ARLINGTON COUNTY, VIRGINIA
OFFICE OF THE PURCHASING AGENT
#1 COURT HOUSE PLAZA, SUITE 500
2100 CLARENDON BOULEVARD
ARLINGTON, VIRGINIA 22201

NOTICE OF AWARD OF CONTRACT

TO: CONNECTICUT HEALTH AND LIFE
INSURANCE COMPANY
900 COTTAGE GROVE ROAD
BLOOMFIELD, CT 06152

DATE ISSUED: November 4, 2014

CURRENT REFERENCE NO: 719-13-1

CONTRACT TITLE: HEALTH PLANS

PRIOR REFERENCE NO: N/A

THIS IS A NOTICE OF AWARD OF CONTRACT AND NOT AN ORDER. NO WORK IS AUTHORIZED UNTIL THE VENDOR RECEIVES A VALID COUNTY PURCHASE ORDER ENCUMBERING CONTRACT FUNDS.

Your firm is awarded the above referenced contract in accordance with the response submitted by you on SEPTEMBER 17, 2014. The contract term covered by this Notice of Award is effective JULY 1, 2014 and expires on JUNE 30, 2017.

This is the FIRST year award notice of a possible SEVEN year contract.

The contract documents consist of the terms, conditions, and specifications of Request for Proposal No. 719-13 and the bid of the Contractor, incorporated herein by reference.

The contract documents consist of the terms and conditions of Agreement No. 719-13-1, including any exhibits, attached or amendments thereto

CONTRACT PRICING:

1) REFER TO AGREEMENT NO. 719-13-1 (ATTACHED)

ATTACHMENTS:

AGREEMENT NO. 719-13-1

EMPLOYEES NOT TO BENEFIT:

NO COUNTY EMPLOYEE SHALL RECEIVE ANY SHARE OR BENEFIT OF THIS CONTRACT NOT AVAILABLE TO THE GENERAL PUBLIC.

VENDOR CONTACT: JULIA HUGGINS VENDOR TEL. NO.: 410-884-2510

VENDOR PAYMENT TERMS: NET 30 DAYS

EMAIL ADDRESS: Julia.huggins@cigna.com

COUNTY CONTACT: KRISTIN YOUNG CONTACT NO.: 703-228-3485

CONTRACT AUTHORIZATION

11/4/14

RICHARD D. WARREN, JR. CPPB
Purchasing Agent

DATE

DISTRIBUTION

VENDOR: 1
BID FOLDER: 2

ARLINGTON COUNTY, VIRGINIA
OFFICE OF THE PURCHASING AGENT
SUITE 500, 2100 CLARENDON BOULEVARD
ARLINGTON, VA 22201

AGREEMENT NO. 719-13-1

THIS AGREEMENT is made, on the date of execution by the County, between Cigna Health and Life Insurance Company, 900 Cottage Grove Road, Bloomfield, CT 06152 ("Contractor"), a Connecticut corporation authorized to do business in the Commonwealth of Virginia, and the County Board of Arlington County, Virginia ("County"). The County and the Contractor, for the consideration hereinafter specified, agree as follows:

RELATED CONTRACTOR ENTITIES
"Cigna HealthCare" refers to various operating subsidiaries of Cigna Corporation. Products and services are provided by these subsidiaries and not by Cigna Corporation. These subsidiaries include Cigna Health and Life Insurance Company, Cigna Vision Care, Inc., Tel-Drug, Inc. and its affiliates, Cigna Behavioral Health, Inc., Intracorp, and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc. "Cigna Tel-Drug" refers to Tel-Drug, Inc. and Tel-Drug of Pennsylvania, L.L.C., which are also operating subsidiaries of Cigna Corporation (also collectively referred to herein as "Related Contractor Entities" and/or "Contractor").

1 .CONTRACT DOCUMENTS

The Contract Documents consist of:

- This Agreement;
- Exhibit A – Scope of Work
- Exhibit A-1 – Onsite Health Clinic Scope of Work
- Exhibit B – Pricing and Payments
- Exhibit B-1 – Discount Guarantees
- Exhibit B-2 – Performance Guarantees
- Exhibit C – Plan Design
- Exhibit D – Sections of the Contractor's Original response to the RFP
- Exhibit E – Business Associates Agreement
- Exhibit F – Metropolitan Washington Council of Governments Rider Clause
- Exhibit G –Claims Audit Agreement

Where the terms and provisions of this Agreement vary from the terms and provisions of the other Contract Documents, the terms and provisions of this Agreement shall prevail over the other Contract Documents and the remaining Contract Documents shall be complementary to each other and if there are any conflicts the most stringent terms or provisions shall prevail.

The Contract Documents set forth the entire agreement between the County and the Contractor. The County and the Contractor agree that no representative or agent of either of them has made any representation or promise with respect to the party's agreement which is not contained in the Contract Documents. The Contract Documents may be referred to herein below as the "Contract" or the "Agreement."

2. SCOPE OF WORK

The Contractor agrees to perform the services described in the Contract Documents (hereinafter "the Work"). The primary purpose of the Work is to assist the County in the administration of the medical and prescription drug health benefits plan sponsored by the County and to provide or arrange for the provision of an Onsite Health Clinic ("Clinic") located at 2100 Clarendon Blvd., Suite 508, Arlington, Virginia. The Contract Documents set forth the minimum work estimated by the County and the Contractor to be necessary to complete the Work. It shall be the Contractor's responsibility, at the Contractor's sole cost, to provide the specific services set forth in the Contract Documents and sufficient services to fulfill the purposes of the Work. Nothing in the Contract Documents shall be construed to limit the Contractor's responsibility to manage the details and execution of the Work.

3. **STANDARD OF CARE**. Contractor's performance of its obligations under this Agreement shall be in keeping with the skill and care reasonably expected of administrators experienced in providing similar services to plans of similar size and characteristics. The ERISA fiduciary standard of care shall apply as if this were an ERISA plan.

With regard to the Onsite Health Clinic, the Contractor warrants to furnish the services described herein at the times and places and in the manner and subject to the conditions set forth in the Contract Documents. The Contractor shall enter upon and complete the performance of services with all due diligence and dispatch.

Contractor's performance of its obligations under this Agreement shall be in keeping with the skill and care reasonably expected of administrators experienced in providing similar services to onsite health care clinics of similar size and characteristics. Clinic Staff shall render services enumerated in this Agreement with the level of skill and care reasonably expected of health care professionals with the same level of education and experience

4. **CONTRACT TERM**

The Work shall commence on July 1, 2014, and shall be completed no later than June 30, 2017 (Contract Term), and may be extended on an annual basis from July 1 to June 30 for up to four (4) separate twelve months periods (each known as a Subsequent Contract Term), through June 30, 2021, subject to any modifications as provided for in the Contract Documents regarding the Contract Term. Notwithstanding the foregoing, Onsite Clinic services under Exhibit A-1 shall commence on September 8, 2014 and shall be completed no later than June 30, 2017 (Contract Term), and may be extended only upon mutual written agreement of the parties. No Work shall be deemed complete until it is accepted by the Project Officer.

5. **CONTRACT AMOUNT**

The County will pay the Contractor in accordance with the terms of the Payment paragraph below, Exhibit B for the Contractor's completion of the Work described and required in the Contract Documents and Exhibit A-1 to this Agreement with regard to Onsite Clinic services. The Contractor agrees that it shall complete the Work for the total amount specified in this section ("Contract Amount") unless such amount is modified as provided in this Agreement.

6. **PAYMENT**

Payment will be made by the County to the Contractor within thirty (30) days after receipt by the County Project Officer of an invoice for work done which is reasonable and allocable to the Contract and which has been performed to the satisfaction of the Project Officer. The Project Officer will either approve the invoice or require corrections. The number of the County Purchase Order pursuant to which authority goods or services have been performed or delivered shall appear on all invoices.

7. **BENEFIT PAYMENTS**

a. County Liability for Payment of Plan Benefits. County is responsible for all payments for Plan benefits as described in Exhibit C including any payments for Plan benefits (also referred to herein as claims incurred or claim check issued) paid as a result of any legal action. Contractor shall reasonably cooperate with County in its defense of such actions in the event that the legal action is outside of the scope of its duty to indemnify the County as described herein.

   The Contractor shall promptly pursue recovery of any overpayments of plan benefits made by the Contractor or Contractor Related Entities which are made known to Contractor, from whatever source, and shall promptly remand to the claim-payment bank account of the County the amounts recovered as a result of these actions. Recoveries of claims paid as a result of retroactive eligibility notification provided by the County shall be net of third party vendor claim recovery charges.

   In identifying overpayments, the Contractor shall comply with the Standard of Care as defined in this Agreement. In pursuing and collecting recovery of overpayments, the Contractor shall use the same standards; follow the same processes and procedures; and meet or exceed the level of efforts it applies to recover overpayments in its fully insured plans.

   Overpayments include but are not limited to payments made to the wrong participants or providers; payments made for services to persons not covered by the plan; payments made for non-covered services, payments made for improperly coded services, and payments of incorrect amounts or incorrect rates for participants, services provided, or providers of services.

If Contractor pays a claim for benefits not covered under the Plan as described in Exhibit C at the written request of County's Project Officer, or designee County is responsible for funding the payment and such payments shall not be considered in determining guarantee amounts or in determining any risk-sharing or performance guarantee reimbursements. County shall reimburse Contractor for any and all plan benefit payments incurred by Contractor in connection with making such payments.

b. County Liability for Plan Related Expenses. County shall reimburse Contractor for any amounts Contractor may be required to pay (i) as state premium tax or any similar Plan-related tax, charge, surcharge or assessment by a governmental entity, or (ii) under any unclaimed or abandoned property, or escheat law, with respect to Plan benefits and any penalties and/or interest thereon related specifically to this Agreement.

8. PROJECT OFFICER

The performance of the Contractor is subject to the review and approval of the County Project Officer ("Project Officer") who shall be appointed by the Director of the Arlington County department or agency requesting the work under this Contract. However, it shall be the responsibility of the Contractor to manage the details of the execution and performance of its work pursuant to the Contract Documents.

9. ADJUSTMENTS FOR CHANGE IN SCOPE

The County may order changes in the Work within the general scope of the Work consisting of additions, deletions or other revisions. No claim may be made by the Contractor that the scope of the work or that the Contractor's services have been changed requiring adjustments to the amount of compensation due the Contractor unless such adjustments have been made by a written amendment to the Contract signed by the County and the Contractor. If the Contractor believes that any particular work is not within the scope of the Work or is a material change or otherwise will call for more compensation to the Contractor, the Contractor must immediately notify the Project Officer after the change or event occurs and within ten (10) calendar days thereafter must provide written notice to the Project Officer. The Contractor's notice must provide to the Project Officer the amount of additional compensation claimed, together with the basis therefor and documentation supporting the claimed amount. With respect to the Onsite Clinic Services provided in Exhibit A-1, Contractor shall not be obligated to perform any additional work or to comply with changes requested by the County, unless and until a written amendment to this Agreement has been signed by the County and the Contractor. The Contractor will not be compensated for performing any work unless a proposal complying with this paragraph has been submitted in the time specified above and a written Contract amendment has been signed by the County and the Contractor and a County purchase order is issued covering the cost of the services to be provided pursuant to the amendment.

10. ADDITIONAL SERVICES

The Contractor shall not be compensated for any goods or services provided except those included in Exhibit A and Exhibit A-1 and included in the Contract Amount unless those goods or services are covered by a written amendment to this Contract signed by the County and the Contractor, and a County Purchase Order is issued covering the expected cost of such services.

11. REIMBURSABLE EXPENSES

No reimbursable expenses are allowed under this Contract. The Contract Amount includes all costs and expenses of providing to the County the services described in this Contract.

12. PAYMENT OF SUBCONTRACTORS

As applicable, the Contractor is obligated to take one of the two following actions within seven (7) days after receipt of amounts paid to the Contractor by the County for work performed by any subcontractor under this Contract:

a. Pay the subcontractor for the proportionate share of the total payment received from the County attributable to the work performed by the subcontractor under this Contract; or

b. Notify the County and the subcontractor, in writing, of the Contractor's intention to withhold all or a part of the subcontractor's payment with the reason for nonpayment.

The Contractor is obligated to pay interest to the subcontractor on all amounts owed by the Contractor to the

subcontractor that remain unpaid after seven (7) days following receipt by the Contractor of payment from the County for work performed by the subcontractor under this Contract, except for amounts withheld as allowed in subsection b., above. Unless otherwise provided under the terms of this Contract, interest shall accrue at the rate of one percent (1%) per month.

The Contractor shall include in each of its subcontracts, if any are permitted, a provision requiring each subcontractor to include or otherwise be subject to the same payment and interest requirements with respect to each lower-tier subcontractor.

The Contractor's obligation to pay an interest charge to a subcontractor pursuant to this section may not be construed to be an obligation of the County. A Contract modification may not be made for the purpose of providing reimbursement for such interest charge. A cost reimbursement claim may not include any amount for reimbursement for such interest charge.

13. NON-APPROPRIATION

All funds for payments by the County to the Contractor pursuant to this Contract are subject to the availability of an annual appropriation for this purpose by the County Board of Arlington County, Virginia. In the event of non-appropriation of funds by the County Board of Arlington County, Virginia for the goods or services provided under this Contract or substitutes for such goods or services which are as advanced or more advanced in their technology, the County will terminate the Contract, without termination charge or other liability to the County, on the last day of the then current fiscal year or when the appropriation made for the then current year for the services covered by this Contract is spent, whichever event occurs first. If funds are not appropriated at any time for the continuation of this Contract, cancellation will be accepted by the Contractor on thirty (30) days prior written notice, but failure to give such notice shall be of no effect and the County shall not be obligated under this Contract beyond the date of termination specified in the County's written notice.

14. COUNTY PURCHASE ORDER REQUIREMENT

County purchases are authorized only if a County Purchase Order is issued in advance of the transaction, indicating that the ordering agency has sufficient funds available to pay for the purchase. Such a Purchase Order is to be provided to the Contractor by the ordering agency. The County will not be liable for payment for any purchases made by its employees without appropriate purchase authorization issued by the County Purchasing Agent. If the Contractor provides goods or services without a signed County Purchase Order, it does so at its own risk and expense.

15. PROJECT STAFF

The County will, throughout the Initial Contract Term and any Subsequent Contract Term, have the right of reasonable rejection and approval of staff or subcontractors assigned to the project by the Contractor. If the County reasonably rejects staff or subcontractors pursuant to this section, the Contractor must provide replacement staff or subcontractors satisfactory to the County in a timely manner and at no additional cost to the County. The day-to-day supervision and control of the Contractor's employees, and employees of any of its subcontractors, shall be the sole responsibility of the Contractor. The foregoing shall not apply to Clinic Staff as defined in Exhibit A-1 to this Agreement, and notwithstanding anything to the contrary herein, and the provisions of Section 6 of Exhibit A-1, "Clinic Staff Performance Management," shall govern.

16. BACKGROUND CHECK

Any Contractor employee or subcontractor assigned by the Contractor to work under this Agreement at the County's site shall be subject to Contractor's standard background check and Contractor shall ensure that such background checks are completed prior to such employee or subcontractor's commencement of services under this Agreement.

17. SUPERVISION BY CONTRACTOR

The Contractor shall at all times enforce strict discipline and good order among the workers performing under this Contract, and shall not employ for the work any person not reasonably proficient in the work assigned.

18. EMPLOYMENT DISCRIMINATION BY CONTRACTOR PROHIBITED

During the performance of this Contract, the Contractor agrees as follows:

a. The Contractor will not discriminate against any employee or applicant for employment because of race, religion, color, sex, national origin, age, disability or any other basis prohibited by state law related to discrimination in employment except where there is a bona fide occupational qualification reasonably necessary to the normal operation of the Contractor. The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices setting forth the provisions of this nondiscrimination clause.

b. The Contractor, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, will state that such Contractor is an Equal Opportunity Employer.

c. Notices, advertisements and solicitations placed in accordance with federal law, rule or regulation shall be deemed sufficient for the purpose of meeting the requirements of this section.

d. The Contractor will comply with the provisions of the Americans with Disabilities Act of 1990 which prohibits discrimination against individuals with disabilities in employment and mandates their full participation in both publicly and privately provided services and activities.

e. The Contractor will include the provisions of the foregoing paragraphs in every subcontract or purchase order of over $10,000, so that the provisions will be binding upon each subcontractor or vendor.

19. EMPLOYMENT OF UNAUTHORIZED ALIENS PROHIBITED

In accordance with §2.2-4311.1 of the Code of Virginia, as amended, the Contractor acknowledges that it does not, and shall not during the performance of this Contract for goods and/or services in the Commonwealth, knowingly employ an unauthorized alien as that term is defined in the Federal Immigration Reform and Control Act of 1986.

20. DRUG-FREE WORKPLACE TO BE MAINTAINED BY CONTRACTOR

During the performance of this Contract, the Contractor agrees to (i) provide a drug-free workplace for the Contractor's employees; (ii) post in conspicuous places, available to employees and applicants for employment, a statement notifying employees that the unlawful manufacture, sale, distribution, dispensation, possession, or use of a controlled substance or marijuana is prohibited in the Contractor's workplace and specifying the actions that will be taken against employees for violations of such prohibition; (iii) state in all solicitations or advertisements for employees placed by or on behalf of the Contractor that the Contractor maintains a drug-free workplace; and (iv) include the provisions of the foregoing clauses in every subcontract or purchase order of over $10,000, so that the provisions will be binding upon each subcontractor or vendor.

For the purposes of this section, "drug-free workplace" means a site for the performance of work done in connection with a specific contract awarded to a contractor by Arlington County in accordance with the Arlington County Purchasing Resolution, the employees of which contractor are prohibited from engaging in the unlawful manufacture, sale, distribution, dispensation, possession or use of any controlled substance or marijuana during the performance of the contract.

21. SAFETY

The Contractor shall comply with, and ensure that the Contractor's employees and subcontractors comply with, all current applicable local, state and federal policies, regulations and standards relating to safety and health, including, by way of illustration and not limitation, the standards of the Virginia Occupational Safety and Health program of the Department of Labor and Industry for General Industry and for the Construction Industry, the Federal Environmental Protection Agency standards and the applicable standards of the Virginia Department of Environmental Quality.

The Contractor shall provide, or cause to be provided, all technical expertise, qualified personnel, equipment, tools and material to safely accomplish the work specified to be performed by the Contractor and subcontractor(s).

The Contractor shall identify to the County Project Officer at least one (1) on-site person who is the Contractor's competent, qualified, and authorized person on the worksite and who is, by training or experience, familiar with and trained in policies, regulations and standards applicable to the work being performed. For purposes of the Onsite Clinic services provided under Exhibit A-1 to this Agreement, the "worksite" shall be limited to the clinic premises at which Clinic services are provided. The competent, qualified and authorized person must be capable of identifying existing and

predictable hazards in the surroundings or working conditions which are unsanitary, hazardous or dangerous to employees, shall be capable of ensuring that applicable safety regulations are complied with, and shall have the authority and responsibility to take prompt corrective measures, which may include removal of the Contractor's personnel from the work site.

The Contractor shall provide to the County, at the County's request, a copy of the Contractor's written safety policies and safety procedures applicable to the scope of work. Failure to provide this information within seven (7) days of the County's request may result in cancellation of this Contract.

22. WARRANTY

The Contractor warrants to furnish the services described herein at the times and places and in the manner and subject to the conditions set forth. The Contractor shall enter upon and complete the performance of services with all due diligence and dispatch and shall exercise the highest degree of skill and competence.

23. TERMINATION FOR CAUSE, INCLUDING BREACH AND DEFAULT; CURE

a. The Contract shall remain in force for the Initial Contract Term or any Subsequent Contract Term(s) and until the County determines that all of the following requirements and conditions have been satisfactorily met: the County has accepted the Work, and thereafter until the Contractor has met all requirements and conditions relating to the Work under the Contract Documents, including warranty and guarantee periods. However, the County shall have the right to terminate this Contract sooner if the Contractor is in breach or default or has failed to perform satisfactorily the Work required, as determined by the County in its discretion.

If the County determines that the Contractor has failed to perform satisfactorily, then the County will give the Contractor written notice of such failure(s) and the opportunity to cure such failure(s) within at least thirty (30) calendar days before termination of the Contract takes effect ("Cure Period"). If the Contractor fails to cure within the Cure Period or as otherwise specified in the notice, the Contract may be terminated for the Contractor's failure to provide satisfactory Contract performance. Upon such termination, the Contractor may apply for compensation for Contract services satisfactorily performed by the Contractor, allocable to the Contract and accepted by the County prior to such termination unless otherwise barred by the Contract ("Termination Costs"). In order to be considered, such request for Termination Costs, with all supporting documentation, must be submitted to the County Project Officer within thirty (30) calendar days after the expiration of the Cure Period. The County may accept or reject, in whole or in part, the application for Termination Costs and notify the Contractor of same within a reasonable time thereafter.

If the County terminates the Contract for default or breach of any Contract provision or condition, then the termination shall be immediate after notice from the County to the Contractor (unless the County in its discretion provides for an opportunity to cure) and the Contractor shall not be permitted to seek Termination Costs.

Upon any termination pursuant to this section, the Contractor shall be liable to the County for all costs incurred by the County after the effective date of termination, including costs required to be expended by the County to complete the Work covered by the Contract, including costs of delay in completing the Work or the cost of repairing or correcting any unsatisfactory or non-compliant work performed or provided by the Contractor or its subcontractors. Such costs shall be either deducted from any amount due the Contractor or shall be promptly paid by the Contractor to the County upon demand by the County. Additionally, and notwithstanding any provision in this Contract to the contrary, the Contactor is liable to the County, and the County shall be entitled to recover, all damages to which the County is entitled by this Contract or by law, including, and without limitation, direct damages, indirect damages, consequential damages, delay damages, replacement costs, refund of all sums paid by the County to the Contractor under the Contract and all attorney fees and costs incurred by the County to enforce any provision of this Contract.

Except as otherwise directed by the County in the notice, the Contractor shall stop work on the date of receipt of notice of the termination or other date specified in the notice, place no further orders or subcontracts for materials, services, or facilities except as are necessary for the completion of such portion of the Work not terminated, and terminate all vendors and subcontracts and settle all outstanding liabilities and claims. Any

purchases after the date of termination contained in the notice shall be the sole responsibility of the Contractor.

In the event any termination for cause, default, or breach shall be found to be improper or invalid by any court of competent jurisdiction then such termination shall be deemed to have been a termination for convenience.

The Contractor shall have the right to terminate this Contract on the date upon which County fails to fund the claim payment bank account as required by this Contract or fails to pay Contractor any charges when due, taking account of any applicable grace period, provided the Contractor gives the County fifteen (15) business days prior written notice of its election to terminate.

b. The foregoing termination provisions in Section 23.a. shall not apply to Onsite Clinic services provided under Exhibit A-1 to the Agreement, but with regard to such Onsite Clinic services, the provisions of Section 10 of Exhibit A-1 shall govern.

c. The Contractor shall have the right to terminate this Contract on the date upon which County fails to fund the claim payment bank account as required by this Contract or fails to pay Contractor any charges when due, taking account of any applicable grace period, provided the Contractor gives the County thirty (30) calendar days prior written notice of its election to terminate.

24. TERMINATION FOR THE CONVENIENCE OF THE COUNTY

The performance of work under this Contract may be terminated by the County's Purchasing Agent in whole or in part whenever the Purchasing Agent shall determine that such termination is in the County's best interest. Any such termination shall be effected by the delivery to the Contractor of a written notice of termination at least sixty (60) days before the date of termination, specifying the extent to which performance of the work under this Contract is terminated and the date upon which such termination becomes effective. The Contractor will be entitled to receive compensation for all Contract services satisfactorily performed by the Contractor and allocable to the Contract and accepted by the County prior to such termination and any other reasonable termination costs as negotiated by the parties, but no amount shall be allowed for anticipatory profits.

After receipt of a notice of termination and except as otherwise directed, the Contractor shall stop all designated work on the date of receipt of the notice of termination or other date specified in the notice; place no further orders or subcontracts for materials, services or facilities except as are necessary for the completion of such portion of the work not terminated; immediately transfer all documentation and paperwork for terminated work to the County except for Onsite Health Clinic medical records and "protected health information" or "PHI" as that term is defined in the HIPAA Privacy Rule, 45 CFR §160.102,; and terminate all vendors and subcontracts and settle all outstanding liabilities and claims. The Contractor shall continue to pay run-out claims as outlined in Exhibit A.

25. INDEMNIFICATION

The Contractor covenants for itself, its employees, and subcontractors to save, defend, hold harmless and indemnify the County, and all of its elected and appointed officials, officers, current and former employees, agents, departments, agencies, boards, and commissions (collectively the "County" for purposes of this section) from and against any and all claims made by third parties or by the County for any and all losses, damages, injuries, fines, penalties, costs (including court costs and attorney's fees), incurred by the County as a result of a non-Plan Benefit claim or action by a third party if due to Contractor's negligent acts or omissions, including the acts or omissions of its subcontractors, or if Contractor is found to have violated the Standard of Care as determined by a court or other tribunal having jurisdiction of the matter. This duty to save, defend, hold harmless and indemnify shall survive the termination of this Contract. If, after notice by the County, the Contractor fails or refuses to fulfill its obligations contained in this section, the Contractor shall be liable for and reimburse the County for any and all expenses, including but not limited to, reasonable attorneys' fees incurred and any settlements or payments made. The Contractor shall pay such expenses upon demand by the County and failure to do so may result in such amounts being withheld from any amounts due to Contractor under this Contract. Notwithstanding, Contractor will not be responsible for special, consequential or exemplary damages (unless caused by Contractor). Contractor will not be held responsible to County for any third party damages caused by the inaccuracy of County provided information or documents.

26. INTELLECTUAL PROPERTY INDEMNIFICATION

The Contractor warrants and guarantees that no intellectual property rights (including, but not limited to, copyright, patent, mask rights and trademark) of third parties are infringed or in any manner involved in or related to the services provided hereunder.

The Contractor further covenants for itself, its employees, and subcontractors to save, defend, hold harmless, and indemnify the County, and all of its officers, officials, departments, agencies, agents, and employees from and against any and all claims, losses, damages, injuries, fines, penalties, costs (including court costs and attorney's fees), charges, liability, or exposure, however caused, for or on account of any trademark, copyright, patented or unpatented invention, process, or article manufactured or used in the performance of this Contract, including its use by the County. If the Contractor, or any of its employees or subcontractors, uses any design, device, work, or materials covered by letters patent or copyright, it is mutually agreed and understood, without exception, that the Contract Amount includes all royalties, licensing fees, and any other costs arising from the use of such design, device, work, or materials in any way involved with the Work. This duty to save, defend, hold harmless and indemnify shall survive the termination of this Contract. If, after Notice by the County, the Contractor fails or refuses to fulfill its obligations contained in this section, the Contractor shall be liable for and reimburse the County for any and all expenses, including but not limited to, reasonable attorneys' fees incurred and any settlements or payments made. The Contractor shall pay such expenses upon demand by the County and failure to do so may result in such amounts being withheld from any amounts due to Contractor under this Contract.

27. COPYRIGHT

The Contractor hereby irrevocably transfers, assigns, sets over and conveys to the County all right, title and interest, including the sole exclusive and complete copyright interest, in any and all copyrightable works created pursuant to this Contract. The Contractor further agrees to execute such documents as the County may request to affect such transfer or assignment.

Further, the Contractor agrees that the rights granted to the County by this paragraph are irrevocable. Notwithstanding anything else in this Contract, the Contractor's remedy in the event of termination of or dispute over the terms of this Contract shall not include any right to rescind, terminate or otherwise revoke or invalidate in any way the rights conferred pursuant to the provisions of this paragraph. Similarly, no termination of this Contract shall have the effect of rescinding, terminating or otherwise invalidating the rights acquired pursuant to the provisions of this "Copyright" paragraph.

The use of subcontractors or third parties in developing or creating input into any copyrightable materials produced as a part of this Contract is prohibited unless the County approves the use of such subcontractors or third parties in advance and such subcontractors or third parties agree to include the provisions of this paragraph as part of any contract they enter into with the Contractor for work related to work pursuant to this Contract.

The parties agree and acknowledge that the relationship set forth in this Agreement does not contemplate the creation of intellectual property by the Contractor on behalf of the County.

The County acknowledges that in providing the services hereunder, Contractor may utilize proprietary materials, reports, models, software, documentation, know-how and processes owned by Contractor or its affiliates that were or are not created specifically by the Contractor for the County ("Contractor Materials"). The County acknowledges that ownership of and title to such Contractor Materials remains with the Contractor and is not transferred to the County.

28. OWNERSHIP AND RETURN OF RECORDS

a. The Contractor agrees that all medical records, medical information, Personally Identifiable Health Information (PHI), findings, memoranda, correspondence, documents or records of any type, whether written or oral, and all documents generated by the Contractor or its subcontractors as a result of the County's request for services under this Contract, are confidential records ("Record" or "Records"), and neither the Records nor their contents shall be released by the Contractor or its subcontractors in violation of any federal or any law of the Commonwealth of Virginia. Inquiries and records generated as a result of this Contract defined as personal health information ("PHI") shall be answered in accordance with the executed Business Associate Agreement (Exhibit F). The Contractor further agrees that all data, information, findings, memoranda, correspondence, documents or records of any type, whether written or oral or electronic, and all documents generated by the Contractor or its subcontractors as a result of the County's request for services under this Contract, are the exclusive property of the County ("Record" or "Records"), and all such Records shall be provided to and/or returned to County upon completion, termination, or cancellation of

this Contract.
The Contractor acknowledges that the County is the sole owner of all eligibility, claim and other Plan-related information ("Plan Information") provided, however, that: (i) such ownership interest shall not extend to Plan Information recorded for or otherwise integrated into Contractor's data processing systems in the ordinary course of business so as to in any way prevent or inhibit Contractor from using such Plan Information on an aggregated and non-member identifiable basis; and (ii) the County acknowledges that Plan Information reflecting the reimbursement rates under Contractor's agreements with Contractor's participating providers/arrangers of health care services/supplies is the proprietary information of Contractor and shall be used solely for the purpose of administering the plan or as otherwise required by law and that such proprietary information shall not be released to any third party without Contractor's written consent and subject to a non-disclosure agreement from the third party that is satisfactory to Contractor.

b. The Contractor agrees to include this and all other state mandated provisions as part of any Contract or Agreement the Contractor enters into with subcontractors or other third parties for work related to work pursuant to this Agreement.

c. The transfer of documentation and paperwork shall not apply to any documentation or paperwork, including medical records, for Onsite Clinic services provided under Exhibit A-1 to this Agreement, due to the confidential nature of the medical and health care services provided. Except as it relates to amount billed to the County hereunder related to Onsite Clinic services, such documentation and paperwork shall remain the sole property of Contractor, and shall not be disclosed to the County or any third party by Contractor except as permitted by applicable federal and state law. The Contractor shall retain medical records in accordance with the HIPAA Privacy Rule, and Virginia regulations, 18 VAC 85-20, *Regulations Governing the Practice of Medicine* and the Virginia Public Records Act. In no case shall records be used by the Contract for any purpose other than that specified in the referenced Virginia Code.

d. No termination of this Agreement shall have the effect of rescinding, terminating or otherwise invalidating this section.

29. DATA SECURITY AND PROTECTION

The Contractor shall hold County Information in the strictest confidence and comply with all applicable County security and network resources policies as well as all local, state and federal laws or regulatory requirements concerning data privacy and security. The Contractor shall develop, implement, maintain, continually monitor and use appropriate administrative, technical and physical security measures to preserve the confidentiality, privacy, integrity and availability of all electronically maintained or transmitted County Information received from, created or maintained on behalf of the County and strictly control access to County Information. For purposes of this provision, and as more fully described in this Contract, "County Information" (also referred to as "County Data" or "data") includes, but is not limited to, electronic information, documents, data, images, and records including, but not limited to, financial records, personally identifiable information, Personal Health Information (PHI), personnel, educational, voting, registration, tax or assessment records, information related to public safety, County networked resources, and County databases, software and security measures which is created, maintained, transmitted or accessed to perform the work under this Contract.

a. **Use of Data**. The Contractor shall ensure that the use, distribution, disclosure or access ("use") to County Information and County networked resources shall not occur in an unauthorized manner. Use of County Information for other than as specifically outlined in this Contract is strictly prohibited, unless such other use is agreed to in writing by the parties. The Contractor will be solely responsible for any unauthorized use, reuse, distribution, transmission, manipulation, copying, modification, access or disclosure of County Information and any non-compliance with this DATA SECURITY AND PROTECTION provision.

b. **Data Protection**. The Contractor agrees that it will protect the County's Information according to standards established by the National Institute of Standards and Technology, including 201 CMR 17.00, Standards for the Protection of Personal Information of Residents of the Commonwealth and the Payment Card Industry Data Security Standard (PCI DSS), as applicable, and no less rigorously than it protects its own data, proprietary and/or confidential information. The Contractor shall provide to the County a copy of its data security policy and procedures for securing County Information and a copy of its disaster recovery plan/s. The Contractor shall provide, if requested by the County, on an annual basis, results of an internal Information Security Risk Assessment provided by an outside firm.

c. **Data Sharing**. Except as otherwise specifically provided for in this Contract, the Contractor agrees that it shall not share, disclosure, sell or grant access to County Information to any third party without the express written authorization of the County's Chief Information Security Officer or designee.

d. **Security Requirements**. The Contractor shall maintain industry standard anti-virus, industry accepted firewalls, industry standard Data Loss Prevention (DLP) and/or other protections on its systems and networking equipment. The Contractor certifies that all systems and networking equipment that support, interact or store County Information meet the above standards and industry best practices for physical, network and system security requirements. Printers, copiers or fax machines that store County Data into hard drives must provide data at rest encryption. Significant deviation from these standards must be approved by the County's Chief Information Security Officer or designee. The downloading of County information onto laptops or other portable storage medium is prohibited without the express written authorization of the County's Chief Information Security Officer or designee, except that the use of laptops or other portable storage media is not prohibited when used by Contractor in the ordinary course of Contractor's provision of Onsite Health Clinic services pursuant to Exhibit A-1 of this Agreement.

e. **Data Protection Upon Conclusion of Contract**. Upon termination, cancellation, expiration or other conclusion of this Contract, the Contractor shall return all County Information to the County in a format specified by the County, unless the County requests that such data be destroyed. This provision shall also apply to all County Information that is in the possession of subcontractors or agents of the Contractor. The Contractor shall complete such return or destruction not less than thirty (30) days after the conclusion of this Agreement and shall certify completion of this task, in writing, to the County Project Officer. County acknowledges that it may not be feasible for the Contractor to return or destroy all County information at termination of the Contract due to Contractors legal obligations; therefore, the Contractor agrees that it will protect the County's Information as if the Contract were still in place for as long as the information is retained by the Contractor, and will limit any further uses and disclosures of the County's Information to the purpose or purposes which make the return or destruction of the County's Information infeasible.

f. **Notification of Security Incidents**. The Contractor agrees to notify the County Chief InformationOfficer and County Project Officer within forty-eight (48) hours of the discovery of any unintended access to, use or disclosure of County Information.

g. **Subcontractors**. To the extent the use of subcontractors is permitted under this Contract, the Contractor agrees to have substantially similar requirements of this entire section incorporated into any subcontractor agreement entered into by the Contractor and any data sharing shall be compliant with these security and protection requirements. In the event of data sharing, subcontractors shall provide to the Contractor a copy of their data security policy and procedures for securing County Information and a copy of their disaster recovery plan/s.

30. ETHICS IN PUBLIC CONTRACTING

This Contract incorporates by reference Article 9 of the Arlington County Purchasing Resolution, as well as any state or federal law related to ethics, conflicts of interest, or bribery, including by way of illustration and not limitation, the State and Local Government Conflict of Interests Act (Code of Virginia § 2.2-3100 et seq.), the Virginia Governmental Frauds Act (Code of Virginia § 18.2-498.1 et seq.), and Articles 2 and 3 of Chapter 10 of Title 18.2 of the Code of Virginia, as amended (§ 18.2-438 et seq.). The Contractor certifies that its offer was made without collusion or fraud and that it has not offered or received any kickbacks or inducements from any other offeror, supplier, manufacturer, or subcontractor and that it has not conferred on any public employee having official responsibility for this procurement any payment, loan, subscription, advance, deposit of money, services, or anything of more than nominal value, present or promised unless consideration of substantially equal or greater value was exchanged.

31. COUNTY EMPLOYEES

No employee of Arlington County, Virginia, shall be admitted to any share in any part of this Contract or to any benefit that may arise therefrom which is not available to the general public.

32. FORCE MAJEURE

The Contractor shall not be held responsible for failure to perform the duties and responsibilities imposed by this Contract if such failure is due to fires, riots, rebellions, natural disasters, wars, or an act of God beyond control of the Contractor,

and outside and beyond the scope of the Contractor's then current, by industry standards, disaster plan, that make performance impossible or illegal, unless otherwise specified in the Contract.

The County shall not be held responsible for failure to perform its duties and responsibilities imposed by the Contract if such failure is due to fires, riots, rebellions, natural disasters, wars, or an act of God beyond control of the County that make performance impossible or illegal, unless otherwise specified in the Contract.

33. AUTHORITY TO TRANSACT BUSINESS

The Contractor shall pursuant to Code of Virginia § 2.2-4311.2, be and remain authorized to transact business in the Commonwealth of Virginia during the Initial Term and any Subsequent Contract Term(s) of this Contract. A contract entered into by a Contractor in violation of this requirement is voidable, without any cost or expense, at the sole option of the County.

34. RELATION TO COUNTY

The Contractor is an independent contractor and neither the Contractor nor its employees or subcontractors will, under any circumstances, be considered employees, servants or agents of the County. The County will not be legally responsible for any negligence or other wrongdoing by the Contractor, its employees, servants or agents. The County will not withhold payments to the Contractor for any federal or state unemployment taxes, federal or state income taxes, Social Security tax, or any other amounts for benefits to the Contractor. Furthermore, the County will not provide to the Contractor any insurance coverage or other benefits, including workers' compensation, normally provided by the County for its employees.

35. ANTITRUST

By entering into this Contract, the Contractor conveys, sells, assigns and transfers to the County all rights, title, and interest in and to all causes of action the Contractor may now have or hereafter acquire under the antitrust laws of the United States or the Commonwealth of Virginia, relating to the goods or services purchased or acquired by the County under this Contract.

36. REPORT STANDARDS

Reports or written material prepared by the Contractor in response to the requirements of this Contract or a request of the Project Officer shall, unless otherwise provided for in the Contract, meet standards of professional writing established for the type of report or written material provided, shall be thoroughly researched for accuracy of content, shall be grammatically correct and not contain spelling errors, shall be submitted in a format approved in advance by the Project Officer, and shall be submitted for advance review and comment by the Project Officer. The cost of correcting grammatical errors, correcting report data, or other revisions required to bring the report or written material into compliance with these requirements shall be borne by the Contractor.

When submitting documents to the County, the Contractor shall comply with the following guidelines:

- All submittals and copies shall be printed on at least thirty percent (30%) recycled-content and/or tree-free paper;
- All copies shall be double-sided;
- Report covers or binders shall be recyclable, made from recycled materials, and/or easily removable to allow for recycling of report pages (reports with glued bindings that meet all other requirements are acceptable);
- The use of plastic covers or dividers should be avoided; and
- Unnecessary attachments or documents not specifically asked for should not be submitted, and superfluous use of paper (e.g. separate title sheets or chapter dividers) should be avoided.

37. AUDIT

The Contractor agrees to retain all books, records and other documents related to this Contract for at least five (5) years after final payment. The County or its authorized agents shall have full access to and the right to examine any of the above documents during this period and during the Initial Contract Term and any Subsequent Contract Term, except that the County shall not be entitled to access to any books, records or other documents which are medical records protected by applicable federal law or the law of the Commonwealth of Virginia. If the Contractor wishes to destroy or dispose of records (including confidential records to which the County does not have ready access) within five (5) years after final payment, the Contractor shall notify the County at least thirty (30) days prior to such disposal, and if the County objects, shall not dispose of the records.

38. ASSIGNMENT
The Contractor shall not assign, transfer, convey, sublet, or otherwise dispose of any award, or any or all of its rights, obligations, or interests under this Contract, without the prior written acknowledgment of the County; provided, however that Contractor may assign any right, interest, or responsibility under this Contract to a corporate affiliate wholly owned by Cigna Corporation and/or subcontract specific obligations under the Contract provided that Contractor shall not be relieved of its obligations under the Contract when doing so and only upon immediate notification to the County.

39. AMENDMENTS
This Contract shall not be amended except by written amendment executed by persons duly authorized to bind the Contractor and the County.

40. ARLINGTON COUNTY PURCHASING RESOLUTION AND COUNTY POLICIES
Notwithstanding any provision to the contrary herein, no provision of the Arlington County Purchasing Resolution or any applicable County policy is waived in whole or in part.

41. DISPUTE RESOLUTION
All disputes arising under this Agreement, or its interpretation, whether involving law or fact, or extra work, or extra compensation or time, and all claims for alleged breach of Contract shall be submitted to the Project Officer for decision at the time of the occurrence or beginning of the work upon which the claim is based, whichever occurs first. Any such claims shall state the facts surrounding it in sufficient detail to identify it together with its character and scope. In accordance with the Arlington County Purchasing Resolution, claims denied by the Project Officer may be submitted to the County Manager in writing no later than sixty (60) days after final payment. The time limit for final written decision by the County Manager in the event of a contractual dispute, as that term is defined in the Arlington County Purchasing Resolution, is thirty (30) days. Procedures for considering contractual claims, disputes, administrative appeals, and protests are contained in the Purchasing Resolution, which is incorporated herein by reference. A copy of the Arlington County Purchasing Resolution is available upon request from the Office of the Purchasing Agent. The Contractor shall not cause a delay in the Work pending a decision of the Project Officer, County Manager, County Board, or a court.

42. APPLICABLE LAW, FORUM, VENUE AND JURISDICTION
This Contract and the work performed hereunder shall be governed in all respects by the laws of the Commonwealth of Virginia and the jurisdiction, forum, and venue for any litigation with respect thereto shall be in the Circuit Court for Arlington County, Virginia, and in no other court. In performing the Work under this Contract, the Contractor shall comply with applicable federal, state, and local laws, ordinances and regulations.

43. ARBITRATION
It is expressly agreed that nothing under the Contract shall be subject to arbitration, and any references to arbitration are expressly deleted from the Contract.

44. NONEXCLUSIVITY OF REMEDIES
All remedies available to the County or to the Contractor under this Contract are cumulative, and no such remedy shall be exclusive of any other remedy available to the County at law or in equity.

45. NO WAIVER
The failure of either party to exercise in any respect a right provided for in this Contract shall not be deemed to be a subsequent waiver of the same right or any other right.

46. SEVERABILITY
The sections, paragraphs, sentences, clauses and phrases of this Contract are severable, and if any phrase, clause, sentence, paragraph or section of this Contract shall be declared invalid by a court of competent jurisdiction, such invalidity shall not affect any of the remaining phrases, clauses, sentences, paragraphs and sections of this Contract.

47. NO WAIVER OF SOVEREIGN IMMUNITY
Notwithstanding any other provision of this Contract, nothing in this Contract or any action taken by the County pursuant to this Contract shall constitute or be construed as a waiver of either the sovereign or governmental immunity of the County. The parties intend for this provision to be read as broadly as possible.

48. SURVIVAL OF TERMS

In addition to any numbered section in this Agreement which specifically state that the term or paragraph survives the expiration of termination of this Contract, the following sections, as expressed by the headings, obligations, duties and/or responsibilities, if included in this Contract also survive:

a. INDEMNIFICATION;
b. RELATION TO COUNTY;
c. OWNERSHIP AND RETURN OF RECORDS;
d. AUDIT;
e. COPYRIGHT;
f. INTELLECTUAL PROPERTY INDEMNIFICATION;
g. WARRANTY;
h. CONFIDENTIAL INFORMATION;
i. DATA SECURITY and PROTECTION
j. COUNTY LIABILITY FOR PAYMENT OF PLAN BENEFIT
k. RUN OUT CLAIMS AS DESCRIBED IN EXHIBITS A AND B AND THE ADMINISTRATION OF CLAIMS RECEIVED PRIOR TO THE TERMINATION OF THIS AGREEMENT
l. PRODUCTION OF HIPAA CERTIFICATES AS DESCRIBED IN EXHIBIT B

49. HEADINGS

The section headings in this Contract are inserted only for convenience and are not to be construed as part of this Contract or a limitation on the scope of the particular section to which the heading precedes.

50. AMBIGUITIES

Each party and its counsel have participated fully in the review and revision of this Agreement. Any rule of construction to the effect that ambiguities are to be resolved against the drafting party shall not apply in interpreting this Agreement. The language in this Agreement shall be interpreted as to its fair meaning and not strictly for or against any party.

51. NOTICES

Unless otherwise provided herein, all notices and other communications required by this Contract shall be deemed to have been given when made in writing and either (a) delivered in person, (b) delivered to an agent, such as an overnight or similar delivery service, or (c) deposited in the United States mail, postage prepaid, certified or registered, addressed as follows:

TO THE CONTRACTOR FOR ASO:
Thomas Pung
Financial Analysis Director
8505 E. Orchard Road,
Greenwood Village, CO 80111

TO THE CONTRACTOR FOR THE ONSITE CLINIC:
Jeff Perry, PhD
Chief Operating Officer and Vice President, Cigna Onsite Health
25500 North Norterra Dr.
Phoenix, AZ 85085

TO THE COUNTY:
Kristin L. Young, Project Officer
2100 Clarendon Blvd, Suite 511
Arlington, VA 22201

Richard D. Warren, Jr., Purchasing Agent
Arlington County, Virginia
2100 Clarendon Boulevard, Suite 500
Arlington, Virginia 22201

AND

52. NON-DISCRIMINATION NOTICE

Arlington County does not discriminate against faith-based organizations.

53. INSURANCE REQUIREMENTS

The Contractor shall provide to the County Purchasing Agent a Certificate of Insurance indicating that the Contractor has in force the coverage below prior to the start of any Work under this Contract and upon any contract extension. The Contractor agrees to maintain such insurance until the completion of this Contract or as otherwise stated in the Contract Documents. All required insurance coverage must be acquired from insurers authorized to do business in the Commonwealth of Virginia, with a rating of "A-" or better and a financial size of "Class VII" or better in the latest edition of the A.M. Best Co. Guides, and acceptable to the County. The minimum insurance coverage shall be:

a. Workers Compensation - Virginia Statutory Workers Compensation (W/C) coverage including Virginia benefits and employers liability with limits of $100,000/100,000/500,000. The County will not accept W/C coverage issued by the Injured Worker's Insurance Fund, Towson, MD.

b. Commercial General Liability - $1,000,000 combined single limit coverage with $2,000,000 general aggregate covering all premises and operations and including Personal Injury, Completed Operations, Contractual Liability, Independent Contractors, and Products Liability. The general aggregate limit shall apply to this Contract. Evidence of Contractual Liability coverage shall be typed on the certificate.

c. Business Automobile Liability - $1,000,000 Combined Single Limit (Owned, non-owned and hired).

d. The Contractor shall carry Errors and Omissions or Professional Liability insurance which will pay for injuries arising out of errors or omissions in the rendering, or failure to render services or perform Work under the contract, in the amount of $1,000,000.

e. Additional Insured - Arlington County, and its officers, elected and appointed officials, and employees shall be named as additional insured's on the Contractor's Commercial General Liability policy; and evidence of the Additional Insured endorsement shall be typed on the certificate.

f. Cancellation - All insurance policies required by this Contract shall be endorsed to include the following provision: "It is agreed that this policy is not subject to cancellation or non-renewal until thirty (30) days prior written notice has been given to the Purchasing Agent, Arlington County, Virginia." If there is a material change or reduction in coverage the Contractor shall notify the Purchasing Agent immediately upon Contractor's notification from the insurer. Any policy on which the Contractor has received notification from an insurer that the policy has or will be cancelled or materially changed or reduced must be replaced with another policy consistent with the terms of this Contract, and the County notified of the replacement, in such a manner that there is no lapse in coverage. Not having the required insurance throughout the Contract Term is grounds for termination of the Contract

g. Any insurance coverage that is placed as a "claims made" policy must remain valid and in force, or the Contractor must obtain an extended reporting endorsement consistent with the terms of this Contract, until the applicable statute of limitations has expired, such date as determined to begin running from the date of the Contractor's receipt of final payment.

h. Contract Identification - The insurance certificate shall state this Contract's number and title.

i. The provisions of Section 16 of Exhibit A-1 to this Agreement shall apply to the County as they relate to the Onsite Health Clinic Services.

The Contractor must disclose the amount of any deductible or self-insurance component applicable to the General Liability, Automobile Liability, Professional Liability, Intellectual Property or any other policies required herein, if any. The County reserves the right to request additional information to determine if the Contractor has the financial capacity to meet its obligations under a deductible. Thereafter, at its option, the County may require a lower deductible, funds equal to the deductible be placed in escrow, a certificate of self-insurance, collateral, or other mechanism in the amount of the deductible to ensure protection for the County.

The Contractor shall require all subcontractors to maintain during the term of this Contract, applicable and appropriate amounts of Commercial General Liability insurance, Business Automobile Liability insurance, and Workers' Compensation insurance as specified by the Contractor. The Contractor shall furnish subcontractors' certificates of insurance to the County immediately upon request by the County.

No acceptance or approval of any insurance by the County shall be construed as relieving or excusing the Contractor from any liability or obligation imposed upon the Contractor by the provisions of the Contract Documents.

The Contractor shall be responsible for the work performed under the Contract Documents and every part thereof, and for all materials, tools, equipment, appliances, and property of any description used in connection with the work. The Contractor assumes all risks for direct and indirect damage or injury to the property or persons used or employed on or in connection with the Work contracted for, and of all damage or injury to any person or property wherever located, resulting from any action, omission, commission or operation under the Contract, or in connection in any way whatsoever with the contracted work.

The Contractor shall be as fully responsible to the County for the acts and omissions of its subcontractors and of persons employed by them as it is for acts and omissions of persons directly employed by it.

Notwithstanding any of the above, the Contractor may satisfy its obligations under this section by means of self-insurance for all or any part of the insurance required, provided that the Contractor can demonstrate financial capacity and the alternative coverage is submitted to and acceptable to the County. The Contractor must also provide its most recent actuarial report and provide a copy of its self-insurance resolution to determine the adequacy of the insurance funding.

54. ACCESSIBILITY OF WEB SITE

If any work performed under this Contract results in design, development, maintenance or responsibility for content and/or format of any County websites, or County's presence on other third party websites, the Contractor shall perform such work in compliance with the requirements set forth in the U.S. Department of Justice document entitled "Accessibility of State and Local Government Websites to People with Disabilities." The document is located at: http://www.ada.gov/websites2.htm

55. HIPAA COMPLIANCE

The Contractor shall comply with all applicable legislative and regulatory requirements of privacy, security and electronic transaction components of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and shall comply with the provisions of Exhibit E, which shall also be separately executed by the parties hereto. If there is an assignment or other subcontract, the Contractor shall ensure that the assignee or the subcontractors or Related Contractor Entities promptly execute the Business Associate Agreement at Exhibit E. The Contractor shall ensure that its subcontractors notify the Contractor, immediately, of any breaches in security regarding Protected Health Information. Contractor takes full responsibility for any failure to execute the appropriate agreements with its subcontractors and for the failure of its subcontractors to comply with the existing or future regulations of HIPAA and/or HITECH, and shall indemnify County for any and all loss, damages, liability, exposure, or costs resulting therefrom.

Notwithstanding the foregoing, the County agrees that Onsite Clinic services provided pursuant to Exhibit A-1 to this Agreement are provided by the Contractor in its capacity as a health care provider, and thus a Covered Entity as that term is defined in the HIPAA Privacy Rule and not as a Business Associate to the County, and as such, Onsite Clinic services are not subject to the Business Associate Agreement. The Contractor in its capacity as a Covered Entity under the HIPAA Privacy Rule shall comply with all provisions of the HIPAA Privacy Rule applicable to Covered Entities.

56. ADA COMPLIANCE

Contractor shall defend and hold the County harmless from any expense or liability arising from the Contractor's non-compliance with the Americans with Disabilities Act of 1990 (ADA). The Contractor will comply with the provisions of the Americans with Disabilities Act of 1990 which prohibits discrimination against individuals with disabilities in employment and mandates their full participation in both publicly and privately provided services and activities. The Contractor's responsibilities related to ADA compliance shall include, but not be limited to, the following:

a. Access to Programs, Services and/or Facilities: The Contractor shall ensure its programs; services and facilities are accessible to persons with disabilities. If a particular facility or program is not accessible, the Contractor shall provide equivalent services in an accessible alternate location or manner to ensure that persons with disabilities are not denied access to services. Notwithstanding the foregoing, as related to the Onsite Health Clinic Services provided in Exhibit A-1 to the Agreement, the County shall be responsible for all access modifications to the Onsite Heath Clinic facility as may be required to comply with applicable law and regulations ("Access Modifications"), subject to the terms of the County's Lease (as defined in Exhibit A-1). The County shall be responsible for all negotiations with the landlord needed to effectuate any Access Modifications. Further, if necessary, the County may initiate, at its discretion, regulatory or legal action as may be necessary to ensure Access Modifications.

b. Effective Communication: The Contractor, upon request, shall provide appropriate aids and services leading to effective communication for qualified persons with disabilities so they can participate equally in the Contractor's programs, services, and activities, including qualified sign language interpreters, documents in Braille, and other ways of making information and communications accessible to people who have speech, hearing, or vision impairments, as required by the ADA.

c. Modifications to Policies and Procedures: The Contractor shall make the necessary modifications to its policies and procedures to ensure that people with disabilities have an equal opportunity to enjoy the Contractor's programs, services, and activities, as may be required by the ADA. For example, individuals with service animals are welcomed in the Contractor's offices or facilities, even where pets are generally prohibited.

d. The Contractor shall not place a surcharge on a person with a disability or any group of individuals with disabilities to cover the cost of providing auxiliary aids/services or reasonable modifications of policy.

e. Employment: The Contractor shall not discriminate on the basis of disability in its hiring or employment practices.

f. Responding to inquiries from the U.S. Department of Labor.

