ATTACHMENT 5: CIGNA MEDICAL AND RX CURRENT CONTRACT

Jessica S. Sheriff
Contractual Agreement Unit Manager
Cigna

Routing B2CAU
900 Cottage Grove Road
Hartford, CT 06152
Telephone 860.226.9743
Facsimile 860.730.3944
jessica.sheriff@cigna.com

September 18, 2013

Ms. Lori Parsons
City of Naples
735 Eighth Street South
Naples, FL 34102

RE: Administrative Services Only Account No. 3327028

Dear Ms. Parsons:

This letter will serve as an amendment to the Administrative Services Only Agreement between Connecticut General Life Insurance Company ("Connecticut General"), and City of Naples ("Employer") effective October 1, 2007, (the "Agreement"), and as amended on October 1, 2009 and October 1, 2010 which was assigned by Connecticut General to Cigna Health and Life Insurance Company, ("CHLIC") on October 1, 2012.

Effective as of October 1, 2013, the Agreement is hereby amended as set forth below. Any provision or subsection set forth in this Amendment shall be deemed to: (a) replace in its entirety the same subsection in the current Agreement; and/or (b) add new provisions or subsections. Only those provisions and subsections set forth in this Amendment are deemed amended or added, and all provisions and subsections not identified herein shall be deemed unaffected by this Amendment and, accordingly, shall remain in full force and effect.

Section 2.c. "Claim Administration and Additional Services," of the Administrative Services Only Agreement, is hereby amended in its entirety as follows:

c. Employer hereby delegates to CHLIC the authority, responsibility and discretion to determine coverage under the Plan based on the eligibility and enrollment information provided to CHLIC by Employer. Employer also hereby delegates to CHLIC the authority, responsibility and discretion to (i) make factual determinations and to interpret the provisions of the Plan to make coverage determinations on claims for Plan Benefits, (ii) conduct a full and fair review of each claim which has been denied as required by ERISA, (iii) decide level one mandatory appeals of "Urgent Care Claims" "Concurrent", "Pre-service" and "Post-service" claims (as those terms are defined under ERISA) and notify the Member or the Member's authorized representative of its decision. Employer will ensure that all summary plan description materials provided to Members reflect this delegation.

"Cigna" is a registered service mark, and the "Tree of Life" logo is a service mark, 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 and not by Cigna Corporation. Such operating subsidiaries include Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company, Cigna Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc.

Section 6.c. "Claim Audits and Confidentiality," of the Administrative Services Only Agreement is hereby amended in its entirety as follows:

c. CHLIC will maintain the confidentiality of all Protected Health Information in its possession in accordance with the Privacy Addendum in Exhibit D and any applicable state privacy laws, including, without limitation, 201 CMR 17.00: Massachusetts Standards for the Protection of Personal Information of Residents of the Commonwealth.

Section 10, "Laws Governing Contract," of the Administrative Services Only Agreement, is hereby amended as follows; the existing paragraph is hereby now referred to as provision a and the following is added as provision b.

b. The Parties shall perform their obligations under this Agreement in conformance with all applicable laws and regulatory requirements.

Section 21, "Definitions," of the Administrative Services Only Agreement, is hereby amended to add the following definition to the existing section as follows:

Applicable Law – means the state, federal and international laws and regulations that apply. Applicable Law includes but is not limited to the Employee Retirement Income Security Act of 1974, as amended and the rules and regulations thereunder ("**ERISA**"), the Health Insurance Portability and Accountability Act of 1996, as amended and the rules and regulations thereunder ("**HIPAA**"), the Foreign Corrupt Practices Act ("**FCPA**") and any other anti-bribery or anti-corruption laws in the countries where the Parties conduct business.

The Schedule of Financial Charges and Exhibit B-Services is hereby deleted in its entirety and replaced with the Schedule of Financial Charges and Exhibit B-Services, attached hereto.

Please indicate your agreement to the Amendment by signing the enclosed copy of this letter where indicated and returning it to me. Alternatively, this Amendment shall become effective on the effective date indicated unless Employer notifies CHLIC either electronically or in writing (at the address indicated above) within sixty (60) days of the date of this letter that it does not accept all the terms of this Amendment notwithstanding any provision to the contrary in the Administrative Services Agreement. In that case, CHLIC shall cooperate to negotiate mutually agreeable terms with Employer.

Once agreement with respect to the terms of the Amendment is reached, the Amendment will apply retroactively to the effective date.

Sincerely,

Jessica S. Sheriff
Its Contractual Agreement Unit Manager
Duly Authorized
Cigna Health and Life Insurance Company
JSS/DC

Accepted by: **CITY OF NAPLES**

By: ______________________________
Name:
Title:

Executed this ____ day of _______, in the year _______.

Schedule of Financial Charges

Certain fees and charges identified in this Schedule of Financial Charges will be billed to Employer monthly in accordance with CHLIC's then standard billing practices. However, CHLIC is authorized to pay all fees and charges from the Bank Account unless otherwise specified in this Agreement.

	MEDICAL ADMINISTRATION CHARGES	
Product	**Description**	**Charge**
Medical	• Open Access Plus (OAP) with PHS Plus Medical Management	**$39.69/participant/month**
Medical	• HRA Open Access Plus (OAP) with PHS Plus Medical Management	**$45.65/participant/month**
	MEDICAL NETWORK ACCESS FEE , UTILIZATION MANAGEMENT FEE AND OPTIONAL PROGRAM FEE	
Product	**Description**	**Charge**
Medical	• OAP Access Fee	**$12.88/participant/month Included in Medical Administration Charge**
Medical	• HRA OAP Access Fee	**$12.88/participant/month Included in Medical Administration Charge**
	CIGNA CHOICE FUND AND OTHER CONSUMER DIRECTED ACCOUNT ADMINISTRATION SERVICES AND CHARGES	
	Product	**Charge**
	• Cigna Choice Fund Health Reimbursement Account (HRA) Administration	**$5.96/participant/month Included in Medical Administration Charge**

Health Advisor – A	Cigna Health Advisor focuses on engaging targeted Members related to a variety of wellness and prevention topics, and is designed to facilitate healthy behaviors and promote achievement of health-related goals. The program includes the following components: • Targeted health and wellness coaching outreach on program topics of focus to help drive behavior change and help Members reach established goals • Education & Referral Coaching on program topics with referral to appropriate internal and external resources available • Access to educational materials and web based Member tools and resources • Identification of gaps in care and outreach to Members to provide coaching for those identified with gaps for high cholesterol, high blood pressure • Support of Participants identified through predictive modeling with certain preference sensitive care conditions by supplying impartial evidence based medical information, to empower Participants' to understand the potential benefits/ disadvantages of a specific courses of action and make more informed care decisions. • Answering health and medical related questions • Counseling Participants on prevention and the benefits of compliance with prescribed medications and treatments • Health and wellness coaching on high blood pressure, high cholesterol, healthy eating, physical activity, prevention, and pre-diabetes using multiple coaching sessions, behavior modification techniques and other motivational interviewing and coaching styles to encourage behavior change that helps Participants reach established goals.	**For HRA Only Included in Medical Access Fee**
	• Dependent Care Flexible Spending Account (DFSA) Administration	**$5.96/participant/month**
	• Health Care Flexible Spending Account (FSA) Administration	**$5.96/participant/month**

CIGNA PHARMACY BENEFIT MANAGEMENT SERVICES CHARGES AND RELATED PROVISIONS

Definitions

- "Average Wholesale Price" or "AWP" is the Average Wholesale Price for a given pharmaceutical product in effect on the dispense date for the actual package size dispensed as published by Medi-Span or other alternative publication or benchmark reasonably designated by CHLIC.
- "Brand Drug Claim" is a claim for a pharmaceutical product that is adjudicated as a brand drug as indicated on the claim record generated by the claim processing system used by CHLIC. For application of discounts and dispensing fees, a "Brand Drug Claim" includes a claim for a generic drug within its exclusivity period or other period of limited competition, as CHLIC reasonably determines under its standard policies.
- "Generic Drug Claim" is a claim for a pharmaceutical product that is adjudicated as a generic drug as indicated on the claim record generated by the claim processing system used by CHLIC. For application of discounts and dispensing fees, a "Generic Drug Claim" excludes a claim for a generic drug within its exclusivity period or other period of limited competition, as CHLIC reasonably determines under its standard policies.
- "Mail Service Pharmacy" or "Cigna Tel-Drug" or "Cigna Home Delivery Pharmacy" is a pharmacy that is owned or operated by CHLIC or an affiliated company(ies) (currently, Tel-Drug, Inc. and Tel-Drug of Pennsylvania, LLC), which dispenses drugs covered under the Plan's Pharmacy Benefit by mail, and is not a Retail Pharmacy.
- "Pharmacy Benefit" means the terms of the Plan that govern coverage and care/utilization management of drugs and related supplies dispensed to Members and charged to the Plan by the Mail Service Pharmacy or Retail Pharmacies through CHLIC's pharmacy claim processing system.
- "Rebates" or "Manufacturer Formulary Payments" means amounts that CHLIC collects under contracts it enters into with drug manufacturers that are based on utilization of certain of the manufacturers' brand drugs under the Plan's Pharmacy Benefit and the drug's status on the Cigna drug formulary.
- "Retail Pharmacy" is a pharmacy that is entitled to payment under the Plan for drugs it dispenses that are covered under the Plan's Pharmacy Benefit, and is not a Mail Service Pharmacy.
- "Specialty Drug Claim" is a claim for a pharmaceutical product that is reasonably determined by CHLIC to be a specialty drug in accordance with industry practice. Specialty drugs generally are (i) injected or infused and derived from living cells, or are oral non-protein compounds (e.g., oral chemotherapy drugs); (ii) target the underlying condition, which is usually one of a relatively rare, chronic and costly nature; and/or (iii) require restricted access and/or close monitoring.

PHARMACY ADMINISTRATION FEE

- Cigna Pharmacy Product administration fee: *Included in Medical Administration Charge*

CHARGES FOR DRUGS COVERED UNDER THE PLAN'S PHARMACY BENEFIT

Drug Dispensed by Mail Service Pharmacy: CHLIC will charge Employer the following for claims covered under the Plan's Pharmacy Benefit and dispensed by the Mail Service Pharmacy:

Brand Drug Claims: AWP minus an average discount of 17.00% plus an average dispensing fee of $0.00.

