsible for payment of the dentist's usual fee or contracted fee for that procedure.

For leased networks, CIGNA would address any balance billing with the dentist or our affiliated network partner(s). In the case of dentist contracted with an affiliated network, the affiliated network contract would apply. Out-of-network dentists may balance bill the difference between the DPPO plan's reimbursement and their usual charges.

11.9.2.6 **Can you pay out-of-network claims at the 90th or 80th percentile of R&C?**

Yes.

11.9.2.7 **If you cannot pay out-of-network claims at the 90th or 80th percentile of R&C, please explain how you pay out-of-network claims.**

This question is not applicable. Our system allows for flexibility in adjusting MRC levels ranging from the 50th to the 95th percentile depending on Maricopa County's specific needs and cost savings goals.

11.10 **Explain your member appeal procedures.**

CIGNA has a two-step appeals process for coverage decisions. The member can submit a verbal or written appeal request within one year of the initial denial. Unless it is an account or state specific appeal, then the appeal processing guidelines to file an appeal will be based on that specific account or specific state's time frame from the initial denial. A dentist, on behalf of a member, can submit an appeal; however, it must be submitted in writing.

Appeal Process (post-treatment)

Level One appeal decisions are made within 30 calendar days by someone not involved in the initial review with an exception to account or state specific appeal process. A dental professional will review all appeals involving dental necessity or clinical appropriateness. If more time or information to make the decision is required, we will contact the member to request an extension and specify any additional information needed to complete the review.

If a member is not satisfied with our level one appeal decision, he/she may request a level two appeal.

Level Two Appeals may be conducted by an appeals committee or reviewed by someone not involved in the Level One appeal decision. If dental necessity or clinical appropriateness is in dispute, a dentist in the same or similar specialty will be involved.

The review will be completed within 30 calendar days unless more time or information is required with an exception to account or state specific appeal process. If needed, we will contact the member to request an extension and specify any additional information needed to complete the review.

We will send written notification of the decision and include the specific contractual or clinical reasons, as applicable.

For ASO accounts, ERISA guidelines are followed. The client is the fiduciary to the plan and can reserve the right to make the final decision if the denial is upheld and the internal appeals process is completed. An ASO client has the option at the time of implementation to select to administer their own employee's appeal process either second level only or both level one and level two.

Note: Time frames or requirements may vary depending on state law.

11.11 **Do you have online access where the County can check on the status of a claim?**

Yes. Claim status verification is available to members via myCIGNA.com.

11.12 **Do you agree that the County has the final jurisdiction in case of a claim denial due to plan limitations and/or exclusions, to have the claim processed for payment?**

For ASO accounts, ERISA guidelines are followed. The client is the fiduciary to the plan and can reserve the right to make the final decision if the denial is upheld and the internal appeals process is completed. An ASO client has the option at the time of implementation to select to administer their own employee's appeal process either second level only or both Level One and Level Two.

12.0 **Eligibility**

12.1 **Is your eligibility system capable of receiving a HIPAA compliant file generated from ADP?**

Yes.

12.2 **Describe your process for handling eligibility exceptions?**

Benefit administrators can speak with a customer service associate (CSA) to verify eligibility. Issues that the CSA cannot answer are referred to the designated eligibility analyst to resolve. This eligibility analyst can make instantaneous eligibility changes online including retroactive transactions, if appropriate. Many, though not all, fallout conditions can also be updated online by the client in the employer maintenance tool on CIGNAaccess.com

12.3 **In the event of an emergency, state your average turnaround time for loading eligibility.**

Urgent updates are processed in four hours; immediate access to care received via email is processed within one hour.

12.4 **State your average turnaround time for loading eligibility file received from ADP.**

Automated eligibility clients can be implemented within 60-90 days from the date the contract is awarded. Eligibility information submitted in a non-standard format may require a longer lead time for programming and testing.

12.5 **Do you have online access where the County or ADP can check or add eligibility for an employee and/or dependent?**

Yes. With the online enrollment and eligibility maintenance tool through CIGNAaccess.com employers can:

- make real-time changes to eligibility information
- enroll new employees and their dependents at any time
- cancel coverages and benefits for employees
- add dependents
- change benefit elections
- change member demographics such as gender, age, and address

Employers can manage their complete automated eligibility process online including:

- access and download user-friendly fallout reports
- receive guidance from an eligibility specialist on how to resolve fallout
- track the status details of a file through automatic email notifications. The options below can be distributed in real time:
 - notice of delinquent file
 - notice file is being held for review
 - notice file has been updated
 - notice eligibility file has been received
 - notice edit reports have been published
- review key file processing metrics, such as file processing timeliness, member defect rates, and error resolution cycle times
- view member benefit information (as allowed by HIPAA)
- review paid claim information on a member level (as allowed by HIPAA)
- track spending and plan performance

13.0 **Communications**

13.1 **Provide a copy of your current provider directory.**

We have included the provider directory for the state of Arizona in the Exhibits section of this proposal.