WITNESS these signatures:

THE COUNTY BOARD OF ARLINGTON COUNTY, VIRGINIA		CIGNA HEALTH AND LIFE INSURANCE COMPANY	
AUTHORIZED SIGNATURE:		AUTHORIZED SIGNATURE:	
NAME:	RICHARD D. WARREN	NAME:	JULIA HUGGINS
TITLE:	PURCHASING AGENT	TITLE:	VICE PRESIDENT
DATE:	9/17/14	DATE:	

EXHIBIT A
To AGREEMENT NO. 719-13-1
SCOPE OF WORK

Cigna Health and Life Insurance Company agrees to provide Third Party Administrator services for Arlington County Government to provide active employees, pre-Medicare retirees, their dependents and COBRA participants with comprehensive medical and prescription drug benefit services for the County's medical plans.

This Agreement is for a self-insured group medical and prescription drug plan arrangement with the Contractor providing Administrative Services Only (ASO).

The following is a listing of services covered by this Agreement, identifying individual services included in the Contract Rates identified in Exhibit B, and identifying additional charge(s), if applicable. Unless otherwise specified, all services are included in the Contract Pricing (Exhibit B).

The County may add or make changes to the Scope of Services for services of a similar nature to those specified in of this Agreement as mutually agreed to and at a price mutually agreed upon as evidenced by a written amendment to the Contract. .

The County's Plan Year for medical and prescription drug services to members shall be from July 1 to June 30th. The Contractor shall provide medical coverage and services to enrolled members of the County's Plan in accordance with Exhibit C Plan Design.

Portions of the Contractor's response to the Request for Proposal (provided as Exhibit D) are incorporated into this Scope of Services. If any response or provision in Exhibit D conflicts with another section of this Agreement, then the other section shall supersede Exhibit D.

The services the Contractor shall provide are as follows:

Task 1: Implementation of Plan Services

- Administration of medical and prescription drug benefit services shall begin on July 1, 2014.
- Implementation services shall include but not be limited to
    - data and technology services to enable the electronic transfer member information from the County to the Contractor
    - providing hard copy and electronic versions of communication materials related to health coverage and programs offered to County employees, retirees, dependents, and COBRA participants
    - assisting County Benefits staff with development of a communications strategy to successfully explain network and/or plan design changes to employees, retirees, dependents, and COBRA participants
    - on-site presence in educating/orienting County staff with regard to network, plan design, data management,
- Contractor shall develop and provide the County with a detailed implementation plan that shall result in a complete and successful enactment of the County's proposed plan design and the conversion of records to reflect new network and plan choices by the beginning of the County's Plan Year. The implementation plan shall include proposed actions and timetable, tasks, responsibilities; deadlines for completions. Implementation plan shall be provided to the County no less than 60 days prior to the beginning of Open Enrollment for review and approval.

Task 2: Account and Data Management

Management Information and Analysis

- Ongoing review and analysis of new/changed state and federal legislation and regulations impacting health care industry and the County's medical and prescription drug plan; provide information and analysis to County Benefits staff via Contractor's website or email
- Assist the County so as to ensure its plan(s) complies with HIPPA, the Affordable Care Act, and other new/changed state and federal laws, standards and regulations by reviewing regulation changes, analyzing the potential impacts to the County's plan, and reporting these changes to County Benefits staff as needed.

- Conduct quarterly meetings to review program utilization metrics and costs; provide recommendations -- such as products, education and outreach efforts, and plan design changes -- to the County Benefits staff to improve effective utilization and to manage costs of the plan. Quantify fiscal impact of all proposed recommendations.
- Provide information and recommendations to County Benefits staff at quarterly management meetings regarding plan management options resulting from changes in healthcare opportunities and potential medical and/or prescription drug plan design options
- Provide dedicated Senior Account Representative, Claims Representatives, Client Engagement Manager, and Enrollment Representatives for medical and prescription drug plans. These personnel may only be replaced in accordance with the Key Personnel paragraph of the Contract.

Eligibility and Enrollment

- Establish and maintain electronic eligibility files; provide online access to eligibility lists/reports for County Benefits staff
- Receive electronic files for active employees and their dependents; receive paper applications for retired employees and their dependents; ensure enrollment data is current and accurate
- Conduct quarterly eligibility audit and provide to the County Project Officer. Assist with eligibility reconciliation by providing weekly error reports to the County Benefits staff and online access to eligibility reports specific to the County.
- Within the first four months after the beginning of the plan year, verify the eligibility of all disabled and handicapped children and adult dependents over age 26 that are enrolled in the plan. Provide an annual report summarizes the findings for each said enrollee to County Benefits staff.

Financial Services

- Provide on-line account management access for County Benefits staff
- Provide County Benefits staff with secure, on-line access to invoices, banking reports, and check registers which provide information regarding checks issued and cleared, a summary of claim activity, banking activity
- Provide County Benefits staff with year-end financial accounting within 60 days of the end of the plan year
- Upon the Contractor's request, County will authorize daily or weekly transfer of funds from County's local bank to the Contractor for the aggregate amount of checks that cleared the night before or during the prior week, or at any other time the account is overdrawn via 1031 Fed Wire transfer.

Financial Analysis:

- Upon request from the County Benefits staff, produce claim projections for future fiscal year(s) to assist the County in budget development
- Upon request from the County Benefits staff, project cost impact for proposed benefit design changes for future fiscal year(s)
- Upon request from the County Benefits staff, project conventional premium equivalent rates for future fiscal year(s) to assist the County in budget development
- Provide annual IBNR reserve estimates to County Benefits staff within 60 days of the end of the plan year
- Establish performance guarantees (delineated in Exhibit B-2)

Task 3: Network Access, Management And Administrative Activities

- Maintain provider credentialing and re-credentialing process, quality assurance program, customer satisfaction program, and customer complaint tracking as stated in Exhibit D (Technical Questionnaire, Section III, Management Capabilities) as tools for monitoring and maintaining the provider network.
- Provide all contract administration associated with maintaining a network of medical and prescription drug providers
- Maintain a current directory of network providers that is available to members, both on-line and in hardcopy
- Maintain a national network(s) of providers, including the District of Columbia, Puerto Rico, and the U.S. Virgin Islands, for the purpose of providing medical and prescription drug services to participants in the plan

Task 4: Reporting/Analysis

Provide County Benefits staff with access to an on-line reporting system including, but not limited to, the following reports and/or reporting tools:

- Utilization Costs and Trend Reports
- Medical trend drivers and solutions
- Membership utilization reporting
- Enrollment reports
- Financial reports such as claims summaries, claims incurred, claims paid, cost containment
- Provide ad hoc reports upon request from County Benefits staff at no additional charge

Task 5: Claims Review and Processing

Claims Processing

- Review, process, validate and adjudicate Claims for services; Process 99% of claims within 30 days of receipt
- Provide accurate calculation of benefits and claim payment preparation in accordance with the Performance Guarantees stated in Exhibit B.
- Prepare standard claim forms for issuance to Plan members
- Coordination of benefits (COB) administration for all claims
- Administer coordination of benefits and third-party subrogation
- Address and research claim disputes and/or appeals within 45 days of receiving appeal
- Provide electronic and hard copy Explanation of Benefit ("EOB") statements directly to members
- Notify claimants of rejected claims and the reason for the rejection within 45 days of claim receipt
- Administer an appeals process for rejected claims

Providers and claims

- Determine the reasonableness, appropriateness, accuracy, and applicability of all provider bills
- Discuss claims with providers
- Provide cost containment recommendations to County Benefit staff on a quarterly basis
- Perform internal audits of claim payments
- Apply claim control procedures to eliminate duplicate invoices, to prevent payment of non-covered services, and to reduce errors.

Task 6: Customer and Member Services (not applicable to Onsite Clinic)

- Provide Transition of Care program to eligible participating members
- Member Services Call Center
  - Provide 24 hours per day / 365 days per year customer service call number
  - Maintain a multi-lingual customer service unit to respond to member inquiries
  - Maintain a toll-free access to customer service call center with TTD or TTY services for hearing impaired members
- Electronic Member Services
  - Provide a secure web site for members to view plan details, to print temporary cards, and to review personal information, claims information and other relevant service information
  - Provide Spanish language version of web site information and material
  - Provide members with online cost comparison data for prescription drugs and medical services
  - Provide access to online members services via a smartphone application

- Member Education and Information materials
  - Provide electronic versions of educational materials for use during the County's Open Enrollment and on the County's intranet site
  - Provide communication and educational materials in English and Spanish
  - Before the start of the County's Open Enrollment, provide electronic Summary Plan Document and Summary of Benefits and Coverage to County Benefits staff for each plan year which comply with all federal regulations

- Provide Member Identification Cards which include but is not limited to:
  - Group Name and Number

- Subscriber Name and ID Number
- Effective Date
- Plan Name
- Member Services Phone Number(s)
- Member Services Web Address
- Plan Co-Pays/ Co-insurance
- Claim submission Address and Electronic claims payor ID (or equivalent)

- Provide on-site customer service representatives at multiple sites for the County a minimum of 8 days each month to provide consumer education, respond to member questions, and address claims issues
- Attend a minimum of 5 annual Open Enrollment meetings and up to 2 periodic Benefit Fairs
- Respond to requests from employees and dependents for access, amendment and accounting of Protected Health Information and to requests for restrictions and alternative communications as required under Federal HIPAA law and regulations pursuant to terms set out in this Agreement and its Exhibits

Task 7: Standard/Core Wellness Programs

Provide core wellness and lifestyle behavior change programs to eligible members. Programs may be administered to eligible members who enroll via a website, telephonic or onsite coaching, and/or on-site education meetings.

Wellness programs shall include but not limited to:

- Disease management and prevention programs
- Gaps in care services
- Medication adherence services and programs
- Coaching programs for chronic conditions such as diabetes, low back pain and osteoarthritis
- Tobacco cessation programs
- Programs to address lifestyle issues such as weight management and stress management
- Personal Health Teams programs and services shall be available to all enrollees. Any participating Arlington County Cigna member may self-enroll in the Personal Health Teams program.
- Health Pregnancies, Healthy Babies program services. Provide services to qualified enrolled members. For this program the Contractor shall administer a reward incentive to enrolled members who complete the program. Incentive payments to members shall be processed as County claims and paid by the County to Contractor
- Contractor will provide the County with $50,000 per plan year to be used at the County's discretion for wellness programs, services, or activities. Cigna will reimburse the County within 60 days upon presentation of the County's invoice for any expenditures made by the County that the County determines to be for wellness programs/services/activities. The content of the wellness program/services/activities and type and manner of expenditures are at the sole discretion of the County. The Contractor and County shall work in collaboration to track wellness dollars each contract year.

Task 8: Prescription Drug Benefit Services:

- Provide services outlined in Tasks 1-6 above
- Administer a mail order transition service which honors all existing prescriptions until expiration of all refills
- Establish Maximum Allowable Cost (MAC) pricing and maintenance
- Develop and maintain prescription drug plan formularies that list covered drugs under the County's plan according to pricing tier (first, second, or third). The formulary shall include a wide rane of generic and brand name drugs that are safe and effective, commonly prescribed, and approved for sale by the US Food and Drug Administration.
- Provide integrated retail and mail order claims processing for prescription drugs so as to achieve performance guarantees outlined in Exhibit B-2.
- Establish and utilize Drug Utilization Review (DUR) programs (concurrent, retrospective, fraud, and abuse) to ensure appropriate medication decision making by providers and postive patient outcomes
- Establish and administer a Specialty pharmacy program that provides a team of clinicians who are available to enrolled members prescribed injected, inhaled, or infused medications; the team shall provide information to help members understand their medication and possible side effects

- Provide enrolled members with access to online mail order services, interactive voice response (IVR) customer service for drug refills, 24-hour telephone access to a licensed pharmacist;
- Provide clinical pharmacy expert on account management team to provide information and assistance to County Benefits staff with regard to prescription drug claims issues and customer service.
- At the County's initiative, participate in and provide funding toward an annual market check on the aggregate value of pharmacy pricing to include the following provisions:
    - A top ten (10) pharmacy benefit management consulting firm or other third party elected by County and agreed to by Contractor, may perform the market check on behalf of the County.
    - The market check can commence during the third quarter of each contract year 3 through 6, as preparation for negotiating prescription drug pricing for contract years 4 through 7.
    - Contractor to provide comments on the market check audit report within ten (10) business days of receipt.
    - If market check audit report indicates current market conditions can yield a 1% or more savings of net plan costs, the parties will reach mutual agreement on revised pricing terms and other applicable provisions.
    - If mutual agreement cannot be reached within sixty (60) days from the date of market check audit report, then County has the right to terminate the agreement.
    - If market check audit report results in revised pricing terms, Contractor will make those revised pricing terms effective within thirty (30) days following written approval from the County of the revised pricing terms.
    - Contractor shall contribute $10,000 in each contract year four through seven, if the County initiates a pharmacy pricing market check.

Task 9: Onsite Health Clinic

Contractor shall operate the County's onsite health clinic. A complete scope of work for the onsite health clinic is provided in Exhibit A-1.

Task 10: Outstanding Check Services

A standard monthly report is provided to County by Contractor. This report is entitled, "Outstanding Checks 9 Months". This report provides the County with a single source for identification and research of checks outstanding 9 months from the issue date. If the checks identified need to be stopped and/or replaced, then the payee can contact the corresponding claim office to initiate this process.

Additional Outstanding Check Services not included in the ASO fee:

Outstanding Checks Research Services are available from the Contractor Client Banking Unit for an Optional Services cost. The basic services are:

- Contractor will send a letter and affidavit to the payees of all checks that are outstanding 9 months from the check issue date.
- Contractor will send a follow-up letter and affidavit to payees from whom no response is received after 60 days.
- Contractor will issue replacement checks and update claim systems for payees completing an affidavit stating the original check is lost and was not cashed.
- Contractor will provide County with a Monthly Activity Report that reflects:
    - Letters sent;
        - Follow-up letters sent;
        - Letters which received no response

Outstanding Checks Research Services does not include completion of escheat filings to the State; as this remains the responsibility of the County.

Pricing for Additional Outstanding Check Services is included in Exhibit B.

Task 11: Other Requirements and Service Provisions.

I. Enrollment and Determination of Eligibility

a. The County will:

i. respond to all routine inquiries from employees concerning enrollment in the Plan and its terms, conditions, and operations;

ii. handle all enrollment activity including the transmission to employees and back to Contractor of employee documents necessary for Health Savings Account (HSA) enrollment and account establishment; and

iii. notify Plan participants (also referred to herein variously as "members" or "associates". May also be referred to as "employees" but only in the appropriate context to only mean those participating in the Plan) of their right to apply for benefits and supply them with claim forms (to be timely provided by Contractor) and claim filing instructions (to be timely provided by the Contractor).

b. Eligibility Determinations and Eligibility Data. In determining any person's right to benefits under the Plan, Contractor shall rely upon eligibility information furnished by the County. It is mutually understood that the effective performance of this Agreement by Contractor will require that it be advised on a timely basis by the County during the continuance of this Agreement 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 Contractor in a form and with such other information as reasonably may be required by Contractor for the proper administration of the Plan. County represents and warrants that its eligibility determinations shall be in accordance with the terms of the Plan.

The County shall provide information regarding the handicapped or disabled status of enrollees. The Contractor shall be responsible for verifying the disabled or handicapped status of all enrolled children and adult dependents that are over the age of 26. Contractor shall determine if the nature of the disability is permanent or temporary. Temporary disabled/handicapped status shall be verified annually for each designated enrollee and reported to the County.

c. Release of Liability. County acknowledges that its prompt furnishing of complete and accurate eligibility and benefit information is essential to the timely and efficient administration by Contractor of claims for the Plan. If County, or any party designated by County, fails to provide Contractor with accurate eligibility information, benefit design requirements, or other agreed-upon data in an accessible and readable format and in a reasonable time frame and format prescribed by Contractor ("Required Data") and mutually agreed to by County, Contractor shall have no liability whatsoever under this Agreement (specifically including but not limited to the Section entitled Non-Plan Benefit Liability herein) for any act or omission by Contractor, or its employees, affiliates, subcontractors, agents, or representatives, which is directly or indirectly caused by such failure. Contractor agrees that County has already met such requirement for implementation and that future changes to requirements will be communicated timely to County.

d. Reconciliation of Eligibility Data. Contractor will periodically and also as necessary provide to the County a report listing potential discrepancies in eligibility data provided by the County. County agrees to review such data and reconcile any discrepancies within thirty (30) days of receipt.

e. Default Terminations. If County does not reconcile within the timeframe specified in subparagraph d above a participant who is listed as eligible in Contractor's eligibility data, but who is not listed as eligible in County's submitted eligibility data, Contractor shall terminate coverage for said participant but only upon prompt notice to the County and the participant (and is or her eligible dependents)

II. Plan Claim Audits, Record Retention and Review

a. The County has the right to perform a claim audit of Plan benefits administered by Contractor pursuant to the following terms. Any audit shall be conditioned upon County's auditor executing Contractor's standard Claim Audit Agreement (Exhibit G). Upon forty-five (45) days' advance written request, all documents relating to the payment of claims shall be made available to the County for its audit or inspection during regular business hours at the place or places of business where it is maintained by Contractor. Any audit shall be conducted pursuant to an executed Claim Audit Agreement, limited to reviewing claims at most two years prior to the date of the claim audit. The County and Contractor shall mutually agree upon any third party auditor that the County retains to perform an audit. The County is entitled to one (1) claim audit per each Plan year at no cost under this provision. Each audit permitted shall be limited to a review of up to 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 County and Contractor.

b. Any release of Protected Health Information to the County or its designee shall be made subject to the HIPAA Business Associate Agreement included in Exhibit E.

c. County will have no interest in, nor shall Contractor have any obligation to provide to County, any claim or payment data recorded for or otherwise integrated into Contractor's data processing systems during the ordinary course of business (provided, however, that claim or payment data will be available to County pursuant to this Section), any information which Contractor reasonably deems to be proprietary in nature or any information which Contractor reasonably believes it cannot divulge due to applicable state and/or federal privacy restrictions.

d. All data and records shall be maintained by Contractor as required by all applicable laws.

e. If, upon the written request by County, Contractor agrees to provide certain of its proprietary information including, but not limited to, information about Contractor's arrangements with health care providers ("Proprietary Information") to County's designee(s), County agrees that the Proprietary Information will be kept confidential and will be used solely for the purpose of satisfying County's responsibilities with respect to the administration of the Plan as identified in its request.

f. The obligations set forth in this section shall survive termination of the Agreement.

III. Run Out Claims

a. Following termination of this Agreement for any reason other than for non-payment of services by the County, or upon termination of eligibility of a Plan participant(s), or upon termination of a benefit option, Contractor shall continue for a period of twelve (12) months to timely administer all claims that were incurred prior to termination. No additional charge shall be assessed for this service.

b. Following termination of this Agreement for any reason other than for non-payment of services by the County, or upon termination of eligibility of a Plan participant(s), or upon termination of a benefit option, and to the extent that County's Plan administered hereunder consisted of a PPO and/or Open Access Plus coverage, the Contractor shall, at the request of the County Project Officer, continue for a period of twelve (12) months to administer all claims for PPO and/or Open Access Plus Plan participants that were incurred prior to termination. The fee for such service, if requested, shall be the sum of the Contract Rates for PPO and Open Access Plus member participants for the four (4) months prior to the termination of this Agreement.

c. After termination of the 12 month run-out period identified above, Contractor shall cease processing run-out claims for all Plans and shall make all records available to County or County's designee which are reasonably required to continue plan administration on an uninterrupted basis. Contractor is not required to provide proprietary information to a new contractor engaged in providing medical services on behalf of the County or to any other party.

d. At the termination of this Agreement, the Contractor shall promptly make all information, records and data relating to all claims incurred during the terms of this Contract available to the County or its successor administrator in a County approved form and format as established in the DATA PROTECTION AND SECURITY section of this Agreement.

EXHIBIT A-1
TO AGREEMENT No. 719-13-1
ONSITE HEALTH CLINIC SCOPE OF WORK

Cigna Health and Life Insurance Company ("Contractor") shall provide or arrange for the provision of an Onsite Health Clinic ("Clinic") located at 2100 Clarendon Blvd., Suite 508, Arlington, Virginia 22201, commencing on September 1, 2014 (and continuing throughout the term of the Agreement. The Clinic shall provide certain low acuity, urgent and episodic health care, prescription services, laboratory services, personalized coaching, limited immunizations, and primary care referrals for the benefit of County eligible employees ("Participants"), as outlined in greater detail herein. The Contractor shall partner with HealthSmart and the County's health plan providers to maximize utilization of existing resources and programs.

Other services the Contractor shall provide that are further described herein include, but are not limited to: regular reporting and assistance with the County's marketing efforts.

Capitalized terms in this Exhibit A-1 shall be as defined in the Agreement, unless otherwise indicated herein. County and Contractor are sometimes referred to herein individually as a "Party" and collectively as the "Parties."

1. CLINIC DAYS AND HOURS OF OPERATION

The Contractor shall provide qualified staff (defined in Qualifications and Roles of the Clinic Staff) and ensure proper staff coverage during Clinic operating hours. Initially, the Clinic will operate 24 hours per week for County employees. Through later mutual agreement of the Parties and amendment to the Agreement, services may be expanded to 40 hours per week and/or for County employees' spouses and/or dependents and/or retirees.

a. Clinic will operate on the following days of the week:

Days	Hours of Operation
Mondays, Wednesdays, and Fridays	Clinic Open for Clinical Services (as defined herein): 8:30 am – 4:30 pm Staff Hours: 8:00 am – 5:00 pm (includes one hour for lunch – staff will alternate lunch times to ensure coverage.)

b. The Clinic will be closed on accordance with the following Cigna Holiday schedule:

New Year's Day

Martin Luther King Day

Memorial Day

Independence Day

Labor Day

Thanksgiving

Day after Thanksgiving

Christmas Day

Day After Christmas

c. In the event that a Holiday falls on a day when the Clinic is scheduled to be open in accordance with Section 1.a. above ("Holiday Closure"), Contractor shall use best efforts to provide an alternative day during the week of such Holiday Closure to offer Clinic services. If despite Contractor's best efforts, Contractor is unable to open the Clinic

for services during the week of the Holiday Closure, Contractor shall arrange for an additional day for operation of the Clinic on a subsequent date. Any such additional days of operation shall be at no cost to the County.

d. Notwithstanding anything to the contrary in Section 32 of the Agreement, in the event of a closure of the Onsite Clinic or an interruption of Onsite Clinic services as defined in this Exhibit A-1 caused by acts or omissions of any third party or Force Majeure as defined in Section 32 of the Agreement, upon determination by the County that the Clinic should remain open with no interruption in services, or reopen in the event of a closure, the County shall be solely responsible for reimbursing the Contractor for the costs and expenses associated with the implementation of contingency plans necessary to prevent such Clinic closure or interruption in services.

2. **PATIENT POPULATION SERVED**

Contractor shall provide Clinical Services to County's full-time and part-time employees provided they are:

a. Eligible for health plan benefits sponsored by the County, regardless of the health benefit plan chosen or actual enrollment in health benefit plan ;

b. Working at least 10 hours per week; and

c. Appear on the Eligibility list provided bi-weekly to the Contractor by the County.

3. **CLINIC STAFF**

a. All clinical and administrative staff shall be employed by or be independent contractors of Contractor or its affiliates or parent companies. Contractor shall determine in its sole discretion, whether such staff must be independently contracted in order to comply with applicable state law.

b. Contractor shall arrange for the following staff to provide Clinical Services ("Clinic Staff"):

One (1) Part-Time Advanced Practice Registered Nurse ("Mid-Level Practitioner") – twenty four (24) hours per week; and

One (1) Part-Time Medical Assistant – twenty four (24) hours per week.

4. **CLINIC STAFF QUALIFICATIONS RESPONSIBILITIES**

a. Nurse Practitioner's Requirements and Responsibilities

1) Graduate degree in nursing or in the appropriate nurse practitioner specialty from an educational program designed to prepare nurse practitioners;

2) Certification that is consistent with the specialty area of the applicant's educational preparation issued by either the American Nurses' Credentialing Center or the American Academy of Nurse Practitioners;

3) Current, valid, unrestricted Virginia nursing license as a RN and Family Nurse Practitioner or Adult Nurse Practitioner;

4) Current and valid Basic Cardiac Life Support (BCLS);

5) Practice in collaboration with and under the medical direction and supervision of a Supervising Physician as defined herein, under a written protocol;

6) Provide direct patient care in accordance with individual clinical privileges and the scope of practice for the Clinic, under the supervision of the Supervising Physician;

7) Perform patient examinations, assessment, treatment intervention and referral and follow-up care as outlined by Contractor's approved clinical guideline tools;

8) Ensure that all health care is adequately and accurately documented in each patient's electronic medical record;

9) Observe and comply with all Contractor's infection control protocols and standards;

10) Promote preventive and health maintenance care, including physical examinations, immunizations, positive health behaviors and self-care skills through education and counseling;

11) Prescribe medications as delineated by Contractor's clinical guideline tools; document instructions given to patient in medical record;

12) Participate in Contractor's Quality Assurance and Quality Improvement Programs;

13) Order diagnostic tests as applicable;

14) Coordinate care with the County's health benefit plans and vendors;

15) Manage the Medical Assistant;

16) Collaborate with onsite disease management nurses.

b. Medical Assistant's Requirements and Responsibilities

1) Graduation from an accredited senior high school or its equivalent;

2) Graduation from a medical assistant program accredited by the Accrediting Bureau of Health Education Schools (ABHES) or an equivalent program.

3) Certification by the American Association of Medical Assistants (AAMA) or eligible to take the examination;

4) A minimum of 1 year related experience;

5) Current and valid BCLS certification;

6) Possess above average computer knowledge to enter information into a computerized system;

7) Ability to use management principles to manage general office operations;

8) Ability to maintain confidentiality in all matters pertaining to medical records and information gained during employment;

9) Basic understanding of medical terminology desirable;

10) Basic understanding of ICD-9 Coding desirable;

11) Take and record vital signs;

12) Stock treatment rooms;

13) Prepare and keep treatment rooms ready for care;

14) Chaperone patients;

15) Perform EKG's, visual acuity tests and pulse oximetry tests;

16) Apply and change dressings and bandages;

17) Perform front desk operations including appointment scheduling; and

18) Perform blood draws

5. **CLINIC SUPERVISING PHYSICIAN**

Contractor will independently contract with a physician ("Supervising Physician") to supervise the Onsite Health Clinic Staff, in accordance with Virginia law.

Qualifications and Responsibilities include:

a. Doctorate Degree in Medicine from an accredited college;

b. Board Certified in Internal Medicine, Emergency Medicine or Family Practice;

c. 1 year experience in providing clinical leadership in a primary care setting;

d. Current, valid and unrestricted Virginia license as a physician;

e. Current Drug Enforcement Agency (DEA) Number;

f. Minimum of 2 years' experience in providing adult medicine;

g. Provide medical consultation and supervision, including participation in the development of a written protocol for the nurse practitioner; development of guidelines for availability and ongoing communications that provide for and define consultation among the collaborating parties and the patient; and periodic joint evaluation of services provided, e.g., chart review, and review of patient care outcomes;

h. Guide the clinical care program to ensure appropriate mechanisms are in place in the delivery of quality patient care;

i. Support training and provide feedback about medical staff to Contractor;

j. Ensure that all health care is adequately and accurately documented in each patient's electronic medical record;

k. Conduct regular reviews of patient charts on which the nurse practitioner has entered a prescription for an approved drug or device.

6. **CLINIC STAFF PERFORMANCE MANAGEMENT**

a. The Contractor will be responsible for recruiting and hiring candidates for the Nurse Practitioner and Medical Assistant positions. All hiring decisions will be made solely by the Contractor. As a courtesy, Contractor will refer qualified candidates to meet with the County during the interview process.

b. Upon written notice from County specifying, in County's good faith belief, the reasons that a Clinic Staff person should be removed from performance of the Clinical Services, including the facts necessary to validate such removal, Contractor shall have a reasonable amount of time not to exceed ten (10) calendar days, to investigate the matter. Upon request of County and after initial inquiry by Contractor, if Contractor determines that there is sufficient business rationale, Contractor shall remove the Clinic Staff person from performing Clinical Services during such investigation. If Contractor deems it appropriate in their discretion that such Clinic Staff person should be removed from providing Clinical Services hereunder for non-discriminatory reasons after investigation, Contractor shall immediately remove such Clinic Staff person from providing Clinical Services and shall as soon as practicable arrange for the provision of a substitute employee or other independent contractor. In addition, if County asserts that such Clinic Staff person has engaged in misconduct as defined by County, County agrees, where necessary, to cooperate with in conducting any investigation or inquiry, and to provide documentation and testimonial support in event of litigation concerning such misconduct. County acknowledges and agrees that the policies and procedures of Contractor as to performance management, disciplinary action and termination shall govern, including any confidentiality requirements contained therein.

7. **CLINIC STAFF PAID TIME OFF AND LEAVE**

a. County acknowledges and agrees that in addition to Contractor Holidays as defined in Section 1.b. of this Exhibit A-1 and time off purchased by the Clinic Staff, the Clinic Staff employed by Contractor shall be entitled to paid time off (PTO) and other leave ("Leave") as defined by and in accordance with Contractor's standard policies and procedures ("Policies").

b. Each year, the Nurse Practitioner shall also be eligible for five (5) days for continuing education requirements (CME).

c. Cigna shall create a proactive plan to fill scheduled absences of the Nurse Practitioner, such that temporary coverage for the Nurse Practitioner is provided. In the event of unscheduled absences of the Nurse Practitioner, Contractor shall use its best efforts to arrange for prompt temporary coverage, at no cost to the County. Contractor shall notify County as soon as practicable in advance if the Clinic will be closed due to time off other than scheduled PTO, Leave and Holidays. County agrees and acknowledges that if after exercise of best efforts Cigna is unable to arrange for temporary coverage by the Nurse Practitioner, the Clinic may remain open and operate under limited scope of services appropriate to a Medical Assistant.

d. For Clinic Staff not employed by Contractor, i.e., independent contractors, the number of days of PTO shall be as defined in the contract between Contractor and the Clinic Staff person.

e. Contractor shall provide a copy of Policies to County upon request.

8. CLINICAL SERVICES

Contractor shall provide Clinical Services in accordance with Contractor standard policies and procedures, and in accordance with the standard of care in Section 3 of the Agreement. All Clinical Services provided shall be within the scope of the licensure and practice of the health professional(s) employed or otherwise retained by Contractor, and further shall be provided in accordance with all applicable federal and state laws and regulations. Contractor shall provide or arrange for the provision of the following clinical services ("Clinical Services"):

a. Low Acuity Urgent Care/Episodic Care/Primary Care Referrals

i. Acute care visits include sufficient scheduled time to allow clinician to perform a full history and exam, lifestyle risk assessments, health promotion and preventive care discussion when needed and includes care coordination referrals and community physician referrals as appropriate. Examples include, but are not limited to:

(a) Colds;

(b) Sore throats;

(c) Urinary infections;

(d) Ear infections;

(e) Bronchitis;

(f) Asthma;

(g) Headache/Migraine;

(h) Sinus Infections;

(i) Gastroenteritis;

(j) Abdominal pain;

(k) Poison ivy or oak;

(l) Skin rashes;

(m) Minor lacerations;

(n) Minor strains and sprains;

(o) Blisters;

(p) Bursitis;

(q) Muscular injuries/pain; and

(r) Tendonitis.

b. Monitoring Chronic Conditions

i. Contractor shall treat or monitor employees with diagnosed chronic illnesses. The Clinic Staff shall place considerable emphasis on educating patients upon diagnosis of any serious chronic condition; ensure that patients with chronic medical conditions have appropriate community physician relationships and collaborate with such physicians as needed; refer patients to appropriate County telephonic and online wellness programs, and encourage healthy lifestyles that address the chronic condition. Examples include, but are not limited to:

(a) Hypertension treatment and blood pressure monitoring;

(b) Diabetes treatment and monitoring;

(c) Cardiac risk analysis;

(d) Hyperlipidemia treatment and monitoring;

(e) Depression screening and appropriate referrals;

(f) Asthma and other chronic respiratory diseases;

(g) Stable hyper- or hypothyroidism treatment and monitoring;

(h) Arthritis treatment;

(i) Asthma treatment and monitoring.

ii. On-going monitoring of response and medication adherence shall be provided by the Nurse Practitioner with patients referred to specialists as appropriate. Effective collaboration and coordination with patients' specialists will be maintained at all times. To facilitate follow up monitoring and care of chronic conditions, the Clinic Staff shall coordinate referral and enrollment in the County's Disease Management Programs.

c. Preventative Health Screenings and Immunizations

i. Annual physical examinations with extended testing capabilities. The County's requirements for these services will be mutually agreed upon in writing by the Parties. Sports physicals are excluded. During scheduled wellness screenings or physical exams, the Nurse Practitioner shall evaluate risk factors that allow the Clinic to target interventions for a patient's risk profile. The biometrics and risk factors that shall be screened include:

(a) Blood pressure;

(b) Blood sugar labs;

(c) Cholesterol and comprehensive lipid panel lab work that includes HDL and LDL levels and coronary risk ratio;

(d) Body Mass Index (BMI) and body composition;

(e) Weight;

(f) Height;

(g) Alcohol use;

(h) Emotional health;

(i) Exercise;

(j) Nutrition; and

(k) Tobacco use.

ii. Contractor shall administer selected immunizations using Centers for Disease Control (CDC) recommendations, including tetanus, and influenza immunizations. Vaccinations shall include:

(a) Influenza vaccine;

(b) Hepatitis A and B vaccines;;

(c) Tetanus/Diphtheria (DTP, DTaP, Tdap, or Td);

(d) Pneumococcal vaccine

iii. For those Participants who had already received allergy injections prior to September 8, 2014 at the County's onsite health clinic managed and operated by a former vendor to the County, the Contractor shall administer allergy injections as mutually agreed upon in writing by the Parties and according to the Contractor's written procedure. Contractor and County will expand allergy injection services on a mutually

agreeable date to Participants who had not received such services at the clinic prior to September 8, 2014. Patient's allergy serum must be received by the Clinic in controlled conditions. Contractor may refuse to administer allergy injections to any patient whose allergy serum is not received in controlled conditions or which does not meet Contractor's applicable written procedure. Controlled conditions include, but are not limited to:

(a) Receipt of the allergy serum directly from the manufacturer; or

(b) Receipt of the allergy serum from another competent provider under conditions appropriate for the transfer of allergy serum.

d. Biometric Screening

i. Capabilities to provide scheduled screenings that may include but not limited to; Height, Weight, BMI, Body Composition, Blood Pressure, Total Cholesterol, HDL Cholesterol, LDL Cholesterol, Coronary Risk Ratio, Blood Glucose.

e. Laboratory Services

i. CLIA-waived (rapid test) laboratory testing on site;

ii. Blood draws, urine collection, and collection of other specimens ordered by Clinic's medical staff or community providers for pick up by contracted lab vendor. Results delivered to ordering provider.

iii. With regard to i. and ii. above, laboratory services shall not be provided for County employees who participate as members of Kaiser Permanente. Clinic staff shall instruct Kaiser Permanent members to seek laboratory services from an appropriate Kaiser Permanente facility.

f. Personalized Coaching

i. Clinic Staff shall provide personalized health education to help support and facilitate the patient's engagement with County' disease management program(s).

ii. Assess lifestyle risks and discuss health improvement and preventive care and coordinate additional care if required.

g. Prescriptions

i. Written prescriptions by Nurse Practitioner, as allowed by law.

ii. Contractor shall track prescriptions through an electronic vendor, which provides the following features:

a) Clinic practitioner(s) can issue a prescription directly from the software (as allowed by federal and state law);

b) Prescriptions can be sent to pharmacies via fax or secure electronic transmissions (if requested by patient);

c) Pharmacies and patients can request prescription refills electronically;

d) Prescriptions can be signed electronically by the Clinic practitioner(s);

e) Prescriptions cannot be issued without Clinic practitioner(s) signature;

f) The Clinic practitioner(s) can cancel a prescription;

g) Using Allscripts electronic prescribing, the system shall check patient prescriptions for:
1. drug-drug interactions;

2. drug-disease interactions;
3. drug-food interactions;
4. patient allergies to drugs;
5. The system shall check patient prescriptions for acceptable dosage ranges;
6. Warn the prescribing Clinic practitioner(s) of medication contraindications if the patient is pregnant;
7. Attach drug level test results from external sources to the patient's electronic medical record;
8. Save commonly prescribed medication orders;
9. Track sample medication distribution;
10. Automatic addition of new prescriptions to the patient record without re-keying; and
11. Add medications prescribed from external providers to the medical record.

iii. With regard to i. and ii. above, prescriptions may be written for County employees who participate as members of Kaiser Permanente. Clinic staff shall either fax the prescription directly to a Kaiser Permanente pharmacy for employee pick-up or instruct the employee to bring the prescription to a Kaiser Permanente pharmacy to be filled. Kaiser Permanente members may not use the Concierge Pharmacy service.

h. Marketing Support

i. Contractor shall support the County's efforts to develop a marketing campaign designed to facilitate communication of the benefits of the medical services that Clinic provides, and to encourage engagement with County employees. The County staff and the Contractor shall collaborate to develop the final design of the marketing program using County resources for implementation.

ii. The Contractor will encourage and promote the completion of Cigna's Health Risk Assessment either directly through Cigna or via CareAllies.

i. Management

i. Daily management of all clinic and administrative activities including but not limited to: appointment scheduling, answering phones, completion of appropriate paperwork, provision of medical/biohazard waste removal and maintaining qualified personnel.

9. FEES AND OPERATING EXPENSES

During the Contract Term and each Subsequent Contract Term, County shall pay and reimburse Contractor for fees and operating expenses ("Fees") for services provided under this Exhibit A-1, Onsite Health Clinic Scope of Work, in accordance with Exhibit B of this Agreement.

10. TERMINATION

10.1 Notwithstanding anything to the contrary in the Contract Documents Provision in Section 1 of the Agreement and the Termination Provisions in Sections 23 and 24 of the Agreement, services under this Exhibit A-1 may be terminated as follows:

a. In the case of material breach of this Exhibit A-1, either Party may terminate this Exhibit A-1 at any time, for cause, upon sixty (60) days written notice to the other Party specifying the manner in which that Party has materially breached its obligations. Exhibit A-1 shall terminate automatically at the expiration of such sixty (60) day period if that Party has not cured its breach within such period and demonstrated such cure to the satisfaction of the non-breaching Party. As used herein, a "material breach" means a significant divergence from the terms of the Exhibit A-1 whereby, if the material breach continued, the injured Party would be deprived of a substantial benefit which can reasonably be expected from the Exhibit A-1.

b. Either Party may immediately terminate this Exhibit A-1 at any time during and after the initial term upon insolvency or bankruptcy of the other Party.

c. Onsite Health Clinic Services will terminate immediately upon termination of the Agreement.

d. Excluding 10.1a. and. b. above: (i) the County may terminate this Exhibit A-1 without cause upon one hundred twenty (120) days written notice to the Contractor ., and (ii) after the first ten (10) months of the Contract Term of the Agreement. Contractor may terminate this Exhibit A-1 upon twelve (12) month's written notice to the County.

e. In the event that during the Contract Term either Party terminates the Agreement or this Exhibit A-1 pursuant to Subsections 10.1 .b., c. or d. above, County shall be responsible in accordance with Exhibit B for any unpaid balance for all monthly installments in the amount of twelve thousand five hundred dollars and no cents ($12,500.00) due and owing, prorated to the date of termination.

f. In addition, in the event that County terminates the Agreement or this Exhibit A-1 during the first ten (10) months of Onsite Health Clinic operation pursuant to Subsections 10.1 c. or d. above County shall be responsible for payment of Implementation Costs to a maximum of twenty seven thousand dollars ($27,000.00).

10.2 If this Agreement is terminated for any reason set forth in this Section, County acknowledges and agrees that:

a. All communication to Clinic Staff related to such termination ("Staff Communication"), including but not limited to (i) the date of termination of the Agreement and/or the related date of the closing of the Clinic or transfer of Clinic operations to a third party vendor, and (ii) Clinic Staff employment status notification, severance, and compensation shall come solely from Contractor as the employer or contractor of Clinic Staff, and County shall not make or cause to be made any Staff Communication without the prior written consent of Contractor;

b. Tours of the Clinic facilities by potential third party vendors to assume Clinic operations on behalf of County (i) shall be conducted at times as mutually agreed upon in writing by the Parties, which includes electronic mail; (ii) shall be conducted in such a fashion as to protect the confidentiality of patient information within the Clinic; and (iii) shall not interfere with the provision of Clinical Services to Participants.

c. County and Contractor agree (i) to act in good faith and cooperate to ensure continuation of care with a replacement vendor for the Clinic, as applicable, and/or with community physicians; , and (ii) to mutually participate in final walk-through of the Clinic and sign an acknowledgement agreeing to the condition of the facility and an inventory of its contents and equipment, including but not limited to condition of furniture and fixtures, removal of signage, disposition of medical supplies and equipment and prescription drugs, retention of certain paperwork and documentation to Cigna, as appropriate, and removal of technological equipment.

11. **CONFIDENTIAL INFORMATION**

a. In the course of the performance of their obligations under this Exhibit A-1, one Party ("Receiving Party") may receive from the other Party ("Disclosing Party") data, information, documents, and other material belonging to, prepared by or for, or concerning the Disclosing Party ("Confidential Information"). For purposes of this Exhibit A-1 "Confidential Information" shall mean any and all technical and business information that the Disclosing Party discloses or reveals to the Receiving Party, including but not limited to services, plans, products, policies, financial information; operational information, trade secrets, health care delivery processes and methods, and technical information including computer software programs, and shall include all summaries, extracts, copies, compilations, analyses, interpretations, presentations, and other materials derived therefrom.

b. The term "Confidential Information" shall not include information which (i) at the time of disclosure to the Receiving Party was publicly available or thereafter becomes publicly available through no fault of the Receiving Party; (ii) is disclosed by the Disclosing Party to a third party without a nondisclosure obligation; (iii) is already rightfully in the Receiving Party's possession or is rightfully received by the Receiving Party without a nondisclosure obligation; or (iv) is independently developed by the Receiving Party as evidenced by independent documentation.

c. If at any time the Receiving Party is requested or required as a result of any law, judicial or regulatory proceeding to disclose any Confidential Information, the Receiving Party agrees to provide the Disclosing Party with prompt notice thereof so that the Disclosing Party may seek an appropriate protective order. If the Receiving Party is compelled by a judiciary or regulatory authority to disclose Confidential Information or else stand liable for contempt or suffer other censure, sanction or penalty, the Receiving Party may disclose such information to the extent required without liability hereunder.

d. The Receiving Party agrees that until such time as any such Confidential Information becomes a part of the public domain without breach of this Agreement by the Receiving Party or any agent or employee of the Receiving Party, and in any event for at least five (5) years after termination of this Exhibit A-1 the Receiving Party shall:

   i. treat, and obligate the Receiving Party's employees, agents and representative to treat as secret and confidential, all such Information whether or not it be identified by the Disclosing Party as confidential;

   ii. not disclose any such Confidential Information to any person, firm, or corporation or use it in any manner whatsoever without first obtaining the Disclosing Party's written approval;

   iii. reveal the Confidential Information only to those employees, agents and representatives of the Receiving Party who require access to such Confidential Information in order to perform the Receiving Party's obligations under this Agreement; and

   iv. not employ the Confidential Information to Receiving Party's advantage, other than as herein provided.

e. Neither Party shall disclose to the other any proprietary information obtained on a confidential basis from any third party unless (1) the Party receiving such information shall have first received written permission from such third party to disclose such information or; (2) such information is in the public domain at the time of disclosure;

f. Neither Party shall attempt to access information not necessary for its performance hereunder. Notwithstanding the above, Contractor understands that County is a public agency and is subject to the Commonwealth of Virginia's public records laws.

12. NON-SOLICITATION

During the term of this Agreement, and for a period of one (1) year after termination of this Agreement for any reason, County shall not directly or indirectly, alone or in concert with others, solicit or entice any employee or independent contractor then engaged to provide the Onsite Health Clinic Services hereunder, to leave the employment or engagement of Contractor in order for County or a vendor or agent engaged by County to provide substantially similar services as those provided in this Agreement.

13. LIMITATION OF LIABILITY

With regard to the performance of their obligations under this Exhibit A-1, except to the extent that liability arises from a party's instances of its gross negligence or willful misconduct, or in the event of personal injury or death, in no event shall either party be liable under Exhibit A-1 (whether in an action in negligence, contract or tort or based on a warranty or otherwise) for loss of profits, revenue, or loss or inaccuracy of data, or any indirect, incidental, punitive, special or consequential damages incurred by the other party even if the party has been advised of the possibility of such damages. Nothing herein shall be construed as a waiver of the County's sovereign immunity.

14. COMPLIANCE WITH LAWS AND REGULATIONS

a. Each Party shall comply with all applicable federal, state and municipal laws and regulations related to their obligations under this Exhibit A-1.

15. CLINIC CONTENTS/CONTRACTOR EQUIPMENT/INSURANCE

a. County is the owner or lessee of the Clinic facility;

b. Except as otherwise noted, County is the owner of all furniture, medical and administrative supplies, medical equipment and other contents of the Clinic ("Clinic Contents") that Contractor or its affiliate(s) has purchased or may purchase on behalf of the County during the Initial or any Renewal Term of the Agreement.

c. Contractor has purchased and shall be the owner of the following equipment ("Contractor Equipment"), and Contractor shall be entitled to retain ownership and possession of all such Contractor Equipment after expiration or termination of this Agreement for whatever reason:

i. Computer CPUs
ii. Monitors
iii. Keyboards
iv. Computer Mice
v. Laptops
vi. VPN Token Keys
vii. Air Cards
viii. Scanners
ix. Multi-Functional Printers
x. Access Boxes (Label Printer/Network Connectors)
xi. Routers

d. During the term of this Agreement, County will maintain at its own cost all necessary insurance concerning Statutory Workers' Compensation in accordance with applicable laws, Commercial General Liability and such other insurance as may be mutually agreed to in writing by the Parties. The parties agree to negotiate in good faith to reach mutual agreement with regard to such insurance coverage. Notwithstanding any of the above, Client may satisfy its obligations under this section by means of self-insurance for all or any part of the insurance required, provided that Client can demonstrate financial capacity.

16. CLINIC PREMISES

a. County shall provide to Contractor for Contractor's use in connection with the Services, and at no charge to Contractor, Clinic space (the "Building" or "Buildings"), consisting of adequate square footage as agreed to by the Parties, in compliance with all applicable state and local laws and regulations (including but not limited to municipal fire and building codes). For this purpose, in part, County leases a Building pursuant to Amended and Restated Office Building Deed of Lease ("Lease") dated October 23, 2002 between VNO Courthouse I, L.L.C. and the County Board of Arlington, Virginia.

b. By entering into this Agreement, the Contractor agrees, after a full and complete inspection thereof, that the Clinic Space is suitable for the Contractor's needs and for the fulfillment of Contractor's obligations under this Agreement.

c. Contractor shall operate the Clinic Space only for the operation of a health Clinic for County employees and other uses incidental thereto, such as Clinic recordkeeping, receptionist services, and marketing of Clinic services. Any proposed change in the use by the Contractor of the Clinic Space shall require the prior written approval of the County, which may be withheld at County's sole discretion.

d. Contractor shall not make any alterations, installations, changes, replacements, repairs, additions or improvements (collectively, "alterations") in or to the structural elements of the Clinic Space. Contractor shall

not make any non-structural or cosmetic alterations to the Clinic Space without the prior written consent of the County, which consent may be granted or withheld in the County's sole and absolute discretion.

e. Contractor shall not use the Clinic Space in any manner that would cause the County to be in violation of the Lease. County shall provide Contractor a copy of said Lease within thirty (30) days of the execution of the Agreement.

f. Contractor, its invitees and employees and Participants shall have the right, in common with other occupants of the Building(s) and their invitees and employees, to use all stairways, elevators, halls, toilets and sanitary facilities, and all other general common facilities contained in the Building(s), and all sidewalks, delivery areas, parking facilities and other appurtenances to the Building(s).

g. County shall furnish at County's sole cost and expense, a telephone system, computer hook-ups, necessary for provision of the Services.

h. County shall verify that there is High Speed Internet service available to the building and extended to the Clinic and work collaboratively with Contractor and Contractor's internet service provider to ensure ongoing availability of service.

i. County and Contractor will identify IT resources to work collaboratively to coordinate with the internet service provider to resolve connectivity issues at the Clinic. During normal Couty business hours, County agrees that IT staff will acknowledge notice of the issue within one (1) hour and be available within a three (3) hour timeframe after acknowledgment.

j. Subject to the terms of its Lease, County shall install, affix and maintain, at its sole expense, fixed signage at the entrance to the Clinic in a mutually agreed form and which at a minimum shall contain the name of the Clinic, as the Parties may mutually agree, the Clinic telephone number, and the hours of operation. Any and all signs shall conform to all applicable regulations and governmental requirements. County shall at its sole expense remove any signs placed on or about the Clinic upon the termination of this Agreement or any extensions thereof, and repair the effects of any such removal.

k. <u>County Obligations</u>

Subject to the terms of its Lease, County agrees, at its sole cost and expense, to:

i. operate the heating and cooling equipment in the Building to maintain the Clinic between 70° F. and 76° F, at all times when the Clinic is in operation;

ii. provide janitorial service, which shall not include the removal, disposal or clean-up of any biohazard waste or medical waste, which remains the sole responsibility of the Contractor.

iii. provide pest control and extermination service to a level consistent with that found in other first-class buildings in the area in accordance with a reasonable schedule;

iv. maintain in good condition the Building, common facilities, common areas, and parking area;

v. adequately light the Clinic, and provide and replace lamps and related equipment when necessary;

vi. provide hot and cold water in the Clinic and provide sanitary and toilet facilities and supplies for use by Contractor, its employees and invitees, and Participants;

vii. furnish and provide the Clinic with electric current for lighting, normal office use, heating, air conditioning;

viii. provide sufficient elevator service for access to the Clinic. At least one (1) elevator shall operate during non-business hours, affording access to the Clinic (if such Clinic is located other than on the ground floor);

ix. provide adequate security services for the Clinic, the Building and common areas in and around the Building, including a Kastle-Key or equivalent perimeter access control system, as well as security guard patrols in and around the Building, parking garage, and other common areas. County shall perform inspections and/or testing of the Building fire alarm system, smoke detectors and fire extinguishers in the Clinic and elsewhere in the Building as required by the County's Fire Prevention Code.

x. provide adequate parking spaces for Clinic Staff at no charge to Contractor or the Clinic Staff as defined herein.

l. If any of the obligations listed in Section 16.j. i. through x. above ("County Obligations") are not within the County's direct control, the County shall, subject to the terms of the Lease, be responsible for all negotiations with the landlord or property manager of the Building as may be needed to effectuate compliance with the County's Obligations. Further, if necessary, the County may initiate at its discretion such regulatory or legal action necessary to ensure compliance with the County Obligations.

m. Contractor shall maintain the Clinic in an attractive and neat condition and shall not permit or allow any waste to any portion of the Clinic. County or its agents and employees shall have the right to enter the Clinic for the purpose of making repairs necessary for the preservation of the Clinic or Contractor's property maintained therein. County shall make a reasonable effort to affect such repairs with a minimum of interference to Contractor, and, when practicable, all work shall be done after business hours.

n. Reimbursements Related to Clinic Premises

To the extent permitted by law, County shall reimburse Contractor, its affiliates and parent companies for any loss, damage or expense paid by Contractor or its affiliates or parent companies, related to death or personal injury that results or arises from hazards related to the Building(s) or the Clinic(s) that are the responsibility of the County, including by way of example and not by way of limitation, claims for personal injuries related to the presence of asbestos, mold or other hazards.

17. OPERATIONAL ASSUMPTIONS

Contractor will ensure that its medical, professional and paraprofessional staff receive all necessary and requisite statutorily mandated in-service, annual or proficiency training, and other such professional or paraprofessional education and training programs needed to ensure current proficiency in the professional or paraprofessional's particular health care discipline or specialty.

18. REPORTING

With respect to Onsite Clinic Services the following reporting will apply:

a. Report Delivery

Contractor will arrange for the production and delivery of quarterly and annual reports ("Reports") to County in accordance with Contractor's standard reporting package and capabilities. Such Reports shall include the following:

i. Quarterly Reports:

a) Clinical

b) Operations

c) Medical Cost Savings and ROI

d) Productivity

e) Referral

ii. Monthly Key Performance Indicators Dashboard

The delivery timeframes, format, method and quantities for each Report shall be as mutually agreed upon in writing between the Parties.

b. Report Privacy

Any and all Reports provided by Contractor or the Clinic(s) to County or its designees concerning the Clinical Services shall be in aggregate, de-identified form, in compliance with applicable federal and state privacy laws and regulations, including but not limited to the Privacy and Security Rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164, as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act.

c. Ad Hoc Reports

Contractor will produce and deliver ad hoc reports in such formats and timeframes as is mutually agreed upon in writing between the Parties, provided that Contractor may assess additional fees for any ad-hoc reports (or time required for specification and development of such ad hoc reports) that have a material impact on the Fees paid by County to Contractor under this Exhibit A-1 to the Agreement. Contractor will estimate any such additional fees for pre-approval by County.

EXHIBIT B
TO AGREEMENT No. 719-13-1
PRICING AND PAYMENTS

Administrative Services Contract Pricing

1. The following Contract Rates are per member per month (PMPM).

   a. Contract Rates for July 1, 2014 through August 30, 2014 are as follows:

	OAP Plan / OAPIN Plan	PPO & COMP fee for USVI & PR sited members
Admin Fee	$10.66	$10.66
Vision	Included	Included
Network Access Fee	$24.59	$24.59
Disease Management	Included	Included
Admin Fee – Rx	Included	Included
UR/UM fees	Included	Included
Total PMPM Rate	$35.25	$35.25

   b. Contract rates for September 1, 2014 through June 30, 2017 (contract year 1 through 3) are as follows:

	OAP Plan / OAPIN Plan	PPO & COMP fee for USVI & PR sited members
Admin Fee	$11.66	$11.66
Vision	Included	Included
Network Access Fee	$24.59	$24.59
Disease Management	Included	Included
Admin Fee – Rx	Included	Included
UR/UM fees	Included	Included
Total PMPM Rate	$36.25	$36.25

   c. For Subsequent Contract Terms, the Contractor agrees to the following caps (in the form of a percentage) on rate increases:

	Rate Increase Cap
Year 4	3%
Year 5	3%
Year 6	3%
Year 7	3%

For these years, proposed rates for the following contract shall be presented to the County no later than November 1 of the current contract year. Final rates for each Subsequent Contract Term shall be negotiated.

