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| --- | --- |
| **MEDICAL/RX PLANS** | |
| **Benefit Field** | **Field Notes** |
| Plan Type Options: [PPO, POS, HMO, EPO, HDHP] | HDHP can only be selected if plan is a qualified HDHP plan |
| In-Network Individual Deductible | Enter annual deductible amount.  For medical, input 0, if there is no deductible.  For Rx-only, leave fields blank, if there is no Rx deductible/carve out. |
| In-Network Family Deductible |
| Out-of-Network Individual Deductible |
| Out-of-Network Family Deductible |
| Rx Only Individual Deductible |
| Rx Only Family Deductible |
| In-Network Individual Out-of-Pocket Maximum | Enter annual out of pocket maximum, which represents the maximum amount employee will pay in the plan year. Includes deductible, coinsurance, and copays.  For Rx-only, leave fields blank, if there is no Rx OOP max/carve out. |
| In-Network Family Out-of-Pocket Maximum |
| Out-of-Network Individual Out-of-Pocket Maximum |
| Out-of-Network Family Out-of-Pocket Maximum |
| Rx Only Individual Out-of-Pocket Maximum |
| Rx Only Family Out-of-Pocket Maximum |
| In-Network Coinsurance | Input the employee's coinsurance amount, not the carrier's amount. |
| Out-of-Network Coinsurance |
| Rx Only Coinsurance |
| Does the Deductible Accumulate Across In/Out Network | Check box if cost share accumulates across in and out of network. |
| Does the Maximum Out of Pocket Accumulate Across In/Out Network |
| Does Deductible and/or Coinsurance Apply to Primary Care Physician Cost Share | Does the Deductible Apply? Option 1: "No Deductible" Option 2: "No Deductible, and Coinsurance" Option 3: "Deductible" Option 4: "Deductible, then Coinsurance"  If the employee is also responsible for a copay, input the copay amount in the appropriate field. |
| Does Deductible and/or Coinsurance Apply to Specialist Cost Share |
| Does Deductible and/or Coinsurance Apply to Emergency Room Cost Share |
| Does Deductible and/or Coinsurance Apply to Urgent Care Cost Share |
| Does Deductible and/or Coinsurance Apply to Lab & Xray Cost Share |
| Does Deductible and/or Coinsurance Apply to Inpatient Cost Share |
| Does Deductible and/or Coinsurance Apply to Outpatient Cost Share |
| Does Deductible and/or Coinsurance Apply to Rx Tier 1 / Generic Cost Share |
| Does Deductible and/or Coinsurance Apply to Rx Tier 2 / Preferred Brand Cost Share |
| Does Deductible and/or Coinsurance Apply to Rx Tier 3 / Non-Preferred Brand Cost Share |
| Does Deductible and/or Coinsurance Apply to Rx Tier 4 / Specialty Cost Share |
| Primary Care Physician Copay | Enter the copay amount, if applicable.  Leave blank, if the cost share only includes the deductible and/or coinsurance. |
| Specialist Copay |
| Emergency Room Copay |
| Urgent Care Copay |
| Lab & Xray Copay |
| Inpatient Copay |
| Outpatient Copay |
| Rx Tier 1 / Generic 30 Day Retail Copay |
| Rx Tier 2 / Preferred Brand 30 Day Retail Copay |
| Rx Tier 3 / Non-Preferred Brand 30 Day Retail Copay |
| Rx Tier 4 / Specialty 30 Day Retail Copay |
| Rx Tier 1 / Generic 90 Day Mail Copay |
| Rx Tier 2 / Preferred Brand 90 Day Mail Copay |
| Rx Tier 3 / Non-Preferred Brand 90 Day Mail Copay |
| Rx Tier 4 / Specialty 90 Day Mail Copay |
| Annual Employee Contribution Amount for Single Employees | Enter annual employee contributions. Rates must be converted into standard 4 tier rates. Do not include surcharges, that is accounted for in a different section. |
| Annual Employee Contribution Amount for EE & Spouse Employees |
| Annual Employee Contribution Amount for EE & Children Employees |
| Annual Employee Contribution Amount for Family Employees |
| Annual Gross Cost Amount for Single Employees | Enter annual total gross premium or premium equivalent rates. Rates must be converted into standard 4 tier rates. |
| Annual Gross Cost Amount for EE & Spouse Employees |
| Annual Gross Cost Amount for EE & Children Employees |
| Annual Gross Cost Amount for Family Employees |
| Are Gross Premium Rates Age Banded? | Check box is gross rates are based on age-banding. |
| Is a HRA Offered With Plan? | Check box if pre-tax healthcare accounts are offered along-side the current Medical/Rx Plan. |
| Is a HSA Offered With Plan? |
| Annual Employer-Provided CDHP Funding Amount for Single Employees | Enter annual funding amount, if HSA or HRA is offered.   HRA funding can be based on Max Funding or Actual Utilization. |
| Annual Employer-Provided CDHP Funding Amount for EE & Spouse Employees |
| Annual Employer-Provided CDHP Funding Amount for EE & Children Employees |
| Annual Employer-Provided CDHP Funding Amount for Family Employees |
|  |  |
| **DENTAL PLANS** | |
| **Benefit Field** | **Field Notes** |
| Plan Type Options: [DPPO, DHMO] | DHMO plans do not allow out of network benefits. |
| In-Network Individual Deductible | Enter annual deductible amount.  Input 0, if there is no deductible. |
| In-Network Family Deductible |
| Out-of-Network Individual Deductible |
