



ATTACHMENT A: Offer and Acceptance

ARIZONA STATE
RETIREMENT SYSTEM
3300 N Central Ave
14th Floor
Phoenix, AZ 85012

ASRS Group Dental Services
Solicitation Code: BPM001922
PART 2 of 2 - Attachments (Response Forms)

Page
1
of
2

Jerry Smith, New Business Manager

Hartford,	CT	06152
Hartford	CT	06152
Sunrise	FL	33323
Glendale	CA	91203
Sunrise	FL	33323
Sunrise	FL	33323
Sunrise	FL	33323
Sunrise	FL	33323
Sunrise	FL	33323
Sunrise	FL	33323
Sunrise	FL	33323
Sunrise	FL	33323
Sunrise	FL	33323
Sunrise	FL	33323
Sunrise	FL	33323
Sunrise	FL	33323
Denison	TX	75020

Website

Cigna.com

Contact Phone

480.426.6759

Contact Email Address

jerry.smith@cigna.com

CERTIFICATION

By signature in the Offer section above, the Offeror certifies:

1. The Offeror shall not discriminate against any employee or applicant for employment in violation of Federal Executive Order 11246, State Executive Order 2009-9 or A.R.S. §§ 41-1461 through 1465.
2. The Offeror has not given, offered to give, nor intends to give at any time hereafter any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor, or service to a public servant in connection with the submitted Offer. Failure to provide a valid signature affirming the stipulations required by this clause shall result in rejection of the Offer. Signing the Offer with a false statement shall void the Offer, any resulting contract and may be subject to legal remedies provided by law.
Confirmed.

3. The Offeror is not debarred by, or otherwise prohibited from participating in any publically-funded contract awarded by any Federal, State or local jurisdiction.

Cigna certifies to the best of its knowledge and belief, that neither the bidding entities nor their principals have been debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency for the services contemplated under this proposal.

4. The Offeror is lawfully authorized to conduct business in Arizona or has no impediments to conduct business in Arizona.
5. The Offeror does not participate in, and agrees not to participate in during the term of the Contract, a boycott of goods or services from the state of Israel in accordance with A.R.S. §35-393 and §35-393.01. This certification does not include boycotts prohibited by 50 United States Code Section 4842 or a regulation issued pursuant to that section in accordance with A.R.S. §35-393.03.



ATTACHMENT A: Offer and Acceptance

ASRS Group Dental Services
Solicitation Code: BPM001922
PART 2 of 2 - Attachments (Response Forms)

Page
1
of
2

**ARIZONA STATE
RETIREMENT SYSTEM**
3300 N Central Ave
14th Floor
Phoenix, AZ 85012

ACCEPTANCE OF OFFER (FOR ARIZONA STATE RETIREMENT SYSTEM)

The Offer is hereby accepted.

The Contractor is now bound to provide the ASRS Group Dental Services outlined in the Contract and based upon the Solicitation, including the Uniform and Special Instructions to Offerors, Uniform and Special Terms and Conditions, Attachments (Response Forms), Scope of Work, Solicitation or Contract Amendments, and Contractor's Best and Final Offer as accepted by the ASRS.

This Contract shall henceforth be referred to as Contract No. _____


The effective date of the Contract is _____

The Contractor is cautioned not to commence any billable work or to provide any ASRS Group Dental Services under this Contract until Contractor receives purchase order, contract release document or written notice to proceed.

Awarded this ____ day of _____ 20

ASRS Signature

Title

	ATTACHMENT B: Exceptions		ARIZONA STATE RETIREMENT SYSTEM 3300 N Central Ave 14 th Floor Phoenix, AZ 85012
	ASRS Group Dental Services Solicitation Code: BPM001922 PART 2 of 2 - Attachments (Response Forms)	Page 1 of 1	

Indicate below any exceptions taken to the terms contained in this Solicitation. Provide both an explanation for the exception and Offeror's recommended alternative language.


Certain exceptions may have a negative impact on the evaluation of the Offeror's proposal. As indicated in the Uniform Instructions to Offerors, Section C(3.2) (Request for Proposals): "All exceptions that are contained in the Offer may negatively impact an Offeror's susceptibility for award. An Offer that takes exception to any material requirement of the Solicitation may be rejected."

Please indicate as appropriate:

☒ **TAKES NO EXCEPTIONS**

☐ **TAKES EXCEPTIONS TO THE FOLLOWING:**

Identify the section of the Solicitation, identify the clause name and number (where applicable), provide the reason for the exception, and propose requested alternative language by restating and redlining the clause.

	ATTACHMENT C: Designation of Confidential, Trade Secret and Proprietary Information		ARIZONA STATE RETIREMENT SYSTEM 3300 N Central Ave 14 th Floor Phoenix, AZ 85012
	ASRS Group Dental Services Solicitation Code: BPM001922 PART 2 of 2 - Attachments (Response Forms)	Page 1 of 3	

All materials submitted as part of a response to a Solicitation are subject to Arizona Public Records Law and will be disclosed if there is an appropriate public records request at the time of or after the award of the Contract. Recognizing there may be materials included in a Solicitation response that are proprietary or a trade secret, a process is set out in A.A.C. R2-7-103 (attached) that will allow qualifying materials to be designated as confidential and excluded from disclosure. For purposes of this process the definition of "trade secret" will be the same as that set out in A.A.C. R2-7-101(50).

This form must be completed and returned with the response to the Solicitation and any supporting information to assist the State in making its determination as to whether any of the materials submitted as part of the Solicitation response should be designated confidential because the material is proprietary or a trade secret and therefore not subject to disclosure.

All Offerors must select one of the following:

- ☐ My response **does not** contain proprietary or trade secret information. I understand that my entire response will become public record in accordance with A.A.C. R2-7-C317.
- ☒ My response **does** contain trade secret information because it contains information that:
1. Is a formula, pattern, compilation, program, device, method, technique or process; **AND**
 2. Derives independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from its disclosure or use; **AND**
 3. Is the subject of efforts by myself or my organization that are reasonable under the circumstances to maintain its secrecy.

Follow Uniform Instructions to Offerors, Section D(5) to clearly mark specific responses as "Confidential." In addition, review and follow Special Instructions to Offerors, Sections F(2.3) and G(1) to ensure items are correctly marked and attached in the Arizona Procurement Portal (APP) as part of Offeror's response.

List and provide an explanation for all parts of Offeror's response that are separately marked as "Confidential."

Please note that failure to include an explanation may result in a determination that the information does not meet the statutory trade secret definition. All information that does not meet the definition of trade secret as defined by A.A.C. R2-7-101(50) will become public in accordance with A.A.C. R2-7-C317. The State reserves the right to make its own determination of Offeror's trade secret materials through a written determination in accordance with A.A.C. R2-7-103.



ATTACHMENT C: Designation of Confidential, Trade Secret and Proprietary Information

ASRS Group Dental Services
Solicitation Code: BPM001922
PART 2 of 2 - Attachments (Response Forms)

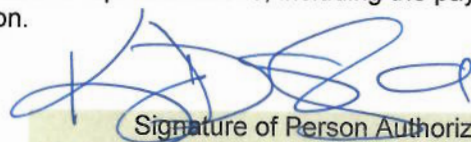
Page
2
of
3

ARIZONA STATE
RETIREMENT SYSTEM
3300 N Central Ave
14th Floor
Phoenix, AZ 85012

If the State agrees with the Offeror's designation of trade secret or confidentiality and the determination is challenged, the undersigned hereby agrees to cooperate and support the defense of the determination with all interested parties, including legal counsel or other necessary assistance.

By submitting this response, Offeror agrees that the entire Offer, including confidential, trade secret and proprietary information may be shared with an evaluation committee and technical advisors during the evaluation process. Offeror agrees to indemnify and hold the State, its agents and employees, harmless from any claims or causes of action relating to the State's withholding of information based upon reliance on the above representations, including the payment of all costs and attorney fees incurred by the State in defending such an action.

Company Name



Signature of Person Authorized to Sign

Cigna Health and Life Insurance Company (CHLIC)
Cigna HealthCare of Connecticut, 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 Kentucky, Inc.
Cigna Dental Health of Kansas, Inc.
Cigna Dental Health of Maryland, Inc.
Cigna Dental Health of Missouri, Inc.
Cigna Dental Health of North Carolina, Inc.
Cigna Dental Health of New Jersey, Inc.
Cigna Dental Health of Ohio, Inc.
Cigna Dental Health of Pennsylvania, Inc.
Cigna Dental Health of Virginia, Inc.
Cigna Dental Health of Texas, Inc.

Address

900 Cottage Grove Road
900 Cottage Grove Road
1571 Sawgrass Corporate Parkway Suite 140
400 N. Brand Blvd Suite 600
1571 Sawgrass Corporate Parkway Suite 140
1571 Sawgrass Corporate Parkway Suite 140
1571 Sawgrass Corporate Parkway Suite 140
1571 Sawgrass Corporate Parkway Suite 140
1571 Sawgrass Corporate Parkway Suite 140
1571 Sawgrass Corporate Parkway Suite 140
1571 Sawgrass Corporate Parkway Suite 140
1571 Sawgrass Corporate Parkway Suite 140
1571 Sawgrass Corporate Parkway Suite 140
1571 Sawgrass Corporate Parkway Suite 140
1571 Sawgrass Corporate Parkway Suite 140
4616 South U.S. Highway 75

Printed Name

Kimberly D. Shepard



ATTACHMENT C: Designation of Confidential, Trade Secret and Proprietary Information

ASRS Group Dental Services
Solicitation Code: BPM001922
PART 2 of 2 - Attachments (Response Forms)

Page
3
of
3

ARIZONA STATE
RETIREMENT SYSTEM
3300 N Central Ave
14th Floor
Phoenix, AZ 85012

City	State	Zip	Title
Hartford,	CT	06152	Vice President and Authorized Signatory
Hartford	CT	06152	
Sunrise	FL	33323	
Glendale	CA	91203	
Sunrise	FL	33323	
Sunrise	FL	33323	
Sunrise	FL	33323	
Sunrise	FL	33323	
Sunrise	FL	33323	
Sunrise	FL	33323	
Sunrise	FL	33323	
Sunrise	FL	33323	
Sunrise	FL	33323	
Sunrise	FL	33323	
Sunrise	FL	33323	
Sunrise	FL	33323	
Sunrise	FL	33323	
Denison	TX	75020	

R2-7-103. Confidential Information


- A. If a person wants to assert that a person's offer, specification, or protest contains a trade secret or other proprietary information, a person shall include with the submission a statement supporting this assertion. A person shall clearly designate any trade secret and other proprietary information, using the term "confidential". Contract terms and conditions, pricing, and information generally available to the public are not considered confidential information under this Section.
- B. Until a final determination is made under subsection (C), an agency chief procurement officer shall not disclose information designated as confidential under subsection (A) except to those individuals deemed by an agency chief procurement officer to have a legitimate state interest.
- C. Upon receipt of a submission, an agency chief procurement officer shall make one of the following written determinations:
1. The designated information is confidential and the agency chief procurement officer shall not disclose the information except to those individuals deemed by the agency chief procurement officer to have a legitimate state interest;
 2. The designated information is not confidential; or
 3. Additional information is required before a final confidentiality determination can be made.
- D. If an agency chief procurement officer determines that information submitted is not confidential, a person who made the submission shall be notified in writing. The notice shall include a time period for requesting a review of the determination by the state procurement administrator.
- E. An agency chief procurement officer may release information designated as confidential under subsection (A) if:
1. A request for review is not received by the state procurement administrator within the time period specified in the notice; or
 2. The state procurement administrator, after review, makes a written determination that the designated information is not confidential.

R2-7-101. Definitions

"Trade secret" means information, including a formula, pattern, device, compilation, program, method, technique, or process, that is the subject of reasonable efforts to maintain its secrecy and that derives independent economic value, actual or potential, as a result of not being generally known to and not being readily ascertainable by legal means.

R2-7-C317. Contract Award

- A. An agency chief procurement officer shall award the contract to the responsible offeror whose offer is determined to be most advantageous to the state based on the evaluation factors set forth in the solicitation. The agency chief procurement officer shall make a written determination explaining the basis for the award and place it in the procurement file.
- B. The agency chief procurement officer shall notify all offerors of an award.
- C. After contract award, the agency chief procurement officer shall return any offer security provided by the offeror.
- D. Within 3 days after contract award the agency chief procurement officer shall make the procurement file, including all offers, available for public inspection, redacting information that is confidential under R2-7-103.

	ATTACHMENT D: Questionnaire		ARIZONA STATE RETIREMENT SYSTEM 3300 N Central Ave 14 th Floor Phoenix, AZ 85012
	ASRS Group Dental Services Solicitation Code: BPM001922 PART 2 of 2 - Attachments (Response Forms)	Page 1 of 42	

All Offerors, including any incumbent or previous service providers, must complete the Questionnaire and provide detailed responses, without assuming the ASRS is familiar with or will accept Offeror's experience, approach, systems, or methodologies.

This Questionnaire is designed to assist the ASRS in gaining an understanding of the Offeror's qualifications for consideration for this engagement. It is important to provide accurate, complete, and thorough information as requested instead of providing general responses reflecting general concepts of dental care delivery or operations. The ASRS may award contracts for all or any portion of the work for which an Offeror has provided a response.

Supplemental documents requested by the ASRS as indicated in Section F(2) of the Special Instructions to Offerors, and related to items in this Questionnaire, should be clearly labeled and included as a single separate attachment entitled "Attachment D1: Supplemental Information."

If Offeror believes any information is confidential in its response to this Questionnaire, include only that section(s) of the response - not the entire response - in a separate attachment entitled "Attachment D2: Confidential Documents" and mark as "Confidential" as indicated in Sections F(2) and G(1) of the Special Instructions to Offerors.

Experience/Expertise/Resources

Company History

- 1. Provide a brief narrative history of your company. This should include the primary function of your company, the number of years the company has provided the services described herein, affiliated companies/underwriters, and locations.**


Through its predecessor companies, Cigna has been in the insurance field for more than 200 years. In 1792, a group of Philadelphia citizens formed the Insurance Company of North America, the first US marine insurance company. In 1865, the governor of Connecticut signed a special law creating Connecticut General Life Insurance Company (CGLIC). In 1982, Cigna was formed through the combination of INA Corporation and Connecticut General Corporation (CGC), the parent companies of Insurance Company of North America and Connecticut General Life, respectively. Cigna refers to various operating subsidiaries of Cigna Corporation. These subsidiaries, not Cigna Corporation, provide plan coverage and services and include Cigna Health and Life Insurance Company (CHLIC); Cigna Home Delivery Pharmacy and its affiliates; Cigna Behavioral Health, Inc.; Cigna Health Management, Inc.; and HMO or service company subsidiaries of Cigna Corporation and Cigna Dental Health, Inc.

Cigna (New York Stock Exchange: CI) is a global health service leader focused on improving the health and health outcomes of the people we serve. We have 74,000 employees serving our clients and members in more than 30 countries and jurisdictions around the world. Cigna services 90 million members worldwide, with 2.9 million in the US Public Sector.

In addition to our health plans, we have specialized in a dental management program since 1974, when Florida granted Dental Health, Inc., a Certificate of Authority to provide managed dental care. In 1984, Dental Health, Inc., became a subsidiary of Cigna Corporation, marking the first entry of a major national insurance organization into the managed dental care field. The Cigna Dental Care® plan is underwritten by Connecticut General Life Insurance Company (CGLIC), Cigna Health and Life Insurance Company (CHLIC), or the subsidiaries of Cigna Dental Health, Inc., depending on state laws and licensing requirements.

The Cigna DPPO plan was introduced in July 1996 and licensed at varying times in states throughout the US, and is underwritten or administered by Connecticut General Life Insurance Company (CGLIC) or Cigna Health and Life Insurance Company (CHLIC). Certain administration and network management services for the DPPO plan are performed on behalf of CGLIC and CHLIC by their affiliate, Cigna Dental Health, Inc.