Generic Drug Claims: The drug's charge on a CHLIC generic Maximum Allowable Charge schedule that generates an annual average aggregate discount across Generic Drug Claims dispensed at CIGNA Home Delivery Pharmacy to CHLIC group-client book of business of AWP minus 71.5% plus an average dispensing fee across such Generic Drug Claims of not more than $0.00.

Specialty Brand Drug Claims: The drug's charge under a national discount schedule that generates a 13.2% annual average aggregate discount off AWP for Specialty Drug Claims dispensed at CIGNA Home Delivery Pharmacy across CHLIC 's group-client book of business (including Specialty Drug Claims dispensed by Mail Service Pharmacy, whether covered under group-clients' Cigna Pharmacy Benefit or Cigna medical benefit)

Drugs Dispensed by Retail Pharmacies: CHLIC will charge Employer the following for drugs covered under the Plan's Pharmacy Benefit and dispensed by a Retail Pharmacy to the Plan Members, subject to the "Drug Charges – Additional Provisions" section:

Retail Brand Drug Claims: The lesser of (i) AWP minus the contracted discount plus the contracted dispensing fee charged by the Retail Pharmacy for the Brand Drug Claim; or (ii) the Retail Pharmacy's usual and customary charge.

Retail Generic Drug Claims (other than those to which the above brand discount applies): The lesser of: (i) the drug's charge on a CHLIC generic Maximum Allowable Charge schedule that generates an annual average aggregate discount across Generic Drug Claims dispensed at Retail Pharmacies to CHLIC group-client book of business of AWP minus 69.5% (Plan-specific results may vary based on drug mix), plus an average dispensing fee across such Generic Drug Claims of no more than $1.90; or (ii) the Retail Pharmacy's usual and customary charge.

Retail Specialty Brand Drug Claims: The lesser of (i) AWP minus an annual average aggregate discount of 10.5%, plus an average dispensing fee of no more than $1.35; or (ii) the Retail Pharmacy's usual and customary charge.

DRUG CHARGES – ADDITIONAL PROVISIONS

- Cigna Home Delivery Pharmacy's discounts are applied to the manufacturer average wholesale price (AWP) for the dispensed size (or to the AWP for the manufacturer-packaged quantity closest to the dispensed size, if there is no AWP for the dispensed size).
- Cigna Home Delivery Pharmacy will be reimbursed through the Bank Account for the price (discounted as per this Schedule) for replacement prescriptions shipped by Cigna Home Delivery Pharmacy which are reported as lost or damaged despite Cigna Home Delivery Pharmacy's shipment to the Participant's correct name and address.
- The amount paid to the Retail Pharmacy for Brand, Generic, or Specialty Drug Claims may or may not be equal to the amount charged to Employer, and CHLIC will absorb or retain any difference.
- An excess achieved in any Plan-specific discount floor or dispensing fee cap offered under this Agreement will be used to offset a shortfall in any other Plan-specific discount floor or dispensing fee cap offered under this Agreement.
- Industry Changes to or Replacement of Average Wholesale Price (AWP). Notwithstanding any other provision in this Agreement, including in this Exhibit, in the event of any major change in market conditions affecting the pharmaceutical or pharmacy benefit management market, including, for example, any change in the markup, methodologies, processes or algorithms underlying the published AWP(s), CHLIC may adjust any or all of the charges, rates, discounts, guarantees and/or fees in connection with CHLIC's administration of the Plan's Pharmacy Benefit hereunder, including any that are based on AWP, as it reasonably deems necessary to preserve the economic value or benefit of this Agreement as it existed immediately prior to such change. Additionally, and notwithstanding any other provision in this Agreement, including in this Exhibit, CHLIC may replace AWP as its pharmaceutical pricing benchmark with an alternative benchmark and/or may replace Medi-Span, or other such publication as its source for the AWP or alternative benchmark with a different pricing source, provided that CHLIC adjusts any or all such AWP-Based Charges or such alternative benchmark-based charges as it reasonably deems necessary to preserve the economic value or benefit of this Agreement as it existed immediately prior to such replacement or immediately prior to the event(s) giving rise to such replacement, as the case may be.

DRUG MANUFACTURER-PAYMENT SHARING

Subject to the caveats below, CHLIC will remit to Employer the following portion of Rebates that CHLIC collects with respect to utilization under the Plan's Pharmacy Benefit:

$2.00 per Retail Pharmacy Brand Drug Claim and $5.00 per Mail Service Pharmacy Brand Drug Claim.

Caveats:

(1) Upon termination of this Agreement, CHLIC may apply Rebates otherwise payable to offset Bank Account or other deficits of charges identified in this Agreement.

(2) Should Employer terminate this Agreement before completion of the then-current Plan Year, no Rebates shall be due with respect to that Plan Year.

(3) All applicable caveats communicated in writing by CHLIC in connection with its proposal made in connection with this Agreement.

(4) For percentage-based sharing arrangements, payout amount may differ slightly from the stated percentage when payout occurs before manufacturers' final reconciliations and payments are made to CHLIC.

(5) Rebates are not paid out on Run-Out Claims.

(6) CHLIC contracts with drug manufacturers on its own behalf, and not as agent of the Employer or the Plan.

Timing of Rebate Pay-Out: Remittance will be provided within ninety (90) days after the close of each applicable calendar year for the portion of such calendar year that coincides with the Plan Year.

AUDIT RIGHTS RELATED TO MANUFACTURER PAYMENTS

Employer's third party auditor may audit records directly related to CHLIC's performance of its obligations hereunder regarding sharing of manufacturer formulary payments (a/k/a "rebates") once in each twelve-month period upon the following conditions: Employer shall provide at least forty-five (45) days written notice to CHLIC; the auditor (including its individual auditors conducting the audit) shall be agreeable to Employer and CHLIC; a mutually agreed upon non-disclosure/non-use contract shall be executed by Employer, the auditor and CHLIC; the records to be audited shall be no more than two years old as of the date of the audit; the scope of records to be audited shall be as mutually agreed upon by Employer's third party auditor and CHLIC as those which are necessary to determine compliance with the rebate-sharing obligations under this Agreement; the audit shall be conducted at a mutually acceptable time during regular business hours at CHLIC's office where such records are located; records shall not be removed or photocopied without CHLIC's express written consent; the auditor shall provide its audit report to CHLIC and Employer at the same time; and the auditor may disclose the aggregate amount of manufacturer formulary payments due Employer but no other details of CHLIC's manufacturer contracts of which the auditor is apprised, if any.

FEES FOR PROCESSING RUN-OUT CLAIMS		
OAP, HRA OAP	Run-Out Period of twelve (12) months CHLIC shall not be required to process Run-Out Claims until it has received full payment of the required fees.	**The sum of the last four (4) months of billed fees applicable to the terminated (i) Agreement, (ii) Plan benefit option or (iii) Members.**
Pharmacy	Run-Out Period of three (3) months for all pharmacy claims CHLIC shall not be required to process Run-Out Claims until it has received full payment of the required fees.	**The sum of the last three (3) months of billed fees applicable to the terminated (i) Agreement, (ii) Plan benefit option or (iii) Members.**
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).	**5% of recovery plus litigation costs if Counsel is retained and an appearance is filed on behalf of CHLIC 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.**

CHLIC COST CONTAINMENT FEES

CHLIC, 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, CHLIC contracts with vendors to perform program related services. Specific vendor fees are available upon request. CHLIC'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; CHLIC pays the applicable vendor fee) or (3) the "recovery" (i.e. the amount recovered) as applicable.

For covered services received from non-Participating Providers, CHLIC 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 CHLIC's own health care insurance business when these programs are implemented. CHLIC 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 AND PHARMACY 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	
	• Line Item Analysis	**Lesser of 5% of hospital bill or the savings achieved**
	• Professional Fee Negotiation	**29% of net savings**
	Outpatient Hospital Bill Review	
	• Professional Fee Negotiation	**29% of net savings**
	• Line Item Analysis Re-pricing	**29% of net savings**

	Physician/Professional Bill Review	**29% of net savings**
	• Professional Fee Negotiation	**29% of net savings**
	• 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 CHLIC 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.	Pharmacy Vendor Recoveries	**30% of recovery**
10.	Class Action Recoveries	**35% of recovery**

CARE MANAGEMENT/COST CONTAINMENT PROGRAM FEES		
	CHLIC 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 CHLIC, 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		
	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		
	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**

STRATEGIC ALLIANCES		
	CHLIC 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 CHLIC'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		
	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 CHLIC'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		
	Unless indicated otherwise in the Schedule of Financial Charges, CHLIC retains all payments it may receive from manufacturers of pharmaceutical products covered under the Plan. Information on the amount of such payments with respect to the Plan will be provided upon request.	**All Pharmacy Products**
	From time to time, CHLIC, directly or through its affiliates, contracts with third party parties (e.g., service vendors, provider network managers) for referring them to Employer or to provide various services (e.g., cost-containment initiatives) in connection with the Plan. CHLIC and its affiliates may receive payments from such third parties for such referrals or to help defray expenses associated with implementing the services provided to the Plan.	**All Products**

	COMPLIANCE ASSISTANCE	
	Upon request by the Employer, CHLIC 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.	
1.	Preparation of SBC, translation notice. CHLIC will not be responsible for any changes that Employer makes to the SBC.	**No charge**
2.	Provide SBC, translation notices prepared by CHLIC to Employer electronically as well as any updates or material modifications.	**No charge**
3.	Include in SBC a summary of benefits administered by carve-out vendor if Employer or carve-out vendor provide CHLIC 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**
	ADDITIONAL SERVICES	
Service	**Description**	**Charge**
HIPAA Certificates	Individual HIPAA certificates for Members who leave active coverage.	**$0.15/participant/month Included in Medical Administration Charge**
Behavioral Health	Behavioral Care Advocacy provides behavioral health services in which claims are funded on a fee-for-service basis. It includes focused utilization review and case management for both inpatient and outpatient, in-network behavioral health services. *(This payment arrangement is with respect to the CA/NC member population only).*	**HRA OAP Product: Included in Medical Access Fee**
Clinical Program	Cigna TheraCare® Program – a targeted condition drug therapy management program that targets individuals using specialty medications for certain chronic conditions and helps them better understand their condition, medication side effects and importance of adherence.	**Included at No Additional Cost**

