Cigna Payer Solutions

CLEAR FORM

PRESALE REQUEST FORM

Today's Date | Payer Name | Submitted by Collective Health | 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.®

Cigna®

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: PPO

- 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.