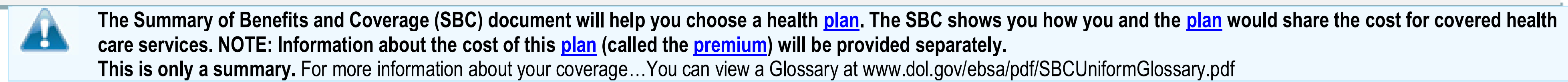


The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage…You can view a Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf

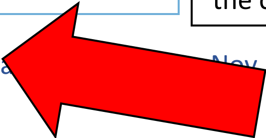
Many plans cover almost none of your health care costs until you've paid *all* of your deductible. This row tells you if any benefits – such as a copay or coinsurance – kick in *before* you've "met" your deductible.

The "OOPL" is like a safety net, though it still has *some* holes.
In general, you can expect to pay your deductible before you get many benefits from your plan, but you might only pay your OOPL in case of a serious illness injury, childbirth, or the like. However in Bronze or Catastrophic plans the OOPL and deductible are often the same.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$500/Individual or $1,000/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $300 for prescription drug coverage and $300 for occupational therapy services.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers $2,500 individual / $5,000 family; for out-of-network providers $4,000 individual / $8,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayments for certain services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.[insert].com or call 1-800-[insert] for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

Exception: If a family plan has an *aggregate* deductible, *no one* receives benefits subject to the deductible until the *family* deductible has been met

These days, most plans have pretty "narrow networks." To find out if a provider you want to use is in network, it's best to call the carrier.



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay first 3 visits before deductible is met. 25% coinsurance after deductible.	40% coinsurance	None
	Specialist visit	$35 copay first 3 visits before deductible is met. 25% coinsurance after deductible.	40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% of the total cost of the service.
	Preventive care/screening/ immunization	No charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.

Read carefully! This example means you pay $35 each for your first 3 visits, primary care *or* specialist, then you pay down your entire deductible, and after that, you owe only 25% of additional visits.

Some things to watch for as you read the rest of the SBC for plans you are considering:

- Coinsurance vs. Copay: Coinsurance is a *percent* you pay for the cost of a service. A copay is a fixed dollar amount. So if a doctor's visit is $200, 30% coinsurance means you pay $60*, but a $30 copay means you pay $30.* (*or more, *if* you have not yet met your deductible *and* the deductible applies).
- Different tiers of drug copays: If you rely on a specific drug, especially a brand name one, call the carrier to find out where it is in the "formulary" – even if it is covered, it may be in a higher cost "specialty" tier. If it is covered, remember, formularies can change without notice!
- If there is any care you receive frequently, pay special attention to whether the deductible applies, the amount of copay/coinsurance, and how much it costs. For example if you get regular blood draws related to a condition or medication, or if you see a mental health or physical therapist every couple of weeks, calculate out the cost per year with different plans. If it is not clear to you, you can call a carrier to find out whether a specific practitioner or service is covered *and* the price on which your cost would be based.
- Note the list of "Services Your Plan Generally Does NOT Cover" toward the end of the SBC. Note that no MNsure plans cover *adult* dental, but you can buy separate dental plans.
- Check out the examples of specific health care events at the end of each SBC. They can give you a better idea of how your cost of care would differ between plans.

Where to find SBCs on MNsure.org:

- Click on Shop and Compare. Answer the basic questions and click Continue until you get to a list of plans available to you.
- Click on any plan name.
- Scroll down slightly, and click on "View Summary of Benefits and Coverage".

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