Your Health First	A proactive health education and improvement program for those with a chronic condition. The program involves services that span across the Member's health needs. Behavioral coaching principles and evidence based medicine guidelines are utilized to optimize self-management skills and foster sustained health improvements. The program targets a chronic population at high risk for near term and future high cost medical expenses. Members are identified as having a chronic condition through a variety of sources which may include: claims data, referrals, and self-identification. A variety of resources is provided to those with a chronic condition, including access to online tools, personalized support, and targeted materials. The program includes the following components for those with a chronic condition: • Chronic Condition-specific coaching • Pre- and post-discharge calls • Lifestyle management coaching: stress, weight management and tobacco cessation • Treatment decision support and coaching In order to continuously improve the effectiveness of our programs, a small sample of Members may be placed in a comparison group which receives alternative services for a limited period of time.	**For OAP & HRA OAP Products: $9.09participant/month**
Medical Conversion Privilege	Converting Employee Resides in FL: Comprehensive, Base Plan/Major Medical & PPO Plans	**$20,000/conversion policy**

Exhibit B – Services

BANKING AND ADMINISTRATION		
Products excluding Health Savings Account		
1.	Furnishing CHLIC's standard Bank Account activity data reports to Employer as and when agreed upon. CHLIC's administration of the Plan does not include performing obligations, if any, under state escheat or unclaimed property laws. It is Employer's responsibility to determine the extent to which these laws may apply to the Plan and to comply with such laws.	**All Products**
2.	Report to Employer the claim payment information required in connection with Section 6041of the Internal Revenue Code.	**All Products**
3.	If Employer has elected, pursuant to section 63 of the New York Health Care Reform Act of 1996 (section 2807-t of the Public Health Law) ("the Act"), to pay the assessment on covered lives set forth in section 63 and has consented to the conditions set forth in section 63, CHLIC shall file such forms and pay such assessment on covered lives on behalf of Employer through the Bank Account to the extent set forth in section 63. Such obligation shall end immediately upon Employer's failure to provide any information required by CHLIC to fulfill this obligation, the failure to comply with any requirement imposed upon Employer pursuant to the Act or the failure of Employer to properly fund the Bank Account. In addition, where permitted, CHLIC will file applicable forms and pay on behalf of Employer and/or the Plan any assessment, surcharge, tax or other similar charge which is required to be made by you or the Plan based on covered lives and/or paid claims or otherwise in accordance with and as required by other applicable state and/or federal laws and regulations and your bank account will be charged for any such payments made by CHLIC.	**All Products**

CLAIM ADMINISTRATION		
Products <u>excluding</u> Health Savings Account		
1.	Calculate benefits, check and/or electronic payments disbursed from Employer's Bank Account. Bank Account payments will appear in Employer's standard Bank Account activity data reports.	**All Products**
2.	Prepare and make available CHLIC's standard claim forms.	**All Products**
3.	Investigate claims, as necessary, by CHLIC's Special Investigations Unit.	**All Products**
4.	Discuss claims, when appropriate, with providers of health services.	**All Products**
5.	Perform internal audits of plan benefit payments on a random sample basis.	**All Products**
6.	Claim control procedures reported annually in Statement on Standards for Attestation Engagements (SSAE) No. 16 Report (SAS70 successor report).	**All Products (excluding Vision)**
7.	Respond to Insurance Department complaints.	**All Products**
8.	Dedicated toll-free telephone line for Member and Provider calls to CHLIC Service Centers.	**All Products**
9.	Member Explanation of Benefit ("EOB") statements including, when applicable, notice of denied claims, denial reason(s) and appeal rights.	**All Products**
10.	Verify enrollment and eligibility using Member information submitted by Employer and/or its authorized agent.	**All Products**
Medical Only		
1.	CHLIC's standard enrollment forms are prepared and delivered to Employer for distribution to individuals eligible to enroll in the Plan.	**All Medical Products**
2.	CHLIC's standard ID card with toll-free telephone number are prepared and mailed directly to Members.	**All Medical Products**
3.	Administration of subrogation/conditional Claim Payment (terms described in Exhibit E).	**All Medical Products**

Pharmacy Only		
1.	CHLIC's standard ID cards with toll-free telephone number are prepared and mailed directly to Members.	**All Pharmacy Products**
2.	Pharmacy claims are adjudicated typically on-line at time of service without access to information on other coverage, and therefore coordination of benefits (COB) for pharmacy claims does not occur. Claims for Plan Benefits will be paid regardless of coverage under another plan.	**All Pharmacy Products**
3.	CHLIC's standard drug utilization review services.	**All Pharmacy Products**
4.	CHLIC may receive and retain payments under contracts with drug manufacturers with respect to utilization covered under the Employer's medical benefit for the manufacturer's specialty drugs, which are drugs that typically are injected or infused and derived from living cells; target an underlying rare, chronic or costly condition; and/or require restricted access and/or close monitoring. If CHLIC enters into any such contracts, it does so on its own behalf, and not as agent of the Employer or the Plan.	**All Pharmacy Products**
Health Care Flexible Spending Account and Dependent Care Flexible Spending Account Only		
1.	Providing generic enrollment forms and reimbursement request forms to Employer for use in connection with Health Care Flexible Spending Account ("FSA") and/or Dependent Care Flexible Spending Account ("DFSA") under which eligible employees (collectively "FSA Members") may elect to reduce their salary on a pre-tax basis up to the IRS maximum contribution allowed for deposit into a FSA and/or DFSA.	**FSA and DFSA Products**
2.	At the end of each reimbursement period of the Plan Year, CHLIC shall issue payments to the extent that funds remain in each FSA Member's account, for the amount that is determined by it to be proper under the Plan. At the end of the final reimbursement period of the Plan Year, CHLIC shall issue payments for any amount then due for those expenses that are determined by it to be proper under the Plan.	**FSA and DFSA Products**
3.	Allowable expenses for reimbursement under a DFSA include all allowable expenses incurred for the care of dependents pursuant to I.R.C. Sections 125 and 129.	**DFSA Product**
4.	Allowable expenses for reimbursement under a FSA include all allowable health-related expenses, pursuant to I.R.C. Sections 125 and 213 except where reimbursement under a FSA is prohibited.	**FSA Product**

5.	FSA Member accounts will remain open after conclusion of the Plan Year until December 31st, (the "Run Out Period"), so that FSA Members can submit any remaining expenses incurred but not paid out during the Plan Year. Separate account balances will be maintained as per FSA Member's election for the new Plan Year.	**FSA and DFSA Products**
6.	Reimbursement requests of terminating FSA Members will continue to be processed for (90) ninety days following termination of Membership for any expenses incurred prior to the Membership termination date. In the case of a DFSA, reimbursement will be up to the balance in the DFSA and in the case of a FSA, reimbursement will be to the originally selected goal amount, minus prior reimbursements, regardless of whether this amount has been funded.	**FSA and DFSA Products**
7.	For FSA payments that are not made with a Debit Card but are a result of Automatic Claim Forwarding of medical or dental claims from a medical or dental plan administered by CHLIC or Direct Submit Request For Reimbursement, an explanation of payment will be mailed to the FSA Member at their home address or, if elected, provided electronically. An explanation of payment is not issued for FSA payments that are issued to a pharmacy at the point of service as a result of Automatic Claim Forwarding from the employee's pharmacy Plan.	**FSA Product**
8.	For DFSA payments made as a result of a Direct Submit Request For Reimbursement, an explanation of payment will be mailed to the DFSA Member at their home address or, if elected, provided electronically.	**DFSA Product**
9.	An 800 number directly linked to CHLIC's Member Services will be available for FSA Members' questions and status inquiries. This 800 number will be listed in the instructions on the reimbursement request form as well as having access to account information via Internet.	**FSA and DFSA Products**
10.	The Employer will identify through eligibility submission, FSA Members who elect to have medical and pharmacy claims processed but unpaid by CHLIC automatically submitted ("rolled over") to their FSA. Such rollover claims will be processed without additional submissions by the Participant and CHLIC shall be entitled to rely on the Employer's submission of the Participant's rollover election that the submitted expenses were properly incurred, not reimbursable from any other source and are eligible for payment under the regulations governing flexible spending accounts.	**FSA Product**
11.	When CHLIC takes over a FSA administration mid-Plan Year, CHLIC will provide administration services from the date CHLIC receives the FSA Plan information for claims incurred anytime during the Plan year.	**FSA and DFSA Product**

Health Reimbursement Account (HRA), Healthy Awards (HA) and Healthy Future (HF) Only		
1.	Providing reimbursement request forms to Employer.	**HRA Products**
2.	Employer will make available specific funds to eligible employees enrolled in the HRA, HA and/or HF as applicable (**"Participating Members"**). At the end of each reimbursement period of the Plan Year, CHLIC shall issue payments to Participating Members (or their medical provider, if appropriate) to the extent of the maximum amount of payment allowed by Employer reduced by prior reimbursements for the same period of coverage, for the amount that is determined by it to be proper under the Plan.	**HRA Products**
3.	Allowable expenses for reimbursement under a HRA, HA and/or HF, as applicable, include all allowable health-related expenses, pursuant to I.R.C. Section 213 except where payment for any such products is prohibited. The Employer can further limit the allowable expenses as agreed to by the Employer during implementation.	**HRA Products**
4.	Account balances for Participating Members active until the end of the Plan Year will remain open after conclusion of the Plan Year for a period of (90) ninety days, (the "**Run Out Period**"), so that such Participating Members can submit any remaining expenses incurred during the Plan Year.	**HRA Products**
5.	Requests of Members terminating as Participants will continue to be processed for (90) ninety days following termination for any expenses incurred prior to their Membership termination date up to the originally selected goal amount, minus prior reimbursements.	**HRA Products**
6.	For reimbursement payments that are made as a result of Automatic Claim Forwarding of medical claims from a medical plan administered by CHLIC or Direct Submit Request For Reimbursement, an explanation of payment will be mailed to the Participating Member at their home address. An explanation of payment is not issued for payments that are issued to a pharmacy at the point of service as a result of Automatic Claim Forwarding from the employee's pharmacy Plan or for any Debit Card transactions.	**HRA Products**
7.	Providing information on account balances and submitted claims to Participating Members calling the number on the ID card. In addition, Participating Members will have access to account information via Internet.	**HRA Products**