We are confident in our ability to service the needs of ASRS. Through our specialized government and education team, we have developed strong, deep connections in Arizona and provide cost-effective, personalized coverage solutions to our government and education clients and their employees in that area. We are committed to designing

	ATTACHMENT D: Questionnaire		ARIZONA STATE RETIREMENT SYSTEM 3300 N Central Ave 14 th Floor Phoenix, AZ 85012
	ASRS Group Dental Services Solicitation Code: BPM001922 PART 2 of 2 - Attachments (Response Forms)	Page 2 of 42	

customized health and wellness solutions that are relevant and effective for each local government, school district, and higher education institution we serve.

- 2. Does your company meet *each* minimum qualification and requirement listed in the Special Instructions to Offerors, Section J? If no, please indicate which ones of qualifications you do not meet and an explanation as to why.**

Confirmed.

- 3. Within the past two (2) years, describe any significant development in your company (e.g. changes in ownership, personnel reorganization, change in business emphasis, etc.)**

As of December 20, 2018, Cigna Corporation successfully completed the acquisition of Express Scripts. The combination of Cigna with Express Scripts integrates two complementary health care service companies, each with industry-leading cost trend capabilities that, together, are positioned to deliver better care and expanded choice as well as drive down health care costs. With Express Scripts, Cigna can dramatically accelerate the number and breadth of value-based relationships. This model of partnership aligns incentives to clinical outcomes, not just consumption of the medication or health care services, adding to Cigna's rapidly expanding collaborative care network. These relationships will be further strengthened by our comprehensive analytics platform, which is based on insights from one billion annual customer touchpoints, and is designed to drive transparency and engagement with clients and members.


In November 2018, Cigna officially closed the acquisition of OnePath Insurance from ANZ Bank New Zealand, Ltd. Aligned with Cigna's "Go Deeper, Go Local, Go Beyond" strategy, the acquisition supports the diversification of Cigna New Zealand's distribution capabilities and product offerings through an additional significant bank assurance channel and independent financial advisor (IFA) distribution. The two brands combined to form New Zealand's third-largest life insurance provider with a 13 percent market share. This combination has allowed Cigna to triple the size of its local market presence and enabled it to offer a diverse range of products and services to a broader set of clients and members in New Zealand.

In December 2017, Cigna acquired Brighter Inc., a leader in the development of digital health plans designed to engage members in a deeper and more personalized way. With Brighter's platform as the digital health engine for Cigna markets and segments, Cigna will be poised to drive change in the marketplace, accelerate its path to becoming a digital health plan, and expand its initiatives to improve value for consumers and health care providers through personalized and seamlessly integrated experiences. The acquisition will build upon the already successful relationship between Cigna and Brighter by accelerating the development of Cigna's mobile and desktop platforms and creating new end-to-end experiences that connect members and provider with the guidance, support, and incentives they need to increase quality of care and maximize cost-savings.

- 3.1. Does your company anticipate any transactions to expand or to become acquired by another business entity within the next five (5) years? If yes, explain the impact in both organizational and directional terms.**

We will continue to invest in innovative solutions and programs to engage and support members in their health and life journeys and partner with health care providers on leading value-based care programs. We will continue to expand our proven footprint and capabilities across the globe for individual and employer clients. Our approach of focusing on health care services over sick care financing has never been more critical.

Cigna Corporation is a publicly traded company. State and federal laws regulate disclosures made by publicly traded companies about acquisition transactions. Proprietary and confidentiality concerns preclude comment on any planned activity. In the event that a merger or acquisition transaction should occur, we would take steps to ensure continued, uninterrupted service to our members.

	ATTACHMENT D: Questionnaire		ARIZONA STATE RETIREMENT SYSTEM 3300 N Central Ave 14 th Floor Phoenix, AZ 85012
	ASRS Group Dental Services Solicitation Code: BPM001922 PART 2 of 2 - Attachments (Response Forms)	Page 3 of 42	

4. For the most recent ten (10) year period, describe any past or pending litigation, regulatory proceedings, investigations and/or complaints filed against your company, or any proposed subcontractor or affiliated organization, or individual identified to perform services for the ASRS. *(If Offeror believes the information is confidential, include response in a separate attachment named Attachment D2: Confidential Documents and mark as "Confidential" as indicated in Special Instructions to Offerors, Sections F(2) and G(1).)*

In an industry where lawsuits are commonplace, Cigna is involved in lawsuits arising, for the most part, in the course of ordinary business. In an average year, Cigna Corporation's subsidiaries, including Connecticut General Life Insurance Company (CGLIC) and Cigna Health and Life Insurance Company (CHLIC), process more than 60 million claims and receive approximately 400 claim-related lawsuits. While the outcome of this litigation cannot be determined, we do not expect litigation to result in losses that would be material to results of operations, liquidity, or financial condition.

Please refer to Form 10-K and Form 10-Q for an updated description of material legal proceedings. These documents are available online: <https://www.cigna.com/about-us/investors/>.

Confidentiality concerns, together with the pending nature of a number of lawsuits, preclude further comment or description.

5. Is your company currently in default on any financing agreement with any bank, financial institution, or other entity? If yes, specify date(s), details, circumstances, and prospects for resolution. *(If Offeror believes the information is confidential, include response in the separate attachment named Attachment D2: Confidential Documents.)*

No.

6. Provide a copy of the company's audited financial statements for the past two (2) years. *(If Offeror believes the information is confidential, include response in the separate attachment named Attachment D2: Confidential Documents.)*

We have provided an annual report for 2017 and 2018 in Attachment D1 of our proposal response.


7. If your company proposes to use subcontractors in the delivery of services to ASRS please list each, the services they will provide, and your company's experience working with the organization.

Cigna serves as the sole provider of services requested in this proposal; however, we have established relationships with subcontractors to enhance our offerings to our clients. These subcontractor arrangements are in place to service Cigna's broader—i.e., entire—book-of-business and have not been specifically contracted to provide the services requested in this proposal. Cigna will hold subcontractors and subsidiaries to the same standards of care to which it is held, and agrees to seek prior written consent of the ASRS for any subcontract work procured specifically to provide the services requested in this proposal.

Account Management and Organizational Processes

1. Provide a brief biography, including name, function and responsibilities, location, years of industry service, and years with the company for any staff who will routinely be assigned to the ASRS account. *(Provide Résumés of Key Personnel as indicated in the Special Instructions to Offerors, Section F(2.4).)*

Please see the account team bios located in Attachment D1 of our proposal response.

	ATTACHMENT D: Questionnaire		ARIZONA STATE RETIREMENT SYSTEM 3300 N Central Ave 14 th Floor Phoenix, AZ 85012
	ASRS Group Dental Services Solicitation Code: BPM001922 PART 2 of 2 - Attachments (Response Forms)	Page 4 of 42	

2. Have you made any significant changes in your company's administrative (IT) systems within the last three years? How did Participants, providers, and plan sponsors benefit from the changes?

No. Cigna has not made any significant changes in our company's administrative (IT) systems within the last three years. Our IT systems are updated/enhanced as required to maintain business functions.

Claim Systems

We update the modules or subsystems from an applications perspective in response to business requirements and enhancements throughout the year, as needed. There are major releases four times a year and smaller releases monthly. Should a production issue arise, processes are in place to take immediate and appropriate action outside the release schedule.

We review hardware capacity on an ongoing basis and make adjustments as necessary to meet database and computer processing unit requirements.

We update system software (database, operating system, tools) as vendors provide upgrades and after adequate testing.

We continually update our systems, which take advantage of state-of-the-art hardware and software technology, to accommodate changes in the dental insurance market as well as to regulatory requirements.

Eligibility

Cigna continually improves the management of eligibility data to accommodate new plans, service offerings, and legislative requirements to ensure high-quality customer service. We work with our clients to improve how we jointly process and manage eligibility information. Our improvement goals include the following:

- ensuring our eligibility information matches client eligibility information
- enhancing our closed-loop eligibility process to ensure downstream eligibility changes are systematically (versus manually) included in the update process, providing faster updates to eligibility
- collapsing processing times for eligibility changes
- improving the overall management and use of eligibility data
- improving the internet eligibility maintenance functionality


Upgrades to our system allow for tracking of user ID, screen, and data accessed for every user.

Internet

We have an extensive review process, at both the technical and managerial levels, to ensure that changes to the applications and data are appropriate and meet the standards prescribed by our required operating procedures.

Cigna's IT department and investments in technology are core components of the drive to be the leading health service company. Our total technology operating expenses for 2018 were approximately \$2.6 billion, with Cigna's spending representing approximately \$1.8 billion and Express Scripts' spending representing approximately \$800 million. Our IT investments and priorities focus on building a retail-centric IT infrastructure as well as developing innovative business capabilities that support affordable health solutions and create a personalized member experience.

3. Briefly describe the capabilities of the claims management information software you utilize.

	ATTACHMENT D: Questionnaire		Page 5 of 42	ARIZONA STATE RETIREMENT SYSTEM 3300 N Central Ave 14 th Floor Phoenix, AZ 85012
	ASRS Group Dental Services Solicitation Code: BPM001922 PART 2 of 2 - Attachments (Response Forms)			

DPPO

In the early 1980s, Cigna's dental claim system, DentaCom, was developed in-house based on our vast experience in the dental industry and the needs of our clients and members. In 1996, when the Cigna DPPO plan was introduced, enhancements were made to support the processing of a DPPO plan. Major upgrades since then have included integration of data entry and auto-adjudication functions into an integrated health care systems environment; a central repository of eligibility and coverage/structure-related data; Cobol II upgrades; automated orthodontia payments; and a new EOB system. Our system is updated annually with new (current) dental terminology codes as well as HIPAA compliance enhancements.

In 2016, we began a replatform of the claim system. The first phase positions Cigna to allow an array of flexible benefits. Rules-based software Pega was leveraged in place of the prior customer information control system and Virtual Storage Access Method (VSAM) files on the mainframe platform. Benefits are as follows:


- Dental logic prevents payment of duplicate submissions, assists with coding accuracy, and automates plan design features. The logic stores claim-adjusting parameters (guidelines based on dentistry standards), coverage exclusions and limitations, procedure frequencies, and dental plan information, enabling us to detect unbundled procedures and appropriate codes for payment and to flag procedures needing further review.
- Dental history maintains the experience of each member to identify duplicate claims, deductibles, and maximum accumulators and ensures the status of the definition is accurate and current.
- Repetitive orthodontic payments are calculated quarterly and automatically sent without additional adjuster intervention until the maximum benefits are paid.
- Combined dental health care provider checks/itemized EOBs are calculated for payments made to specific providers on a given day.
- Flexible plan designs are administered based on maximum reimbursable charge (MRC), percentage-off billed charges, or scheduled coverage. The alternate coverage provision allows for consideration of what is commonly performed for that condition regardless of whether it is less or more costly.
- Accumulators by plan year and calendar year as well as lifetime maximums ensure the correct amount is paid. Deductibles and out-of-pocket maximums are also tracked.

Our claim system automatically does the following:

- loads eligibility files from the eligibility system's electronic feed
- tracks unprocessed mail/provides aged-mail reports
- verifies pertinent information for each transaction
- verifies treatment and coverage dates
- protects against payment for prior procedures
- checks history for tooth number, procedure code, and date of service
- identifies any errors occurring during input
- compares claims against contractual limitations to avoid overutilization
- calculates payments according to MRC allowances and/or scheduled benefit amounts
- identifies claims where potential COB opportunities exist for follow-up investigation by the processor
- generates correspondence
- issues checks and EOBs
- produces weekly bulk mailing of dentist checks and EFT issuances

DHMO

Cigna's dental claim processing system, Webster, was developed in-house in the early to mid-1990s to handle the specific needs of a DHMO plan. In December 2002, we began using Sun hardware and the Solaris operating system. The application provides online access to every service center supporting DHMO plans. Hardware upgrades are

	ATTACHMENT D: Questionnaire		ARIZONA STATE RETIREMENT SYSTEM 3300 N Central Ave 14 th Floor Phoenix, AZ 85012
	ASRS Group Dental Services Solicitation Code: BPM001922 PART 2 of 2 - Attachments (Response Forms)	Page 6 of 42	

planned as appropriate based on business processing requirements and changes in technology. We also update applications regularly to meet new plan coverage needs and industry changes.

Our system consists of every module necessary to administer our plan, including account data, dental health care provider files, specialty referrals, encounters, and eligibility. Specialty referrals are processed according to processing guidelines, and referral and encounter processing verifies eligibility. The system also processes payments to providers. Although we accept paper eligibility, over 80 percent arrive electronically, which provides for an efficient and timely process and eliminates errors related to manual data entry. Further, we offer a single eligibility-feed solution and a convenient consolidated bill for clients with more than one Cigna plan.

Our claim system automatically does the following:

- loads eligibility from the eligibility system's electronic feed
- verifies pertinent employee and dependent information
- checks treatment history for tooth number, procedure code, and date of service
- identifies to the operator (for immediate correction) any errors during input
- compares encounters against contractual limitations (to avoid overutilization)
- verifies a match between treatment dates and dates of coverage for employees and dependents

3.1. Is the system customizable to the client's needs and requirements?

Our experience has shown that too many edits can be counterproductive and too few can affect accuracy. We have carefully selected our data edits to ensure maximum accuracy while maintaining productivity and preventing delays in claim/specialty referral payment.


DPPO

Our claim payment system identifies network providers and automatically applies discounts per contractual arrangements. In addition, our system can apply maximum reimbursable charge (MRC) and frequency limits, calculate COB, and rebundle procedures. Some of the confirmation checks applied within the claim system are as follows:

- **Basic Data Entry Verification** - These values must be verified as defined in the program specifications and/or tables:
 - procedure code
 - relationship code
 - date (correct format)
 - employee identification number (numeric; specified number of positions)
- **File Edits** - The value entered is edited against other data or files. These include the following:
 - The employee/dependent register must exist for the employee/dependent.
 - Dates of service require that "last date" cannot be earlier than "first date."
- **Claim Calculation Edits** - Data entered is edited at the claim level against individual and family history files and against specific plan data in the master to identify suspected duplicate claims, calendar year maximums that have been reached, and charges exceeding scheduled amounts.
- **Other File Edits** - Data entered is edited against other files and tables. This includes verifying eligibility for the employee and dependents and MRC allowances. It also identifies indications of COB and verifies providers are legitimate.

DHMO

Our claim system can apply the appropriate patient charge schedule (PCS), define network dental health care providers, and identify potential unbundling procedures. It also maintains the following information to ensure accurate claim and specialty referral processing:

	<h1>ATTACHMENT D: Questionnaire</h1>		<p>ARIZONA STATE RETIREMENT SYSTEM 3300 N Central Ave 14th Floor Phoenix, AZ 85012</p>
	ASRS Group Dental Services Solicitation Code: BPM001922 PART 2 of 2 - Attachments (Response Forms)	Page 7 of 42	

- **Basic Data Entry Verification** - These values must be verified as defined in the program specifications and/or tables:
 - procedure code
 - relationship code
 - date (correct format)
 - employee identification number (numeric; specified number of positions)
- **File Edits** - Relational database technology enforces constraints at the data level to prevent incorrect entry of claim, provider, and member information.
- **Claim Calculation Edits** - Data entered is edited at the claim level against individual and family history tables and against specific plan data to identify suspected fraud and duplicate claims.
- **Other File Edits** - The following information is also verified:
 - eligibility for the employee and dependents
 - providers
 - duplicate entries based on service date, procedure code, tooth number, and/or quadrant
 - time intervals related to periodontal care
 - age limitation (e.g., for pediatric care)
 - active versus inactive status

4. Does your company have documented Business Continuity Plan (“BCP”) and Disaster Recovery Plans (“DRP”)?


Yes. Cigna is committed to excellence in helping members enhance their health, well-being and peace of mind. Such a commitment requires that we be prepared to provide our services and offer our products virtually without fail. Thus, when our ability to provide service is affected for any reason, we must react in a manner that minimizes the impact by responding quickly to the situation and restoring operations as soon as possible. This response will ensure the continued confidence of our clients, members, and shareholders as well as ensure our position within the competitive marketplace.

Cigna has a business continuity planning program that establishes and documents procedures designed to respond to a wide array of incidents. The program—which is reviewed, updated, and documented annually—addresses both data recovery and continuation of business functions. Cigna’s business continuity plan (BCP) uses dedicated personnel and supporting technology to recover critical business operations in the event of unexpected disruptions.

