IFP Benefits Template v5.0

Issuer ID	Product Smart ID	Plan ID	Plan Name	Plan Effective Date	Plan Expiration Date	Product Type	HSA-Eligible	Same-Sex Partners	Domestic Partners	Annual Deductible (IN)	Annual Deductible (OON)	No Deductible	Deductible Exceptions	Other Deductible 1	Other Deductible 1 (IN)
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.	Enter Yes or No. Enter Yes 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?	Enter the Annual In-Network Deductible for this plan.	Enter the Annual Out-of-Network Deductible for this plan.	List the services not subject to the deductible separated by commas.	Lists the services that do not count towards the deductible separated by commas	Enter a service for which there is a seperate deductible	Enter the In-Network Deductible for this service

Collection Control Number(s): 0938-1086; 1545-2229; 1210-0147; and 0938-1146).

Other Deductible 1 (OON)	Other Deductible 2	Other Deductible 2 (IN)	Other Deductible 2 (OON)	Other Deductible 3	Other Deductible 3 (IN)	Other Deductible 3 (OON)	More Deductibles	PCP Copay (IN)	PCP Copay (OON)	Coinsurance (IN)	Coinsurance (OON)	Annual Out-of-Pocket Limit (IN)	Annual Out-of-Pocket Limit (OON)	Annual Out-of-Pocket Limit Elements
Enter the Out-Of-Network Deductible for this service	Enter a service for which there is a seperate deductible	Enter the In-Network Deductible for this service	Enter the Out-Of-Network Deductible for this service	Enter a service for which there is a seperate deductible	Enter the In-Network Deductible for this service	Enter the Out-Of-Network Deductible for this service	If there are additional services that require a separate Deductible select "Yes" otherwise select "No"	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.	Enter the Out-of-Network Out-of-Pocket Maximum amount for this plan.	Enter what elements are calculated the for the Annual Out-of-Pocket Limit.

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Excluded Annual Out-of-Pocket Limit (IN)	Excluded Annual Out-of-Pocket Limit (OON)	Annual Max Benefit (IN)	Is a Referral Required to see a Specialist?	Type of Specialists Requiring a Referral	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	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)
Describe exclusions to the Annual Out-of-Pocket Limit (IN)	**Describe exclusions to the Annual Out-of-Pocket Limit (OON)**	**Enter the Annual In-Network Maximum Benefit amount for this plan.**	**Select "Yes" if a Referral is required to see a specialist otherwise select "No"**	**Enter the specialists by service and indicate if its In or Out of Network (e.g Specialist (IN), Diagnostic X-Ray (OON)) separated by commas**	**Enter the applicable In-Network amount.**	**Enter the applicable Out-of-Network amount.**	**Each limitation or exception should specify dollar amounts, service limitations, and annual maximums if applicable. Language should be formatted as follows "Coverage is limited to $XX/visit and $XXX annual max." or "No coverage for XXXX."**	**Enter the applicable In-Network amount.**	**Enter the applicable Out-of-Network amount.**	**Each limitation or exception should specify dollar amounts, service limitations, and annual maximums if applicable. Language should be formatted as follows "Coverage is limited to $XX/visit and $XXX annual max." or "No coverage for XXXX."**	**Enter the applicable In-Network amount.**	**Enter the applicable Out-of-Network amount.**	**Each limitation or exception should specify dollar amounts, service limitations, and annual maximums if applicable. Language should be formatted as follows "Coverage is limited to $XX/visit and $XXX annual max." or "No coverage for XXXX."**	**Enter the applicable In-Network amount.**	**Enter the applicable Out-of-Network amount.**