8.	Medical claims processed but unpaid by CHLIC will be automatically submitted for reimbursement from the HRA and/or HA Member's HRA and/or HA account. Such "rollover" claims will be processed without additional submissions by the Participating Member.	**HRA Products**
9.	When CHLIC takes over HRA, HA and/or HF administration mid-Plan Year, CHLIC will provide administrative services from the date the Plan information is received.	**HRA Products**
10.	Pharmacy claims: Eligible pharmacy expenses, under the HRA and/or HA that are processed but unpaid by CHLIC may be automatically submitted ("rolled over") to the Reimbursement Accounts Claim Office for reimbursement from the Participating Member's HRA, HA and/or HF account if the AutoPay option is enabled. Such rollover claims will be processed without additional submissions by the Participating Member. When pharmacy is covered and Cigna Pharmacy is the pharmacy vendor, the HRA and/or HA will automatically pay the pharmacy through the HRA and/or HA at the point of sale for all Participating Member obligations under the pharmacy Plan including deductibles, copays, and/or coinsurance obligations. A Participating Member will not receive an Explanation of Benefits for these payments.	**HRA Products**
DOCUMENT PRODUCTION		
Products excluding Health Savings Account		
	Prepare Member benefit booklet drafts to Employer.	**All Products**
UNDERWRITING SERVICES		
1.	5500 Schedule C reporting.	**All Products**
2.	5500 Schedule A or Annual Reconciliation Disclosure reporting (when applicable)	**All Products**
3.	CHLIC's standard Underwriting services: a) benefit design analysis-b) projected cost analysis.	**All Products**
HIPAA INDIVIDUAL RIGHTS		
Products excluding Health Savings Account		
	Handling of requests from Members for access to, amendment and accounting of protected health information, and requests for restrictions and alternative communications as required under federal HIPAA law and regulations, as set out in this Agreement and its Exhibits.	**All Products**

	COST CONTAINMENT	
1.	Maximum reimbursable charge determinations of non-Participating Provider charges for covered services.	**All Medical Products (with out-of-network benefits)**
2.	CHLIC's standard cost containment controls: Application of non-duplication and coordination of benefits rules and coordination with Medicare.	**All Medical Products**
3.	Delivery of information, as necessary, regarding standard application of non-duplication or coordination of benefits.	**All Medical Products**
4.	Review of medical bills in accordance with CHLIC's then current Medical Bill Review program.	**All Medical Products**
5.	Network Savings Program, a national vendor network that provides discounted rates when a Member accesses care through a Network Savings Program contracted provider.	**All Medical Products**
6.	Annual reporting of CHLIC's standard cost containment results upon Employer's request.	**All Medical Products**
7.	Pharmacy Vendor Recoveries.	**All Pharmacy Products**
	CUSTOMER REPORTING	
1.	Summary reports of medical and pharmacy cost and utilization experience are available through Cigna's web site, CignaAccess.com.	**All Medical and Pharmacy Products**
2.	CHLIC's standard pharmacy utilization reports.	**Pharmacy Product Only**
3.	Claim Reporting: CHLIC will provide its standard reports and information based upon paid claim data only. CHLIC will not provide information on incurred-but-not reported claims, projected claims, pre-certifications of coverage, case management information or information on a Member's prognosis or course of treatment. Stop Loss Reporting is an optional service provided at an additional fee to Employers who have stop loss through another entity other than CHLIC. CHLIC will provide its standard reporting only after the stop loss carrier and Employer have executed CHLIC's standard Hold Harmless/Confidentiality Agreement.	**All Medical Products**

4.	CHLIC's standard management and statistical reports for Employer.	**FSA and DFSA Products**
5.	CHLIC's standard Individual Summary Statements for applicable Participants.	**FSA, DFSA, and HRA Products**
6.	CHLIC's standard Health Reimbursement Account, Healthy Awards and/or Healthy Future activity report for Employer.	**HRA Products**
	COMPLIANCE	
	Employer directs CHLIC in administering the Health Care Flexible Spending Account and/or Health Reimbursement Account benefit to comply with COBRA as follows:	
1.	Each FSA Member who experiences a qualifying event and elects continuation of account coverage in accordance with COBRA will be maintained until the earlier of the end of the Plan Year, the exhaustion of the FSA balance or other termination of the FSA.	**FSA Product**
2.	FSA Members electing continuation of FSA coverage under COBRA will continue contributions at a rate not to exceed 102% of the applicable premium. The Employer may require after-tax contributions, or may allow the continuant to elect a lump-sum salary reduction in the amount required in contributions for the remainder of the coverage period.	**FSA Product**
3.	FSA Members who continue under COBRA and whose contributions have been made as required may submit Reimbursement Requests for themselves and any eligible dependents, for expenses incurred before or after the date of the qualifying event but prior to the end of the coverage period. Requests may be submitted until the earlier of the end of the Plan Year or the termination of the FSA, including any applicable Run-Out Period.	**FSA Product**
4.	The HRA, HA and/or HF of each HRA, HA and/or HF Member who experiences a qualifying event and elects continuation of account coverage in accordance with COBRA will be maintained similar to the maintenance of an active employee. HF members that have not met their vesting requirements determined by the plan are not required to be offered COBRA for the HF.	**HRA Products**

MEMBER EXTERNAL REVIEW PROGRAM		
	CHLIC contracts with three (3) independent review organizations that meet the Patient Protection and Affordable Care Act (PPACA) external review requirements. Members may appeal eligible claims to an external independent review organization which is selected by CHLIC on a random basis. If Employer has chosen not to participate in this program, the Employer may be responsible for making other arrangements to meet the Patient Protection and Affordable Care Act (PPACA) external review requirements.	**All Medical Products**
MEDICAL MANAGEMENT SERVICES		
	CHLIC provides integrated medical management that includes (depending upon the terms of the Plan) the following core services.	
1.	Pre-Admission Certification and Continued Stay Review (PAC/CSR) services to certify coverage of acute and sub-acute inpatient admissions/stays or provides guidance to appropriate alternative settings. Administered in accordance with CHLIC's then applicable medical management and claims administration policies, practices and procedures.	**All Medical Products**
2.	Case Management and Retrospective Review of Inpatient Care, a service designed to provide assistance to a Member who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support.	**All Medical Products**
3.	Assisting providers with resources and tools to enable them to develop long term treatment plans in the management of chronic or catastrophic cases.	**All Medical Products**
4.	The Cigna HealthCare Healthy Babies® Program is a one time educational mailing which provides Participants with prenatal care education and resources to help them better manage their pregnancy.	**All Medical Products**
5.	HealthCare Cost and Quality tools on myCigna.com	**All Medical Products**
6.	A panel of physicians and other clinicians to assess the safety and effectiveness of new and emerging medical technologies. The panel meets monthly to review and update coverage policies.	**All Medical Products**
7.	Cigna HealthCare 24-Hour Health Information Line℠ a service that provides 24 hour toll free access to registered nurses who provide answers to healthcare questions, recommend appropriate settings for care and assist Participants in locating physicians. It also includes access to an extensive audio library on a wide range of medical topics.	**All Medical Products**

8.	Cigna *LifeSOURCE* Transplant Network® contracts with over six-hundred (600) transplant programs at more than one-hundred forty five independent transplant facilities and provides access to solid organ and bone marrow/stem cell transplantation while improving cost containment and reducing financial risk.	**All Medical Products**
9.	A health education program that delivers mailings to Members with certain conditions.	**All Medical Products Except Comprehensive and Indemnity**
10.	If behavioral health services are provided/arranged by Cigna Behavioral Health (CBH), CBH provides utilization review and case management for both inpatient and outpatient, in-network behavioral health services.	**HRA OAP Product:** ***All Members*** **OAP Product:** ***Non-CA/NC Members***
11.	Implementing clinical quality measurements, managing data, tracking and validating performance and initiating continuous quality improvement.	**All Medical Products Except Comprehensive and Indemnity**
12.	Transition of care services to allow Members with defined conditions to continue treatment with non-Participating Providers after enrollment for continued uninterrupted care for a limited time.	**All Medical Products Except Comprehensive and Indemnity**
13.	Focused utilization management of outpatient procedures and identification of appropriate alternatives. Administered in accordance with CHLIC's then applicable medical management and claims administration policies, practices and procedures.	**All Medical Products with PHS Plus**
NETWORK MANAGEMENT SERVICES		
	CHLIC, and/or its affiliates shall:	
1.	Provide or arrange access to the applicable network of Participating Providers to furnish health care services/products to Members at negotiated rates and methods of reimbursement (e.g. fee-for service, capitation, per diem charges, incentive bonuses, case rates, withholds etc.). The amount and type of negotiated reimbursement may vary depending upon the type of plan. For example, a hospital may accept less for patients enrolled in certain types of plans than others;	**All Medical Products**
2.	Credential and re-credential Participating Providers in accordance with CHLIC's credentialing requirements and ensure that third-party network vendors credential/re-credential Participating Providers in accordance with CHLIC's requirements;	**All Medical Products**

3.	Review Participating Provider compliance with protocols and procedures for quality, Participant satisfaction, and grievance resolution;	**All Medical Products**
4.	Facilitate the identification of Participating Providers by Members; and	**All Medical Products**
5.	Dedicated toll-free telephone line for Member and Provider calls to CHLIC Service Centers.	**All Medical Products**
BEHAVIORAL HEALTH		
	CHLIC has contracted with an affiliate, Cigna Behavioral Health ("CBH"), to provide or arrange for the provision of managed in-network behavioral health services, CBH is a Participating Provider, and is reimbursed primarily on a monthly fixed fee basis. This fixed fee for CBH services will be paid as claims and will appear in Employer's monthly reporting and on financial documents as capitation. Such payments will be at the relevant monthly rates then in effect. The monthly rates paid to CBH vary depending on geographic location of Members and on benefit design, and may be subject to change. The rates will be made available upon request. The fixed fee also includes lifestyle management programs, a cognitive behavioral modification program, a Complex Psychiatric Case Management program, and a Narcotics Therapy Management program. Behavioral claims from a client specific network are not included in the behavioral monthly fixed fee and will be paid from the Bank Account. In some states, payment for behavioral health services must be paid on a fee-for-service basis. In these states, fee-for-service payments for behavioral health services and the CBH administrative fee (including the lifestyle management programs, a cognitive behavioral modification program a Complex Psychiatric Case Management program and a Narcotics Therapy Management program) will be paid from the Bank Account as claims and will appear in Employer's monthly reporting.	**These services are included in the following products:** **OAP, HRA OAP**

