Executive Summary Form

Agenda Number: HLT

Recommendation:
Approve the new Ancillary Services Agreement between Cochise Health & Social Services and Cigna Healthcare of Arizona, Inc. This Agreement will run for one year and be renewed for subsequent one-year periods.

Background:
CHSS is strategically working to expand our network of insurance company payers, while at the same time, Cigna is working to expand their network of providers in Cochise County.

Radi Ann Porter (Director of Nursing) has reviewed and is satisfied with the Agreement from an operational perspective, and Terry Bannon has reviewed and is satisfied from a legal standpoint. The LOA may be terminated by either party with sixty days' written notice.

Fiscal Impact & Funding Sources: Cochise County will benefit by being able to bill Cigna for services provided to its members.

Next Steps/Action Items/Follow-up:

Your approval is respectfully requested.

Impact of Not Approving:

Not approving this Agreement will prevent Cochise County from collecting for services provided to Cigna members in the county.

Ancillary Services Agreement

This Ancillary Services Agreement ("Agreement") is by and between Cigna Healthcare of Arizona, Inc. ("Cigna") and _____ ("Provider") and shall be effective on _____ (the "Effective Date").

SECTION 1. DEFINITIONS

1.1 Administrative Guidelines
means the rules, policies and procedures adopted by Cigna or a Payor to be followed by Provider in providing services and doing business with Cigna and Payors under this Agreement.

1.2 Benefit Plan
means a certificate of coverage, summary plan description or other document or agreement which specifies the health care services to be provided or reimbursed for the benefit of a Participant.

1.3 Cigna Affiliate
means any subsidiary or affiliate of Cigna Corporation.

1.4 Coinsurance
means a payment that is the financial responsibility of the Participant under a Benefit Plan for Covered Services that is calculated as a percentage of the contracted reimbursement rate for such services or, if reimbursement is on a basis other than a fee-for-service amount, as a percentage of a Cigna determined fee schedule or as a Cigna determined percentage of actual charges.

1.5 Copayment
means a payment that is the financial responsibility of the Participant under a Benefit Plan for Covered Services that is calculated as a fixed dollar amount.

1.6 Covered Services
means those health care services for which a Participant is entitled to receive coverage under the terms and conditions of the Participant's Benefit Plan.

1.7 Deductible
means a payment for Covered Services calculated as a fixed dollar amount that is the financial responsibility of the Participant under a Benefit Plan prior to qualifying for reimbursement for subsequent health care costs under the terms of a Benefit Plan.

1.8 Medically Necessary/Medical Necessity
means services and supplies that satisfy the Medical Necessity requirements under the applicable Benefit Plan. No service is a Covered Service unless it is Medically Necessary.

1.9 Participant

means any individual, or eligible dependent of such individual, whether referred to as "Insured", "Subscriber", "Member", "Participant", "Enrollee", "Dependent", or similar designation, who is eligible and enrolled to receive Covered Services.

1.10 Participating Provider
means a hospital, physician or group of physicians, or any other health care practitioner or entity that has a direct or indirect contractual arrangement with Cigna to provide Covered Services with regard to the Benefit Plan covering the Participant.

1.11 Payor
means the person or entity obligated to a Participant to provide reimbursement for Covered Services under the Participant's Benefit Plan and which Cigna has agreed may access Provider's services under this Agreement.

1.12 Quality Management
means the program described in the Administrative Guidelines relating to the quality of Covered Services provided to Participants.

1.13 Utilization Management
means a process to review and determine whether certain health care services provided or to be provided are Medically Necessary and in accordance with the Administrative Guidelines.

SECTION 2. DUTIES OF PROVIDER

2.1 Provider Services.
Provider shall provide Covered Services to Participants upon the terms and conditions set forth in this Agreement and the Administrative Guidelines.