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Preventive Care/Screening/Immunization Exceptions	Diagnostic Test (X-Ray and Lab Work) (IN)	Diagnostic Test (X-Ray and Lab Work) (OON)	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 -Retail (IN)	Generic Drugs -Retail (OON)	Generic Drugs -Mail Order (IN)	Generic Drugs -Mail Order (OON)	Generic Drugs Exceptions	Preferred Brand Drugs - Retail (IN)	Preferred Brand Drugs - Retail (OON)	Preferred Brand Drugs - Mail Order (IN)	Preferred Brand Drugs - Mail Order (OON)	Preferred Brand Drugs Exceptions	Non-Preferred Brand Drugs - Retail (IN)	Non-Preferred Brand Drugs - Retail (OON)
Each limitation or exception should specify dollar amounts, service limitations, and annual maximums if applicable. Language should be formatted as follows "Coverage is limited to $XX/visit and $XXX annual max." or "No coverage for XXXX."	Enter the applicable In-Network amount.	Enter the applicable Out-of-Network amount.	Each limitation or exception should specify dollar amounts, service limitations, and annual maximums if applicable. Language should be formatted as follows "Coverage is limited to $XX/visit and $XXX annual max." or "No coverage for XXXX."	Enter the applicable In-Network amount.	Enter the applicable Out-of-Network amount.	Each limitation or exception should specify dollar amounts, service limitations, and annual maximums if applicable. Language should be formatted as follows "Coverage is limited to $XX/visit and $XXX annual max." or "No coverage for XXXX."	Enter the applicable Fixed Cost or Co-Insurance amount.	Enter the applicable Fixed Cost or Co-Insurance amount.	Enter the applicable Fixed Cost or Co-Insurance amount.	Enter the applicable Fixed Cost or Co-Insurance amount.	Each limitation or exception should specify dollar amounts, service limitations, and annual maximums if applicable. Language should be formatted as follows "Coverage is limited to $XX/visit and $XXX annual max." or "No coverage for XXXX."	Enter the applicable Fixed Cost or Co-Insurance amount.	Enter the applicable Fixed Cost or Co-Insurance amount.	Enter the applicable Fixed Cost or Co-Insurance amount.	Enter the applicable Fixed Cost or Co-Insurance amount.	Each limitation or exception should specify dollar amounts, service limitations, and annual maximums if applicable. Language should be formatted as follows "Coverage is limited to $XX/visit and $XXX annual max." or "No coverage for XXXX."	Enter the applicable Fixed Cost or Co-Insurance amount.	Enter the applicable Fixed Cost or Co-Insurance amount.

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Non-Preferred Brand Drugs - Mail Order (IN)	Non-Preferred Brand Drugs - Mail Order (OON)	Non-Preferred Brand Drugs Exceptions	Specialty Drugs - Retail (IN)	Specialty Drugs - Retail (OON)	Specialty Drugs - Mail Order (IN)	Specialty Drugs - Mail Order (OON)	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)	Outpatient Surgery Physician/Surgical Services - Exceptions	Emergency Room Services (IN)	Emergency Room Services (OON)	Emergency Room Services Exceptions	Emergency Transportation/Ambulance (IN)
Enter the applicable Fixed Cost or Co-Insurance amount.	**Enter the applicable Fixed Cost or Co-Insurance amount.**	**Each limitation or exception should specify dollar amounts, service limitations, and annual maximums if applicable. Language should be formatted as follows “Coverage is limited to $XX/visit and $XXX annual max.” or “No coverage for XXXX.”**	**Enter the applicable Fixed Cost or Co-Insurance amount.**	**Enter the applicable Fixed Cost or Co-Insurance amount.**	**Enter the applicable Fixed Cost or Co-Insurance amount.**	**Enter the applicable Fixed Cost or Co-Insurance amount.**	**Each limitation or exception should specify dollar amounts, service limitations, and annual maximums if applicable. Language should be formatted as follows “Coverage is limited to $XX/visit and $XXX annual max.” or “No coverage for XXXX.”**	**Enter the applicable In-Network amount.**	**Enter the applicable Out-of-Network amount.**	**Each limitation or exception should specify dollar amounts, service limitations, and annual maximums if applicable. Language should be formatted as follows “Coverage is limited to $XX/visit and $XXX annual max.” or “No coverage for XXXX.”**	**Enter the applicable In-Network amount.**	**Enter the applicable Out-of-Network amount.**	**Each limitation or exception should specify dollar amounts, service limitations, and annual maximums if applicable. Language should be formatted as follows “Coverage is limited to $XX/visit and $XXX annual max.” or “No coverage for XXXX.”**	**Enter the applicable In-Network amount.**	**Enter the applicable Out-of-Network amount.**	**Each limitation or exception should specify dollar amounts, service limitations, and annual maximums if applicable. Language should be formatted as follows “Coverage is limited to $XX/visit and $XXX annual max.” or “No coverage for XXXX.”**	**Enter the applicable In-Network amount.**