CIGNA STAFF MODEL HEALTHPLAN SERVICES		
	The Cigna HealthCare of Arizona, Inc. staff model ("Cigna Medical Group") is a Participating Provider located in metropolitan Phoenix, Arizona. Plan Participants may at some time receive treatment from a Cigna Medical Group ("CMG") facility or provider even if they do not reside in Arizona (as when traveling). Participants utilizing the IPA network will access certain specialty and/or ancillary services (including laboratory and urgent care services) through the CMG system. Lab services are not provided by CMG for Participants in PPO or EPO plans. Except as provided below, for services provided to Participants, CMG is paid at the rates in effect at the time of service (as may be revised from time to time). Representative rates for routinely performed services are attached. A complete copy of the rates is available on request under a mutually agreed nondisclosure agreement (NDA). If the Plan requires Participants to select a primary care physician (PCP), Phoenix area Participants who do not select a PCP during open enrollment are assigned to a CMG PCP. CMG is paid a monthly primary care capitation amount for those Phoenix area Participants who select or are assigned to a CMG PCP. Charges will appear in Employer's standard Bank Account activity data reports at the rates in effect at the time of payment. Primary care capitation charges are age/sex adjusted and may be revised from time to time. A primary care capitation rate grid and a list of the services included in the capitation are available upon request under a mutually agreed NDA. Primary care services rendered to Participants in Open Access Plans that do not provide for PCP assignment are paid at the rates then in effect, as described above.	**All Medical Products**

CIGNA HEALTHCARE OF ARIZONA - CIGNA MEDICAL GROUP (CMG) REPRESENTATIVE RATES FOR ROUTINELY PERFORMED MEDICAL SERVICES EFFECTIVE OCTOBER 1, 2012

(Applicable to all Open Access Plus Products)

CPT Service Code	Service Description	Rates
45330	Sigmoidoscopy, flexible; Diagnostic (combined rate, includes facility fee $485.00)	$557.97
45378	Diagnostic Colonoscopy (combined rate, includes facility fee $650)	$907.75
71020	Chest X-Ray, Pa & Lat	$30.38
74000	Abdomen X-Ray (Kub)	$24.57
80053	Comprehensive Metabolic Panel	$14.87
80061	Cardiac Risk	$18.85
82565	Creatinine; Blood	$7.22
82947	Glucose, Serum	$5.52
84075	Phosphatase, Alkaline,Blood	$7.28
84443	Tsh, Assay	$23.64
84450	Sgot (Ast) Transaminase	$7.28
84520	Bun (Urea Nitrogen)Assay	$5.56
85025	CBC and Differential	$9.03
87086	Culture, Urine, Colony Ct	$11.36
88164	Cytopathology, Slides	$14.87
88305	Surg Path, Gross and Micro	$104.59
92014	Eye Exam & Treatment	$109.35
92567	Tympanometry	$15.62
93000	Electrocardiogram, Complete	$21.86
94760	Oximetry Single Determination	$2.47
95115	Allergy Injection, Single	$9.69
95117	Allergy Injection, Multiple	$11.85
99211	Office Visit, Est Min (Md Or Non-Md)	$19.21
99212	Office Visit, Est Prob Focused	$39.18
99213	Office Visit, Est Exp Prob Foc	$65.80
99214	Office Visit, Est Detailed	$98.58
99231	Subsequent Hospital Care	$38.26
99242	Office Consult, Exp Prob Focused, 30 Minutes	$92.15
99395	Well Exam, Est, 18-39 Years	$94.20
99396	Well Exam, Est, 40-64 Years	$102.94
G0202	Mammogram, Screening (Bilateral) Digital	$129.54
77052	Add on for iCad	$11.48

The Urgent Care case rate excluding radiology and laboratory services is $115.

The CMG CareToday (CMG low acuity clinics) visit rate is $59. Lab tests performed at the CMG CareToday facilities are $10 per service. A complete list of rates for CMG CareToday services is available on request.

ASC (Ambulatory surgical center) grouper rates based on 2006 Medicare for facility component of outpatient surgery services:

Group 1 - $485
Group 2 - $650
Group 3 - $740
Group 4 - $900
Group 5 - $950
Group 6 - $1100
Group 7 - $1420
Group 8 - $1400
Group 9 - $1200
Unlisted - $740

CMG pharmacy rates:

Brand Name: AWP – 10.56% + $2.75 dispensing fee
Generic: If MAC pricing is available then MAC +$2.75
If no MAC price available then AWP – 15% + $2.75 dispensing fee

Plan charges are reduced by any applicable copayment, coinsurance and/or deductible for service. Services not identified by CPT code or codes without established RVUs are reimbursed at the 50th Percentile of the Arizona Regional Medicode Schedule.

ATTACHMENT 6: MEDICAL CLAIMS EXPERIENCE

CITY OF NAPLES

MONTHLY HEALTHCARE DETAIL EXPERIENCE REPORT

January 2013 thru December 2013

RAT : RETROSPECTIVELY RATED - PARTICIPATNG
Reported Claims: All Claims, All HRA
Note: Paid claim dollars include amounts deducted from your account and paid to vendors for cost containment services.

YTD/MONTH	ACCOUNT	PRODUCT TYPE	CAP	MEDICAL	DRUG	HAF	TOTAL CLAIMS	HRA	TOTAL HRA & CLAIMS	TOTAL SUBS	TOTAL MBRS
Jan-13	3327028	OAPIN	$0	$142	$0	$0	$142	$0	$142	0	0
		OAP1	$12,439	$248,513	$22,351	$3,900	$287,204	$63,437	$350,640	427	995
	ACCOUNT Total		**$12,439**	**$248,656**	**$22,351**	**$3,900**	**$287,346**	**$63,437**	**$350,783**	**427**	**995**
Jan-2013 Total			**$12,439**	**$248,656**	**$22,351**	**$3,900**	**$287,346**	**$63,437**	**$350,783**	**427**	**995**
Feb-13	3327028	OAPIN	$0	($813)	$0	$0	($813)	$0	($813)	0	0
		OAP1	$12,479	$313,972	$38,576	$3,863	$368,890	$37,731	$406,621	427	997
	ACCOUNT Total		**$12,479**	**$313,159**	**$38,576**	**$3,863**	**$368,077**	**$37,731**	**$405,808**	**427**	**997**
Feb-2013 Total			**$12,479**	**$313,159**	**$38,576**	**$3,863**	**$368,077**	**$37,731**	**$405,808**	**427**	**997**
Mar-13	3327028	OAPIN	$0	($6,001)	$0	$0	($6,001)	$0	($6,001)	0	0
		OAP1	$11,981	$165,111	$41,271	$3,918	$222,281	$36,352	$258,633	429	1,003
	ACCOUNT Total		**$11,981**	**$159,111**	**$41,271**	**$3,918**	**$216,281**	**$36,352**	**$252,632**	**429**	**1,003**
Mar-2013 Total			**$11,981**	**$159,111**	**$41,271**	**$3,918**	**$216,281**	**$36,352**	**$252,632**	**429**	**1,003**
Apr-13	3327028	OAPIN	$0	$3,661	$0	$0	$3,661	$15	$3,676	0	0
		OAP1	$12,538	$174,279	$37,340	$3,900	$228,056	$33,142	$261,198	430	1,011
	ACCOUNT Total		**$12,538**	**$177,940**	**$37,340**	**$3,900**	**$231,717**	**$33,157**	**$264,874**	**430**	**1,011**
Apr-2013 Total			**$12,538**	**$177,940**	**$37,340**	**$3,900**	**$231,717**	**$33,157**	**$264,874**	**430**	**1,011**
May-13	3327028	OAPIN	$0	$117	$0	$0	$117	$0	$117	0	0
		OAP1	$12,611	$245,620	$41,304	$3,918	$303,452	$26,012	$329,465	431	1,016
	ACCOUNT Total		**$12,611**	**$245,736**	**$41,304**	**$3,918**	**$303,569**	**$26,012**	**$329,581**	**431**	**1,016**
May-2013 Total			**$12,611**	**$245,736**	**$41,304**	**$3,918**	**$303,569**	**$26,012**	**$329,581**	**431**	**1,016**
Jun-13	3327028	OAP1	$13,536	$152,544	$44,222	$3,954	$214,256	$17,664	$231,921	433	1,023
	ACCOUNT Total		**$13,536**	**$152,544**	**$44,222**	**$3,954**	**$214,256**	**$17,664**	**$231,921**	**433**	**1,023**
Jun-2013 Total			**$13,536**	**$152,544**	**$44,222**	**$3,954**	**$214,256**	**$17,664**	**$231,921**	**433**	**1,023**
Jul-13	3327028	OAPIN	$0	$0	$1,183	$0	$1,183	$0	$1,183	0	0

Dec-13 Paid Claims includes a charge of $9824.01 that was deducted from you account and paid as capitation to Cigna Behavioral Health.
HAF includes charges for such health advocacy programs as disease/condition management and health coaching.

CITY OF NAPLES

MONTHLY HEALTHCARE DETAIL EXPERIENCE REPORT

January 2013 thru December 2013

RAT : RETROSPECTIVELY RATED - PARTICIPATNG
Reported Claims: All Claims, All HRA
Note: Paid claim dollars include amounts deducted from your account and paid to vendors for cost containment services.

