

PRESALE REQUEST FORM

Today's Date Payer Name Submitted by Phone #

RFP Due Date Payer Sales Contact Name Phone #

Client Effective Date Client Name Client Headquarters Location

Street Address City State Zip

Total EE Count Total EE on Plan Nature of Business (SIC code) Situs State

Self-Funded Yes No Retirees Covered Yes No Is Payer the Incumbent Administrator Yes No

Current Administrator Current Medical Network Current PBM

Current Dental Network Current Reinsurer

Broker Name Brokerage Firm Name

Broker SSN/TIN: Brokerage Firm SSN/TIN:

Broker Mailing Address:

Broker Phone #:

Broker e-mail:

Please answer the following questions for all Medical Network requests:

1. What is the Lifetime Maximum? \$
2. Is Cigna's Network the sole network being offered to the client? Yes No
3. Is the client a health care professional - e.g., Health System, Hospital, Facility, Provider? Yes No
4. Does the benefit plan have any of the following:
 - a. Scheduled Benefit Plan - also known as a tiered benefit plan with 3 or more tiers? Yes No
 - b. Client Specific Network - e.g., employer has a specific contract with a local hospital or health system? Yes No
 - c. A minimum of 70% in-network coinsurance on all services? Yes No
 - d. A minimum of 10% benefit differential between in- and out-of-network coinsurance on all services? Yes No
5. Is the group domiciled and/or have over 50% of membership in the Alliance Networks service area [Health Alliance Plan (MI), Health Partners (MN, WI, and ND), MVP (NY)]? Yes No

Together, all the way.®



Offered by: Cigna Health and Life Insurance Company.

6. Is this a tribal organization? Yes No
 If Yes, what percentage of the membership is tribal?
7. Is the group requesting an exception to using the Cigna LifeSOURCE Transplant Network® (required with medical coverage)? Yes No
 If Yes, please explain (for groups with a fully insured transplant policy, please indicate carrier and provide Cigna with a copy of the policy).
8. Is this group classified as a Trust, Professional Employer Organization (PEO), Multiple Employer Welfare Arrangement (MEWA), or Captive? Yes No
 If yes, please explain
9. Is this group composed of multiple separate/unaffiliated companies Yes No
10. Is this group composed of Student business Yes No

Please select all requested PreSale analytics below (standard turn-around times noted):

Network:

Select Network:

- Geo Access (4 business days)
- CPT Analysis (4 business days)
- Discount Analysis (3-digit zip) (4 business days)
- Disruption (5 business days)
- Repricing (7 business days)
- RFP (10 business days)

Pharmacy:

Disruption

Network

- National (7 business days)
- Cigna 90 Now (7 business days)
- National without Walgreens (7 business days)
- National without CVS (7 business days)
- National without Walgreens and CVS (7 business days)

Formulary

- Advantage (7 business days)
- Performance (7 business days)

Repricing

Network

- National (7 business days)
- Cigna 90 Now (7 business days)
- National without Walgreens (7 business days)
- National without CVS (7 business days)
- National without Walgreens and CVS (7 business days)

Formulary

- Advantage (7 business days)
- Performance (7 business days)
- RFP (10 business days)

Dental:

Dental NAF Option

- Geo Access (4 business days)
- Disruption (5 business days)
- Repricing (10 business days)
- RFP (10 business days)

Cigna Care Network (CCN):

- Geo Access (4 business days)
- Disruption:
 - CCN - 18 (18 Specialties) (7 business days)
 - CCN - 21 (18 Specialties + 3 Primary Care) (7 business days)

Stop Loss:

- Individual (Specific) and Aggregate (7 business days)
- Individual (Specific) Only (7 business days)

Employee Assistance Program (EAP):

- Telephone Only (TEL) (5 business days)
- 1 - 3 Face-to-Face (FTF) (5 business days)
- Other/Special Instructions:

PRESALE REQUEST FORM – STOP LOSS ADDENDUM

Please answer the following questions for Cigna Stop Loss.

Proposed effective date:

Census submitted (required): Yes No

(Census to ideally include: Date of birth/age, employee home zip code, gender, family status and opt-out status.)

Group location(s):

(Please include all locations and indicate number of employees at each location.)

Current plan description and proposed plan design submitted: Yes No

(Current schedule of benefits required; if multiple plan options are provided, please include the number of employees/members assumed in each plan.)

Current Stop Loss carrier:

Network quoted: PPO OAP

Contract options to be quoted: ISL ASL

Incurred Contract (12/36):

Paid Contract:

12/12* (first year only):

Run-In 15/12:

Run-In 18/12:

Run-Out (Terminal Liability) 12/15:

Run-Out (Terminal Liability) 12/18:

*12/12 contract not offered for renewals

Contract option requests not shown above:

Plan changes in the last 2 years: Yes No

If Yes, please describe:

Is infertility treatment covered? Yes No

Is MH/SA covered? Yes No

If currently self-funded, current and renewal Individual (Specific) rates and aggregate factors:

If currently fully insured, current and renewal rates:

Coverages to be quoted: Individual (Specific) only Individual (Specific) and Aggregate

Maximum reimbursement:

(Unlimited lifetime max for Individual (Specific); maximum of \$2 million for Aggregate)

Covered expenses:

Individual (Specific): Medical Medical and Rx

Aggregate: (check all that apply) Medical Rx Dental Vision

Individual (Specific) deductible:

(Subject to state minimums.)

For hospital groups: % domestic reimbursement % foreign reimbursement

Aggregate corridor: 120% 125%

Commission level:

Comments/Special instructions:

Individual (Specific) Data: (please indicate that required data has been submitted)

Large Claim Information:

Preferred: Minimum of 9-24 months in open policy period Yes No

Basic: 6 months in open policy period Yes No

Rx: If quoting Medical and Rx, Rx claims must be included with large Claim reports

Rx included Yes No

Large Claim Report Data Requirements:

Preferred: Claim total, diagnosis, dates of service, clinical information, case management notes, treatment plan, projected costs, projected costs, facility/location of services Yes No

Basic: Claim total and diagnosis Yes No

Omitted data:

Aggregate Data (please indicate that required data has been submitted)

Preferred: Monthly claims and enrollment on a recent 21- to 24-month period Yes No

Basic: Monthly claims and enrollment on a recent 12-month period Yes No

Rx: If quoting Medical and Rx, monthly Rx claims must be included on aggregate reports

Rx included: Yes No

Note: Please provide the large claim amounts for the same time period as the monthly experience.

PLEASE SUBMIT REQUEST TO: PS_Sales@Cigna.com

All non-standard product requests must be submitted via the **Exception Gateway** prior to requesting analytics.



Cigna Payer Solutions Stop Loss Insurance Policies, underwritten, issued and insured by Cigna Health and Life Insurance Company, are administered by Medical Risk Managers, Inc.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.

896835 b 02/17 © 2017 Cigna. Some content provided under license.