2. **Payments**

a. The Contractor will pay the County 100% of prescription rebates or manufacturer rebates on a semi-annual basis in January and June.

b. Funding and Payment of Claims. The County will establish in its name a benefit plan account ("Account") in accordance with the provisions of 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 above, which are paid to Contractor's health plan affiliates for the establishment and maintenance of provider networks and (ii) pay-for-performance incentive payments to Participating Providers.

i. Contractor, as agent for the County, for purposes noted in this subsection (a) only, shall issue payments from the Account for Plan benefits and Plan-related expenses in the amount Contractor determines to be proper under the Plan and/or under this Agreement.

Upon the Contractor's request, County will authorize daily or weekly transfer of funds from County's local bank account to the Contractor to replenish the Account for the aggregate amount of checks that cleared the night before or during the prior week, or at any other time the Account is overdrawn via 1031 Fed Wire transfer.

The Contractor shall be responsible for any imprest fund required for the Account.

In the event that sufficient funds are not available in the Account to pay all Plan benefits and Plan-related expenses when due, then Contractor shall cease to process claims (including Run Out claims, if applicable) under this Agreement.

In the event Contractor pays any person less than the amount to which he is entitled under the Plan, Contractor shall promptly adjust the underpayment by drawing the additional funds from the County's Account.

ii. Contractor shall indemnify and save the County harmless from any loss, fees and expenses proximately caused by criminal or intentionally wrongful or negligent acts or omission by any employee of Contractor or Subcontractor arising out of its use of the Account and the corollary check stock under its control. This indemnity shall survive the termination of this Agreement. The County will give Contractor notice of any fact or condition which comes to its attention which may give rise to a claim of indemnity under this paragraph.

iii. Following termination of this Agreement, the County will 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. County will reimburse Contractor to the extent Contractor makes any such payment. In no event shall any payment of Plan benefits or fees, including pay-for-performance incentive payments, by Contractor be construed to oblige Contractor to assume any liability of the County for the payment of such benefits or fees. This provision shall survive the termination of this Agreement.

c. Contract Rates

i. Contract Rates. County shall pay to the Contractor the Contract Rates for services performed under this Agreement in the amounts and according to this Exhibit plus any sales or use taxes, or any similar benefit- or plan-related charge, surcharge or assessment, however denominated, which are imposed by any governmental authority (collectively hereafter referred to as "Contracted Rates" or "Contract Rates").

ii. Monthly Statement. A monthly statement showing (i) Contract Rates determined in accordance with the schedule set forth in Exhibit B, except to the extent that such Contract Rates are processed through the

Account, plus (ii) the fees for any requested, in writing, optional services, if any, identified in Exhibit A plus, 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 Contractor and provided to the County's Project Officer for approval within 10 days after the last day of each month. The Contract Rates shall be computed by reference to the actual number of employees covered for such month (see subparagraphs f and g below), the actual number of Service Lines Processed for such month, if applicable, the actual number of Claim Checks Issued for such month, if applicable, and/or the number of prescriptions processed for such month, if applicable. The Project Officer shall either approve the statement or require the Contractor to make corrections to the statement. The County will pay the Contractor within 30 days after the date of receipt of a correct (as determined by the Project Officer) statement approved by the Project Officer.

iii. Due Date. The charges shall be due on the date of receipt of a correct (as determined by the Project Officer) statement approved by the Project Officer ("Due Date"). Approved charges paid in full within 30 days from the Due Date are not subject to late payment charges.

iv. Late Payment Charges. Payments for charges approved by the Project Officer issued by the County after 30 days from the Due Date shall be subject to late payment charges, from the Due Date, at a rate of one percent (1%) per month.

v. Employee Contract Rates – Additions and Terminations.

a) Additions. If an employee becomes covered by the Plan on or before the fifteenth (15th) day of the month, full Contract rate shall be due for that employee for that month. If coverage begins on any other day of the month, no contracted rate shall be due for that employee for that month.

b) Terminations. If coverage ceases on or before the fifteenth (15th) day of the month for an employee, no Contract Rate shall be due for that employee for that month. If coverage ceases on any other day of the month for an employee, full contracted are due for that employee for that month.

vi. Retroactive Changes and Terminations. County will remain responsible for all Contract Rates and claims incurred or charged through the date of the County's notice of a retroactive change or termination. However, if the change or termination would work a reduction in fees, Contractor shall credit to County 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 Contractor processes the notice, or (b) the period from the date of the change or termination to the date Contractor processes the notice.

vii. For purposes of this Exhibit:

a) a "Claim Check Issued," if applicable, means any payment by Contractor to or on behalf of an individual under the Plan; and

b) a "Service Line Processed", if applicable, means the line item created by Contractor's claim systems upon review of service/treatment codes submitted in accordance with the Plan.

3. **Outstanding Check Services – Additional Purchased Service**

The cost of Outstanding Checks Research Services is:

- $10.00 for each letter sent. This covers the cost of the mailing, system processing, reporting and staff support. This charge also applies to follow-up letters, but not to re-directed mail (there is no additional cost for re-directed mail).

- $5.00 for each replacement check issued. This covers the cost of issuing the check, system processing, reporting and staff support.

Charges are processed monthly, in arrears. They are processed through the Optional Services System and can be included in the monthly premium or ASO bill or charged to the account by the Underwriter at renewal.

4. Subrogation

Subrogation/Conditional Claim Payment. Identification, investigation and recovery of claim payments involving other party liability or where another entity is responsible for payment (including by way of example but not by limitation automobile insurance, homeowner insurance, commercial property insurance, worker's compensation). (This service is only provided with respect to Medical coverage).

All conditional claim payment and/or subrogation recoveries under the Plan will be handled by Contractor. The County hereby confers upon Contractor and its subcontractors' discretionary authority to reduce recovery amounts by as much as fifty percent (50%) of the total amount of benefits paid on Employer's behalf, and to enter into binding settlement agreements for such amounts. In the event a settlement offer represents a reduction greater than the percentage identified above, Contractor and its subcontractors should seek settlement advice from:

Name:
Title:
Address:
Telephone:

All amounts reimbursed to the County's Bank Account shall be refunded at the gross amount. Contractor's and its subcontractors' subrogation administration fee on cases where Contractor and its subcontractors' have retained counsel and in cases where no counsel has been retained by Contractor and its subcontractors are as follows:

- 5% of recovery plus litigation costs if Counsel is retained and an appearance is filed on behalf of Contractor or Employer in any litigation, or a lawsuit is filed on their behalf;
- 29% of recovery if no Counsel is retained and in all other instances, including cases where state law requires that employee benefit plans be named as party defendants or involuntary plaintiffs.

Except where agreed to by Contractor and the County, Contractor and its subcontractors shall have no duty or obligation to represent Employer in any litigation or court proceeding involving any matter which is the subject of this Agreement, but shall make available to the County and/or the County's counsel such information relevant to such action or proceeding as Contractor and its subcontractors may have as a result of its handling of any matter under this Agreement.

5. Cost Containment Fees

Contractor, a Cigna company, administers the following programs to contain costs with respect to charges for health care service/supplies that are covered by the Plan. In administering these programs, Contractor contracts with vendors to perform program related services. Specific vendor fees are available upon request. Contractor's charge for administering these programs is the percentage (indicated below) of either (1) the "net savings" (i.e., the difference between the charge that the provider would have made absent the program savings and the charge made as a result of the program savings, less the applicable vendor fee which generally ranges from 7-11% of the program savings) or (2) the "gross savings" (i.e., the difference between the charge that the provider would have made absent the program savings and the charge made as a result of the program savings; Contractor pays the applicable vendor fee) or (3) the "recovery" (i.e., the amount recovered) as applicable.

For covered services received from non-Participating Providers, Contractor may apply discounts available under agreements with third parties or through negotiation of the billed charges. These programs are identified below as the Network Savings Program, Supplemental Network & Medical Bill Review (pre-payment). This is consistent with the claim administration practices applicable to Contractor's own health care insurance business when these programs are implemented. Contractor charges the percentage shown for administering these programs. Applying these discounts may result in higher payments than if the maximum reimbursable charge is applied. Whereas

application of the maximum reimbursable charge may result in the patient being balance billed for the entire unreimbursed amount, applying these discounts avoids balance billing and substantially reduces the patient's out-of pocket cost.

	MEDICAL COST CONTAINMENT	
1.	Network Savings Program	**29% of net savings**
2.	Supplemental Network	**29% of net savings**
3.	Medical Bill Review – (Pre-payment Cost Containment for Non-contracted claims):	
	Inpatient Hospital Bill Review	
	a. Line Item Analysis	**Lesser of 5% of hospital bill or the savings achieved**
	b. Professional Fee Negotiation	**29% of net savings**
	Outpatient Hospital Bill Review	
	a. Professional Fee Negotiation	**29% of net savings**
	b. Line Item Analysis Re-pricing	**29% of net savings**
	Physician/Professional Bill Review	
	a. Professional Fee Negotiation	**29% of net savings**
	b. Line Item Analysis Re-pricing	**29% of net savings**
4.	Medical Bill Review – (Pre or Post-payment Cost Containment for Non-contracted and Contracted claims):	
	Bill Audit	**29% of the savings/recovery achieved plus hospital fees or expenses passed through**
	Diagnosis Related Grouping (DRG) Validation/Audits and Recovery. An overpayment audit and recovery program in which Contractor or its vendors review paid claim data to identify overpayments based on inaccurate DRG coding.	**29% of recovery plus any fees or expenses passed through by the hospital or regulatory agency**
	Inpatient Admission Retrospective Review	**29% of recovery**
	Medical Implant Device Audits	**29% of recovery**
5.	COB Vendor Recoveries (Exclusive of pharmacy programs where claims are adjudicated at time prescription is received.]	**29% of recovery**
6.	Secondary Vendor Recovery Program	**29% of recovery**
7.	Provider Credit Balance Recovery Program	**29% of recovery**
8.	High Cost Specialty Pharmaceutical Audits	**29% of recovery**
9.	Class Action Recoveries	**35% of recovery**
	CARE MANAGEMENT/COST CONTAINMENT PROGRAM FEES	
1.	Contractor arranges for third parties to provide care management services to: (i) contain the cost of specified health care services/items overall with respect to all plans insured and/or administered by Contractor, and/or (ii) improve adherence to evidence based guidelines designed to promote patient safety and efficient patient care.	**Specific vendor fees and care management program services are available upon request.**
	ELIGIBILITY OVERPAYMENT RECOVERY FEES	
1.	Eligibility Overpayment Recovery Vendor Services. Identification and recovery of funds in situations where the overpayment is due to the late receipt of Member termination information. (This service is only provided with respect to Medical coverage).	**29% of recovery**
	EXTERNAL REVIEW AND CONSULTATIVE REVIEW FEES	

1.	When a Member elects an External Review (as that term is defined in ERISA) of a benefit determination by an independent third party, the cost of a specific third party review is dependent on the nature and complexity of the issue on appeal. In highly complex, non-routine cases or cases related to new technology or experimental-investigational treatment, as part of the internal appeal process a panel of reviewers may be necessary. Third party review charges will be commensurate with the number of reviewers (usually only one is used), as well as their level of expertise and time required to complete the review.	**$300-$4,000 Review**
	VISION CARE	
1.	Capitation or fee-for-service charges for vision care services will be paid as claims and will appear in Employer's standard Bank Account activity data reports. Such payments will be at Contractor's applicable capitation or fee-for-service charges then in effect, which may be amended from time to time. Some Vision services are provided by Contractor and/or designated vendors. The applicable rates to Employer for this product and identity of the provider of vision services will be made available upon request.	**All Vision Products**
	STRATEGIC ALLIANCES	
1.	Contractor contracts directly or indirectly with other managed care entities and third party network vendors for access to their provider networks and discounts. These third parties charge either a network access fee, which is included in Contractor's monthly charges, or a percentage of the savings realized on a claim by claim basis as a result of the application of their discounts. Charges based on percentage of savings are paid from the Bank Account. Additional details regarding specific charges will be provided upon request.	**All Medical Products**
	OTHER VENDORS AND HEALTH CARE SERVICES PROVIDERS	
1.	Capitation and fee-for-service charges for various vendors and other providers/arrangers of health care services and/or supplies will be paid as claims for Plan Benefits. Such payments will be at Contractor's applicable capitation or fee-for-service charges then in effect, which may be amended from time to time. Additional details regarding charges and the identity of the vendor or provider of health care services will be made available upon request.	**All Products**
	NOTICE REGARDING PAYMENTS FROM THIRD PARTIES	
1.	From time to time, Contractor, directly or through its affiliates, arranges with third party parties (e.g., service vendors, provider network managers) to provide various services (e.g., cost-containment initiatives) in connection with the Plan. Contractor and its affiliates may receive payments from such third parties to help defray Contractor's expenses associated with the implementation and/or ongoing administration of these arrangements. Contractor may also receive compensation from third-party vendors that Employer may retain based upon a referral from Contractor.	**All Products**
	COMPLIANCE ASSISTANCE	
1.	Contractor shall provide the following services to assist Employer in meeting its compliance obligations under section 2715 of the Public Health Service Act as added by the Patient Protection and Affordable Care Act and applicable regulations with respect to the provision of the Summary of Benefits ("SBC), translation notice and glossary. Applicable to all medical plans including HRA and FSA which are considered "group health plans" subject to the SBC requirements.	
	a. Preparation of SBC, translation notice. Contractor will not be responsible for any changes that Employer makes to the SBC.	**No charge**
	b. Provide SBC, translation notices prepared by Contractor to Employer electronically as well as any updates or material modifications.	**No charge**
	c. Include in SBC a summary of benefits administered by carve-out vendor if Employer or carve-out vendor provide Contractor with necessary carve-out benefit information at least 12 weeks prior to the date the SBCs are to be delivered to Employer.	**$500 for each benefit option under the Plan for which carve-out vendor benefits are included in SBC**

Onsite Clinic Contract Pricing

1. Fees for Services Under Exhibit A-1, Onsite Health Clinic Scope of Work

Contract rates for September 8, 2014 through June 30, 2017 are as follows:

One Hundred Fifty Thousand Dollars ($150,000.00) for each twelve (12) month period, paid by the County to the Contractor in equal monthly installments in the amount of twelve thousand five hundred dollars and no cents ($12,500), on or before the 15th day of each month.

2. Contractor shall use best efforts to efficiently and effectively manage the operating costs and expenses related to the Onsite Clinic, which may vary based upon the volume of patients seen at the clinic and other factors.

EXHIBIT B -1
To AGREEMENT 719-13-1
DISCOUNT GUARANTEES

1. Medical Discount Guarantees

Open Access Plus Discount Guarantee Proposal (Total Target)

a. Contractor shall pay, on each Plan Renewal date of this contract, a sum equal to $6.00 Per Employee Per Month (PEPM) of the Network Access Fee (NAF) for the physical sites that are included in this guarantee if the discounts listed below are not achieved, subject to the conditions below.

b. One discount will be guaranteed per site, encompassing all categories of utilization (IP, OP, physician, etc.).

c. Applies to In-Network Fee-For-Service charges only.

d. Guarantee does not apply to:
   - Charges that are not fee-for-service charges (e.g., capitation payments)
   - Charges for services/supplies that are not Covered Services (such as COB, plan exclusions, UM denials, pending or duplicate charges, etc.)
   - Charges made by providers that are not Participating Providers in a Service Area
   - Charges that involve payment of in-network benefits to out-of-network providers
   - Services provided under an agreement with providers where all billed charges equal negotiated discounted charges (such as Gentiva, NIA, etc.)
   - Charges made by any Cigna HealthCare company (e.g. including but not limited to Tel-Drug, Inc., Tel-Drug of Pennsylvania, Inc., Cigna Behavioral Health and Cigna HealthCare of Arizona, Inc.'s staff model)
   - Claims for members over age 65.

e. Claims in excess of $100,000 will be removed in their entirety from the discount guarantee calculation.

f. Guarantee presumes that the normal charges made by network providers (i.e., hospital's charge masters and billed charges for other providers) remain flat or increase. In the event that the normal charges of participating providers decrease, the discount target will be reduced accordingly.

g. Guarantee presumes there will be no substantial changes (i.e., including but not limited to the addition of a new participating hospital, termination of a participating hospital) in Cigna HealthCare's network in the Service Area that could potentially affect the discount in place.

h. If the actual number of employees enrolled on the Effective Date differs by 15% or more from the projected enrollment Cigna HealthCare may revise the Performance Guarantees to account for such difference.

i. Guarantee will be reconciled after the close of the policy period by comparing a *weighted average* of actual discounts achieved to a *weighted average* of the guaranteed discounts. The weighting used to determine the weighted average will be the proportion of In-Network considered charges generated in each site as a percentage of the total.

j. Guarantee assumes an industry standard Covered Charges trend from a third party. If the increase in Covered Charges from the third party is greater than the actual increase in Covered Charges by more than 1%, Cigna HealthCare may revise the discount guarantee percentage.

k. Maximum Pay-out is equal to $6.00 PEPM of the Access Fee for the sites that are included in this guarantee.

l. No pay-out will occur if the *actual* weighted average discount is within 2 percentage points of the *guaranteed* weighted average discount. [e.g., actual of 52.2% vs. guarantee of 54.2%]

m. If the actual weighted average discount is greater than 2 percentage points and less than or equal to 4 percentage points lower than the guaranteed weighted average discount, then Cigna will pay policyholder 50% of the maximum payout. (e.g., actual of 50.2% vs. guarantee of 54.2%]

n. If the actual weighted average discount is less than the guaranteed weighted average discount by more than 4 percentage points, then Cigna will pay policyholder 100% of the maximum payout. [e.g., actual of 48.2% vs. guarantee of 54.2%]

Below is a listing of the discount percentage being guaranteed in each site.

Arlington County Government

Total Discount Guarantee

Effective July 1, 2014 - June 30, 2015

Summary by Rating Area

OAP Scenario

Product	Rating Area	Rating_Area or Network Name	Charge	PS Discount
OAP	MD300B	VA, FAIRFAX	$21,753,670.72	56.1%
OAP	MD300E	MD, OTHER VIRGINIA	$11,940,302.00	52.5%
OAP	MD300D	MD, SUBURBAN MARYLAND	$3,325,506.13	53.9%
OAP	MD300F	MD, WASHINGTON DC	$1,443,892.20	61.1%
OAP	MD300C	MD, OTHER MARYLAND	$1,037,755.35	50.0%
OAP	VA300C	VA, CHARLOTTESVILLE	$646,649.19	48.3%
OAP	VA300B	VA, RICHMOND	$636,137.88	57.1%
OAP	VA300H	VA, PENINSULA	$486,885.19	49.2%
OAP	MD300G	MD, WEST VIRGINIA OUTLIER	$437,049.38	38.4%
OAP	OK300B	OK, TULSA	$382,166.07	31.2%
OAP	SC300E	SC, PREFERRED	$164,556.28	48.6%
OAP	PA300Z	PA, CENTRAL - AREA Z	$155,871.52	32.7%
OAP	FL305F	FL, FORT MYERS	$140,493.99	65.8%
OAP	FL305H	FL, TAMPA	$127,935.21	59.9%
OAP	TX302F	TX, FORT WORTH ARLINGTON	$117,410.75	61.9%
OAP	NC300F	NC, WILMINGTON	$116,094.38	44.5%
OAP	FL305K	FL, PALM BEACH	$112,022.59	73.1%
OAP	TX302X	TX, DFW OUTLYING	$110,007.24	46.4%
OAP	MD300A	MD, BALTIMORE	$101,403.18	42.0%
OAP	PA300E	PA, ERIE	$98,471.29	77.3%
OAP	WV300B	WV, WEST VIRGINIA - OUTLIERS OH	$80,261.20	40.5%
OAP	FL305S	FL, SARASOTA	$76,555.92	62.2%
OAP	FL305I	FL, BROWARD	$67,284.40	74.7%
OAP	NC300G	NC, EAST	$57,117.60	43.0%
OAP	PA300Y	PA, CENTRAL - AREA Y	$46,574.04	29.0%
OAP	SC300F	SC, NON-PREFERRED	$45,641.82	49.9%
OAP	AZ300B	AZ, PHOENIX IPA	$43,332.96	75.6%
OAP	VT300K	NH, SOUTHERN	$38,381.39	40.5%
OAP	NC300B	NC, CHARLOTTE	$34,220.20	45.0%
OAP	VA300F	VA, LYNCHBURG/SOUTH BOSTON	$34,207.91	49.5%
OAP	PA300X	PA, CENTRAL - AREA X	$30,701.81	53.5%
OAP	WV300A	WV, WEST VIRGINIA	$29,337.65	26.5%
OAP	VA300E	VA, MARTINSVILLE	$28,571.82	30.2%
OAP	FL305B	FL, LAKE	$27,155.52	55.9%
OAP	PA300A	PA, PHILADELPHIA SUBURBAN	$25,990.76	59.9%
OAP	PA300D	PA, PITTSBURGH	$23,285.52	51.4%
OAP	No Rating Area Available	No Rating Area Available	$22,316.92	37.2%

OAP	CA350N	CA, INLAND EMPIRE	$22,115.64	46.9%
OAP	VA300I	VA, SOUTHSIDE	$20,390.72	46.6%
OAP	PA350	PA, CENTRAL PHCS	$19,233.34	51.6%
OAP	KY300A	KY, LOUISVILLE	$18,758.32	58.4%
OAP	FL305D	FL, JACKSONVILLE	$18,043.71	51.0%
OAP	FL305V	FL, VOLUSIA	$17,850.11	55.5%
OAP	VA300D	VA, ROANOKE	$16,998.87	47.7%
OAP	SC300H	SC, CHARLESTON	$16,798.83	45.6%
OAP	NY300O	NY, METRO OTHER BOROUGHS	$15,635.00	51.3%
OAP	FL305G	FL, POLK	$15,501.41	65.3%
OAP	DE350	DE, DELAWARE	$14,767.28	50.2%
OAP	PA300B	PA, PHILADELPHIA METRO	$14,461.52	39.2%
OAP	MI356B	MI, DETROIT NON-METRO HAP	$14,234.95	59.0%
OAP	GA300A	GA, ATLANTA	$13,829.03	62.8%
OAP	IN300B	IN, INDIANAPOLIS	$13,348.29	45.0%
OAP	AZ300E	AZ, TUCSON METRO	$13,048.63	64.8%
OAP	AR300C	AR, RURAL	$12,989.31	51.4%
OAP	FL305N	FL, PENSACOLA	$12,421.99	61.7%
OAP	PA300L	PA, LEHIGH VALLEY	$11,791.11	57.7%
OAP	TX302A	TX, AUSTIN	$11,787.27	52.1%
OAP	FL305L	FL, MARTIN	$11,155.28	63.8%
OAP	TX302G	TX, RURAL CENTRAL	$11,029.75	24.7%
OAP	TN303I	TN, KNOXVILLE	$10,895.86	49.9%
OAP	NY300M	NY, METRO	$10,006.46	56.2%
OAP	AZ300D	AZ, TUCSON RURAL	$9,175.36	57.2%
OAP	TN303E	TN, MEMPHIS	$8,668.03	59.6%
OAP	PA300S	PA - SCRANTON/WILKES-BARRE	$7,857.00	47.3%
OAP	TX302D	TX, DALLAS	$7,769.50	51.3%
OAP	CO300B	CO, LARIMER/WELD	$7,599.06	25.8%
OAP	GA300D	GA, AUGUSTA	$7,382.37	64.7%
OAP	TN303J	TN, TRI CITIES	$6,393.25	53.2%
OAP	NV300A	NV, LAS VEGAS	$6,259.88	61.8%
OAP	CA350L	CA, SOUTH LA	$4,645.95	50.7%
OAP	VA300K	VA, RURAL	$4,462.85	41.9%
OAP	AZ300C	AZ, GILA & PINAL COUNTIES	$4,414.00	73.0%
OAP	VA300G	VA, SAW	$3,946.42	33.8%
OAP	NC300H	NC, WEST	$3,436.62	59.1%
OAP	FL305C	FL, OCALA/GAINESVILLE	$3,095.52	62.7%
OAP	NC300C	NC, TRIAD	$3,026.00	41.8%
OAP	SC300J	SC, ANDERSON	$2,896.07	49.3%
OAP	NE350B	IA, IOWA - MIDLANDS TPV	$2,806.16	42.0%
OAP	PA352	PA, PITTSBURGH PHCS	$2,695.00	45.6%
OAP	TN303F	TN, JACKSON	$2,572.99	56.0%
OAP	TX302Y	TX, EAST HOUSTON	$2,419.96	40.0%
OAP	NY300L	NY, METRO LONG ISLAND	$2,367.47	66.5%
OAP	OR353C	OR, NON PORTLAND RURAL	$1,792.23	18.0%
OAP	MN351B	MN, OTHER MN - HEALTHPARTNERS	$1,561.30	22.1%
OAP	ME300E	ME, SOUTHERN	$1,302.05	43.1%
OAP	NC300D	NC, TRIANGLE NON CORE	$1,084.52	28.2%
OAP	NE350C	SD, SOUTH DAKOTA - MIDLANDS TPV	$1,023.09	36.4%
OAP	GA300F	GA, COLUMBUS	$711.88	47.0%
OAP	CA350H	CA, CENTRAL VALLEY	$699.98	48.5%

OAP	WI350C	WI, RURAL	$632.60	8.2%
OAP	NJ301N	NJ, NORTHERN	$618.00	52.4%
OAP	WV350	WV, WEST VIRGINIA PHCS	$534.00	71.7%
OAP	NY353B	NY, MVP-BUFFALO	$510.00	37.8%
OAP	TX302Z	TX, WEST HOUSTON	$303.78	31.5%
OAP	NC300E	NC, CHARLOTTE NON CORE	$160.00	26.4%
OAP	NY352	NY, WESTERN PHCS	$70.00	19.9%
		Total	**$44,517,204**	**54.2%**

2. Pharmacy Discount Guarantees

RETAIL 30 Type of Network:	Broadest Network		
	Year 1	Year 2	Year 3
Ingredient Cost Adjudication Formula: Lowest of pharmacy's usual and customary (U&C) price, maximum allowable cost (MAC) (where applicable), or discounted average wholesale price (AWP)	Ingredient Cost of a claim will be whichever of the discounted AWP (AWP-%), U&C, or MAC price that minimizes the following formula: (AWP-%|U&C|MAC) + applicable dispensing fee + applicable Sales Tax	Ingredient Cost of a claim will be whichever of the discounted AWP (AWP-%), U&C, or MAC price that minimizes the following formula: (AWP-%|U&C|MAC| + applicable dispensing fee + applicable Sales Tax	Ingredient Cost of a claim will be whichever of the discounted AWP (AWP-%), U&C, or MAC price that minimizes the following formula: (AWP-%|U&C|MAC) + applicable dispensing fee + applicable Sales Tax
Minimum AWP Discount Guarantees			
SS-Brands (nonMAC + MAC)	AWP - 16.4%	AWP - 16.5%	AWP - 16.6%
MS-Brands (nonMAC + MAC)			
Other Brands (describe)			
All Brands			
All SS-Generics (nonMAC + MAC)	AWP - 73.50%	AWP - 76.0%	AWP - 76.3%
All MS-Generics (nonMAC + MAC)			
Other Generics (describe)			
All Generics			
Maximum Dispensing Fee per Paid Claim			
Brands	$1.00	$1.00	$1.00
Generics	$1.00	$1.00	$1.00
Compounds			
Ingredient cost adjudication formula	Ingredient Cost of a claim will be whichever of the discounted AWP (AWP-%), U&C, or MAC price that minimizes the following formula: (AWP-%|U&C|MAC) + applicable dispensing fee + applicable Sales Tax	Ingredient Cost of a claim will be whichever of the discounted AWP (AWP-%), U&C, or MAC price that minimizes the following formula: [AWP-%|U&C|MAC) + applicable dispensing fee + applicable Sales Tax	Ingredient Cost of a claim will be whichever of the discounted AWP (AWP-%), U&C, or MAC price that minimizes the following formula: (AWP-%|U&C|MAC) + applicable dispensing fee + applicable Sales Tax
Administrative Fee, if any			
Per Paid Claim, OR	$0.00	$0.00	$0.00
Per Member Per Month	$0.00	$0.00	$0.00

RETAIL 90			
Type of Network:	Retail-90 Network		
	Year 1	Year 2	Year 3
Ingredient Cost Ad)udication Formula: Lowest of pharmacy's U&C price, MAC (where applicable), or discounted AWP	Group does not have Retail 90	Group does not have Retail 90	Group does not have Retail 90
Minimum AWP Discount Guarantees			
SS-Brands (nonMAC + MAC)	N/A	N/A	N/A
MS-Brands (nonMAC + MAC)			
Other Brands (describe)			
All Brands			
All SS-Generics (nonMAC + MAC)	N/A	N/A	N/A
All MS-Generics (nonMAC + MAC)			
Other Generics (describe)			
All Generics			
Maximum Dispensing Fee per Paid Claim			
Brands	N/A	N/A	N/A
Generics	N/A	N/A	N/A
Compounds			
Ingredient cost ad)udication formula	N/A	N/A	N/A
Administrative Fee, if any			
Per Paid Claim, OR	N/A	N/A	N/A
Per Member Per Month	N/A	N/A	N/A
EGWP Per Member Per Month	N/A	N/A	N/A

MAIL ORDER			
	Year 1	Year 2	Year 3
Ingredient Cost Adjudication Formula: Lower of MAC (where applicable) or discounted AWP	Ingredient Cost of a claim will be whichever of the discounted AWP (AWP-%), U&C, or MAC price that minimizes the following formula: (AWP-%|U&C|MAC) + applicable dispensing fee + applicable Sales Tax	Ingredient Cost of a claim will be whichever of the discounted AWP (AWP-%), U&C, or MAC price that minimizes the following formula: (AWP-%|U&C|MAC) + applicable dispensing fee + applicable Sales Tax	Ingredient Cost of a claim will be whichever of the discounted AWP (AWP-%), U&C, or MAC price that minimizes the following formula:)AWP-%|U&C|MAC) + applicable dispensing fee + applicable Sales Tax
Minimum AWP Discount Guarantees			
SS-Brands (nonMAC + MAC)	AWP - 25.0%	AWP - 25.5%	AWP - 25.75%
MS-Brands (nonMAC + MAC)			
Other Brands (describe)			
All Brands			
All SS-Generics (nonMAC + MAC)	AWP - 80.5%	AWP - 81.5%	AWP - 81.5%
All MS-Generics (nonMAC + MAC)			
Other Generics (describe)			
All Generics			
Maximum Dispensing Fee per Paid Claim			
Brands	$0.00	$0.00	$0.00
Generics	$0.00	$0.00	$0.00
Compounds			
Ingredient cost adjudication formula	Ingredient Cost of a claim will be whichever of the discounted AWP (AWP-%), U&C, or MAC price that minimizes the following formula: |AWP-%|U&C|MAC) + applicable dispensing fee + applicable Sales Tax	Ingredient Cost of a claim will be whichever of the discounted AWP (AWP-%), U&C, or MAC price that minimizes the following formula: (AWP-%|U&C|MAC) + applicable dispensing fee + applicable Sales Tax	Ingredient Cost of a claim will be whichever of the discounted AWP (AWP-%), U&C, or MAC price that minimizes the following formula: (AWP-%|U&C|MAC) + applicable dispensing fee + applicable Sales Tax
Administrative Fee, if any			
Per Paid Claim, OR	$0.00	$0.00	$0.00
Per Member Per Month	$0.00	$0.00	$0.00

SPECIALTY (THROUGH PARTICIPATING RETAIL PHARMACIES)			
	Year 1	Year 2	Year 3
Ingredient Cost Adjudication Formula: Lowest of pharmacy's U&C price, MAC (where applicable), or discounted AWP	Ingredient Cost of a claim will be whichever of the discounted AWP (AWP-%), U&C, or MAC price that minimizes the following formula: (AWP-%|U&C|MAC) + applicable dispensing fee + applicable Sales Tax	Ingredient Cost of a claim will be whichever of the discounted AWP (AWP-%), U&C, or MAC price that minimizes the following formula: (AWP-%|U&C|MAC] + applicable dispensing fee + applicable Sales Tax	Ingredient Cost of a claim will be whichever of the discounted AWP (AWP-%), U&C, or MAC price that minimizes the following formula: (AWP-%|U&C|MAC) + applicable dispensing fee + applicable Sales Tax
Minimum Brand AWP Discount Guarantee			
All Brands	AWP - 13.9%	AWP - 13.9%	AWP - 13.9%
Maximum Dispensing Fee per Paid Claim			
All Brands and Generics	$1.00	$1.00	$1.00
Compounds			
Ingredient cost adjudication formula	Ingredient Cost of a claim will be whichever of the discounted AWP (AWP-%), U&C, or MAC price that minimizes the following formula: (AWP-%|U&C|MAC) + applicable dispensing fee + applicable Sales Tax	Ingredient Cost of a claim will be whichever of the discounted AWP (AWP-%), U&C, or MAC price that minimizes the following formula: (AWP-%|U&C|MAC) + applicable dispensing fee + applicable Sales Tax	Ingredient Cost of a claim will be whichever of the discounted AWP (AWP-%), U&C, or MAC price that minimizes the following formula: (AWP-%|U&C|MAC) + applicable dispensing fee + applicable Sales Tax
Administrative Fee, if any			
Per Paid Claim, OR	$0.00	$0.00	$0.00
Per Member Per Month	$0.00	$0.00	$0.00

SPECIALTY (THROUGH YOUR PREFERRED SPECIALTY VENDOR)			
	Year 1	Year 2	Year 3
Ingredient Cost Adjudication Formula: Lowest of pharmacy's U&C price, MAC (where applicable), or discounted AWP	Ingredient Cost of a claim will be whichever of the discounted AWP (AWP-%), U&C, or MAC price that minimizes the following formula: (AWP-%|U&C|MAC) + applicable dispensing fee + applicable Sales Tax	Ingredient Cost of a claim will be whichever of the discounted AWP (AWP-%), U&C, or MAC price that minimizes the following formula: (AWP-%|U&C|MAC) + applicable dispensing fee + applicable Sales Tax	Ingredient Cost of a claim will be whichever of the discounted AWP (AWP-%), U&C, or MAC price that minimizes the following formula: (AWP-%|U&C|MAC) + applicable dispensing fee + applicable Sales Tax
Minimum Brand AWP Discount Guarantee			
All Brands	AWP - 15.0%	AWP - 15.0%	AWP - 15.0%
Maximum Dispensing Fee per Paid Claim			
All Brands and Generics	$0.00	$0.00	$0.00
Compounds			
Ingredient cost adjudication formula	Ingredient Cost of a claim will be whichever of the discounted AWP (AWP-%), U&C, or MAC price that minimizes the following formula: (AWP-%|U&C|MAC) + applicable dispensing fee + applicable Sales Tax	Ingredient Cost of a claim will be whichever of the discounted AWP (AWP-%), U&C, or MAC price that minimizes the following formula: (AWP-%|U&C|MAC) + applicable dispensing fee + applicable Sales Tax	Ingredient Cost of a claim will be whichever of the discounted AWP (AWP-%), U&C, or MAC price that minimizes the following formula: (AWP-%|U&C|MAC) + applicable dispensing fee + applicable Sales Tax
Administrative Fee, if any			
Per Paid Claim, OR	$0.00	$0.00	$0.00
Per Member Per Month	$0.00	$0.00	$0.00

OTHER COSTS AND FEES	
Clinical Program Fees - see pricing basis in parentheses	
Prior Authorizations (per Review)	Basic pre-authorizations are included
Quantity Limits (PMPM)	Benefit Exclusion, Intensive Appropriateness of Use and Utilization of Cost and Unit Cost Management programs are included
Step Therapies (PMPM)	Recommended package is included
Other(s) (PMPM)	Narcotic Therapy Management and Complex Psychiatric Case Management Programs are included
Retrospective DUR (targeted communications about lower cost alternatives) (PMPM)	Benefit Exclusion, Intensive Appropriateness of Use and Utilization of Cost and Unit Cost Management programs are included

Concurrent DUR (Hard Edit at POS) (PMPM)	Included		
Appeals (per Review)			
First level	Included		
Second level (includes Urgent)	Included		
IRO (Third Party)	ASO claim litigation is available for an additional charge of $3500 annually		
Data feeds to other vendors (beyond minimum number required in Technical Questionnaire) (per feed per year)	Contract pricing assumes integration with Cigna medical. Data feeds are available for an additional fee of $750 per report times frequency needed.		
ID Card Production and Delivery :			
# of Cards, Free	Included for all members		
Cost/Card, after # Free	Included		
Member Enrollment Packages ("packet")			
# of Packets, Free	Included for all subscribers		
Cost/Packet, after # Free	Included		
Paper Claims, if any	Included		
Installation or Set-up Charges, if any	Included		
Other Program Fee(s)/Cost(s)	N/A		
CREDITS AND REBATES			
Program Implementation Credit/Allowance	We are the incumbent and have included a program implementation credit of $10,000		
Pre-implementation Audit Credit	We have included $30,000 pre-implementation audit credit as well as up to $3,000 for travel costs if necessary		
Rebate Percentage shared with the Plan	100%		
Guaranteed Minimum Rebate Per Paid Brand Claim	MINIMUM REBATE GUARANTEES (PER BRAND BASIS)		
	Year 1	Year 2	Year 3
Per Retail Claim	$25.44 per brand	$26.84 per brand	$27.37 per brand
Per Mail Claim	$99.52 per brand	$102.62 per brand	$102.62 per brand
Per Specialty Claim (Dispensed through participating Retail Pharmacy)	$25.44 per brand	$26.84 per brand	$27.37 per brand
Per Specialty Claim (Dispensed through Vendor's Mail Pharmacy)	$99.52 per brand	$102.62 per brand	$102.62 per brand

EXHIBIT B-2
To AGREEMENT 719-13-1
PERFORMANCE GUARANTEES

Contractor and the County desire to implement service performance guarantees (also referred to as Performance Guarantees) according to the terms of this Performance Guarantee Exhibit, as set forth below.

The Contractor shall perform, to the satisfaction of the County Project Officer, the services described in the left column in this Exhibit herein. Services will be monitored on a monthly or quarterly basis as described in this Exhibit and if the Contractor fails to perform the required services to the satisfaction of the County Project Officer, the Contractor shall, upon receipt of request from the County Project Officer, pay to the County the quarterly equivalent of the "Guarantee Amount" (i.e. one-fourth of the annual Guarantee Amount listed) or annual "Guarantee Amount" as specified below. Contractor payment terms are Net thirty (30) days.

Section 1. Definitions

1.1 Account Level – the Performance Guarantee is measured with respect to Claims (that is, County's claims; see definition below) processed during the Guarantee Period. Claim Quality Performance Guarantees are measured at either the Account Level or the Office Level.

1.2 Benefit Profile – the benefits offered under Plan(s), including plan design and structure.

1.3 Business Days – mean the days of the week that Service Centers and Call Centers are open to the public for conducting business, which excludes Saturdays, Sundays and holidays observed by Contractor.

1.4 Call Center – member service center of Contractor that receives and responds to Plan Participant telephone calls.

1.5 Claim – refers to claims received by Contractor under the Plan(s). If the term "claim" is used without a capital c, it refers to claims received by Contractor, whether under the County's Plan(s) or under other plans.

1.6 Customer Service Representative – or "CSA" is a person responding to callers at a Call Center.

1.7 Effective Date – The initial effective date is July 1, 2014. For the purposes of this Agreement, that date is the Plan Effective Date. The first Plan Renewal Date is July 1, 2015; Subsequent Contract Terms are July 1 of each successive calendar year.

1.8 Employee – a person who is employed by County and eligible to be covered under the Plan.

1.9 ERISA – Employee Retirement Income Security Act of 1974, as amended.

1.10 Guarantee Amount (also known as "Performance Guarantee" and "Guarantees") – these dollar amounts are available during the initial Contract Term and any Subsequent Contract Term. A Guarantee Amount is the delineated amount due to the County if the Contractor does not meet its obligations and performance goals or commitments to the satisfaction of the County's Project Officer. For each obligation, performance goal or Performance Guarantee, a specified Guarantee Amount is established in the chart set out in Exhibit B-2. The Contractor's total liability in the aggregate under this Exhibit cannot exceed the Maximum Guarantee Amount.

1.11 Guarantee Period – the Guarantee Period is the only period for which these payments will be made. The Guarantee Period is twelve months or less; see Section 2 below for the factors determining the length of the Guarantee Period under this Agreement.

1.12 Inquiry – an answered call, received at a Call Center, about the services Contractor provides to the Plan(s).

1.13 Maintenance Eligibility – means additions, deletions and changes in eligibility that are processed during the Guarantee Period. Maintenance Eligibility does not include any eligibility loads that are done at or before the beginning of the plan year to prepare for Plan administration.

1.14 Maintenance ID Cards – means ID Cards issued during the Guarantee Period for changes in member address, changes in enrollment, etc. Maintenance ID Cards does not include the initial issuance of ID cards at the beginning of the Plan year.

1.15 Maximum Guarantee Amount – the maximum amount owed to the County per Contract Term if the related performance goals are not met. This Maximum Guarantee Amount of $465,123 may be subject to adjustment under Section 4 ("Evaluation of Service and Payment of Guarantees") of this Exhibit. Because the Maximum Guarantee Amount is set with reference to the total amount of fees expected to be paid by County to Contractor for administration of the Plan(s), the Maximum Guarantee Amount is also subject to change by Contractor, upon notice to and agreement by the County, if the total amount of administrative fees to be paid by County during a Contract Term significantly changes. The Maximum Guarantee Amount will increase as set forth in Section 4, section 4.5. The increase or decrease in the Maximum Guarantee Amount, as applicable, will be apportioned on a pro rata basis between all Guarantee Amounts.

1.16 Performance Guarantees – the Contractor's specific obligations, goals and/or Performance Guarantees to reach a specific level of service or performance. Performance Guarantees are paired with a Guarantee Amount, which is subject to payment to the County as noted herein. The Performance Guarantees are delineated in the chart in this Exhibit. Not all obligations under this Agreement are subject to Performance Guarantees.

1.17 Plan – the employee welfare benefit plan sponsored by County.

1.18 Plan Participants – employees, retirees (if any), and dependents enrolled in the Plan(s).

1.19 Processed – A Claim/claim shall be considered "processed" when Contractor has made a determination as to whether the billed services are covered and, if covered, determined the amount of reimbursement.

1.20 Service Center – a claim processing office of Contractor that processes Claims.

1.21 Service Termination Date – the date on which Contractor ceases to administer the Plan(s), not including any run-out periods or the date in which the Administrative Service Agreement and/or Policy is terminated, whichever is earliest.

1.22 Signature Date – the date this Agreement is executed by County.

Section 2. Guarantee Period

2.1 The Guarantee Period shall be equal to each twelve month period in the Contract Term and any Subsequent Contract Term except in the following limited circumstances:

2.1.1 If this Agreement is terminated sooner than twelve (12) months from the Effective Date or Subsequent Renewal Dates, there is no Guarantee Period under this Agreement and no payment of Guarantee Amounts shall be due pursuant to this Agreement.

2.2 If this Agreement is executed on or after the Effective Date, Contractor's performance will be measured from the effective date.

Section 3. Performance Guarantees and Guarantee Amounts

3.1 Performance Guarantees and Guarantee Amounts for selected services provided by the Contractor are set forth in Exhibits B-1 and B-2. All Contract Terms and any Subsequent Contract Terms shall be subject to Performance Guarantees and Guarantee Amounts unless otherwise noted as a "one time only guarantee." Performance Guarantees apply to the Contract Term and any Subsequent Contract Term unless the parties mutually agree to modify them in a subsequent contract term

Section 4. Evaluation of Services and Payment of Guarantees

4.1 Within four (4) months after the end of the Contract Term and any Subsequent Contract Term, Contractor shall compile the necessary documentation and perform the necessary calculations to evaluate its fulfillment of each

Performance Guarantee set forth in this Agreement; the Contractor shall then submit a report and any requested documentation to the County Project Officer detailing its compliance or noncompliance with each Performance Guarantee. The County Project Office shall also notify the Contractor of any Guarantee Amounts that it is owed.

4.2 Any dispute concerning whether or not the Performance Guarantee has been met and/or concerning the total amount Contractor or County determines to be owed under this Agreement must be raised in writing within sixty (60) days of the date that Contractor notifies County in writing of the results of its evaluation.

4.3 If Contractor fails to meet any of the Performance Guarantees set forth in Exhibit B-1 Contractor shall pay or credit to County the appropriate Guarantee Amount set forth in Exhibit B-1. Such amounts may be subject to adjustment under this Section 4.

4.4 In the event that, in accordance with Section 2, the Guarantee Period is less than twelve (12) consecutive months, the Guarantee Amounts set forth in Exhibit B-1 shall be pro-rated to correspond to the length of the Guarantee Period unless this Agreement is terminated, in which case there is no Guarantee Period under this Agreement and no payment of Guarantee Amounts shall be due pursuant to this Agreement.

4.5 The Guarantee Amounts in Exhibit B-1 have been established in relationship to the number of employees that the County has estimated will be enrolled on the Effective Date. In the event that the actual number of employees enrolled on the Effective Date is greater than one-hundred and fifteen percent (115%) of the projected number, the County reserves the right to increase the Guarantee Amounts in proportion to the variation between the actual and projected number of enrolled employees. Correspondingly, Contractor reserves the right to decrease the Guarantee Amounts in proportion to the variation between the actual and projected number of enrolled employees in the event that the actual number of employees enrolled on the Effective Date is less than eighty-five percent (85%) of the projected number.

4.6 The total amount payable by Contractor during the Contract Term and Subsequent Contract Term for failure to meet the Performance Guarantees set forth in this Agreement shall not exceed the Maximum Guarantee Amount.

Section 5. Change in Reporting Format or Measurement

Contractor reserves the right to replace or modify any Performance commitment if necessitated by a change in the way Contractor tracks or measures the applicable performance metric. In formulating any such substitute Performance Guarantee, Contractor shall, to the extent possible and in keeping with the Standard of Care, attempt to reflect the same performance level reflected in the original commitment, consistent with its new measurement/tracking methodology. Contractor shall explain the reasons for the change of any Performance Guarantee pursuant to this section when it notifies the County of the substitute commitment. Contractor shall provide no less than thirty (30) days advance notice of such modification. Similarly, upon annual review of Performance Guarantees and Guarantee Amounts, the County reserves the right to replace or modify any or all of the Performance Guarantees, provided Contractor can and will objectively measure any new performance area requested. The County reserves the right to reasonably reject or modify any proposed Performance Guarantees. In no instance will a modification decrease the Maximum Guarantee Amount.

Performance Guarantees

IMPLEMENTATION	GUARANTEE AMOUNT
Identification Card Delivery Implementation ID Card Timeliness. 98% of the ID cards will be mailed by the agreed upon commitment date in the Implementation Calendar. Results measured at Account Level.	Amount At Risk $2,500.00
Claim Readiness Implementation Claim Readiness. Benefit Profile and eligibility information loaded on claims processing system as of the Commitment Date set forth in the approved Implementation Calendar. Results measured at Account Level.	Amount At Risk $2,500.00

IMPLEMENTATION	GUARANTEE AMOUNT
Call Readiness Implementation Call Readiness. Service Center(s) ready to respond to customer inquiries as of the Commitment Date set forth in the approved Implementation Calendar. Results measured at Account Level.	Amount At Risk $2,500.00
Implementation Satisfaction Implementation Satisfaction. Score of no less than three (3) on Statement 1 of the CIGNA HealthCare Implementation Survey. Results measured at Account Level.	Amount At Risk $2,500.00

SERVICE	GUARANTEE AMOUNT
Claim Time-to-Process Medical Time to Process. Measured for the Term of the Agreement, results will meet or exceed: 98% of Claims processed w/in 30 Calendar Days. Results measured at Account Level.	Amount At Risk $8,400.00
Claim Time-to-Process Medical Time to Process. Measured for the Term of the Agreement, results will meet or exceed: 92% of Claims processed w/in 14 Calendar Days. Results measured at Account Level.	Amount At Risk $8,400.00
Financial Accuracy Medical Financial Accuracy. Measured for the Term of the Agreement, results will meet or exceed: 99.2% of total audited claim dollars are correctly paid. Results measured at Office Level.	Amount At Risk $8,400.00
Processing Accuracy Medical Processing Accuracy (Overall Accuracy). Measured for the Term of the Agreement, results will meet or exceed: 95% of total audited claims are correctly processed. Results measured at Office Level.	Amount At Risk $8,400.00
Payment Accuracy Medical Payment Accuracy. Measured for the Term of the Agreement, results will meet or exceed: 97% of total audited claims are correctly paid. Results measured at Office Level.	Amount At Risk $8,400.00
Average Speed of Answer Medical ASA. Measured for the Term of the Agreement, results will not exceed: 30 seconds to answer a phone call. Results measured at Special Account Queue.	Amount At Risk $8,400.00
Call Abandonment Rate Medical Call Abandonment Rate. Measured for the Term of the Agreement, results will not exceed: 3% of calls received by Call Center(s) terminated. Results measured at Special Account Queue.	Amount At Risk $8,400.00
First Call Resolution Medical First Call Resolution. 90% of calls resolved on first call, 45 day look back/forward. Results measured at Account Level.	Amount At Risk $8,400.00
CSA Quality Medical CSA Quality. 95% quality standard. Results measured at Office Level.	Amount At Risk $8,400.00

SERVICE	GUARANTEE AMOUNT
Account Management Account Management. Composite Score (all categories) of 3.0 or better on the Account Management Report Card based on four (4) quarterly assessments. Results measured at Account Level.	Amount At Risk $26,500.00
Other Inquiry Medical - Written Correspondence Resolved. CIGNA will guarantee our Client Service Partner, or qualified back-up, will provide a response to inquiries from the Arlington County Government Benefits Team within 24 hours. For issues that require additional research, we will provide an acknowledgement within 24 hours and we will provide periodic updates of our progress until the issue is resolved.	Amount At Risk $8,400.00
Reporting Reports Delivered on Time/AL. Produce agreed upon reports at agreed upon dates/intervals.	Amount At Risk $8,400.00
Other Network Change Notification. Network Adequacy - Report network changes to the County Project officer on a quarterly basis. Contractor shall brief County quarterly with regard to network changes or loss of any currently listed hospital, or laboratory. A determination of whether the Guarantee Amount is due and payable shall be made based on overall annual results.	Amount At Risk $8,400.00
Other Provider Directories Updates/Distribution. Production/Printing of provider directories are updated semi-annually, if not more often due to state leg requirements. Online versions are updated weekly. However, may take up to 10 calendar days after the updated directories are sent to our provider directory vendor. They review the data to ensure there are no fallouts or missing data elements, then they do a compare/add audit to the existing data tables, after which he updates are run.	Amount At Risk $8,400.00
Other Network Access/Provider Availability. Open Practices - maintain a satisfactory number of open providers (hospitals & physicians) in all managed care locations. If network is not being maintained as noted above and/or if County members are not using the network (less than 80% of total claims are in network) the Guarnatee Amount shall be paid to the County. A determination of whether the Guarantee Amount is due and payable shall be made based on overall annaul results.	Amount At Risk $8,400.00

DISCOUNT	GUARANTEE AMOUNT
Discount One Way Medical Discount Guarantee.	Amount At Risk $206,640.00

CLINICAL	GUARANTEE AMOUNT
Case Management Metrics Case Management ROI. ROI Ratio of Savings to Case Management Fees Spent: 1.5:1 ratio. One year Guarantee Period. Results measured at CIGNA Book of Business level.	Amount At Risk 25.00 %

CLINICAL	GUARANTEE AMOUNT
Case Management Metrics Case Management Satisfaction. At least 85% of survey responses received from individuals participating in a CIGNA HealthCare Case Management Program will indicate satisfaction with their case management experience. One year Guarantee Period. Results measured at CIGNA Book of Business level.	Amount At Risk 10.00 %
HEDIS HEDIS Network - Controlling High Blood Pressure. The rate of high blood pressure screening for the Guarantee Period should be at or above the NCQA Quality Compass National Average. If the rate of high blood pressure screening for the Guarantee Period is not at or above NCQA Quality Compass National Average the rate shall be improved by at least one percentage point compared to the previous year reported rate. Per healthplan site; see list of sites included in Exhibit B. Results measured at Book of Business level.	Amount At Risk $1,560.00
HEDIS HEDIS Network - Colorectal Cancer. The rate of Colorectal Cancer Screening for the Guarantee Period should be at or above the NCQA Quality Compass National Average If the rate of Colorectal Cancer Screening is not at or above NCQA Quality Compass National Average the rate for the Guarantee Period shall be improved by at least one percentage compared to the previous year reported rate point. Per healthplan site; see list of sites included in Exhibit B. Results measured at Book of Business level.	Amount At Risk $1,560.00
HEDIS HEDIS Network - Diabetes Care. The HgbA1c testing rate for the Guarantee Period should be at or above the NCQA Quality Compass National Average If the HgbA1c Testing rate is not at or above NCQA Quality Compass National Average the rate for the Guarantee Period shall be improved by at least one percentage point compared to the previous year reported rate. Per healthplan site; see list of sites included in Exhibit B. Results measured at Book of Business level.	Amount At Risk $1,560.00
HEDIS HEDIS PPO - Asthma. The rate for Asthma Medication Management for the Guarantee Period should be at or above the NCQA Quality Compass National Average. If the reported rate for Asthma Medication Management is not at or above NCQA Quality Compass National Average the rate shall be improved by at least one percentage point compared to the previous year reported rate. Per healthplan site; see list of sites included in Exhibit B. Results measured at Book of Business level.	Amount At Risk $1,560.00
HEDIS HEDIS PPO - Breast Cancer. The rate of Breast Cancer Screening for the Guarantee Period should be at or above the NCQA Quality Compass National Average. If the reported rate of Breast cancer screening is not at or above NCQA Quality Compass National Average the rate shall be improved by at least one percentage point compared to the previous year reported rate. Per healthplan site; see list of sites included in Exhibit B. Results measured at Book of Business level.	Amount At Risk $1,560.00

CLINICAL	GUARANTEE AMOUNT
HEDIS HEDIS Network - Prenatal Care. The rate of pregnant participants receiving prenatal care during the first trimester of pregnancy for the Guarantee Period should be at or above the NCQA Quality Compass National Average. If the rate of pregnant Participants receiving prenatal care during the first trimester of pregnancy is not at or above NCQA Quality Compass National Average the rate for the Guarantee Period shall be improved by at least one percentage point compared to the previous year reported rate. Per healthplan site; see list of sites included in Exhibit B. Measured at Book of Business Level.	Amount At Risk $1,560.00

IPHT/YHF	GUARANTEE AMOUNT
YHF Account Metrics YHF 200 - Regional <5,000 Clinical Compliance & ROI (Book of Business)	Amount At Risk 30.00 %

PHARMACY SERVICE	GUARANTEE AMOUNT
Mail Order Turn Around Time Pharmacy Mail Order Turnaround Time for Prescription Drugs Requiring No Intervention. Measured for the Term of the Agreement, results will meet or exceed: 95% within 2 business days with no intervention. Results measured at CIGNA Book of Business.	Amount At Risk $5,830.00
Mail Order Turn Around Time Pharmacy Mail Order Turnaround Time for Prescription Drugs Overall. Measured for the Term of the Agreement, results will not exceed: Average of 2.5 business days. Results measured at CIGNA Book of Business.	Amount At Risk $5,830.00
Retail and Mail Order Claims Processing Accuracy (Overall Accuracy) Pharmacy Processing Accuracy (Overall Accuracy). Measured for the Term of the Agreement, results will meet or exceed: 98% of total audited claims are correctly processed. Results measured at CIGNA Book of Business.	Amount At Risk $5,830.00
Mail Order Pharmacy - Class I Dispensing Accuracy Pharmacy Class 1 Dispensing Accuracy. Measured for the Term of the Agreement, results will meet or exceed: 99.992% of Prescriptions shall be accurately dispensed. Results measured at CIGNA Book of Business.	Amount At Risk $5,830.00
Mail Order Pharmacy - Class II Dispensing Accuracy Pharmacy Class 2 Dispensing Accuracy. Measured for the Term of the Agreement, results will meet or exceed: 99.85% of Prescriptions shall be accurately dispensed. Results measured at CIGNA Book of Business	Amount At Risk $5,830.00

PHARMACY MANAGEMENT	GUARANTEE AMOUNT
Ingredient Cost Discounts Mail Order Generic Discount Overall. Ingredient cost discount on covered generic prescription will be equal to or exceed the target percentage of AWP for all generics MAC and non-MAC. Target is 80.00% of the AWP.	Amount At Risk N/A

PHARMACY MANAGEMENT	GUARANTEE AMOUNT
Retail Network Dispensing Fee Retail Discount and Dispensing Fee Guarantee Retail brand AWP – 16.0%, generic AWP – 72.65% and dispensing $1.10. The generic discount covers all generics. Single source generics are included under the generic discount. Zero Balance and U & C claims are excluded in this guarantee. Specialty is not included in this guarantee. Should we fail to meet these guarantees, we will make the client whole up to the level of the overall guarantee.	Amount At Risk N/A
Other Pharmacy Management Retail Network Discount - Specialty. Ingredient cost discount on covered retail network specialty prescription will be equal to or exceed the target percentage of AWP. Target is 13.50% of the AWP.	Amount At Risk N/A
Other Pharmacy Management Mail Order Discount - Specialty. Ingredient cost discount on covered mail order specialty prescription will be equal to or exceed the target percentage of AWP. Target is 80.00% of the AWP.	Amount At Risk N/A

ONSITE HEALTH CLINIC	GUARANTEE AMOUNT
1. Customer Satisfaction Score 90% of patients surveyed are "very satisfied" with clinic services >= 90% = Zero payout >=80% = 50% payout <80% = 100% payout	Amount At Risk $2,000 (10% of Clinic Management Fee)
2. Patient Wait Time 90% of patients experience a wait time of 15 minutes or less >= 90% = Zero payout >=80% = 50% payout <80% = 100% payout	$2,000 (10% of Clinic Management Fee)

SUMMARY OF BENEFITS

Cigna Health and Life Insurance Co.
For Employees of - Arlington County Government
Open Access Plus IN Plan

Selection of a Primary Care Provider - Your plan may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If your plan requires designation of a primary care provider, Cigna may designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card.