Cigna has a team of personnel committed to maintaining and growing its business continuity program. Business continuity planning is overseen within the enterprise risk management area, reporting up to Cigna’s chief risk officer. The corporate BCP team is made up of certified continuity planners who interact with designated BCP staff in each business area. The BCP team oversees the entire BCP process, which includes the annual completion/updating of the business impact analysis and recovery plans as well as validating/implementing approved recovery strategies. The process of updating plans includes a thorough review and sign-off by the plan owner. Certain personnel have been preassigned to incident response teams; these individuals can travel to the disaster site quickly and possess all the required expertise in recovery. The majority of Cigna sites around the country designate specific personnel to participate in business continuity planning and assure that local recovery needs are met.

Cigna’s critical applications run in “hard sites,” which are protected by emergency generators. Data center recovery plans are in place with the objective of fully recovering all critical applications. Workaround procedures are documented and followed until systems are restored.

As a key part of business continuity planning, Cigna annually prioritizes its various business functions using a business impact analysis. The business impact analysis is used to update the recovery strategy of each functional area and integrate the individual strategies into an enterprise-wide recovery strategy. These

	<h1>ATTACHMENT D: Questionnaire</h1>		ARIZONA STATE RETIREMENT SYSTEM 3300 N Central Ave 14 th Floor Phoenix, AZ 85012
	ASRS Group Dental Services Solicitation Code: BPM001922 PART 2 of 2 - Attachments (Response Forms)	Page 8 of 42	

strategies outline where and how critical operations will be recovered. In addition, Cigna has set recovery time objectives for each line of business. Critical vendors and resources necessary for the recovery and resumption of business processes are identified in the BCP. All critical action plans are maintained in an enterprise-wide, web-based disaster management system that is available online with appropriate security.

In the event of a crisis, whether a man-made, natural disaster, or epidemic/pandemic, Cigna's corporate crisis team, led by the global business continuity officer, will gather to centralize decision making while managing the response and restoration to normal operations. The team is comprised of senior leadership across the enterprise from many different critical areas (e.g., HR, communications, legal, privacy, IT, security, risk). Crisis team members participate in annual mock disaster exercises. During a crisis, client communications would be at the direction of the corporate crisis team and channeled through appropriate account executives.

Cigna employs six methods of recovery:


- **Rerouting of Business Functions** - All of Cigna's customer service contact centers have load-balancing capabilities that allow calls to be rerouted in the event of heavy volume or closings due to inclement weather or emergencies. Additionally, Cigna has moved key incoming toll-free phone numbers into a dedicated, hardened center that is protected by an emergency generator to ensure maximum control.
- **Personnel Relocation to an Alternate Cigna Site** - Many Cigna sites around the country have excess space that can be utilized by personnel from a site that has been affected by a disaster. Many conference rooms have been prewired so that they can be used as workspaces if needed. Cigna's standard platforms can be run from these locations.
- **Data Center Recovery** - The network capacity between Cigna's primary Windsor data center and its backup, the Ashburn data center, allows for data and server replication between sites. The Ashburn data center includes infrastructure to recover the top prioritized business functions and related systems and applications.
- **Independent Vendor "Hot Site" Usage** - Cigna maintains a "hot-site" contract with recognized third-party recovery vendors for alternative workstations for Cigna personnel. This method is tested annually with live calls and data.
- **Mobile Recovery** - High-volume call centers have the availability of mobile recovery. This provides office space/equipment and encrypted satellite communication for voice and data. These self-contained mobile offices can be set up in less than 72 hours and come with their own power source. When used in conjunction with load-balancing capabilities, this method provides robust recovery.
- **Work at Home** - Cigna has an increasing number of staff who work from home on a full-time basis. They are provided with work-at-home technology on a part-time/casual basis. Because these capabilities are prepositioned, at the time of disaster, our staff can immediately work from home using virtual private network (VPN) connections to dial into the data centers.

As part of its overall commitment to business continuity planning, Cigna tests each unique recovery solution at an enterprise-wide level annually. Furthermore, specific business function plan testing is performed on a rolling two-year cycle. All offices are required to test Cigna's emergency employee notification system annually.

4.1. How often are they tested, reviewed and updated?

Our business continuity planning program is reviewed, updated, documented and tested annually. We test disaster recovery from our secondary data center multiple times per year.

4.2. When were the last BCP and DRP tests conducted, and what was the scope of each test and the results? *(If Offeror believes the information is confidential, include response in a separate attachment named Attachment D2: Confidential Documents and mark as "Confidential" as indicated in Special Instructions to Offerors, Sections F(2) and G(1).)*

	ATTACHMENT D: Questionnaire		ARIZONA STATE RETIREMENT SYSTEM 3300 N Central Ave 14 th Floor Phoenix, AZ 85012
	ASRS Group Dental Services Solicitation Code: BPM001922 PART 2 of 2 - Attachments (Response Forms)	Page 9 of 42	

We test both our hot sites and our data center multiple times per year. Our recent tests of IT infrastructure met our test objectives of recovering the intended environment from our backup data center. Additional details regarding the results from our most recent business continuity tests are proprietary and cannot be provided at this time.

5. Does your company have information security and privacy policies and procedures and if so, how are they documented?

Yes. The Cigna Information Protection organization, with input from stakeholders appropriate to the topic(s), is responsible for updates to Cigna's Information Protection Policy. Once an update is drafted, it is reviewed for input and comment by the information protection policy and standards task team as well as the information protection leadership team and information protection coordinators.

On an annual basis updates to the policy are sent for endorsement to the following individuals in sequence:

- the chief information security officer (CISO);
- depending on the significance and breath of the policy, the chief information officer (CIO); and/or
- the CFO.

After the review, the CIO and CFO submit any updates to senior management for formal approval and subsequent publication as a new version of the Cigna Information Protection Policy.

Modifications to the security program are made as needed to align with the revised policy. This includes training and awareness, incident response, compliance with the information protection policy, etc.

5.1. What areas are addressed in documented information security and privacy policies (e.g., Electronic Access Control, Password Management, Privacy and Confidentiality)?


We design security solutions using the following framework:

- Identification and Authentication - confirms identity
- Access Control - prevents unauthorized use
- Confidentiality - prevents unauthorized disclosure
- Data Integrity - prevents unauthorized modification
- Data Availability - ensures availability of data
- Auditing - maintains evidence of unauthorized use
- Nonrepudiation - provides evidence of origin and receipt

An extensive security policy for our employees and contractors covers areas such as

- computing resource use;
- information handling;
- physical protection;
- business continuity planning; and
- information protection awareness and training.

Security standards specify how our hardware and software should be configured, and a privacy policy governs the handling and use of member information. Dedicated, professional security staff develop safeguards and help ensure that standards and policies are followed. We have processes in place to investigate and contain

	ATTACHMENT D: Questionnaire		ARIZONA STATE RETIREMENT SYSTEM 3300 N Central Ave 14 th Floor Phoenix, AZ 85012
	ASRS Group Dental Services Solicitation Code: BPM001922 PART 2 of 2 - Attachments (Response Forms)	Page 10 of 42	

computer viruses and internal security incidents and to detect any unauthorized access to our computer network.

A three-level system maintains physical security at our facilities by authorizing appropriate access into our facilities, properly identifying each person, and defining the working areas to which people have access.

5.2. How are the information security and privacy policies and procedures monitored and enforced?

The Privacy Office conducts targeted risk assessments regularly based on compliant and incident data, business processes and technology safeguards. Internal Audit performs assessment activities that identify privacy risk and drive remediation activities. The Privacy Office participates in all external vendor reviews, system development life cycle reviews and enterprise projects with Cigna Information Protection to conduct an assessment to ensure compliance with the HIPAA Privacy and Security rule.

5.3. What overarching framework do you utilize for information management and control strategy?

National Institute of Standards and Technology (NIST), SANS, and International Organization for Standardization and the International Electrotechnical Commission (ISO/IEC) 27002 are the most leveraged security frameworks within Cigna's security program to achieve robust processes and controls.

Cigna also performs a benchmark assessment to evaluate emerging security practices and assist in prioritizing future security initiatives. The benchmarking process is based on established, internationally adopted security frameworks. Cigna also adopts the Committee of Sponsoring Organizations of the Treadway Commission framework for internal controls over financial reporting in accordance with SEC requirements.

6. Do you have an Information Security Office? If so, describe its functions, responsibilities and overall procedures for the safekeeping of clients' data.


Yes. The chief information security officer (CISO) is accountable for security and leads the Cigna Information Protection organization that provides centralized governance and direction for information protection activities. The organization's responsibilities include the following:

- developing corporate-wide policies, requirements, standards, and guidelines
- providing technical expertise, assessment, and implementation of new security plans
- developing awareness/communication packages and security training curriculums
- warehousing the inventory of corporate information assets
- performing compliance monitoring
- providing Cigna's senior management with periodic progress assessments (i.e., scorecards)
- developing (with business input) tools, templates, and methodologies to support consistent risk assessment, data classification and ownership, and information asset inventories for the businesses and the systems community

6.1. Is this a distinct function/team within the information technology department?

Yes. Cigna's Information Protection team is a distinct function.

7. Please describe any physical security your company has to restrict access to servers/computer rooms, stored data and documentation to prevent unauthorized destruction, modification, disclosure or use of a client's data?

	ATTACHMENT D: Questionnaire		ARIZONA STATE RETIREMENT SYSTEM 3300 N Central Ave 14 th Floor Phoenix, AZ 85012
	ASRS Group Dental Services Solicitation Code: BPM001922 PART 2 of 2 - Attachments (Response Forms)	Page 11 of 42	

Cigna's primary data center has a high degree of physical security. Physical access to Cigna's data centers is restricted to a limited number of people, and access is controlled by a badge reader, PIN code, and biometrics. Cigna requires extensive reference and security checks for sensitive personnel positions. Cigna also has cameras, 24/7 surveillance, security guards, and identification verification booths throughout the facilities.

The data center buildings cannot be identified as Cigna buildings. The primary data center includes a state-of-the-art chilling capability, uninterruptible power supply, raised floor, humidity control, and backup generators. In addition, the data centers are equipped with fire detection/suppression equipment, monitoring systems, and uninterruptible power supply systems that provide continuous power as well as alternate power supplies that use diesel generators.

Physical security is tested annually as part of Cigna's System and Service Organization Controls (SOC1) reports.

8. How are client claims documents maintained? Where (online, offline, offsite) does your company maintain them and for how long?

We retain claim data for 10 years from the date of contract termination for adults and for 10 years from the date of majority for minors.

Cigna maintains its records in accordance with legal, regulatory, and business requirements as well as our own record retention policy. Cigna has record retention/destruction policies in place that address every type of record, including paper and electronic.

Cigna's external service provider review process includes information security, privacy, and physical security considerations. While all necessary contractual obligations are obtained from subcontractors, Cigna operates under the expectation that a contract cannot substitute for the program diligence necessary to ensure the protection of its own and its members' and clients' data.

DPPO

Our claim system maintains history online for 12–24 months; however, procedures with specific frequency limitations remain online until the specified period has passed. Our claim system automatically transfers data (needed to respond to inquiries or perform audits) older than 12 months to our electronic archive, where it is kept in the online retrieval system. We maintain the data an additional seven years in our claim center, and the magnetic tapes are stored in our data center; a copy is held in another center (for disaster recovery purposes). This ensures our compliance with ERISA requirements.

Our claim system feeds from our reporting system, which holds five years of claim data for utilization reporting and client ad hoc reporting. We also keep structure and eligibility information online for 24 months and purge the system once per year.

We destroy original forms and copies of material issued to members after those originals and copies are imaged and stored.

DHMO


We maintain treatment history online indefinitely for use within plan limitations (e.g., the 24-month limitation on orthodontia). We also keep specialty referral, billing, and eligibility files online indefinitely. We destroy original forms and copies of materials issued to members after those originals and copies are imaged and stored.

9. How is confidentiality of claims maintained?

Cigna's privacy policies require that every member's personal information be safeguarded and kept confidential in accordance with applicable law, including HIPAA/Health Information Technology for Economic and Clinical Health Act (HITECH). This policy applies to every Cigna employee, agent, and director.

Highlights of the corporate privacy policy include the following:

- PHI and personally identifiable information is collected only as necessary and through ethical means.

	ATTACHMENT D: Questionnaire		ARIZONA STATE RETIREMENT SYSTEM 3300 N Central Ave 14 th Floor Phoenix, AZ 85012
	ASRS Group Dental Services Solicitation Code: BPM001922 PART 2 of 2 - Attachments (Response Forms)	Page 12 of 42	

- PHI and personally identifiable information is used and disclosed only as permitted or required by, and in accordance with, the requirements of applicable law, including laws requiring prior notice to or consent of the member.
- The minimum amount of PHI and personally identifiable information will be used or disclosed as necessary to accomplish the purpose of the permissible use or disclosure.
- Every Cigna employee and business associate is responsible for protecting the personal information of members and complying with the privacy policy.
- A privacy council is responsible for maintaining awareness of emerging privacy developments and laws and monitoring the company's privacy program.
- Cigna will not sell, rent, or license PHI and personally identifiable information unless approved by the subject of the personal information or permitted by law (Non-US affiliates/branches may seek privacy council exceptions where allowed by law).
- Internal sharing of PHI and personally identifiable information is permitted only if allowed by law and a legitimate business need exists. If the purpose of sharing information is not clearly consistent with the purpose for which the PHI and personally identifiable information was collected, approval by the privacy council is required before sharing the PHI and personally identifiable information.

Method of Approach and Quality of Plan

1. Describe the three most important actions your company has taken in the last two years to improve the following:

- **Quality of dental services**

The following describes our quality improvement initiatives.

Quarterly Grievance Committee

The quarterly grievance committee meets to review dental offices that have a disproportionate number of complaints and network follow-ups. The committee reviews the issues in detail and makes decisions about appropriate next steps, including counseling by network management or a dental director. After such counseling and any other follow-up, the network manager or dental director forwards information to the credentialing committee for further review as well as a final decision about the office's continued network participation.

Performance Monitoring: Scorecard Studies


Scorecards are a tool for monitoring network general dental offices and include cumulative measures of both clinical and nonclinical performance. Their objective is to identify network dentists who have low quality scores in one or more of the measures. Once identified, we contact the dentists and make them aware of their scores (with the goal of improving these scores).

We also use scorecards as a primary identification and counseling tool for outlier offices we have not otherwise identified or counseled or that were identified in other venues (e.g., national and state grievance subcommittees, periodic quality assessments [PQAs], clinical and nonclinical follow-ups, focus studies other than performance monitoring studies).

We base scorecard studies on DHMO data, though education and counseling may also occur for dentists contracted on the DPPO plan.

2018 Quality Measurement Focus Study: Complaint Process (Request for Records)

The objective of the 2018 Quality Measurement Focus Study was to improve the experience of members participating in the complaint process. To do this, we evaluated full-year 2017 and YTD (as of study) 2018 network follow-up incidents related to noncompliance with requests for records by the Cigna Dental national appeals unit. Offices with at least one incident (127) received a letter explaining the request

	ATTACHMENT D: Questionnaire		ARIZONA STATE RETIREMENT SYSTEM 3300 N Central Ave 14 th Floor Phoenix, AZ 85012
	ASRS Group Dental Services Solicitation Code: BPM001922 PART 2 of 2 - Attachments (Response Forms)	Page 13 of 42	

process and encouraging compliance as required by the dentist network agreement. Provider relations managers counseled dental service organizations (6) with identified offices. Contact occurred during August 2018, and we will run a report in 2019 to check for improvement.

2017 Quality Measurement Focus Study: Network - Member Experience

The objective of the 2017 Quality Measurement Focus Study was to improve the experience of members visiting a network dental office. To do this, we evaluated full-year 2016 POSE surveys. Offices with at least 10 surveyed members and an average score of less than 80 percent in one of the categories were reviewed for possible counseling by our provider relations personnel.

Nationally, 24 offices were identified as outliers. These offices were then contacted (in June 2017) by letter and phone to review survey results and counsel office staff as needed. The interim results appeared to indicate the offices appreciated the information and would take corrective action on identified issues.