13.2 **How often are your provider directories updated?**

Printed state directories are updated two times per year (August and December), unless a state requires different frequency requirements. Our automated Dental Office Locator is updated nightly and our websites are updated weekly.

13.3 **Do you have a Web site with up-to-date participating provider information? Is your website available in English and Spanish?**

Yes. Provider information is available through our websites, www.CIGNA.com and myCIGNA.com. Spanish directories can be accessed through CIGNA.com and myCIGNA.com.

- 13.4 **If you have a website with up-to-date participating provider information, provide the web address.**
As mentioned above, provider information is available through our websites, www.CIGNA.com and myCIGNA.com.
- 13.5 **Describe how a member can obtain a hard-copy directory of participating providers or participating provider information.**
Printed state directories are available to employees upon request. Directory updates can be arranged through your account management team.
- 13.6 **Do you issue I.D. cards?**
Yes.
- 13.7 **Are the I.D. cards personalized or generic?**
Identification cards are generic and are printed with the company name, account number, claim office information, and phone number for our automated Dental Office Locator. A space is provided for the employee to insert their name. We are able to offer personalized ID cards for an additional charge.
- 13.8 **Provide a sample of your I.D. card.**
We have included a sample ID card in the Exhibits section of this proposal.
- 13.9 **Provide a sample of all your collaterals in English and Spanish?**
We have included our sample collaterals in English and Spanish in the Exhibits section of this proposal.
- 13.10 **Are your collaterals available electronically in a PDF file format?**
Yes.
- 13.11 **What is your turnaround time from the time eligibility is loaded until I.D. cards are mailed?**
Nearly 99 percent of ID cards are mailed within 10 business days after the ID card vendor receives clean and accurate eligibility from CIGNA.
- 13.12 **What is the frequency of your mailings of I.D. cards?**
A sufficient amount of identification cards with the client's account information are bulk-shipped to the location specified by the client, at no charge.
Members can also print ID cards instantly on myCIGNA.com.
- 13.13 **Describe your Internet capabilities for this product including plan and claim documents.**
The following member self-service functions are available through myCIGNA.com:
- personalized benefits information
 - claim status inquiry
 - deductible and lifetime maximum accumulation data
 - network dentist search with maps and directions
 - claim forms and information on where to submit forms
 - explanation of benefits (EOBs)
 - dental prevention and wellness information, including WebMD articles
 - glossary of dental terms
 - print ID cards
 - dental and claim office phone numbers and addresses
 - list of frequently asked questions
 - periodontal gum disease risk assessment quiz
 - dental Treatment Cost Estimator
 - dental Cavity Risk Assessment tool
 - information about our Healthy Rewards[®] discount program

14.0 **Reporting**

- 14.1 **State the frequency of the reports to be provided in the reporting package.**
We can provide our standard reporting package at no charge on a quarterly basis.
- 14.2 **How will standard reports be distributed – electronically or in paper format?**
Our preferred format is electronic. However paper copies are also available at no additional cost.
- 14.3 **Confirm that the cost of your standard reports is included in your stated rates.**
Confirmed
- 14.4 **Do you have a query tool available where the County can generate ad hoc reports?**
Yes. Our website at CIGNAaccess.com provides the following reporting features at no charge:
- **Financial Reports:** Review standard financial reports which include monthly experience reports (excluding premium) and lag reports.
 - **Eligibility Reports and Statistics:** Create and download eligibility reports that include membership listings and census reports.
 - **Banking Reports and Statistics:** View current banking reports based on a pre-selected request (daily, weekly, or monthly depending on the report type).
- 14.5 **Are ad hoc reports available upon request and if so, how are they charged?**
Standard ad hoc reports are available at a cost of \$300 per report. Exact charges for customized reports will depend on the volume and complexity of the request(s), but generally range from \$500 to \$700.
- 14.6 **Are your utilization data and standard reports available in Excel formatted files?**
Our standard management reporting package is only available in an electronic PDF file at this time.