| Out-of-Network Family Deductible |
| In-Network Maximum Benefit Per Person | Enter annual maximum benefit amount (maximum amount carrier pays). |
| In-Network Maximum Benefit Per Person for Orthodontia |
| Out-of-Network Maximum Benefit Per Person |
| Out-of-Network Maximum Benefit Per Person for Orthodontia |
| Preventive Care In-Network Coinsurance | Input the employee's coinsurance amount, not the carrier's amount.Copays are not tracked for dental plans. |
| Preventive Care Out-of-Network Coinsurance |
| Basic Care In-Network Coinsurance |
| Basic Care Out-of-Network Coinsurance |
| Major Care In-Network Coinsurance |
| Major Care Out-of-Network Coinsurance |
| Orthodontia Care In-Network Coinsurance |
| Orthodontia Care Out-of-Network Coinsurance |
| Does Deductible Apply to Preventive Care | Does the Deductible Apply? Option 1: "No Deductible" Option 2: "Deductible" |
| Does Deductible Apply to Basic Care |
| Does Deductible Apply to Major Care |
| Does Deductible Apply to Orthodontia Care |
| Orthodontia Age Limit | Enter age limit, if applicable. |
| Annual Employee Contribution Amount for Single Employees | Enter annual employee contributions. Rates must be converted into standard 4 tier rates. |
| Annual Employee Contribution Amount for EE & Spouse Employees |
| Annual Employee Contribution Amount for EE & Children Employees |
| Annual Employee Contribution Amount for Family Employees |
| Annual Gross Cost Amount for Single Employees | Enter annual total gross premium or premium equivalent rates. Rates must be converted into standard 4 tier rates. |
| Annual Gross Cost Amount for EE & Spouse Employees |
| Annual Gross Cost Amount for EE & Children Employees |
| Annual Gross Cost Amount for Family Employees |
|  |  |
| **VISION PLANS** | |
| **Benefit Field** | **Field Notes** |
| Exam Monthly Frequency | Each benefit has a separate “renewal” period that requires the employee to wait a specific amount of months before they can use the benefit again. Figures must be provided on a monthly basis. |
| Lenses Monthly Frequency |
| Frames Monthly Frequency |
| Elective Contacts Monthly Frequency |
| Exam Copay Amount | Enter the copay amount, if applicable. |
| Lenses Copay Amount |
| Frames Copay Amount |
| Elective Contacts Copay Amount |
| Exam Annual Allowance | Enter the in network allowance, if applicable. |
| Lenses Annual Allowance |
| Frames Annual Allowance |
| Elective Contacts Annual Allowance |
| Out of Network Exam Annual Allowance | Enter the out of network allowance, if applicable. |
| Out of Network Lenses Annual Allowance |
| Out of Network Frames Annual Allowance |
| Out of Network Elective Contacts Annual Allowance |
| Annual Employee Contribution Amount for Single Employees | Enter annual employee contributions. Rates must be converted into standard 4 tier rates. |
| Annual Employee Contribution Amount for EE & Spouse Employees |
| Annual Employee Contribution Amount for EE & Children Employees |
| Annual Employee Contribution Amount for Family Employees |
| Annual Gross Cost Amount for Single Employees | Enter annual total gross premium or premium equivalent rates. Rates must be converted into standard 4 tier rates. |
| Annual Gross Cost Amount for EE & Spouse Employees |
| Annual Gross Cost Amount for EE & Children Employees |
| Annual Gross Cost Amount for Family Employees |
|  |  |
| **LIFE PLANS** | |
| **Benefit Field** | **Field Notes** |
| Plan Type Options: [Multiple of Salary, Flat Amount] | Select the correct group term life plan type/structure |
| Salary Factor | Only input for Multiple of Salary plans |
| Maximum Benefit Amount |
| Flat Amount | Only input for Flat Amount plans |
| Does Plan Include AD&D Coverage | Check box if AD&D is included |
| Gross Premium Cost Share Options: [100% Employer Paid, Employee Cost Share] | Do employees share some of the premium cost? Voluntary plans are not allowed |
|  |  |
| **STD PLANS** | |
| **Benefit Field** | **Field Notes** |
| Salary Continuation | Is plan based on employer salary continuation? |
| Injury Waiting Days | Injury disability waiting days before benefits are paid |
| Sick Waiting Days | Sick disability waiting days before benefits are paid |
| Duration Weeks | Disability benefit duration weeks |
| Benefit Percentage | The percentage of employee income used for disability |
| Maximum Amount | The maximum amount employees receive each week |
| Gross Premium Cost Share Options: [100% Employer Paid, Employee Cost Share] | Do employees share some of the premium cost? Voluntary plans are not allowed |
|  |  |
| **LTD PLANS** | |
| **Benefit Field** | **Field Notes** |
| Waiting Weeks | Disability waiting weeks before benefits are paid |
| Benefit Percentage | The percentage of employee income used for disability |
| Maximum Amount | The maximum amount employees receive each month |
| Gross Premium Cost Share Options: [100% Employer Paid, Employee Cost Share] | Do employees share some of the premium cost? Voluntary plans are not allowed |