A new report was run for the 24 identified outlier offices based on surveys taken between June 20, 2017, and June 20, 2018. This new set reflected member visits that occurred after dental offices received the aforementioned letters and counseling. Of the 24 original outlier offices, 8 were no longer an outlier in any of the questions, and most (19/24 [79 percent]) improved their overall scores from the previous year. Overall average scores for each question for all dental offices also improved from the previous year, with the exception of the question about "overall care received from the hygienist," which dropped slightly (by 1.0 percent). Other changes were as follows:


Survey Question	Percent Improvement (%)
Based on your experience, how likely would you be to recommend this dentist's office to a friend or relative?	16.0
Considering everything about your visit to this dental office, how would you rate your overall experience with this visit?	11.0
How would you rate the overall dental care received from the dentist?	6.5
How would you rate the dentist or staff discussing treatment options with you?	4.0
How would you rate the amount of time waiting in the office to see the dentist or hygienist?	4.0

We also saw a slight improvement in results related to the following question: "How would you rate the dentist or staff explaining the treatment procedures?"

2016 Quality Measurement Focus Study: Network Access - Member Transfers

The objective of the 2016 focus study was to ensure reasonable and appropriate member access to care. This was accomplished by evaluating dental offices transfer-out reasons for full-year 2015. Provider relations reviewed offices with a high percentage of member transfer-outs due to appointment scheduling issues, patient/dentist rapport, and staff attitude for possible counseling.

Nationally, 37 offices were identified as outliers. These offices were contacted (in August and September 2016) by letter and phone to review the report of member transfer-outs, and we counseled the office as needed.

	ATTACHMENT D: Questionnaire		ARIZONA STATE RETIREMENT SYSTEM 3300 N Central Ave 14 th Floor Phoenix, AZ 85012
	ASRS Group Dental Services Solicitation Code: BPM001922 PART 2 of 2 - Attachments (Response Forms)	Page 14 of 42	

A new member-transfer report was run for full-year 2016 to compare results for the 37 outlier offices to see if they improved any of the three member-transfer reason categories. Of the identified offices, 35/37 (95 percent) showed significant improvement over their 2015 results.

We continue to monitor member satisfaction through our quality management program.

- **Customer service**

We support our mission to provide our clients, members, and providers with consistent, high-quality service through a disciplined and integrated combination of tools and technology, processes, and people. Through expanded technology, such as self-service internet solutions, automated telephone systems, electronic data interchange (EDI), and our OneView customer service system, we are continuously improving our self-service, e-commerce, and customer service functions.

These tools enable customer service advocates (CSAs) to respond to inquiries quickly and accurately. Members can access information when they choose and in a setting and format comfortable to them.

Cigna provides members with fast, easy access to information and timely responses to their questions. We offer several continuously enhanced services and resources:

- **Intelligent Call Routing** - This capability ensures that calls are directed to available and appropriate customer service advocates (CSAs).
- **Common Inquiry Desktop** - CSAs have a single view of up-to-date member data, including eligibility, claim, and call history. This allows them to answer member questions about medical, dental, or pharmacy coverage quickly and accurately.
- **Self-Service Solutions** - Members may access plan information and request changes through the automated phone system and on myCigna.
- **Confirmation Number** - We provide members with a confirmation number to access previous call history information. Should the member need to speak to a CSA, this information is readily available to speed up the inquiry.
- **Improved EOB** - Our award-winning EOB has simplified language, larger type, and clear information on what members owe.
- **Online Access to EOB** - Members can access EOBs online and choose to no longer receive EOBs in the mail, which allows members to go green.


We now have the capability to allow our members and customer service advocates (CSAs) to interact via a secure emailing channel, leveraging the secure inbox messaging functionality on myCigna. This option allows our members who are registered on myCigna to receive and send files. Our standard turnaround time for responses is 30 minutes; however, our CSAs typically respond within a few minutes.

Members cannot initiate communication with a CSA through the secure emailing channel; it is only for follow-up communication after members make initial contact via phone or live chat.

In addition to this feature, members can access a variety of health plan information and services 24 hours a day, 7 days a week, 365 days a year on myCigna or by calling customer service at 800.Cigna24.

- **Network participation**

Incentives play an important role at increasing participation. Network dentists are paid based on discounted fee schedules that vary by three-digit zip code. Our discounted schedules encourage preventive dentistry by offering more aggressive payment on preventive services while holding deeper discounts on Class II and Class III procedures. Network dentists and specialists are also contractually obligated to provide a 20 percent discount off their usual fees for any covered services not included in the fee schedule. For noncovered services, members are responsible for paying the dentist's usual fee for that procedure.

	ATTACHMENT D: Questionnaire		ARIZONA STATE RETIREMENT SYSTEM 3300 N Central Ave 14 th Floor Phoenix, AZ 85012
	ASRS Group Dental Services Solicitation Code: BPM001922 PART 2 of 2 - Attachments (Response Forms)	Page 15 of 42	

There is no risk sharing or risk pool. Primary care dentists and specialists are contracted on a discounted fee-for-service (FFS) schedule based on average charges in a geographic area.

Over 97 percent of dentists receive claim payments weekly. The remaining checks, which are special issues, are paid daily. Dentists also receive patient copays, which are generally collected at the time treatment is rendered.

- **Financial performance**

Please see the annual report located in Attachment D1 of our proposal response.

- **Participant use of preventive services**

Cigna Dental Wellness*Plus*

We have introduced incentive features, known as Cigna Dental Wellness*Plus*, for our DPPO plan. With Wellness*Plus*, members are rewarded for receiving annual preventive services, which are often covered at no cost or low cost, depending on plan design. Clients have the option of selecting one of the following features:

- progressive maximum
- progressive coinsurance benefit
- progressive/regressive coinsurance benefit

With Wellness*Plus*, members who receive preventive services annually are rewarded. Depending on the feature the client chooses, members receive an increase in their annual dollar maximum or benefit level the following year (up to the amount specified by the plan design). This incentive encourages preventive care, which is important because regular oral care may help employees address minor problems before they become major—and more expensive to treat. With the regressive option, when members do not receive preventive care each plan year, their benefit level for class II (basic restorative) and/or class III (major restorative) services will decrease the following plan year; however, it will never fall below the initial level specified by the client.

Cigna Dental Health Connect


As Cigna Dental continues to innovate and align our focus on whole-person health, we are bringing together existing programs including our Cigna Dental Oral Health Integration Program® (OHIP) and our Dental Outreach Program under an umbrella brand name that captures our approach to whole-person health: Cigna Dental Health Connect.

Cigna Dental Health Connect is not a program or a service. It's the embodiment of our approach to whole-person health through innovative dental solutions and actionable insights.

Through this approach, we use clinical insights and expertise to identify opportunities to improve outcomes, and then use this information to develop innovative dental solutions designed to help our customers overcome barriers to achieving good health. The result is more meaningful dental health solutions that are specifically designed to fit our customers' lives and needs. So taking care of their oral health – and their overall health – is easier and more affordable.

With Cigna Dental Health Connect, dental members with the following conditions can get 100 percent reimbursement of their out-of-pocket costs for certain dental services:

- pregnancy
- diabetes
- heart disease
- stroke
- head and neck cancer

	<div> <div>ATTACHMENT D: Questionnaire</div> <div> ASRS Group Dental Services Solicitation Code: BPM001922 PART 2 of 2 - Attachments (Response Forms) </div> <div> Page 16 of 42 </div> </div>	<div> ARIZONA STATE RETIREMENT SYSTEM 3300 N Central Ave 14th Floor Phoenix, AZ 85012 </div>
--	---	---

- organ transplant
- CKD

Cigna Dental Oral Health Integration Program (OHIP)

We have recently implemented an improved Oral Health Integration Program (OHIP), lower-cost DHMO plans, teeth whitening services, the Cigna Identity Theft Protection Plan for DHMO, and clinical innovations (e.g., brush biopsy coverage).

Research has shown an association between periodontal (gum) disease and bacterial infection to complications for heart disease, stroke, diabetes, preterm birth, preeclampsia, and other health issues. At Cigna, we draw the connection between dental and medical health by offering an integrated benefits program that reinforces the importance of good oral health in relation to overall health. When we developed OHIP in 2006, we were the first dental administrator/carrier to introduce a program to offer enhanced dental benefits to members with certain conditions (cardiovascular disease, diabetes, and maternity). Cigna continues to stay abreast of new clinical research showing associations between oral health and certain medical conditions. As a result, we have continued to enhance the program to reflect this latest medical and dental research, and additions to it include the following:

- cerebrovascular disease (stroke)
- chronic kidney disease (CKD)
- head and neck cancer radiation
- organ transplants

Encouraging appropriate treatment for gum disease and dental caries may help prevent complications related to these medical conditions and reduce the need for costly dental and medical treatments. (The program also provides 100 percent copay and coinsurance payment for certain dental procedures.)

Additional benefits of this program include the following:

- **Behavioral Guidance** - Program participants have access to resources developed by a team of dental and behavioral clinicians to provide guidance on behavioral issues related to oral health, including fear of going to the dentist, stress and its impact on health, and tobacco cessation.
- **Discounts** - Program participants who have pharmacy coverage through Cigna can obtain discounts of up to 50 percent off prescription mouthwash through our home delivery pharmacy, Express Scripts Pharmacy (a Cigna company).


OHIP is a coverage solution we believe will help members achieve their health care goals and help clients reduce costs, increase productivity, and improve the health and well-being of their employees.

Cigna Health Rewards

The Cigna Healthy Rewards® program provides discounts and amenities to encourage and promote healthy behaviors and lifestyles. The program is easy for members to use, adding value at no additional cost.

Healthy Rewards offers more choices for members, more ways to lead a healthier lifestyle, and more ways to focus on wellness and prevention. Available member discounts include

- complementary and alternative medicine health care providers, including chiropractors, acupuncturists, massage therapists, and registered dieticians;
- low-cost fitness club memberships;
- virtual workout videos;
- wearable fitness devices;
- yoga products;
- Just Walk 10,000 Steps-a-Day employer challenge;
- meal delivery service;
- hearing aids and exams; and

	ATTACHMENT D: Questionnaire		ARIZONA STATE RETIREMENT SYSTEM 3300 N Central Ave 14 th Floor Phoenix, AZ 85012
	ASRS Group Dental Services Solicitation Code: BPM001922 PART 2 of 2 - Attachments (Response Forms)	Page 17 of 42	

- laser vision correction, vision exams, lenses, and frames.

Healthy Rewards is a national discount program. Third parties are solely responsible for the goods, services, and discounts offered through Healthy Rewards. Some Healthy Rewards programs are not available in every state, and programs can discontinue at any time. Healthy Rewards discounts are separate from medical covered services. A discount program is not insurance, and the member must pay the entire discounted charge.

2. For a fully insured plan(s), please describe any gainsharing or risk-sharing agreement your company would be willing to enter into with the ASRS.

There are no financial incentives, monetary bonuses, or withholds built into our network payment agreements, but general dentists receiving capitation may be eligible for our pay-for-performance program in New York, New Jersey, California, Florida, Texas, and Tennessee.

DPPO

There is no risk sharing or risk pool. Primary care dentists and specialists are contracted on a discounted fee-for-service (FFS) schedule based on average charges in a geographic area.

Over 97 percent of dentists receive claim payments weekly. The remaining checks, which are special issues, are paid daily. Dentists also receive patient copays, which are generally collected at the time treatment is rendered.

There are no financial incentives or penalties related to utilization.

DHMO

Network general dentists receive a monthly payment that includes a fixed monthly patient fee (capitation) for the current month and supplemental fees (where allowable by state law) for services performed in the previous month. The dentist also receives patient charges, which are generally collected at the time treatment is rendered.

There are no financial incentives or penalties related to utilization, although we may make additional payments to dentists who have experienced significant utilization during a given period of time.

We pay network specialists on a fee-for-service (FFS) basis based on a reduced fixed-fee schedule.


Members enrolled in Minnesota have the option of seeking care from out-of-network dentists of their choice without a referral. Out-of-network general dentists and specialists as well as network general dentists treating unassigned members are paid using a combination of patient charges (copays) and a preset schedule of payments using average Minnesota dental charges. Dentists can accept the full fee directly from the member, with Cigna paying the member for the covered amount, or they can submit the claim to us for processing. If a dentist's usual charge exceeds the copay and Cigna's payment, he or she can balance bill the member for the difference.

When a member resides in Oklahoma/South Carolina and chooses to use an out-of-network dentist, Cigna will pay the dentist the same amount we would pay a network dentist for covered services; however, out-of-network dentists have not agreed to Cigna's contracted rates so the patient charge schedule (PCS) will not apply. The member must pay the difference between the dentist's usual fee and the amount of Cigna's payment.

Through our pay-for-performance rewards program, Cigna's network general dentists can earn a bonus payment when they meet performance goals set for preventive care, specialty procedures, and patient satisfaction.

Implementation

- 1. Identify significant tasks, highest areas of risk, required information, roles and responsibilities of you, the ASRS, and the other contractor, and a time frame that is typically required for successful implementation. (Provide an Implementation/Project Plan or a detailed project management outline with milestones and roles/responsibilities as indicated in Special Instructions to Offerors, Section F(2.5(3)).)**

	ATTACHMENT D: Questionnaire		ARIZONA STATE RETIREMENT SYSTEM 3300 N Central Ave 14 th Floor Phoenix, AZ 85012
	ASRS Group Dental Services Solicitation Code: BPM001922 PART 2 of 2 - Attachments (Response Forms)	Page 18 of 42	

Client input, assistance, and partnership simplify the transition from a prior carrier, ensuring a minimum amount of disruption. We would like a 90 day lead time from the start date to ensure the successful implementation of ASRS's plan(s).

A member of the account management team will coordinate a communication strategy that meets the needs of the ASRS and its employees. The implementation project plan establishes meeting dates, times, and logistics mutually agreed on by ASRS and Cigna. During the implementation process, our experienced implementation team will focus on delivering accurate and timely results. The team will keep ASRS informed of the project's status and upcoming milestones through robust documentation.

Please see the implementation plan located in section Attachment D1 of our proposal response.

2. How does your company propose communicating a transition plan to ASRS Participants?

The implementation manager has end-to-end project management oversight for implementation. Together with the client service executive, the implementation manager remains involved throughout the relationship with the ASRS. The implementation manager's ongoing involvement and accountability is critical for success, since he or she has firsthand knowledge of ASRS's coverage, structure, and specialized service needs.

Network/Provider Management

3. With respect to Arizona, does your company wholly own, partially own, or lease a network?

DPPO

We lease less than 16 percent of the network.

Cigna Dental directly contracts with individual or group private dental practices for most of our DPPO network, which also includes additional dentists contracted with Zelis. This relationship provides additional dentists for greater choice and access: Zelis dentists are in every state, and members can access Zelis dentists the same way they access Cigna Dental's contracted dentists. Using Zelis dentists will not impact claim payment or administration.

DHMO

Cigna contracts directly with individual or group private dental practices for our DHMO network, which we own.


4. How does your company encourage quality providers to participate/continue to participate in your network?

We developed the Cigna Quality Management Program to reinforce our commitment to excellence and continuously improve the delivery of dental care and services to our clients and members. This program helps ensure that members achieve better oral health and are fully satisfied with their dental plan.

The program is under the direction and management of the national governing body, which is made up of the Cigna Dental president and CEO, the national dental director, and representatives from other business units. The national governing body establishes standards by which the quality of care and services are measured and appoints regional quality management committees and subcommittees to implement the program regionally.

The program's four main objectives are as follows:

- to promote and maintain consistent networks that meet Cigna Dental's credentialing requirements
- to improve members' oral health through effective guidance, monitoring, and evaluation of treatment
- to identify opportunities for improvement and take appropriate steps to implement corrective actions
- to maintain compliance with local, state, and federal regulatory requirements and standards

	<p style="text-align: center;">ATTACHMENT D: Questionnaire</p> <hr/> <div> <div>ASRS Group Dental Services Solicitation Code: BPM001922 PART 2 of 2 - Attachments (Response Forms)</div> <div>Page 19 of 42</div> </div>		<p style="text-align: center;">ARIZONA STATE RETIREMENT SYSTEM 3300 N Central Ave 14th Floor Phoenix, AZ 85012</p>
--	---	--	--

These objectives are realized through set Quality Management Program activities that include the following.

Initial Credentialing - Dentists must meet stringent credentialing requirements to participate in Cigna Dental networks.