15.0 **Rating/Financials**

- 15.1 **Describe in detail the funding arrangement you are proposing.**
We are proposing our fully-insured and ASO funding arrangements at this time.
- 15.2 **Indicate any minimum requirement for employee and dependent participation in the plan.**
Our standard minimum participation requirement is 65 percent of the overall employee population.
- 15.3 **To what degree are renewals based on the County’s own experience?**
The County’s experience is fully credible. 100% of the experience will be utilized to determine future renewals.
- 15.4 **What has been your dental rating trend in Arizona for participating providers for the past 3 years?**
2009: 5.4% 2010: 4.7% 2011: 4.7%
- 15.5 **What has been your dental rating trend in Arizona for non-participating providers for the past 3 years?**
2009: 6.3% 2010: 6.0% 2011: 6.0%
- 15.6 **On what do you base your trend calculation?**
Pricing trends are a combination of unit cost, utilization, and plan leveraging.
- 15.7 **Describe how you pay for out-of-network claims?**
CIGNA’s standard maximum reimbursable charge (MRC) allowance for out-of-network DPPO claims payments, except for orthodontic procedures, is the 80th percentile of submitted charges for a given area.
- 15.8 **Are out-of-network claims based on a percentile of R&C, MAC or some other reimbursement?**

Out-of-network claims are based upon maximum reimbursable charge (MRC).

- 15.9 **Is the out-of-network reimbursement you have built into your proposal mandatory or are there alternatives the client could choose?**

Our system allows for flexibility in adjusting MRC levels ranging from the 50th to the 95th percentile depending on Maricopa County's specific needs and cost savings goals.

- 15.10 **What are the options available for out-of-network reimbursement?**

Our system allows for flexibility in adjusting MRC levels ranging from the 50th to the 95th percentile.

- 15.11 **What would the cost impact be to the County to offer the other out-of-network options?**

The cost impact to move to the 80th percentile is a decrement of 1.5% which is industry standard along with the 90th percentile. For MAC out-of-network reimbursement, the overall cost would be reduced by -12.5%.

- 15.12 **It is the intent of the County to determine the method by which your renewal rates will be calculated prior to entering into a contract. Describe your renewal calculation procedure in detail.**

Fully Insured

CIGNA will use as many complete months of a client's own immature claims available at the time of the first renewal, adjusted for claim credibility levels and changes in benefits, then divided by a maturation factor to calculate a mature incurred claim equivalent. This figure will be trended for cost and utilization, and adjusted for changes in enrollment to calculate expected claims. Expected claims will be divided by a desired loss ratio to calculate needed premium which may include a network access fee for the DPPO.

ASO

CIGNA will use as many complete months of a client's own immature claims available at the time of the first renewal, adjusted for claim credibility levels and changes in benefits, then divided by a maturation factor to calculate a mature incurred claim equivalent. This figure will be trended for cost and utilization, and adjusted for changes in enrollment to calculate expected claims. ASO fees are then derived based on a formula that incorporates premium equivalents, member counts, projected claim transactions, structure/reporting requirements, and any optional services requested by the client. A network access fee is added for our DPPO product.

- 15.13 **Are the retention estimate, margin and renewal procedures guaranteed with respect to the County contract?**

The retention and margin will be guaranteed for six years as outlined by the ASO fees and Guaranteed Cost rates in the financial exhibit.

- 15.14 **How long are your retention estimate, margin and renewal procedures guaranteed?**

CIGNA is offering a 3 year guaranteed on both ASO and Guaranteed Cost rates. For ASO, "not to exceed" escalators will be provided in year 4,5, and 6. For insured, "not to exceed escalators" of 10% will be offered in years 4,5,6.

- 15.15 **How, if at all, will the initial renewal methodology differ from subsequent renewals?**

Fully Insured

At subsequent renewals, CIGNA will use the most recent 12 months of paid claims and the employee count for the 12 month period ending 2 months prior to the paid claim period, to compute adjusted claims. For example, if the 12 month paid claim period is January through December, then employee counts from the period November through October would be used in the calculation. Expected claims will include considerations for benefit, enrollment and utilization changes, credibility, and cost trend.

ASO

At subsequent renewals, CIGNA will use the most recent 12 months of paid claims and the employee counts for the 12 month period ending 2 months prior to the paid claim period to compute adjusted claims. For example, if the 12 month paid claim period is January through

December, then employee counts from the period November through October would be used in the calculation. Expected claims will include considerations for benefit, enrollment and utilization changes, credibility, and cost trend.

15.16 Describe the financial obligations of the County in the event of contract termination for incurred but unpaid claims

(Fully insured)

We have contractual liability for run-out claims incurred prior to the date of cancellation but presented for payment thereafter. Therefore, the reserves accrued to meet these obligations must be retained by CIGNA.

(ASO)

IBNR factors are not applicable to the proposed product.

15.17 Describe your claims run-out process and limits in the event of contract termination.

Fully-Insured

We are contractually liable for all run-outs (defined as any claim incurred prior to cancellation but presented for payment thereafter) for clients with fully insured funding (either shared returns or non-participating). We do not charge a separate fee for administration of fully insured run-outs. The charge is built into rates.