**Frequently Asked Questions (FAQs)**

**FAQ#1: What are ruling surrounding data integrity across the various regions?**

In order to ensure strict data integrity, [Bnchmrk.com](https://urldefense.proofpoint.com/v2/url?u=http-3A__Bnchmrk.com&d=DwMGaQ&c=TpNN6HvgTmJVd5yKTlfUHw&r=uPQAxgw-EfcksL392baITA&m=6NyNeM-nAp8sCGg-lC-cV58ZWBLctQx3pAdt980zKn0&s=koR_p2sHGfrNRPia_R3EFWTskNaHXQdYMVqD_2PibJk&e=) has connected (since launch) our BenIQ ruleset to the HR Tech platform. This forces users across all regions to comply with data standards and is enforced at the point where the data is submitted from HRTech to our site.

All data points must pass BenIQ rules in order to be saved into the database; if not, the user receives various error messages detailing any and all rule violations.  So while the HR Tech forms present all fields, the data will not be blindly accepted.

The rules include:

* “Natural laws” (e.g. the employee contributions cannot be greater than gross premiums)
* Benefit laws (e.g. HMO plans cannot have out of network benefits)
* Government laws (i.g. HSA funding limits)
* Additionally, BenIQ has pseudo-A.I. rules that prevent users from inputting monthly or bi-weekly rates into the system (as opposed to annual rates) by employing minimum and maximum limits. Monthly gross premiums are detected and the user is presented with a minimum annual amount to correct the issue.

**FAQ#2: How do you enter benchmarking data for employee contribution salary banding vs. benefit classes?**

For salary banded employee contribution plans, users should be inputting a single plan and blend the employee contributions into a single set of (composite) rates. Best practice here would be to utilize one of the following methods:

1. Select the band with the greatest enrollment and use those rates; equivalent to selecting the band with the median salary (*recommended*)
2. Calculate the average contribution per enrollment tier (*also accurate, but the most data intensive*)

For plans with benefit classes, the user should create separate benefit plans for each class. Our reasoning here is that the benefit classes truly represent separate plan offerings, they are just bound together on the same policy for accounting and administrative purposes (but this does not correlate with benchmarking). We do ask that the user provides separate names for each plan/class that accurately describes the underlying population; however, there is no standard naming convention in place for classes.

