IFP Benefits Template v1.0

Issuer ID	Product Smart ID	Plan ID	Plan Name	Plan Effective Date	Plan Expiration Date	Product Type
Enter the Issuer ID.	Enter the Product Smart ID.	Enter the Plan ID.	Enter the Plan Name.	Enter the Plan Effective Date.	Enter the Plan Expiration Date.	Enter one of the following Plan Types: Indemnity, PPO, POS, EPO, HMO, or Other/Describe.

HSA-Eligible	Same-Sex Partners	Domestic Partners
Enter Y or N. Enter Y if this plan qualifies as an HSA-Eligible HDHP.	Does this plan allow enrollment of same-sex partners?	Does this plan allow enrollment of domestic partners?

Annual Deductible (IN)	Annual Deductible (OON)	PCP Copay (IN)	PCP Copay (OON)	Coinsurance (IN)	Coinsurance (OON)	Annual Out-of-Pocket Limit (IN)
Enter the Annual In-Network Deductible for this plan.	Enter the Annual Out-of-Network Deductible for this plan.	Enter the In-Network PCP Copay for this plan.	Enter the Out-of-Network PCP Copay for this plan.	Enter the In-Network Coinsurance amount for this plan.	Enter the Out-of-Network Coinsurance amount for this plan.	Enter the In-Network Out-of-Pocket Maximum amount for this plan.

Annual Out-of-Pocket Limit Elements (IN)	Annual Max Benefit (IN)	Primary Care Visit to Treat Injury or Illness (IN)	Primary Care Visit to Treat Injury or Illness (OON)	Primary Care Visit to Treat Injury or Illness Exceptions	Specialist Visit (IN)	Specialist Visit (OON)	Specialist Visit Exceptions
Enter what elements are calculated the for the Annual Out-of-Pocket Limit (IN).	Enter the Annual In-Network Maximum Benefit amount for this plan.	Enter the applicable In-Network amount.	Enter the applicable Out-of-Network amount.	Enter the applicable Limitations or Exceptions.	Enter the applicable In-Network amount.	Enter the applicable Out-of-Network amount.	Enter the applicable Limitations or Exceptions.

Other Practitioner Office Visit (Nurse,Physician Assistant) (IN)	Other Practitioner Office Visit (Nurse,Physician Assistant) (OON)	Other Practitioner Office Visit (Nurse,Physician Assistant) Exceptions	Preventive Care/Screening/Immunization (IN)	Preventive Care/Screening/Immunization (OON)	Preventive Care/Screening/Immunization Exceptions	Diagnostic Test (X-Ray and Lab Work) (IN)	Diagnostic Test (X-Ray and Lab Work) (OON)
Enter the applicable In-Network amount.	Enter the applicable Out-of-Network amount.	Enter the applicable Limitations or Exceptions.	Enter the applicable In-Network amount.	Enter the applicable Out-of-Network amount.	Enter the applicable Limitations or Exceptions.	Enter the applicable In-Network amount.	Enter the applicable Out-of-Network amount.

Diagnostic Test (X-Ray and Lab Work) Exceptions	Imaging (CT/PET Scans, MRIs) -(IN)	Imaging (CT/PET Scans, MRIs) -(OON)	Imaging (CT/PET Scans, MRIs) Exceptions	Generic Drugs	Generic Drugs Exceptions	Preferred Brand Drugs	Preferred Brand Drugs Exceptions	Non-Preferred Brand Drugs
Enter the applicable Limitations or Exceptions.	Enter the applicable In-Network amount.	Enter the applicable Out-of-Network amount.	Enter the applicable Limitations or Exceptions.	Enter the applicable Fixed Cost or Co-Insurance amount.	Enter the applicable Limitations or Exceptions.	Enter the applicable Fixed Cost or Co-Insurance amount.	Enter the applicable Limitations or Exceptions.	Enter the applicable Fixed Cost or Co-Insurance amount.