2.2 Standards.
Provider shall provide Covered Services with the same standard of care, skill and diligence customarily used by similar providers in the community, the requirements of applicable law, and the standards of applicable accreditation organizations. Provider shall provide Covered Services to all Participants in the same manner, under the same standards, and with the same time availability as offered to other patients. Provider shall not differentiate or discriminate in the treatment of any Participant because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age, health status, veteran's status, handicap or source of payment. Provider shall assure that all health care providers who perform any of the services for which the Provider is responsible under this Agreement maintain all necessary licenses or certifications required by state and federal law. Provider shall immediately restrict, suspend, or terminate any such health care provider from providing services to Participants under this Agreement if such provider ceases to meet the licensing/certification requirements or other professional standards described in this Agreement.

2.3 Insurance/Application for Participation Information.

Provider shall maintain general and professional liability coverage in a form and amount acceptable to Cigna, give Cigna evidence of such coverage upon request and provide Cigna with immediate written notice of a material modification or termination of such insurance. Provider shall also notify Cigna in writing within 30 days of any material change in the information contained in Provider's application for participation with Cigna.

2.4 Administrative Guidelines.
Provider shall comply with the Administrative Guidelines. Some or all Administrative Guidelines may be communicated in the form of a provider reference manual, in other written materials distributed by Cigna to Provider and/or at a website identified by Cigna. Administrative Guidelines may change from time to time. Cigna will give Provider advance notice of material changes to Administrative Guidelines.

2.5 Quality Management.
Provider shall comply with the requirements of and participate in Quality Management as specified in the Administrative Guidelines.

2.6 Utilization Management.
Provider shall comply with the requirements of and participate in Utilization Management as specified in this Agreement and the Administrative Guidelines. Payment may be denied for failure to comply with such Utilization Management requirements, and Provider shall not bill the Participant for any such denied payment. Cigna's Utilization Management requirements include, but are not limited to, the following: a) precertification must be secured from Cigna or its designee for those services and procedures for which it is required as specified in the Administrative Guidelines; b) Provider must provide Cigna or Cigna's designee with all of the information requested by Cigna or its designee to make its Utilization Management determinations within the timelines specified by Cigna or its designee in such request; and c) Provider will refer Participants to and/or use Participating Providers for the provision of Covered Services except in the case of an emergency or as otherwise required by law.

2.7 Records.
Provider shall maintain medical records and documents relating to Participants as may be required by applicable law and for the period of time required by law. Medical records of Participants and any other records containing individually identifiable information relating to Participants will be regarded as confidential, and Provider and Cigna shall comply with applicable federal and state law regarding such records. Provider will obtain Participants' consent to or authorization for the disclosure of private and medical record information for any disclosures required under this Agreement if required by law. Upon request, Provider will provide Cigna with a copy of Participants' medical records and other records maintained by Provider relating to Participants. These records shall be provided to Cigna at no charge and within the timeframes requested by Cigna and will also be made available during normal business hours for inspection by Cigna, Cigna's designee, accreditation

organizations, or to any governmental agency that requires access to these records. This provision survives the termination of this Agreement.

2.8 Cooperation with Cigna and Cigna Affiliates.
Provider shall cooperate with Cigna in the implementation of Cigna's Participant appeal procedure. Provider shall also cooperate with Cigna and Cigna Affiliates in implementing those policies and programs as may be reasonably requested by Cigna or a Cigna Affiliate for purposes of Cigna's or the Cigna Affiliate's business operations or required by Cigna or a Cigna Affiliate to comply with applicable law or accreditation requirements.

SECTION 3. DUTIES OF CIGNA

3.1 Payors, Benefit Plan Types, Notice of Changes to Benefit Plan Types.
Cigna may allow Payors to access Provider's services under this Agreement for the following Benefit Plan types: a) Benefit Plans where Participants are offered a network of Participating Providers and are required or given the option to select a Primary Care Physician; b) Benefit Plans where Participants are offered a network of Participating Providers and are not required or given the option to select a Primary Care Physician; and c) Benefit Plans where Participants are not offered a network of Participating Providers from which they may receive Covered Services. Benefit Plans may include workers' compensation plans. Cigna will give Provider advance notice if Cigna changes this list of Benefit Plan types for which Payors may access Provider's services under this Agreement. Notwithstanding anything else to the contrary, the terms and rates in this Agreement do not apply to Covered Services provided to Medicare Participants enrolled in the Medicare Advantage Program.