Recredentialing - Regularly, and at least every three years, we reverify the credentials of every dentist to ensure initial-credentialing standards continue to meet accepted industry standards.

Dentist Accessibility Monitoring - We conduct ongoing dentist accessibility monitoring in several different ways, including periodic outreach to dental offices, onsite visits, member satisfaction surveys, reviews of complaint and grievance data, and geographic access analysis.

Health Promotion and Preventive Care - Prevention is the way to achieve optimal oral health; it also reduces the long-term costs of dental care for both the patient and plan sponsor. In keeping with this philosophy, most of our plans provide preventive services with no patient charge, which eliminates a barrier to obtaining preventive care. We promote preventive services through employee communications and client health fairs; in addition, the Cigna Dental internet site offers members a wealth of educational and preventive facts and tips as well as other important information about Cigna.

Network Dentist Performance Monitoring - Through our performance monitoring program, we have a process that includes ongoing analyses and other focused activities to affect continuous improvement in the care and services network dentists provide. The performance measurement tools include dentist profiling, grievance tracking, and member satisfaction reports. Corrective action plans are implemented as needed, and we maintain a system to track dentist-based corrective actions. This system is used under the direction of the regional dental director, and it is maintained by our network management, customer service, and quality departments.

Performance Monitoring Studies - Performance monitoring studies are designed to monitor, evaluate, and improve the delivery of services by our network dentists. The national governing body approves the topics for these special studies, which are then conducted under the direction of the national quality management committee.

Complaint and Grievance Review - The purpose of the complaint and grievance review process is to identify and help resolve member concerns quickly and efficiently and to identify corrective actions for improvement in the delivery of dental services. We refer inquiries relating to quality of care to the regional dental directors and network management for investigation. Follow-up actions are under the direction of the regional dental director.


Member and Dentist Satisfaction Surveys - Member satisfaction is assessed through evaluation of member surveys (conducted by a third-party research firm) and complaints. Dentist satisfaction surveys are performed yearly, and we review results to identify areas for improvement and subsequent action plans.

Setting Administrative Standards for Accuracy and Response - We provide members, clients, and dentists with cost-effective, caring, and responsive claim and inquiry services through one consistent national service delivery model. The model includes uniform standards and state-of-the-art systems capabilities that achieve fast, accurate, and responsive service.

Oversight of Reporting Results and the Implementation of Corrective Actions - The National Quality Management Committee reports the results of Quality Management Program activities biannually to the national governing body. To measure the effectiveness of the Quality Management Program, we conduct an annual evaluation that includes every aspect of the program, with an emphasis on determining whether network dentists have demonstrated improvements in the delivery of services. As part of our continuous efforts to keep members satisfied, we use the results to develop the work plan for the following year.

4.1. How does your company monitor and evaluate both provider performance and provider satisfaction?

Our performance monitoring program is an ongoing process of analysis and other focused activities to effect continuous quality improvement in the care and services rendered by our network dentists. The performance measurement tools used in this process include: provider profile reports, specialty referral patterns,

	ATTACHMENT D: Questionnaire		ARIZONA STATE RETIREMENT SYSTEM 3300 N Central Ave 14 th Floor Phoenix, AZ 85012
	ASRS Group Dental Services Solicitation Code: BPM001922 PART 2 of 2 - Attachments (Response Forms)	Page 20 of 42	

Page
20
of
42

compliance/grievance activity and patterns, utilization patterns, customer satisfaction measures, and facility and patient record reviews.

Cigna Dental uses a database program to monitor and evaluate each dental office on the number and type of services rendered as compared to norms for the network. Specific service categories include diagnostic, restorative, crown and bridge, endodontics, periodontics, prosthodontics, and oral surgery. Additionally, quality measurement focus studies are designed to monitor and evaluate the quality and appropriateness of services. The National Governing Body approves the topics for these special studies, which are then conducted under the direction of the National/State Quality Management Committee.

DPPO Process:

Treatment profiles include fees per patient, total procedures per patient, and incidence of targeted procedures as a percentage of other procedures, e.g., the number of crown buildups as compared to the number of total crown procedures. Each provider's profile is then compared to the MSA, state and national averages. Based on the Dental Director's evaluation of these results, counseling or corrective action may be initiated.

DHMO Process:

The Provider Scorecard includes the following metrics: Usage Score, Diagnostic-Preventive Score, Rapport Score, Complaint Activity Score, Access Score, and Audit Score. The objective of the Provider Scorecard is to identify providers in our network that have low quality scores in one or more of these measures and who were not identified through other components of Cigna Dental's Quality Management Program. Once identified, the providers are counseled by Network staff or Dental Directors with corrective action plans to improve scores.

Complaint Review:

The objective of the complaint review process is to identify and resolve customer concerns quickly and efficiently, and to identify corrective actions for improvement in the delivery of service.

All grievances are tracked, trended and reviewed periodically. DHMO complaints related to quality of care are referred to the regional Dental Directors for review. The Network

Management staff is contacted for follow-up as needed. All follow-up is documented in our systems.

Depending on the issue, the regional Dental Directors may request additional information or other actions such as, an onsite office review or referral to the credentialing committee for consideration of termination of the network dentist agreement. Provider counseling from the Network Management staff, and/or the Dental Directors takes place as necessary.

Overall a very small portion of our network is terminated due to poor performance.


5. Describe your company's approach to addressing timely access issues and areas where access (such as rural areas) is insufficient.

In Arizona, Cigna has 996 unique providers in the Dental Care Access Plus network and 3,851 in the Total Cigna DPPO network.

To ensure appropriate and convenient access, we focus our expansion efforts on the dentists and in the areas that are important to you.

DPPO

We generally use direct phone outreach to contact dentists in target markets or identified by ASRS employees to gauge their interest. Follow-up discussions, generally by phone or electronic capabilities, include qualifications and

	ATTACHMENT D: Questionnaire		ARIZONA STATE RETIREMENT SYSTEM 3300 N Central Ave 14 th Floor Phoenix, AZ 85012
	ASRS Group Dental Services Solicitation Code: BPM001922 PART 2 of 2 - Attachments (Response Forms)	Page 21 of 42	

payment negotiations. We provide dentists with appropriate documentation, including an application and a contract, to complete, and they can return these to us on paper or electronically. Upon receipt of the completed application, signed contract, and other documentation, we will review the dentist for acceptance into our Cigna DPPO network.

DHMO

We generally use direct phone outreach to contact dentists in target markets or identified by ASRS employees to gauge their interest. Follow-up discussions, generally by phone or electronic capabilities, include qualifications and payment negotiations. We provide the dentists with appropriate documentation, including an application and a contract, to complete, and they can return these to us on paper or electronically.

A network management or clinical staff member will visit an office to perform an initial quality assessment review as part of our credentialing requirements. The assessment is an onsite review to confirm key requirements are met, including accessibility as well as emergency procedures.

Upon receipt of the completed application, signed contract, initial quality assessment, and other documentation, we will review the dentist for acceptance into our Cigna Dental Care® Access Plus network.

5.1. How does your company notify an enrolled Participant of additions and terminations to the provider network?

DPPO

Since there is no need to select a primary care dentist, we do not notify members if a dentist leaves the network. Members can verify the status of a dentist by calling our toll-free number, 800.Cigna24, or visiting www.cigna.com.

DHMO

We report national network changes monthly and compare these to current clients' members' locations. Depending on the impact, we notify ASRS up to 60 days before a dentist leaves the network. We then transition members to another network dentist through written notification.

For the latest information about additions or changes to the network, and for assistance in enrollment or dental office transfers, members can use our automated dental office locator, which allows them to enter their zip code and hear a list of nearby dental offices 24 hours a day, 7 days a week, 365 days a year. The dental office locator can also fax this list. In addition, members can enter a dentist's phone number to see if he or she participates in the Cigna Dental Care® Access network. If there are multiple dentists with the same phone number, the system speaks the name of each dentist at that office. The list includes offices currently accepting patients. To use the dental office locator, members dial our toll-free number, 800.Cigna24.


Dental office lists are also available 24 hours a day, 7 days a week, 365 days a year via www.cigna.com.

6. Describe how a Participant who requires care while temporarily outside of a service area or outside of normal provider business hours can be provided service.

DPPO

There are no restrictions within the Cigna DPPO plan about the use of noncontracted dentists. Cigna DPPO members always have the choice to receive care from a network dentist at in-network levels and discounts or from an out-of-network dentist at out-of-network levels.

Our agreements with dentists require them to provide or arrange for emergency care 24 hours a day, 7 days a week, 365 days a year and to provide emergency attention within 24 hours of requests. If a member experiences a true dental emergency and receives care at an out-of-network dental office, the related bills are payable at the in-network

	ATTACHMENT D: Questionnaire		ARIZONA STATE RETIREMENT SYSTEM 3300 N Central Ave 14 th Floor Phoenix, AZ 85012
	ASRS Group Dental Services Solicitation Code: BPM001922 PART 2 of 2 - Attachments (Response Forms)	Page 22 of 42	

level. Services and materials that are not considered an emergency are paid at out-of-network levels if care is received from an out-of-network dentist.

DHMO

We use the services of noncontracted dentists under the following scenarios:

- **Emergency Treatment** - If an emergency occurs while a member is more than 50 miles away from home or if his or her primary care dentist is unavailable, we will pay the cost of diagnostic and therapeutic dental procedures administered by any licensed dentist during regularly scheduled office hours. The claim will be paid up to a maximum of \$50 for each emergency, less applicable patient charges.
- **Second Opinions** - If a member wants a second opinion, we will arrange for a consultation with a mutually agreed-upon dentist at no cost to the member.
- **Specialty Referral** - If a contracted specialist is not available, an out-of-network specialist will be selected on the basis of a referral from the general dentist, with proper payment certification from us.

Claim Administration

1. **Briefly describe your company's approach to providing comprehensive claim management services to provide the expeditious delivery of benefits.**

Our goal is to increase electronic volume to reduce operating costs and improve service and data quality. We have established a network of electronic submitters who have the capability to serve our clients based on their market share in specific geographical areas. We currently receive claims electronically from multiple electronic data interchange (EDI) partners.

We also send and receive other types of electronic transactions, such as those related to claim status, encounters, and referrals. We receive electronic claims in a standard format defined by the ANSI; this format is called the Healthcare Claim Transaction Set (837). By using this standard format, we can add new trading partners to the network.

DHMO

Cigna offers dental offices the ability to submit claims and encounter/specialty referrals electronically, the benefits of which include the following:


- no need to stock and submit claim forms
- claims not getting lost in the mail, which results in simplified record keeping
- quicker claim submissions, leading to faster payment
- reduced clerical time and cost (to process and mail paper claims)
- no need to submit claims to multiple locations

Dental offices can submit data electronically through several clearinghouses, and they can submit attachments electronically to Cigna. Claim payment information is available online shortly after processing so dental offices can view results without delay.

We receive over 15 percent of specialty referrals electronically.

DPPO

Each day, we receive 80.81 percent of claims electronically through several clearinghouses, including Change Healthcare (formerly Emdeon/WebMD) DentalXChange (which now includes EDI Health Group, Inc.), and Tesia, or directly, and at no charge, through PNT Data (formerly Post-n-Track). In addition, we accept electronic attachments through Dentrix and National Electronic Attachments.

	<h1>ATTACHMENT D: Questionnaire</h1>		<p>ARIZONA STATE RETIREMENT SYSTEM 3300 N Central Ave 14th Floor Phoenix, AZ 85012</p>
	<p>ASRS Group Dental Services Solicitation Code: BPM001922 PART 2 of 2 - Attachments (Response Forms)</p>	<p>Page 23 of 42</p>	

The clearinghouse electronically edits and sorts claims by carrier and claim office and forwards the claims to us electronically within 24–48 hours of receipt from the provider. The claim office receives the transmission through a batch process. We process the claim within our 48-hour electronic claim processing standard. This electronic process allows us to receive and process claims and payments as quickly as possible: the provider can anticipate receiving a payment within 14 days of the initial electronic submission.

Cigna uses a highly automated claim processing system to intake claims and route them to designated processors, which drives processing accuracy. Auto-adjudication allows the system to process a significant portion of claims without further need for review by the claim processing team. When claims do not auto-adjudicate, the system routes them electronically to our team of highly trained, experienced processors who specialize in managing specific types of claims.

2. Describe your company’s approach to working with the ASRS to receive, process, and maintain Participant eligibility files (e.g., data transfer, frequency, reconciliation).

Eligibility Submission Process

Three options are available for establishing and maintaining eligibility:

- **Internet-Based Enrollment Maintenance Tool (EMT)** - ASRS can submit and view real-time eligibility or reporting information via the EMT on our client website, CignaAccess.com. This method can be used in conjunction with either automated eligibility or manual eligibility.
- **Automated Eligibility** - ASRS can submit eligibility information by electronic transmission. We publish the reporting results for the automated file processing to our client website for review.
- **Manual Eligibility** - ASRS use paper enrollment forms or the Standard Eligibility Spreadsheet (also called the SES Excel spreadsheet) for open enrollment and ongoing maintenance updates.

If the three solutions above do not meet the ASRS’s needs, we may be able to accommodate other solutions, pending a detailed review of request specifics. Additional fees may apply to nonstandard processes.

ASRS cannot accept or support transfer via magnetic tape, cartridge, and/or diskette from new or existing clients.

Updates Frequency

We can structure the frequency of eligibility updates to meet the needs of ASRS, with options for submitting data weekly, biweekly, semimonthly, or monthly. There are no fees for these standard frequencies. We can also accept three or more eligibility files a week for an additional fee.


In addition, ASRS can use our online enrollment maintenance tool (EMT) to update eligibility in real time. There is no fee for updating eligibility via the EMT.

Reconciliation

To verify that the eligibility information is accurate, we perform audits/reconciliations at least quarterly. The client should submit any eligibility discrepancies within 30 calendar days to avoid ongoing discrepancies and to ensure coverage for its eligible employees. The audit process varies depending on the media used to submit eligibility.

Automated Eligibility

The automated eligibility system performs a total audit on each positive file sent, including positive add/change files. The default cancel process lists active members not currently on the automated eligibility submission furnished. We ask ASRS to review this record and submit a corrected record within 45 days, which is the maximum time we can remove ineligible members and still make retroactive financial adjustments. After 30 days (standard threshold; variable based on request), if no action has been taken, we cancel these members to reconcile our records and prevent erroneous coverage payments and fees. The tolerance period is from 1 to 30 days, depending on ASRS’s needs. Standard automatic eligibility is free of charge; nonstandard formats may be subject to additional fees.

	ATTACHMENT D: Questionnaire		ARIZONA STATE RETIREMENT SYSTEM 3300 N Central Ave 14 th Floor Phoenix, AZ 85012
	ASRS Group Dental Services Solicitation Code: BPM001922 PART 2 of 2 - Attachments (Response Forms)	Page 24 of 42	

Page
24
of
42

Manual Eligibility

We perform standard audits based on enrollment/maintenance received and reasonable extraction of data. Standard manual eligibility is free of charge; nonstandard formats may be subject to additional fees.

3. Does your company have a dedicated claims processing team? Where is the team located?

DPPO

Our dental claim service model leverages our technology to support a highly efficient virtual network of experienced claim processors. To ensure optimal accuracy, we pay claims across the network based on processor expertise within specific claim categories.

Our claim processors are located in Visalia, California; Denison, Texas; and Delhi, India; we also have claim processors who work from home.

The address of the Visalia Customer Service Center is 5300 West Tulare Avenue, Visalia, CA 93277. The phone number is 559.738.2000.

The address of the Denison Customer Service Center is 4616 US Highway 75 South, Denison, TX 75020. The phone number is 903.337.2300.

DHMO

We process specialty referrals in the Visalia, California, customer service center, located at 5300 West Tulare Avenue, Visalia, CA 93277.

3.1. What level of access will your company provide ASRS to review eligibility and claims? Real-time, online, or as requested?

ASRS can use our online enrollment maintenance tool (EMT) to update eligibility in real time. There is no fee for updating eligibility via the EMT.


This tool streamlines the eligibility process and includes a series of automated eligibility reports.

