Benefits Map

ATTACHMENT 4

INSTRUCTIONS AND NOTES ON BENEFIT DOCUMENTATION

1 The purpose of the Benefits Map is to codify the principal elements that define each benefit package offered by the carrier to the Small Group and Individual markets. In most cases, cells have been limited to a pre-determined drop-down menu of selected values to promote uniformity among plan descriptions.

If more than three plans are offered please add additional tabs

2 The term *Cost-Sharing* applies to the mechanism by which member out-of-pocket contribution is determined, according to the type of service being rendered. Basic cost-sharing can be in the form of copayments (i.e. fixed dollar amounts), coinsurance (i.e. a fixed percentage of the cost of services), or front-end deductibles where the member covers 100% of the cost of services up to the defined deductible amount, after which point plan coverage begins. More complex cost-sharing can be in the form of mixed coinsurance and copayments, where minimum and maximum dollar amounts are in place around a base coinsurance amount (e.g. 20% coinsurance with a minimum $15 copayment, or 25% coinsurance with a maximum copayment amount of $300).

3 In some plan designs, reduced cost-sharing is available in the medical coverage if certain preferred facilities are utilized. If this is the case, indicate so by selecting 'Y' (yes) under the column '*Preferred Facility Y or N* ' for the specified service category, and then enter the reduced cost-share ($ or %) in the '*Preferred Facility Copay* ' column beside the 'Y.'

4 For purposes of the Benefits Map, in order to indicate that a certain benefit is **NOT COVERED**, or that the member is in a *Deductible Phase* (as in the case of Rx Coverage with a front-end deductible), the *Member Cost-Share* should reflect COINSURANCE of 100% (i.e. the member pays 100% of the cost).

5 Some plan designs may contain a feature, such as a *Major Medical* rider, which allows the member to submit for reimbursement amounts paid for services rendered by non-participating providers. Some of these riders limit reimbursement to services rendered in Puerto Rico while others include services rendered in the United States. The Benefits Map allows plans to indicate whether they include such a rider, whether or not they cover U.S. services, and whether those services require prior authorization. Typically these riders carry an annual front-end deductible per individual (with a maximum deductible per family covered), followed by cost-sharing based on a defined member coinsurance amount. Often these riders contain a provision which caps member cost-sharing to an annual *Out-of-Pocket Maximum* , defined both at the individual and family contract levels.

6 Plans that cover Dental Services may carry Overall Annual Benefit Limits (*General Annual Limits*) and/or specific *Category Lifetime Limits* (such as for Orthodontia). Please indicate such limits as they may apply in the Dental Coverage section.

7 In the case of Prescription Drug Coverage, plans should indicate which rule applies to the dispensing of brand drugs which have a generic bioequivalent substitution (i.e. Multi-Source Brand Drugs). Select '*Generics Not Mandatory* ' if members are not required to select a generic medication as a first option. Select 'Dispense As Written (D.A.W.)' if the member is required (via a copay penalty) to select generics as a first option, but where such penalty is waived if the physician indicates "Do Not Substitute" on the prescription. Select '$ Penalty + Generic Copay' if members are required to select generics as a first option (regardless of physician indications) or pay a copay penalty (usually the difference in price between the generic and brand versions), plus the amount of the generic copayment. If instead the amount of the penatly is added to the BRAND copay, then select '*$ Penalty + Brand Copay* .'

8 Indicate other features of the Prescription Drug Coverage such as whether Step Therapy and/or Drug Formularies apply, and whether OTC medications are covered, along with the corresponding copay.

9 Since many prescription drug plan designs offer different levels of coverage at different expenditure levels throughout the policy year, the Benefits Map provides for up to three (3) different benefit phases in order to codify such plan designs. For example, a complex plan design may carry a $500 front-end deductible before benefits kick in, later providing benefits at $5 $5 for generics and $15 for brand drugs up until $2,000 in annual expenditures. After that point, the plan design may only cover 50% of the cost of brand drugs, while covering generics with a flat copay of $15. The Benefits Map provides the necessary paramaters to codify this design by indicating 100% coinsurance (no coverage) in *Phase I* from $0 to $500, indicating $5 Generic and $15 Brand in *Phase II* from $500 to $2,000, and finally indicating $15 Generic and 50% coinsurance for Brand in *Phase III* from $2,000 to $99,999. **Note: The limit of $99,999 indicates that the given Rx benefit phase has no limit.**