3.2 Benefit Information.
Cigna will give Provider access to benefit information concerning the type, scope and duration of benefits to which a Participant is entitled as specified in the Administrative Guidelines.

3.3 Participant and Participating Provider Identification.
Cigna will establish a system of Participant identification and will identify Participating Providers to those Payors and Participants who are offered a network of Participating Providers. However, Cigna makes no representations or guarantees concerning the number of Participants that will be referred to Provider as a result of this Agreement and reserves the right to direct Participants to selected Participating Providers and/or influence a Participant's choice of Participating Provider.

SECTION 4. COMPENSATION

4.1 Payments.
Payments for Covered Services will be the lesser of the billed charge or the applicable fee under Exhibit A , subject to the Administrative Guidelines and minus any applicable Copayments, Coinsurance and Deductibles. The rates in this Agreement will be payment in full for all services furnished to Participants under this Agreement.

Provider shall submit claims for Covered Services at the location identified by Cigna and in the manner and format specified in this Agreement and the Administrative Guidelines. Claims for Covered Services must be submitted within 90 days of the date of service or, if Payor is the secondary payor, within 90 days of the date of the explanation of payment from the primary payor. Claims received after this 90 day period may be denied except as provided in the Administrative Guidelines, and Provider shall not bill Cigna, the Payor or the Participant for those denied services. Amounts due and owing under this Agreement with respect to complete claims for Covered Services will be payable within the timeframes required by applicable law.

4.2 Underpayments.

If Provider believes a Covered Service has been underpaid, Provider must submit a written request for an appeal or adjustment with Cigna or its designee within 180 days from the date of Payor's payment or explanation of payment. The request must be submitted in accordance with Cigna's dispute resolution process set out in the Administrative Guidelines. Requests for appeals or adjustments submitted after this date may be denied for payment, and Provider will not be permitted to bill Cigna, the Payor or the Participant for those services.

4.3 Copayments, Coinsurance and Deductibles.

Provider may charge Participants applicable Copayments, Coinsurance and Deductibles in accordance with the process set out in the Administrative Guidelines.

4.4 Limitations On Billing Participants.

Provider shall not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Participants or persons other than the applicable Payor for Covered Services or for any amounts denied or not paid under this Agreement due to Provider's failure to comply with the requirements of Cigna's or its designee's Utilization Management Program or other Administrative Guidelines, failure to file a timely claim or appeal. This provision does not prohibit collection of any applicable Copayments, Coinsurance and Deductibles. This provision survives termination of this Agreement, is intended to be for the benefit of Participants, and supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Provider and a Participant or persons acting on the Participant's behalf. Modifications to this section will become effective no earlier than the date permitted by applicable law.

4.5 Billing Patients Who Cease to Be Participants.

Provider may bill a patient directly for any services provided following the date that patient ceases to be a Participant, and Payor has no obligation to pay for services for such patients.

4.6 NonMedically Necessary Services.

Provider shall not charge a Participant for a service that is not Medically Necessary unless, in advance of providing the service, Provider has notified the Participant that the particular service will not be covered and the Participant acknowledges in writing that he or she will be responsible for payment for such service.

4.7 Reimbursement of Amounts Collected In Error.
If Provider collects payment from a Participant when not permitted to collect under either this Agreement or the Administrative Guidelines, Provider must repay the amount within 2 weeks of a request from Cigna or the Participant or of the date Provider has knowledge of the error. If Provider fails to make the repayments, then Cigna may (but is not obligated to) reimburse the Participant the amount inappropriately paid and then withhold this amount from future payments.