Non-Preferred Brand Drugs Exceptions	Specialty Drugs	Specialty Drugs Exceptions	Outpatient Facility Fee (e.g., Ambulatory Surgery Center) (IN)	Outpatient Facility Fee (e.g., Ambulatory Surgery Center) (OON)	Outpatient Facility Fee (e.g., Ambulatory Surgery Center) - Exceptions	Outpatient Surgery Physician/Surgical Services (IN)	Outpatient Surgery Physician/Surgical Services (OON)
Enter the applicable Limitations or Exceptions.	Enter the applicable Fixed Cost or Co-Insurance amount.	Enter the applicable Limitations or Exceptions.	Enter the applicable In-Network amount.	Enter the applicable Out-of-Network amount.	Enter the applicable Limitations or Exceptions.	Enter the applicable In-Network amount.	Enter the applicable Out-of-Network amount.

Outpatient Surgery Physician/Surgical Services - Exceptions	Emergency Room Services (IN)	Emergency Room Services (OON)	Emergency Room Services Exceptions	Emergency Transportation/Ambulance (IN)	Emergency Transportation/Ambulance (OON)	Emergency Transportation/ Ambulance Exceptions	Urgent Care (IN)
Enter the applicable Limitations or Exceptions.	Enter the applicable In-Network amount.	Enter the applicable Out-of-Network amount.	Enter the applicable Limitations or Exceptions.	Enter the applicable In-Network amount.	Enter the applicable Out-of-Network amount.	Enter the applicable Limitations or Exceptions.	Enter the applicable In-Network amount.

Urgent Care (OON)	Urgent Care Exceptions	Inpatient Hospital Services (e.g., Hospital Stay) (IN)	Inpatient Hospital Services (e.g., Hospital Stay) (OON)	Inpatient Hospital Services (e.g., Hospital Stay) Exceptions	Inpatient Physician and Surgical Services (IN)	Inpatient Physician and Surgical Services (OON)	Inpatient Physician and Surgical Services Exceptions
Enter the applicable Out-of-Network amount.	Enter the applicable Limitations or Exceptions.	Enter the applicable In-Network amount.	Enter the applicable Out-of-Network amount.	Enter the applicable Limitations or Exceptions.	Enter the applicable In-Network amount.	Enter the applicable Out-of-Network amount.	Enter the applicable Limitations or Exceptions.

Mental/Behavioral Health Outpatient Services (IN)	Mental/Behavioral Health Outpatient Services (OON)	Mental/Behavioral Health Outpatient Services Exceptions	Mental/Behavioral Health Inpatient Services (IN)	Mental/Behavioral Health Inpatient Services (OON)	Mental/Behavioral Health Inpatient Services Exceptions
Enter the applicable In-Network amount.	**Enter the applicable Out-of-Network amount.**	**Enter the applicable Limitations or Exceptions.**	**Enter the applicable In-Network amount.**	**Enter the applicable Out-of-Network amount.**	**Enter the applicable Limitations or Exceptions.**

Substance Abuse Disorder Outpatient Services (IN)	Substance Abuse Disorder Outpatient Services (OON)	Substance Abuse Disorder Outpatient Services Exceptions	Substance Abuse Disorder Inpatient Services (IN)	Substance Abuse Disorder Inpatient Services (OON)	Substance Abuse Disorder Inpatient Services Exceptions	Prenatal and Postnatal Care (IN)
Enter the applicable In-Network amount.	Enter the applicable Out-of-Network amount.	Enter the applicable Limitations or Exceptions.	Enter the applicable In-Network amount.	Enter the applicable Out-of-Network amount.	Enter the applicable Limitations or Exceptions.	Enter the applicable In-Network amount.

Prenatal and Postnatal Care (OON)	Prenatal and Postnatal Care Exceptions	Delivery and All Inpatient Services for Maternity Care (IN)	Delivery and All Inpatient Services for Maternity Care (OON)	Delivery and All Inpatient Services for Maternity Care Exceptions	Home Health Care Services (IN)	Home Health Care Services (OON)	Home Health Care Services Exceptions	Inpatient Rehabilitation Services (IN)
Enter the applicable Out-of-Network amount.	Enter the applicable Limitations or Exceptions.	Enter the applicable In-Network amount.	Enter the applicable Out-of-Network amount.	Enter the applicable Limitations or Exceptions.	Enter the applicable In-Network amount.	Enter the applicable Out-of-Network amount.	Enter the applicable Limitations or Exceptions.	Enter the applicable In-Network amount.