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Emergency Transportation/ Ambulance (OON)	Emergency Transportation/Ambulance Exceptions	Urgent Care (IN)	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	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)
Enter the applicable Out-of-Network amount.	**Each limitation or exception should specify dollar amounts, service limitations, and annual maximums if applicable. Language should be formatted as follows "Coverage is limited to $XX/visit and $XXX annual max." or "No coverage for XXXX."**	**Enter the applicable In-Network amount.**	**Enter the applicable Out-of-Network amount.**	**Each limitation or exception should specify dollar amounts, service limitations, and annual maximums if applicable. Language should be formatted as follows "Coverage is limited to $XX/visit and $XXX annual max." or "No coverage for XXXX."**	**Enter the applicable In-Network amount.**	**Enter the applicable Out-of-Network amount.**	**Each limitation or exception should specify dollar amounts, service limitations, and annual maximums if applicable. Language should be formatted as follows "Coverage is limited to $XX/visit and $XXX annual max." or "No coverage for XXXX."**	**Enter the applicable In-Network amount.**	**Enter the applicable Out-of-Network amount.**	**Each limitation or exception should specify dollar amounts, service limitations, and annual maximums if applicable. Language should be formatted as follows "Coverage is limited to $XX/visit and $XXX annual max." or "No coverage for XXXX."**	**Enter the applicable In-Network amount.**	**Enter the applicable Out-of-Network amount.**	**Each limitation or exception should specify dollar amounts, service limitations, and annual maximums if applicable. Language should be formatted as follows "Coverage is limited to $XX/visit and $XXX annual max." or "No coverage for XXXX."**	**Enter the applicable In-Network amount.**	**Enter the applicable Out-of-Network amount.**

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Mental/Behavioral Health Inpatient Services 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)	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)
Each limitation or exception should specify dollar amounts, service limitations, and annual maximums if applicable. Language should be formatted as follows "Coverage is limited to $XX/visit and $XXX annual max." or "No coverage for XXXX."	**Enter the applicable In-Network amount.**	**Enter the applicable Out-of-Network amount.**	**Each limitation or exception should specify dollar amounts, service limitations, and annual maximums if applicable. Language should be formatted as follows "Coverage is limited to $XX/visit and $XXX annual max." or "No coverage for XXXX."**	**Enter the applicable In-Network amount.**	**Enter the applicable Out-of-Network amount.**	**Each limitation or exception should specify dollar amounts, service limitations, and annual maximums if applicable. Language should be formatted as follows "Coverage is limited to $XX/visit and $XXX annual max." or "No coverage for XXXX."**	**Enter the applicable In-Network amount.**	**Enter the applicable Out-of-Network amount.**	**Each limitation or exception should specify dollar amounts, service limitations, and annual maximums if applicable. Language should be formatted as follows "Coverage is limited to $XX/visit and $XXX annual max." or "No coverage for XXXX."**	**Enter the applicable In-Network amount.**	**Enter the applicable Out-of-Network amount.**	**Each limitation or exception should specify dollar amounts, service limitations, and annual maximums if applicable. Language should be formatted as follows "Coverage is limited to $XX/visit and $XXX annual max." or "No coverage for XXXX."**	**Enter the applicable In-Network amount.**	**Enter the applicable Out-of-Network amount.**	**Each limitation or exception should specify dollar amounts, service limitations, and annual maximums if applicable. Language should be formatted as follows "Coverage is limited to $XX/visit and $XXX annual max." or "No coverage for XXXX."**	**Enter the applicable In-Network amount.**