Direct Access to Obstetricians and Gynecologists - You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card. For children, you may designate a pediatrician as the primary care provider.

Plan Highlights	In-Network
Lifetime Maximum	Unlimited
Coinsurance	You pay 10% coinsurance
Calendar Year Deductible • After each eligible family member meets his or her individual deductible, covered expenses for that family member will be paid based on the coinsurance level specified by the plan. Or, after the family deductible has been met, covered expenses for each eligible family member will be paid based on the coinsurance level specified by the plan.	Individual: None Family: None
Calendar Year Out-of-Pocket Maximum • Plan deductible contributes towards your out-of-pocket maximum. • All copays and benefit deductibles contribute towards your out-of-pocket maximum. • Mental Health and Substance Abuse covered expenses contribute towards your out-of-pocket maximum. • After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.	Individual: $2,000 Family: $4,000
Pre-Existing Condition Limitation (PCL)	Not Applicable

Plan Highlights	In-Network
Pre-certification - Continued Stay Review - PHS+ Inpatient - required for all inpatient admissions	Coordinated by your physician
Pre-certification - Continued Stay Review - PHS+ Outpatient Prior Authorization - required for selected outpatient procedures and diagnostic testing	Coordinated by your physician
Benefit	**In-Network**
Physician Services	
Primary Care Physician (PCP) Office Visit	You pay 10% coinsurance
Specialty Care Physician Office Visit	You pay 10% coinsurance
Surgery Performed in Physician's Office	You pay 10% coinsurance
Allergy Treatment/Injections	You pay 10% coinsurance
Allergy Serum Dispensed by the physician in the office	Plan pays 100% coinsurance
Benefit	**In-Network**
Preventive Care	
Routine Preventive Care - All Ages • Includes well-baby, well-child, well-woman and adult preventive care • Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit.	Plan pays 100%, no plan deductible
Immunizations - All Ages	Plan pays 100%, no plan deductible
Mammogram, PAP, PSA Tests • Coverage includes the associated Preventive Outpatient Professional Services. • Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service.	Plan pays 100%, no plan deductible
Benefit	**In-Network**
Inpatient	
Inpatient Hospital Facility	You pay 10% coinsurance
Inpatient Hospital Physician's Visit/Consultation	You pay 10% coinsurance
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	You pay 10% coinsurance

Benefit	In-Network
Inpatient	
Multiple Surgical Reduction	Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.
Benefit	**In-Network**
Outpatient	
Outpatient Facility Services	You pay 10% coinsurance
Outpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	You pay 10% coinsurance
Short-Term Rehabilitation Per Calendar YearMaximums: • Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy and Occupational Therapy – 52 days • Cardiac Rehabilitation - 90 days • Chiropractic Care - Unlimited days Note: Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum.	You pay 10% coinsurance
Benefit	**In-Network**
Other Health Care Facilities/Services	
Home Health Care (includes outpatient private duty nursing days when approved as medically necessary) • 90 days maximum per Calendar Year • 16 hour maximum per day	You pay 10% coinsurance
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility • 180 days maximum per Calendar Year	You pay 10% coinsurance
Durable Medical Equipment • Unlimited maximum per Calendar Year	You pay 10% coinsurance
Breast Feeding Equipment and Supplies • Limited to the rental of one breast pump per birth as ordered or prescribed by a physician. • Includes related supplies	Plan pays 100%
External Prosthetic Appliances (EPA) • Unlimited maximum per Calendar Year	You pay 30% coinsurance

Benefit	In-Network
Other Health Care Facilities/Services	
Acupuncture • 20 days maximum per Calendar Year	You pay 10% coinsurance

Place of Service - You pay based on where you receive services.

Benefit	Physician's Office	Outpatient Facility	Emergency Room/ Urgent Care Facility	Independent Lab	Inpatient Hospital
	In-Network	In-Network	In-Network	In-Network	In-Network
Lab and X-ray	You pay 10% coinsurance	You pay 10% coinsurance	You pay 10% coinsurance	You pay 10% coinsurance	Covered under plan's Inpatient Hospital benefit
Advanced Radiology Imaging (MRI, MRA, CAT Scan, PET Scan, etc.)	You pay 10% coinsurance	You pay 10% coinsurance	You pay 10% coinsurance	Not Applicable	Covered under plan's Inpatient Hospital benefit

Place of Service - You pay based on where you receive services.

Benefit	Physician's Office	Emergency Room	Outpatient Professional Services (Radiologist, Pathologist, ER Physician)	*Ambulance
	In-Network	In-Network	In-Network	In-Network
Emergency Care	You pay 10% coinsurance after plan deductible is met	You pay 10% coinsurance	You pay 10% coinsurance	You pay 10% coinsurance

* Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.

Place of Service - You pay based on where you receive services.

Benefit	Physician's Office	Urgent Care Facility	Outpatient Professional Services	*Ambulance
	In-Network	In-Network	In-Network	In-Network
Urgent Care	You pay 10% coinsurance	You pay 10% coinsurance	You pay 10% coinsurance	You pay 10% coinsurance

* Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.

Place of Service - You pay based on where you receive services.

Benefit	Initial Visit to Confirm Pregnancy	All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges	Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist)	Delivery - Facility (Inpatient Hospital, Birthing Center)
	In-Network	In-Network	In-Network	In-Network
Maternity	You pay 10% coinsurance	You pay 10% coinsurance	You pay 10% coinsurance	Covered same as plan's Inpatient Hospital benefit

Place of Service - You pay based on where you receive services.		
Benefit	**Inpatient Hospital and Other Health Care Facilities**	**Outpatient Services**
	In-Network	**In-Network**
Hospice (provided as part of Hospice Care Program)	You pay 10% coinsurance	You pay 10% coinsurance

Place of Service - You pay based on where you receive services.					
Benefit	**Physician's Services - Office Visit**	**Inpatient Hospital Facility**	**Outpatient Facility Services**	**Inpatient Professional Services**	**Outpatient Professional Services**
	In-Network	**In-Network**	**In-Network**	**In-Network**	**In-Network**
Family Planning - Men's Services	You pay 10% coinsurance	You pay 10% coinsurance	You pay 10% coinsurance	You pay 10% coinsurance	You pay 10% coinsurance
Includes surgical services, such as vasectomy (excludes reversals)					
Family Planning - Women's Services	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Includes surgical services, such as tubal ligation (excludes reversals).					
Contraceptive devices as ordered or prescribed by a physician.					
Infertility	You pay 10% coinsurance	You pay 10% coinsurance	You pay 10% coinsurance	You pay 10% coinsurance	You pay 10% coinsurance
Infertility covered services: lab and radiology test, counseling, surgical treatment, includes artificial insemination and excludes in-vitro fertilization, GIFT, ZIFT, etc.					

Place of Service - You pay based on where you receive services.					
Benefit	**Physician's Office**	**Inpatient Facility**	**Outpatient Facility**	**Inpatient Professional Services**	**Outpatient Professional Services**
	In-Network	**In-Network**	**In-Network**	**In-Network**	**In-Network**
TMJ, Surgical and Non-Surgical - case-by-case basis. Always excludes appliances & orthodontic treatment. Subject to medical necessity.	You pay 10% coinsurance	You pay 10% coinsurance	You pay 10% coinsurance	You pay 10% coinsurance	You pay 10% coinsurance
Non-Surgical: Unlimited maximum per lifetime					

Place of Service - You pay based on where you receive services.			
Benefit	**Inpatient**	**Outpatient - Physician's Office (includes individual, group therapy mental health and intensive outpatient mental health)**	**Outpatient Facility (includes individual, group therapy mental health and intensive outpatient mental health)**
	In-Network	**In-Network**	**In-Network**
Mental Health	You pay 10% coinsurance	You pay 10% coinsurance	You pay 10% coinsurance

Place of Service - You pay based on where you receive services.			
Benefit	**Inpatient**	**Outpatient - Physician's Office (includes individual, group therapy mental health and intensive outpatient mental health)**	**Outpatient Facility (includes individual, group therapy mental health and intensive outpatient mental health)**
	In-Network	**In-Network**	**In-Network**
• Unlimited maximum per Calendar Year • Mental Health services are paid at 100% after you reach your out-of-pocket maximum			

Place of Service - You pay based on where you receive services.			
Benefit	**Inpatient**	**Outpatient - Physician's Office (includes individual and intensive outpatient substance abuse)**	**Outpatient Facility (includes individual and intensive outpatient substance abuse)**
	In-Network	**In-Network**	**In-Network**
Substance Abuse	You pay 10% coinsurance	You pay 10% coinsurance	You pay 10% coinsurance
Note: Detox is covered under medical • Unlimited maximum per Calendar Year • Substance Abuse services are paid at 100% after you reach your out-of-pocket maximum			

Pharmacy	In-Network	Out-of-Network
Cigna Pharmacy three-tier copay plan • Patient is responsible for the applicable copay based upon the tier of the dispensed medication. • Self Administered injectable drugs - excludes infertility drugs • Oral contraceptives included • Includes oral contraceptives - with specific products covered 100% • Lifestyle drugs included - limited to sexual dysfunction • Prescription smoking cessation drugs included • Prescription vitamins included • Oral Fertility drugs included • Insulin, glucose test strips, lancets, insulin needles & syringes, insulin pens and cartridges included • Mandatory home delivery: Maintenance medications, including oral contraceptives, must be filled through home delivery; otherwise after 3 retail fills you pay the entire cost of the prescription	**Retail** - 30 day supply Generic: You pay $10 Preferred Brand: You pay $30 Non-Preferred Brand: You pay $55 **Home delivery** - 90 day supply Generic: You pay $20 Preferred Brand: You pay $60 Non-Preferred Brand: You pay $110	Not covered
Pharmacy Clinical Management and Prior Authorization • Your plan is subject to certain clinical edits and prior authorization requirements.		
Pharmacy Cost Management Program **Step Therapy** is a prior authorization program that may require you to try other medications available to treat the same condition before the "Step Therapy" medication is covered.		

Pharmacy	In-Network	Out-of-Network

- All possible Step Therapy medications are identified on the Cigna prescription drug list with an "ST" suffix. To determine if a specific drug is subject to Step Therapy for your plan, please call Customer Service at the phone number listed on your ID card or visit the Prescription Drug Price Quote tool on myCigna.com.
- Some Step 3 (Non-Preferred Brand) medications are not covered and require the use of Generic or Preferred Brand products instead.

Specialty Pharmacy Management:

- Clinical Programs
  - Prior authorization is required on specialty medications but quantity limits may apply.
  - Theracare® Program
- Medication Access Option
  - Retail and/or Home Delivery

Definitions

Coinsurance - After you've reached your deductible, you and your plan share some of your medical costs. The portion of covered expenses you are responsible for is called coinsurance.
Copay - A flat fee you pay for certain covered services such as doctor's visits or prescriptions.
Deductible - A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services.
Out-of-Pocket Maximum - Specific limits for the total amount you will pay out of your own pocket before your plan coinsurance percentage no longer applies. Once you meet these maximums, your plan then pays 100 percent of the "maximum reimbursable charges" or negotiated fees for covered services.
Prescription Drug List - The list of prescription brand and generic drugs covered by your pharmacy plan.
Transition of Care - Provides in-network health coverage to new customers when the customer's doctor is not part of the Cigna network and there are approved clinical reasons why the customer should continue to see the same doctor.

Dollars & Sense

DOLLARS & SENSE: Easy ways to decrease your out-of-pocket health care expenses.
In-network care
Using doctors, hospitals and facilities that participate in the Cigna network can save you money. In addition, choosing Cigna Care designated specialists - doctors in 19 specialties who have been identified for their superior performance in quality and cost efficiency - may save you even more. You can verify that a doctor or facility is in Cigna's network and learn more about the Cigna Care designation by checking the directory on myCigna.com or Cigna.com, or by calling the customer service number on the back of your Cigna ID card. Cigna is open 24/7.
Urgent care
(Average urgent care center cost $131 / Average hospital ER cost $1,523)
Many people use the emergency room (ER) for conditions that are not serious or life-threatening. Using an urgent care center or your doctor's office instead of an ER can save you hundreds of dollars and provides the same quality of care as an ER. If you need care and are not sure if you need to go to the ER, speak with your doctor or call Cigna's 24-hour nurse line at the number on the back your Cigna ID card to determine the most appropriate location for urgent care.
Convenience care or retail clinics
(Average convenience care clinic cost $61 / Average hospital ER cost $1,523)
Convenience care clinics provide quick and easy access to high quality treatment for common medical conditions when your doctor is not available. These clinics are located in department stores, grocery stores and pharmacies. To locate convenience care clinics, you can check the Directory on myCigna.com or Cigna.com, or call the customer service number on the back of your Cigna ID card. Cigna is open 24/7.
Laboratory and pathology tests
(Average LabCorp/Quest cost $9 / Average other lab cost $24 / Average outpatient hospital lab cost $48)

Dollars & Sense

Two of the nation's largest and most prominent laboratories, Quest Diagnostics, Inc. (Quest) and Laboratory Corporation of America (LabCorp), participate in the Cigna network. Services at these labs can cost 70-75% less and offer the same or better quality than hospital laboratories. When you need lab services, discuss these options with your doctor. To find the nearest Quest and LabCorp locations, check the directory on myCigna.com or Cigna.com.

Radiology services (MRI or CT scan)

(Average independent radiology facility cost $591 / Average outpatient hospital cost $1,198)

If you need to have an MRI or CT scan, you can save hundreds of dollars by using an independent radiology center. While Cigna contracts with all types of facilities that provide radiology services, using independent radiology centers will save you money, without any difference in quality. Discuss location options with your doctor. For help locating the most cost effective facility in which to have an MRI or CT scan, you can use the cost comparison tools on myCigna.com or call the customer service number on the back of your Cigna ID card.

Colonoscopy, endoscopy or arthroscopy

(Average freestanding surgery center cost $1,438 / Average outpatient hospital cost $2,821)

When a doctor recommends a colonoscopy, GI endoscopy or arthroscopy, make sure you know your options. Using a freestanding outpatient surgery center for these procedures instead of a hospital can often save hundreds of dollars, while maintaining the same high quality as a hospital. Talk with your doctor about options. For help locating the most appropriate facility, you can use our cost comparison tools on myCigna.com or call the customer service number on the back of your Cigna ID card.

Cigna Home Delivery Pharmacy

You can save money and enjoy convenient home delivery by using Cigna Home Delivery Pharmacy for your prescription medications. You can get up to a 90-day supply of your medication.

Exclusions

What's Not Covered (not all-inclusive):

Your plan provides coverage for most medically necessary services. Examples of things your plan does not cover, unless required by law or covered under the pharmacy benefit, include (but aren't limited to):

- Cosmetic services
- Custodial and other non-skilled services
- Dental care, unless due to accidental injury to sound natural teeth
- Experimental or investigational treatments, except for routine patient care costs related to qualified clinical trials as described in your plan document
- Eyeglass lenses and frames, contact lenses and surgical vision correction
- Genetic screenings
- Non-prescription and anti-obesity drugs
- Reversal of sterilization procedures
- Services for an injury or illness that occurs while working for pay or profit including services covered by worker's compensation benefits
- Services provided through government programs
- Services that aren't medically necessary
- Telephone, email and internet consultations in the absence of a specific benefit
- Travel immunizations
- Treatment of sexual dysfunction
- Weight loss programs
- Hearing aids

These are only the highlights
This summary outlines the highlights of your plan. For a complete list of both covered and not covered services, including benefits required by your state, see your employer's insurance certificate or summary plan description -- the official plan documents. If there are any differences between this summary and the plan documents, the information in the plan documents takes precedence. This summary provides additional information not provided in the Summary of Benefits and Coverage document required by the Federal Government.

SUMMARY OF BENEFITS

Cigna Health and Life Insurance Co.
For Employees of - Arlington County Government
Open Access Plus IN Plan

Selection of a Primary Care Provider - Your plan may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If your plan requires designation of a primary care provider, Cigna may designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card.

Direct Access to Obstetricians and Gynecologists - You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card. For children, you may designate a pediatrician as the primary care provider.

Plan Highlights	In-Network
Lifetime Maximum	Unlimited
Coinsurance	Plan pays 100%
Calendar Year Deductible • After each eligible family member meets his or her individual deductible, covered expenses for that family member will be paid based on the coinsurance level specified by the plan. Or, after the family deductible has been met, covered expenses for each eligible family member will be paid based on the coinsurance level specified by the plan.	Individual: None Family: None
Calendar Year Out-of-Pocket Maximum • Plan deductible contributes towards your out-of-pocket maximum. • All copays and benefit deductibles contribute towards your out-of-pocket maximum. • Mental Health and Substance Abuse covered expenses contribute towards your out-of-pocket maximum. • After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.	Individual: $6,350 Family: $12,700
Pre-Existing Condition Limitation (PCL)	Not Applicable

Plan Highlights	In-Network
Pre-certification - Continued Stay Review - PHS+ Inpatient - required for all inpatient admissions	Coordinated by your physician
Pre-certification - Continued Stay Review - PHS+ Outpatient Prior Authorization - required for selected outpatient procedures and diagnostic testing	Coordinated by your physician
Benefit	**In-Network**
Physician Services	
Primary Care Physician (PCP) Office Visit	You pay $30 PCP copay
Specialty Care Physician Office Visit	You pay $60 Specialist copay
Surgery Performed in Physician's Office	You pay $30 PCP or $60 Specialist copay
Allergy Treatment/Injections	You pay lesser of $30 PCP or $60 Specialist copay or actual charge
Allergy Serum Dispensed by the physician in the office	Plan pays 100%
Benefit	**In-Network**
Preventive Care	
Routine Preventive Care - All Ages • Includes well-baby, well-child, well-woman and adult preventive care • Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit.	Plan pays 100%
Immunizations - All Ages	Plan pays 100%
Mammogram, PAP, PSA Tests • Coverage includes the associated Preventive Outpatient Professional Services. • Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service.	Plan pays 100%
Benefit	**In-Network**
Inpatient	
Inpatient Hospital Facility	You pay $500 per admission copay
Inpatient Hospital Physician's Visit/Consultation	Plan pays 100%
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Plan pays 100%

Benefit	In-Network
Inpatient	
Multiple Surgical Reduction	Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.
Benefit	**In-Network**
Outpatient	
Outpatient Facility Services • Non-surgical treatment procedures are not subject to the facility per visit copay/benefit deductible	You pay $250 per facility visit copay
Outpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Plan pays 100%
Short-Term Rehabilitation Per Calendar YearMaximums: • Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy and Occupational Therapy – 52 days • Cardiac Rehabilitation - 90 days • Chiropractic Care - Unlimited days Note: Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum.	You pay $30 PCP or $60 Specialist copay
Benefit	**In-Network**
Other Health Care Facilities/Services	
Home Health Care (includes outpatient private duty nursing days when approved as medically necessary) • 90 days maximum per Calendar Year • 16 hour maximum per day	Plan pays 100%
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility • 180 days maximum per Calendar Year	Plan pays 100%
Durable Medical Equipment • Unlimited maximum per Calendar Year	Plan pays 100%
Breast Feeding Equipment and Supplies • Limited to the rental of one breast pump per birth as ordered or prescribed by a physician. • Includes related supplies	Plan pays 100%

Benefit	In-Network
Other Health Care Facilities/Services	
External Prosthetic Appliances (EPA) • Unlimited maximum per Calendar Year	You pay 30% coinsurance
Acupuncture • 20 days maximum per Calendar Year	You pay $60 Specialist copay

Place of Service - You pay based on where you receive services.

Benefit	Physician's Office	Outpatient Facility	Emergency Room/ Urgent Care Facility	Independent Lab	Inpatient Hospital
	In-Network	In-Network	In-Network	In-Network	In-Network
Lab and X-ray	You pay $30 PCP or $60 Specialist copay	Plan pays 100%	Plan pays 100%	Plan pays 100%	Covered under plan's Inpatient Hospital benefit
Advanced Radiology Imaging (MRI, MRA, CAT Scan, PET Scan, etc.)	You pay $100 copay per type of scan per day	You pay $100 copay per type of scan per day	Plan pays 100%	Not Applicable	Covered under plan's Inpatient Hospital benefit

Place of Service - You pay based on where you receive services.

Benefit	Physician's Office	Emergency Room	Outpatient Professional Services (Radiologist, Pathologist, ER Physician)	*Ambulance
	In-Network	In-Network	In-Network	In-Network
Emergency Care	You pay $30 PCP or $60 Specialist copay	You pay $200 per visit (copay waived if admitted)	Plan pays 100%	Plan pays 100%
* Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.				

Place of Service - You pay based on where you receive services.

Benefit	Physician's Office	Urgent Care Facility	Outpatient Professional Services	*Ambulance
	In-Network	In-Network	In-Network	In-Network
Urgent Care	You pay $30 PCP or $60 Specialist copay	You pay $75 per visit (copay waived if admitted)	Plan pays 100%	Plan pays 100%
* Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.				

Place of Service - You pay based on where you receive services.				
Benefit	**Initial Visit to Confirm Pregnancy**	**All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges**	**Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist)**	**Delivery - Facility (Inpatient Hospital, Birthing Center)**
	In-Network	**In-Network**	**In-Network**	**In-Network**
Maternity	You pay $30 PCP or $60 Specialist copay	Plan pays 100%	You pay $30 PCP or $60 Specialist copay	Covered same as plan's Inpatient Hospital benefit

Place of Service - You pay based on where you receive services.		
Benefit	**Inpatient Hospital and Other Health Care Facilities**	**Outpatient Services**
	In-Network	**In-Network**
Hospice (provided as part of Hospice Care Program)	Plan pays 100%	Plan pays 100%

Place of Service - You pay based on where you receive services.					
Benefit	**Physician's Services - Office Visit**	**Inpatient Hospital Facility**	**Outpatient Facility Services**	**Inpatient Professional Services**	**Outpatient Professional Services**
	In-Network	**In-Network**	**In-Network**	**In-Network**	**In-Network**
Family Planning - Men's Services	You pay $30 PCP or $60 Specialist copay	You pay $500 per admission copay	You pay $250 per facility visit copay	Plan pays 100%	Plan pays 100%
Includes surgical services, such as vasectomy (excludes reversals)					
Family Planning - Women's Services	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Includes surgical services, such as tubal ligation (excludes reversals).					
Contraceptive devices as ordered or prescribed by a physician.					
Infertility	You pay $30 PCP or $60 Specialist copay	You pay $500 per admission copay	You pay $250 per facility visit copay	Plan pays 100%	Plan pays 100%
Infertility covered services: lab and radiology test, counseling, surgical treatment, includes artificial insemination and excludes in-vitro fertilization, GIFT, ZIFT, etc.					

Place of Service - You pay based on where you receive services.					
Benefit	**Physician's Office**	**Inpatient Facility**	**Outpatient Facility**	**Inpatient Professional Services**	**Outpatient Professional Services**
	In-Network	**In-Network**	**In-Network**	**In-Network**	**In-Network**
TMJ, Surgical and Non-Surgical - case-by-case basis. Always excludes appliances & orthodontic treatment. Subject to medical necessity.	You pay $30 PCP or $60 Specialist copay	You pay $500 per admission copay	You pay $250 per facility visit copay	Plan pays 100%	Plan pays 100%
Non-Surgical: Unlimited maximum per lifetime					

Place of Service - You pay based on where you receive services.			
Benefit	**Inpatient**	**Outpatient - Physician's Office (includes individual, group therapy mental health and intensive outpatient mental health)**	**Outpatient Facility (includes individual, group therapy mental health and intensive outpatient mental health)**
	In-Network	**In-Network**	**In-Network**
Mental Health	You pay $500 per admission copay	You pay $60 copay	You pay $60 copay
• Unlimited maximum per Calendar Year • Mental Health services are paid at 100% after you reach your out-of-pocket maximum			

Place of Service - You pay based on where you receive services.			
Benefit	**Inpatient**	**Outpatient - Physician's Office (includes individual and intensive outpatient substance abuse)**	**Outpatient Facility (includes individual and intensive outpatient substance abuse)**
	In-Network	**In-Network**	**In-Network**
Substance Abuse	You pay $500 per admission copay	You pay $60 copay	You pay $60 copay
Note: Detox is covered under medical • Unlimited maximum per Calendar Year • Substance Abuse services are paid at 100% after you reach your out-of-pocket maximum			

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Plan Highlights	In-Network	Out-of-Network
Lifetime Maximum	Unlimited	Unlimited
Coinsurance	You pay 10% coinsurance	You pay 30% coinsurance
Maximum Reimbursable Charge Out-of-Network services are subject to a Calendar Year deductible and maximum reimbursable charge limitations. Payments made to health care professionals not participating in Cigna's network are determined based on the lesser of: the health care professional's normal charge for a similar service or supply, or a percentile (80%) of charges made by health care professionals of such service or supply in the geographic area where it is received. These charges are compiled in a database selected by Cigna. The health care professional may bill the customer the difference between the health care professional's normal charge and the Maximum Reimbursable Charge as determined by the benefit plan, in addition to applicable deductibles, co-payments and coinsurance.	Not Applicable	80th Percentile

Plan Highlights	In-Network	Out-of-Network
Calendar Year Deductible • Only the amount you pay for in-network covered expenses counts toward your in-network deductible. The amount you pay for out-of-network covered expenses counts toward both your in-network and out-of-network deductibles. • After each eligible family member meets his or her individual deductible, covered expenses for that family member will be paid based on the coinsurance level specified by the plan. Or, after the family deductible has been met, covered expenses for each eligible family member will be paid based on the coinsurance level specified by the plan.	Individual: None Family: None	Individual: $300 Family: $600
Calendar Year Out-of-Pocket Maximum • Only the amount you pay for in-network covered expenses counts toward your in-network out-of-pocket maximum. The amount you pay for out-of-network covered expenses counts toward both your in-network and out-of-network out-of-pocket maximums. • Plan deductible contributes towards your out-of-pocket maximum. • All copays and benefit deductibles contribute towards your out-of-pocket maximum. • Mental Health and Substance Abuse covered expenses contribute towards your out-of-pocket maximum. • After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.	Individual: $2,000 Family: $4,000	Individual: $3,000 Family: $6,000
Pre-Existing Condition Limitation (PCL)	Not Applicable	Not Applicable

Plan Highlights	In-Network	Out-of-Network
Pre-certification - Continued Stay Review - PHS Inpatient - required for all inpatient admissions	Coordinated by your physician	Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance. • $250 penalty applied to hospital inpatient charges for failure to contact Cigna Healthcare to precertify admission. • Benefits are denied for any admission reviewed by Cigna Healthcare and not certified. • Benefits are denied for any additional days not certified by Cigna Healthcare.
Benefit	**In-Network**	**Out-of-Network**
Physician Services		
Primary Care Physician (PCP) Office Visit	You pay 10% coinsurance	You pay 30% coinsurance after plan deductible is met
Specialty Care Physician Office Visit	You pay 10% coinsurance	You pay 30% coinsurance after plan deductible is met
Surgery Performed in Physician's Office	You pay 10% coinsurance	You pay 30% coinsurance after plan deductible is met
Allergy Treatment/Injections	You pay 10% coinsurance	You pay 30% coinsurance after plan deductible is met
Allergy Serum Dispensed by the physician in the office	You pay 10% coinsurance	You pay 30% coinsurance after plan deductible is met
Benefit	**In-Network**	**Out-of-Network**
Preventive Care		
Routine Preventive Care - All Ages • Includes well-baby, well-child, well-woman and adult preventive care • Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit.	Plan pays 100%, no plan deductible	You pay 30% coinsurance after plan deductible is met
Immunizations - All Ages	Plan pays 100%, no plan deductible	You pay 30% coinsurance after plan deductible is met

Benefit	In-Network	Out-of-Network
Preventive Care		
Mammogram, PAP, PSA Tests • Coverage includes the associated Preventive Outpatient Professional Services. • Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service.	Plan pays 100%, no plan deductible	You pay 30% coinsurance after plan deductible is met
Benefit	**In-Network**	**Out-of-Network**
Inpatient		
Inpatient Hospital Facility	You pay 10% coinsurance	You pay $250 per admission deductible, plus 30% coinsurance after plan deductible is met
Inpatient Hospital Physician's Visit/Consultation	You pay 10% coinsurance	You pay 30% coinsurance after plan deductible is met
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	You pay 10% coinsurance	You pay 30% coinsurance after plan deductible is met
Multiple Surgical Reduction	Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.	
Benefit	**In-Network**	**Out-of-Network**
Outpatient		
Outpatient Facility Services	You pay 10% coinsurance	You pay 30% coinsurance after plan deductible is met
Outpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	You pay 10% coinsurance	You pay 30% coinsurance after plan deductible is met

Benefit	In-Network	Out-of-Network
Outpatient		
Short-Term Rehabilitation Per Calendar YearMaximums: • Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy and Occupational Therapy – 52 days • Cardiac Rehabilitation - 90 days • Chiropractic Care - Unlimited days In Network, 20 days Out of Network Note: Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum.	You pay 10% coinsurance	You pay 30% coinsurance after plan deductible is met
Benefit	**In-Network**	**Out-of-Network**
Other Health Care Facilities/Services		
Home Health Care (includes outpatient private duty nursing days when approved as medically necessary) • 90 days maximum per Calendar Year • 16 hour maximum per day	You pay 10% coinsurance	You pay 30% coinsurance after plan deductible is met
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility • 180 days maximum per Calendar Year	You pay 10% coinsurance	You pay 30% coinsurance after plan deductible is met
Durable Medical Equipment • Unlimited maximum per Calendar Year	You pay 10% coinsurance	You pay 30% coinsurance after plan deductible is met
Breast Feeding Equipment and Supplies • Limited to the rental of one breast pump per birth as ordered or prescribed by a physician. • Includes related supplies	Plan pays 100%	You pay 30% coinsurance after plan deductible is met
External Prosthetic Appliances (EPA) • Unlimited maximum per Calendar Year	You pay 30% coinsurance	You pay 30% coinsurance after plan deductible is met
Acupuncture • 20 days maximum per Calendar Year	You pay 10% coinsurance	You pay 70% coinsurance after plan deductible is met

Place of Service - You pay based on where you receive services.										
Benefit	Physician's Office		Outpatient Facility		Emergency Room/ Urgent Care Facility		Independent Lab		Inpatient Hospital	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Lab and X-ray	You pay 10% coinsurance	You pay 30% coinsurance after plan deductible is met	You pay 10% coinsurance	You pay 30% coinsurance after plan deductible is met	You pay 10% coinsurance		You pay 10% coinsurance	You pay 30% coinsurance after plan deductible is met	Covered under plan's Inpatient Hospital benefit	Covered under plan's Inpatient Hospital benefit
Advanced Radiology Imaging (MRI, MRA, CAT Scan, PET Scan, etc.)	You pay 10% coinsurance	You pay 30% coinsurance after plan deductible is met	You pay 10% coinsurance	You pay 30% coinsurance after plan deductible is met	You pay 10% coinsurance		Not Applicable	Not Applicable	Covered under plan's Inpatient Hospital benefit	Covered under plan's Inpatient Hospital benefit

Place of Service - You pay based on where you receive services.								
Benefit	Physician's Office		Emergency Room		Outpatient Professional Services (Radiologist, Pathologist, ER Physician)		*Ambulance	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Emergency Care	You pay 10% coinsurance after plan deductible is met		You pay 10% coinsurance		You pay 10% coinsurance		You pay 10% coinsurance	
* Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.								

Place of Service - You pay based on where you receive services.								
Benefit	Physician's Office		Urgent Care Facility		Outpatient Professional Services		*Ambulance	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Urgent Care	You pay 10% coinsurance		You pay 10% coinsurance		You pay 10% coinsurance		You pay 10% coinsurance	
* Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.								

Place of Service - You pay based on where you receive services.								
Benefit	**Initial Visit to Confirm Pregnancy**		**All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges**		**Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist)**		**Delivery - Facility (Inpatient Hospital, Birthing Center)**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Maternity	You pay 10% coinsurance	You pay 30% coinsurance after plan deductible is met	You pay 10% coinsurance	You pay 30% coinsurance after plan deductible is met	You pay 10% coinsurance	You pay 30% coinsurance after plan deductible is met	Covered same as plan's Inpatient Hospital benefit	Covered same as plan's Inpatient Hospital benefit

Place of Service - You pay based on where you receive services.				
Benefit	**Inpatient Hospital and Other Health Care Facilities**		**Outpatient Services**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Hospice (provided as part of Hospice Care Program)	You pay 10% coinsurance	You pay 30% coinsurance after plan deductible is met	You pay 10% coinsurance	You pay 30% coinsurance after plan deductible is met

Place of Service - You pay based on where you receive services.										
Benefit	**Physician's Services - Office Visit**		**Inpatient Hospital Facility**		**Outpatient Facility Services**		**Inpatient Professional Services**		**Outpatient Professional Services**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Family Planning - Men's Services	You pay 10% coinsurance after plan deductible is met	You pay 30% coinsurance after plan deductible is met	You pay 10% coinsurance	You pay $250 per admission deductible, plus 30% coinsurance after plan deductible is met	You pay 10% coinsurance	You pay 30% coinsurance after plan deductible is met	You pay 10% coinsurance	You pay 30% coinsurance after plan deductible is met	You pay 10% coinsurance	You pay 30% coinsurance after plan deductible is met
Includes surgical services, such as vasectomy (excludes reversals)										

Place of Service - You pay based on where you receive services.										
Benefit	**Physician's Services - Office Visit**		**Inpatient Hospital Facility**		**Outpatient Facility Services**		**Inpatient Professional Services**		**Outpatient Professional Services**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Family Planning - Women's Services	Plan pays 100%	You pay 30% coinsurance after plan deductible is met	Plan pays 100%	You pay $250 per admission deductible, plus 30% coinsurance after plan deductible is met	Plan pays 100%	You pay 30% coinsurance after plan deductible is met	Plan pays 100%	You pay 30% coinsurance after plan deductible is met	Plan pays 100%	You pay 30% coinsurance after plan deductible is met
Includes surgical services, such as tubal ligation (excludes reversals).										
Contraceptive devices as ordered or prescribed by a physician.										
Infertility	You pay 10% coinsurance	You pay 30% coinsurance after plan deductible is met	You pay 10% coinsurance	You pay $250 per admission deductible, plus 30% coinsurance after plan deductible is met	You pay 10% coinsurance	You pay 30% coinsurance after plan deductible is met	You pay 10% coinsurance	You pay 30% coinsurance after plan deductible is met	You pay 10% coinsurance	You pay 30% coinsurance after plan deductible is met
Infertility covered services: lab and radiology test, counseling, surgical treatment, includes artificial insemination and excludes in-vitro fertilization, GIFT, ZIFT, etc.										

Place of Service - You pay based on where you receive services.										
Benefit	**Physician's Office**		**Inpatient Facility**		**Outpatient Facility**		**Inpatient Professional Services**		**Outpatient Professional Services**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
TMJ, Surgical and Non-Surgical - case-by-case basis. Always excludes appliances & orthodontic treatment. Subject to medical necessity.	You pay 10% coinsurance	You pay 30% coinsurance after plan deductible is met	You pay 10% coinsurance	You pay $250 per admission deductible, plus 30% coinsurance after plan deductible is met	You pay 10% coinsurance	You pay 30% coinsurance after plan deductible is met	You pay 10% coinsurance	You pay 30% coinsurance after plan deductible is met	You pay 10% coinsurance	You pay 30% coinsurance after plan deductible is met
Non-Surgical: Unlimited maximum per lifetime										

Place of Service - You pay based on where you receive services.						
Benefit	**Inpatient**		**Outpatient - Physician's Office (includes individual, group therapy mental health and intensive outpatient mental health)**		**Outpatient Facility (includes individual, group therapy mental health and intensive outpatient mental health)**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Mental Health	You pay 10% coinsurance after plan deductible is met	You pay $250 per admission deductible, plus 30% coinsurance after plan deductible is met	You pay 10% coinsurance	You pay 30% coinsurance after plan deductible is met	You pay 10% coinsurance	You pay 30% coinsurance after plan deductible is met
• Unlimited maximum per Calendar Year • Mental Health services are paid at 100% after you reach your out-of-pocket maximum						

Place of Service - You pay based on where you receive services.						
Benefit	**Inpatient**		**Outpatient - Physician's Office (includes individual and intensive outpatient substance abuse)**		**Outpatient Facility (includes individual and intensive outpatient substance abuse)**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Substance Abuse	You pay 10% coinsurance	You pay $250 per admission deductible, plus 30% coinsurance after plan deductible is met	You pay 10% coinsurance	You pay 30% coinsurance after plan deductible is met	You pay 10% coinsurance	You pay 30% coinsurance after plan deductible is met

Note: Detox is covered under medical

- Unlimited maximum per Calendar Year
- Substance Abuse services are paid at 100% after you reach your out-of-pocket maximum

Pharmacy	In-Network	Out-of-Network
Cigna Pharmacy three-tier copay plan • Patient is responsible for the applicable copay based upon the tier of the dispensed medication. • Self Administered injectable drugs - excludes infertility drugs • Oral contraceptives included • Includes oral contraceptives - with specific products covered 100% • Lifestyle drugs included - limited to sexual dysfunction • Prescription smoking cessation drugs included • Prescription vitamins included • Oral Fertility drugs included • Insulin, glucose test strips, lancets, insulin needles & syringes, insulin pens and cartridges included • Mandatory home delivery: Maintenance medications, including oral contraceptives, must be filled through home delivery; otherwise after 3 retail fills you pay the entire cost of the prescription	**Retail** - 30 day supply Generic: You pay $10 Preferred Brand: You pay $30 Non-Preferred Brand: You pay $55 **Home delivery** - 90 day supply Generic: You pay $20 Preferred Brand: You pay $60 Non-Preferred Brand: You pay $110	Not covered

Pharmacy Clinical Management and Prior Authorization

- Your plan is subject to certain clinical edits and prior authorization requirements.

Pharmacy Cost Management Program

Step Therapy is a prior authorization program that may require you to try other medications available to treat the same condition before the "Step Therapy" medication is covered.

- All possible Step Therapy medications are identified on the Cigna prescription drug list with an "ST" suffix. To determine if a specific drug is subject to Step Therapy for your plan, please call Customer Service at the phone number listed on your ID card or visit the Prescription Drug Price Quote tool on myCigna.com.
- Some Step 3 (Non-Preferred Brand) medications are not covered and require the use of Generic or Preferred Brand products instead.

Pharmacy	In-Network	Out-of-Network

Specialty Pharmacy Management:

- Clinical Programs
  - Prior authorization is required on specialty medications but quantity limits may apply.
  - Theracare® Program
- Medication Access Option
  - Retail and/or Home Delivery

Definitions

Coinsurance - After you've reached your deductible, you and your plan share some of your medical costs. The portion of covered expenses you are responsible for is called coinsurance.
Copay - A flat fee you pay for certain covered services such as doctor's visits or prescriptions.
Deductible - A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services.
Out-of-Pocket Maximum - Specific limits for the total amount you will pay out of your own pocket before your plan coinsurance percentage no longer applies. Once you meet these maximums, your plan then pays 100 percent of the "maximum reimbursable charges" or negotiated fees for covered services.
Prescription Drug List - The list of prescription brand and generic drugs covered by your pharmacy plan.
Transition of Care - Provides in-network health coverage to new customers when the customer's doctor is not part of the Cigna network and there are approved clinical reasons why the customer should continue to see the same doctor.

Dollars & Sense

DOLLARS & SENSE: Easy ways to decrease your out-of-pocket health care expenses.
In-network care
Using doctors, hospitals and facilities that participate in the Cigna network can save you money. In addition, choosing Cigna Care designated specialists - doctors in 19 specialties who have been identified for their superior performance in quality and cost efficiency - may save you even more. You can verify that a doctor or facility is in Cigna's network and learn more about the Cigna Care designation by checking the directory on myCigna.com or Cigna.com, or by calling the customer service number on the back of your Cigna ID card. Cigna is open 24/7.
Urgent care
(Average urgent care center cost $131 / Average hospital ER cost $1,523)
Many people use the emergency room (ER) for conditions that are not serious or life-threatening. Using an urgent care center or your doctor's office instead of an ER can save you hundreds of dollars and provides the same quality of care as an ER. If you need care and are not sure if you need to go to the ER, speak with your doctor or call Cigna's 24-hour nurse line at the number on the back your Cigna ID card to determine the most appropriate location for urgent care.
Convenience care or retail clinics
(Average convenience care clinic cost $61 / Average hospital ER cost $1,523)
Convenience care clinics provide quick and easy access to high quality treatment for common medical conditions when your doctor is not available. These clinics are located in department stores, grocery stores and pharmacies. To locate convenience care clinics, you can check the Directory on myCigna.com or Cigna.com, or call the customer service number on the back of your Cigna ID card. Cigna is open 24/7.
Laboratory and pathology tests
(Average LabCorp/Quest cost $9 / Average other lab cost $24 / Average outpatient hospital lab cost $48)
Two of the nation's largest and most prominent laboratories, Quest Diagnostics, Inc. (Quest) and Laboratory Corporation of America (LabCorp), participate in the Cigna network. Services at these labs can cost 70-75% less and offer the same or better quality than hospital laboratories. When you need lab services, discuss these options with your doctor. To find the nearest Quest and LabCorp locations, check the directory on myCigna.com or Cigna.com.
Radiology services (MRI or CT scan)

Dollars & Sense

(Average independent radiology facility cost $591 / Average outpatient hospital cost $1,198)
If you need to have an MRI or CT scan, you can save hundreds of dollars by using an independent radiology center. While Cigna contracts with all types of facilities that provide radiology services, using independent radiology centers will save you money, without any difference in quality. Discuss location options with your doctor. For help locating the most cost effective facility in which to have an MRI or CT scan, you can use the cost comparison tools on myCigna.com or call the customer service number on the back of your Cigna ID card.

Colonoscopy, endoscopy or arthroscopy
(Average freestanding surgery center cost $1,438 / Average outpatient hospital cost $2,821)
When a doctor recommends a colonoscopy, GI endoscopy or arthroscopy, make sure you know your options. Using a freestanding outpatient surgery center for these procedures instead of a hospital can often save hundreds of dollars, while maintaining the same high quality as a hospital. Talk with your doctor about options. For help locating the most appropriate facility, you can use our cost comparison tools on myCigna.com or call the customer service number on the back of your Cigna ID card.

Cigna Home Delivery Pharmacy
You can save money and enjoy convenient home delivery by using Cigna Home Delivery Pharmacy for your prescription medications. You can get up to a 90-day supply of your medication.

Exclusions

What's Not Covered (not all-inclusive):
Your plan provides coverage for most medically necessary services. Examples of things your plan does not cover, unless required by law or covered under the pharmacy benefit, include (but aren't limited to):

- Cosmetic services
- Custodial and other non-skilled services
- Dental care, unless due to accidental injury to sound natural teeth
- Experimental or investigational treatments, except for routine patient care costs related to qualified clinical trials as described in your plan document
- Eyeglass lenses and frames, contact lenses and surgical vision correction
- Genetic screenings
- Non-prescription and anti-obesity drugs
- Reversal of sterilization procedures
- Services for an injury or illness that occurs while working for pay or profit including services covered by worker's compensation benefits
- Services provided through government programs
- Services that aren't medically necessary
- Telephone, email and internet consultations in the absence of a specific benefit
- Travel immunizations
- Treatment of sexual dysfunction
- Weight loss programs
- Hearing aids

These are only the highlights
This summary outlines the highlights of your plan. For a complete list of both covered and not covered services, including benefits required by your state, see your employer's insurance certificate or summary plan description -- the official plan documents. If there are any differences between this summary and the plan documents, the information in the plan documents takes precedence. This summary provides additional information not provided in the Summary of Benefits and Coverage document required by the Federal Government.

Welcome to Cigna Vision Schedule of Vision Coverage		
Coverage	**In Network Benefit**	**Out of Network Benefit**
Exam Copay	$10	n/a
Exam Allowance (once per frequency period)	Covered at 100% after Copay	$45
Lenses	Single Vision Lenses: $20 allowance Bifocal Lenses: $30 allowance Trifocal Lenses: $40 allowance Lenticular Lenses: $75 allowance	Single Vision Lenses: $20 allowance Bifocal Lenses: $30 allowance Trifocal Lenses: $40 allowance Lenticular Lenses: $75 allowance
Contacts (Retail Allowance)	Elective: $75 allowance	Elective: $75 allowance
Frames (Retail Allowance)	Frames: $30 allowance	Frames: $30 allowance

* Declining balance can be applied towards any covered Materials (Frames, Lenses, and Contact Lenses) and drawn against throughout the stated frequency.

**Frequency Period is 12 months for all Vision services

** Your Frequency Period begins on January 1 (Calendar year basis)

Definitions:
Copay: the amount you pay towards your exam.
Coinsurance: the percentage of charges Cigna will pay. Customer is financially responsible for the balance.
Allowance: the maximum amount Cigna will pay. Customer is financially responsible for any amount over the allowance.
Materials: eyeglass lenses, frames, and/or contact lenses.

- If you use other discounts and/or promotions instead of this vision coverage, or go to an out-of-network eye care professional, you may file an out-of-network claim to be reimbursed for allowable expenses.

In-Network Coverage Includes:
- One vision and eye health evaluation including but not limited to eye health examination, dilation, refraction, and prescription for glasses;
- Stated allowance applied towards the in-network offered savings of 20% for purchased frame, lenses, lens options, and up to 15% savings on the contact lens professional services (including fitting and evaluation), offered savings does not apply to contact lens materials.

Vision Network Savings Program:
- When you see a Cigna Vision Network Eye Care Professional, you can save 20% (or more) on additional frames and/or lenses, including lens options, with a valid prescription. This savings does not apply to contact lens materials. See your Cigna Vision Network Eye Care Professional for details.

What's Not Covered:
- Orthoptic or vision training and any associated supplemental testing

- Medical or surgical treatment of the eyes
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment
- Any injury or illness when paid or payable by Workers' Compensation or similar law, or which is work-related
- Charges in excess of the usual and customary charge for the Service or Materials
- Charges incurred after the policy ends or the insured's coverage under the policy ends, except as stated in the policy
- Experimental or non-conventional treatment or device
- Magnification or low vision aids not shown as covered in the Schedule of Vision Coverage
- VDT (video display terminal)/computer eyeglass benefit
- Claims submitted and received in excess of twelve (12) months from the original Date of Service

How to use your Cigna Vision Benefits

1. Finding a doctor
There are three ways to find a quality eye doctor in your area:

1. Log in to **myCigna.com**, go to your Vision coverage page and search the Cigna Vision Directory.
2. Don't have access to **myCigna.com**? Go to **Cigna.com** and click on the Find a Doctor tab at the top. Then select "Eye Doctor" from the list below and click on the "Cigna Vision Directory" link.
3. Prefer the phone? Call our 1.800 number, found on your Cigna insurance card, and speak with a Cigna Vision customer service representative

2. Schedule an appointment
Identify yourself as a Cigna Vision customer when scheduling an appointment. Present your Cigna or Cigna Vision ID card at the time of your appointment, which will quickly assist the doctor's office with accessing your plan details and verifying your eligibility.

3. Out-of-network plan reimbursement

How to use your Cigna Vision Benefits

Send a completed Cigna Vision claim form and itemized receipt to: Cigna Vision, Claims Department: PO Box 997561, Sacramento, CA 95899-7561.

To get a Cigna Vision claim form:
• Go to **Cigna.com** and go to Forms, Vision Forms
• Go to **myCigna.com** and go to your vision coverage page

Cigna Vision will pay for covered expenses within ten business days of receiving the completed claim form and itemized receipt.

Benefits are underwritten or administered by Connecticut General Life Insurance Company or Cigna Health and Life Insurance Company. Any benefit information is intended as a summary of benefits only. It does not describe all the terms, provisions and limitations of your plan. Participating providers are independent contractors solely responsible for your routine vision examinations and products.

"Cigna" is a registered service mark, and the "Tree of Life" logo, "Cigna Vision" and "CG Vision" are service marks, of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries, including Connecticut General Life Insurance Company and Cigna Health and Life Insurance Company, and not by Cigna Corporation. In Arizona and Louisiana, the Cigna Vision product is referred to as CG Vision. Vision Network Savings Program powered by Cigna Vision is a discount program, not an insured benefit.

Request for Medical Proposal (RFP) for Arlington County Government
RFP No. 719-13 General Questions
General Questionnaire

To Offeror: Use Column Q to provide a brief explanation. However if the length of the explanation is greater than 400 characters, you must use the "Explanation" worksheet to provide your detail explanation.

MEDICAL RFP	Answer Format	Format Type	Response	Explanation
GENERAL PLAN INFORMATION	**Answer Format**	**Format Type**	**Response**	**Explanation**
Offeror Brand Name	text	Text	Cigna Health and Life Insurance Company (CHLIC), Cigna HealthCare of California, Inc., Cigna Dental Health Plan of Arizona, Inc., Cigna Dental Health of California, Inc., Cigna Dental Health of Colorado, Inc., Cigna Dental Health of Delaware, Inc., Cigna Dental Health of Florida, Inc., Cigna Dental Health of Kansas, Inc., Cigna Dental Health of Maryland, Inc., Cigna Dental Health of Missouri, Inc., Cigna Dental Health of New Jersey, Inc., Cigna Dental Health of North Carolina, Inc., Cigna Dental Health of Pennsylvania, Inc., Cigna Dental Health of Texas, Inc., and Cigna Dental Health of Virginia, Inc.	
Parent Co. Legal Entity Name	text	Text	Cigna Corporation	
Offeror is providing Medical quote	drop down box	Listbox.ListYesNo	Yes	
Offeror is providing Prescription Drug quote	drop down box	Listbox.ListYesNo	Yes	
Offeror is providing Dental quote	drop down box	Listbox.ListYesNo	Yes	

GENERAL VENDOR FINANCIAL RATING INFORMATION	Answer Format	Format Type	Response	Explanation
Please confirm that your proposal is issued in accordance with the specifications/assumptions stated in this Request for Proposal. If there are deviations, please identify them clearly. If you need more space, please use the "Explanation" column and/or worksheet. Indicate the question answered.	text	Text	Yes	
Provide your company's most recent rating or filing (identify date) from each of the following:				
A.M. Best	drop down box	Listbox. ListRated	Rated	
Rating	text	Text	A	
Date	Month Day, Year	Date	December 31, 2012	
Moody's	drop down box	Listbox. ListRated	See "Explanation"	Not Applicable
Rating	text	Text		Not Applicable
Date	Month Day, Year	Date		Not Applicable
Standard & Poor's	drop down box	Listbox. ListRated	See "Explanation"	Not Applicable
Rating	text	Text		Not Applicable
Date	Month Day, Year	Date		Not Applicable
Fitch	drop down box	Listbox. ListRated	See "Explanation"	Not Applicable
Rating	text	Text		Not Applicable
Date	Month Day, Year	Date		Not Applicable
If the offeror is not rated, is the policyholders' surplus at least USD $50 million.	drop down box	Listbox.ListYesNo		Not Applicable

Request for Medical Proposal (RFP) for Arlington County Government
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General Questionnaire

To Offeror: Use Column Q to provide a brief explanation. However if the length of the explanation is greater than 400 characters, you must use the "Explanation" worksheet to provide your detail explanation.