YTD/MONTH	ACCOUNT	PRODUCT TYPE	CAP	MEDICAL	DRUG	HAF	TOTAL CLAIMS	HRA	TOTAL HRA & CLAIMS	TOTAL SUBS	TOTAL MBRS
		OAP1	$12,837	$210,267	$48,969	$3,900	$275,973	$19,408	$295,380	430	1,016
	ACCOUNT Total		**$12,837**	**$210,267**	**$50,152**	**$3,900**	**$277,156**	**$19,408**	**$296,564**	**430**	**1,016**
Jul-2013 Total			**$12,837**	**$210,267**	**$50,152**	**$3,900**	**$277,156**	**$19,408**	**$296,564**	**430**	**1,016**
Aug-13	3327028	DPP4	$0	$266	$0	$0	$266	$0	$266	0	0
		OAPIN	$0	($9)	$0	$0	($9)	$0	($9)	0	0
		OAP1	$12,693	$249,245	$50,982	$3,909	$316,829	$18,372	$335,201	430	1,014
	ACCOUNT Total		**$12,693**	**$249,502**	**$50,982**	**$3,909**	**$317,086**	**$18,372**	**$335,458**	**430**	**1,014**
Aug-2013 Total			**$12,693**	**$249,502**	**$50,982**	**$3,909**	**$317,086**	**$18,372**	**$335,458**	**430**	**1,014**
Sep-13	3327028	DPP4	$0	$197	$0	$0	$197	$0	$197	0	0
		OAPIN	$0	($1,703)	$390	$0	($1,312)	$198	($1,114)	0	0
		OAP1	$12,598	$329,974	$47,724	$3,854	$394,150	$16,190	$410,341	428	1,012
	ACCOUNT Total		**$12,598**	**$328,469**	**$48,114**	**$3,854**	**$393,035**	**$16,388**	**$409,423**	**428**	**1,012**
Sep-2013 Total			**$12,598**	**$328,469**	**$48,114**	**$3,854**	**$393,035**	**$16,388**	**$409,423**	**428**	**1,012**
Oct-13	3327028	OAPIN	$0	($539)	$0	$0	($539)	$0	($539)	0	0
		OAP1	$12,913	$281,509	$26,911	$3,891	$325,225	$98,004	$423,228	427	1,013
	ACCOUNT Total		**$12,913**	**$280,970**	**$26,911**	**$3,891**	**$324,685**	**$98,004**	**$422,689**	**427**	**1,013**
Oct-2013 Total			**$12,913**	**$280,970**	**$26,911**	**$3,891**	**$324,685**	**$98,004**	**$422,689**	**427**	**1,013**
Nov-13	3327028	OAP1	$12,947	$268,567	$11,997	$3,945	$297,455	$96,944	$394,399	430	1,011
	ACCOUNT Total		**$12,947**	**$268,567**	**$11,997**	**$3,945**	**$297,455**	**$96,944**	**$394,399**	**430**	**1,011**
Nov-2013 Total			**$12,947**	**$268,567**	**$11,997**	**$3,945**	**$297,455**	**$96,944**	**$394,399**	**430**	**1,011**
Dec-13	3327028	OAP1	$12,978	$194,867	$24,746	$3,918	$236,508	$65,081	$301,590	431	1,012
	ACCOUNT Total		**$12,978**	**$194,867**	**$24,746**	**$3,918**	**$236,508**	**$65,081**	**$301,590**	**431**	**1,012**
Dec-2013 Total			**$12,978**	**$194,867**	**$24,746**	**$3,918**	**$236,508**	**$65,081**	**$301,590**	**431**	**1,012**
Grand Total			**$152,550**	**$2,829,787**	**$437,966**	**$46,868**	**$3,467,172**	**$528,550**	**$3,995,722**	**5,153**	**12,123**

Dec-13 Paid Claims includes a charge of $9824.01 that was deducted from you account and paid as capitation to Cigna Behavioral Health.
HAF includes charges for such health advocacy programs as disease/condition management and health coaching.

CITY OF NAPLES

MONTHLY HEALTHCARE DETAIL EXPERIENCE REPORT

January 2012 thru December 2012

RAT : RETROSPECTIVELY RATED - PARTICIPATNG
Reported Claims: All Claims, All HRA
Note: Paid claim dollars include amounts deducted from your account and paid to vendors for cost containment services.

YTD/MONTH	ACCOUNT	PRODUCT TYPE	CAP	MEDICAL	DRUG	HAF	TOTAL CLAIMS	HRA	TOTAL HRA & CLAIMS	TOTAL SUBS	TOTAL MBRS
Jan-12	3327028	DPP4	$0	($4)	$0	$0	($4)	$0	($4)	0	0
		OAPIN	$0	$1,981	$46	$0	$2,027	($959)	$1,068	0	0
		OAP1	$9,090	$228,109	$23,799	$3,791	$264,789	$42,853	$307,641	422	969
	ACCOUNT Total		**$9,090**	**$230,086**	**$23,845**	**$3,791**	**$266,811**	**$41,893**	**$308,705**	**422**	**969**
Jan-2012 Total			**$9,090**	**$230,086**	**$23,845**	**$3,791**	**$266,811**	**$41,893**	**$308,705**	**422**	**969**
Feb-12	3327028	OAPIN	$0	$1,541	$0	$0	$1,541	$0	$1,541	0	0
		OAP1	$11,484	$196,200	$36,254	$0	$243,939	$36,834	$280,773	425	975
	ACCOUNT Total		**$11,484**	**$197,742**	**$36,254**	**$0**	**$245,480**	**$36,834**	**$282,314**	**425**	**975**
Feb-2012 Total			**$11,484**	**$197,742**	**$36,254**	**$0**	**$245,480**	**$36,834**	**$282,314**	**425**	**975**
Mar-12	3327028	OAPIN	$0	($241)	$0	$0	($241)	($622)	($863)	0	0
		OAP1	$11,335	$221,848	$39,463	$3,827	$276,473	$33,787	$310,260	427	977
	ACCOUNT Total		**$11,335**	**$221,607**	**$39,463**	**$3,827**	**$276,232**	**$33,165**	**$309,397**	**427**	**977**
Mar-2012 Total			**$11,335**	**$221,607**	**$39,463**	**$3,827**	**$276,232**	**$33,165**	**$309,397**	**427**	**977**
Apr-12	3327028	DPP4	$0	($123)	$0	$0	($123)	$0	($123)	0	0
		OAPIN	$0	$230	$0	$0	$230	$1,439	$1,669	0	0
		OAP1	$11,563	$160,587	$36,787	$7,672	$216,608	$18,321	$234,929	424	973
	ACCOUNT Total		**$11,563**	**$160,693**	**$36,787**	**$7,672**	**$216,715**	**$19,760**	**$236,475**	**424**	**973**
Apr-2012 Total			**$11,563**	**$160,693**	**$36,787**	**$7,672**	**$216,715**	**$19,760**	**$236,475**	**424**	**973**
May-12	3327028	OAPIN	$0	$22	$0	$0	$22	$0	$22	0	0
		OAP1	$11,536	$182,908	$47,207	$3,918	$245,568	$18,406	$263,974	427	993
	ACCOUNT Total		**$11,536**	**$182,930**	**$47,207**	**$3,918**	**$245,591**	**$18,406**	**$263,996**	**427**	**993**
May-2012 Total			**$11,536**	**$182,930**	**$47,207**	**$3,918**	**$245,591**	**$18,406**	**$263,996**	**427**	**993**
Jun-12	3327028	OAPIN	$0	$32	$0	$0	$32	($146)	($114)	0	0
		OAP1	$11,707	$326,923	$43,403	$3,818	$385,851	$21,367	$407,219	424	988
	ACCOUNT Total		**$11,707**	**$326,956**	**$43,403**	**$3,818**	**$385,883**	**$21,222**	**$407,105**	**424**	**988**

Dec-12 Paid Claims includes a charge of $9628.22 that was deducted from you account and paid as capitation to Cigna Behavioral Health.
HAF includes charges for such health advocacy programs as disease/condition management and health coaching.

CITY OF NAPLES

MONTHLY HEALTHCARE DETAIL EXPERIENCE REPORT

January 2012 thru December 2012

RAT : RETROSPECTIVELY RATED - PARTICIPATNG
Reported Claims: All Claims, All HRA
Note: Paid claim dollars include amounts deducted from your account and paid to vendors for cost containment services.

YTD/MONTH	ACCOUNT	PRODUCT TYPE	CAP	MEDICAL	DRUG	HAF	TOTAL CLAIMS	HRA	TOTAL HRA & CLAIMS	TOTAL SUBS	TOTAL MBRS
Jun-2012 Total			**$11,707**	**$326,956**	**$43,403**	**$3,818**	**$385,883**	**$21,222**	**$407,105**	**424**	**988**
Jul-12	3327028	DPP4	$0	$465	$0	$0	$465	$0	$465	0	0
		OAPIN	$0	$535	$0	$18	$552	($38)	$514	0	0
		OAP1	$11,697	$371,651	$38,714	$3,909	$425,971	$15,572	$441,543	423	989
	ACCOUNT Total		**$11,697**	**$372,651**	**$38,714**	**$3,926**	**$426,988**	**$15,534**	**$442,521**	**423**	**989**
Jul-2012 Total			**$11,697**	**$372,651**	**$38,714**	**$3,926**	**$426,988**	**$15,534**	**$442,521**	**423**	**989**
Aug-12	3327028	OAPIN	$0	($877)	$0	$0	($877)	$0	($877)	0	0
		OAP1	$11,712	$310,952	$56,983	$3,800	$383,447	$13,904	$397,351	422	992
	ACCOUNT Total		**$11,712**	**$310,076**	**$56,983**	**$3,800**	**$382,570**	**$13,904**	**$396,475**	**422**	**992**
Aug-2012 Total			**$11,712**	**$310,076**	**$56,983**	**$3,800**	**$382,570**	**$13,904**	**$396,475**	**422**	**992**
Sep-12	3327028	OAPIN	$0	$15	$0	($106)	($91)	$0	($91)	0	0
		OAP1	$12,065	$251,033	$47,064	$3,872	$314,034	$13,300	$327,334	419	984
	ACCOUNT Total		**$12,065**	**$251,048**	**$47,064**	**$3,766**	**$313,943**	**$13,300**	**$327,242**	**419**	**984**
Sep-2012 Total			**$12,065**	**$251,048**	**$47,064**	**$3,766**	**$313,943**	**$13,300**	**$327,242**	**419**	**984**
Oct-12	3327028	DPP4	$0	$269	$0	$0	$269	$0	$269	0	0
		OAP1	$11,649	$400,278	$32,411	$3,981	$448,319	$92,947	$541,266	425	997
	ACCOUNT Total		**$11,649**	**$400,546**	**$32,411**	**$3,981**	**$448,588**	**$92,947**	**$541,535**	**425**	**997**
Oct-2012 Total			**$11,649**	**$400,546**	**$32,411**	**$3,981**	**$448,588**	**$92,947**	**$541,535**	**425**	**997**
Nov-12	3327028	OAPIN	$0	$0	$0	$0	$0	($134)	($134)	0	0
		OAP1	$12,785	$132,568	$13,986	$3,781	$163,121	$83,694	$246,814	423	994
	ACCOUNT Total		**$12,785**	**$132,568**	**$13,986**	**$3,781**	**$163,121**	**$83,559**	**$246,680**	**423**	**994**
Nov-2012 Total			**$12,785**	**$132,568**	**$13,986**	**$3,781**	**$163,121**	**$83,559**	**$246,680**	**423**	**994**
Dec-12	3327028	OAPIN	$0	($3,077)	$3	$0	($3,074)	$17	($3,056)	0	0
		OAP1	$12,396	$287,424	$23,460	$3,963	$327,243	$68,720	$395,964	429	997
	ACCOUNT Total		**$12,396**	**$284,348**	**$23,463**	**$3,963**	**$324,170**	**$68,738**	**$392,907**	**429**	**997**

Dec-12 Paid Claims includes a charge of $9628.22 that was deducted from you account and paid as capitation to Cigna Behavioral Health.
HAF includes charges for such health advocacy programs as disease/condition management and health coaching.