4.8 Overpayments.
Provider shall refund to Cigna any excess payment made by a Payor to Provider if Provider is for any reason overpaid for health care services or supplies. Cigna may, at its option, deduct the excess payment from other amounts payable, and Provider will be notified of any such deduction as specified in the Administrative Guidelines.

4.9 Audits.
Upon reasonable notice and during regular business hours, Cigna or its designee will have the right to review and make copies of all records maintained by Provider with respect to all payments received by Provider from all sources for Covered Services provided to Participants. Cigna or its designee will have the right to conduct audits of such records and may audit its own records to determine if amounts have been properly paid under this Agreement. Any amounts determined to be due and owing as a result of such audits must be promptly paid or, at the option of the party to whom such amounts are owed, offset against amounts due and owing by such party hereunder. This provision survives the termination of this Agreement.

4.10 Coordination of Benefits.
Certain claims for Covered Services are claims for which another payor may be primarily responsible under coordination of benefit rules. Provider may pursue those claims in accordance with the process set out in the Administrative Guidelines. When a Participant's coverage under a Benefit Plan is secondary, Payor will pay an amount no greater than that which, when added to amounts payable from other sources under applicable coordination of benefits rules, equals 100% of the reimbursement for Covered Services under this Agreement, but may be less as determined by the terms of the Participant's Benefit Plan.

4.11 Applicability of the Rates.
The rates in this Agreement apply to all services rendered to Participants in the Benefit Plan types covered by this Agreement, including services covered under a Participant's in-network or out-of-network benefits, and whether the Payor or Participant is financially responsible for payment.

4.12 Excluded Services.
This Agreement excludes services that Cigna has elected to obtain under an arrangement between Cigna or a Cigna Affiliate and a national or regional vendor or provider or a capitated provider, except as otherwise agreed by Cigna. Provider will not be reimbursed and will not bill Participants for any such excluded services. If

Cigna notifies Provider that it no longer chooses to exclude a particular service from this Agreement, that service will no longer be excluded and those services will be reimbursed as specified in Exhibit A .

4.13 Provider Facilities.
This Agreement shall specifically exclude those services rendered at Provider facilities other than those facilities agreed upon and utilized as of the Effective Date unless otherwise agreed in writing by Cigna.

SECTION 5. TERM AND TERMINATION

5.1 Term of This Agreement.
This Agreement begins on the Effective Date and continues from year to year unless terminated as set forth below.

5.2 How This Agreement Can Be Terminated.
Either Provider or Cigna can terminate this Agreement at any time by providing at least 60 days advance written notice. Either Provider or Cigna can terminate this Agreement immediately if the other becomes insolvent. Cigna can terminate this Agreement immediately (or upon such longer notice required by applicable law, if any) if Provider no longer maintains the licenses required to perform its duties under this Agreement, Provider is disciplined by any licensing, regulatory, accreditation organization, or any other professional organization with jurisdiction over Provider, or if Provider no longer satisfies Cigna's credentialing requirements. Upon termination of this Agreement for any reason, the rights of each party terminate, except as provided in this Agreement. Termination will not release Provider or Cigna from obligations under this Agreement prior to the effective date of termination.

5.3 Services Upon Termination.
If this Agreement is terminated without cause, Provider shall continue to provide Covered Services for those Participants suffering from a chronic condition requiring continuity of care for whom an alternative means of receiving necessary care was not arranged at the time of such termination. Provider shall continue to provide Covered Services to such Participants so long as the Participant retains eligibility under a Benefit Plan, until the earlier of completion of such services or the assumption of treatment by another provider. Payment for Covered Services provided to any such Participant after termination of this Agreement shall be in accordance with the terms of the Participant's Benefit Plan. If, after termination of this Agreement, Provider determines that Cigna has not used due diligence to arrange for alternative care, Provider may terminate the provider-patient relationship. Provider has no obligation under this Agreement to provide services to individuals who cease to be Participants.