MEDICAL RFP	Answer Format	Format Type	Response	Explanation
If your rating has changed within the past 12 months for any of the rating agencies, discuss changes. If you need more space, please use the "Explanation" column and/or worksheet. Indicate the question answered.	text	Text	Not Applicable.	
Provide a copy of your 3 most recent audited financial statement. Name the file: [Your Organization's Name]_G-1 Most Recent Audited Financial Statement.	drop down box	Listbox, ListAttachedNAExplain	Attached	Cigna Health and Life Insurance Company's 2012 financial statements have not been audited as of yet. We have provided 2011 and 2010.
Please provide a copy of your company's most recent annual report. Name the file: [Your Organization's Name]_G-2 Annual Report.	drop down box	Listbox, ListAttachedNAExplain	Attached	

Contacts	Answer Format	Format Type	Response	Explanation
Please indicate the vendor contact, should there be any questions concerning submitted responses.				
Primary Contact				
Name	text	Text	Sheila Heaphy	
Title	text	Text	Client Manager	
Address	text	Text	10490 Little Patuxent Parkway	
City	text	Text	Columbia	
State	text	Text	Maryland	
Zip	text	Text	21044	
Phone Number	text	Text	410-884 2511	
Fax Number	text	Text	800-657-3073	
E-mail Address	text	Text	sheila.heaphy@cigna.com	
Secondary Contact				
Name	text	Text	Beth Truffer	
Title	text	Text	Vice President	
Address	text	Text	10490 Little Patuxent Parkway	
City	text	Text	Columbia	
State	text	Text	Maryland	
Zip	text	Text	21044	
Phone Number	text	Text	410-884.2594	
Fax Number	text	Text	800-657-3073	
E-mail Address	text	Text	beth truffer@cigna.com	

LEGAL/CONTRACTUAL CONSIDERATIONS	Answer Format	Format Type	Response	Explanation
We understand that terminology and contract provisions may vary from Offeror to Offeror. We will permit such alternative language provided they are reviewed and approved by the County and APS.				
The contract will be issued in Virginia	drop down box	Listbox.ListYesNo	Yes	
APS (Actives/U65)				
On or about March 1, 2014 will be the contract effective date.	drop down box	Listbox.ListYesNo	Yes	
January 1 is the anniversary date.	drop down box	Listbox.ListYesNo	Yes	
January 1 to December 31 is the plan year	drop down box	Listbox.ListYesNo	Yes	
County ((Active/U65)(Medicare Retirees--Dental Only))				
On or about March 1, 2014 will be the contract effective date	drop down box	Listbox.ListYesNo	Yes	
July 1 is the anniversary date.	drop down box	Listbox.ListYesNo	Yes	

Request for Medical Proposal (RFP) for Arlington County Government
RFP No. 719-13 General Questions
General Questionnaire

To Offeror: Use Column Q to provide a brief explanation. However if the length of the explanation is greater than 400 characters, you must use the "Explanation" worksheet to provide your detail explanation.

MEDICAL RFP	Answer Format	Format Type	Response	Explanation
July 1 to June 30 is the plan year	drop down box	Listbox,ListYesNo	Yes	
Offeror agrees to the mandatory Procurement language of each Agency as provided in accompanying RFP Procurement documents. Offeror understands that failure to agree to mandatory provisions will result in Offeror's proposal not being considered.	drop down box	Listbox,ListYesNo	Yes	
The County and APS shall have the right, in its sole and absolute discretion and without the payment of any penalty, to terminate the contract in whole or in part at any time during the term thereof upon 30 days prior written notice to Offeror.	drop down box	Listbox,ListYesNo	Yes	However, Cigna reserves the right to suspend bank account claim payments or immediately terminate this agreement if Arlington County Government & Arlington Public Schools fails to properly fund the claims bank account or fails to pay fees or premiums beyond the grace period.
There will be no restrictions or benefit limitations for pre-existing conditions applied to any employees or their dependents under the plan.	drop down box	Listbox,ListYesNo	Yes	
Employees who are not actively at work due to disablement on the program effective date will be covered.	drop down box	Listbox,ListYesNo	Yes	
The Offeror must agree to transfer to the County and to APS, within 30 days of notice of termination, all required data and records necessary to administer the plans subject to state and federal confidentiality considerations. The transfer may be made electronically, in a file format to be determined based on the mutual agreement between the County/APS and the provider of services.	drop down box	Listbox,ListYesNo	Yes	However, Cigna requires the execution of a hold harmless agreement in a form acceptable to Cigna by Arlington County Government and the new carrier to whom records are being provided.Records to be transferred can generally be provided within 48 hours of receipt of the final hold harmless agreement. Medical history by paper or tape is no charge as well as

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MEDICAL RFP	Answer Format	Format Type	Response	Explanation
The County/APS will neither recognize the appointment of any agent, general agent or broker by a respondent to these bid specifications nor authorize any payment or remuneration of any kind by a health plan to a party not approved in writing by the County/APS.	drop down box	Listbox,ListYesNo	Yes	
If requested, the health plan agrees to assume claim fiduciary responsibilities including appeals and defense of "utilization review" decisions.	drop down box	Listbox,ListYesNo	Yes	Please see Explanation Tab for more details.
Offeror agrees to provide necessary legal defense in the event of litigation.	drop down box	Listbox,ListYesNo	Yes	UW- Confirm you put this in as a line item; If so, delete Explanation
Offeror agrees to cover all costs associated with legal defense in the event of litigation.	drop down box	Listbox,ListYesNo	Yes	UW- Confirm you put this in as a line item; If so, delete Explanation
Offeror agrees to prepare and file all legal documents necessary to implement and maintain the plan, including policies, amendments, contracts, required state filings, and development of booklet/certificate formats.	drop down box	Listbox,ListYesNo	Yes	Please see Explanation Tab for more details.
Offeror agrees to monitor federal and state legislation affecting the delivery of medical benefits under the plan and to report to Client on those issues in a timely fashion prior to the effective date of any mandated plan changes.	drop down box	Listbox,ListYesNo	Yes	Cigna's state and federal governmental affairs department monitors legislative, market, and industry trends. Clients will be notified of legislative changes that affect our ability to provide client and employee services.
Provide information on network-related litigation experience during the past three years, including pending cases, awards, and settlements (both in and out of court) in the **"Explanation" column** and/or **worksheet**.	drop down box	Listbox,ListYesNo	Yes	Please see Explanation Tab for more details.
Effective for claims filed on or after 7/1/2014, Offeror certifies that it will comply with the Department of Labor's final claims procedure regulations, including:				
The notice requirements for improper and incomplete claims	drop down box	Listbox,ListYesNo	Yes	Cigna has processes in place to comply with federal laws, regulatory requirements, and state laws to the extent they are not preempted by applicable provisions of federal laws that are applicable to our services.

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MEDICAL RFP	Answer Format	Format Type	Response	Explanation
The appropriate timeframes for adjudicating urgent, pre-service and post-service claims	drop down box	Listbox.ListYesNo	Yes	Cigna has processes in place to comply with federal laws, regulatory requirements, and state laws to the extent they are not preempted by applicable provisions of federal laws that are applicable to our services. Please note that we do not pay pre-service claims.
The appropriate timeframes for notice of appeal decisions.	drop down box	Listbox.ListYesNo	Yes	See Explanation Document.
The Offeror selected during this proposal process will be responsible for claims administration of incurred claims up to the termination date of the contract, regardless of paid date, in the event the contract awarded during this marketing is subsequently terminated. The replacement Offeror will have the responsibility to administer claims incurred after the termination date of the contact.(Applicable to fully-insured coverages)	drop down box	Listbox, ListYNNANoExplain	Yes	

Compliance, General	Answer Format	Format Type	Response	Explanation
The Offeror agrees to comply with the Department of Labor's final claims procedure regulations, including the appropriate timeframes for adjudicating claims and notice of appeal decisions.	drop down box	Listbox.ListYNNANoExplain	Yes	See Explanation Document.
Offeror will provide participants with annual notice that the plan provides for coverage for breast reconstruction following mastectomy.	drop down box	Listbox.ListYNNANoExplain	Yes	If Arlington does not use our certificate, group service agreement or pre-enrollment materials (or booklet/enrollment materials for ASO funding), then it is Arlington's responsibility to provide the notices to their employees. Otherwise, the annual notice is included in the annual compliance rider issued by Cigna.

Compliance, HIPAA	Answer Format	Format Type	Response	Explanation

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General Questionnaire

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MEDICAL RFP	Answer Format	Format Type	Response	Explanation
Offeror certifies that it will comply with the interim final rules on nondiscrimination in the group health market, including:				
Coverage for self-inflicted injuries for persons who suffer from medical conditions (such as depression)	drop down box	Listbox,ListYNNANoEx plain	Yes	
Coverage for persons who are hospital-confined or not actively at work when coverage would otherwise take effect.	drop down box	Listbox,ListYNNANoEx plain	Yes	
Offeror certifies that it reports to the national Healthcare Integrity and Protection Databank (HIPDB) as required and, as may be necessary, submits inquiries to the HIPDB to determine whether any final adverse legal actions have been taken against its member providers.	drop down box	Listbox,ListYNNANoEx plain	Yes	
Offeror certifies that, if it conducts Standard Transactions, it is in full compliance with HIPAA's administrative simplification standards relating to electronic data interchange (EDI)	drop down box	Listbox,ListYNNANoEx plain	Yes	
Offeror will not require that enrollment and eligibility information electronically transmitted by Client to Offeror comply with EDI	drop down box	Listbox,ListYNNANoEx plain	No - See "Explanation"	
Offeror certifies that it is in full compliance with HIPAA's regulations protecting the privacy of individually identifiable health information.	drop down box	Listbox,ListYesNo	Yes	

Compliance, Privacy and Confidentiality	Answer Format	Format Type	Response	Explanation
The vendor agrees to make internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by organization available to the Secretary of the Department of Health and Human Services for purposes of the Secretary of the Department of Health and Human Services determining organization's compliance with the privacy rules.	drop down box	Listbox,ListYNNANoEx plain	Yes	
The vendor adopts and implements written confidentiality policies and procedures in accordance with applicable law to ensure the confidentiality of member information used for any purpose.	drop down box	Listbox,ListYNNANoEx plain	No	
The vendor will not use or further disclose protected health information (PHI) other than as permitted or required by the Business Associate Agreement or as required by law.	drop down box	Listbox,ListYNNANoEx plain	Yes	
The vendor agrees to use appropriate safeguards to prevent the unauthorized use or disclosure of the PHI. Vendor agrees to report to the plan sponsor any unauthorized use or disclosure of the PHI.	drop down box	Listbox,ListYNNANoEx plain	Yes	
The vendor agrees to mitigate, to the extent practicable, any harmful effect that is known to vendor of a use or disclosure of PHI by vendor in violation of the requirements of the federal privacy rule.	drop down box	Listbox,ListYNNANoEx plain	Yes	
The vendor agrees to ensure that any agent, including a subcontractor, to whom it provides PHI received from, or created or received by the vendor agrees to the same restrictions and conditions that apply to vendor with respect to such information.	drop down box	Listbox,ListYNNANoEx plain	Yes	

Request for Medical Proposal (RFP) for Arlington County Government
RFP No. 719-13 General Questions
General Questionnaire

To Offeror: Use Column Q to provide a brief explanation. However if the length of the explanation is greater than 400 characters, you must use the "Explanation" worksheet to provide your detail explanation.

MEDICAL RFP	Answer Format	Format Type	Response	Explanation
The vendor agrees to provide access to PHI in a "designated record set" in order to meet the requirements under 45 CFR §164.524.	drop down box	Listbox,ListYNNANoEx plain	Yes	Cigna makes ongoing updates to our internal claim electronic data interchange (EDI) gateway to support compliant transactions. We are in production with required transactions prescribed by the HIPAA transaction and code set regulations that went into effect on October 16, 2003.
The vendor agrees to make any amendment(s) to PHI in a "designated record set" pursuant to 45 CFR §164.526.	drop down box	Listbox,ListYNNANoEx plain	Yes	Cigna makes ongoing updates to our internal claim electronic data interchange (EDI) gateway to support compliant transactions. We are in production with required transactions prescribed by the HIPAA
The vendor agrees to document such disclosures of PHI and information related to such disclosures as would be required to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR §164.528.	drop down box	Listbox,ListYNNANoEx plain	Yes	
The vendor agrees to (i) implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits, (ii) report to the plan sponsor any security incident (within the meaning of 45 CFR § 164.304) of which vendor becomes aware, and (iii) ensure that any vendor employee or agent, including any subcontractor to whom it provides PHI received from, or created or received by the vendor agrees to implement reasonable and appropriate safeguards to protect such PHI.	drop down box	Listbox,ListYNNANoEx plain	Yes	
PHI is owned by the County or APS for self-insured plans.	drop down box	Listbox,ListYNNANoEx plain	Yes	Please see Explanation Tab
County staff have access to vendor sponsored Secure E Mail system to communicate employee issues.	drop down box	Listbox,ListYNNANoEx plain	Yes	
County or APS have access to PHI upon request.	drop down box	Listbox,ListYNNANoEx plain	Yes	As permitted by law

Request for Medical Proposal (RFP) for Arlington County Government
RFP No. 719-13 General Questions
Explanation

This worksheet should be used to provide additional explanations for any questions for which a "See Explanation" response was given. Explanations must be numbered to correspond to the question to which they pertain and they must be brief.

Section/ Question #	Explanation
II. Legal Contractual Considerations / #10	ASO To the extent Arlington County Government has delegated responsibility for the administration of both levels of claim appeals as definec Cigna agrees to act as the appropriately named claim fiduciary of the Plan as defined under ERISA. In addition, Cigna has also assumec that we will provide claim litigation management services in which Cigna is also responsible for handling every lawsuit alleging denial of c under the terms of the Plan. Our fee structure would be altered to reflect our assumption of additional risk and administrative responsibili Fully Insured Cigna agrees to act as the appropriately named claim fiduciary of the Plan as defined under ERISA. Cigna is also responsible for handlir lawsuit alleging denial of coverage under the terms of the Plan.
II. Legal Contractual Considerations / #11 & 12	If Arlington County Government & Arlington Public Schools elect to pay the optional claim litigation charge as outlined in this proposal, th assume responsibility for the management of any claim-related legal action, and bear the legal expenses associated with defending such long as we processed the claim(s) in dispute. Each party will provide notice to the other of any action, and will fully cooperate in the defei action unless a potential conflict of interest exists. Arlington County Government & Arlington Public Schools shall remain responsible for any benefits determined due under the Plan and any damages or penalties assessed in connection with the action. This option does not actions against any party related to the payment of extra-contractual benefits.
II. Legal Contractual Considerations / #13 & 14	The compliance and contract development staff is responsible for monitoring state and federal laws, regulations, etc. This includes analy impact of such laws on customers' contracts, on the claims operations and other administrative functions, and distributing such informatic functional areas. Every effort is made to keep our offices fully informed of statutory requirements and we perform periodic audits to ensu compliance. Cigna has processes in place to comply with all applicable federal laws and applicable state laws to the extent they are not applicable provisions of federal laws.
II. Legal Contractual Considerations / #15	In an average year, Cigna Corporation's subsidiaries, including Connecticut General Life Insurance Company (CGLIC) and Cigna Health Insurance Company (CHLIC), process more than 60 million claims and receive approximately 400 claim-related lawsuits. While the outcc litigation cannot be determined, litigation is not expected to result in losses that would be material to results of operations, liquidity, or fina condition.Litigation related to managed care plans is referred to a specialized unit of in-house legal counsel for review and handling. Afte review of the facts and circumstances of each case, in-house counsel attempts to resolve the matter as expeditiously as possible, freque achieving resolution through in-house administrative processes.Please refer to Form 10-K and Form 10-Q for an updated description of r proceedings. These documents are available online: http://www.cigna.com/aboutus/sec-filings Confidentiality concerns, together with the nature of a number of lawsuits, preclude further comment or description.
II. Legal Contractual Considerations / #16c	Cigna complies with the current standards for appeals processing as set forth by the NCQA and URAC accrediting organizations and the Department of Labor's ERISA regulatory requirements. This includes informing the member or his/her representative of the right to pursu court pursuant to Section 502(a) of ERISA, and the Interim Final Rules relating to internal claims and appeals and external review proces the Patient Protection and Affordable Care Act (PPACA).
II. Compliance,General/ #18	Cigna has processes in place to comply with federal laws, regulatory requirements, and state laws to the extent they are not preempted provisions of federal laws that are applicable to our services. Cigna complies with the current standards for appeals processing as set forth by the NCQA and URAC accrediting organizations and the Department of Labor's ERISA regulatory requirements. This includes informing the member or his/her representative of the right to pursu court pursuant to Section 502(a) of ERISA, and the Interim Final Rules relating to internal claims and appeals and external review proces the Patient Protection and Affordable Care Act (PPACA).

Request for Medical Proposal (RFP) for Arlington County Government
RFP No. 719-13 General Questions
Explanation

This worksheet should be used to provide additional explanations for any questions for which a "See Explanation" response was given. Explanations must be numbered to correspond to the question to which they pertain and they must be brief.

Section/ Question #	Explanation
II. Compliance,HIPAA/ #23	From an automated standpoint, we only accept automated client eligibility layouts and electronic data interchange (EDI) 834 enrollment t a client is unable to send us those formats and would prefer to stay automated, there may be optional service charges based on specific requests. From a manual standpoint, we can also accept a standard eligibility spreadsheet (a macro enabled excel file) that clients can u their eligibility, manual enrollment forms, and online enrollment tool.
II. Legal Contractual Considerations / #35	The Business Associate acknowledges that it has a responsibility to provide Covered Entity with access to PHI in Business Associate's p plan administration purposes. Business Associate agrees to transfer claim data to a successor administrator to the extent administrative Ownership rights with respect to the PHI provided by or created on behalf of Covered Entity shall remain with the Covered Entity, howev Business Associate may retain and use all Plan-related claim and Plan Benefit payment information recorded for or otherwise integrated Associate's business records including claim processing systems during the ordinary course of business.

Request for Medical Proposal (RFP) for Arlington County Government and Arlington County Public Schools
RFP No. 719-13 Medical Plan
Technical Questionnaire

To Offeror: Use Column Q to provide a brief explanation. However if the length of the explanation is greater than 400 characters, you must use the "Explanation" worksheet to provide your detail explanation.

MEDICAL RFP	Answer Format	Format Type	Response	Explanation
GENERAL PLAN INFORMATION	**Answer Format**	**Format Type**	**Response**	**Explanation**
Offeror Brand Name	text	Text	Cigna Health and Life Insurance Company (CHLIC) and Cigna Healthcare of California, Inc.	
Please confirm the proposed network for each of the current plan designs.				
Arlington County Government				
CIGNA POS (Active/ Pre-Medicare Retirees)	text	Text	Option 1: Cigna POS and Cigna Network POS	
CIGNA HMO (OAP) (Active/ Pre-Medicare Retirees)	text	Text	Cigna Open Access Plus	
Arlington County Public Schools				
CIGNA POS (Active/ Pre-Medicare Retirees)	text	Text	Cigna Network POS	
CIGNA OAP (Active/ Pre-Medicare Retirees)	text	Text	Cigna Open Access Plus	

PLAN DESIGN/FINANCIAL INFORMATION	Answer Format	Format Type	Response	Explanation
Adhere to the current plan design in preparing the quote.				
Please confirm that your proposal is issued in accordance with the specifications/assumptions stated in this Request for Proposal. If there are deviations, please identify them clearly. If you need more space, please use the "**Explanation**" **column** and/or **worksheet**. Indicate the question answered.	drop down box	Listbox,ListYesNoSeeExplain	Yes	
For self insured plans, please describe the process for the County/APS to grant an exception to the plan design	drop down box	Listbox,ListYesNoSeeExplain	The Account Manager is the single point of contact for all plan exceptions.	

EXHIBIT D
To AGREEMENT NO. 719-13-1
SECTIONS OF THE CONTRACTOR'S ORIGINAL RESPONSE TO THE RFP

Request for Medical Proposal (RFP) for Arlington County Government and Arlington County Public Schools
RFP No. 719-13 Medical Plan
Technical Questionnaire

To Offeror: Use Column Q to provide a brief explanation. However if the length of the explanation is **greater than 400 characters**, you must use the **"Explanation"** worksheet to provide your detail explanation.

MEDICAL RFP	Answer Format	Format Type	Response	Explanation
Plan Design	**Answer Format**	**Format Type**	**Response**	**Explanation**
County/APS is requesting that offerors duplicate the current plan designs offerings. Please indicate (yes/no) if your organization is quoting on a specific plan. If the plan you are quoting matches current in every way, indicate "NO DEVIATIONS" in your response. Please list any deviations in the workbook named "APS and County Plan Design Deviations". Note that bidders may elect to quote one or more of the following plans:				
Arlington County Government : Please see the detailed SPD's located within the RFP				
CIGNA POS (Active/ Pre-Medicare Retirees)	drop down box	Listbox,ListYesNoSeeExplain	Yes	NO DEVIATIONS
CIGNA HMO (OAP) (Active/ Pre-Medicare Retirees)	drop down box	Listbox,ListYesNoSeeExplain	Yes	NO DEVIATIONS
Arlington County Public Schools : Please see **http://www.apsva.us/Page/1207** for detailed plan design information				
CIGNA POS (Active/ Pre-Medicare Retirees)	drop down box	Listbox,ListYesNoSeeExplain	Yes	NO DEVIATIONS
CIGNA OAP (Active/ Pre-Medicare Retirees)	drop down box	Listbox,ListYesNoSeeExplain	Yes	NO DEVIATIONS
Include a concise description of how this health plan covers transitional treatments/conditions, such as pregnancy, chemotherapy, etc., if a new member is receiving treatment from a non-participating provider. Specifically indicate duration member may receive approved transitional care (from a non-network provider) at the network provider contracted benefits/cost.	text	Text	For new members transitioning to Cigna from a non-Cigna plan, Cigna offers transition of care (TOC) services to allow enrolled members to continue to receive services for specified medical conditions for a period of time from doctors and other health care professionals who do not participate in the Cigna network until a safe transfer of care to a participating doctor or facility can be arranged.	In each case, Cigna makes every effort to manage the member's TOC in a way that avoids a discontinuation of services that could impact the member's health status. Please refer to the Explanation Tab for more details.

EXHIBIT D
To AGREEMENT NO. 719-13-1
SECTIONS OF THE CONTRACTOR'S ORIGINAL RESPONSE TO THE RFP

Request for Medical Proposal (RFP) for Arlington County Government and Arlington County Public Schools
RFP No. 719-13 Medical Plan
Technical Questionnaire

To Offeror: Use Column Q to provide a brief explanation. However if the length of the explanation is greater than 400 characters, you must use the "Explanation" worksheet to provide your detail explanation.

MEDICAL RFP	Answer Format	Format Type	Response	Explanation

MEDICAL DELIVERY SYSTEM Employees' Access to Providers	Answer Format Answer Format	Format Type Format Type	Response Response	Explanation Explanation
Has the Geo-Access reporting been completed using the requested parameters in the accompanying file "**APS Access**" and "**County Access?**" **Note that a separate Geo Access is requested for Active and Pre-Medicare Retirees.**	**drop down box**	**Listbox,ListYesNo**	Yes	
Using the census data provided, prepare a list to indicate which employees reside within and outside of your service area. Name the file: **[Your Organization's Name]_ M-1 ServiceAreaSummary.**	**drop down box**	**Listbox,ListAttached**	Attached	
Has the Provider Disruption reporting been completed using the requested parameters in the accompanying file "**Disruption?**" Note that multiple disruption analysis is requested for the County and APS (i.e. facility, provider, etc.)	**drop down box**	**Listbox,ListYesNo**	Yes	

REPORTING	Answer Format	Format Type	Response	Explanation
Please indicate your willingness to provide reports separately to the County and APS and to comply with the following reporting requirements. Each report must reflect claims and enrollment (enrollees as well as members) by lines of coverage split between employees, COBRA participants and Pre-Medicare Retirees, plus a total for all activity) **Applies to the County only**: Pre- Medicare retirees must be spilt into additional sub-groups. The County has retired public safety members eligible for Commonwealth Line of Duty benefits. (This group may have split members – i.e. retiree will be in line of duty group as will some, but not all, dependents				

Request for Medical Proposal (RFP) for Arlington County Government and Arlington County Public Schools

RFP No. 719-13 Medical Plan

Technical Questionnaire

To Offeror: Use Column Q to provide a brief explanation. However if the length of the explanation is **greater than 400 characters**, you must use the **"Explanation"** worksheet to provide your detail explanation.

MEDICAL RFP	Answer Format	Format Type	Response	Explanation
Separate reports will be provided for the County and APS strategic business units (as noted above) for each plan type requested.	drop down box	Listbox,ListYesNo	Yes	
You agree to production of promised reports and data on agreed upon dates.	drop down box	Listbox,ListYesNo	Yes	
You agree to analyze the County and APS utilization and claims data and meet with each of them on at least a semi-annual basis to review emerging trends and account servicing.	drop down box	Listbox,ListYesNo	Yes	
You will provide the County and APS with access to a web-based reporting platform.	drop down box	Listbox,ListYesNo	Yes	
Employer reports can be exported into an excel, text, csv, etc. format.	drop down box	Listbox,ListYesNo	Yes	
Monthly reporting contains at least the following information:				
Paid Claims	drop down box	Listbox,ListYesNo	Yes	
Administrative/Network Fees (if applicable)	drop down box	Listbox,ListYesNo	Yes	
Large Claims Report	drop down box	Listbox,ListYesNo	Yes	
Monthly enrollment counts (enrollees and members).	drop down box	Listbox,ListYesNo	Yes	
Quarterly reporting contains at least the following information:				
Electronic eligibility listing	drop down box	Listbox,ListYesNo	Yes	
Claims paid by $ amount increments	drop down box	Listbox,ListYesNo	Yes	
Individual claims >$50,000 threshold	drop down box	Listbox,ListYesNo	Yes	
Reconciliation of claim drafts to paid claims	drop down box	Listbox,ListYesNo	Yes	
Actual utilization and trends compared to benchmark	drop down box	Listbox,ListYesNo	Yes	
Eligibility reporting to validate data, including full and changes only reports	drop down box	Listbox,ListYesNo	Yes	
Age out report for dependent children 3 months before turn age 26	drop down box	Listbox,ListYesNo	Yes	
Report and track children >26 disabled/handicap status	drop down box	Listbox,ListYesNo	Yes	
Verify disabled/handicapped status	drop down box	Listbox,ListYesNo	Yes	
Track and report out the name of Medicare Subscriber of pre medicare dependents	drop down box	Listbox,ListYesNo	Yes	

Request for Medical Proposal (RFP) for Arlington County Government and Arlington County Public Schools
RFP No. 719-13 Medical Plan
Technical Questionnaire

To Offeror: Use Column Q to provide a brief explanation. However if the length of the explanation is **greater than 400 characters**, you must use the **"Explanation"** worksheet to provide your detail explanation.

MEDICAL RFP	Answer Format	Format Type	Response	Explanation
General/Management-type claim utilization reports will be provided semi-annually or on an as-needed basis by plan identifying at a minimum:				
Claims submitted	drop down box	Listbox,ListYesNo	Yes	
Claims eligible	drop down box	Listbox,ListYesNo	Yes	
Deductible and coinsurance application	drop down box	Listbox,ListYesNo	Yes	
Payment reductions due to network negotiated rates	drop down box	Listbox,ListYesNo	Yes	
R&C cutbacks and savings	drop down box	Listbox,ListYesNo	Yes	
COB savings	drop down box	Listbox,ListYesNo	Yes	
Ineligible expenses	drop down box	Listbox,ListYesNo	Yes	
Net benefits paid	drop down box	Listbox,ListYesNo	Yes	
And will also include the above claims and utilization separately for:				
Employees	drop down box	Listbox,ListYesNo	Yes	
Dependents	drop down box	Listbox,ListYesNo	Yes	
Under 65 Retireesand Under 65 Dependents of Medicare Retirees	drop down box	Listbox,ListYesNo	Yes	
COBRA Participants	drop down box	Listbox,ListYesNo	Yes	
These utilization management reports will also include actual utilization statistics and measures compared to offeror's book of business or industry-specific benchmarks, such as:	drop down box	Listbox,ListYesNo	Yes	
ALOS	drop down box	Listbox,ListYesNo	Yes	
Days/1,000	drop down box	Listbox,ListYesNo	Yes	
Emergency Room (ER) and Urgent Care visits	drop down box	Listbox,ListYesNo	Yes	
Office visits	drop down box	Listbox,ListYesNo	Yes	
Trends	drop down box	Listbox,ListYesNo	Yes	
Other standard utilization measures and benchmarks	drop down box	Listbox,ListYesNo	Yes	
Claim lag reports will be provided when requested, in the format requested.	drop down box	Listbox,ListYesNo	Yes	
All of the above reporting will be provided for no additional charge.	drop down box	Listbox,ListYesNo	Yes	

Request for Medical Proposal (RFP) for Arlington County Government and Arlington County Public Schools

RFP No. 719-13 Medical Plan

Technical Questionnaire

To Offeror: Use Column Q to provide a brief explanation. However if the length of the explanation is greater than 400 characters, you must use the "Explanation" worksheet to provide your detail explanation.

MEDICAL RFP	Answer Format	Format Type	Response	Explanation
Ad-hoc reporting will be provided for no additional charge.	drop down box	Listbox,ListYesNo	Yes	We will continue to provide Arlington County Government and Arlington Public School ad hoc reports for no additional charge.
A year-end financial accounting report for the program will be provided within 45 days of the contract anniversary date for no additional charge.	drop down box	Listbox,ListYesNo	Yes	

ADMINISTRATIVE AND OPERATIONAL ISSUES Implementation Services	Answer Format	Format Type	Response	Explanation
Prepare a detailed schedule and time frame to implement this program by the effective date. Please indicate the implementation responsibilities of your organization and County/APS . Name the file: **[Your Organization's Name]_ M-2 Implementation.**	drop down box	Listbox,ListAttached	Attached	
Indicate your willingness to provide the following services, if required:				

Request for Medical Proposal (RFP) for Arlington County Government and Arlington County Public Schools
RFP No. 719-13 Medical Plan
Technical Questionnaire

To Offeror: Use **Column Q** to provide a brief explanation. However if the length of the explanation is **greater than 400 characters**, you must use the **"Explanation"** worksheet to provide your detail explanation.

MEDICAL RFP	Answer Format	Format Type	Response	Explanation
Design, submit for the County and APS approval, and print forms with County/APS's logo for claims submission, where required.	**drop down box**	**Listbox,ListYesNo**	Yes	Generic member materials, such as member handbooks and certificates can be provided to Arlington County Government and Arlington Public Schools for review. Requests for customized materials are reviewed on a per-case basis, and may be subject to an additional fee. Cigna offers Arlington County Government and Arlington Public Schools the

Request for Medical Proposal (RFP) for Arlington County Government and Arlington County Public Schools
RFP No. 719-13 Medical Plan
Technical Questionnaire

To Offeror: Use Column Q to provide a brief explanation. However if the length of the explanation is greater than 400 characters, you must use the "Explanation" worksheet to provide your detail explanation.

MEDICAL RFP	Answer Format	Format Type	Response	Explanation
Provide network service area zip codes and electronic directories for the County and APS voice and/or online enrollment system.	drop down box	Listbox,ListYesNo	Yes	Pursuant to our data release policies and a detailed review of request and format specifics, Cigna may be able to create a custom feed. Based upon the level of customization required, additional fees may apply.

Request for Medical Proposal (RFP) for Arlington County Government and Arlington County Public Schools
RFP No. 719-13 Medical Plan
Technical Questionnaire

To Offeror: Use **Column Q** to provide a brief explanation. However if the length of the explanation is **greater than 400 characters**, you must use the **"Explanation"** worksheet to provide your detail explanation.

MEDICAL RFP	Answer Format	Format Type	Response	Explanation
Load, audit and insure clean eligibility data at least 5 days prior to program effective date.	drop down box	Listbox,ListYesNo	Yes	In our standard implementation process, eligibility data should be complete 30 days prior to the effective date. The account management team will work with Arlington County Government and Arlington Public Schools to establish process requirements and timelines.
Be able to implement plan in 90 days and meet deadlines set forth in an agreed upon implementation schedule.	drop down box	Listbox,ListYesNo	Yes	
Production and distribution of current up-to-date provider directories to the County and APS offices prior to the enrollment period.	drop down box	Listbox,ListYesNo	Yes	
Production and distribution of ID cards prior to effective date with accuracy equal to data provided by the County and APS.	drop down box	Listbox,ListYesNo	Yes	
Appropriate members of account team to perform a service and operational audit for County/APS within the first three months of the program.	drop down box	Listbox,ListYesNo	Yes	
Provide the County and APS with a benefits and financial contract 90 days prior to the effective date.	drop down box	Listbox,ListYesNo	Yes	
Meet or exceed the County and APS subjective assessment of satisfaction with program implementation.	drop down box	Listbox,ListYesNo	Yes	

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MEDICAL RFP	Answer Format	Format Type	Response	Explanation
Account Management	**Answer Format**	**Format Type**	**Response**	**Explanation**
A designated senior account manager must be assigned to County/APS. This account representative will have the responsibility and authority to manage the entire range of services discussed in this RFP and must be able to respond immediately to all ongoing account issues, concerns and changes.				
Account Manager Name	text	Text	Sheila Heaphy will continue to be the client manager for Arlington County Government and Arlington Public Schools account.	
Number of accounts currently servicing	text	Text	10	
New case responsibility	text	Text	Sheila's customer base will not exceed 10 accounts and will mainly focus on Government business.	
Provide a separate bio on the account manager that would be assigned to the County and APS. Highlight experience including years in your organization, years in the industry, size of other current accounts and type of other accounts (self funded, plan type, etc.). Name the file: **[Your Organization's Name]_Client Acct Manager Bio) M-3**	text	Text	Attached	

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MEDICAL RFP	Answer Format	Format Type	Response	Explanation
Identify key personnel that will directly support this contract, and whose performance appraisal is impacted by their performance on this contract. Do not include first-line supervisor personnel at this point. Be sure to include, at a minimum, the AM, Senior Underwriter, Network Relations, Implementation, Member Services, Reporting Manager, Wellness Director, etc. Also, please indicate the expected percentage of time that each manager will devote to this contract and the number of years of experience in handling contract similar in scope to County/APS's.	text	Text	Sheila Heaphy - Client Manager – 15 years: Amy Rothenberger - Client Engagement Manager - 10 years: Keisha Lewis - Onsite Care Coordinator 3 years: Trina Bruno - Service Implementation Executive - 4 years: Jason Youngblood - Behavioral Specialist – 4 years: Joanne Jeanguenat – Network Relations - 7 years: Dan Zimmerman - Information Consultant - 3 years: Dan Resetar - Pharmacy Benefits Manager - 3 years: Michael Johnson - Senior Underwriter - 10 years: Eileen Noakes - Health Promotions Manager - 7 years	
If in the foreseeable future there is a reasonable chance that any of these individuals will be reassigned, retire, or otherwise be unavailable to fulfill the duties described herein, please identify the replacement(s). Also, provide all of the requested information about any such individual.	text	Text	Not Applicable	
You agree to provide account management and/or member services support for and attendance at 2-5 open enrollment benefit fairs/meetings per year, for each entity and/or other benefit events the County/APS may choose to sponsor.	drop down box	Listbox, ListYNNAExplain	Yes	
You agree that the County and APS has the right to decline the proposed Account Manager and if necessary, participate in selecting a replacement Account Manager.	text	Text	Yes	

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MEDICAL RFP	Answer Format	Format Type	Response	Explanation
You agree to provide to the County/APS an on site representative with authority to handle both claims and educational issues at least 4 days a month.	drop down box	Listbox, ListYNNAExplain	Yes	
You agree to assign a designated contact person for enrollment and claims management for medical and behavioral health and a Wellness Coordinator.	drop down box	Listbox, ListYNNAExplain	Yes	

Member Services	Answer Format	Format Type	Response	Explanation
A designated member services team will be assigned to the County and APS account	text	Text	Confirmed.	
Briefly describe the members services team that would be responsible for the County and APS account including how many staff members are assigned and how you ensure the County and APS members are routed directly to the designated team.	text	Text	There are currently 1471 customer service associates (CSAs) in the Scranton, Pennsylvania, service center. All CSAs are trained in Cigna benefits and programs as well as Arlington County Government and Arlington Public Schools specific benefits.The Service Implementation Executive is responsible for training the CSAs on the specifics of the Arlington County Government and Arlington Public Schools account, culture and nuances to ensure a consistent service experience. The advanced desktop tools the CSAs have access to allow for a full picture of each member's unique benefits and interactions with Cigna.	It is important that members receive timely assistance from customer service. To decrease wait time, especially during peak volume hours, we use a combination of dynamic call-load balancing and intelligent contact management technology to route calls to the next available appropriately trained CSA

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MEDICAL RFP	Answer Format	Format Type	Response	Explanation
Where will the member service unit reside?	text	Text	Member services will be primarily handled out of our Scranton, Pennsylvania service center.	
Customer Service representative will have full access to and understanding of the County/APS benefits designs.	drop down box	Listbox,ListYesNo	Yes	
What real-time data will be available to the representatives?	text	Text	Customer service associates (CSAs) have access to critical member information through Cigna OneViewSM. It means quicker response time and less chance for confusion since the CSA initially responding to the phone call now has the resources to help with almost any issue.OneView reduces the need for moving between multiple information sources, enabling the CSA to better focus on the needs of each caller. Information is linked across multiple plan types and platforms, allowing representatives to resolve members' questions more quickly and accurately on the first call. Transfers between lines of business are minimized.	The information useful in responding to member inquiries is presented on one screen view, including a member's past service interactions, eligibility and coverage details, and claims summary information.

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MEDICAL RFP	Answer Format	Format Type	Response	Explanation
The network's management information systems routinely collects information on patient complaints and this information is communicated to the participating provider at least two times per year.	drop down box	Listbox, ListYNNAExplain	See "Explanation"	We match inquiries, quality of service, and quality of care complaints to the treating health care professional via call documentation records that link the health care professional's name and/or ID to the issue. Please see the Explanation tab for more detail.
Each new member receives a member handbook or other relevant member materials that describes grievance procedures.	drop down box	Listbox, ListYNNAExplain	Yes	
Network management requires that each provider accommodate an appointment request within three weeks.	drop down box	Listbox, ListYNNAExplain	Yes	
There is a single toll-free, customer service telephone number for addressing claims payment, member services and any appeals.	drop down box	Listbox, ListYNNAExplain	Yes	

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MEDICAL RFP	Answer Format	Format Type	Response	Explanation
You provide a dedicated individual or staff responsible for resolving claim disputes or other issues.	drop down box	Listbox, ListYNNAExplain	Yes	Arlington County Government and Arlington Public Schools will continue to have access to their Service Implementation Executive (SIE), Trina Bruno, who will be a key liason to the service center for any claims related issues or discputes that need to be escalated.
Interacitve Voice Response (IVR) operational 24 hours a day.	drop down box	Listbox, ListYNNAExplain	Yes	
Customer Service phone line has multilingual reps.	drop down box	Listbox, ListYNNAExplain	Yes	
A toll-free customer service telephone number is operational on normal business days between at least 7 a.m. and 7 p.m. in every time zone containing County and APS members.	drop down box	Listbox, ListYNNAExplain	Yes	Cigna will continue to offer your employees live customer services 24/7.
There is access to member services via your organization's website.	drop down box	Listbox, ListYNNAExplain	Yes	
There is access to member services via a mobile app, e-mail or chat line.	drop down box	Listbox, ListYNNAExplain	Yes	
Customer satisfaction surveys are conducted and reported on annually.	drop down box	Listbox, ListYNNAExplain	Yes	

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MEDICAL RFP	Answer Format	Format Type	Response	Explanation
How are member inquiries logged and tracked?	text	Text	We document inquiries, whether received by phone, mail, or Internet, in OneView, our desktop inquiry tracking system. We track: • date of contact • member's name and ID • nature of the inquiry • steps to resolve the issue • action taken to address inquiries not initially resolved, and progress status Daily, weekly, monthly, and quarterly reports are available to analyze and track types of inquiries, including: • Responsiveness - monitor telephone system accessibility and use • Call type - identify the type and number of calls received over a specified period of time, sorted by client • Open call - identify and track open or unresolved inquiries	
How are out-of-area and out-of-county emergencies handled?	text	Text	Please refer to the Explanation tab.	

Health Care Reform/ACA Support	Answer Format	Format Type	Response	Explanation
Confirm that offeror will provide full support related to Health Care Reform/ ACA to ensure the County and APS remains compliant and has the most up to date information available.	drop down box	Listbox, ListCompletedNAExplain	Completed	Yes
Will you agree to provide communication materials to members and to County and APS staff to ensure compliance with ACA?	drop down box	Listbox, ListCompletedNAExplain	Completed	Yes

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MEDICAL RFP	Answer Format	Format Type	Response	Explanation
Briefly describe the support and materials you will provide relative to HCR/ACA.	text	Text	Please refere to the Explanation tab for more details.	
Will you agree to provide information on Exchanges, including availability, benefits and pricing as applicable?	drop down box	Listbox, ListCompletedNAExplain	Not Completed - See "Explanation"	Cigna is willing to share any public information on Cigna benefit designs and rates in the areas we offer individual solutions, both on and off exchange. Please note the following: Private Exchange - In 2013 Cigna is participating in the AonHewitt Corporate Exchange. However, as of 1/1/2014, Cigna will not be offered in the Corporate Exchange. Cigna has announced publicly that we will participate in
Briefly describe the support and materials you will provide relative to Exchanges.	text	Text	Please refere to the Explanation tab for more details.	

Network Maintenance	Answer Format	Format Type	Response	Explanation
Maintenance of satisfactory number of providers (hospitals and physicians) in all implemented locations.	drop down box	Listbox,ListYesNo	Yes	

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MEDICAL RFP	Answer Format	Format Type	Response	Explanation
Provider Directories:				
Are updated at least every six months	**drop down box**	**Listbox, ListYNNAExplain**	Yes	
Have special notations for provider no longer accepting new patients	**drop down box**	**Listbox, ListYNNAExplain**	Yes	However, this is not applicable to our Open Access Plus product.
Provide a toll free number for continuous updates and updated provider directories	**drop down box**	**Listbox, ListYNNAExplain**	Yes	
Are available via the Internet	**drop down box**	**Listbox, ListYNNAExplain**	Yes	
Indicate the frequency at which internet provider directory information is updated (i.e. daily, weekly)	**text**	**Text**	Our online provider directory is updated daily.	
Actively pursue physicians nominated by the County and APS employees to participate in network.	**drop down box**	**Listbox,ListYesNo**	Yes	

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MEDICAL RFP	Answer Format	Format Type	Response	Explanation
Briefly describe how you are improving quality among network providers.	text	Text	In partnership with our contracted network providers, we endeavor to establish a collaborative working relationship that facilitates quality patient care and services. Program activities used to achieve this goal demonstrate the commitment to quality through the establishment of policies/guidelines, monitoring for performance against the policies/guidelines, and identification of opportunities for improvement.	Specifically, Cigna uses credentialling and recredentiallin g, peer review, targeted outreach including gaps in care, performance management, HEDIS, case review and quality recognition as methods to monitor and improve quality amongst providers. Please refer to the Explanation Tab for more detail.

Data Management	Answer Format	Format Type	Response	Explanation
You will accept eligibility information electronically (on-line access, etc.).	drop down box	Listbox,ListYesNo	Yes	
You will accept eligibility information via hard copy forms.	drop down box	Listbox,ListYesNo	Yes	

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MEDICAL RFP	Answer Format	Format Type	Response	Explanation
Can the offeror meet the County's and APS file layouts and specifications. See attached zip file with specifications: **Medical Client File Specs**.zip	drop down box	Listbox,ListAttached	Attached	From an automated standpoint, we only accept automated client eligibility layouts and electronic data interchange (EDI) 834 enrollment transaction. If a client is unable to send us those formats and would prefer to stay automated, there may be optional service charges based on specific programming requests.
Offeror can administer eligibility requirements.	drop down box	Listbox,ListYesNo	Yes	See Explanation Document.
The claims system maintains on-line eligibility files that are updated at least weekly.	drop down box	Listbox,ListYesNo	Yes	
A real-time, management information system is available, which supports the County's and APS requirements for database maintenance and management reporting (i.e. The County and APS have electronic access to the system to make changes name, correct DOB, modify enrollment, view claims, verify dependent coverage etc.	drop down box	Listbox,ListYesNo	Yes	

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MEDICAL RFP	Answer Format	Format Type	Response	Explanation
Other Services	**Answer Format**	**Format Type**	**Response**	**Explanation**
List the location(s) of your service centers that would be servicing the County's and APS employees and the corresponding geographic areas/regions covered by the respective location. Use the "Explanation" column and/or worksheet if you need more space.				
Service Center 1				
Location 1	text	Text	Scranton, Pennsylvania	
Geographic Region(s) Covered 1	text	Text	All	
Service Center 2				
Location 2	text	Text	N/A	
Geographic Region(s) Covered 2	text	Text	N/A	
Service Center 3				
Location 3	text	Text	N/A	
Geographic Region(s) Covered 3	text	Text	N/A	
The County and APS reserves the right to accept or decline the designated service centers.	drop down box	Listbox,ListYesNo	No	
Attach a description of premium or administrative fee billing procedures. Include information on the timing of billing, billing-payment reconciliations and ability to provide for client self-billing. Name the file: **[Your Organization's Name]_ M-4 PremiumBilling.**	drop down box	Listbox,ListAttached	Attached	
For PPO and POS plan(s), are participants required to submit claim forms and bills:				
In-Network	drop down box	Listbox,ListYesNoNA	No	
Out-of-Network	drop down box	Listbox,ListYesNoNA	Yes	For our Open Access Plus product, participants are not required to submit claims.
Out-of-Area	drop down box	Listbox,ListYesNoNA	Yes	

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MEDICAL RFP	Answer Format	Format Type	Response	Explanation
At what R&C percentile will out-of-network PPO claims be paid?	percent, 1	Percent,1	85.0%	
At what R&C percentile will out-of-network POS claims to be paid?	percent, 1	Percent,1	85.0%	
Can you pay at various R&C percentiles at the direction of the County and APS?	drop down box	Listbox,ListYesExplain	Yes - See "Explanation"	Percentiles are applied by plan, and not by individual claim. Plan options for different R&C percentiles can be provided.
When customized printing is required, the health plan must present a proof to the County and APS for approval.	drop down box	Listbox,ListYesNo	Yes	
Plan will provide educational materials in a variety of formats (e.g., print, webinar, video) for open enrollment and other needs	drop down box	Listbox,ListYesNo	Yes	
The health plan will pay for printing costs for:				
ID Cards	drop down box	Listbox,ListYesNo	Yes	
Certificates	drop down box	Listbox,ListYesNo	No	Not applicable. Cigna is not quoting fully insured coverage for MCA.
SPDs	drop down box	Listbox,ListYesNo	Yes	Standard SPDs are included in quoted administrative fees.
Open Enrollment Materials	drop down box	Listbox,ListYesNo	Yes	
The health plan can provide SPDs in an electronic format.	drop down box	Listbox,ListYesNo	Yes	
Plan summaries are available in Spanish.	drop down box	Listbox, ListYNNAExplain	Yes	

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MEDICAL RFP	Answer Format	Format Type	Response	Explanation
Educational programs are available in Spanish.	drop down box	Listbox, ListYNNAExplain	Yes	
The health plan will produce complete SBCs in an electronic format for no additional charge.	drop down box	Listbox,ListYesNo	Yes	if requested by Arlington County Government
The health plan will incorporate prescription drug data from the County and APS, should they decide to carve-out the pharmacy program, into the medical plan SBC (produced by your organization) for no additional charge.	drop down box	Listbox,ListYesNo	No	Our pharmacy quote assumes integration with Cigna medical, however, there would be an additional charge of $6,000 set up and $570 per month to incorporate prescription drug data if the pharmacy were to be carved out.
The health plan agrees that no external communications material that mentions the County's or APS benefit plans may be circulated without written approval from them..	drop down box	Listbox,ListYesNo	Yes	
The County and APS (or its representative(s)) reserves the right to audit claims (and/or capitation payments, if applicable) upon reasonable advance notice.	drop down box	Listbox,ListYesNo	Yes	
Indicate your capabilities regarding electronic referrals for all plans requiring physician referral:				

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MEDICAL RFP	Answer Format	Format Type	Response	Explanation
The offeror currently has an electronic referral process.	drop down box	Listbox,ListYesNo	No	We are providing Arlington County Government and Arlington Public Schools with our OAP, Network, and Network POS products, which give members direct access to specialists in our networks without a referral from a PCP or another specialist. As formal referrals are not required, no electronic referral process has been developed.
If no, when will this capability be available	text	Text	This is not applicable, as formal referrals are not required for the products quoted for Arlington County Government and Arlington Public Schools.	

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MEDICAL RFP	Answer Format	Format Type	Response	Explanation
Offeror can meet COB requirements.	drop down box	Listbox, ListWillingNAExplain	Willing	Cigna has standard COB processes in place, designed to minimize the possibility of profit from over-insurance, while helping to ensure that claimants recover as much of the expense as their coverage type permits, without exceeding allowable expenses under either plan.
Offeror can handle claims reimbursements through ACH transfers.	drop down box	Listbox,ListYesNo	Yes	
If no, identify specific banking requirements for claims payment	text	Text	N/A	
All claim records and eligibility data used by the carrier in its role as claim administrator shall remain the property of the County and APS as Plan Sponsor and Plan Administrator.	drop down box	Listbox,ListYesNo	No	Please see the Explanation tab.
Each of your networks serving the County and APS members is supported by a computerized, on-line direct access claims processing system containing plan/claim information storage and retrieval.	drop down box	Listbox, ListYNNAExplain	Yes	
Are all of your internal systems integrated (e.g., claims payment, medical and behavioral health eligiblity, and customer service)?	drop down box	Listbox, ListYNNAExplain	Yes	

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MEDICAL RFP	Answer Format	Format Type	Response	Explanation
The claims system maintains dependent eligibility files.	drop down box	Listbox, ListYNNAExplain	Yes	
Confirm the County and APS may add employee eligiblity online for emergencies and new participants. Confirm these changes would not be overwritten by the next file feed..	drop down box	Listbox, ListYNNAExplain	Yes	
How are retroactive terminations handled and what is your process for collecting and crediting any claims that were paid after termination?	text	Text	Our retroactive termination policy limits our financial responsibility for member termination submissions to 60 days before the client notifies us of the termination. If we are notified within 60 days, we return the payments that we have collected for the terminated members. The payments are not returnable if we receive notification after 60 days from the date of termination. We will attempt to recover any claim payments for services the member received after ending coverage that we paid before we received notification of the termination.	
The claims system automatically screens for duplicate bills.	drop down box	Listbox, ListYNNAExplain	Yes	

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MEDICAL RFP	Answer Format	Format Type	Response	Explanation
What is your contingency plan in the event that the proposed customer service center is off-line/down?	text	Text	High volume call centers have the "mobile recovery" process available. This provides office space/equipment and encrypted satellite communication for voice and data. These mobile offices can be set up in less than 72 hours. They are self-contained and come with their own power sources. In addition, this solution can be used in conjunction with load balancing to bring about an even more robust recovery. This solution is tested annually with "live" calls and data.	
What is the process of handling uncashed (outstanding) checks?	text	Text	Please refere to the Explanation tab for more details.	
The above described service is at no additional cost.	drop down box	Listbox, ListYNNAExplain	Yes	

Performance Benchmarks	Answer Format	Format Type	Response	Explanation
Focusing specifically on the claim office(s) that would be used for the County and APS, indicate if performance for 2012 did or did not meet the specified standards below. If more than six Service Centers proposed, provide requested data in ""Explanation"" column and/or worksheet."				
Service Center #1				

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MEDICAL RFP	Answer Format	Format Type	Response	Explanation
Financial Dollar Accuracy was 99% or greater.	drop down box	Listbox,ListMetNotMet	Met	99.77% within our Scranton, Pennsylvania service center
Procedural Accuracy was 98% or greater.	drop down box	Listbox,ListMetNotMet	Met	99.66%within our Scranton, Pennsylvania service center.
90% of claims were processed in 10 business days or less.	drop down box	Listbox,ListMetNotMet	Met	98.45% in our Scranton, Pennsylvania service center
At least 90% of telephone calls to member services were answered within 20 seconds.	drop down box	Listbox,ListMetNotMet	Not Met	Average speed to answer in our Scranton, Pennsylvania service center was 30 seconds, which is our Cigna standard.
Service Center #2				
Financial Dollar Accuracy was 99% or greater.	drop down box	Listbox,ListMetNotMet		N/A
Procedural Accuracy was 98% or greater.	drop down box	Listbox,ListMetNotMet		N/A
90% of claims were processed in 10 business days or less.	drop down box	Listbox,ListMetNotMet		N/A
At least 90% of telephone calls to member services were answered within 20 seconds.	drop down box	Listbox,ListMetNotMet		N/A
Service Center #3				
Financial Dollar Accuracy was 99% or greater.	drop down box	Listbox,ListMetNotMet		N/A
Procedural Accuracy was 98% or greater.	drop down box	Listbox,ListMetNotMet		N/A
90% of claims were processed in 10 business days or less.	drop down box	Listbox,ListMetNotMet		N/A

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MEDICAL RFP	Answer Format	Format Type	Response	Explanation
At least 90% of telephone calls to member services were answered within 20 seconds.	drop down box	Listbox,ListMetNotMet		N/A

Subcontracted Services	Answer Format	Format Type	Response	Explanation
Indicate if you: (1) changed any of your subcontracted service providers in the last 12 months; (2) are planning any changes in your subcontracted arrangements during the upcoming 12 months; (3) N/A - Services not changed or planned to change; or (4) N/A - Service Not Subcontracted. For services where subcontractor was either changed or planned to be changed, please provide the name of the new service provider in the space provided below.				
Customer service	drop down box	Listbox,ListSubcontractServ	N/A - Not Subcontracted	
Name of new subcontracted service provider	text	Text		
Large Case Management	drop down box	Listbox,ListSubcontractServ	N/A - Not Subcontracted	
Name of new subcontracted service provider	text	Text		
Utilization Management	drop down box	Listbox,ListSubcontractServ	N/A - Not Subcontracted	
Name of new subcontracted service provider	text	Text		
Provider quality data	drop down box	Listbox,ListSubcontractServ	N/A - Not Subcontracted	
Name of new subcontracted service provider	text	Text		
24/7 nurse-line	drop down box	Listbox,ListSubcontractServ	N/A - Not Subcontracted	
Name of new subcontracted service provider	text	Text		
Organ Transplant Networks	drop down box	Listbox,ListSubcontractServ	N/A - Not Subcontracted	
Name of new subcontracted service provider	text	Text		
Coordination of Benefits	drop down box	Listbox,ListSubcontractServ	N/A - No Changes	
Name of new subcontracted service provider	text	Text		
Behavioral Health Network and Intake Services	drop down box	Listbox,ListSubcontractServ	N/A - Not Subcontracted	
Name of new subcontracted service provider	text	Text		
Claims Administration	drop down box	Listbox,ListSubcontractServ	N/A - Not Subcontracted	

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RFP No. 719-13 Medical Plan
Technical Questionnaire

To Offeror: Use Column Q to provide a brief explanation. However if the length of the explanation is greater than 400 characters, you must use the "Explanation" worksheet to provide your detail explanation.