With the EMT, ASRS can

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

ASRS can also manage their automated eligibility process online, which includes the following:

- tracking the status details of a file through automatic email notifications with several options distributed in real time
 - notice of delinquent file
 - notice edit reports published
 - notice file held for review
 - notice eligibility file received
 - notice file updated

	ATTACHMENT D: Questionnaire		ARIZONA STATE RETIREMENT SYSTEM 3300 N Central Ave 14 th Floor Phoenix, AZ 85012
	ASRS Group Dental Services Solicitation Code: BPM001922 PART 2 of 2 - Attachments (Response Forms)	Page 25 of 42	

- viewing member coverage information, as allowed by HIPAA
- accessing and downloading user-friendly error reports
- receiving guidance from an eligibility specialist on how to resolve errors
- reviewing key file processing metrics, such as file processing timeliness, member defect rates, and error resolution cycle times

Through CignaAccess.com ASRS can view DPPO paid claim information at the member level and view deductible and lifetime maximum accumulation data at the member level. ASRS must be a recipient of PHI per HIPAA. Viewing DHMO claim information is not available on our client website.

ASRS can also contact your designated account management team to receive all necessary information.

- 4. Describe in detail the workflow, including maximum turnaround times, for dental claim processing and evaluating a claim. Include methods for matching pre-certification requests, checking for duplicate charges, obtaining/furnishing the coordination of benefits, provider status and coding, and communication with Participants.**

Claim Processing/Turnaround Times

We update claimant files overnight via batch processing upon receipt of the file from the eligibility book-of-record database. We can update files online and in real time, if required, for immediate claim or specialty referral processing.

DPPO

Eighty percent of claims are auto-adjudicated. Dental reviewers receive training in dental terminology and procedures to make nonsystematic determinations. Manual operations are only required if a plan has nonstandard coverage for the following:


- verifying potential duplicate expenses
- screening claims for missing data
- adhering to certain state legislative mandates
- entering missing data into the system
- identifying procedures for consultant review
- processing procedures where X-rays, written narratives, pathology reports, and the like are required to verify the necessity of the procedure
- processing orthodontic claims

We open, sort, and scan incoming mail, within 24 hours of receipt, into our stored image retrieval system. As we image each piece of mail, we assign a document control number. Rapid data entry combines the document number with a new or existing member record for the system to respond to inquiries within 48 hours. An overnight batch process auto-adjudicates approximately 80–83 percent of the claims entered and prepares EOBs and payments for mailing.

During the batch process, we edit claims for the following:

- special accounts, such as nonstandard deductible and coinsurance factors, special coverage, and foreign accounts, which require the conversion of dentist fees to American dollars
- procedure codes that cause the system to pay or place the claim on hold (e.g., multiple crowns, bridgework)

We forward claims that fail the eligibility edits (e.g., incorrect SSN, employee name, account number) to data correction operators who verify, add, or change the eligibility information for the employee and/or dentist.

	ATTACHMENT D: Questionnaire		ARIZONA STATE RETIREMENT SYSTEM 3300 N Central Ave 14 th Floor Phoenix, AZ 85012
	ASRS Group Dental Services Solicitation Code: BPM001922 PART 2 of 2 - Attachments (Response Forms)	Page 26 of 42	

Claims needing further investigation are pended for claim processors or dental reviewers, who are able to view from their desktops images that include information about the status of a particular claim, letters sent, and dentists the patient has used in the past.

DHMO

Our claim system processes approximately 80 percent of general dentist encounter data automatically, and our dental staff manually processes specialty referrals and encounters. Additionally, we manually adjust specialty referrals that were previously processed.

Our standards for the claim turnaround time is as follows:

Metric	Standard (%)
10-Day TTP (Business Days) - DPPO	92.0
10-Day TTP (Business Days) – DHMO	95.0
15-Day TTP (Business Days) – DHMO	98.0
20-Day TTP (Business Days) - DPPO	99.0

Turnaround Time - Our system monitors turnaround time. We date claims the day we receive them and give them a unique document control number. We automatically track the document control number from the date received through the date processed. When a claim is processed and denied, paid, or pended, the clock stops. This monitors the number and timing of processed claims. We generate reports daily, weekly, and monthly at 10-, 15-, and over-15-day intervals.

Prior Authorization

DPPO

Preapprovals come from the dentist and generally include information such as X-rays. The dentist completes a claim form, leaving the “date of services completed” column blank, and marks the pretreatment box. This shows that he or she is requesting a pretreatment estimate for proposed work.

We enter the claim into our claim payment system and produce a pretreatment estimate. We then return the estimate, showing the plan liability, to the dentist. Once the dentist completes the work, he or she inputs the completed date and sends the same form back to us for payment.

DHMO


We contract with orthodontists, endodontists, pediatric dentists, periodontists, and oral and maxillofacial surgeons, and while recommended, referrals to network specialists do not require prior authorization of payment. A participating general dentist refers members directly to a specialist if they require a procedure beyond the scope of general dentistry (except pediatric dentistry for children under age 13, which does not require a referral, and orthodontic care, which members can directly access without a referral). Although it is not required for payment of services, the specialist submits prior authorization requests to Cigna.

The specialty referral department reviews the prior authorization and determines eligibility, frequency limitations, and exclusions. The specialist receives the prior authorization and schedules treatment with the member, at which time the patient charges identified on the patient charge schedule (PCS) apply. If members elect to have treatment not covered on their PCS, they are responsible for paying the dentist’s normal fee.

Prior Authorization

Although not required for payment of services, the network specialist requests preapprovals. The process is as follows:

- The network general dentist takes any necessary X-rays and refers the member to a specialist.
- The member makes an appointment with the specialist and gives him or her the referral form and X-rays.

	ATTACHMENT D: Questionnaire		ARIZONA STATE RETIREMENT SYSTEM 3300 N Central Ave 14 th Floor Phoenix, AZ 85012
	ASRS Group Dental Services Solicitation Code: BPM001922 PART 2 of 2 - Attachments (Response Forms)	Page 27 of 42	

- The specialist completes a claim form (treatment plan) and sends it, along with the referral and X-rays, to Cigna.
- We approve services based on plan specifics and return the approval to the specialist.
- The specialist finishes the services and returns the form, with the date he or she completed the services filled out, to Cigna for payment.

Coordination of Benefits

DPPO

Our system automatically flags the following types of COB:

- **Maintenance of Benefits** - This limits the total amount an insured can receive to the benefit Cigna would have paid as the primary carrier. Under this type of plan, Cigna's normal liability is reduced by the primary carrier's benefit. If the primary carrier's benefit payment is equal to or greater than the secondary plan's, there is no benefit due from the secondary plan. The insured can receive from both carriers no more than Cigna's original liability:
 - Cigna does not pay any additional monies if the primary carrier pays what we would have paid (or more).
 - We pay up to what we would have normally paid.
 - Benefit credits are not available for this option.
 - Maintenance of benefits is not available in some states.
- **Carve Out** - This applies to coordination between medical and dental.
- **Nonduplication** - If benefits are covered under dental, they are not covered under medical. This is similar to maintenance of benefits: the secondary plan will not duplicate payment of benefits covered by the primary plan.
- **Traditional** - This is based on National Association of Insurance Commissioners (NAIC) rules. The secondary plan will pay the difference between the primary plan payment taken from the higher of the two allowable expenses but no more than the secondary plan would have paid in the absence of other insurance.

DHMO

Cigna coordinates benefits only for specialty referral procedures. We administer standard COB rules manually


Provider Status and Communication with Members

The following member information and self-service functions are available through myCigna:

- coverage details lookup
- DPPO claim status inquiry capabilities
- DPPO electronic EOB and explanation of payment (EOP) display
- DPPO deductible, out-of-pocket, and lifetime maximum accumulation presentment
- DPPO claim forms and submission information
- dental claim office phone numbers and addresses and customer service contact information
- FAQ
- dental treatment cost estimator

5. **Do you review claims for billing irregularities by a provider? (e.g., regular overcharging, unbundling of procedures, up coding or billing for inappropriate care for stated diagnosis)**

Yes.

	ATTACHMENT D: Questionnaire		ARIZONA STATE RETIREMENT SYSTEM 3300 N Central Ave 14 th Floor Phoenix, AZ 85012
	ASRS Group Dental Services Solicitation Code: BPM001922 PART 2 of 2 - Attachments (Response Forms)	Page 28 of 42	

6. Describe the use and role of dental consultants in reviewing questionable claims.

Dental consultants are an integral part of our quality and utilization management program. They have extensive industry experience and represent general dentistry as well as various dental specialties. We employ 23 full- and part-time dental consultants to provide professional expertise in the dental claim process.

We also have access to additional dental expertise through our clinical advisory panel. Participants' qualifications include education and licensing, experience in clinical practice and dental care delivery, and knowledge of treatment procedures, codes, and standards. The majority have more than five years' experience working with Cigna.

DPPO

We have established policies and procedures that determine the level of review for certain types of services, and our systems flag procedures for review by dental consultants.

Our dental clinical review staff is made up of 4 dental directors, 14 full-time dental consultants, and 5 part-time dental consultants. We also have 6 independent dental consultants to assist with reviews.

We pay dental consultants on a salaried or wage basis; we do not pay them based on the results of their reviews. There is no additional charge to the ASRS.

DHMO

Dental consultants review claims from network specialists to determine if the care is appropriate based on our payment criteria and guidelines.

7. How is information shared between the providers and your company's claim systems?

DPPO (In-Network)

The network dentist will submit a claim form to us for processing, and we pay him or her. We then send an EOB to the member detailing the remaining balance due to the dentist, if any. Alternatively, a member can choose to pay the dentist and submit a claim form to us him- or herself; we would then process the claim and pay the member.

DPPO (Out-of-Network)

If the dentist completes a claim form, he or she accepts assignment for the payment. Then, the dentist submits the form to us for processing, and we send the payment to him or her. We also send an EOB to the member, detailing the remaining balance due to the dentist, if any. Alternatively, a member can choose to pay the dentist and submit a claim form to us him- or herself; we would then process the claim and pay the member.


DHMO

The Cigna Dental Care® plan does not require the submission of claim forms. A claim submission is required only for specialty referral.

8. If a claim is received with missing information, explain how such a claim would be handled. What steps are taken obtain missing information?

DHMO

We pend specialty referrals when the information provided is not sufficient to process prior authorization or payment to the specialist. We request missing or additional information directly from the specialist at 30 days and again at 60 days, and we pend the referral in the claim system until we receive the information. After 90 days, we deny the

	ATTACHMENT D: Questionnaire		ARIZONA STATE RETIREMENT SYSTEM 3300 N Central Ave 14 th Floor Phoenix, AZ 85012
	ASRS Group Dental Services Solicitation Code: BPM001922 PART 2 of 2 - Attachments (Response Forms)	Page 29 of 42	

referral if we do not receive the requested information. We pend approximately 3 percent of specialty referral prior authorization requests for additional information (e.g., missing X-rays).

DPPO

We externally pend claims to obtain needed information to apply the appropriate benefits. Examples include those under COB investigation, accident information requests, and/or inquiries into clinically rendered services such as periodontal charting and X-rays. Once we externally pend a dental claim for additional information, we send a system-generated letter to the member and/or dentist stating the data required and that we can take no further action on the claim. If the dentist makes the request for more information, the member automatically receives a delay letter showing that the claim is pended and awaiting additional information from the provider. After 30 days, if we do not receive the information, the system logic reissues the inquiry to the provider. We deny the claim if we have still not received any information after 90 days, but once the additional information has been gathered, the claim may be resubmitted for reconsideration.

- 9. For a self-insured plan, on what basis does your company negotiate provider reimbursements? (e.g., lower of a fee schedule, prevailing charge rate)**

For each three-digit zip code, we set fees based on average area charges per procedure and target discounts. Average charges are based on our own extensive national database of over 15 million claims per year and on data from the Prevailing Healthcare Charges System (PHCS), which is published by FAIR Health. Network negotiated fees are set at a discount off the average charges in the three-digit zip code. We negotiate/renew our plans about 10-15% of our entire network of providers, annually.

- 9.1. What source does your company use in determining the prevailing charge rate for out-of-network claims? (e.g., FAIR Health, National Dental Advisory Service (NDAS), Book of Business, Other)**

We use data from the Prevailing Healthcare Charges System, published by FAIR Health, to determine MRC. If FAIR Health does not supply the MRC or a procedure code in a geographical area, Cigna will pay as billed. Our claim payment systems maintain fee schedules based on FAIR Health data.


- 9.2. Does your company's prevailing charge methodology differ based on geographic location?**

Yes. The FAIR Health supplies the MRC or a procedure code in a geographical area.

- 9.3. Does your company have the flexibility to change the percentile used to determine the prevailing charge rate for out-of-network claims?**

Yes. Cigna's standard MRC allowance for out-of-network DPPO and indemnity claim payments, except for orthodontic procedures, is the 80th percentile of the amount billed for a given area; however, our system allows for flexibility in adjusting MRC levels (50th–95th percentile, depending on the ASRS's specific needs and cost-saving goals).

- 9.4. With what frequency does your company update the prevailing charge profiles?**

	ATTACHMENT D: Questionnaire		ARIZONA STATE RETIREMENT SYSTEM 3300 N Central Ave 14 th Floor Phoenix, AZ 85012
	ASRS Group Dental Services Solicitation Code: BPM001922 PART 2 of 2 - Attachments (Response Forms)	Page 30 of 42	

Cigna updates their maximum reimbursable charges (MRCs) at least once a year.

10. What information does the Explanation of Benefits (EOB) display? (e.g., negotiated charge, actual charge, adjustments, accumulator fields, reasons for denial or reductions, appeal process/timelines). What information can be customized?

DPPO

Submissions for unassigned claims will generate an EOB attached to the check the employee receives. Submissions for assigned claims will generate an EOB to the employee and a bulk check to the dentist. An EOB will not be generated if there is no patient responsibility. In this instance, only the bulk check will be mailed to the dentist.

EOBs are prepared and mailed nightly from our Easton, Pennsylvania, distribution center. We mail payment vouchers to dentists and members once per week and at the end of each month. EOBs are produced for each claim processed regardless of whether payment is issued. The EOBs may include the following information:

- date and type of service rendered
- name of dentist
- explanation of calculated benefits
- charge amount and covered amount
- deductible amount (along with deductible balance)
- amount of check issued
- maximum amount
- standard ERISA statement
- remarks

DHMO

We produce EOBs for members and dentists in every state for preapprovals and specialty treatment payments. Upon conclusion of the specialty referral review process, we produce EOBs to tell members and their dentists of the specialty review outcome.

The EOB shows the status and reason codes for each procedure code submitted for prior authorization or payment. The member's copay, if any, is shown on the EOB for the specific procedure requested. The plan does not contain deductibles or out-of-pocket limits; therefore, these items are not addressed on the EOB. Instructions are also included on how members can initiate a reconsideration or appeal.


After specialty referrals are processed, EOBs are prepared and mailed from our Easton, Pennsylvania, distribution center. We mail payment vouchers three times per week to dentists and nightly to members.'

The information that is customizable on the EOB are: client specific phone number, accumulators, client specific language, and client specific logo.

Claim Appeals

1. Describe your company's claims appeal process. Include methods of informing Participants of appeal rights/ processes, levels of appeal, and coordination with the ASRS.

Fully Insured

	<p style="text-align: center;">ATTACHMENT D: Questionnaire</p> <hr/> <div> <div>ASRS Group Dental Services Solicitation Code: BPM001922 PART 2 of 2 - Attachments (Response Forms)</div> <div>Page 31 of 42</div> </div>		<p style="text-align: center;">ARIZONA STATE RETIREMENT SYSTEM 3300 N Central Ave 14th Floor Phoenix, AZ 85012</p>
--	---	--	--

Level One Appeal

Someone not involved in the initial claim process reviews appeals, and a dental professional reviews appeals involving dental necessity or clinical appropriateness.

As required by state regulations, we follow state requirements when responding to concerns about pre- or postservice denial requests. Cigna notifies the member of the decision in writing, including the specific contractual or clinical reasons for the decision, as applicable.

Only preservice reviews are eligible for expedited processing. A member may request an expedited review if our standard time frames to respond would seriously jeopardize his or her life, health, or ability to regain the dental functionality that existed before the onset of the condition. A dental professional, in consultation with the treating dentist, decides whether an expedited review is necessary and communicates an oral response within 72 hours. He or she then follows up in writing. (Time frames or requirements may vary depending on state-specific law.)