SECTION 6. GENERAL PROVISIONS

6.1 Confidentiality.
As a result of this Agreement, Provider may have access to certain of Cigna's confidential and proprietary information. Provider shall hold such information,

including the terms of this Agreement, in confidence and will not use or disclose such information to any person without the prior written consent of Cigna except as may be required by law. This provision does not prohibit communications necessary or appropriate for the delivery of health care services, communications about coverage and coverage appeal rights or any other communications specifically protected under applicable law. This provision survives the termination of this Agreement.

6.2 Independent Parties.

Provider is an independent contractor. Cigna and Provider do not have an employer-employee, principal-agent, partnership, or similar relationship. Nothing in this Agreement, including Provider's participation in Quality Management and Utilization Management programs, nor any coverage determination made by Cigna or a Payor, is intended to interfere with or affect Provider's independent judgment in providing health care services to its patients.

6.3 Internal Dispute Resolution.

Disputes that might arise between the parties regarding the performance or interpretation of the Agreement must first be resolved through the applicable internal dispute resolution process outlined in the Administrative Guidelines. In the event the dispute is not resolved through that process, either party can request in writing that the parties attempt in good faith to resolve the dispute promptly by negotiation between designated representatives of the parties who have authority to settle the dispute. If the matter is not resolved within 60 days of such a request, either party may initiate arbitration by providing written notice to the other. With respect to a payment or termination dispute, Provider must submit a request for arbitration within 12 months of the date of the letter communicating the final decision under Cigna's internal dispute resolution process unless applicable law specifically requires a longer time period to request arbitration. If arbitration is not requested within that 12 month period, Cigna's final decision under its internal dispute resolution process will be binding on Provider, and Provider shall not bill Cigna, Payor or the Participant for any payment denied because of the failure to timely submit a request for arbitration.

6.4 Arbitration.

If the dispute is not resolved through Cigna's internal dispute resolution process, the controversy shall be resolved through binding arbitration. The arbitration shall be conducted in 60 days in accordance with the American Health Lawyers Association Alternative Dispute Resolution Service Rules of Procedure for Arbitration, and which to the extent of the subject matter of the arbitration, shall be binding not only on all parties to the agreement, but on any other entity controlled by, in control of or under common control with the party to the extent that such affiliate joins in the arbitration, and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof. Each party shall assume its own costs, but the compensation and expenses of the mediator and any administrative fees or costs shall be borne equally by the parties. The decision of the arbitrator shall be final, conclusive and binding, and no action at law or in equity may be instituted by either party other than to enforce the award of the arbitrator. The parties intend this alternative dispute

resolution procedure to be a private undertaking and agree that an arbitration conducted under this provision shall not be consolidated with an arbitration involving other hospitals or third parties, and that the arbitrator shall be without power to conduct an arbitration on a class basis. Judgment upon the award rendered by the arbitrator may be entered in any court of competent jurisdiction.

6.5 Material Adverse Change Amendments.
For amendments that are a material adverse change in the terms of this Agreement, Cigna can amend this Agreement by providing 90 days advance written notice except if a shorter notice period is required to comply with changes in applicable law. The change will become effective at the end of the 90 day notice period or, if applicable, the shorter notice period required to comply with changes in applicable law. If Provider objects to the material adverse change and notifies Cigna of its intent to terminate within 30 days of the date of the notice of amendment, the termination will be effective at the end of the 90 day notice of the material adverse change or, if applicable, at the end of the shorter notice period required to comply with changes in applicable law, unless Cigna agrees to retract the amendment, in which case the Agreement will remain in force without the proposed amendment.

6.6 All Other Amendments.
For amendments that are not material adverse changes in the terms of this Agreement, Cigna can amend this Agreement by providing 30 days advance written notice to Provider. Alternatively, both parties can agree in writing to amend this Agreement.