CITY OF NAPLES

MONTHLY HEALTHCARE DETAIL EXPERIENCE REPORT

January 2012 thru December 2012

RAT : RETROSPECTIVELY RATED - PARTICIPATNG
Reported Claims: All Claims, All HRA
Note: Paid claim dollars include amounts deducted from your account and paid to vendors for cost containment services.

YTD/MONTH	*ACCOUNT*	*PRODUCT TYPE*	*CAP*	*MEDICAL*	*DRUG*	*HAF*	*TOTAL CLAIMS*	*HRA*	*TOTAL HRA & CLAIMS*	*TOTAL SUBS*	*TOTAL MBRS*
Dec-2012 Total			**$12,396**	**$284,348**	**$23,463**	**$3,963**	**$324,170**	**$68,738**	**$392,907**	**429**	**997**
Grand Total			**$139,018**	**$3,071,250**	**$439,580**	**$46,243**	**$3,696,091**	**$459,260**	**$4,155,351**	**5,090**	**11,828**

Dec-12 Paid Claims includes a charge of $9628.22 that was deducted from you account and paid as capitation to Cigna Behavioral Health.
HAF includes charges for such health advocacy programs as disease/condition management and health coaching.

ATTACHMENT 7: CIGNA DENTAL SCHEDULE OF BENEFITS

Cigna Dental Benefit Summary
City of Naples Dental PPO
Effective 10/01/2013

All deductibles, plan maximums, and service specific maximums (dollar and occurrence) cross accumulate between in and out of network.

Benefits	***Cigna Dental PPO***			
	In-Network		***Out-of-Network***	
Network	***Cigna DPPO -Radius***		***Cigna Savings -Radius***	
Plan Year Maximum (Class I, II and III expenses)	$1,500		$1,500	
Plan Year Deductible Individual Family	$50 per person $150 per family		$50 per person $150 per family	
Reimbursement Levels**	Based on Reduced Contracted Fees		80th percentile of Reasonable and Customary Allowances	
	Plan Pays	***You Pay***	***Plan Pays***	***You Pay***
Class I - Preventive & Diagnostic Care Oral Exams Routine Cleanings Full Mouth X-rays Bitewing X-rays Panoramic X-ray Periapical X-rays Fluoride Application Sealants Space Maintainers Emergency Care to Relieve Pain Histopathologic Exams	100%	No Charge	100%	No Charge
Class II - Basic Restorative Care Fillings Root Canal Therapy/Endodontics Osseous Surgery Periodontal Scaling and Root Planing Denture Adjustments and Repairs Oral Surgery – Simple Extractions Oral Surgery – all except simple extractions Anesthetics Surgical Extractions of Impacted Teeth Repairs to Bridges, Crowns and Inlays	80%*	20%*	80%*	20%*
Class III - Major Restorative Care Crowns Dentures Bridges Inlays/Onlays Prosthesis Over Implant	50%*	50%*	50%*	50%*
Class IV - Orthodontia Lifetime Maximum	50% $1,500 Covered for Children & Adults	50%	50% $1,500 Covered for Children & Adults	50%

Dental Network Savings Program (DNSP): Using an out-of-network dental health care professional will cost you more than using in-network care. You may be able to save some money on out-of-pocket expenses if you use a dental health care professional that participates in Cigna's Dental Network Savings Program.
Missing Tooth Limitation – Teeth missing prior to coverage under the Cigna Dental plan are not covered.
Pretreatment review is available on a voluntary basis when extensive dental work in excess of $200 is proposed.
* Subject to annual deductible
Dental Oral Health Integration Program (OHIP) - All dental customers = Clinical research shows an association between oral health and overall health. The Cigna Dental Oral Health Integration Program (OHIP)® is designed to provide enhanced dental coverage for customers with certain eligible medical conditions. Eligible conditions for the program include cardiovascular disease, cerebrovascular disease (stroke), diabetes, maternity, chronic kidney disease, organ transplants, and head and neck cancer radiation. The program provides:

- 100% coverage for certain dental procedures
- guidance on behavioral issues related to oral health
- discounts on prescription and non-prescription dental products

For more information and to see the complete list of eligible conditions, go to www.mycigna.com or call customer service 24/7 at 1.800.CIGNA24.
**For services provided by a Cigna Dental PPO network dentist, Cigna Dental will reimburse the dentist according to a Contracted Fee Schedule. For services provided by an out-of-network dentist, Cigna Dental will reimburse according to Reasonable and Customary Allowances but the dentist may balance bill up to their usual fees.

Cigna Dental PPO Exclusions and Limitations

Procedure	Exclusions and Limitations
Exams	Two per Plan year
Prophylaxis (Cleanings)	Two per Plan year
Fluoride	1 per Plan year for people under 19
Histopathologic Exams	Various limits per Plan year depending on specific test
X-Rays (routine)	Bitewings: 2 per Plan year
X-Rays (non-routine)	Full mouth: 1 every 36 consecutive months., Panorex: 1 every 36 consecutive months
Model	Payable only when in conjunction with Ortho workup and extensive Perio treatment
Minor Perio (non-surgical)	Various limitations depending on the service
Perio Surgery	Various limitations depending on the service
Crowns and Inlays	Replacement every 5 years
Bridges	Replacement every 5 years
Dentures and Partials	Replacement every 5 years
Relines, Rebases	Covered if more than 6 months after installation
Adjustments	Covered if more than 6 months after installation
Repairs - Bridges	Reviewed if more than once
Repairs - Dentures	Reviewed if more than once
Sealants	Limited to posterior tooth. One treatment per tooth every three years up to age 14
Space Maintainers	Limited to non-Orthodontic treatment
Prosthesis Over Implant	1 per 60 consecutive months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or bridges
Alternate Benefit	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna HealthCare will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses

Benefit Exclusions:

- Services performed primarily for cosmetic reasons
- Replacement of a lost or stolen appliance
- Replacement of a bridge or denture within five years following the date of its original installation
- Replacement of a bridge or denture which can be made useable according to accepted dental standards
- Procedures, appliances or restorations, other than full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of TMJ, stabilize periodontally involved teeth, or restore occlusion
- Veneers of porcelain or acrylic materials on crowns or pontics on or replacing the upper and lower first, second and third molars
- Bite registrations; precision or semi-precision attachments; splinting
- A surgical implant of any type
- Instruction for plaque control, oral hygiene and diet
- Dental services that do not meet common dental standards
- Services that are deemed to be medical services
- Services and supplies received from a hospital
- Charges which the person is not legally required to pay
- Charges made by a hospital which performs services for the U.S. Government if the charges are directly related to a condition connected to a military service
- Experimental or investigational procedures and treatments
- Any injury resulting from, or in the course of, any employment for wage or profit
- Any sickness covered under any workers' compensation or similar law
- Charges in excess of the reasonable and customary allowances
- To the extent that payment is unlawful where the person resides when the expenses are incurred;
- Procedures performed by a Dentist who is a member of the covered person's family (covered person's family is limited to a spouse, siblings, parents, children, grandparents, and the spouse's siblings and parents);
- For charges which would not have been made if the person had no insurance;
- For charges for unnecessary care, treatment or surgery;
- To the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- To the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law. Cigna HealthCare will take into account any adjustment option chosen under such part by you or any one of your Dependents.
- In addition, these benefits will be reduced so that the total payment will not be more than 100% of the charge made for the Dental Service if benefits are provided for that service under this plan and any medical expense plan or prepaid treatment program sponsored or made available by your Employer.

This benefit summary highlights some of the benefits available under the proposed plan. A complete description regarding the terms of coverage, exclusions andlimitations, including legislated benefits, will be provided in your insurance certificate or plan description. Benefits are insured and/or administered by Connecticut General Life Insurance Company.

"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 Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company, and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc.

BSD32279

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ATTACHMENT 8: DENTAL CLAIMS EXPERIENCE

CITY OF NAPLES

GC MONTHLY HEALTHCARE DETAIL EXPERIENCE REPORT

October 2013 thru December 2013

FAT : TRADITIONAL
RAT : FULLY INSURED NON-PARTICPATING
Reported Premium: Billed Premium without fees

YTD/MONTH	ACCOUNT	PRODUCT GROUP	IN NETWORK	OUT OF NETWORK	TOTAL CLAIMS	BILLED PREMIUM	TOTAL SUBS	TOTAL MBRS
Oct-13	3327028	DENT	$18,809	$11,401	$30,210	$29,219	469	1,044
	ACCOUNT Total		**$18,809**	**$11,401**	**$30,210**	**$29,219**	**469**	**1,044**
Oct-2013 Total			**$18,809**	**$11,401**	**$30,210**	**$29,219**	**469**	**1,044**
Nov-13	3327028	DENT	$14,540	$8,330	$22,870	$29,299	472	1,048
	ACCOUNT Total		**$14,540**	**$8,330**	**$22,870**	**$29,299**	**472**	**1,048**
Nov-2013 Total			**$14,540**	**$8,330**	**$22,870**	**$29,299**	**472**	**1,048**
Dec-13	3327028	DENT	$17,842	$7,998	$25,840	$29,290	473	1,049
	ACCOUNT Total		**$17,842**	**$7,998**	**$25,840**	**$29,290**	**473**	**1,049**
Dec-2013 Total			**$17,842**	**$7,998**	**$25,840**	**$29,290**	**473**	**1,049**
Grand Total			**$51,191**	**$27,728**	**$78,920**	**$87,809**	**1,414**	**3,141**