MEDICAL RFP	Answer Format	Format Type	Response	Explanation
Name of new subcontracted service provider	text	Text		
Provider Credentialing	drop down box	Listbox,ListSubcontractServ	N/A - Not Subcontracted	
Name of new subcontracted service provider	text	Text		
Other	drop down box	Listbox,ListSubcontractServ	N/A - No Changes	
Name of new subcontracted service provider	text	Text		

Behavioral Health Capabilities	Answer Format	Format Type	Response	Explanation
Please provide the following information in electronic format and name the file as specified:				
There is a behavioral health triage system in place, operational 24-hours/7-days a week and staffed by behavioral health professionals with at least a master's degree, to direct members to appropriate levels of mental health or substance abuse care.	drop down box	Listbox,ListYesNo	Yes	The Cigna staff who provide referrals are personal advocates who are a mix of master's and bachelor's level professionals.
Urgent problem visits are available within 24-hours.	drop down box	Listbox,ListYesNo	Yes	
Health plan members have access to a range of alternative behavioral health services; including, residential treatment, partial hospitalization, halfway houses, intensive outpatient care, and home therapy.	drop down box	Listbox,ListYesNo	Yes	
The network has a multidisciplinary mixture of board-certified psychiatrists, independently licensed doctoral psychologists, and master's-level clinicians.	drop down box	Listbox,ListYesNo	Yes	
Offeror establishes standards for the number and geographic distribution of behavioral healthcare practitioners; including, psychiatrists, psychologists, clinical social workers, psychiatric nurses, and other behavioral healthcare specialists.	drop down box	Listbox,ListYesNo	Yes	

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MEDICAL RFP	Answer Format	Format Type	Response	Explanation
Offeror has established standards for timeliness of routine and urgent care, behavioral healthcare appointments, and access to after-hours care	drop down box	Listbox,ListYesNo	Yes	
Offeror monitors responsiveness of member services or appointment telephone lines.	drop down box	Listbox,ListYesNo	Yes	
To make UM decisions, Offeror uses written utilization review criteria for determination of clinical appropriateness.	drop down box	Listbox,ListYesNo	Yes	
The utilization management department sends written notification to members and practitioners, as appropriate, of the reason for each claim denial.	drop down box	Listbox,ListYesNo	Yes	
Written policies and procedures address the types of practitioners accepted to participate in the network; including, psychiatrists and/or physicians who are certified in addiction medicine, doctoral and/or master's level psychologists who are state-certified or state-licensed, master's level clinical social workers who are state-certified or state-licensed, and master's level clinical nurse specialists who are nationally- and/or state-licensed to practice independently.	drop down box	Listbox,ListYesNo	Yes	
The County and APS have an in-house EAP program. The Offeror must be willing to coordinate treatment with County and APS EAP staff.	drop down box	Listbox,ListYesNo	Yes	

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Explanation

This worksheet should be used to provide additional explanations for any questions for which a "See Explanation" response was given. Explanations must be numbered to correspond to the question to which they pertain and they must be brief.

Section/ Question #	Explanation
Section II/#4	Members must apply in writing for in-network level TOC within 30 days of enrollment in the plan (unless a longer period of time is mandated by the applicable state). If approved by Cigna, a member may continue to receive services from that doctor, hospital, or other health care professional for a specified period of time, with covered services paid at the in-network coverage level.
Section II/#4 (continued)	Examples of conditions that may qualify for TOC coverage are: • second or third trimester of pregnancy as of the start date of coverage • newly diagnosed or relapsed cancer in the midst of chemotherapy, radiation therapy, or reconstruction • transplant candidates, unstable recipients, or recipients in need of ongoing care due to complications associated with a transplant • acute conditions such as heart attacks, strokes, or unstable chronic conditions in active treatment • recent major surgeries still in the follow-up period (generally six to eight weeks) • hospital confinement on the plan start date (for plans that do not have extension of coverage provisions) • trauma
Section II/#4 (continued)	• non-participating facility services for inpatient care, (maternity or hospice care associated with a TOC request when non-participating docto hospital, or other health care professional services are approved for TOC and the doctor, hospital, or other health care professional does no have privileges at a participating facility) Cigna completes a medical necessity review once the clinical information is received from the member or health care professional, and a determination is made about coverage of the above services. Unless otherwise mandated by applicable state mandates, which always take precedence, TOC certifications apply to an appropriate period time following the member's start date (e.g., 30, 60, or 90 days), or until care has been completed or transitioned to a participating doctor, hospital, or other health care professional, or coverage limitations are exceeded, whichever occurs first. Certification does not generally exceed a period of 90 days.
Section V/ #37	In the case of an emergency, we encourage members to seek care at the closest appropriate facility. Emergency and urgent care is covered the in-network coverage level, regardless of where the service is provided. We use prudent layperson criteria when defining an emergency. Network POS Out of Network Our Network POS is a national network, which allows members to access care at in-network levels from Network POS providers in any of ou local networks when away from home. Dependents living away from home can access care from local Network POS providers. Participating provider information can be obtained from our website or by contacting customer service. Out of Area Routine care is covered based on the plan's network access and benefit plan design. A member with chronic medical conditions should consult their PCP about care needs while traveling outside their network area.
Section V/ #37 (continued)	Open Access Plus (OAP) Out of Network With our OAP Plan, members can access care in- or out-of-network without a referral. For plans with out-of-network coverage, services deemed as urgent care (non-life threatening) are reimbursed at the in-network level. For plans with only in-network coverage, urgent care services provided at non-network facilities are also reimbursed at the in-network coverage level. Out of Area The member will generally be asked to remit payment at the time services are provided. Cigna will translate the claim, and any payment mac will be sent directly to the member. Routine care is not covered when traveling outside of the U.S.
Section V/ #40	Cigna views reform as another strategic opportunity to meet client needs. Within days of the passage of the Patient Protection and Affordabl Care Act (PPACA), Cigna was the first national carrier to launch a reform-dedicated site. A one-stop-shopping resource, www.informedonreform.com is also a vehicle to showcase Cigna's reform thought leadership and expertise. Cigna launched www.informedonreform.com with the goal of providing a dynamic, comprehensive resource for a primarily business-to-business audience. Tl site is meeting or exceeding our expectations in terms of traffic and engagement. User feedback is also very positive.

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Explanation

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Section/ Question #	Explanation
Section V/#40 (continued)	Cigna uses this channel to provide education and insights for our client and benefit consultant audiences so that they can better understand reform, anticipate impacts, and take a proactive approach implementing it with their clients and employees. The site also provides commentary on critical legislative decisions which includes the Reform Today column, advocacy papers, web meetinç and fact sheets; each of which have been authored by recognized industry experts.
Section V/#41	Cigna is willing to share any public information on Cigna benefit designs and rates in the areas we offer individual solutions, both on and off exchange. Please note the following: Private Exchange - In 2013 Cigna is participating in the AonHewitt Corporate Exchange. However, as of 1/1/2014, Cigna will not be offered the Corporate Exchange. Cigna has announced publicly that we will participate in the Mercer Marketplace. Public Exchange - We are only on the public exchange in TX, FL, AZ, TN and CO for 2014, so, we will have nothing to share in VA for 2014. No 2015 public exchange participation decisions have been made yet.
Section V/#42	Cigna understands that our clients continue to face cost pressures and a sustainable solution must address the long term affordability for employers and employees, and we are committed to ensuring that we have solutions to meet our varying clients' needs as the market evolve Accordingly, Cigna is actively engaged in assessing Private Exchange solutions to meet our clients' needs. One of Cigna's greatest strengths is the ability to compose benefit programs that reflect a company's culture and the demographics and hea status of their workforce. Through integrated solutions designed to meet the unique needs of our Employers, we are able to maximize the health and productivity of their workforce. We believe that the ability to offer our integrated solutions within an exchange framework will be of interest to some employers. Additionally, for many employers, self-insurance will continue to be a critical component of the benefit program. As such, our Defined Contribution/'Exchange' solutions will incorporate both insured and self-insured offerings. We will continue to monitor mark interest to determine the pace of our development efforts and associated readiness dates.
Section V/Question #47	Cigna's Collaborative Accountable Care (CAC) initiatives are a variation of the Accountable Care Organization (ACO) model. Although founded on the principles of the Patient-Centered Medical Home (PCMH), the primary difference between this model and the PCMH and AC approaches lies in the clinical collaboration, consultative guidance, patient-specific actionable information, and performance reporting that Cigna brings to these initiatives.

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Explanation

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Section/ Question #	Explanation
Section V/#51	To establish eligibility files for your employees and their dependents, we require the network and PCP identification number (when appropriate), and established indicator for each member, as well as the following for each participating member: • SSN • name • date of birth (DOB) • sex • mailing address • home and work telephone numbers Note - Required if HSA or Integrated Personal Health Team (IPHT) • coverage structure information • start date of coverage • cancellation date, if applicable For covered dependents we require: • first name • last name • sex • DOB • student status • relationship to member • dependent SSN for over age 45 • coverage structure information • start date of coverage • cancellation date, if applicable • dependent health insurance claim number if Medicare eligible and under age 45
Section V/ #65a	
Section V/ #71	Cigna owns and shall own all rights, title and interest in and to the systems, procedures, methodologies and practices used by it in connectio with the claims processing, claims payment and utilization monitoring functions, together with the Participating Provider network, the negotiated fees, terms and discounts with Providers, claims processing, claims history and utilization data and information (collectively, the "Cigna Proprietary Information"), all of which is proprietary, confidential and a trade secret of Cigna. Employer shall have no right, title or interest in or to Cigna Proprietary Information. Employer agrees to treat all Cigna Proprietary Information in a confidential manner.
Section V/ #79a	In an ASO environment, the client is responsible for their escheatment process. Cigna assists the client by providing the nine months check report free of charge; and outstanding checks services at an additional cost. These two reports can only be provided if the client has elected receive PHI under HIPAA regulations. Outstanding checks are automatically "aged voided" at 15 months by Citibank or JPMorgan Chase. If "aged voided," checks are not reissuec and the client should follow appropriate state unclaimed property regulations. Under a fully insured arrangement, the unclaimed property unit is responsible for handling uncashed, traditionally funded claim checks. Our procedures are based on state regulatory requirements including: • guidelines for contacting payees • time frames for remitting unresolved items to the appropriate states • information required for reporting to the states Payees are contacted through mailings so that payees can work directly with us to resolve/receive payments before remitting funds to the state. If an item cannot be resolved, funds are remitted in the payee's name to the appropriate state under the requirements outlined in that state's regulatory statutes.

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Wellness Questionnaire

To Offeror: Use Column Q to provide a brief explanation. However if the length of the explanation is greater than 400 characters, you must use the "Explanation" worksheet to provide your detail explanation.

Wellness Questionnaire	Answer Format	Format Type	Response	Explanation

The County and APS are soliciting information regarding your organization's capabilities to deliver Wellness and Lifestyle Behavior Change services including: incentive and data management, reporting, an online wellness portal, health challenges, online and telephonic health coaching, onsite education and face to face coaching, and employee communication. At this time the County and APS is interested in understanding the capabilities of your organization to be their strategic partner and the fees associated with these capabilities. Exact timing of the roll-out of the services is still to be determined.

The County currently operates a comprehensive wellness program called HealthSmart. The County is considering partnering exclusively with their health plan partner to support and enhance the HealthSmart program, but may also partner with an external third party to provide some services and program support, which would require their health plan to integrate and coordinate with the external wellness vendor).

ORGANIZATIONAL INFORMATION	Answer Format	Format Type	Response	Explanation
The County and APS may consider carving out the wellness program in the future. Do you offer wellness services on a carve-out basis?	drop down box	Listbox,ListYNNAExplain	No	
If so, would you agree to provide all necessary data, reporting and integration required of the Offeror selected by the County/APS?	drop down box	Listbox,ListYNNAExplain	No	
List the total number of self-insured employer clients and the corresponding total number of eligible employees for whom your organization was providing comprehensive wellness services as of 1/1/2013.				
Total number of self-insured employer clients	number, 0	Number, 0	January 1, 2013: 6,191 May 31, 2013: 6,696	Cigna does not track the number of self-insured clients for our wellness programs. As an alternative, the number of self-insured clients for all medical products has been provided.
Total number of eligible employees	number, 0	Number, 0	January 1, 2013: 4,964,462 May 31, 2013: 5,072,600	Cigna does not track the number of eligible employees for our wellness programs. As an alternative, the number or self-insured employees for all medical products has been provided.
Does your organization currently provide wellness services for any other local government or public school system clients? If yes, provide the names of those local governments or public school systems for whom you currently provide these services.	drop down box	Listbox,ListYNNAExplain	Yes	Anne Arundel County Govt, Baltimore County and Baltimore County Schools, Fairfax County Government, Frederick County Government, Loudoun County Govt and Loudoun County Public Schools, Montgomery County Public Schools, Richmond Public Schools.
Does your organization currently provide wellness services for any clients where some eligible employees are not enrolled in medical coverage or are enrolled in a health plan other than yours?	drop down box	Listbox,ListYNNAExplain	Yes	
If yes, briefly describe any wellness services that are not available to eligible employees not enrolled in your health plan. Also describe any services that are available but may be modified for non-enrolled employees.	drop down box	Listbox,ListYNNAExplain	Yes	We offer a variety of wellness services to employees not enrolled in the health plan which includes health education awareness communications, seminars, onsite classes, hourly coaching, and turnkey health challenges. We also offer buy up options for health assessment and telephonic coaching

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Wellness Questionnaire

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Wellness Questionnaire	Answer Format	Format Type	Response	Explanation
Does your organization currently provide onsite clinic services (such as onsite medical or dental services, onsite pharmacy, onsite physical therapy, etc.) for any of your self-insured clients? If yes, describe the types of onsite clinic services that you provide.	drop down box	Listbox,ListYNNAExplain	Yes	Please refer to the Wellness Explanation tab.
What is the minimum lead-time needed to work with the county and APS to provide a comprehensive wellness program that is fully integrated with the current in house programs?	drop down box	Listbox, ListMinLeadTime	Other - See "Explanation"	It depends on what is being offered as part of the overall wellness program but recommend during implementation to start discussing the overall wellness stratey planning.
Account Management				
Will you designate a wellness consultant to work with the County and APS?	drop down box	Listbox,ListYNNAExplain	Yes	
Describe the responsibilities of the wellness consultant.	drop down box	Listbox,ListYNNAExplain	See "Explanation"	The Health Promotion Manager (HPM) works closely with the Cigna Account Management Team. The HPM identifies the right opportunities and the most appropriate wellness programs that will target the specific needs of an organization's employee/dependent population. Relying primarily on Health Assessment data, with supplemental information from claim and utilization reports, the HPM in partnership with Arlington County Government and Arlington Public Schools continue to will develop the right mix of programs resulting in a customized annual calendar of health education and wellness initiatives.
What is the average number of clients that the wellness consultant works with?	number, 0	Number, 0	15-20	
Will the wellness consultant be local and available to meet with the County and APS onsite as needed regarding the program? If yes, what is the frequency that the wellness consultant will meet with the County and/or APS?	text	Text	Yes, the Health Promotion Manager will be available as needed to support the wellness strategy being put in place. There will also be a Client Engagement Manager who will execute the strategy and is available as much is as needed to help implement the strategy.	
Will the wellness consultant be available to attend and provide support during onsite events/initiatives if needed?	text	Text	Yes	
Subcontractor Information				
Are any of your wellness services subcontracted?	drop down box	Listbox, ListYNNAExplain	Yes	We own and administer the majority of our health promotion and wellness programs. Please note that Cigna subcontractors are not specific to this contract and deliver services to Cigna's entire book of business. We contract with the following vendors for additional programs and resources.
If yes, list the outsourced service(s) and the name of the corresponding outsourced partner (includes all services - e.g. communications, biometrics, coaching, online programs and information, etc.):				

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Wellness Questionnaire

To Offeror: Use Column G to provide a brief explanation. However if the length of the explanation is greater than 400 characters, you must use the "Explanation" worksheet to provide your detail explanation.

Wellness Questionnaire	Answer Format	Format Type	Response	Explanation
Comment: If no, leave the following section blank.				
Outsourced service #1	text	Text	Health Assessment Tool	
Outsource partner	text	Text	University of Michigan	
Length of time providing outsourced services	text	Text	Since 2007	
Outsourced service #2	text	Text	Biometric Screenings and Flu Shots	
Outsource partner	text	Text	Summit Health	
Length of time providing outsourced services	text	Text	since 2007	
Outsourced service #3	text	Text	Disease and Condition Content	
Outsource partner	text	Text	Healthwise®	
Length of time providing outsourced services	text	Text	since 2003	
Outsourced service #4	text	Text	Online, customer-directed health care solutions and information.	
Outsource partner	text	Text	WebMD Health ®	
Length of time providing outsourced services	text	Text	since 2003	
Communications				
Briefly describe the types of standard communication materials available and whether any related charges for those materials.	drop down box	Text	The "Vitalnet" communications series delivers "vital health information in a minute" to help keep your workforce engaged, motivated, and healthy throughout the year. Each month, you will receive employee materials focused on a different theme. Materials will include: • newsletter filled with information to help improve or maintain a healthy lifestyle • email with health tips and a healthy recipe • health observance eCard provided six months of the year Optional Program Components Additional components of Cigna's Health Promotion and Awareness Program include: • Our 12-month Employee Wellness Calendar - Includes a fun monthly goal and six chair exercises to help keep employees healthy. Additional fees may apply. • Onsite Health & Wellness Programs - These onsite offerings are designed to educate your employees about their health and help build a culture of well-being at your worksite. The 2013 program calendar has optional no-cost seminars or wellness challenges listed for each month to provide you with flexibility in choosing topics for your	• Health Promotion Campaigns - A great way to reach your employees with a short-term health engagement strategy, these turnkey electronic communications promote health tips and available resources. Each campaign has customized materials based on the topic, which may include eCards, newsletters, posters, and flyers. • Health Observance eCards - These eCards are a way to increase awareness among your employees about popular national health observances and screenings that focus on heart health, nutrition, blood pressure, UV safety, depression, and smoking cessation. • Health Awareness Day Resources - Included are planning guides and interactive health modules to help make your health awareness days successful. • The Well - This client website houses an assortment of free health and wellness resources to clients to promote awareness and program participation. Standard communications are available for no additional charge.
Is your organization able to provide editable communications materials to the County and APS, that may be modified for use regardless of health plan enrollment? If yes, describe how these materials will be provided (format and medium).	drop down box	Listbox,ListYNNAExplain	Yes	Amy Rothenberger, your Client Engagement Manager, will work with the HR teams for a customized communication strategy which may include customized communications. We offer both paper and electronic communications to our clients and members.

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Wellness Questionnaire

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Wellness Questionnaire	Answer Format	Format Type	Response	Explanation
Are the following customizations to standard communications available? If yes, indicate in the explanation column if there is an additional fee for the customization.				
County/Health Smart program or APS "branding" may be added to standard communication materials.	drop down box	Listbox,ListYNNAExplain	Yes	
County/Health Smart program or APS program "branding" may be added to health portal.	drop down box	Listbox,ListYNNAExplain	Yes	
County/Health Smart program or APS program "branding" may be added to the health assessment.	drop down box	Listbox,ListYNNAExplain	No	
Customization of standard text in member letters and other paper based communications.	drop down box	Listbox,ListYNNAExplain	Yes	
Customization of standard content in electronic member communications.	drop down box	Listbox,ListYNNAExplain	Yes	
Removal (or minimization) of health plan name and logos from communications materials, health portal and health assessment to support use with non-health plan enrolled members.	drop down box	Listbox,ListYNNAExplain	No	
List languages other than English in which communication materials are readily available. If applicable, detail additional costs.	drop down box	Listbox,ListYNNAExplain	Yes	Spanish

HEALTH ASSESSMENT & BIOMETRICS Health Assessment (HA)	Answer Format	Format Type	Response	Explanation
HA Validation				
Has your HA tool been validated internally?	drop down box	Listbox,ListYNNAExplain	No	
Briefly describe the validation process.	text	Text	Not Applicable.	
Has your HA tool been validated externally?	drop down box	Listbox,ListYNNAExplain	Yes	
Briefly describe the validation process.	text	Text	Please see Wellness Explanation tab.	
How long has your organization been providing this HA?	text	Text	We have been providing health assessments since 2007.	
Is your HA available in languages other than English?	drop down box	Listbox,ListYNNAExplain	Yes	
If "yes", specify which languages are currently available or planned and any additional costs incurred for having access to non-English versions.	text	Text	Spanish	There is no additional fee.
Is the HA available in the following formats?				
Online	drop down box	Listbox,ListYNNAExplain	Yes	
Paper	drop down box	Listbox,ListYNNAExplain	Yes	
Telephonic	drop down box	Listbox,ListYNNAExplain	No	
What is the reading level (grade level) of the HA?	text	Text	The reading level of health assessments is the 8th grade reading level.	

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Wellness Questionnaire	Answer Format	Format Type	Response	Explanation
How long on average does it take for a participant to complete the HA?	text	Text	It takes between 15-20 minutes to complete the health assessment.	
Is there a time limit to complete? Can participants complete the HA over multiple sessions?	text	Text	Participants can complete the health assessment over multiple sessions during the enrollment period.	
Are "readiness to change" questions included in the questionnaire and used to tailor feedback in the individual reports back to members?	drop down box	Listbox,ListYNNAExplain	Yes	
Are "productivity" questions included in the questionnaire?	drop down box	Listbox,ListYNNAExplain	Yes	
Do the questions specifically address self-reported absenteeism?	drop down box	Listbox,ListYNNAExplain	Yes	
Do the questions specifically address self-reported presenteeism?	drop down box	Listbox,ListYNNAExplain	Yes	
Is a health score communicated to the individual completing the HA?	drop down box	Listbox,ListYNNAExplain	Yes	
Briefly describe one or two key features that differentiate your HA from your competitors.	text	Text	Please see Wellness Explanation tab.	
Does your HA integrate game theory and game mechanics to engage members? If yes, briefly describe how these tools are integrated in the HA.	drop down box	Listbox,ListYNNAExplain	Yes	Cigna has partnered with Audax Health to develop and pilot a new digital member experience. It is available to clients that have been qualified for the pilot. Cigna is currently piloting these new capabilities and is targeting broad market availability in 2014. Features of the new digital environment are expected to include: • an easy and fun gamified health assessment with visually supported questions, divided into easily consumable sets that provides rewards along the way Members earn rewards ("coins") for completing every five to six questions in the health assessment to keep them motivated. Questions are simple and easy and contain images for those who do not read English well to ensure a client's entire population can finish it.
Are the County and APS able to customize the HA by adding and/or deleting specific questions? In the explanation column, briefly describe how deletion of questions may impact validation/scoring.	drop down box	Listbox,ListYNNAExplain	No	At this time, the questions and appearance of the health assessment are standardized and are not customizable. The health assessment used by Cigna is based on years of research and analysis by the University of Michigan Health Management Research Center (UM-HMRC).
Can HA triggers for identification of individuals for health coaching outreach be modified/customized?	drop down box	Listbox,ListYNNAExplain	No	
Are HA results used to prioritize program offerings and provide ongoing targeted health information to members after initial results are provided (i.e. throughout program year)? Please describe.	drop down box	Listbox,ListYNNAExplain	Yes	Please see Wellness Explanation tab.

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Wellness Questionnaire	Answer Format	Format Type	Response	Explanation
Does HA comply with GINA? (i.e., health history is voluntary and participants qualify for incentives by completing the portion that does not call for family medical history)	drop down box	Listbox,ListYNNAExplain	Yes	
If the County or APS should decide to utilize a third party HA, can the health plan HA be "turned off" to avoid confusing members?	drop down box	Listbox,ListYNNAExplain	No	
Biometric Screenings				
Do you have the capability to do onsite biometric screenings either internally or through a vendor partner?	drop down box	Listbox,ListYNNAExplain	Yes	
If so, what is the minimum number of participants needed per location?	text	Text	We require a minimum of 30 participants.	
Do you deliver results immediately to participants?	drop down box	Listbox,ListYNNAExplain	Yes	
Are results explained by a counselor/nurse present at the screenings?	drop down box	Listbox,ListYNNAExplain	Yes	
Would you accept biometric information directly from physicians of participants? If so, describe how this would be done.	drop down box	Listbox,ListYNNAExplain	No	
Do you provide "at home" biometric data collection kits?	drop down box	Listbox,ListYNNAExplain	See "Explanation"	We also intend to offer a home screening product sometime in 2013.
Do you have arrangements with area labs to conduct biometric screenings for members that cannot attend an onsite screening?	drop down box	Listbox,ListYNNAExplain	Yes	In order to accommodate smaller worksite locations and/or remote workers, Cigna offers an electronic biometric screening voucher option. The vouchers will be emailed directly to Arlington County Government and Arlington Public Schools in a PDF file. Arlington County Government and Arlington Public Schools is responsible for distributing screening information to employees/participants. Participants take their packets to an approved LabCorp facility, where the laboratory screening measures each participant's cholesterol and glucose value. Participants are required to fast ahead of this venipuncture test (eight hours, water and medications permitted). Voucher participants record their own blood pressure, height, weight, and waist circumference measurements in the provided behavioral questionnaire with consent and return it upon completion. After the screening, Summit Health mails participants their results, and notifies participants separately if and when a screening produces an "alert" test result.
List names of laboratory partners, if applicable.	text	Text	LabCorp	

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Wellness Questionnaire

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Wellness Questionnaire	Answer Format	Format Type	Response	Explanation
Are you able to accept screening results from the HealthSmart Wellness Clinic? If yes, how would the information need to be provided and are there additional fees to accept this data?	drop down box	Listbox,ListYNNAExplain	Yes	Cigna accepts biometric data feeds, in the Cigna standard file format, from external vendors who provide screening services. This capability allows us to pre-populate health plan members' health assessments with blood pressure, total cholesterol, HDL, height, weight, and waist circumference values received from an external source (e g , doctor visit or outside screening center). Integrating these values into the University of Michigan Health Management Research Center Health Assessment (UM-HMRC health assessment) increases our ability to proactively identify at-risk members who are eligible for various health programs. We can then proceed with individual outreach, where appropriate.
Are you able to provide the following specific biometric screening approaches?				
Fingerstick	drop down box	Listbox,ListYNNAExplain	Yes	
Venipuncture	drop down box	Listbox,ListYNNAExplain	Yes	
Fasting	drop down box	Listbox,ListYNNAExplain	Yes	
Non-fasting	drop down box	Listbox,ListYNNAExplain	Yes	
Indicate the specific health elements (blood pressure, blood glucose, BMI, etc.) recommended in your proposed biometric screenings.	text	Text	Available screening packages include: Standard Healthy Heart Screening Package • total cholesterol - HDL - coronary risk ratio • glucose measurement* (fasting suggested- 8 hours) • blood pressure and pulse measurement • weight measurement • height measurement • waist circumference • BMI • health coaching Expanded Healthy Heart Screening Package • total cholesterol - HDL - LDL - triglycerides - coronary risk ratio • glucose measurement* (fasting required for 8 hours) • blood pressure and pulse • weight measurement • height measurement • waist circumference • BMI • health coaching	*Summit Health employs a finger-stick collection process, and Cholestech technology to analyze the results and provide immediate feedback.

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Wellness Questionnaire	Answer Format	Format Type	Response	Explanation
Describe any other tests that you can provide at an onsite screening (e.g. Cotinine, step test, etc.)	text	Text	The following additional screenings can be provided for an additional fee: • serum cotinine • hemoglobin A1c (HbA1c) • vitamin d • PSA • thyroid-stimulating hormone • c-reactive protein • bone density • comprehensive metabolic panel	
Can you auto-populate the HA with results from:				
Onsite biometric screening event	drop down box	Listbox,ListYNNAExplain	Yes	
At home biometric screening tests	drop down box	Listbox,ListYNNAExplain	Not Applicable - See "Explanation"	We intend to offer a home screening product in 2013.
At lab biometric screenings	drop down box	Listbox,ListYNNAExplain	Yes	
At physician's office/provider form	drop down box	Listbox,ListYNNAExplain	Yes	
HealthSmart Wellness Clinic	drop down box	Listbox,ListYNNAExplain	Yes	Cigna accepts biometric data feeds, in the Cigna standard file format, from external vendors who provide screening services. This capability allows us to pre-populate health plan members' health assessments with blood pressure, total cholesterol, HDL, height, weight, and waist circumference values received from an external source (e.g., doctor visit or outside screening center). Integrating these values into the University of Michigan Health Management Research Center Health Assessment (UM-HMRC health assessment) increases our ability to proactively identify at-risk members who are eligible for various health programs. We can then proceed with individual outreach, where appropriate.
What is your timeframe for loading results from:				
Onsite biometric screening event	text	Text	12 business days	
At home biometric screening tests	text	Text	N/A	We intend to offer a home screening product sometime in 2013.
At lab biometric screenings	text	Text	Immediately	
At physician's office/provider form	text	Text	Immediately	
HealthSmart Wellness Clinic	text	Text	Once the data feed is received by Cigna, the data is immediately available for integration	
Can you lock the electronically populated biometric values so that they cannot be manually overwritten?	drop down box	Listbox,ListYNNAExplain	No	
Do you have an online scheduling tool that member's may use to schedule onsite biometric screenings?	drop down box	Listbox,ListYNNAExplain	Yes	
Is the online tool customizable? If yes, briefly describe available customizations in the explanation column.	drop down box	Listbox,ListYNNAExplain	No	

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Wellness Questionnaire	Answer Format	Format Type	Response	Explanation
Does the tool include backdoor access for the County or APS to monitor activity and report back to wellness champions or other support staff if needed?	drop down box	Listbox,ListYNNAExplain	No	

HEALTH PORTAL/WEB-BASED INTERACTIVE TOOLS	Answer Format	Format Type	Response	Explanation
Indicate if the following programs, categories of information and tools are available on your portal. Indicate in the explanation column if additional fees apply.				
Health and Condition Information?	drop down box	Listbox,ListYNNAExplain	Yes	
Medication information (including prescription medications, herbals and OTC medication)?	drop down box	Listbox,ListYNNAExplain	Yes	
Health trackers (e.g. weight, blood pressure, steps, diet, etc.)? Briefly describe in the explanation column.	drop down box	Listbox,ListYNNAExplain	Yes	As part of our decision support tools, our Health Trackers allow the member to track health measurements over time and display results in easy-to-read charts. Members input their information for key health indicators such as blood pressure, blood sugar, cholesterol (total/LDL/HDL), exercise, height, and weight. Data can be edited easily, displayed in charts, printed, and shared with medical professionals.
Health newsfeed (updated daily)?	drop down box	Listbox,ListYNNAExplain	Yes	
Online newsletter (updated at least monthly)?	drop down box	Listbox,ListYNNAExplain	Yes	
Customizable client bulletin board?	drop down box	Listbox,ListYNNAExplain	Yes	
Health tips, information or reminders via portal messaging?	drop down box	Listbox,ListYNNAExplain	Yes	
Health tips, information or reminders via text messaging?	drop down box	Listbox,ListYNNAExplain	Yes	
Personalized content based on member interest?	drop down box	Listbox,ListYNNAExplain	Yes	
Personalized content based on HRQ and screening results?	drop down box	Listbox,ListYNNAExplain	Yes	
Ergonomics / workplace safety?	drop down box	Listbox,ListYNNAExplain	Yes	
Smart phone access to portal? If yes indicate in the explanation column which smart phone(s) your portal is able to interface with and what portal features are available via smart phone access.	drop down box	Listbox,ListYNNAExplain	Yes	Please refer to the Wellness Explanation tab

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Wellness Questionnaire	Answer Format	Format Type	Response	Explanation
Describe any other smart phone apps available (beyond portal access).	text	Text	In addition to the myCigna.com mobile app, members can download the Cigna App Pack and the Go You mobile app. Cigna's mobile capabilities will continue to evolve and new features will be pushed to the myCigna.com mobile app throughout 2013 and 2014. Plans include Spanish capabilities, integration with our members' personal health record (PHR), simplified coverage information, voice navigation, and integration with Cigna's digital ecosystem of applications. Over the next 12-60 months, we also plan to drive deeper member engagement via mobile devices through the enhancements listed below: • comprehensive cost and quality comparisons for informed health care decisions • a "medicine cabinet" (pill reminders, drug interaction alerts, allergy diary, etc.) • personal trackers, diaries and journals, biometrics tracking, and tracking via wellness programs (weight, tobacco, stress, sleep, nutrition, fitness)	(Continued) • application-programming interface for simple integration between the most popular health and wellness apps, and Cigna coaches and systems • device integration, so that devices used to monitor glucose, sleep, exercise, etc. are seamlessly integrated with Cigna coaches/systems • incentives tracking integration - sending mobile data to web engine • share PHRs while at a doctor appointment • social networking and live/virtual chat, including: - health care professional precertification and health care professional directory - click-to-chat for coaching programs - policy quotes and renewals
Ability to download data from smart phone apps or other biometric devices? If yes, indicate in the explanation column what devices your portal is currently able to interface with.	drop down box	Listbox,ListYNNAExplain	Yes	Members have the ability to print or email identification cards.
Online interaction between members (e.g. live chat, discussion boards, challenges, etc. hosted by the wellness portal - NOT via public social media sites such as Facebook or Twitter)	drop down box	Listbox,ListYNNAExplain	No	
Portable personal health record (PHR)?	drop down box	Listbox,ListYNNAExplain	Yes	
Is a log on and password required for access to web-based tools?	drop down box	Listbox,ListYNNAExplain	Yes	
Is access to the web-based tools via a single sign on? (i.e. no need to register/log-in to access tools promoted on the site).	drop down box	Listbox,ListYNNAExplain	Yes	

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Wellness Questionnaire	Answer Format	Format Type	Response	Explanation
Briefly describe how you keep participants engaged in web-based programs. How do you increase utilization?	text	Text	Cigna's online coaching programs provide members with the opportunity to engage in health behavior change programs at their own pace over a period of six to eight weeks. Each program includes educational information and resources to help members better understand how making small changes to their nutrition, sleep, activity, or stress habits can have a big impact on their health. Members who would benefit from health behavior change programs are identified through their health assessment responses and are immediately invited to voluntarily enroll via email. To promote enrollment, the initial invitation is followed by a series of high-impact launch communications to encourage maximum enrollment throughout a target population. Once a member has opted in to the program, he or she receives periodic reminder emails linking back to the health assessment and online coaching website to promote continued participation.	Members may be identified to participate in more than one program; however, the system directs each person to one module at a time to maximize effectiveness. The order in which multiple modules are ranked is determined by risk, in order to address the greatest risk first. It is possible for a proactive person to participate in more than one program concurrently if they self-enroll on the website.As noted above, Cigna is developing a digital engagement platform that leverages the technology and methods used in popular social networking, health devices, and online gaming products to help members improve their health. We expect our digital engagement platform to provide a fun and interesting way for members to stay involved in our web-based programs. This new platform is targeted for a phased release beginning late 2013 through 2014, and wide-market availability by January of 2015. Access to the product during the phased release (soft launch) will be a gating process.
Briefly describe how game theory and game mechanics are integrated into the portal to improve engagement.	text	Text	Please refer to the Wellness Explanation tab.	
Does your web-based interactive programming incorporate readiness to change theory?	drop down box	Listbox,ListYNNAExplain	Yes	
Are the following portal customizations available? Indicate in the explanation column if there are additional fees for customization.				
County/Health Smart or APS program branding?	drop down box	Listbox,ListYNNAExplain	Yes	Additional fees may apply
Links from the County or APS intranet site or other vendor partner portals to the wellness program?	drop down box	Listbox,ListYNNAExplain	Yes	Additional fees may apply
Links from wellness portal to other County or APS program or Offeror portals?	drop down box	Listbox,ListYNNAExplain	Yes	Additional fees may apply
Customization of portal text?	drop down box	Listbox,ListYNNAExplain	Yes	Additional fees may apply
Customizable bulletin board for County and APS specific events/information?	drop down box	Listbox,ListYNNAExplain	Yes	Additional fees may apply
Ability to push targeted communications based on demographics or business specifics such as segment, division, etc.	drop down box	Listbox,ListYNNAExplain	Yes	Additional fees may apply

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Wellness Questionnaire	Answer Format	Format Type	Response	Explanation
Briefly discuss how you handle both scheduled and unscheduled system maintenance issues.	text	Text	Web IT's current service-level agreements are to ensure that our websites will be available 98.5 percent of the time. Actual results for 2012 exceeded this standard, as the average availability of our websites was 99.25 percent, with no site at less than 98.52 percent availability. Generally speaking, our websites are available 97-99 percent of the time, 24 hours a day, 7 days a week, 365 days a year. Availability in this context means "major systems fully functional." Login response times for Web IT sites averaged between 5-9 seconds, with the myCigna com website at 5.08 seconds for 2012. Navigation between pages averaged 0.98 seconds, including page-generation time. Downtime for applications includes a scheduled monthly maintenance window. Major releases are scheduled between midnight Saturday to 10:00 a.m. Sunday. The need for unscheduled system maintenance is minimal.	
Briefly describe any plans to expand web-based information technology that will be effective within the next 12 months.	text	Text	Please refer to the Wellness Explanation tab.	
Please provide demo log-in information such as user ID and password needed to access your web site (sufficient to experience the web site as the County and APS' participants would). Provide 6 guest log-ins.	text	Text	Access to the actual myCigna site is available thru https://my.cigna.com/web/public/guest ; userid: userdemo123; password: review1 (case sensitive).	

LIFESTYLE BEHAVIOR CHANGE PROGRAMS	Answer Format	Format Type	Response	Explanation
Do you offer online coaching programs including but not limited to the following? If yes, specify in the explanation column whether the module is a one-time session or if the module requires multiple sessions for completion.				
Nutrition Management	drop down box	Listbox,ListYNNAExplain	Yes	Multiple Sessions as part of our Lifestyle Management Programs
Stress Management	drop down box	Listbox,ListYNNAExplain	Yes	Multiple Sessions as part of our Lifestyle Management Programs
Tobacco Cessation	drop down box	Listbox,ListYNNAExplain	Yes	Multiple Sessions as part of our Lifestyle Management Programs
Weight Management	drop down box	Listbox,ListYNNAExplain	Yes	Multiple Sessions as part of our Lifestyle Management Programs
Exercise Management	drop down box	Listbox,ListYNNAExplain	Yes	Multiple sessions as part of our nutrition management online coaching program
Sleep Disorders	drop down box	Listbox,ListYNNAExplain	Yes	Multiple Sessions

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Wellness Questionnaire	Answer Format	Format Type	Response	Explanation
Cholesterol	drop down box	Listbox,ListYNNAExplain	Yes	Multiple Sessions as part of our Cigna Health Advisor Program
Blood pressure	drop down box	Listbox,ListYNNAExplain	Yes	Multiple Sessions as part of our Cigna Health Advisor Program
Glucose/Pre-diabetes	drop down box	Listbox,ListYNNAExplain	Yes	Multiple Sessions as part of our Cigna Health Advisor Program
Family Oriented Programs (if yes, please list available programs in Explanation column)	drop down box	Listbox,ListYNNAExplain	No	
Child Specific Programs (if yes, please list available programs in Explanation column)	drop down box	Listbox,ListYNNAExplain	No	
Ergonomics / workplace safety	drop down box	Listbox,ListYNNAExplain	No	
Other Programs - specify	text	Text	No	
Do you offer telephonic coaching programs including but not limited to the following? If yes, specify in the explanation column the average number of calls/sessions for each program and the timing of the calls (e.g. weekly, monthly, etc.).				
Nutrition Management	drop down box	Listbox,ListYNNAExplain	Yes	We offer members nutrition information through our weight management program telephonically and online. Coaches reassess members for progress at each coaching call and modify the plan as needed; therefore, the number of coaching calls will vary by each member. In addition to the call structure outlined below, members may initiate calls to their wellness coaches for support throughout the duration of the program and after graduation.The telephonic program does not typically exceed 11 telephone sessions with a wellness coach, plus follow-up calls at 6 months and 12 months.
Stress Management	drop down box	Listbox,ListYNNAExplain	Yes	The program does not typically exceed six coaching calls over eight weeks (in addition to the intake, assessment, and follow-up calls). Should a member need additional support and time in the program, a coach can increase the number of calls or the duration of the program. Members may also initiate calls to their wellness coaches.
Tobacco Cessation	drop down box	Listbox,ListYNNAExplain	Yes	Coaches reassess members for progress at each coaching call and modify the plan as needed; therefore, the number of coaching calls will vary by each member. Depending on stratification, members receive different levels of support. In general, every member receives the following types of calls: • initial registration • stratification assessment (may happen with registration) • coaching calls (four to seven or more) • optional group session call(s) • follow-up call(s)

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Wellness Questionnaire	Answer Format	Format Type	Response	Explanation
Weight Management	drop down box	Listbox,ListYNNAExplain	Yes	Coaches reassess members for progress at each coaching call and modify the plan as needed; therefore, the number of coaching calls will vary by each member. In addition to the call structure outlined below, members may initiate calls to their wellness coaches for support throughout the duration of the program and after graduation. The telephonic program does not typically exceed 11 telephone sessions with a wellness coach, plus follow-up calls at 6 months and 12 months.
Exercise Management	drop down box	Listbox,ListYNNAExplain	Yes	Coaches reassess members for progress at each coaching call and modify the plan as needed; therefore, the number of coaching calls will vary by each member. In addition to the call structure outlined below, members may initiate calls to their wellness coaches for support throughout the duration of the program and after graduation. The telephonic program does not typically exceed 11 telephone sessions with a wellness coach, plus follow-up calls at 6 months and 12 months.
Sleep Disorders	drop down box	Listbox,ListYNNAExplain	Yes	We offer members sleep information through our weight management program telephonically and online. Coaches reassess members for progress at each coaching call and modify the plan as needed, therefore, the number of coaching calls will vary by each member. In addition to the call structure outlined below, members may initiate calls to their wellness coaches for support throughout the duration of the program and after graduation.The telephonic program does not typically exceed 11 telephone sessions with a wellness coach, plus follow-up calls at 6 months and 12 months.
Cholesterol	drop down box	Listbox,ListYNNAExplain	Yes	There is no limit to the number of calls that are made and the frequency.
Blood pressure	drop down box	Listbox,ListYNNAExplain	Yes	There is no limit to the number of calls that are made and the frequency.
Glucose/Pre-diabetes	drop down box	Listbox,ListYNNAExplain	Yes	There is no limit to the number of calls that are made and the frequency.
Family Oriented Programs (if yes, please list available programs in Explanation column)	drop down box	Listbox,ListYNNAExplain	No	
Child Specific Programs (if yes, please list available programs in Explanation column)	drop down box	Listbox,ListYNNAExplain	No	
Ergonomics / workplace safety	drop down box	Listbox,ListYNNAExplain	No	
Other Programs - specify	text	Text	N/A	
Briefly describe your identification/risk stratification approach below.				

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Wellness Questionnaire	Answer Format	Format Type	Response	Explanation
Does the program use self-reported HA data to identify the member's overall level of risk? If yes, specify in the explanation column what risk factors are used to identify/risk stratify members.	drop down box	Listbox,ListYNNAExplain	Yes	The University of Michigan Health Management Research Center Health Assessment (UM-HMRC health assessment) includes measures of demographics, health behaviors, psychological perception, physiological risk, medical and behavioral health status, change status, learning styles, biometric data, and other variables. The major health risk factors are: Health Risks • alcohol • blood pressure • body weight • cholesterol • existing medical problems • HDL cholesterol • illness days • life satisfaction • job satisfaction • perception of health • physical activity • safety belt use • smoking • stress • health age index • drug use (for relaxation) • nutrition
Does the program use validated biometric data to identify the member's overall level of risk? If yes, specify in the explanation column which values are used to identify/risk stratify members.	drop down box	Listbox,ListYNNAExplain	Yes	The University of Michigan Health Management Research Center Health Assessment (UM-HMRC health assessment) includes measures of demographics, health behaviors, psychological perception, physiological risk, medical and behavioral health status, change status, learning styles, biometric data, and other variables. The major health risk factors are: Health Risks • blood pressure • body weight • cholesterol • existing medical problems • HDL cholesterol

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Wellness Questionnaire	Answer Format	Format Type	Response	Explanation
Does the program use medical and/or Rx claims to identify members at risk? If yes, specify in the explanation column what risks are identified via claims and used in the identification/risk stratification process.	drop down box	Listbox,ListYNNAExplain	Yes	• Current and Historical Medical Data - including the current primary diagnosis and frees staff to focus on the conversation with the member, not on documenting information • Medical Claim Highlights - includes dates, diagnosis, and place of service for past medical events; related claims data, such as for behavioral claims • Pharmacy Information - from both internal and external pharmacy programs, lists current and previous prescription medications and automatically calculates medication possession ratios, which can help identify gaps in care
Are members able to self-refer to telephonic coaching programs regardless of risk? If no, briefly explain the program rationale in the explanation column.	drop down box	Listbox,ListYNNAExplain	Yes	
Are members invited to participate in specific coaching programs (i.e. online versus telephonic) based on their level of risk and readiness to change? If yes, briefly explain the approach in the explanation column and the average % of HA participants targeted for each approach.	drop down box	Listbox,ListYNNAExplain	Yes	Please see the Wellness Explanation tab.
The County currently employs health coaches on staff. Would your organization be willing to integrate with the County staff by providing some or all of the operational support for the coaches (identification, system access for documentation, tracking and reporting, fulfillment of educational materials, etc.)? If yes, briefly describe how you would support the onsite health coaches. List any additional fees that would apply.	drop down box	Listbox,ListYNNAExplain	Yes	Cigna's team is designed to collaborate with and provide ongoing support for on staff health coaches. A Health Promotion Manager and Client Engagement Manager is assigned, in addition to an onsite Care Advocate and the Account Manager, to work with coaches, provide them with data from pharmacy, medical, and care management that identifies potential target areas for wellness programs, develop a strategy and report results. These resources, educational materials and seminars for employees about Cigna's products and services are provided at no additional cost.
Do you currently partner with any clients who provide their own onsite coaching? Briefly describe how you support the coaches.	text	Listbox,ListYNNAExplain	Yes	Please see the Wellness Explanation tab.
Can you sponsor/administer "Wellness challenges" periodically throughout the year? (e.g. team or individual based walking challenge, "biggest loser", etc.)	drop down box	Listbox,ListYNNAExplain	Yes	
If so, briefly describe the Wellness challenges that are currently available.	text	Text	Please see the Wellness Explanation tab.	
Are the challenges available online and in paper format?	text	Text	We have both options.	

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Wellness Questionnaire	Answer Format	Format Type	Response	Explanation
Do the County and APS have the ability to create their own challenges and use the wellness portal to support the program (communication, tracking, reporting, etc.)? If yes, describe any additional fees that may apply.	text	Text	Cigna's MotivateMe incentive program offers an easy-to-use online member experience with single sign-on (SSO) through myCigna.com. The program does allow for self report, client created and administered programs. The MotivateMe program has detail reports on member activity that clients can access online and use to facilitate the fulfillment of HSA deposits, premium adjusts, or any other client-administered award type. The ability to administer and track these programs is included in the base fee for the MotivateMe program.	
Indicate other wellness/lifestyle behavior change coaching program delivery methods available (briefly describe using the explanation column):				
Secure email communications	drop down box	Listbox,ListYNNAExplain	Yes	
Text messages	drop down box	Listbox,ListYNNAExplain	No	
Online live chat with a coach	drop down box	Listbox,ListYNNAExplain	No	
Video materials	drop down box	Listbox,ListYNNAExplain	Yes	
Audio materials	drop down box	Listbox,ListYNNAExplain	Yes	
Promotional awareness campaigns	drop down box	Listbox,ListYNNAExplain	Yes	
Smartphone apps	drop down box	Listbox,ListYNNAExplain	Yes	
Other - please specify	drop down box	Listbox,ListYNNAExplain	Not Applicable	
Briefly describe how you increase utilization and keep participants engaged in wellness/lifestyle behavior change programs.	text	Text	Customized communication and education programs designed in partnership with Arlington's HR/Benefits and health coaching staff.	
What do you consider successful completion in your wellness program?				
Online program	text	Text	Please see the Wellness Explanation tab.	
Telephonic coaching	text	Text	Please see the Wellness Explanation tab.	
Will you provide a primary health coach model for telephonic coaching? (i.e. The same coach works with participants throughout the duration of the program.)	drop down box	Listbox,ListYNNAExplain	Yes	
Do the coaches use a "whole person" approach where they manage multiple risks regardless of the program the member originally enrolled in?	drop down box	Listbox,ListYNNAExplain	Yes	
Briefly describe your health coaches' qualifications and training.	text	Text	Please see the Wellness Explanation tab.	
Does your program utilize "enrollment" staff to initially reach out and engage members in coaching?	drop down box	Listbox,ListYNNAExplain	Yes	

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Wellness Questionnaire	Answer Format	Format Type	Response	Explanation
If yes, briefly describe your enrollment staff's qualifications and training.	text	Text	Although not required, a bachelor's degree in a related field is preferred for our engagement specialists. Currently, each member of our staff has obtained at least a bachelor's degree.	Care associates have excellent customer service and communication skills, are well versed in our programs and services, and have a working knowledge of medical terminology, so they may communicate professionally with plan members. We prefer that they have experience in phone-based coaching and experience in the customer service/medical related field. Care associates are specifically trained to determine the callers goals and needs, and then assign the caller to an appropriate clinically trained health advocate.
Do your health coaches accept in-bound calls and place out-bound calls?	drop down box	Listbox.ListInOutBound	Both in-bound/out-bound	
What are your hours of operation and days of operation for member outreach and in-bound calls? Be sure to specify time zones.	text	Text	Lifestyle Management Program Coaches Coaching sessions are scheduled between 8:00 a.m. and 8:00 p.m. Monday through Friday (every time zone) and from 8:00 a.m. to 5:00 p.m. (CST) on Saturdays. Members can self-enroll, 24 hours a day, 7 days a week, 365 days a year. They can also leave messages for their dedicated wellness coach at any time; messages are returned within one business day.	Health Advisor Coaches Health advocates are available between the hours of 9:00 a.m. and 9:00 p.m. Monday through Friday, and 9:00 a.m. to 12:00 noon on Saturday for continental U.S. time zones. In addition, trained nurses are available to assist members with their questions and alleviate their immediate concerns, or help the member select an appropriate level of care, 24 hours a day, 7 days a week, 365 days a year. When members call during times that health advocates are not immediately available, the nurses can refer the caller for follow-up outreach by a health advocate when appropriate, or can arrange for a call back from a health advocate at a specific date and time that is convenient for the member.
How many times do you attempt to call someone to enroll in the program if you are unable to reach them?	text	Text	[illegible] outreach calls will be made.	The Cigna Health Advisor® team staff, or our Direct Connect vendor, make a minimum of three attempts to reach members.
How many letters do you send out if you are unable to make phone contact with the member?	text	Text	Lifestyle Management Program If a member's highest ranked risk is a lifestyle issue related to tobacco, stress, or weight, he or she receives one letter encouraging enrollment in lifestyle management. Any additional attempts at outreach are via phone. Health Advisor We do not send letters for outreach.	
What do you do with individuals who decline the program? Are these members flagged for outreach again later in the program?	text	Text	Please see the Wellness Explanation tab.	
What do you do if the phone number is not correct? Briefly describe your process for acquiring updated phone numbers including use of external agencies to find phone numbers (include name search tool/company used).	text	Text	Please see the Wellness Explanation tab.	