**FAQ#3:** **How should we account for salary-banded employee contributions?  Take an average of all tiers?  Create a plan for each tier?  This would apply to medical/dental/vision?**

 See response to FAQ#2

**FAQ#4: How do I enter premiums values when they are different and based upon the employee’s age?**

First, check the box next to "Age Rated” (located in the Premiums section under the Plan tab) to identify the plan properly. Then, there are two options:

1. Calculate standard 4 tier composite Gross Rates by selecting the single rate associated with the median age of eligible employees and then multiplying it by the member slopes, we recommend the following slopes:
   * Employee: 1
   * Employee + Spouse: 2.28
   * Employee + Child(ren): 1.87
   * Family: 3.06

OR

1. If this calculation is not feasible, you can just leave the rates blank (field requirements get overridden when "Age Rate” check box is selected)

**FAQ#5:** **For HRA funding where applicable, we need to decide if we want it based on max funding or actual utilization.  If people choose, it will be reported differently group to group?**

Users should input the amount based on Utilization, not Maximum; however there have been reports that that data was not available, so Maximums were entered in its absence.

**FAQ#6: We ask whether it’s a DMO or PPO dental plan but all of the fields are based on a PPO plan design.  DMO’s are typically copay based per service and don’t have deductibles/coinsurance/maximums the way PPO plans do.  If we don’t want any of the DMO plan design details we should just indicate to leave all of the fields blank.**

We don’t track copays for dental (DMOs) because the variation and quantity of copays in the schedule of benefits render benchmarking useless. When entering DMO plans, users should leave the fields blank that do not apply and BenIQ will enforce the rules.

**FAQ#7: How do we account for different classes of benefits at a group, for example, with group life plans?  Create a new plan per class?  Also would apply to LTD and STD plans?**

For plans with benefit classes, the user should create separate benefit plans for each class. Our reasoning here is that the benefit classes truly represent separate plan offerings, they are just bound together on the same policy for accounting and administrative purposes (but this does not correlate with benchmarking). We do ask that the user provides separate names for each plan/class that accurately describes the underlying population; however, there is no standard naming convention in place for classes.

**FAQ#8: It appears the benchmarking application only has placeholders to update employer paid life fields? What about employee paid fields?**

Voluntary Life, STD and LTD plans should not be included in the benchmarking section of HR Tech (BenIQ will try to detect voluntary plans and ask the user not to submit). We only want "100% employer paid" plans or “employer cost share” plans, where the employer is contribution some of the premium (e.g. core-buy up plans).

**FAQ#9: What does the field “is plan based on employer salary continuation” represent?  Are we asking if disability checks are cut to the employer vs. employee or if the employer is self-insuring a salary continuation plan?  Or if salary continuation is an offset?**

We are asking if the employer is self-insuring a salary continuation plan

**FAQ#10: For life/LTD/STD we say voluntary plans “are not allowed” so is that meant to exclude 100% employee paid group LTD and STD or tax-choice plans?**

Correct - 100% employee paid plans are not allowed

**FAQ#11: LTD elimination periods are measured in days, but the field asks for it in weeks. How does one handle this scenario?**

In order to fit the benefit model, we ask the user to convert the day figure to weeks and round the result

**FAQ#12: What would the process be to convert 2 or 3 tier contributions to 4 tier (the guide notes they must be contributed to 4 tier)? That is a pretty big step that will require additional communication with both analytics and the carriers, and is a big to-do for groups not actually asking to see that as an option during renewal. It also seems like a lost benchmark opportunity to not capture how many of our clients are 2 vs. 3 vs. 4 tiered.)**

Here is our recommended/best practice for inputing 2/3//5 tier rates:

• 2 Tiers: Employee Only and Family - Apply the Family rate to the Employee + Spouse (Tier 2) and Employee + Children (Tier 3) rates

• 3 Tiers: Employee Only, Employee + One, and Family - Apply the Employee + One rate to the Employee + Spouse (Tier 2) and Employee + Children (Tier 3) rates

• 5+ Tiers - Use averages of two (or more) tiers in order to reduce the number of rates.

Our software can figure out if the plan is 2 or 3 tier rates by comparing each tier and determine how many distinct values are there.