Inpatient Rehabilitation Services (OON)	Inpatient Rehabilitation Services Exceptions	Outpatient Rehabilitation Services (IN)	Outpatient Rehabilitation Services (OON)	Outpatient Rehabilitation Services Exceptions	Habilitation Services	Habilitation Services Exceptions	Skilled Nursing Facility (IN)
Enter the applicable Out-of-Network amount.	Enter the applicable Limitations or Exceptions.	Enter the applicable In-Network amount.	Enter the applicable Out-of-Network amount.	Enter the applicable Limitations or Exceptions.	Enter the applicable amount.	Enter the applicable Limitations or Exceptions.	Enter the applicable In-Network amount.

Skilled Nursing Facility (OON)	Skilled Nursing Facility Exceptions	Durable Medical Equipment (IN)	Durable Medical Equipment (OON)	Durable Medical Equipment Exceptions	Hospice Services (IN)	Hospice Services (OON)	Hospice Services Exceptions	Routine Eye Exam for Children (IN)
Enter the applicable Out-of-Network amount.	Enter the applicable Limitations or Exceptions.	Enter the applicable In-Network amount.	Enter the applicable Out-of-Network amount.	Enter the applicable Limitations or Exceptions.	Enter the applicable In-Network amount.	Enter the applicable Out-of-Network amount.	Enter the applicable Limitations or Exceptions.	Enter the applicable In-Network amount.

Routine Eye Exam for Children (OON)	Routine Eye Exam for Children Exceptions	Eye Glasses for Children (IN)	Eye Glasses for Children (OON)	Eye Glasses for Children Exceptions	Dental Check-Up for Children (IN)	Dental Check-Up for Children (OON)	Dental Check-Up for Children Exceptions	Acupuncture
Enter the applicable Out-of-Network amount.	Enter the applicable Limitations or Exceptions.	Enter the applicable In-Network amount.	Enter the applicable Out-of-Network amount.	Enter the applicable Limitations or Exceptions.	Enter the applicable In-Network amount.	Enter the applicable Out-of-Network amount.	Enter the applicable Limitations or Exceptions.	Select the applicable coverage.

Bariatric Surgery	Non-Emergency Care when Travelling Outside the U.S.	Chiropractic Care	Cosmetic Surgery	Routine Dental Services (Adult)	Hearing Aids	Infertility Treatment	Long-Term/ Custodial Nursing Home Care	Private-Duty Nursing
Select the applicable coverage.	Select the applicable coverage.	Select the applicable coverage.	Select the applicable coverage.	Select the applicable coverage.	Select the applicable coverage.	Select the applicable coverage.	Select the applicable coverage.	Select the applicable coverage.

					Voluntary Co		
					Having a baby (normal c		
Routine Eye Exam (Adult)	Routine Foot Care	Weight Loss Programs	Routine Hearing Tests	Plan Brochure	Deductibles	Co-pays	Co-insurance
Select the applicable coverage.	Select the applicable coverage.	Select the applicable coverage.	Select the applicable coverage.	Enter the Plan Brochure URL.	Enter the dollar amount	Enter the dollar amount	Enter the dollar amount

verage Example Reporting for Deemed Compliance with SBC Requirements						
delivery)		Managing type 2 diabetes (routine maintenance, well-controlled)				
Limits or Exclusions	**Total**	**Deductibles**	**Co-pays**	**Co-insurance**	**Limits or Exclusions**	**Total**
Enter the dollar amount	**Enter the dollar amount**	**Enter the dollar amount**	**Enter the dollar amount**	**Enter the dollar amount**	**Enter the dollar amount**	**Enter the dollar amount**