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Wellness Questionnaire	Answer Format	Format Type	Response	Explanation
What follow-up do you provide to the County/APS?	text	Text	For our ASO clients, we can provide an Inaccurate and Missing Phone Number Layout report once per year at no charge. Additional reports will incur an additional charge.	
What is your rate of obtaining correct phone numbers for those whose number is not correct?	text	Text	The average return rate is between 40-60 percent. In some instances, significantly higher.	
What % of HA/Biometric screening participants are targeted for telephonic coaching? Online programs?	text	Text	Lifestyle Management Programs- Results show that between 45-65 percent of people who finish the health assessment are eligible for one of the lifestyle management programs. If an individual's highest ranked risk is a lifestyle issue related to tobacco, stress, or weight, he or she is encouraged through outreach to enroll in lifestyle management. To support the customer's preference, both online and telephonic participation are detailed during outreach.	
Do the County and APS have the flexibility to limit or expand the number of individuals targeted for online and telephonic coaching intervention?	drop down box	Listbox,ListYNNAExplain	See "Explanation"	Lifestyle Management Programs- We are willing to discuss this request for program flexibility, including associated costs. Please note that we are also exploring alternative forms of outreach that include more digital capabilities, with the goal of reaching more members using the communication modality they prefer. The Health Advisor and Personal Health Team -Services do not target a certain number of individuals for program participation. Rather, we focus on identifying any and all individuals who may be eligible for health and wellness outreach and coaching; education and referral coaching; potential gaps in care outreach; and preference sensitive care coaching.
Do the County and APS have the flexibility to alter the stratification criteria to target specific risks (such as tobacco or BMI)?	drop down box	Listbox,ListYNNAExplain	Not Applicable - See "Explanation"	
Is your organization able to provide onsite health education and coaching resources (i.e. nutritionist, diabetes educator, etc.) one day a week (based on the County and APS' discretion) including but not limited to the following:				
Health screening (e.g. dermatologist for skin screening)	drop down box	Listbox,ListYNNAExplain	Yes	
Face to face coaching	drop down box	Listbox,ListYNNAExplain	Yes	
Health education presentations for employees	drop down box	Listbox,ListYNNAExplain	Yes	
Education and enrollment related to wellness program resources	drop down box	Listbox,ListYNNAExplain	Yes	

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Wellness Questionnaire	Answer Format	Format Type	Response	Explanation
If yes, describe any fees related to these services	drop down box	Listbox,ListYNNAExplain		Cigna can provide onsite health and coaching resources. Additional information would be needed to determine if any fees would apply.

INCENTIVE MANAGEMENT	Answer Format	Format Type	Response	Response
Can you administer (track and report on) incentives for the following:				
Non-health plan enrollees?	drop down box	Listbox, ListYNNAExplain	No - See "Explanation"	MotivaSteme is only offered through our myCigna.com platform. Expanding this
Completion of HA	drop down box	Listbox, ListYNNAExplain	Yes	
Completion of biometric screenings	drop down box	Listbox, ListYNNAExplain	Yes	
Participation in or completion of telephonic health coaching programs	drop down box	Listbox, ListYNNAExplain	Yes	
Participation in or completion of online Lifestyle Behavior Change programs	drop down box	Listbox, ListYNNAExplain	Yes	
Participation in or completion of onsite health coaching programs	drop down box	Listbox, ListYNNAExplain	Yes	
Meeting or making progress toward a health goal defined by the member or coach	drop down box	Listbox, ListYNNAExplain	Yes	
Meeting a defined health standard defined by the County and APS (e.g. BMI, cholesterol, blood pressure, glucose, etc.)	drop down box	Listbox, ListYNNAExplain	Yes	
Progress toward meeting a health standard (e.g. loss of 5% of body weight)	drop down box	Listbox, ListYNNAExplain	Yes	
Participation in programs offered by the County and APS or the County and APS's other vendors or at the local onsite level (if participation reports are provided)	drop down box	Listbox, ListYNNAExplain	Yes	
Do any of these incentives require an additional fee? If yes describe the fee.	text	Text	Yes	$1.25 PEPM
Are you able and willing to report information on active program participants to the County and APS and the claims payer (including other than your own organization) that permits administration of the following:				
Reduced premium contribution	drop down box	Listbox, ListYNNAExplain	Yes	
Lower prescription drug co-payments	drop down box	Listbox, ListYNNAExplain	Yes	
Different co-payments/co-insurance for medical services.	drop down box	Listbox, ListYNNAExplain	Yes	
Different HSA contributions	drop down box	Listbox, ListYNNAExplain	Yes	
Are there additional fees for providing incentive reports?	drop down box	Listbox, ListYNNAExplain	No	
Do you offer a points based tracking tool via your website?	drop down box	Listbox, ListYNNAExplain	Yes	

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Wellness Questionnaire	Answer Format	Format Type	Response	Explanation
Does the tool have the flexibility to accept and track both self-reported activity and/or validated activities/data based on the County or APS' preference?	drop down box	Listbox, ListYNNAExplain	Not Applicable	
Can the tool be customized to support the County's or APS' incentive strategy? If yes, briefly describe available customizations.	drop down box	Listbox, ListYNNAExplain	Not Applicable	
Are there additional fees for the points based incentive tracking tool?	drop down box	Listbox, ListYNNAExplain	Not Applicable	
Are there additional fees to customize the tool?	drop down box	Listbox, ListYNNAExplain	Not Applicable	
Is your company able to provide incentive fulfillment for the following? If you partner with a third party to provide incentive fulfillment, indicate the name of your partner in the explanation column.				
Health related merchandise (such as pedometers, resistance bands or fitness equipment)?	drop down box	Listbox, ListYNNAExplain	No - See "Explanation"	We do not offer health related merchandise as part of our MotivateMe program, however, through our Healthy Rewards program members can receive merchandise through our fitness program.
Other merchandise?	drop down box	Listbox, ListYNNAExplain	No - See "Explanation"	We do not offer health related merchandise as part of our MotivateMe program, however, through our Healthy Rewards program members can receive merchandise through our fitness program.
Gift Cards?	drop down box	Listbox, ListYNNAExplain	No - See "Explanation"	We do not offer health related merchandise as part of our MotivateMe program, however, through the Cigna Incentive Points Program offered through the vendor, IncentOne, members can receive gift cards for meeting goals.
Online shopping mall?	drop down box	Listbox, ListYNNAExplain	No - See "Explanation"	We do not offer health related merchandise as part of our MotivateMe program, however, through our Healthy Rewards program members can receive merchandise through our fitness program.

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Wellness Questionnaire	Answer Format	Format Type	Response	Explanation
Briefly describe the incentive options your company has found to yield the greatest results in terms of increased participation and improved outcomes.	text	Text	Based on experience administering incentives, and analysis of higher performing clients, we recommend a multi-year strategy that incorporates several best practices that lead to higher engagement. Year one should be focused on helping employees know and understand their own health status by rewarding health assessment completion and biometric screenings. This should be supported with a strategic communications campaign that educates them about the Cigna health advocacy programs and wellness services available to support them. Year two should focus on continuing health status awareness, and should be expanded to include incentives for participating in health advocacy programs such as lifestyle management and personal health coaching for your high-risk/chronic employees. Year three should move employees to the next level by adding outcome-focused metrics such as biometric outcome incentive for meeting key health markers such as BMI and total cholesterol.	

VENDOR INTEGRATION	Answer Format	Format Type	Response	Explanation
Indicate below how the organization will collaborate to provide integrated delivery of the programs with the County and APS, their onsite clinic and their other health care initiatives or vendors.				
Warm transfer to onsite clinic and other vendors	drop down box	Listbox, ListYNNANoExplain	Yes	Due to HIPAA we need a signed release in order to do so.
Accept inbound warm transfers	drop down box	Listbox, ListYNNANoExplain	Yes	Due to HIPAA we need a signed release in order to do so.
Send referrals to the onsite clinic and other vendors via fax or secure email with member consent.	drop down box	Listbox, ListYNNANoExplain	Yes	At the time of program implementation we coordinate with our clients and their external vendor partners to establish standard procedures for communication, process flows, data exchange protocols, and collaborative referral procedures. We create management processes that enable us to outline the responsibilities of each program/party, and determine the technical processes that allow us to share appropriate information. Phone numbers, fax numbers, and secured email addresses are exchanged during this process.

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Wellness Questionnaire	Answer Format	Format Type	Response	Explanation
Accept inbound referrals via fax or secure email and provide outreach to members based on the referral.	drop down box	Listbox, ListYNNANoExplain	Yes	Cigna can receive secure electronic data feeds into our technology infrastructure from client health centers for follow-up and care coordination purposes. Accepted data formats include FTP- or Excel-based files.
Develop a hierarchy for program outreach with the County and APS, the County's onsite clinic and other health management programs such as case management and condition management, regardless of which health plan the member is enrolled in.	drop down box	Listbox, ListYNNANoExplain	Yes	At the time of program implementation we coordinate with our clients and their external vendor partners to establish standard procedures for communication, process flows, data exchange protocols, and collaborative referral procedures. We create management processes that enable us to outline the responsibilities of each program/party, and determine the technical processes that allow us to share appropriate information. Phone numbers, fax numbers, and secured email addresses are exchanged during this process.
Provide participation reports to the County and APS' other vendors to support the integrated program.	drop down box	Listbox, ListYNNANoExplain	Yes	At the time of program implementation we coordinate with our clients and their external vendor partners to establish standard procedures for communication, process flows, data exchange protocols, and collaborative referral procedures. We create management processes that enable us to outline the responsibilities of each program/party, and determine the technical processes that allow us to share appropriate information. Phone numbers, fax numbers, and secured email addresses are exchanged during this process.
Participate in monthly calls to discuss program administration and member cases?	drop down box	Listbox, ListYNNANoExplain	Yes	At the time of program implementation we coordinate with our clients and their external vendor partners to establish standard procedures for communication, process flows, data exchange protocols, and collaborative referral procedures. We create management processes that enable us to outline the responsibilities of each program/party, and determine the technical processes that allow us to share appropriate information. Phone numbers, fax numbers, and secured email addresses are exchanged during this process.

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Wellness Questionnaire	Answer Format	Format Type	Response	Explanation
Track and report inbound and outbound referral activity and disposition?	drop down box	Listbox,ListYNNAExplain	Yes	At the time of program implementation we coordinate with our clients and their external vendor partners to establish standard procedures for communication, process flows, data exchange protocols, and collaborative referral procedures. We create management processes that enable us to outline the responsibilities of each program/party, and determine the technical processes that allow us to share appropriate information. Phone numbers, fax numbers, and secured email addresses are exchanged during this process.

REPORTING	Answer Format	Format Type	Response	Explanation
Attach one sample of all standard reports that would be provided to the County and APS. Name the file: [Your Organization's Name]_Wellness Sample Reports M-5	drop down box	Listbox, ListAttachedNAExplain	Attached	
Do the standard reports include the following:				
Activity and participation results for all program components including HA, biometric screening, coaching programs, online tools/program/portal activity, challenges, onsite programs.	drop down box	Listbox, ListYNNAExplain	Yes	These reports are provided as part of our health assessment,biometric screening, and consultative analytical platform (CAP) reports. CAP reporting is provided on an annual basis.
Population health risks by risk level (based on HA and biometric screening results)	drop down box	Listbox, ListYNNAExplain	Yes	These reports are provided as part of our health assessment and biometric screening reports as part of our CAP reporting.
Population health risks by individual risk factor (based on HA and biometric screening results)	drop down box	Listbox, ListYNNAExplain	Yes	These reports are provided as part of our health assessment and biometric screening reports as part of our CAP reporting.
Readiness to change	drop down box	Listbox, ListYNNAExplain	Yes	These report are part of our Your Health First activitly and outcome reportinga as part of our CAP reports.
Self-reported productivity results	drop down box	Listbox, ListYNNAExplain	Yes	These report are part of our Your Health First activitly and outcome reportinga as part of our CAP reports.
Year over year shifts in risk levels and readiness to change.	drop down box	Listbox, ListYNNAExplain	Yes	These report are part of our Your Health First activitly and outcome reportinga as part of our CAP reports.
Goals met	drop down box	Listbox, ListYNNAExplain	Yes	These report are part of our Your Health First activitly and outcome reportinga as part of our CAP reports.
Member satisfaction	drop down box	Listbox, ListYNNAExplain	Yes	These report are part of our Your Health First activitly and outcome reportinga as part of our CAP reports.
Are reports exportable to Excel, text, or csv file format to allow the County and APS to manipulate the data?	drop down box	Listbox, ListYNNAExplain	No - See "Explanation"	Our CAP reports will continue to be provided in person by your designated informatics consultant.

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Wellness Questionnaire	Answer Format	Format Type	Response	Explanation
For each report included in the sample reporting package provided, indicate the name of the report, describe the information reported and the frequency of the issuance of the report. Up to 5 reports can be described below; if you need more space, use the "Explanation" column and/or worksheet. Indicate the question answered.				
Standard Report #1: Report Name	text	Text	Consultative Analytic Platform (CAP) Reporting	
Standard Report #1: Description	text	Text	Please refer to the Wellness Explanation tab.	
Standard Report #1: Frequency	drop down box	Listbox, ListStandReportFreq	Annually	
Standard Report #1: Format/File Type	drop down box	Listbox, ListStandReportFileType	This report is provided in person by the Informatics Consultant	
Standard Report #2: Report Name	text	Text		N/A
Standard Report #2: Description	text	Text		N/A
Standard Report #2: Frequency	drop down box	Listbox, ListStandReportFreq		N/A
Standard Report #2: Format/File Type	drop down box	Listbox, ListStandReportFileType		N/A
Standard Report #3: Report Name	text	Text		N/A
Standard Report #3: Description	text	Text		N/A
Standard Report #3: Frequency	drop down box	Listbox, ListStandReportFreq		N/A
Standard Report #3: Format/File Type	drop down box	Listbox, ListStandReportFileType		N/A
Standard Report #4: Report Name	text	Text		N/A
Standard Report #4: Description	text	Text		N/A
Standard Report #4: Frequency	drop down box	Listbox, ListStandReportFreq		N/A
Standard Report #4: Format/File Type	drop down box	Listbox, ListStandReportFileType		N/A
Standard Report #5: Report Name	text	Text		N/A
Standard Report #5: Description	text	Text		N/A
Standard Report #5: Frequency	drop down box	Listbox, ListStandReportFreq		N/A
Standard Report #5: Format/File Type	drop down box	Listbox, ListStandReportFileType		N/A
Will County/APS's specific results be compared to:				
National averages (as appropriate)	drop down box	Listbox, ListYNNAExplain	Yes	
Your book of business results	drop down box	Listbox, ListYNNAExplain	Yes	
The County and APS's industry - local government	drop down box	Listbox, ListYNNAExplain	Yes	
The County and APS may require reporting at a business unit level, and perhaps at a sub-unit level. Indicate how many reporting segments are included in your pricing.	drop down box	Text	Please refer to the Wellness Explanation tab.	

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Explanation

This worksheet should be used to provide additional explanations for any questions for which a "See Explanation" response was given. Explanations must be numbered to correspond to the question to which they pertain and they must be brief.

Section/ Question #	Explanation
I/ #7	As part of the Health Promotion and Awareness Program, Arlington County Government and Arlington Public Schools' Client engagement manager will willingly visit Arlington County Government and Arlington Public Schools' locations and present complimentary, introductory health seminars, upon request. Our Health Promotion and Awareness Program is provided to Arlington County Government and Arlington Public Schools at no additional charge. Cigna can also provide the following onsite wellness services at Arlington County Government an Arlington Public Schools locations for additional fees: • Onsite Biometric Screening Events - The highly effective health screening packages help identify prevalent conditions including hypertension, elevated glucose levels, and elevated cholesterol levels. These screenings are presented directly by Summit Health. • Onsite Flu Clinics - This seasonal immunization positively impacts the overall health and wellness of the employee population. These immunizations are presented directly by Summit Health. • Onsite In-depth Wellness Seminars - We closely analyze the workforce and biometric screening results to determine which of the over 65 available seminar topics are most suitable for certain populations at various locations. • Onsite Coaching - Cigna provides full-time, part-time, or hourly worksite health coaching. • Onsite Lifestyle Management Programs - The Metabolic Syndrome Improvement Program is a multi-modal lifestyle improvement program that offers members the education and tools to incorporate healthier nutritional and physical activity habits into their lives, and to sustain these changes as life-long commitments. Health Awareness Days A health awareness day event (sometimes called a health fair) gives Arlington County Government and Arlington Public Schools the opportunity to provide its employees and their family members the following services: • disseminate health information • raise awareness of targeted health issues • provide demonstrations of healthy practices • provide preventive health screenings and immunizations • inform participants about available wellness program resources Arlington County Government and Arlington Public Schools can use designated wellness fund money to pay for the above services. Every service can be provided to spouses and adult dependents, upon client request.
II/ 1d.	The content of the University of Michigan Health Management Research Center Health Assessment (UM-HMRC health assessment) questionnaire and algorithms that comprise the Trend Management System™ (TMS) have been developed over the past 25 years by Dr. Dee Edington and his colleagues at the UM-HMRC. Both the UM-HMRC health assessment questionnaire and the TMS analytic engine ar based on extensive research (more than 140 published papers in peer-reviewed medical journals) on the relationship of health risks to future health care, disability, and lost productivity costs.
II/ # 15	Our long-term agreement with the University of Michigan gives us access to intellectual property developed by Professor D.W. Edington, PhD, and the researchers within the UM-HMRC, including the following advantages in identifying members at risk: • exclusive access to UM-HMRC's TMS and risk clustering analysis • a unique ability to predict into the future, with 83 percent accuracy, which members will become the next high utilizers of health care services based on their risk combinations

II/ # 12	After taking the University of Michigan Health Management Research Center Health Assessment (UM-HMRC health assessment), members are stratified using a three-step process. The first is stratification into the following health risk levels: • low (0 – 2 health risks) • medium (3 – 4 health risks) • high (more than 5 health risks) The next step is risk clustering, where members are grouped into 1 of 4 groups and then into 1 of 240 subgroups. The four main groups include: • low/no risk • biometric • risk taking (missing preventive exams, driving without seatbelt or over speed limit) • psychological Finally, the member is assigned an outreach or active participation strategy depending on their risk level and cluster. The strategies includ • preventive care • risk reduction • risk avoidance • disease management • readiness to change Members who take the UM-HMRC health assessment receive feedback via the member profile report and information about any appropria online coaching program. If the responses show that the member might be helped from a health coaching program (disease management, lifestyle management, or health coach) the member is referred for the appropriate outreach.
III/ # 11	The first component of Cigna Mobile addresses the long tail of smartphone devices that are serviced via Cigna's mobile web (www.Cigna.com and myCigna.com), and currently includes access to the health care professional directory, urgent care center locations, drug price quotes, and account balance information. This is a not a "one size fits all" approach, but instead optimizes the display based on the member's own device. Cigna Mobile Web is accessible via any mobile device with a web browser versus a downloaded application. Therefore, we can ensure greater access via most mobile devices from the iPhone, to Android, to Blackberry, and more. It also leverages the native GPS capabilities available in a smartphone to display doctors and pharmacies "near me." A responsive myCigna.com mobile website was rolled out in May of 2013. It replaces the existing mobile website that has limited functionality with the more robust functionality available on myCigna.com. It uses with the latest responsive design technology to be fully optimized for the device the customer is using, making the mobile site easier to read and navigate with minimal resizing, panning, and scrolling. All the features currently available on myCigna.com are available on the new responsive myCigna mobile web.

III/ #4	Cigna is developing a digital engagement platform that leverages the technology and methods used in popular social networking, health devices, and online gaming products to help members improve their health. This new digital engagement platform is now in a pilot phase, targeted for a phased release beginning late 2013 through 2014, and wide-market availability by January of 2015. Access to the product during the phased release (soft launch) will be a gating process and only qualified clients will have initial access. This digital engagement platform is the foundation for a new Cigna product with the features noted below: Simple and Fun Health Assessment - Members earn rewards ("coins") for completing every five to six questions in the health assessment keep them motivated. Questions are simple and easy and contain images for those who do not read English well to ensure a client's entire population can finish it. Health and Wellness Social Networks - Members can enjoy the support and encouragement of peers in a variety of online communities geared toward their health and wellness needs. A Cigna coach supports these online communities where members share ideas, as well as give and receive support to others of like mind or interest. Common topics include weight, nutrition, and even chronic conditions such as diabetes. Members can voluntarily join a community, be invited based on their health assessment, and they can also be encouraged to join by their over-the-phone coach. Individual and Group Online Challenges - Members can participate in individual or group challenges that help make achieving their specific health goals fun and easy. Simple challenges can range from drinking more water to exercising regularly. Also, tracking is easy. Members can connect common fitness trackers and simply upload their information, or they can add their activity manually. Like the communities, members can self enroll, get invited, or be referred by a coach—getting fit has never been easier. Health News Feeds - Members will receive personalized recommendations for news from objective sources based on their health assessment—like Cooking Light and Shape Magazine—which educate them on topics such as losing weight, nutrition, and managing chronic conditions such as diabetes. Rewards - Completing almost any healthy activity on the platform can earn rewards, such as coins to redeem for merchandise on the platform's website. Clients have the ability to select the reward option that meets their company goals and the needs of the members. Reward options available include coins, deposits, and premium adjustments.
III/ #8	Future updates to myCigna.com will include: • Our "manage my claims" coverage dashboard will offer a snapshot view of the member's account/deductible/incentive balance informatic recent account transactions, and claim status alerts (paid/pending/denied/owe for medical, dental, pharmacy, behavioral health, and visior • We will further enhance our multilingual experience through extensive development spanning every aspect of the site for members and their dependents. • The My Health Dashboard (currently in pilot phase) is an enhanced feature on myCigna.com that provides each member with a focused, organized story around their health—based on their values and goals. The dashboard features a personalized snapshot of member health information and key health advocacy programs; it also identifies important tests, prescription refills, vaccines, or health screenings that ma be due based on claim history. Members can further customize their dashboard (using their medium of choice) to prioritize their goals and what actions they want to take first on their path to better health. Cigna's mobile capabilities will continue to evolve and new features will be pushed to the myCigna.com mobile app throughout 2013 and 2014. Plans include Spanish capabilities, integration with our members' personal health record (PHR), simplified coverage information, voice navigation, and integration with Cigna's digital ecosystem of applications. Over the next 12-60 months, we also plan to drive deeper customer engagement via mobile devices through the enhancements listed below: • comprehensive cost and quality comparisons for informed health care decisions • a "medicine cabinet" (pill reminders, drug interaction alerts, allergy diary, etc.) • personal trackers, diaries and journals, biometrics tracking, and tracking via wellness programs (weight, tobacco, stress, sleep, nutrition, and fitness) • application-programming interface for simple integration between the most popular health and wellness apps and Cigna coaches and systems • device integration, so that devices used to monitor glucose, sleep, exercise, etc., are seamlessly integrated with Cigna coaches/systems • incentives tracking integration - sending mobile data to web engine • share personal health records while at a doctor's appointment • social networking and live/virtual chat, including: - health care professional precertification and health care professional directory - click-to-chat for coaching programs - policy quotes and renewals

IV/ #4	After taking the University of Michigan Health Management Research Center Health Assessment (UM-HMRC health assessment), members are stratified using a three-step process. The first is stratification into the following health risk levels: • low (0 – 2 health risks) • medium (3 – 4 health risks) • high (more than 5 health risks) The next step is risk clustering, where members are grouped into 1 of 4 groups and then into 1 of 240 subgroups. The four main groups include: • low/no risk • biometric • risk taking (missing preventive exams, driving without seatbelt or over speed limit) • psychological Finally, the member is assigned an outreach or active participation strategy depending on their risk level and cluster. The strategies includ • preventive care • risk reduction • risk avoidance • disease management • readiness to change Members who take the UM-HMRC health assessment receive feedback via the member profile report and information about any appropria online coaching program. If the responses show that the member might be helped from a health coaching program (disease management, lifestyle management, or health coach) the member is referred for the appropriate outreach. All members are approached for any one of our coaching programs.
IV/#5a	Cigna willingly coordinates with external parties and uses information provided by external client programs, including but not limited to the following plan coverages and services: onsite wellness initiatives, fitness facilities, onsite health centers, work safety programs, and/or incentives initiatives. This coordination allows Cigna to gain a better understanding of member health care and available initiatives. When onsite health centers share data with us, we are able to use that data during phone-based, member-clinician coaching sessions. This data coordination allows us to stay informed of what a member is experiencing, and adjust member outreach and/or programs accordingly. The coordination between Cigna and an external vendor is successful when the various companies collaborate to establish the criteria for referrals and points of contact and associated workflows. Onsite staff members should act as an extension of Arlington County Governmer and Arlington Public Schools' Cigna medical team, heavily promoting Arlington County Government and Arlington Public Schools-provided programs, educating members about the services delivered by the programs, and identifying opportunities to refer members to our programs via warm transfers. During the implementation phase of a client's selected programs and services, we create management processes that enable us to outline the responsibilities of each program, and determine the technical processes that allow us to share appropriate information. Phone numbers, fax numbers, and secured email addresses are each identified during this process. Additional charges may apply, but a complete review of the interface request is required before fees can be finalized.
IV/#6a	We have multiple wellness challenge options. The first are four manual challenges available at no cost which run from 6 to 8 weeks - Maintain Don't Gain, Make Fitness Fun, Resolution Revolution, and Strive for Five. We also have multiple online challenges rolling out 1/1/14 on a variety of topics both on an individual and group level.
IV/ #11a&b	Tobacco Cessation - Cigna Quit Today-Today, participants finish the program by accessing and completing every module of the online program and zero use on Tobacco Tracker or finishing every step of the program (accessing and interacting each of the six steps and information contained within the modules, i.e., articles, downloads). Participants finish the program by entering tobacco usage on the sixth and final module of the online program. Stress Management - Strength & Resilience-Participants finish the program by accessing articles on three unique dates over the eight weeks of the program. Weight Loss - Cigna Healthy Steps to Weight Loss-Entering in weight and waist measurement in the 12th and final module of the online program This response is specific to our Lifestyle Management Programs. When it comes to our other online wellness coaching programs, membe do not graduation from these programs since the online program is self-guided, members end participation in the programs on their own.

IV/ #14	Provided below are the qualifications and training for our Lifestyle Management Program coaches: Wellness Coach Qualifications Wellness coaches are trained health professionals with a minimum of a bachelor's degree in psychology, nursing, counseling, health education, or related social services fields. Coaches are hired for a primary specialty (weight, stress, and tobacco) based on their skill sets and experience, and are initially trained fo that specific program. Once they have successfully completed our CARE coach training and are functioning at a high level of competence, we offer the option of cross-training for additional programs. Wellness Coach Initial Training Wellness coaches are trained in motivational interviewing, coaching methodology, cognitive behavioral treatment modalities, and lifestyle management program practice guidelines. Wellness coaches complete over 150 hours of training before engaging members. Additionally, every new employee participates in an extensive series of orientation and training sessions within the first month of hire. We maintain a formal document to track the new employee's progress and ensure a successful orientation. The Cigna CARE Coaching® model, featuring collaborative, affirming, respectful, and empowering coaching, is a foundational training approach for our health advocates. The model is adaptable to unique characteristics, including diverse ethnic groups, regional areas, cultural groups, and socio-economic levels. The techniques applied for each member depend upon the needs of his or her current situation, and the lifestyle changes that the member wants to achieve and sustain. Specific to the Cigna Health Advisor® and our Personal Health Team programs, the majority of introduction calls are made by our Direct Connect service; however, some calls may be handled by Cigna staff. Incoming calls are taken by care associates, who determine when calls should be transferred to a health advocate nurse, a health educator, or someone else on the team of experts. These associates also assist with a variety of general requests such as educating members about available health resources, web tools, and internal programs, and referring members to these resources when appropriate.
IV/ #19	Lifestyle Management Program-If a member is not receptive to coaching initially, using an opt-out approach allows us to reach out in the future as new information becomes available to us and/or as the member's willingness to participate changes. At any time, members (including those who do not complete the Cigna health assessment) may self-refer to the lifestyle management program by calling the toll-free enrollment number or accessing an online link to self-enroll. Health Advisor-If we are unable to reach the member after these attempts or the member has not placed a return call or declined the program we reach out to them in the future with the same or a different risk or condition. We open a new case, as people's willingness to engage with a coaching program can change over time.
IV/ #20	The best strategy for obtaining accurate phone numbers is through the client's eligibility data. For those members we are unable to reach due to incorrect or unavailable phone numbers, automated Direct Connect technology uses an external vendor to obtain current phone number information. The vendor maintains the correct phone number in the event a member is included in a subsequent data file with the original incorrect phone number. The vendor's data analyst updates the two files to avoid unnecessary additional searches for the same correct phone number.
IV/ #23	Lifestyle Management Programs-Our stratification model cannot be altered. Health Advisor Program-For Health Advisor health and wellness coaching, when a member's health assessment responses trigger for topics or conditions that are the focus of the Health Advisor program, the assigned risk intervention level is dependent upon the responses inclusive of indications of the member's willingness to change. All members that are considered high or moderate risk based on health assessment responses receive telephonic outreach. Predictive modeling (claims and imaging) identifies and stratifies members for preference sensitive care (PSC) coaching. Those members identified as high or moderate risk from the PSC predictive model (e.g., in decision making window) receive telephonic outreach. We do not provide telephonic outreach to those determined to be at low risk. Our experience tells us that these individuals are not likely to move into a decision making window. All members identified for pre-diabetes receive an outbound call via Direct Connect technology (i.e., stratification does not apply for the purposes of determining outreach).

VII/ #3a	We recognize our clients' need for superior reporting and analysis software so that they are equipped to make health care decisions that maximize their investment. Our approach is to provide industry-leading reporting capabilities supported by consultation. Our Consultative Analytical Platform is Cigna's primary tool for developing consultative reviews with clients and producers. This report is produced through our Consultative Analytics, an industry-leading reporting capability based upon a data model that accumulates information at a member-level across eligibility, claims (medical and pharmacy), clinical outcomes, and individual interactions (for example, the University of Michig Health Management Research Center [UM-HMRC] health assessment and customer website usage). Our consultative approach, along with the Consultative Analytics reporting package and the option of additional ad hoc reporting delivers value to our clients by assessing performance across three critical dimensions: • Operational effectiveness – Is the plan performing optimally? • Strategic opportunities – Are there investment opportunities to mitigate plan cost and improve member health? • Outcomes evaluation – Is Cigna delivering value for the programs and solutions that are in place? Although this capability is flexible and can be tailored to address Arlington County Government and Arlington Public Schools' key areas of interest, the consultative package offers the following standard analytical reports: • Financial summary – an analysis of financial cost and trend, and key trend drivers • Assessment of outliers – an assessment of trend driven by high cost claimants or population changes • Population profile – an assessment of risk based upon claims data, lab data, and UM-HMRC health assessment data • Preventive care compliance summary – an assessment of the use of preventive services and compliance with therapies for key conditior • Service category analysis – a detailed drill-down analysis into inpatient, outpatient and professional categories • Cost quality results – an assessment of the use of services that have a high variability of cost and/or quality • Clinical summary – showing activities and savings associated with Cigna's clinical management programs Since the reporting capability is built upon a member-level framework, numerous analyses can be assessed to perform root cause analysi Examples include: • Health status – chronic, episodic, and health • Health condition – cancer, diabetes, and cardiac • Type of service – prevention, acute, and maintenance • Population type – existing members, new members, and termed members • Organizational division – salary, hourly, and union The Consultative Analytical Platform report is prepared annually.
VIII/#5	Cigna's reporting solutions can be configured based upon client structure information. For instance, reporting can be specifically based upon the coverage option code and the branch code. These structure codes can then be assigned to up to three dimensions including pla type, status group, and division. A common example would be to assign plan type (e.g., HMO or PPO), status groupings (e.g., actives and retirees), and a divisional or geographic grouping (e.g., management, operations, part-time). Configuration is performed during account implementation and can be changed at any time to meet client preferences. These specific client dimensions can then be reported throug Cigna reporting programs. Note that structure assignments can be 'grouped' into logical reporting schemas; however, requests to produce multiple report 'cuts' (exceeding three per client per reporting period) may incur additional charges.

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I.		Offeror Accreditations	Answer Format	Format Type	Response	Explanation
	1.	Does your firm currently have URAC accreditation for:				
	a.	Pharmacy Benefit Management	drop down box	Listbox, ListYNNoExplain	Yes	
	b.	Specialty Pharmacy	drop down box	Listbox, ListYNNoExplain	No - See "Explanation"	Cigna Pharmacy Management's URAC accreditation is for our core pharmacy benefit management business only. This does not include our specialty pharmacy program. We are hoping to pursue accreditation for specialty pharmacy services in 2013.
	c.	Mail Service Pharmacy	drop down box	Listbox, ListYNNoExplain	No - See "Explanation"	Cigna Pharmacy Management's URAC accreditation is for our core pharmacy benefit management business only. This does not include our home delivery program. We are hoping to pursue accreditation for mail order services in 2013.
	2.	NCQA Disease Management Program Accreditation	drop down box	listbox, ListNCQADMAcc	Patient & Practitioner Accreditation	
	a.	Expiration date of accreditation/certification.	date	date	July 1, 2013	
	3.	List any other accreditations for which your organization has been certified:	text	Text	NCQA Certified - All Products URAC - All Products VIPPS Certified - Cigna Home Delivery Pharmacy	

		Services Overview	Answer Format	Format Type	Response	Explanation
	4.	Do you subcontract any of the following services?	drop down box	ListYesNo	Yes	
	a.	**Appeals Processing:**	drop down box	Listbox, ListDeliver	In-House	
		Name of Contracted Vendor, if outsourced/subcontracted	Text	Text	Not applicable.	
		Exclusive Relationship? (Yes / No)	drop down box	ListYesNo	Not applicable.	
		Effective Date of Subcontract	Month Day, Year	Date	Not applicable.	
	b.	**Biotech / Specialty Pharmacy Distribution or Management**	drop down box	Listbox, ListDeliver	In-House	
		Name of Contracted Vendor, if outsourced/subcontracted	Text	Text	Not applicable.	
		Exclusive Relationship? (Yes / No)	drop down box	ListYesNo	Not applicable.	
		Effective Date of Subcontract	Month Day, Year	Date	Not applicable.	
	c.	**Communications**	drop down box	Listbox, ListDeliver	In-House	
		Name of Contracted Vendor, if outsourced/subcontracted	Text	Text	Not applicable.	
		Exclusive Relationship? (Yes / No)	drop down box	ListYesNo	Not applicable.	
		Effective Date of Subcontract	Month Day, Year	Date	Not applicable.	
	d.	**Customer Service / Call Center**	drop down box	Listbox, ListDeliver	In-House	
		Name of Contracted Vendor, if outsourced/subcontracted	Text	Text	Not applicable.	
		Exclusive Relationship? (Yes / No)	drop down box	ListYesNo	Not applicable.	
		Effective Date of Subcontract	Month Day, Year	Date	Not applicable.	

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e.	**Data Warehousing / Integration**	drop down box	Listbox, ListDeliver	In-House	
	Name of Contracted Vendor, if outsourced/subcontracted	Text	Text	Not applicable.	
	Exclusive Relationship? (Yes / No)	drop down box	ListYesNo	Not applicable.	
	Effective Date of Subcontract	Month Day, Year	Date	Not applicable.	
f.	**Disease Management**	drop down box	Listbox, ListDeliver	In-House	
	Name of Contracted Vendor, if outsourced/subcontracted	Text	Text	Not applicable.	
	Exclusive Relationship? (Yes / No)	drop down box	ListYesNo	Not applicable.	
	Effective Date of Subcontract	Month Day, Year	Date	Not applicable.	
g.	**Electronic Claim Processing/Adjudication**	drop down box	Listbox, ListDeliver	Subcontracted/Outsourced	
	Name of Contracted Vendor, if outsourced/subcontracted	Text	Text	Argus Health Systems	
	Exclusive Relationship? (Yes / No)	drop down box	ListYesNo	No	
	Effective Date of Subcontract	Month Day, Year	Date	1991	
h.	**Eligibility Maintenance**	drop down box	Listbox, ListDeliver	In-House	
	Name of Contracted Vendor, if outsourced/subcontracted	Text	Text	Not applicable.	
	Exclusive Relationship? (Yes / No)	drop down box	ListYesNo	Not applicable.	
	Effective Date of Subcontract	Month Day, Year	Date	Not applicable.	
i.	**File Backup - System Security**	drop down box	Listbox, ListDeliver	In-House	
	Name of Contracted Vendor, if outsourced/subcontracted	Text	Text	Not applicable.	
	Exclusive Relationship? (Yes / No)	drop down box	ListYesNo	N/A	
	Effective Date of Subcontract	Month Day, Year	Date	Not applicable.	
j.	**Formulary Management:**	drop down box	Listbox, ListDeliver	In-House	
	Name of Contracted Vendor, if outsourced/subcontracted	Text	Text	Not applicable.	
	Exclusive Relationship? (Yes / No)	drop down box	ListYesNo	Not applicable.	
	Effective Date of Subcontract	Month Day, Year	Date	Not applicable.	
k.	**Generic "MAC" List Establishment and Maintenance**	drop down box	Listbox, ListDeliver	In-House	
	Name of Contracted Vendor, if outsourced/subcontracted	Text	Text	Not applicable.	
	Exclusive Relationship? (Yes / No)	drop down box	ListYesNo	Not applicable.	
	Effective Date of Subcontract	Month Day, Year	Date	Not applicable.	
l.	**ID Card Production and Distribution**	drop down box	Listbox, ListDeliver	Subcontracted/Outsourced	
	Name of Contracted Vendor, if outsourced/subcontracted	Text	Text	Our vendor agreement precludes us from disclosing the name of our vendor.	
	Exclusive Relationship? (Yes / No)	drop down box	ListYesNo	No	
	Effective Date of Subcontract	Month Day, Year	Date	1988	
m.	**Mail Order Dispensing/Fulfillment**	drop down box	Listbox, ListDeliver	In-House	
	Name of Contracted Vendor, if outsourced/subcontracted	Text	Text	Not applicable.	
	Exclusive Relationship? (Yes / No)	drop down box	ListYesNo	Not applicable.	
	Effective Date of Subcontract	Month Day, Year	Date	Not applicable.	
n.	**Network Pharmacy Credentialing/Re-credentialing**	drop down box	Listbox, ListDeliver	In-House	
	Name of Contracted Vendor, if outsourced/subcontracted	Text	Text	Not applicable.	

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	Exclusive Relationship? (Yes / No)	drop down box	ListYesNo	Not applicable.	
	Effective Date of Subcontract	Month Day, Year	Date	Not applicable.	
o.	**Pharmacy and Therapeutic (P&T) Committee**	drop down box	Listbox, ListDeliver	In-House	
	Name of Contracted Vendor, if outsourced/subcontracted	Text	Text	Not applicable.	
	Exclusive Relationship? (Yes / No)	drop down box	ListYesNo	Not applicable.	
	Effective Date of Subcontract	Month Day, Year	Date	Not applicable.	
p.	**Paper Claim Processing**	drop down box	Listbox, ListDeliver	In-House	
	Name of Contracted Vendor, if outsourced/subcontracted	Text	Text	Not applicable.	
	Exclusive Relationship? (Yes / No)	drop down box	ListYesNo	Not applicable.	
	Effective Date of Subcontract	Month Day, Year	Date	Not applicable.	
q.	**Pharmacy Auditing**	drop down box	Listbox, ListDeliver	Subcontracted/Outsourced	
	Name of Contracted Vendor, if outsourced/subcontracted	Text	Text	ACS Audit and Compliance Solutions	
	Exclusive Relationship? (Yes / No)	drop down box	ListYesNo	No	
	Effective Date of Subcontract	Month Day, Year	Date	2008	
r.	**Reporting**	drop down box	Listbox, ListDeliver	In-House	
	Name of Contracted Vendor, if outsourced/subcontracted	Text	Text	Not applicable.	
	Exclusive Relationship? (Yes / No)	drop down box	ListYesNo	Not applicable.	
	Effective Date of Subcontract	Month Day, Year	Date	Not applicable.	
s.	**Utilization Review**	drop down box	Listbox, ListDeliver	In-House	
	Name of Contracted Vendor, if outsourced/subcontracted	Text	Text	Not applicable.	
	Exclusive Relationship? (Yes / No)	drop down box	ListYesNo	Not applicable.	
	Effective Date of Subcontract	Month Day, Year	Date	Not applicable.	
t.	**Coordination of Benefits**	drop down box	Listbox, ListDeliver	In-House	
	Name of Contracted Vendor, if outsourced/subcontracted	Text	Text	Not applicable.	
	Exclusive Relationship? (Yes / No)	drop down box	ListYesNo	Not applicable.	
	Effective Date of Subcontract	Month Day, Year	Date	Not applicable.	
u.	**Other, specify**	drop down box	Listbox, ListDeliver	Subcontracted/Outsourced	
	Name of Contracted Vendor, if outsourced/subcontracted	Text	Text	DRX	DRX (formally DestinationRx) provides our Prescription Drug Price Quote Tool. Available on myCigna.com, this tool allows members to check their out-of-pocket costs for a specific prescription drug through any of our network pharmacies and/or Cigna Home Delivery Pharmacy. The tool also provides members with more affordable generic and therapeutic medication equivalents.
	Exclusive Relationship? (Yes / No)	drop down box	ListYesNo	No	
	Effective Date of Subcontract	Month Day, Year	Date	2,007	
5.	**If your organization is a healthcare organization, are you willing to offer PBM services on a stand-alone basis (e.g., unbundled from any other healthcare coverage)?**				

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b.	For self-insured Employer Clients?	drop down box	Listbox, ListYNNoExplain	Yes	

II.	TECHNICAL QUESTIONNAIRE BENEFIT COVERAGE/PLAN DESIGN	Answer Format	Format Type	Response	Explanation
1.	**Confirm your firm's ability to administer the following plan designs even though some may not be part of the current benefit design, but may be considered in the future:**				
a.	The proposed plan design (see the "Plan Design" Worksheets)	drop down box	Listbox, ListYNNoExplain	Yes	
b.	Co-insurance at Retail	drop down box	Listbox, ListYNNoExplain	Yes	
c.	Co-insurance at Mail	drop down box	Listbox, ListYNNoExplain	Yes	
d.	Mixed copayments at Retail (fixed dollar and coinsurance)	drop down box	Listbox, ListYNNoExplain	Yes	
e.	Mixed copayments at Mail (fixed dollar and coinsurance)	drop down box	Listbox, ListYNNoExplain	Yes	
f.	Coinsurance with Min/Max amounts per Rx	drop down box	Listbox, ListYNNoExplain	Yes	
g.	Annual OOP maximums per person	drop down box	Listbox, ListYNNoExplain	Yes	
h.	OOP max per Rx	drop down box	Listbox, ListYNNoExplain	Yes	
i.	Therapeutic Class "MAC's"	drop down box	Listbox, ListYNNoExplain	Yes	
j.	Reverse copays (i.e. Client pays fixed amount, member pays the rest)	drop down box	Listbox, ListYNNoExplain	No	
k.	Greater than four tiers	drop down box	Listbox, ListYNNoExplain	No	
l.	Coverage of OTC products	drop down box	Listbox, ListYNNoExplain	No - See "Explanation"	Cigna does not typically provide coverage for OTC products.
m.	Waive copays for the first x-number of fills	drop down box	Listbox, ListYNNoExplain	Yes	
n.	Value based design with reduced or waived copays for certain drug classes	drop down box	Listbox, ListYNNoExplain	Yes	
o.	Copays based on previous drug trials (e.g., higher copay if claims history does not include trial of first-line/preferred drug/drug class)	drop down box	Listbox, ListYNNoExplain	Yes	
p.	Copay incentives based on place of service (e.g., preferred retail pharmacies, specialty pharmacies, etc.)	drop down box	Listbox, ListYNNoExplain	Yes	
q.	Copays dependent on participant's behavior (e.g. enrollment or stratification level in a disease management program)	drop down box	Listbox, ListYNNoExplain	Yes	
r.	Copay proration at retail, mail and specialty based on days supply (e.g., apply retail copay for a specialty claim with a 30-day supply)	drop down box	Listbox, ListYNNoExplain	Yes	
s.	Limit specialty drugs to a 30-day supply via mail/specialty pharmacies	drop down box	Listbox, ListYNNoExplain	Yes	
t.	Allow County or APS authorize an exception to the plan design for an individual situation?	drop down box	Listbox,ListYesNoSee Explain	Yes	

	Eligibility				
2.	Can the offeror meet the County's and APS file layouts and specifications. See attached zip file with specifications: **Med-RX Client File Specs** zip	drop down box	Listbox, ListYNNoExplain	Yes	Eligibility data can be provided in various formats: magnetic tape, cartridge, diskette, or electronic transmission. Charges may apply for non-standard forms.

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3.	You will also be capable of supporting manual updates and off-cycle files, which may arise from new acquisitions or strike situations.	drop down box	Listbox, ListYNNoExplain	Yes	
4.	You will provide immediate on-line real-time manual eligibility updates for urgent requests by the County/ APS staff.	drop down box	Listbox, ListYNNoExplain	Yes	
5.	You must capture both the 9-digit SSN and the X digit alphanumeric the County/ APS ID in your eligibility system.	drop down box	Listbox, ListYNNoExplain	Yes	
	Provide an age out report for dependent children 3 months before turn age 26	drop down box	Listbox,ListYesNo	Yes	
	Track children >26 disabled/handicap and adult dependents' status	drop down box	Listbox,ListYesNo	Yes	
	Track and report out the name of Medicare Subscriber of pre medicare dependents	drop down box	Listbox,ListYesNo	Yes	
6.	**Based on the eligibility files you receive, you will:**				
a.	Add coverage for members who have joined the plan within 48 hours of receipt of eligibility data	drop down box	Listbox, ListYNNoExplain	Please refer to the Explanation worksheet for details.	
b.	Update member information (e g , address changes) within 48 hours of receipt of eligibility data	drop down box	Listbox, ListYNNoExplain	Please refer to the Explanation worksheet for details.	
c.	Notify appropriate party of eligibility issues within 24 hours of receipt of eligibility data	drop down box	Listbox, ListYNNoExplain	Yes	File discrepancies, along with weekly eligibility error reports, are sent to Arlington County Government and Arlington Public Schools for clarification and correction.
d.	Be able to accept eligibility information via hard copy forms.	drop down box	Listbox,ListYesNo	Yes	
7.	ID Cards				
a.	If requested, you will produce and send prescription drug ID cards for receipt by the County on or before July 1 and for APS members on or before January 1st of each plan year.	drop down box	Listbox, ListYNNoExplain	Yes	
b.	You will produce and send prescription drug ID cards for distribution to new the County/ APS members within 4 business days or less of receipt of clean eligibility and enrollment files.	drop down box	Listbox, ListYNNoExplain	No - See "Explanation"	New members will continue to receive ID cards approximately 7-10 business days after eligibility data is released to the ID card vendor. Some situations will prolong the process, such as non-standard ID cards. The additional time needed depends upon the request. Replacement ID cards are also subject to the same 7-10 business day timeframe.
c.	If related to PBM errors or PBM initiated charges, you will be responsible for cost to reproduce ID cards (including priority shipping).	drop down box	Listbox, ListYNNoExplain	Yes	
8.	Overrides				
a.	Currently, the County/ APS allows a vacation override of 1 additional fill per retail and mail order Rx per member per year with approval. You must have the ability to override retail and mail order prescriptions and provide up to a 30 day and a 90 day supply, respectively for overseas travel/vacation	drop down box	Listbox, ListYNNoExplain	Yes	

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9.	Retail Networks				
a.	Please complete the **"Network Access" Worksheet** included in this Workbook for the Broadest Retail Network, the Retail 90 Network and the Limited Retail Network and indicate if it has been completed.	drop down box	Listbox, ListCompleteNot	Completed	
b.	Excluding exceptions made for custom networks, do you offer at least one 90-Day Supply Retail pharmacy network (i.e., Retail-90 Network).	drop down box	Listbox, ListYNNoExplain	Yes	
c.	If you offer more than one Retail-90 Network, provide the number of different Retail-90 networks available for clients to choose from.	number, 0	Number, 0	Not applicable.	Cigna offers one 90-day at retail network.
d.	If you offer more than one Retail-90 Network, please identify them by name, provide the number of participating pharmacies and major chains, and explain how they differ. Note: If you offer multiple Retail-90 Networks, please propose the Retail-90 Network (and present terms in the **"Rx Pricing Offer" worksheet)** for the network that offers clients the broadest choice of pharmacies and does not require the client mandate use).	text	Text	Not applicable.	
e.	In the event of a network change resulting in more than 5% reduction in participating pharmacies, you will provide improved pricing to the County/ APS for the remaining pharmacies.	drop down box	Listbox, ListYNNoExplain	Yes	

10.	Mail Service	Answer Format		Response	Explanation
a.	Provide the total number of Mail Order facilities nationwide:	number, 0	Number, 0	2	
b.	You have an auto-refill feature available for members so that refills will automatically be made for maintenance medications on valid prescriptions	drop down box	Listbox, ListYNNoExplain	Yes	
c.	You will communicate any delays beyond three days in the delivery of prescriptions to the participant	drop down box	Listbox, ListYNNoExplain	No - See "Explanation"	Members will be contacted if the prescription has not been filled within seven days of receipt of the order at the facility.
d.	You agree to arrange and pay for a short-term retail supply of a delayed or incorrectly processed mail order prescription caused by your organization. In addition, you agree not to charge the County/ APS members for expedited delivery of the mail order prescription if the prescription delay is caused by your organization.	drop down box	Listbox, ListYNNoExplain	Yes	
e.	In the event of a natural disaster or national emergency, you will continue to fill all prescription requests, proactively obtaining any necessary overrides to facilitate this process, and provide members with expedited delivery to convenient locations.	drop down box	Listbox, ListYNNoExplain	Yes	
f.	You will assure that 100% of mail order prescriptions will be imaged and entered when received at mail service (including Specialty prescriptions). You will assure that you will be able to electronically track 100% of all mail order prescriptions (including Specialty) throughout the filling process, on a timely basis, from the point of prescription is received until it is shipped to the member.	drop down box	Listbox, ListYNNoExplain	Yes	

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g.	You assure that, within 24 hours, you will contact prescribers and/or members via a telephone call or email for 100% of incomplete mail order prescriptions (including Specialty) that require additional information.	drop down box	Listbox, ListYNNoExplain	Yes	We make every effort to contact members or prescribers within 24 hours, or as soon as possible. In some cases, contact may take longer than 24 hours. We use every option
h.	You will provide both email and telephone voicemail capabilities to communicate to members their mail order has been received and the date the order has been shipped to members.	drop down box	Listbox, ListYNNoExplain	No - See "Explanation"	Members have multiple ways in which they can track their prescriptions. They may contact Cigna Home Delivery Pharmacy by phone, toll-free, where customer service associates
i.	You will have the capability to accept early refill orders and suspend or "queue" these orders in your system until the earliest refill date for processing.	drop down box	Listbox, ListYNNoExplain	Yes	
j.	You will have the capability to accept major credit cards (including flexible spending account cards) and store credit card number(s) by member account for future mail order prescriptions. You must have the capability to advise members 30 days in advance of the date their credit card number is doing to expire.	drop down box	Listbox, ListYNNoExplain	Yes	Cigna does store credit card data for use in future orders and has the capability to inform members in advance of credit card expiration; however, this is not a standard service we provide and will require further discussion at a later stage.
k.	If requested, will you provide members with checks for monies owed to them instead of maintaining credits at your mail facility?	drop down box	Listbox, ListYNNoExplain	No - See "Explanation"	Cigna does not currently or routinely offer payment via check back to the member, but we are willing to discuss this
l.	The County/ APS requires that the floor limit for accepting prescription orders from members without the correct payment be $250. Please confirm that your firm is willing to administer this floor limit?	drop down box	Listbox, ListYNNoExplain	No - See "Explanation"	Cigna's standard floor limit is $150. Floor limits are not customizable at the client or member level
m.	You will not require the County/ APS to pay outstanding balances owed by membership.	drop down box	Listbox, ListYNNoExplain	Yes	
n.	The County/ APS shall have the right to advise you in writing to change the floor limit for all members or just those with unpaid balances after 120 days of dispensing.	drop down box	Listbox, ListYNNoExplain	No - See "Explanation"	Floor limits are not customizable at the client or member level. Any balance due after 120 days will be turned over to a collection agency.
o.	You will not require the County/ APS to mandate use of the mail pharmacies.	drop down box	Listbox, ListYNNoExplain	Yes	
p.	If requested, you will provide members who are currently using the incumbent's mail facility an 800-number that may be called to provide you the information necessary to transfer their current mail-order prescriptions to your mail facility	drop down box	Listbox, ListYNNoExplain	Yes	
q	If requested, you are willing and able to prorate copays at mail order for claims that are processed for less than or equal to a 60 day supply.	drop down box	Listbox, ListYNNoExplain	Yes	

11.	Mail Order Facilities	Answer Format	Format Type	Response	Explanation
	Provide information on the proposed Mail Order Facilities for this client (use the Census file to determine the geographic location of employees):				
a.	**Primary Mail Order Facility Location:**	text	Text	Sioux Falls, SD	Not designated as primary or secondary.
	Address:				
	Street Address	text	Text	4901 N. 4th Avenue	
	City	text	Text	Sioux Falls	
	State	text	Text	South Dakota	

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	Zip Code	text	Text	57104-9660	
	% Current Capacity/month	percent, 1	Percentage, 1	57.0%	
	What is the mail service dispensing capacity per month	number, 0	Number, 0	840,000	
b.	**Secondary Mail Order Facility Location(s)**				
	Facility #1	text	Text	Horsham, PA	Not designated as primary or secondary.
	Address:				
	Street Address	text	Text	206 Welsh Road	
	City	text	Text	Horsham	
	State	text	Text	Pennsylvania	
	Zip Code	text	Text	19044	
	% Current Capacity/month	percent, 1	Percentage, 1	57.0%	
	What is the mail service dispensing capacity per month	number, 0	Number, 0	840,000	
c.	**Third Mail Order Facility Location(s)**	text	Text	Not applicable	
	Address:				
	Street Address	text	Text	Not applicable.	
	City	text	Text	Not applicable.	
	State	text	Text	Not applicable.	
	Zip Code	text	Text	Not applicable.	
	% Current Capacity/month	percent, 1	Percentage, 1	Not applicable.	
	What is the mail service dispensing capacity per month	number, 0	Number, 0	Not applicable.	
d.	**Fourth Mail Order Facility Location(s)**	text	Text	Not applicable	
	Address:				
	Street Address	text	Text	Not applicable.	
	City	text	Text	Not applicable.	
	State	text	Text	Not applicable.	
	Zip Code	text	Text	Not applicable.	
	% Current Capacity/month	percent, 1	Percentage, 1	Not applicable.	
	What is the mail service dispensing capacity per month	number, 0	Number, 0	Not applicable.	
e.	What are your standard hours of operation?	text	Text	Cigna Home Delivery Pharmacy hours of operation for distribution are Monday through Friday, 7:00 a.m. to 12:00 midnight. In addition, if volume demands, we will run an extra shift Saturday or Sunday. Our call center is available 24 hours a day, 7 days per week, 365 days a year.	
12.	**Service Statistics for all Mail Order Facilities (not just the ones proposed for this client):**				
a.	Quarterly Dispensing Capacity	number, 0	Number, 0	2,500,000 quarterly	
b.	Number of Prescriptions Dispensed in the Most Recent Quarter	number, 0	Number, 0	1,500,000 quarterly	
c.	Ratio of Pharmacists to Pharmacy Technicians	X:XX	Text	1:02	
d.	Average Number of Prescriptions Dispensed per Pharmacist per Hour	number, 1	Number, 1	42.0	
13.	**Average turnaround time in the most recent quarter for prescriptions that:**				
a.	Required intervention (in days)	number, 2	Number, 2	1.54 business days	

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b.	Did not require intervention (in days)	number, 2	Number, 2	1.54 business days	

	Specialty Pharmacy Services	Answer Format	Format Type	Response	Explanation
14. a.	How do you define specialty drugs?	Text	Text	Please refer to the Explanation worksheet for details.	
b.	Provide the total # of Specialty pharmacies nationwide in your network:	number, 0	Number, 0	2	
c.	You will not require the County/ APS to mandate use of your Specialty pharmacy(ies).	drop down box	Listbox, ListYNNoExplain	Yes	Cigna believes that members should access their specialty medications in the setting that most appropriately matches their needs. Members can obtain specialty medications through retail, mail order, or when appropriate, through the physician's office.
15.	Describe your shipping and handling policy for Specialty products. Indicate your primary shipping carrier.	text	Text	Please refer to the Explanation worksheet for details.	
16.	Will your Specialty pharmacy ship to members choice of location (i.e., physician office, etc.)?	drop down box	Listbox, ListYNNoExplain	Yes	
17.	Indicate if your organization receives educational funding or support from pharmaceutical manufacturers.	drop down box	Listbox, ListYNNoExplain	No	
a.	Describe exactly how these monies are used.	Text	Text	Not applicable.	
18.	Describe the contracts you have in place to provide drugs that you do not buy and dispense. Include limited and closed distribution drugs and drug categories where you do not hold distribution rights or contracts.	Text	Text	Please refer to the Explanation worksheet for details.	
19.	Briefly describe your Specialty clinical management capabilities, including the UM programs offered.	text	Text	Please refer to the Explanation worksheet for details.	
20.	Do your Specialty pharmacies have access to complete patient profiles (i.e., are the Specialty, Retail and Mail systems fully integrated so that a complete patient profile is accessible)?	drop down box	Listbox, ListYNNoExplain	Yes	
21.	You will allow the County/ APS the flexibility to determine if participants can fill specialty drug prescriptions at retail, and will include pricing for a voluntary option (open retail network/no retail refill limit) and a closed network option (retail lockout or retail refill limit).	drop down box	Listbox, ListYNNoExplain	Yes	
22.	Pricing for Specialty Drugs added to the list on or after effective date shall be competitive in the marketplace and considered on an individual drug basis, and shall not automatically default to a minimum discount.	drop down box	Listbox, ListYNNoExplain	Yes	
23.	Briefly describe your specialty patient support services. When and how are patients identified, contacted, and monitored?	Text	Text	Please refer to the Explanation worksheet for details.	
24.	Briefly describe how you improve the compliance of participants receiving specialty pharmacy products. Include methods used to measure compliance, reports for documentation, frequency of measurement, and any costs associated.	Text	Text	Please refer to the Explanation worksheet for details.	