**FAQ#13: For medical plans, what if plan is a tiered network?**

If the plan is a tiered network, the user ultimately must select one of the tiers to represent the in-network cost share and there is a bit of subjectivity when making that selection. We highly recommend that the user selects the highest performance network (assuming it is large enough to drive meaningful utilization and covers enough services/providers, unlike some limited internal hospital plans). We try to enforce this as much as possible, but our BenIQ rules cannot strictly enforce this.

**FAQ#14: For dental plans, what happens if it’s a tiered INN plan? I’m thinking of Cigna’s Dental plan that has the DPPO Advantage vs. DPPO INN. Do we just go with the DPPO Advantage?**

Yes. This is our recommended best practice (in line with our recommendation to use higher network for medical) and try to enforce it when we see Advantage plans.

**FAQ#15: On the Client Strategy Questionnaire, what value ought to be entered for the Tobacco Surcharge Annual Amount field when you check the Do You Surcharge for Tobacco Use field?**

Tobacco Surcharge amounts must be entered on an annualized, composite (PEPY) basis. If the surcharge varies by membership tier, please use one of the following options to convert to a composite rate:

1. Use the tier with the greatest enrollment (recommended and requires the least amount of time)
2. Divide the total annual tobacco surcharge collected by the total number of employees with an imposed surcharge

**FAQ#16: For the CDHP funding question – is this only for HSA or would you add HRA information here?**

You can put either HRA or HSA funding in the CDHP funding section. The bnchmrk application will tie the funding to the account selected (via the check boxes at the bottom of the Questionnaire form).

**FAQ#17:** **Most of our clients also have a 6-Tier Rx program. The Benchmark program only tracks up to Tier-4.   How do we effectively show all 6 tiers?**

While it varies by carrier, the typical 6 tier Rx would map to our 4 tier Rx by consolidating the "Preferred generic” and “Generic” tiers (either by taking just the most utilized of the two or take the average), and then you can use the rest in the following chart:

|  |  |  |
| --- | --- | --- |
| 6 - TIER SAMPLE NAMES | 4 - TIER MAP | MAP GUIDE |
| Preferred generic - Tier 1 | Tier 1 | Use average or most utilized |
| Generic - Tier 2 | Tier 1 | Use average or most utilized |
| Preferred brand - Tier 3 | Tier 2 | Direct map |
| Nonpreferred drug - Tier 4 | Tier 3 | Direct map |
| Specialty - Tier 5 | Tier 4 | Direct map |
| Select care - Tier 6 | N/A | Not covered |

**FAQ#18:** **We have a client that has an Out Of Network deductible on a per member basis, rather than an OON family deductible. How do we show this?**

In order to estimate the family deductible, apply the same single to family ratio for the In Network benefit (e.g. 3x) to the OON individual member amount (e.g. 3 x 4,000 = 12,000). This will produce the best comparison analysis for your clients.

**FAQ#19: We have a client with a first dollar plan ($0 deductible). For the Copay Requirements, how do you want us to show this? Technically nothing “tracks towards the deductible” since there is no deductible?**

Enter the copay amount and the select False for the deductible dropdown. The application will understand that the benefit requires only the copay.

**FAQ#20: What do we enter for the pretax questions for a 100% employer paid benefit?**

The questions on "100% employer paid" and pretax do not have any cross dependencies for benchmarking purposes. When we ask about "100% employer paid”, we just need to know if the employee is funding any portion of the benefit and therefore, making it less competitive.

**FAQ#21: For benefits with a multiyear rate guarantee, do we do as 1 year and constantly renew, or do we just enter the dates per the guarantee?**

For multiyear rate guarantee, please add it as a 1 year plan and then renew it as-is, until guarantee is up or the benefit is moved/changed.  
  
**FAQ #22: The inpatient hospital benefit line asks for a copay amount and it also asks if the inpatient benefit is a copay per day.  If the benefit is a copay per day, I interpret this to mean the copay per day should be entered in the copay field (not the copay per day x the max number of days) and the box for “per day” should be checked.  Do you agree?**

Correct. The Bnchmrk algorithm will attempt to true up the benefits for comparison purposes.

**FAQ #23 If the plan does not have Rx carved out but does have an additional Rx deductible that applies in addition to the Rx copays, should the Rx deductible section still be omitted?**  
No. If the plan has a separate Rx deductible (as part of a carve out or not), that amount should be entered in the Rx Deductible section.