6.7 Assignment and Delegation.
Neither Cigna nor Provider may assign any rights or delegate any obligations under this Agreement without the written consent of the other party; provided, however, that any reference to Cigna includes any successor in interest and Cigna may assign its duties, rights and interests under this Agreement in whole or in part to a Cigna Affiliate or may delegate any and all of its duties to a third party in the ordinary course of business.

6.8 Sale of Business/Change in Management.
If, during the term of this Agreement, Provider desires (i) to sell, transfer or convey its business or any substantial portion of its business assets to another entity, whether through a stock or asset transaction, or (ii) enter into a management contract with another entity, Provider shall so advise Cigna in writing at least 120 days prior to the sale, transfer or contract effective date. Provider warrants and covenants that this Agreement will be part of the transfer, and will be assumed by the new entity and that the new entity will honor and be fully bound by the terms and conditions of this Agreement unless the new entity already has an agreement with Cigna or a Cigna Affiliate, in which case Cigna, in its sole discretion, will determine which Agreement will prevail. Notwithstanding the above, if Cigna, in its sole discretion, is of the opinion that the Agreement cannot be satisfactorily performed by the assuming entity or does not want to do business with that entity for whatever reason, Cigna may terminate this Agreement by giving Provider 60 days written notice, notwithstanding any other provision in the Agreement.

6.9 Use of Name.

Provider agrees that Cigna may include descriptive information about Provider in literature distributed to existing or potential Participants, Participating Providers and Payors. That information will include, but not be limited to, Provider's name, telephone number, address, and specialties. Provider may identify itself as a Participating Provider with respect to those Benefit Plan types in which Provider participates with Cigna. Provider's use of Cigna's name or a Cigna Affiliate's name, or any other use of Provider's name by Cigna will be upon prior written approval or as the parties may agree.

6.10 Notices.

Any notice required under this Agreement must be in writing and sent by United States mail, postage prepaid, to Cigna and Provider at the addresses below. Cigna may also notify Provider by sending an electronic notice with automatic receipt verification to Provider's e-mail address below. Either party can change the address for notices by giving written notice of the change to the other party in the manner just described.

6.11 Governing Law/Regulatory Addenda.

Applicable federal law and the law of the jurisdiction where Provider is domiciled governs this Agreement. One or more regulatory addenda may be attached to the Agreement setting out provisions that are required by law with respect to Covered Services rendered to certain Participants (i.e. Participants under an insured plan). These provisions are incorporated into this Agreement to the extent required by law and as specified in such Addenda.

6.12 Waiver of Breach/Severability/Entire Agreement/Copy of Original Agreement. If any party waives a breach of any provision of this Agreement, it will not operate as a waiver of any subsequent breach. If any portion of this Agreement is unenforceable for any reason, it will not affect the enforceability of any remaining portions. This Agreement, including any exhibits to this Agreement, contains all of the terms and conditions agreed upon and supersedes all other agreements between the parties, either oral or in writing, regarding the subject matter. A copy of this fully executed Agreement is an acceptable substitute for the original fully executed Agreement.

AGREED AND ACCEPTED BY:

_____
Address: _____

_____
Email Address: _____

By: _____

Printed Name: _____

Title: _____

Date Signed: _____
Federal Tax ID: _____
National Provider Identifier: _____

Cigna HealthCare of Arizona, Inc.
Address: 11001 N. Black Canyon Hwy.
Phoenix, AZ 85029

Attention: AVP of Provider Contracting

By: _____

Printed Name: _____

Title: _____

Date Signed: _____

ANCILLIARY SERVICES AGREEMENT DETERMINATION

Re: Ancillary Services Agreement to working to expand our network of insurance company payers, while at the same time, Cigna is working to expand their network of providers in Cochise County; between the Cochise Health & Social Services, Cigna Healthcare of Arizona, Inc.

The attached agreement, which is an agreement between public agencies, has been reviewed pursuant to A.R.S. §11-952 on behalf of the Cochise Health & Social Services by the undersigned Deputy County Attorney who has determined that it is in proper form and is within the powers and authority granted under the laws of the State of Arizona.