CITY OF NAPLES

GC MONTHLY HEALTHCARE DETAIL EXPERIENCE REPORT

October 2012 thru September 2013

FAT : TRADITIONAL
RAT : FULLY INSURED NON-PARTICPATING
Reported Premium: Billed Premium without fees

YTD/MONTH	ACCOUNT	PRODUCT GROUP	IN NETWORK	OUT OF NETWORK	TOTAL CLAIMS	BILLED PREMIUM	TOTAL SUBS	TOTAL MBRS
Oct-12	3327028	DENT	$20,407	$11,161	$31,568	$28,658	463	1,036
	ACCOUNT Total		**$20,407**	**$11,161**	**$31,568**	**$28,658**	**463**	**1,036**
Oct-2012 Total			**$20,407**	**$11,161**	**$31,568**	**$28,658**	**463**	**1,036**
Nov-12	3327028	DENT	$15,987	$8,758	$24,745	$28,743	463	1,036
	ACCOUNT Total		**$15,987**	**$8,758**	**$24,745**	**$28,743**	**463**	**1,036**
Nov-2012 Total			**$15,987**	**$8,758**	**$24,745**	**$28,743**	**463**	**1,036**
Dec-12	3327028	DENT	$14,129	$7,728	$21,856	$28,874	468	1,037
	ACCOUNT Total		**$14,129**	**$7,728**	**$21,856**	**$28,874**	**468**	**1,037**
Dec-2012 Total			**$14,129**	**$7,728**	**$21,856**	**$28,874**	**468**	**1,037**
Jan-13	3327028	DENT	$15,216	$6,654	$21,870	$28,760	467	1,032
	ACCOUNT Total		**$15,216**	**$6,654**	**$21,870**	**$28,760**	**467**	**1,032**
Jan-2013 Total			**$15,216**	**$6,654**	**$21,870**	**$28,760**	**467**	**1,032**
Feb-13	3327028	DENT	$18,125	$10,239	$28,364	$28,760	467	1,032
	ACCOUNT Total		**$18,125**	**$10,239**	**$28,364**	**$28,760**	**467**	**1,032**
Feb-2013 Total			**$18,125**	**$10,239**	**$28,364**	**$28,760**	**467**	**1,032**
Mar-13	3327028	DENT	$13,487	$12,680	$26,168	$28,940	469	1,037
	ACCOUNT Total		**$13,487**	**$12,680**	**$26,168**	**$28,940**	**469**	**1,037**
Mar-2013 Total			**$13,487**	**$12,680**	**$26,168**	**$28,940**	**469**	**1,037**
Apr-13	3327028	DENT	$17,210	$9,761	$26,971	$29,224	470	1,047
	ACCOUNT Total		**$17,210**	**$9,761**	**$26,971**	**$29,224**	**470**	**1,047**

CITY OF NAPLES

GC MONTHLY HEALTHCARE DETAIL EXPERIENCE REPORT

October 2012 thru September 2013

FAT : TRADITIONAL
RAT : FULLY INSURED NON-PARTICPATING
Reported Premium: Billed Premium without fees

YTD/MONTH	ACCOUNT	PRODUCT GROUP	IN NETWORK	OUT OF NETWORK	TOTAL CLAIMS	BILLED PREMIUM	TOTAL SUBS	TOTAL MBRS
Apr-2013 Total			**$17,210**	**$9,761**	**$26,971**	**$29,224**	**470**	**1,047**
May-13	3327028	DENT	$15,996	$9,028	$25,024	$29,223	471	1,047
	ACCOUNT Total		**$15,996**	**$9,028**	**$25,024**	**$29,223**	**471**	**1,047**
May-2013 Total			**$15,996**	**$9,028**	**$25,024**	**$29,223**	**471**	**1,047**
Jun-13	3327028	DENT	$12,801	$7,318	$20,118	$29,443	473	1,054
	ACCOUNT Total		**$12,801**	**$7,318**	**$20,118**	**$29,443**	**473**	**1,054**
Jun-2013 Total			**$12,801**	**$7,318**	**$20,118**	**$29,443**	**473**	**1,054**
Jul-13	3327028	DENT	$14,668	$8,090	$22,758	$29,130	471	1,041
	ACCOUNT Total		**$14,668**	**$8,090**	**$22,758**	**$29,130**	**471**	**1,041**
Jul-2013 Total			**$14,668**	**$8,090**	**$22,758**	**$29,130**	**471**	**1,041**
Aug-13	3327028	DENT	$21,750	$11,594	$33,343	$29,190	472	1,043
	ACCOUNT Total		**$21,750**	**$11,594**	**$33,343**	**$29,190**	**472**	**1,043**
Aug-2013 Total			**$21,750**	**$11,594**	**$33,343**	**$29,190**	**472**	**1,043**
Sep-13	3327028	DENT	$13,459	$6,875	$20,333	$29,175	469	1,036
	ACCOUNT Total		**$13,459**	**$6,875**	**$20,333**	**$29,175**	**469**	**1,036**
Sep-2013 Total			**$13,459**	**$6,875**	**$20,333**	**$29,175**	**469**	**1,036**
Grand Total			**$193,234**	**$109,886**	**$303,120**	**$348,120**	**5,623**	**12,478**

CITY OF NAPLES

GC MONTHLY HEALTHCARE DETAIL EXPERIENCE REPORT

October 2011 thru September 2012

FAT : TRADITIONAL
RAT : FULLY INSURED NON-PARTICPATING
Reported Premium: Billed Premium without fees

YTD/MONTH	ACCOUNT	PRODUCT GROUP	IN NETWORK	OUT OF NETWORK	TOTAL CLAIMS	TOTAL BILLED PREMIUM	TOTAL SUBS	TOTAL MBRS
Oct-11	3327028	DENT	$17,033	$13,540	$30,573	$24,576	454	1,020
	ACCOUNT Total		**$17,033**	**$13,540**	**$30,573**	**$24,576**	**454**	**1,020**
Oct-2011 Total			**$17,033**	**$13,540**	**$30,573**	**$24,576**	**454**	**1,020**
Nov-11	3327028	DENT	$14,676	$11,887	$26,563	$24,232	450	1,006
	ACCOUNT Total		**$14,676**	**$11,887**	**$26,563**	**$24,232**	**450**	**1,006**
Nov-2011 Total			**$14,676**	**$11,887**	**$26,563**	**$24,232**	**450**	**1,006**
Dec-11	3327028	DENT	$13,464	$6,925	$20,389	$24,397	452	1,014
	ACCOUNT Total		**$13,464**	**$6,925**	**$20,389**	**$24,397**	**452**	**1,014**
Dec-2011 Total			**$13,464**	**$6,925**	**$20,389**	**$24,397**	**452**	**1,014**
Jan-12	3327028	DENT	$20,981	$9,844	$30,826	$24,434	454	1,012
	ACCOUNT Total		**$20,981**	**$9,844**	**$30,826**	**$24,434**	**454**	**1,012**
Jan-2012 Total			**$20,981**	**$9,844**	**$30,826**	**$24,434**	**454**	**1,012**
Feb-12	3327028	DENT	$17,217	$6,699	$23,916	$24,584	456	1,016
	ACCOUNT Total		**$17,217**	**$6,699**	**$23,916**	**$24,584**	**456**	**1,016**
Feb-2012 Total			**$17,217**	**$6,699**	**$23,916**	**$24,584**	**456**	**1,016**
Mar-12	3327028	DENT	$14,199	$6,589	$20,788	$24,668	460	1,021
	ACCOUNT Total		**$14,199**	**$6,589**	**$20,788**	**$24,668**	**460**	**1,021**
Mar-2012 Total			**$14,199**	**$6,589**	**$20,788**	**$24,668**	**460**	**1,021**
Apr-12	3327028	DENT	$12,960	$6,348	$19,309	$24,469	458	1,016
	ACCOUNT Total		**$12,960**	**$6,348**	**$19,309**	**$24,469**	**458**	**1,016**

CITY OF NAPLES

GC MONTHLY HEALTHCARE DETAIL EXPERIENCE REPORT

October 2011 thru September 2012

FAT : TRADITIONAL
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Reported Premium: Billed Premium without fees

YTD/MONTH	ACCOUNT	PRODUCT GROUP	IN NETWORK	OUT OF NETWORK	TOTAL CLAIMS	TOTAL BILLED PREMIUM	TOTAL SUBS	TOTAL MBRS
Apr-2012 Total			**$12,960**	**$6,348**	**$19,309**	**$24,469**	**458**	**1,016**
May-12	3327028	DENT	$12,422	$7,578	$20,000	$24,568	460	1,023
	ACCOUNT Total		**$12,422**	**$7,578**	**$20,000**	**$24,568**	**460**	**1,023**
May-2012 Total			**$12,422**	**$7,578**	**$20,000**	**$24,568**	**460**	**1,023**
Jun-12	3327028	DENT	$17,842	$7,144	$24,986	$24,462	459	1,020
	ACCOUNT Total		**$17,842**	**$7,144**	**$24,986**	**$24,462**	**459**	**1,020**
Jun-2012 Total			**$17,842**	**$7,144**	**$24,986**	**$24,462**	**459**	**1,020**
Jul-12	3327028	DENT	$21,216	$5,754	$26,971	$24,454	459	1,020
	ACCOUNT Total		**$21,216**	**$5,754**	**$26,971**	**$24,454**	**459**	**1,020**
Jul-2012 Total			**$21,216**	**$5,754**	**$26,971**	**$24,454**	**459**	**1,020**
Aug-12	3327028	DENT	$17,468	$7,041	$24,509	$24,444	458	1,022
	ACCOUNT Total		**$17,468**	**$7,041**	**$24,509**	**$24,444**	**458**	**1,022**
Aug-2012 Total			**$17,468**	**$7,041**	**$24,509**	**$24,444**	**458**	**1,022**
Sep-12	3327028	DENT	$12,850	$11,906	$24,757	$24,359	457	1,014
	ACCOUNT Total		**$12,850**	**$11,906**	**$24,757**	**$24,359**	**457**	**1,014**
Sep-2012 Total			**$12,850**	**$11,906**	**$24,757**	**$24,359**	**457**	**1,014**
Grand Total			**$192,329**	**$101,257**	**$293,586**	**$293,645**	**5,477**	**12,204**