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Inpatient Rehabilitation Services (OON)	Inpatient Rehabilitation Services Exceptions	Outpatient Rehabilitation Services (IN)	Outpatient Rehabilitation Services (OON)	Outpatient Rehabilitation Services Exceptions	Habilitation Services (IN)	Habilitation Services (OON)	Habilitation Services Exceptions	Skilled Nursing Facility (IN)	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.	**Each limitation or exception should specify dollar amounts, service limitations, and annual maximums if applicable. Language should be formatted as follows "Coverage is limited to $XX/visit and $XXX annual max." or "No coverage for XXXX."**	**Enter the applicable In-Network amount.**	**Enter the applicable Out-of-Network amount.**	**Each limitation or exception should specify dollar amounts, service limitations, and annual maximums if applicable. Language should be formatted as follows "Coverage is limited to $XX/visit and $XXX annual max." or "No coverage for XXXX."**	**Enter the applicable In-Network amount.**	**Enter the applicable Out-of-Network amount.**	**Each limitation or exception should specify dollar amounts, service limitations, and annual maximums if applicable. Language should be formatted as follows "Coverage is limited to $XX/visit and $XXX annual max." or "No coverage for XXXX."**	**Enter the applicable In-Network amount.**	**Enter the applicable Out-of-Network amount.**	**Each limitation or exception should specify dollar amounts, service limitations, and annual maximums if applicable. Language should be formatted as follows "Coverage is limited to $XX/visit and $XXX annual max." or "No coverage for XXXX."**	**Enter the applicable In-Network amount.**	**Enter the applicable Out-of-Network amount.**	**Each limitation or exception should specify dollar amounts, service limitations, and annual maximums if applicable. Language should be formatted as follows "Coverage is limited to $XX/visit and $XXX annual max." or "No coverage for XXXX."**	**Enter the applicable In-Network amount.**	**Enter the applicable Out-of-Network amount.**	**Each limitation or exception should specify dollar amounts, service limitations, and annual maximums if applicable. Language should be formatted as follows "Coverage is limited to $XX/visit and $XXX annual max." or "No coverage for XXXX."**	**Enter the applicable In-Network amount.**

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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	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	Routine Eye Exam (Adult)	Routine Foot Care	Weight Loss Programs
Enter the applicable Out-of-Network amount.	Each limitation or exception should specify dollar amounts, service limitations, and annual maximums if applicable. Language should be formatted as follows "Coverage is limited to $XX/visit and $XXX annual max." or "No coverage for XXXX."	Enter the applicable In-Network amount.	Enter the applicable Out-of-Network amount.	Each limitation or exception should specify dollar amounts, service limitations, and annual maximums if applicable. Language should be formatted as follows "Coverage is limited to $XX/visit and $XXX annual max." or "No coverage for XXXX."	Enter the applicable In-Network amount.	Enter the applicable Out-of-Network amount.	Each limitation or exception should specify dollar amounts, service limitations, and annual maximums if applicable. Language should be formatted as follows "Coverage is limited to $XX/visit and $XXX annual max." or "No coverage for XXXX."	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.	Select the applicable coverage.	Select the applicable coverage.	Select the applicable coverage.	Select the applicable coverage.

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Routine Hearing Tests	Plan Brochure	Is notice required for Pregnancy?	Maternity Deductibles	Maternity Co-pays	Maternity Co-insurance	Maternity Limits or Exclusions	Is Diabetes wellness program offered?	Diabetes Deductibles	Diabetes Co-pays	Diabetes Co-insurance	Diabetes Limits or Exclusions
Select the applicable coverage.	Enter the Plan Brochure URL.	Select "Yes" if notice is required for Pregnancy, otherwise select "No"	Enter the Deductible amount	Enter the Co-pays amount	Enter the Co-insurance amount	Enter the Limits or Exclusion amount	Select "Yes" if Diabetes wellness program is offered, otherwise select "No"	Enter the Deductible amount	Enter the Co-pays amount	Enter the Co-insurance amount	Enter the Limits or Exclusion amount

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