Approved as to form this 11th day of April, 2013.

EDWARD G. RHEINHEIMER
Cochise County Attorney

By: _____
Terry Bannon
Deputy County Attorney

ADDENDUM TO ANCILLARY AGREEMENT FOR THE STATE OF ARIZONA

The provisions set forth in this Addendum are being added to the Agreement to comply with legislative and regulatory requirements of the State of Arizona regarding provider contracts with providers rendering health care services in the State of Arizona. To the extent that such Arizona laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

1. The Overpayments provision of the Agreement is amended to add the following sentence:

   In the case of a non-Medicare HMO plan offered by Cigna or an insured plan offered by a Cigna Affiliate, and except in cases of fraud, Cigna will adjust or request adjustment of the payment of a claim within one year after the date Cigna has paid the claim, unless the parties agree to a mutually applicable longer period of time.

2. The Underpayments provision of the Agreement is hereby deleted and replaced with the following:

   The following applies in the event that Provider believes Provider has been underpaid for a Covered Service. In the case of a non-Medicare HMO plan offered by Cigna or an insured plan offered by a Cigna Affiliate, and except in cases of fraud, Provider must submit a written request for an appeal or adjustment with Cigna or its designee within one year from the date of Cigna's payment or explanation of payment, unless the parties agree to a mutually applicable longer period of time. In the case of a self-insured plan administered by a Cigna Affiliate, Provider must submit a written request for an appeal or adjustment with Cigna or its designee within 180 days from the date of Payor's payment or explanation of payment. All requests for appeal or adjustment must be submitted in accordance with Cigna's provider payment appeal process set forth in the Administrative Guidelines. Requests for appeals or adjustments submitted after the date specified may be denied for payment, and Provider will not be permitted to bill Cigna, Payor or the Participant for those services for which payment was denied.

3. In the event of Cigna's insolvency, Provider shall continue to provide Covered Services to Participants covered under an HMO Benefit Plan at the same rates and subject to the same terms and conditions established in the Agreement, until the earliest of the following:

a. The expiration of Participant's contract period or 60 days from the date insolvency is declared, whichever is later.

b. The date the receiver notifies the court and Participating Providers of the receiver's determination that Cigna's plan for the risk of insolvency is inadequate to pay the costs of continuation of benefits for the period described in subsection a., above.

c. A determination by the court that Cigna is either unable to pay, or unable to provide adequate assurance that it will be able to pay, Participating Providers' claims for Covered Services that were rendered to Participants after Cigna is declared insolvent.

d. A determination by the court that continuation of the Agreement would constitute undue hardship to Provider.

e. A determination by the court that Cigna has satisfied its obligations to all Participants under its HMO Benefit Plans.

Cigna HealthCare

Exhibit C _____

This Rate Exhibit applies to the following Cigna HealthCare Benefit Plan Families:
Medicare Advantage Benefit Plan Family: No
HMO Benefit Plan Family: Yes
Network Benefit Plan Family: Yes
Open Access Plus Benefit Plan Family: Yes
All Other: Yes

This is an Exhibit to an Agreement between:
Provider: _____
Cigna Party: Cigna HealthCare of Arizona, Inc.
Effective Date: _____
This Rate Exhibit:
Applies to: _____
Federal Tax ID: _____
National Provider Identifier: _____
Effective Date: _____

I. DEFINITIONS

Cigna Standard Fee Schedule means the standard Cigna fee schedule in effect at the time of service and applicable to this Agreement for certain Covered Services provided to Participants. The Cigna Standard Fee Schedule is subject to change. For workers' compensation Benefit Plans, the Cigna Standard Fee Schedule shall not exceed the state fee schedule.

II. FEE FOR SERVICE REIMBURSEMENT

Covered Services will be reimbursed at the lesser of billed charges or the applicable fee under the Cigna Standard Fee Schedule, less applicable Copayments, Deductibles and Coinsurance.