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

Level Two Appeal

A committee or someone not involved in the level one appeal may conduct appeals. If specialty care is in dispute, we may involve a dentist in the same or a similar specialty.

As required by state regulations, we follow state requirements when responding to concerns about pre- or postservice denial requests. Cigna notifies the member of the decision in writing, including the specific contractual or clinical reasons for the decision, as applicable.

Only preservice reviews are eligible for expedited processing. A member may request an expedited review if our standard time frames to respond would seriously jeopardize his or her life, health, or ability to regain the dental functionality that existed before the onset of the condition. A dental professional, in consultation with the treating dentist, decides whether an expedited review is necessary and communicates an oral response within 72 hours. He or she then follows up in writing. (Time frames or requirements may vary depending on state-specific law.)

Self-Insured

Cigna offers a single level appeal for coverage decisions. The member can submit a verbal or written appeal request within 180 days of the initial denial. Someone not involved in the initial claim process reviews appeals, and a dental professional reviews appeals involving dental necessity or clinical appropriateness. We respond to postservice clinical denials within 30 calendar days and to postservice administrative denials within 60 calendar days.


2. Describe your company's approach to reviewing disputed claims for dental necessity and billing appropriateness.

If a member has a complaint or concern, he or she can contact customer service by phone or in writing. Our goal is to resolve the matter during the initial outreach; however, if we need more time to review or investigate the concern, we communicate the outcome to the member within 30 days (though the majority of issues resolve within 1 business day).

If a member is not satisfied with the results of a review, he or she may start the appeals procedure by submitting an appeal in writing or contacting customer service to initiate the process verbally (some state-specific requirements may apply).

Customer Service

- 1. Describe the customer service function for Participants by reflecting how the customer service unit is accessed (e.g., phone, web chat, voice message, email), hours of operation, location of services, and information access (e.g., representatives can view real-time claims).**

	ATTACHMENT D: Questionnaire		ARIZONA STATE RETIREMENT SYSTEM 3300 N Central Ave 14 th Floor Phoenix, AZ 85012
	ASRS Group Dental Services Solicitation Code: BPM001922 PART 2 of 2 - Attachments (Response Forms)	Page 32 of 42	

Customer service for ASRS's employees will be provided by customer service advocates (CSAs) in our customer service centers in Denison, Texas; Moosic, Pennsylvania; and Visalia, California.

Members can call our toll-free customer service number, 800.Cigna24, 24 hours a day, 7 days a week, 365 days a year to talk to a customer service advocate (CSA) about coverage, dental office transfers for DHMO, DPPO claims, procedures, or any other concerns. In addition, our voice response system is also available 24 hours a day, 7 days a week, 365 days a year. DHMO members can use this system to access eligibility and coverage information or use our automated quick transfer option to change network dental offices. DPPO members can use the voice response system to check claim status, eligibility, and coverage information.

Our voice response system is also available 24 hours a day, 7 days a week, 365 days a year. DHMO members can use this system to access eligibility and coverage information or use our automated quick transfer option to change network dental offices.

Members can use the voice response system to check claim status, eligibility, and coverage information.

The toll-free number allows members to enter their zip code and hear a list of nearby dental offices via the dental office locator. The toll-free number can also immediately fax the list to assist in enrollment or dental office transfers (DHMO). Members can also enter a dentist's phone number to see if he or she participates in the network. If multiple dentists have the same phone number, the system speaks back the name of each dentist and clearly identifies DHMO-capped dental offices. The system is updated nightly.

Our customer service organization focuses on providing quality service to our members. Members can access more than 1,000 health and dental topics through our health information line by calling the toll-free dental customer service number.

Updated network information, referral status, and eligibility verification is available on myCigna.

Live Chat

As part of Cigna's emerging technology and enhanced customer service solutions, we continually evaluate our capabilities and assess opportunities to improve the member experience. In support of this goal, a real-time, live chat feature is available to members who have access to myCigna.

myCigna members can chat with a live agent from 8:00 a.m. to 8:00 p.m. (EST). Chat agents are able to answer a host of questions and help direct members to the right information. Chats are retained and may be accessed by the member and Cigna call centers.

Email


We now have the capability to allow our members and CSAs to interact via a secure emailing channel, leveraging the secure inbox messaging functionality on myCigna. This option allows our members who are registered on myCigna to receive and send files. Our standard turnaround time for responses is 30 minutes; however, our CSAs typically respond within a few minutes.

Members cannot initiate communication with a CSA through the secure emailing channel; it is only for follow-up communication after members make initial contact via phone or live chat.

Information Access

The following information is online and readily available to our customer service advocates (CSAs):

- **Policies and Procedures** - Claim and specialty referral files are automatically updated online after a transaction is complete; this enables claim processors/specialty referral reviewers and CSAs to access current eligibility and claim history.
- **Coverage Information** - Plan features (e.g., types of service, coverage limitations, amount of deductible, specific procedure exclusions, levels of coinsurance, maximums) are entered into plan-specification databases, which drive the automatic calculation portion of the claim payment process for DEPO, DPPO, and indemnity claims.

	<h2 style="text-align: center;">ATTACHMENT D: Questionnaire</h2>		<p style="text-align: center;">ARIZONA STATE RETIREMENT SYSTEM 3300 N Central Ave 14th Floor Phoenix, AZ 85012</p>
	<p>ASRS Group Dental Services Solicitation Code: BPM001922 PART 2 of 2 - Attachments (Response Forms)</p>	<p>Page 33 of 42</p>	

- **Member Information** - Part of the claim payment/specialty referral process is verifying employee and patient eligibility information by comparing it to the account's plan specifications as well as information supplied on the claim/encounter form and by the client.
- **Dentist Information** - Online dentist information includes TIN or SSN, name, address and phone number, specialty, education, languages spoken, hours of operation, years in practice, board certification (if applicable), and fee schedules.
- **Claim Information** - CSAs have online access to up-to-date specialty referral and claim information. If they need information they cannot find in the system (i.e., purged information), they can obtain it within two weeks.

Cigna Online Dental Tools

At Cigna, we believe that dental coverage should be easy and offer the same transparencies and tools that members expect in every other part of their lives. We launched new online tools to make these and other services possible. This innovative technology is now available on www.cigna.com, myCigna, and our mobile app. Available 24 hours a day, 7 days a week, 365 days a year, these features provide on-the-go access anytime, anywhere from mobile phones or tablets.

The tools include the following:

Brighter Score Ranking - use this scoring method developed by www.brighter.com to compare dentists based on factors such as affordability, patient experience, and professional history (may not be available with all Cigna dental plans)

Dental Office Reviews and Comparisons - find detailed information to compare dental offices, including dentist profiles with pictures, video content, and verified patient reviews (may not be available with all Cigna dental plans)

Enhanced Search and Transparent Pricing - search for a dentist by procedure or group of procedures and get personalized information based on the plan; results show pricing is inclusive of coinsurance, copays, and deductibles (may not be available with all Cigna dental plans)

Treatment Cost Estimator-


The dental treatment cost estimator is a user-friendly, web-based tool available through the health care professional directory on myCigna. This tool allows members enrolled in any Cigna dental plan to easily estimate and plan for their dental care costs—both on a procedure code level and a treatment level for over 400 treatments and procedures. The dental treatment cost estimator bases estimates on the member's actual plan design, including coinsurance/copays, maximums, and deductibles.

We would be happy to demonstrate our system capabilities in future presentations.

In addition, customer service advocates (CSAs) have online access to network dentist information, including the following:

- dental school and year of graduation
- languages spoken
- office locations and phone numbers
- hours of operation
- years in practice
- areas of specialization
- board certification (specialists)

We do not provide information about age, race, national origin, malpractice history, history of disciplinary actions or licensing sanctions, subjective information or opinions, popularity in the community, number of complaints received, or patient satisfaction scores. If specifically requested by the member, we will provide the dentist's gender.

	ATTACHMENT D: Questionnaire		ARIZONA STATE RETIREMENT SYSTEM 3300 N Central Ave 14 th Floor Phoenix, AZ 85012
	ASRS Group Dental Services Solicitation Code: BPM001922 PART 2 of 2 - Attachments (Response Forms)	Page 34 of 42	

1.1. What are the training procedures for client-specific account information? How is performance monitored?

We provide seven weeks of in-depth training to our customer service advocates (CSAs). CSAs spend the first three weeks in a classroom environment where they learn how to handle member coverage and eligibility questions. The new hires then receive a week of on-the-job training handling live coverage and eligibility calls. During the next two weeks, they receive training on more complex member and dentist questions, followed by a week of additional on-the-job training. We then assess and verify their skills through testing and hands-on demonstration of simulated and live calls.

Following these seven weeks, trainees receive a permanent assignment. The manager and quality management team continually monitor staff to ensure they are providing quality service. We measure this through live call monitoring, postrecorded call handling, and external customer service survey responses. Trainers communicate performance expectations throughout training, and their manager reinforces it through routine counseling. CSAs' customer service skills continue to be developed on the floor through experience, targeted coaching, and additional training pushed to each CSA's desktop through an automated learning management system.

2. Identify and describe available automated, interactive systems (e.g., online, IVR) that provide Participants with information and the type of information (e.g., claim status, claim payment history) provided.

Members can call our toll-free customer service number, 800.Cigna24, 24 hours a day, 7 days a week, 365 days a year to talk to a customer service advocate (CSA) about coverage, dental office transfers for DHMO, DPPO claims, procedures, or any other concerns. In addition, our voice response system is also available 24 hours a day, 7 days a week, 365 days a year. DHMO members can use this system to access eligibility and coverage information or use our automated quick transfer option to change network dental offices. DPPO members can use the voice response system to check claim status, eligibility, and coverage information.

Our voice response system is also available 24 hours a day, 7 days a week, 365 days a year. DHMO members can use this system to access eligibility and coverage information or use our automated quick transfer option to change network dental offices.


Members can use the voice response system to check claim status, eligibility, and coverage information.

The toll-free number allows members to enter their zip code and hear a list of nearby dental offices via the dental office locator. The toll-free number can also immediately fax the list to assist in enrollment or dental office transfers (DHMO). Members can also enter a dentist's phone number to see if he or she participates in the network. If multiple dentists have the same phone number, the system speaks back the name of each dentist and clearly identifies DHMO-capped dental offices. The system is updated nightly.

Members can access more than 1,000 health and dental topics through our health information line by calling the toll-free dental customer service number.

3. How does your company monitor Participant satisfaction? What transactions/interactions are evaluated? (Provide Offeror's Sample Participant Satisfaction Surveys indicated in Special Instructions to Offerors, Section F(2.5(5)).)

We use a variety of member-centric quality mechanisms to evaluate our customer service and enable continuous call service improvement:

	ATTACHMENT D: Questionnaire		ARIZONA STATE RETIREMENT SYSTEM 3300 N Central Ave 14 th Floor Phoenix, AZ 85012
	ASRS Group Dental Services Solicitation Code: BPM001922 PART 2 of 2 - Attachments (Response Forms)	Page 35 of 42	

- **Surveys** - An industry-leading market research firm completes postservice member surveys. These surveys give our members a chance to acknowledge superior service and to provide us feedback and opportunities for improvement. The survey asks general satisfaction and associate-level questions. The goal is for each customer service advocate (CSA) to receive five surveys per month. We have provided a sample Satisfaction Survey in Attachment D1 of this proposal for your review.
- **Internal Call Monitoring Audits** - Our quality team completes internal call monitoring audits to ensure CSAs are following our member-centric internal policies and procedures. Recorded calls and screen capture (available on a sampling of recorded calls) allow for auditing, which measures the CSA's accuracy, call ownership, and adherence to other standards and guidelines (e.g., HIPAA regulations). Internal process steps are also evaluated to ensure appropriate action is taken for issue resolution, such as following standard operating procedures/job aids, workflows, and call management. This audit type is used for our out-of-scope advocates, global service partners, and performance guarantee accounts.
- **Real-Time Coaching Program** - In January 2014, we rolled out real-time support to the advocate population. This provides live, in-the-moment coaching to impact the member during the phone-based coaching session. This system allows the coach to interact directly with the CSA. By developing goals that support direct observations, we can have a greater impact on the member experience.
- **Call Recording** - Cigna records approximately 99 percent of incoming calls (voice only), and we retain recordings for one year.
- **Feedback and Improvement Process** - Member feedback is carefully analyzed and used to pinpoint areas that we can improve to enhance satisfaction, drive process efficiency, and increase overall service levels.

Each month, our internal quality department audits 1 percent of our calls. Given the high volume of calls received, this percentage provides a statistically valid sampling. We also produce monthly reports that measure CSA against overall service standards, such as hold time, call length, and abandonment rate. We conduct a monthly business controls audit to monitor and assess a set of standards (e.g., open calls, external correspondence, standard operating procedures). We do not share our internal employee specific audits with our clients. Client-specific reports on customer service audit programs are not available.

Supervisors perform reviews of our CSAs; however, they do not review them daily.

Enrollment


1. **As the ASRS reviews your New Participant Welcome Kit (as indicated in Special Instructions to Offerors, Section F(2.5(4))), does your company have any additional commentary or information to add?**

We have included marketing materials in Attachment D1 of our proposal response. Prior to implementation, we will provide a welcome kit.

2. **When will your company produce and issue identification cards prior to the effective date of coverage?**

We mail members ID cards within five business days of the release of clean and accurate eligibility information to the ID card vendor.

3. **Describe your company's engagement in appropriate transition of care planning, including the approval process for continuing care plans?**

	<p style="text-align: center;">ATTACHMENT D: Questionnaire</p> <hr/> <div> <div>ASRS Group Dental Services Solicitation Code: BPM001922 PART 2 of 2 - Attachments (Response Forms)</div> <div>Page 36 of 42</div> </div>		<p style="text-align: center;">ARIZONA STATE RETIREMENT SYSTEM</p> <p>3300 N Central Ave 14th Floor Phoenix, AZ 85012</p>
--	---	--	---

Inlays and onlays initiated before changing to Cigna must be completed under the terms of the previous carrier.

DPPO

In-Network Orthodontia

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

Out-of-Network Orthodontia

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

History Data Transfer

To arrange for coverage for orthodontic treatment in progress, a history tape transferred to us from the previous carrier may eliminate delay. Based on the complexity of the data transfer, a service charge may apply.

DHMO

There may be a contribution toward orthodontic benefits in progress. The contribution, if any, is a predetermined amount based on the coverage and number of months remaining (excluding the months for retention) at the start date to complete the interceptive or comprehensive treatment. It is important to note that enrollment in our plans does not modify any obligation members have to their original contract with their orthodontist, even if the dentist participates in the Cigna Dental network.


Reporting

1. Describe your record keeping system and the process by which you manage records at the client level and the individual Participant/dependent level?

Cigna's reporting systems include the following data sources and models:

- **Cigna's Member-Centric Data Repository** - Our member-centric data repository is the one data source that we monitor for quality and consistency. We leverage this data source for client reporting, whether it is for aggregate reports, incentive reports, biometric results data feeds, or Consultative Analytics reports.
- **Consultative Analytics** - This is the primary reporting vehicle we use to perform analysis. This industry-leading reporting capability is based on a data model that accumulates information at the member level across eligibility, claims (medical and pharmacy), clinical outcomes, and member interactions (e.g., member website usage, health assessment). We deliver this data through a tailored consultative presentation to address ASRS's specific needs. As part of our consultative package, ASRS also receive financial experience and ad hoc reports.
 - Cigna's Automated Data Validation Integrated Customer Experience reporting application provides internal and external clients with financial experience reports. The available suite of configurable reports includes paid claims, membership, and premium information. Automated Data Validation Integrated Customer Experience reports are customizable, and internal users can save their report parameters as a template, providing them the option of running the same report on a recurring basis. These reports post to CignaAccess.com for clients and brokers. The available reporting suite includes financial experience, claim lag, detailed claimant (member level), and reconciliation reports.
 - SAS software generates ad hoc reporting through our member-reporting data mart. Our reporting analysts and consultants are well versed in the SAS language, allowing them to easily provide customized ad hoc reporting.