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25.	How do you confirm appropriateness of therapy?	Text	Text	Please refer to the Explanation worksheet for details.	
26.	Confirm that any or all UM programs can be suppressed.	drop down box	Listbox, ListYNNoExplain	Yes	
27.	Describe the standard reporting, including new and/or critical patient alerts, available as part of your specialty program?	Text	Text	Please refer to the Explanation worksheet for details.	
28.	Do your Specialty pharmacies have access to complete patient profiles (i.e., are the Specialty, Retail and Mail systems fully integrated so that a complete patient profile is accessible)?	drop down box	Listbox, ListYNNoExplain	Yes	
29.	If a Specialty drug package is lost, stolen, or not delivered, you will not charge the client or client participant for the Specialty Drug or any handling/reprocessing, etc. fee.	drop down box	Listbox, ListYNNoExplain	Yes	

	Channel Management - Internal Audits	Answer Format	Format Type	Response	Explanation
30.	**Indicate the percentage of your network pharmacies in your Broadest Retail Network for which:**				
a.	On-site audits are conducted	percent, 1	Percentage, 1	3-4%	
b.	Desk-top audits are conducted.	percent, 1	Percentage, 1	2-3%	
31.	You agree to share 100% of retail network audit recoveries with the Plan.	drop down box	ListYesNo	Yes	We will share 100 percent, minus the 30 percent required by the audit vendor.
32.	**Confirm that the same audits performed on your retail pharmacy network will be conducted on the:**				
a.	Mail Order Pharmacies utilized	drop down box	Listbox, ListYNNoExplain	Yes	
b.	Specialty Pharmacies utilized.	drop down box	Listbox, ListYNNoExplain	Yes	

	QUALITY AND CLINICAL PROGRAMS	Answer Format	Format Type	Response	Explanation
33.	**You have the capability to integrate medical and prescription drug claims data to enhance:**				
a.	Concurrent Drug Utilization Reviews (i.e., drug-disease interactions)	drop down box	Listbox, ListYNNoExplain	Yes	
b.	Therapeutic management initiatives (i.e., prior authorization programs)	drop down box	Listbox, ListYNNoExplain	Yes	
c.	Compliance programs	drop down box	Listbox, ListYNNoExplain	Yes	
d.	Gaps in (Omissions in) care	drop down box	Listbox, ListYNNoExplain	Yes	
	Comment: If you charge a fee for this service, disclose the fee in the "Explanation" column or Worksheet, if you require more space.				
34.	**Clinical program offering includes:**				
a.	Evidenced-based approach	drop down box	Listbox, ListYNNoExplain	Yes	
b.	Compliance (poor adherence)	drop down box	Listbox, ListYNNoExplain	Yes	
c.	Funding from pharmaceutical manufacturers	drop down box	Listbox, ListYNNoExplain	No	
d.	Information available via the web	drop down box	Listbox, ListYNNoExplain	Yes	
e.	Outcomes data (savings and member impact)	drop down box	Listbox, ListYNNoExplain	Yes	

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35.	You will only communicate with participants about alternative medications or places of service when a change will save both the participant and the County/ APS money before the application of rebates.	drop down box	Listbox, ListYNNoExplain	Yes	
36.	You will allow the County/ APS the ability to "opt-out" of clinical programs, which include but are not limited to therapeutic substitution programs.	drop down box	Listbox, ListYNNoExplain	Yes	
37.	If requested, you will allow "grandfathering" of copays (formulary tier levels) for current utilizers for a specified period of time.	drop down box	Listbox, ListYNNoExplain	Yes	
38.	You are willing and capable of providing reporting specific to the activity and outcomes associated with all of the utilization management tools and programs you answered "yes" in the question directly above as frequently as the plan requests.	drop down box	Listbox, ListYNNoExplain	Yes	
39.	**Provide the number of programs available for the following specific types:**				
a.	Prior authorization programs	number, 0	Number, 0	5	Our prior authorization program is based on the clinical package purchased.
b.	Prior authorization programs specific for "specialty drugs"/self-administered injectable medications	number, 0	Number, 0	5	Our prior authorization program is based on the clinical package purchased.
c.	Quantity limitation or dose duration programs	number, 0	Number, 0	Please refer to the Explanation worksheet for details.	
d.	Step therapy protocol programs	number, 0	Number, 0	14	Please refer to the Explanation worksheet for details.
40.	How often are your clinical programs reviewed to ensure they remain up-to-date?	text	Text	Our programs are reviewed on an ongoing basis, at least quarterly.	

	Pharmacy & Therapeutic Committee	Answer Format	Format Type	Response	Explanation
41.	**Pharmacy & Therapeutic Committee employs:**				
a.	Academy of Managed Care Pharmacy's (AMCP) formulary submission process	drop down box	Listbox, ListYNNoExplain	Yes	
	Data provided by one or more of your employees	drop down box	Listbox, ListYNNoExplain	Yes	
b.	Multi-disciplinary approach	drop down box	Listbox, ListYNNoExplain	Yes	
c.	Outcomes data	drop down box	Listbox, ListYNNoExplain	Yes	
d.	Pharmaceutical manufacturer representatives or their prepared data in decision-making	drop down box	Listbox, ListYNNoExplain	No	
e.	Pharmacoeconomical data.	drop down box	Listbox, ListYNNoExplain	N/A	
42.	**You utilize a Pharmacy & Therapeutic Committee to develop and maintain:**				
a.	Your formulary(ies)	drop down box	Listbox, ListYNNoExplain	Yes	
b.	Utilization management programs and coverage rules	drop down box	Listbox, ListYNNoExplain	Yes	
43.	**Provide the following information concerning the Pharmacy & Therapeutic Committee:**				
a.	Frequency of meetings	drop down box	Listbox, ListFrequency	Quarterly Semi-Annually (twice a year)	Meetings are held quarterly.
b.	Number of physicians	number, 0	Number, 0	11	
c.	Number of pharmacists	number, 0	Number, 0	4	
d.	Number of nurses	number, 0	Number, 0	0	
e.	Number of PBM employees	number, 0	Number, 0	9	

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f.	Do PBM employees have voting rights?	drop down box	Listbox, ListYNNoExplain	Yes	
g.	List disciplines represented	text	Text	Pediatrics Primary Care / Internal Medicine Infectious Disease Cardiology Behavioral Health Other	
44.	The Committee considers the non-clinical considerations like member impact and the costs of products, net of rebates, during their review for formulary representation.	drop down box	Listbox, ListYNNoExplain	Yes	
45.	The Committee accepts funds from pharmaceutical manufacturers.	drop down box	Listbox, ListYNNoExplain	No	
46.	The Committee considers the costs of products, including rebates, during its review for formulary representation.	drop down box	Listbox, ListYNNoExplain	Yes	
47.	Your formulary always follows the recommendations of the P&T Committee.	drop down box	Listbox, ListYNNoExplain	Yes	The Pharmaceutical and Therapeutics Committee (P&T Committee) decisions are independent of financial considerations. If, however, the P&T Committee decides that a drug under review is equivalent to existing formulary products, they may defer a final approval decision to the business decision team to consider financial comparisons between the products involved.

48.	Rebates	Answer Format	Format Type	Response	Explanation
a.	Discuss your policies related to "bundling" rebates.	Text	Text	Cigna's pharmacy management services contracts are not bundled. "Bundling" within consideration (pharmaceutical manufacturer rebate) contracts implies that the manufacturer's rebate for a certain drug is tied to the carrier's utilization of other drugs developed by that manufacturer. Cigna believes this type of arrangement could potentially affect drug-specific decisions that may be contrary to our low net cost strategy.	
b.	What percent of current rebate contracts are bundled and why?	Text	Text	Not applicable.	
c.	When and how will these bundled agreements be retired?	Text	Text	Not applicable.	

49.	Customer Service	Answer Format	Format Type	Response	Explanation
a.	You will provide the County/ APS a dedicated toll-free telephone line/chat line with live caller support through a designated member service team that is operational on normal business days between at least 7 a.m. and 7 p.m. in every time zone containing County and APS members	drop down box	Listbox, ListYNNoExplain	The pharmacy customer service center, located in Scranton, Pennsylvania, serves all pharmacy members. Our call center is available 24 hours a day, 7 days per week, 365 days a year. Members call one toll-	
b.	IVR and web support will be available through the dedicated toll-free telephone line 24 hours a day, seven days a week, 365 days a year.	drop down box	Listbox, ListYNNoExplain	Our call center and website are available 24 hours a day, 7 days per week, 365 days a year.	

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c.	The member service team will be knowledgeable of the County/ APS's specific pharmacy benefit programs to respond to member questions.	drop down box	Listbox, ListYNNoExplain	Yes	
d.	Member/provider servica representatives will always have access to a pharmacist in the event the call requires the attention of a clinician.	Text	Listbox, ListYNNoExplain	Yes	
e.	Your customer service representatives will offer the name and phone number of the "manager/supervisor" for escalated issues if requested.	drop down box	Listbox, ListYNNoExplain	Yes	
f.	You (or your designee at your expense) will perform a client-specific (versus book-of-business) member satisfaction survey at least once annually.	drop down box	Listbox, ListYNNoExplain	Yes	
h.	You are able and willing to customize messaging for the County/ APS-specific plan design issues.	drop down box	Listbox, ListYNNoExplain	Yes	Custom materials are produced on a fee-for-service (FFS) basis at competitive prices. Our vendors produce quality health care communication materials for many of the country's largest corporations. Once specifications are determined, a guaranteed quotation can be provided.
i.	How many languages does your call center support ? (Note, at minimum Offeror must be able to support Spanish and English)	number, 0	Number, 0	Language Line Services offers translation services for more than 175 languages.	Please refer to the Explanation worksheet for details.
j.	Do you currently provide versions of your member site in multiple languages that offer the same functionality as the English version?	drop down box	Listbox, ListYNNoExplain	Yes	The Cigna website is available in English and Spanish.
k.	Will you provide plan summaries and other materials to all members in multiple languages?	drop down box	Listbox, ListYNNoExplain	Yes	We will continue to work with you to create an effective communications program in any language. There are standard collateral materials available in Spanish at no additional cost. Client-specific material created in Spanish or other languages is subject to additional fees.
l.	Your customer service representatives have access to an application that allows them to review alternative drug therapies (e.g., formulary status, generic alternatives available, etc.) for members requesting this information.	drop down box	Listbox, ListYNNoExplain	Yes	
m.	Your customer service representatives have access to an application that allows them to run "test claims" (to obtain prices) for members requesting this information.	drop down box	Listbox, ListYNNoExplain	Yes	
n.	Is some or all of your Customer Service support provided offshore?	drop down box	Listbox, ListYNNoExplain	No	
50.	**If so, provide the following statistics on your offshore calls:**				
a.	# handled offshore	number, 0	Number, 0	0	
b.	% handled offshore	percent, 1	Percentage, 1	0.0%	
51.	You measure Customer Service turnover.	drop down box	Listbox, ListYNNoExplain	Yes	
	If "yes," provide the following statistics:				

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a.	% turnover during last six months (include turnover due to promotions, resignations and terminations).	percent, 1	Percentage, 1	15.3%	
b.	% turnover during last 12-month period (include turnover due to promotions, resignations, and terminations.	percent, 1	Percentage, 1	23.0%	This job function is typically not considered, by employees, as a long-term career goal, but rather a solid starting point within the
c.	Definition of turnover	Text	Text	Our definition of turnover would include promotions and transfers out of the CSA role, as well as voluntary and involuntarty terminations.	

	Web-Capabilities	Answer Format	Format Type	Response	Explanation
52.					
a.	Provide a sample of the website screenshots in an electronic file and name the file **[Your Organization Name]_Sample Website Screens.**	drop down box	Listbox, ListProvideNA	Provided	
53.	**Participants will have access to a web-based application, which allows them to review:**				
a.	Claims history.	drop down box	Listbox, ListYNNoExplain	Yes	
b.	Alternative drug therapies (i.e., formulary status, generic alternatives available, etc.) and cost of each.	drop down box	Listbox, ListYNNoExplain	Yes	
c.	Retail pharmacy locator.	drop down box	Listbox, ListYNNoExplain	Yes	
d.	Compare price of a medication at retail versus mail order.	drop down box	Listbox, ListYNNoExplain	Yes	
e.	Price a medication (including retail pricing from local retail pharmacies)	drop down box	Listbox, ListYNNoExplain	Yes	
54.	**The website has the following services/capabilities:**				
a.	Email notification of next refill to participant	drop down box	Listbox, ListYNNoExplain	Yes	
b.	PBM will have the ability to develop and maintain custom websites for the County/ APS plan members, as well as pre-member websites for prospective members.	drop down box	Listbox, ListYNNoExplain	Yes	
c.	Ability for member to log on to the website and pay outstanding bills on-line	drop down box	Listbox, ListYNNoExplain	Yes	

	Client Service				
55.	Please provide a copy of an Implementation Plan. Name the file: **C-2 [Your Organization's Name]_Implementation Plan**	drop down box	Listbox, ListProvideNA	Provided	
56.	Please provide a complete set of materials you would use to communicate pharmacy services provided to the County/ APS's employees. Name the file: C-4 [Your Organization's Name]_Sample Employee Communication Materials.	drop down box	Listbox, ListProvideNA	Provided	
57.	You will ensure communications sent to participants are specific to the County/ APS's plan designs	drop down box	Listbox, ListYNNoExplain	Yes	
58.	You are able and willing to customize refill-too-soon edits.	drop down box	Listbox, ListYNNoExplain	Yes	
59.	In the event of a change in vendors, you agree to administer all runout claims.	drop down box	Listbox, ListYNNoExplain	Yes	We will continue to administer claims that were incurred before termination for a period of 12
60.	You will agree to invoice the County/ APS monthly for administrative fees.	drop down box	Listbox, ListYNNoExplain	Yes	

Account Management	Answer Format	Format Type	Response	Explanation

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61.	Describe the account team you are proposing for the County/ APS. For each team member, include years of experience servicing similar types of organizations. Also provide an organization chart identifying the functions and reporting relationships of each key members responsible for the administrative services to the County/ APS.	text	Text	[illegible] management team is skilled at coordinating all resources used to effectively manage your benefit plan. This team contines to provide dedicated resources for customer service, accounting, claims, and underwriting. They bring [illegible]	
62.	Give the name and title of the person with overall responsibility for planning, supervising, and providing administrative services to the County/ APS. Does that person also have sales and marketing goals? What percent (%) of their time is spent on marketing and sales duties?	text	Text	Sheila Heaphy, Senior Client Manager. Sheila's goals are all account management-based, she is not responsible for sales & marketing.	
63.	Describe each team member's current client base and work load. How will other responsibilities be transitioned?	text	Text	Sheila's customer base is mainly focused on large government and education business. Her book of business will not exceed 10 accounts.	
64.	Confirm the team you are proposing will be a dedicated Account team. Explain how you determined the proposed staff levels.	drop down box	Listbox, ListYNNoExplain	No - See "Explanation"	Our staffing levels are based on the size, complexity and needs of each client.
65.	Describe each team member's current client base and work load. How will other responsibilities be transitioned?	text	Text	The client base for each team member varies from 10 to 18 accounts. The client base & work load of the individuals	
66.	You will coordinate with the County/ APS for management of the SPD. This includes, but not limited to, reviewing changes to the SPD, making sure that you administer the plan as reflected in the SPD, and communicating any plan/clinical program changes to the County/ APS for inclusion in the SPD.	drop down box	Listbox, ListYNNoExplain	Yes	
67.	The County/ APS's satisfaction with the account manager will be measured how often during the contract period.	text	Text	Annually	
68.	If requested by the County/ APS, the account executive or manager will be replaced with one that Client is allowed to interview.	drop down box	Listbox, ListYNNoExplain	Yes	
69.	The account manager will participate on the implementation team.	drop down box	Listbox, ListYNNoExplain	Yes	
70.	Using the "Acct Management Plan" Worksheet, describe your plan for managing the account, including periodic reviews of cost and utilization and recommendations for plan design changes from the County/ APS's representatives.	drop down box	Listbox, ListProvideNA	Provided	Sales to confirm

Implementation Support - if applicable	Answer Format	Format Type	Response	Explanation
71. You will provide a designated implementation team for the County/ APS that will include an implementation manager and the account manager; they will provide assistance during the transition/implementation process and participate in regularly scheduled status meetings (at least weekly) with the County/ APS.	drop down box	Listbox, ListYNNoExplain	N/A	This is not applicable as Cigna is the incumbent vendor.
72. You will maintain an implementation project plan and issue log documenting all implementation issues, actions, due dates and responsible parties. Implementations must be supported year round as required by the County/ APS.	drop down box	Listbox, ListYNNoExplain	N/A	

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73.	You agree to accept and load all open mail order and specialty pharmacy refills, prior authorization histories, and at least six months of historical claims data at no additional cost to the County/ APS during the implementation process.	drop down box	Listbox, ListYNNoExplain	N/A	
74.	You can provide alternative approaches to minimize the need for members to request new prescriptions during transition.	drop down box	Listbox, ListYNNoExplain	N/A	

	Client Audit Rights	Answer Format	Format Type	Response	Explanation
75.	**The County/ APS reserves the right to conduct audits as follows. Confirm you agreement with each of the following:**				
a.	Right to audit any data necessary to ensure your firm is complying with all contract terms, which includes but is not limited to 100% of pharmacy Right to claims data, which includes at least all NCPDP fields from the most current version and release; retail pharmacy contracts; data management, pharmaceutical manufacturer and wholesaler agreements, mail and specialty pharmacy contracts to the extent they exist with other vendor(s), approved and denied utilization management reviews; clinical program outcomes; appeals; information related to the reporting and measurement of performance guarantees, etc.	drop down box	Listbox, ListYNNoExplain	No - See "Explanation"	Please refer to the Explanation worksheet for details.
b.	Right to audit at no charge except at a direct pass-through of any data retrieval fees, which may be required if data requested has already been stored	drop down box	Listbox, ListYNNoExplain	Yes	There will be no charge for Cigna's costs related to the audit; however, Arlington County Government and Arlington Public Schools will
c.	Right to audit post termination	drop down box	Listbox, ListYNNoExplain	Yes	Our standard is to allow audit one year after termination.
d.	Right to audit more than once per year if the audits are different in scope or for different services	drop down box	Listbox, ListYNNoExplain	Yes	Audit caveats provided in the Explanation worksheet apply.
e.	Right to perform additional audits during the year of similar scope if requested as a follow-up to ensure significant/material errors found in an audit have been corrected and are not recurring or if additional information becomes available to warrant further investigation.	drop down box	Listbox, ListYNNoExplain	Yes	Audit caveats provided in the Explanation worksheet apply.
76.	You agree to provide reasonable cooperation with requests for information, which includes but is not limited to the timing of the audit, deliverables, data/information requests and your response time to our questions during and after the process. Your firm will also provide a response to all "findings" it receives within 30 days, or at a later date if mutually determined to be more reasonable based on the number and type of findings.	drop down box	Listbox, ListYNNoExplain	Yes	Audit caveats provided in the Explanation worksheet apply.
77.	Your firm agrees to pay the Plan 100% of any overpayments made by the Plan as determined from an audit by a firm that the Plan chooses, and no later than 30 days after both parties have agreed to the recoveries, subject to a compounding interest penalty of 1% per month.	drop down box	Listbox, ListYNNoExplain	No - See "Explanation"	We do not agree to reimburse for overpayments unless the result of Cigna's gross negligence or intentional wrongdoing concerning the administration of claims under Arlington County Government and Arlington Public Schools'
78.	You will allow the County/ APS, or any other party selected by the County/ APS, to audit claims at any time, including, but not limited to, rebates, ingredient cost discounts, and dispensing fees.	drop down box	Listbox, ListYNNoExplain	No - See "Explanation"	Audit caveats provided in the Explanation worksheet apply.

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79.	The County/ APS, or any other party selected by the County/ APS, will conduct a quality review of the plan design to be loaded in the claims system(s) prior to implementation (or as soon thereafter as reasonably possible). As the selected pharmacy benefit provider, you agree to pay the cost of this review, up to $30,000. You will provide all necessary support to the County/ APS or any other party selected by the County/ APS to review claims in a test environment that mirrors the plan information present in the "live" claims processing system. If this review cannot be supported remotely and requires an on-site meeting, you will be responsible for travel costs up to $3,000. All costs associated with this review shall not be included in your pricing offer.	drop down box	Listbox, ListYNNoExplain	Yes	Please refer to the Pricing worksheet for details.

	Systems - General	Answer Format	Format Type	Response	Explanation
80.	Claims data are stored on-line for a minimum of 36 months post adjudication.	drop down box	Listbox, ListYNNoExplain	Yes	
81.	If requested, you will accept from the incumbent a claims file that you can use to transfer current prior authorization approvals.	drop down box	Listbox, ListYNNoExplain	N/A	This is not applicable as Cigna is the incumbent vendor.
82.	If requested, you will accept from the incumbent a refill file that you can use to transfer prescriptions to your mail and specialty pharmacy.	drop down box	Listbox, ListYNNoExplain	N/A	This is not applicable as Cigna is the incumbent vendor.
83.	What is your policy on selling clients' pharmacy data?	text	Text	Please refer to the Explanation worksheet for details.	
84.	Will you accept electronic or other type files from a selected medical carrier?	drop down box	Listbox, ListYNNoExplain	Yes	Our proposal assumes an integrated Cigna medical and pharmacy plan.

	Data Feeds/Exchange	Answer Format	Format Type	Response	Explanation
85.	You agree to provide periodic electronic data feeds at no additional cost to a minimum of 3 unique vendors. Each data feed could be unique in nature and would range from real time to weekly to quarterly transmission intervals.	drop down box	Listbox, ListYNNoExplain	No - See "Explanation"	$5,000 set up and $570 per feed per month
86.	Accumulators for CDH plans and drugs that accumulate to a combined medical/Rx accumulator will be exchanged in real time with the medical vendor.	drop down box	Listbox, ListYNNoExplain	Provided	
87.	Please confirm your ability to exchange accumulators in real-time with each of the following Medical vendors and define real-time transfer for each.				
a.	Aetna	drop down box	Listbox, ListYNNoExplain	No	
	Real-Time Defined as:	text	Text	Not applicable.	
b.	Blue Cross Blue Shield	drop down box	Listbox, ListYNNoExplain	No	
	Real-Time Defined as:	text	Text	Not applicable.	
c.	Kaiser	drop down box	Listbox, ListYNNoExplain	No	
	Real-Time Defined as:	text	Text	Not applicable.	
d.	UHC	drop down box	Listbox, ListYNNoExplain	No	
	Real-Time Defined as:	text	Text	Not applicable.	
e.	CIGNA	drop down box	Listbox, ListYNNoExplain	Yes	
	Real-Time Defined as	text	Text	Immediately	

Request for Prescription Drug Proposal (RFP) for Arlington County Government and Arlington County Public Schools

RFP No. 719-13 Prescription Drug Plan

Questionnaire

PBM RFP 2013

	Health Care Reform/ACA Support	Answer Format	Format Type	Response	Explanation
88.	Confirm that Offeror will provide full support related to Health Care Reform/ ACA to ensure the County and APS remains compliant and has the most up to date information available.	drop down box	Listbox, ListYNNoExplain	Yes	
89.	Will you agree to provide communication materials to members and to County and APS staff to ensure compliance with ACA?	drop down box	Listbox, ListYNNoExplain	Yes	
90	Briefly describe the support and materials you will provide relative to HCR/ACA.	text	Text	Please refer to the Explanation worksheet for details.	

EXHIBIT E
To AGREEMENT 719-13-1
BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement is hereby entered into between Cigna Health and Life Insurance Company (hereafter referred to as "Business Associate") and the County Board of Arlington County, Virginia (hereafter referred to as "Covered Entity" or "County") (collectively "the parties") and is hereby made a part of any Underlying Agreement for goods or services entered into between the parties.

Recitals

The County provides services to its residents and employees which may cause it or others under its direction or control to serve as covered entities for purposes of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The County, in its capacity as a covered entity, may provide Business Associate with certain information that may include Protected Health Information (PHI), so that Business Associate may perform its responsibilities pursuant to its Underlying Agreement(s) with and on behalf of County.

Covered Entity and Business Associate intend to protect the privacy of PHI and provide for the security of any electronic PHI received by Business Associate from Covered Entity, or created or received by Business Associate on behalf of Covered Entity in compliance with HIPAA; in compliance with regulations promulgated pursuant to HIPAA, at 45 CFR Parts 160 and Part 164; and in compliance with applicable provisions of the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 (the "HITECH Act") and any applicable regulations and/or guidance issued by the U.S. Department of Health and Human Services ("DHHS") with respect to the HITECH Act (collectively "federal law").

WHEREAS, federal law and the specific regulations promulgated pursuant to HIPAA at 45 CFR § 164.314, 45 CFR § 164-502(e) and 45 CFR § 164.504(e) require a Covered Entity to enter into written agreements with all Business Associates (hereinafter "Business Associate Agreement");

WHEREAS, the parties desire to comply with HIPAA and desire to secure and protect such PHI from unauthorized disclosure;

THEREFORE, **Business Associate** and **Covered Entity,** intending to be legally bound, agree as follows. The obligations, responsibilities and definitions may be changed from time to time as determined by federal law and such changes are incorporated herein as if set forth in full text:

1) **Definitions**

The capitalized terms used in this Business Associate Agreement shall have the meaning set out below:

a) **Accounting**. "Accounting" means a record of disclosures of protected health information made by the Business Associate.

b) **Breach**. "Breach" means the acquisition, access, use, or disclosure of protected health information in a manner not permitted by this Business Associate Agreement and/or by HIPAA which compromises the security or privacy of the protected health information. A Breach does not include any unintentional acquisition, access, or use of PHI by an employee or individual acting under the authority of Contractor if such acquisition, access, or use was made in good faith and within the course and scope of the employment or other professional relationship of such employee or individual with Contractor; and any inadvertent disclosure from an individual who is otherwise authorized to access PHI at a facility operated by Contractor to another similarly situated individual at the same facility; and such information is not further acquired, accessed, used, or disclosed without authorization by any person.

c) **Business Associate**. "Business Associate" means a person who creates, receives, maintains, or transmits protected health information on behalf of a Covered Entity to accomplish a task regulated by HIPAA and not as a member of the Covered Entity's workforce. A Business Associate shall include, but is not limited to, a non-workforce person/entity who performs data processing/analysis/transmission, billing, benefit management, quality assurance, legal, actuarial, accounting, administrative and/or financial services on behalf of the Covered Entity involving protected health information. A Business Associate also includes a subcontractor of the Business Associate that creates, receives, maintains or transmits PHI on behalf of the Business Associate.

d) **Covered Entity**. "Covered Entity" means a health plan, a health care clearinghouse, and/or a health care provider who transmits any health information in electronic form in connections with an activity regulated by HIPAA.

e) **Data Aggregation**. "Data Aggregation" means, with respect to PHI created or received by Business Associate in its capacity as the Business Associate of Covered Entity, the combining of such PHI by the Business Associate with the PHI received by the Business Associate in its capacity as a Business Associate of another covered entity, to permit data analyses that relate to the health care operations of the respective covered entities.

f) **Designated Record Set**. "Designated Record Set" means all records, including medical, enrollment, billing, payment, claims, and/or case management maintained by and/or for a Covered Entity.

g) **Discovery**. "Discovery" shall mean the first day an unauthorized use or disclosure is known or reasonably should have been known by Business Associate, including when it is or should have been known by any person other than the person who engaged in the unauthorized use/disclosure who is an employee, officer, or agent of Business Associate.

h) **Electronic Protected Health Information**. "Electronic Protected Health Information" means individually identifiable health information that is transmitted by or maintained in electronic media.

i) **HIPAA.** "HIPAA" means the Health Insurance Portability and Accountability Act of 1996 as in effect and/or as amended.

j) **HITECH Act**. "HITECH Act" means the portions of the Health Information Technology for Economic and Clinical Health Act which serve as amendments to HIPAA. HITECH is included within the definition of HIPAA unless stated separately.

k) **Individual**. "Individual" means the person who is the subject of protected health information and/or a person who would qualify as a personal representative of the person who is the subject of protected health information.

l) **Protected Health Information**. "Protected Health Information" or "PHI" means individually identifiable health information transmitted and/or maintained in any form.

m) **Remuneration**. "Remuneration" means direct or indirect payment from or on behalf of a third party.

n) **Required By Law.** "Required By Law" means an activity which Business Associate is required to do or perform based on the provisions of state and/or federal law.

o) **Secretary**. "Secretary" means the Secretary of the Department of Health and Human Services or the Secretary's designee.

p) **Security Incident**. "Security Incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with the system operations in an information system.

q) **Underlying Agreement**. "Underlying Agreement" means the County contract for goods or services made through the County's procurement office which the parties have entered into and which the County has determined requires the execution of this Business Associate Agreement.

r) **Unsecured Protected Health Information**. "Unsecured Protected Health Information" means protected health information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology approved by the Secretary.

2) **Obligations and Activities of Business Associate**

a) Business Associate acknowledges and agrees that it is obligated by law (or upon the effective date of any portion thereof shall be obligated) to meet the applicable provisions of HIPAA and such provisions are incorporated herein and made a part of this Business Associate Agreement. Covered Entity and Business Associate agree that any regulations and/or guidance issued by DHHS with respect to HIPAA that relate to the obligations of business associates shall be deemed incorporated into and made a part of this Business Associate Agreement.

b) In accordance with 45 CFR §164.502(a)(3), Business Associate agrees not to use or disclose PHI other than as permitted or required by this Business Associate Agreement or as Required by Law.

c) Business Associate agrees to develop, implement, maintain and use appropriate administrative, technical, and physical safeguards that reasonably prevent the use or disclosure of PHI other than as provided for by this Business Associate Agreement, in accordance with 45 CFR §§164.306, 310 and 312. Business Associate agrees to develop, implement, maintain and use administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic PHI, in accordance with 45 CFR §§164.306, 308, 310, and 312. In accordance with 45 CFR §164.316, Business Associate shall also develop and implement policies and procedures and meet the documentation requirements as and at such time as may be required by HIPAA.

d) Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate, of a use or disclosure of PHI by Business Associate in violation of the requirements of this Business Associate Agreement.

e) In accordance with 45 CFR §§164.308, 314 and 502, Business Associate will ensure that any workforce member or agent, including a vendor or subcontractor, whom Business Associate engages to create, receive, maintain, or transmit PHI on Business Associates' behalf agrees to the same restrictions and conditions that apply through this Business Associate Agreement to Business Associate with respect to such information, including minimum necessary limitations. Business Associate will ensure that any workforce member or agent, including a vendor or subcontractor, whom Business Associate engages to create, receive, maintain, or transmit PHI on Business Associates' behalf, agrees to implement reasonable and appropriate safeguards to ensure the confidentiality, integrity, and availability of the PHI.

f) At the request of Covered Entity, Business Associate will provide Covered Entity, or as directed by Covered Entity, an Individual, access to PHI maintained in a Designated Record Set in a time and manner that is sufficient to meet the requirements of 45 CFR § 164.524, and, where required by HIPAA, shall make such information available in an electronic format where directed by the Covered Entity.

g) At the written request of Covered Entity, (or if so directed by Covered Entity, at the written request of an Individual), Business Associate agrees to make any amendment to PHI in a Designated Record Set, in a time and manner that is sufficient to meet the requirements of 45 CFR § 164.526.

h) In accordance with 45 CFR §164.504(e)(2), Business Associate agrees to make its internal practices, books, and records, including policies and procedures, and any PHI, relating to the use and disclosure of PHI, available to Covered Entity or to the Secretary for purposes of determining compliance with applicable law. To the extent permitted by law, said disclosures shall be held in strictest confidence by the Covered Entity. Business Associate will provide such access in a time and manner that is sufficient to meet any applicable requirements of applicable law.

i) Business Associate agrees to document and maintain a record of disclosures of PHI and information related to such disclosures, including the date, recipient and purpose of such disclosures, in a manner that is sufficient for Covered Entity or Business Associate to respond to a request by Covered Entity or an Individual for an Accounting of disclosures of PHI and in accordance with 45 CFR § 164.528. Business Associate further shall provide any additional information where required by HIPAA and any implementing regulations. Unless otherwise provided under HIPAA, Business Associate will maintain the Accounting with respect to each disclosure for at least six years following the date of the disclosure.

j) Business Associate agrees to provide to Covered Entity upon written request, or, as directed by Covered Entity, to an Individual, an Accounting of disclosures in a time and manner that is sufficient to meet the requirements of HIPAA, in accordance with 45 CFR §164.528. In addition, where Business Associate is contacted directly by an Individual based upon information provided to the Individual by Covered Entity and where so required by HIPAA and/or any implementing regulations, Business Associate shall make such Accounting available directly to the Individual.

k) In accordance with 45 CFR §164.502(b), Business Associate agrees to make reasonable efforts to limit use, disclosure, and/or requests for PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request. Where required by HIPAA, Business Associate shall determine (in its reasonable judgment) what constitutes the minimum necessary to accomplish the intended purpose of a disclosure.

l) In accordance with 45 CFR §502(a)(5), Business Associate shall not directly or indirectly receive remuneration in exchange for any PHI of an Individual, except with the express written pre-approval of Covered Entity.

m) To the extent Business Associate is to carry out one or more of the Covered Entity's obligation(s) under Subpart E of 45 CFR Part 164, Business Associate shall comply with the requirements of Subpart E that apply to the Covered Entity in the performance of such obligation(s).

n) In accordance with 45 CFR §164.314(a)(1)(i)(C), Business Associate agrees to promptly report to Covered Entity any Security Incident of which Business Associate becomes aware.

o) In accordance with 45 CFR §164.410 and the provisions of this Business Associate Agreement, Business Associate will report to Covered Entity, following Discovery and without unreasonable delay, but in no event later than five business days following Discovery, any Breach of Unsecured Protected Health Information (including privacy related incidents that might, upon further investigation, be deemed to be a Breach). Business Associate shall investigate the Breach, assess the impact under applicable state and federal law, including HITECH, and make a recommendation to the Covered Entity as to whether notification is required pursuant to 45 C.F.R. §§164.404-408 and/or applicable state breach notification laws. With the Covered Entity's prior approval, Business Associate will issue notices to such individuals, state and federal agencies, including the Department of Health and Human Services, and/or the media as the Covered Entity is required to notify pursuant to, and in accordance with the requirements of applicable law (including 45 C.F.R. §§164.404-408). Business Associate will pay the costs of issuing notices required by law and other remediation and mitigation which, in Business Associate's discretion, are appropriate and necessary to address the Breach. Business Associate will not be required to issue notifications that are not mandated by applicable law. Business Associate shall provide the Covered Entity with information necessary for the Covered Entity to fulfill its obligation to report Breaches affecting fewer than 500 Individuals to the Secretary as required by C.F.R. §164.408(c).

   Business Associate's report under this subsection shall, to the extent available at the time the initial report is required, or as promptly thereafter as such information becomes available but no later than 30 days from discovery, include:

   1. The identification (if known) of each Individual whose Unsecured Protected Health Information has been, or is reasonably believed by Business Associate to have been, accessed, acquired, or disclosed during such Breach;

   2. A description of the nature of the unauthorized acquisition, access, use, or disclosure, including the

date of the Breach and the date of discovery of the Breach;

3. A description of the type of Unsecured PHI acquired, accessed, used or disclosed in the Breach (e.g., full name, Social Security number, date of birth, etc.);

4. A description of what Business Associate is doing to investigate the Breach, to mitigate losses, and to protect against any further breaches; and

5. Contact information for Business Associate's representatives knowledgeable about the Breach.

p) Business Associate shall maintain for a period of six years all information required to be reported under paragraph "o". This records retention requirement does not in any manner change the obligation to timely disclose all required information relating to a non-permitted acquisition, access, use or disclosure of Protected Health Information to the County Privacy Officer and the County Project Officer or designee five business days following Discovery.

3) **Permitted Uses and Disclosures by Business Associate**

Except as otherwise limited in this Business Associate Agreement, Business Associate may use or disclose PHI, consistent with HIPAA, as follows:

a) Business Associate may use or disclose PHI as necessary to perform functions, activities, or services to or on behalf of Covered Entity under any service agreement(s) with Covered Entity, including Data Aggregation services related to the health care operations of Covered Entity, if called for in the Underlying Agreement, if Business Associate's use or disclosure of PHI would not violate HIPAA if done by Covered Entity.

b) Business Associate may use PHI for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate.

c) Business Associate may disclose PHI for the proper management and administration of Business Associate if:

1. Disclosure is Required By Law;

2. Business Associate obtains reasonable assurances from the person to whom the PHI is disclosed that the PHI will remain confidential, and will be used or further disclosed only as Required By Law or for the purpose for which it was disclosed, and the person agrees to promptly notify Business Associate of any known breaches of the PHI's confidentiality; or

3. Disclosure is pursuant to an order of a Court or Agency having jurisdiction over said information.

d) Business Associate may use PHI to report violations of law to appropriate Federal and State authorities, consistent with 45 CFR § 164.502(j)(1).

4) **Obligations of Covered Entity**

a) Covered Entity will notify Business Associate of any limitations on uses or disclosures described in its notice of privacy practices (NOPP).

b) Covered Entity will notify Business Associate of any changes in, or revocation of, permission by an Individual to use or disclose PHI, to the extent that such changes or revocation may affect Business Associate's use or disclosure of PHI.

c) Covered Entity will notify Business Associate of any restriction of the use or disclosure of PHI, to the extent that

such restriction may affect Business Associate's use or disclosure of PHI.

d) Covered Entity will notify Business Associate of any alternative means or locations for receipt of communications by an Individual which must be accommodated or permitted by Covered Entity, to the extent that such alternative means or locations may affect Business Associate's use or disclosure of PHI.

e) Except as otherwise provided in this Business Associate Agreement, Covered Entity will not ask Business Associate to use or disclose PHI in any manner that would not be permissible under HIPAA if such use and/or disclosure was made by Covered Entity.

5) **Term, Termination and Breach**

a) This Business Associate Agreement is effective when fully executed and will terminate when all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, including any material provided to subcontractors. If it is infeasible to return or destroy all PHI, protections are extended to such information, in accordance with the Section 5(d) and 5(e) below.

b) Upon Covered Entity's determination that Business Associate has committed a violation or material breach of this Business Associate Agreement, and in Covered Entity's sole discretion, Covered Entity may take any one or more of the following steps:

1. Provide an opportunity for Business Associate to cure the breach or end the violation, and if Business Associate does not cure the Breach or end the violation within a reasonable time specified by Covered Entity, terminate this Business Associate Agreement;

2. Immediately terminate this Business Associate Agreement if Business Associate has committed a material breach of this Business Associate Agreement and cure of the material breach is not feasible; or,

3. If neither termination nor cure is feasible, elect to continue this Business Associate Agreement and report the violation or material breach to the Secretary.

c) If Business Associate believes Covered Entity has failed to fulfill any of its duties under this Business Associate Agreement, Business Associate will promptly notify Covered Entity as to same and Covered Entity shall promptly address the matter with Business Associate.

d) Except as provided in Section 5(e) upon termination of this Business Associate Agreement for any reason, Business Associate will return or destroy, at the discretion of Covered Entity, all PHI received from Covered Entity or created or received by Business Associate on behalf of Covered Entity. This provision will also apply to PHI that is in the possession of workforce members, subcontractors, or agents of Business Associate. Neither Business Associate, nor any workforce member, subcontractor, or agent of Business Associate, will retain copies of the PHI.

e) If Business Associate determines that returning or destroying all or part of the PHI received or created by and/or on behalf of Covered Entity is not feasible, Business Associate will notify Covered Entity of the circumstances making return or destruction infeasible. Business Associate will extend the protections of this Business Associate Agreement 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. Business Associate further agrees to retain the minimum necessary PHI to accomplish those tasks/responsibilities which make return and/or destruction infeasible.

6) **Miscellaneous**

a) Covered Entity and Business Associate agree to take any action necessary to amend this Business Associate Agreement from time to time as may be necessary for Covered Entity or Business Associate to comply with the

requirements of HIPAA, and/or any other implementing regulations or guidance.

b) Notwithstanding the expiration or termination of this Business Associate Agreement or any Underlying Agreement, it is acknowledged and agreed that those rights and obligations of Business Associate which by their nature are intended to survive such expiration or termination shall survive, including but not limited to Sections 5(d) and 5(e) herein.

c) In the event the terms of this Business Associate Agreement conflict with the terms of any other agreement between Covered Entity and Business Associate or the Underlying Agreement, then the terms of this Business Associate Agreement shall control.

d) Notices and requests provided for under this Business Associate Agreement will be made in writing to Covered Entity, delivered by hand-delivery, overnight mail or first class mail, postage prepaid at:

(1) Marcy Foster
Arlington County Privacy Officer
2100 Clarendon Blvd.
Suite 511
Arlington, Virginia 22201

(2) Stephen MacIsaac
County Attorney
2100 Clarendon Blvd.
Suite 511
Arlington, Virginia 22201

(3) Kristin L. Young
County Project Officer
2100 Clarendon Blvd.
Suite 511
Arlington, Virginia 22201

Notice and requests provided for under this Business Associate Agreement will be made in writing in the manner described above to Business Associate at:

Cigna Health and Life Insurance Company
ATTN: Sheila Heaphy
10490 Little Patuxent Parkway, Suite 400
Columbia, MD 21044

e) Covered Entity will have the right to inspect any records of Business Associate or to audit Business Associate to determine whether Business Associate is in compliance with the terms of this Business Associate Agreement. However, this provision does not create any obligation on the part of Covered Entity to conduct any inspection or audit.

f) Nothing in this Business Associate Agreement shall be construed to create a partnership, joint venture, or other joint business relationship between the parties or any of their affiliates, or a relationship of employer and employee between the parties. Rather, it is the intention of the parties that Business Associate shall be an independent contractor.

g) Nothing in this Business Associate Agreement provides or is intended to provide any benefit to any third party.

h) The Business Associate will indemnify and hold harmless Arlington County, its elected officials, officers, directors,

employees and/or agents from and against any employee, federal administrative action or third party claim or liability, including attorney's fees and costs, arising out of or in connection with the Business Associate's violation (or alleged violation) and/or any violation and/or alleged violation by Business Associate's workforce, agent/s, or subcontractor/s of the terms of this Business Associate Agreement, federal law, HIPAA, the HITECH Act, and/or other implementing regulations or guidance or any associated audit or investigation.

The obligation to provide indemnification under this Business Associate Agreement shall be contingent upon the party seeking indemnification providing the indemnifying party with written notice of any claim for which indemnification is sought. Any limitation of liability provisions contained in the Underlying Agreement do not supersede, pre-empt, or nullify this provision or the Business Associate Agreement generally.

This indemnification shall survive the expiration or termination of this Business Associate Agreement or the Underlying Agreement.

i) Any ambiguity in this Business Associate Agreement shall be resolved to permit the parties to comply with HIPAA, its implementing regulations, and associated guidance. The sections, paragraphs, sentences, clauses and phrases of this Business Associate agreement are severable. If any phrase, clause, sentence, paragraph or section of this Business Associate Agreement is declared invalid by a court of competent jurisdiction, such invalidity shall not affect any of the remaining phrases, clauses, sentences and sections of this Business Associate Agreement.

j) If any dispute or claim arises between the parties with respect to this Business Associate Agreement, the parties will make a good faith effort to resolve such matters informally, it being the intention of the parties to reasonably cooperate with each other in the performance of the obligations set forth in this Business Associate Agreement. The Dispute Resolution clause of the Underlying Agreement ultimately governs if good faith efforts are unsuccessful.

k) A waiver with respect to one event shall not be construed as continuing, or as a bar to or waiver of any other right or remedy as to any subsequent events.

l) Neither party may assign any of its rights or obligations under this Business Associate Agreement without the prior written consent of the other party.

m) This Business Associate Agreement and the rights and obligations of the parties hereunder shall be construed, interpreted, and enforced with, and shall be governed by, the laws of the Commonwealth of Virginia and the United States of America.

n) This Business Associate Agreement shall remain in effect for the duration of the Underlying Agreement between the parties, any renewals, extension or continuations thereof, and until such time as all PHI in the possession or control of the Business Associate has been returned to the Covered Entity and/or destroyed. If such return or destruction is not feasible, the Business Associate shall use such PHI only for such limited purposes that make such return or destruction not feasible and the provision of this Business Associate Agreement shall survive with respect to such PHI.

o) The Business Associate shall be deemed to be in violation of this Business Associate Agreement if it knew of, or with the exercise of reasonable diligence or oversight should have known of, a pattern of activity or practice of any subcontractor, subsidiary, affiliate, agent or workforce member that constitutes a material violation of that entity's obligations in regard to PHI unless the Business Associate took prompt and reasonable steps to cure the breach or end the violation, as applicable, and if such steps were unsuccessful, terminated the contract or arrangement with such entity, if feasible.

p) Upon the enactment of any law or regulation affecting the use or disclosure of PHI, or any change in applicable federal law including revisions to HIPAA; upon publication of any decision of a court of the United States or of the Commonwealth of Virginia, relating to PHI or applicable federal law; upon the publication of any interpretive policy or opinion of any governmental agency charged with the enforcement of PHI disclosures or applicable

federal law, the County reserves the right, upon written notice to the Business Associate, to amend this Business Associate Agreement as the County determines is necessary to comply with such change, law or regulation. If the Business Associate disagrees with any such amendment, it shall so notify the County in writing within thirty (30) days of the County's notice. In case of disagreement, the parties agree to negotiate in good faith the appropriate amendment(s) to give effect to such revised obligation. In the County's discretion, the failure to enter into an amendment shall be deemed to be a default and good cause for termination of the Underlying Agreement.

q) The County makes no warranty or representation that compliance by the Business Associate with this Business Associate Agreement, HIPAA, the HITECH Act, federal law or the regulations promulgated thereunder will be adequate or satisfactory for the Business Associate's own purposes or to ensure its compliance with the above. The Business Associate is solely responsible for all decisions made by it, its workforce members, agents, employees, subsidiaries and subcontractors regarding the safeguarding of PHI and compliance with federal law.

r) The Business Associate agrees that its workforce members, agents, employees, subsidiaries and subcontractors shall be bound by the confidentiality requirements herein and the provisions of this Business Associate Agreement shall be incorporated into any training or contracts with the same.

s) This Business Associate Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same document.

t) This Business Associate Agreement shall replace and supersede any prior Business Associate Agreement entered between the parties.

IN WITNESS WHEREOF, each party hereto has executed this Business Associate Agreement in duplicate originals on the date below written:

Arlington County, Virginia		**Cigna Health and Life Insurance Company**	
By:	Marcy Foster (Signature)	By:	Julia Huggins (Signature)
Name:	Marcy Foster	Name:	Julia Huggins
Title:	County Privacy Officer	Title:	Vice President
Date	9/16/14	Date:	

EXHIBIT F
To AGREEMENT No. 719-13-1
Metropolitan Washington Council of Governments Rider Clause

USE OF CONTRACT(S) BY MEMBERS COMPRISING THE METROPOLITAN WASHINGTON COUNCIL OF GOVERNMENTS PURCHASING OFFICERS' COMMITTEE.

A. If authorized by the bidder(s), resultant contract(s) will be extended to any or all of the listed members as designated by the bidder to purchase at contract prices in accordance with contract terms.

B. Any member utilizing such contract(s) will place its own order(s) directly with the successful contractor. There shall be no obligation on the part of any participating member to utilize the contract(s).

C. A negative reply will not adversely affect consideration of your bid/proposal.

D. It is the awarded vendor's responsibility to notify the members shown below of the availability of the Contract(s).

E. Each participating jurisdiction has the option of executing a separate contract with the awardee. Contracts entered into with a participating jurisdiction may contain general terms and conditions unique to that jurisdiction including, by way of illustration and not limitation, clauses covering minority participation, non-discrimination, indemnification, naming the jurisdiction as an additional insured under any required Comprehensive General Liability policies, and venue. If, when preparing such a contract, the general terms and conditions of a jurisdiction are unacceptable to the awardee, the awardee may withdraw its extension of the award to that jurisdiction.

F. The issuing jurisdiction shall not be held liable for any costs or damages incurred by another jurisdiction as a result of any award extended to that jurisdiction by the awardee.

BIDDER'S AUTHORIZATION TO EXTEND CONTRACT:

YES	NO	JURISDICTION	YES	NO	JURISDICTION
		Alexandria, Virginia			Manassas, Virginia
		Alexandria Public Schools			City of Manassas Public Schools
		Alexandria Sanitation Authority			Manassas Park, Virginia
		Arlington County, Virginia			Maryland-National Capital Park & Planning Comm.
		Arlington County Public Schools			Metropolitan Washington Airports Authority
		Bowie, Maryland			Metropolitan Washington Council of Governments
		Bladensburg, Maryland			Montgomery College
		Charles County Public Schools			Montgomery County, Maryland
		College Park, Maryland			Montgomery County Public Schools
		Culpeper County, Virginia			OmniRide
		District of Columbia			Prince George's County, Maryland
		District of Columbia Courts			Prince George's Public Schools
		District of Columbia Public Schools			Prince William County, Virginia
		Fairfax, Virginia			Prince William County, Virginia
		Fairfax County, Virginia			Prince William County Public Schools
		Fairfax County Water Authority			Prince William County Service Authority
		Falls Church, Virginia			Rockville, Maryland
		Fauquier County, Virginia Schools & Government			Spotsylvania County Schools
		Frederick, Maryland			Stafford County, Virginia
		Frederick County, Maryland			Takoma Park, Maryland
		Gaithersburg, Maryland			Upper Occoquan Sewage Authority
		Greenbelt, Maryland			Vienna, Virginia
		Herndon, Virginia			Virginia Railway Express
		Leesburg, Virginia			Washington Metropolitan Area Transit Authority
		Loudoun County, Virginia			Washington Suburban Sanitary Commission
		Loudoun County Public Schools			Winchester, Virginia
		Loudoun County Sanitation Authority			Winchester Public Schools

VENDOR NAME: _____

EXHIBIT G
To AGREEMENT No. 719-13-1
CLAIMS AUDIT AGREEMENT

A. WHEREAS, Cigna Health and Life Insurance Company ("Cigna") desires to cooperate with requests by Arlington County Government("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 Cigna.

C. WHEREAS, the Auditor and the Employer recognize Cigna'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, Cigna, the Employer and the Auditor hereby agree as follows:

1. Audit Specifications

The Auditor will specify to Cigna 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

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

3. Access to Information

Cigna 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 Cigna 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 Cigna at the same time that the Audit findings and the Audit Report are submitted to the Employer.

5. Comment on Audit Report

Cigna 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 Cigna 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 Cigna;

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 Cigna 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 Cigna executed by an officer of Cigna, 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 Cigna 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 Cigna's provision of information to the Auditor.

8. Termination

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

Date _____ Cigna Health and Life Insurance Company

By: TO BE SIGNED AT TIME OF AUDIT
Duly Authorized

Date _____ Auditor: _____

By: TO BE SIGNED AT TIME OF AUDIT
Duly Authorized

Date _____ Employer: _____

By: TO BE SIGNED AT TIME OF AUDIT
Duly Authorized