ASO

Our ASO fees do not include payment of run-out claims. If Maricopa County wants CIGNA to provide run-out administration, we will keep the account open for a period of 12 months, and charge a fee equal to the last 4 months of administrative charges.

EXHIBIT C

CLAIM AUDIT AGREEMENT - SAMPLE

- A. WHEREAS, Connecticut General Life Insurance Company ("Connecticut General") desires to cooperate with requests by _____("Employer") to permit an audit for the purposes set forth below; and
- B. WHEREAS, _____("the Auditor") has been retained by Employer for the purpose of performing an audit ("Audit") of claims administered by Connecticut General.
- C. WHEREAS, the Auditor and the Employer recognize Connecticut General's legitimate interests in maintaining the confidentiality of its claim information, protecting its business reputation, avoiding unnecessary disruption of its claim administration, and protecting itself from legal liability;

NOW THEREFORE, IN CONSIDERATION of the premises and the mutual promises contained herein, Connecticut General, the Employer and the Auditor hereby agree as follows:

1. Audit Specifications

The Auditor will specify to Connecticut General in writing at least forty-five (45) days prior to the commencement of the Audit the following "Audit Specifications":

- a. the name, title and professional qualifications of individual Auditors;
- b. the Claim Office locations, if any, to be audited;
- c. the Audit objectives;
- d. the scope of the Audit (time period, lines of coverage and number of claims);
- e. the process by which claims will be selected for audit;
- f. the records/information required by the Auditor for purposes of the Audit; and
- g. the length of time contemplated as necessary to complete the Audit.

2. Review of Specifications

Connecticut General will have the right to review the Audit Specifications and to require any changes in, or conditions on, the Audit Specifications which may be necessary to protect Connecticut General's legal and business interests identified in paragraph C above.

3. Access to Information

Connecticut General will make the records/information called for in the Audit Specifications available to the Auditor at a mutually acceptable time and place.

4. Audit Report

The Auditor will provide Connecticut General with a true copy of the Audit's findings, as well as of the Audit Report, if any, that is submitted to the Employer. Such copies will be provided to Connecticut General at the same time that the Audit findings and the Audit Report are submitted to the Employer.

5. Comment on Audit Report

Connecticut General reserves the right to provide the Auditor and the Employer with its comments on the findings and, if applicable, the Audit Report.

6. Confidentiality

The Auditor understands that Connecticut General is permitting the Auditor to review the claim records/information solely for purposes of the Audit. Accordingly, the Auditor will ensure that all information pertaining to individual claimants will be kept confidential in accordance with all applicable laws and/or regulations. Without limiting the generality of the foregoing, the Auditor specifically agrees to adhere to the following conditions:

- a. The Auditor shall not make photocopies or remove any of the claim records/information without the express written consent of Connecticut General;
- b. The Auditor agrees that its Audit Report or any other summary prepared in connection with the Audit shall contain no individually identifiable information.

7. Restricted Use of the Audit Information

With respect to persons other than the Employer, the Auditor will hold and treat information obtained from Connecticut General during the Audit with the same degree and standard of confidentiality owed by the Auditor to its clients in accordance with all applicable legal and professional standards. The Auditor shall not, without the express written consent of Connecticut General executed by an officer of Connecticut General, disclose in any manner whatsoever, the results, conclusions, reports or information of whatever nature which it acquires or prepares in connection with the Audit to any party other than the Employer except as required by applicable law. The Employer and Auditor agree to indemnify and to hold harmless Connecticut General for any and all claims, costs, expenses and damages which may result from any breaches of the Auditor's obligations under paragraphs 6 and 7 of this Agreement or from Connecticut General's provision of information to the Auditor. The Employer authorizes Connecticut General to provide to the designated Auditor the necessary information to perform the audit in a manner consistent with all Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Privacy Standards and in compliance with the signed Business Associate Agreement ("BAA").

8. Termination

Connecticut General may terminate this agreement with prior notice. The obligations set forth in Sections 4 through 7 shall survive termination of the Agreement.

Connecticut General Life Insurance Company

By: TO BE SIGNED AT TIME OF AUDIT
Duly Authorized

Print Name: _____

Title: _____

Date _____

Auditor: _____

By: TO BE SIGNED AT TIME OF AUDIT
Duly Authorized

Print Name: _____

Title: _____

Date _____

Employer: _____

By: TO BE SIGNED AT TIME OF AUDIT
Duly Authorized

Print Name: _____

Title: _____

Date _____

CIGNA DENTAL, 11001 N. BLACK CANYON HWY., 3RD FLOOR, PHOENIX, AZ 85029

PRICING SHEET: NIGP CODE 95348

Vendor Number: 2011001696 1

Certificates of Insurance Required

Contract Period: To cover the period ending **June 30, 2015 2018.**