The data source for our utilization reporting is the member-reporting data mart, a member-centric repository that serves as the foundation for client reporting. It contains raw data topics, such as medical, pharmacy, and behavioral

	ATTACHMENT D: Questionnaire		ARIZONA STATE RETIREMENT SYSTEM 3300 N Central Ave 14 th Floor Phoenix, AZ 85012
	ASRS Group Dental Services Solicitation Code: BPM001922 PART 2 of 2 - Attachments (Response Forms)	Page 37 of 42	

claims, health assessments, and clinical program participation and intervention, as well as derived topics, such as evidence-based medicine (EBM) rules and ETG.

1.1. As the ASRS reviews your Sample Client Reporting Package (as indicated in Special Instructions to Offerors, Section F(2.5(6))), please provide a brief explanation each report’s purpose.


We generally provide a standard package of dental information reports quarterly or annually at no charge; however, a charge applies for standard reports produced more frequently and for optional reports. We deliver our Consultative Analytics package to ASRS in person, generally within 120 days of the close of the plan year.

Dental reports include the following:

- **Dental Dashboard** - exhibits three key summary components: membership, oral health behaviors, and savings
- **Dental Membership Summary** - exhibits dental membership by relationship and age bands
- **Dental Cleanings Utilization** - exhibits percentage of unique members with one or more cleanings
- **Dental Top 15 Procedure Types** - exhibits the top 15 procedures based on the number of services in descending order
- **DPPO - Oral Health Behaviors** - exhibits focus areas of the population relative to dental health (those who have initiated dental health, those who have a gap, and those who have no dental claims)
- **DPPO Plan Fundamentals** - exhibits financial breakdown of plan maximum accumulation, orthodontia, and additional covered benefits
- **Dental Claim Summary** - exhibits total cost waterfall (submitted, employer paid, and member cost share) and per capita costs compared to book-of-business norms
- **Dental Claim Cost and Savings Summary** - exhibits waterfall of total charges, savings, and discounts for one or two time periods versus norm
- **Dental Claim Cost and Savings - Network** - exhibits waterfall of total charges, savings, and discounts for one time period by network option
- **Dental Claim Distribution (Including Orthodontic)** - exhibits payable claims by dollar range counted by unique member with orthodontic costs
- **Dental Claim Distribution (Excluding Orthodontic)** - exhibits payable claims by dollar range counted by unique member without orthodontic costs
- **Dental Utilization by Type of Service and Network** - exhibits per capita cost and utilization by service category by network option for a single time period
- **DHMO Summary** - exhibits summary statistics for membership, utilization, and savings for the DHMO plan
- **Dental Utilization by Type of Service** - exhibits service categories details for DHMO utilization
- **Dental - The Value of Integration - Retrospective** - exhibits population of dental cleaning by engaged versus nonengaged and associated savings

Dental claim reports include the following:

- **Dental Claim Summary** - exhibits total cost waterfall (submitted, employer paid, and member cost share) and per capita costs compared to book-of-business norms
- **Dental Claim Cost and Savings Summary** - exhibits waterfall of total charges, savings, and discounts for one or two periods versus norm
- **Dental Claim Distribution (Including Orthodontic)** - exhibits payable claims by dollar range counted by unique member with orthodontic costs
- **Dental Claim Distribution (Excluding Orthodontic)** - exhibits payable claims by dollar range counted by unique member without orthodontic costs

	<h1>ATTACHMENT D: Questionnaire</h1>		<p>ARIZONA STATE RETIREMENT SYSTEM 3300 N Central Ave 14th Floor Phoenix, AZ 85012</p>
	ASRS Group Dental Services Solicitation Code: BPM001922 PART 2 of 2 - Attachments (Response Forms)	Page 38 of 42	

Additional reports are available online through CignaAccess.com.

Please see the sample CAP report located in the Attachment D1 section of our proposal response.

1.2. Is there a portal for the ASRS to run its own standard reports? If yes, describe the portal's functions and list of reports available.

Yes. CignaAccess.com provides tools and information to support ASRS in the following key areas:

- **Claim Inquiry** - ASRS can view DPPO paid claim information at the member level and view deductible and lifetime maximum accumulation data at the member level. ASRS must be a recipient of PHI per HIPAA. Viewing DHMO claim information is not available on our client website.
- **Eligibility and Coverage Inquiry** - ASRS can view DPPO eligibility and coverage information at the member level. ASRS can also view and/or print temporary ID cards. This feature does not require ASRS to be a recipient of PHI. Viewing DHMO eligibility and coverage information is not available on our client website.
- **Automated Eligibility Management and Reporting Tool** – If ASRS will submit eligibility via our automated eligibility process, you can access and download fallout reports. You can review key file processing metrics that provide a historical view of file processing results, including timeliness, member defect rates, and error resolution cycle times.
- **Eligibility Reports and Statistics** - ASRS can create and download eligibility reports that include member listings and census reports. You can also tailor the reports to meet your needs. Data is available in real time (as it appears in our eligibility system at the time of the request). If ASRS will submit electronic eligibility files, you can also use the automated eligibility management and reporting tool to access and download user-friendly fallout reports and key file processing metrics.
- **Premium/Fee Invoices and Online Bill Payment** - Electronic versions (PDF) of the premium/fee invoices are available. Additionally, ASRS can receive a system-generated notification when the invoice is ready; retrieve, view, save, or print the invoices at their convenience; and pay their bills online.
- **Financial Reports** - ASRS can review standard DPPO financial reports, which include monthly experience (excluding premium) and lag reports. We post reports to the website by the 10th calendar day of the month.
- **Banking Reports and Statistics** - ASRS can view current DPPO banking reports based on a preselected request (daily, weekly, or monthly, depending on the report type). Reports include worksheets, issued check registers, cleared check registers, and claim refunds.


Monthly reports are available by the 10th business day of the following month; weekly reports are available the 1st business day of the following week; daily issued reports are available the next business day. Daily cleared reports are available two business days later.

Cigna offers a tour of CignaAccess.com and its capabilities at www.maier.com/cigna/cigna-access. The demonstration already includes the user ID and password. Note that we are currently working to provide an enhanced client experience; as such, the “look and feel” of the demo may not reflect its future state.

1.3. Does your company have any limitations with respect to providing reports at a detail field level specified by the client? If so, explain the limitations.

No. Cigna is willing to discuss with ASRS's their reporting needs.

2. Describe your company's data analytics capabilities and how they will be used to assist the ASRS.

	<p style="text-align: center;">ATTACHMENT D: Questionnaire</p> <hr/> <div> <div>ASRS Group Dental Services Solicitation Code: BPM001922 PART 2 of 2 - Attachments (Response Forms)</div> <div>Page 39 of 42</div> </div>		<p style="text-align: center;">ARIZONA STATE RETIREMENT SYSTEM 3300 N Central Ave 14th Floor Phoenix, AZ 85012</p>
--	---	--	--

DPPO

Our dental information reporting system can provide a dental utilization versus norms report upon request. This report compares the traditional DPPO plan charges and frequency data to norms developed from our entire dental book-of-business. It is based on 10 American Dental Association (ADA) categories of selected procedures. These norms are a composite of our dental book-of-business; therefore, they reflect new versus mature cases, various regional differences, plan designs, and many other components of our book-of-business.

DHMO

The Cigna Dental Care® (DHMO) plan is capitated and does not require the filing of claims; therefore, this question does not apply.

Financial Management

1. Describe your company's methodology for calculating plan premium rates (e.g., administration, network access, risk charges, and other retentions, expected claims, and reserves).

In a fully insured participating funding arrangement, ASRS pay components of the premium rate to Cigna as monthly premiums. We collect money to pay claims and expenses and to hold reserves in-house. We apply the excess resulting from the difference in premium paid and actual expenses to the following:

- recovering deficits
- establishing a premium stabilization reserve (to offset future rate increases/deficits)

We may also return it to ASRS.

Advantages of this arrangement include the following:

- direct interest credit for the reserves
- locked-in "insurance" costs
- dividend payout (if claims and expenses come in lower than the total premium paid)

In a nonparticipating funding arrangement, the ASRS pays the premium to Cigna in advance (typically monthly). Cigna collects money to pay claims and expenses and to hold reserves. If claims, reserves, and expenses come in lower than predicted, Cigna will retain the excess as additional profit. If they are higher than predicted, Cigna is responsible for the shortfall. There is no margin/deficit calculation. Advantages of this arrangement include the following:


- predictable monthly installments (enables easier budgeting)
- no risk as long as the premium is paid on time
- no risk of generating or carrying forward deficits

Under an ASO funding arrangement, the ASRS is self-insured and pays Cigna to handle only the administrative/claim-handling costs. ASRS pay PMPM fees as well as a per-check charge. There is no margin or deficit (carryover). In addition to the basic administrative fee, we charge an additional fee for extra services (e.g., legal, underwriting, printing, reporting). Typically, ASO funding attracts companies that have a predictable-enough claim experience to allocate appropriate claim dollars.

Advantages of this arrangement include the following:

- no compliance with state mandates (in most states)
- low or no premium tax
- increased cash flow for claim dollars

2. Describe your company's billing process for a direct bill Participant.

	ATTACHMENT D: Questionnaire		ARIZONA STATE RETIREMENT SYSTEM 3300 N Central Ave 14 th Floor Phoenix, AZ 85012
	ASRS Group Dental Services Solicitation Code: BPM001922 PART 2 of 2 - Attachments (Response Forms)	Page 40 of 42	

Direct billing will be provided thorough our subsidiary, Allegiance. We will discuss direct billing in more detail during the finalist stages of the presale process.

For self-funded plans

- 3. Indicate your procedures for reconciling the funding account and the information and statements that you will provide to the ASRS.**

ASRS send their premium/fee payments to a bank lockbox. The bank processes the received payments as deposits to the account and forwards an electronic file to our cash control unit. In addition, the bank sends any paper backup in the form of check copies and any paperwork included with the payment to revenue management. Revenue management then forwards it via next-day air to Diversified Information Technologies for scanning, which enables our billing analysts to view this information.

Once received by the cash control unit, we apply payments in the accounts receivable cash system. To ensure accuracy, we audit the totals in the accounts receivable system against the checks received and the electronic file. The billing analyst reconciles the payment to the invoice, reviews any additional scanned information, and notes discrepancies. Upon completing reconciliation, he or she provides a bill-balance letter to ASRS.

Audit and Accounting

- 1. Do you have dedicated staff to conduct regular audits to maintain the integrity of services? If not, who conducts audits to ensure quality control?**

Yes.


- 1.1. Describe your internal audit procedures to ensure quality control and stated procedures are followed. Include the frequency, the average percentage of pre-/post-disbursement claims audited and how selected for audit.**

We randomly select 2 percent of processed claims. We review these claims daily for accuracy and measure them based on payment accuracy, financial accuracy, and overall claim processing accuracy. Internal random auditors are located throughout the network and are responsible for audits and feedback. The performance guarantee auditors report to our service operations quality team and make recommendations for retraining based on the trends noted in the audit. We may also perform focused audits on a processor if the trends noted in the audit reflect a pattern. For instance, if the trend analysis shows that the processor has difficulty with orthodontics claim processing, we will audit more orthodontic claims to provide the processor more feedback and additional help.

We share audit results with dental reviewers monthly and include them in performance evaluations. We provide results to senior management in weekly and monthly reports.

- 2. Do you conduct an annual independent assessment of processes? If so, provide a copy. If not, what other types of assessments do you conduct to ensure transactional processes are sound? (If Offeror believes the information is confidential, include response in the separate attachment named "Attachment D1: Confidential Responses".)**

Yes. For our self-funded plans, an external auditing firm conducts an annual independent examination of our claims processes, procedures, and systems according to the Statement on Standards for Attestation Engagements 18 (SSAE 18), "Reporting on Controls at a Service Organization." The report provides information about the control

	ATTACHMENT D: Questionnaire		ARIZONA STATE RETIREMENT SYSTEM 3300 N Central Ave 14 th Floor Phoenix, AZ 85012
	ASRS Group Dental Services Solicitation Code: BPM001922 PART 2 of 2 - Attachments (Response Forms)	Page 41 of 42	

environment, computer information systems, claim processing, and banking functions we perform on behalf of our clients. We have engaged an independent external accounting firm to conduct the most recent audit of our claims processing system.

The SSAE 18 is a Service Organization Controls Report (SOC 1) Type II report. The requirements and guidance for US auditors reporting under the SSAE 18 report supersede those of the Type II SAS 70 and became effective as of June 15, 2011.

Semiannual Type II Statement on Standards for Attestation Engagements 18 (SSAE 18) audits of our claim processing systems began in 2005. In 2010, we rescheduled the SSAE 18 audits to occur yearly.

The reporting period is October 1–September 30. The approximate release date of the SSAE 18 is December 1. PricewaterhouseCoopers selects a random sample of claims from the entire 12-month population of claims Cigna audited internally. One of the control objectives involves testing claim payment completeness, accuracy, and timeliness.

We will agree to provide a copy of the most recent Statement on Standards for Attestation Engagements 18 (SSAE 18) report to ASRS upon being named a finalist and upon executing a confidentiality agreement in a form acceptable to Cigna.

The Cigna DHMO and DPPO fully-insured plan does not undergo an annual Statement on Standards for Attestation Engagements 18 (SSAE 18).

3. Describe your company's data analytics capabilities and how they will be used to assist the ASRS.

DHMO

The DHMO system contains the data and processes to manage and run the DHMO business. These include major modules such as account structure and setup, coverage definition, member eligibility and history, health care provider, payment, client, referral, and encounter processing. Because our system is an integrated environment, there are minimal interfacing systems required to administer DHMO business.

Our system receives eligibility information from Cigna's centralized eligibility database. We base our billing on this database and send a common single bill (with medical) to clients. We also leverage the shared Cigna enterprise gateways for internet, electronic, and HIPAA transactions and direct those that come through the gateway to the correct system within the Cigna environment for processing.

Our system sends files to other areas as well (e.g., Cigna Reporting Data Mart, our repository-of-eligibility database, our banking and financial systems, our actuarial department).


DPPO

We have several types of interfacing systems; some that support our claim payment systems and some that our claim payment systems support.

Systems that support our claim payment systems are as follows:

- **Client Database** - This database, which we update nightly, supports client structure and covered services. It interacts with the claim system during claim processing.
- **Centralized Eligibility Database** - This database supports automated eligibility loads to our claim systems.
- **Electronic Data Interchange (EDI)** - EDI accepts claim transactions electronically from value-added networks and clearinghouses.
- **Cigna Accounts Receivable and Billing System** - This is our billing system, and the information entered in it controls claim processing in an indirect way: If premium or fees are not received, we apply a "stop pay" to the client's record and send it to the client database. We also send structure information to our claim systems nightly; this stops claim processing and pends claims.

Systems that our claim systems support are as follows:

	ATTACHMENT D: Questionnaire		ARIZONA STATE RETIREMENT SYSTEM 3300 N Central Ave 14 th Floor Phoenix, AZ 85012
	ASRS Group Dental Services Solicitation Code: BPM001922 PART 2 of 2 - Attachments (Response Forms)	Page 42 of 42	

- **EOB** - This is our nightly batch processing system, which cuts checks and vouchers to providers and members for claims processed during the day.
- **Cigna Issuance Repository Processing System** - This is our banking repository, and we send payment and check information on processed claims to it nightly.
- **Settlement and Settlement Tracking and Reserve Systems** - We use these two underwriting systems during renewal processing.
- **Information Management Database** - This database holds claim transactions and other data used during the settlement process (renewal).
- **The Cigna Reporting Data Mart** - This leverages the Consultative Analytics Platform in our reporting system to produce our dental utilization statistics.

Our claim systems are also integrated with a host of applications: myCigna, CignaAccess.com, CignaforHCP.com, our automated voice response system, HIPAA 270/271, 835, and OneView are our main member support applications, and our claim systems are integrated with them to provide clients, members, and customer service advocates (CSAs) with the most accurate and up-to-date information.

We also have an additional process in place: Each day, the data transfer team extracts information from system files for ad hoc reporting, legislative requirements, client cancellation, and other requests. We perform these extracts through programs that take information from every area (e.g., eligibility, provider, claim processing). These are not standard feeds or extracts; rather, we complete these tasks at the request of the client, a state, or our sales department.