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, or to get a copy of the complete terms of coverage, see http://www.abs-tpa.com and/or call 1-833-239-1273. For definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-833-239-1273 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Olin Health Center: None. In-Network: Individual **$125**; Family **$250**. Out-of-Network: Individual **$250**; Family **$500**.	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 individual must meet their own deductible before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. In-network: Lab, preventive care emergency services, some prescription drugs, and Olin Health Center visits 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Olin Health Center and In-Network (Combined): Individual **$1,500**; Family **$3,000**. Out-of-Network: Individual **$2,300**; Family **$4,600**.	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?	Penalties for failure to obtain pre-authorization for services, premiums, balance-billing charges, health care this plan doesn't cover, pediatric vision	Even though you pay these expenses, they don't count toward the out–of–pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-800-859-8452 for a list of in-network providers.	You pay the least if you use a provider at Olin Health Center for available services. You may pay more if you use a provider in your 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?	No.	You can see the specialist you choose without a referral. However, we will assign an Olin Health Center physician as primary care. You may change your primary care physician at your discretion.

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: MSU Student Health Services at Olin Health Center	What You Will Pay: In-Network Coverage	What You Will Pay: Out-of-Network Coverage	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay/visit Deductible does not apply.	$15 copay/visit	Deductible + 20% coinsurance	Copay includes all related charges provided at health care provider's office.
	Specialist visit	$15 copay/visit Deductible does not apply.	$15 copay/visit	Deductible + 20% coinsurance	See above.
	Preventive care/screening/ immunization	No charge; deductible does not apply.	No charge; deductible does not apply.	Deductible + 20% coinsurance	Well child visits covered. Maximum number of visits may apply. You may have to pay for services that aren't considered preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.

Common Medical Event	Services You May Need	What You Will Pay: MSU Student Health Services at Olin Health Center	What You Will Pay: In-Network Coverage	What You Will Pay: Out-of-Network Coverage	Limitations, Exceptions, & Other Important Information
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Deductible + 5% coinsurance Deduct	Deductible + 20% coinsurance	Select services available at Olin Health Center and are covered in full. May require preauthorization. No charge and deductible does not apply for lab services
	Imaging (CT/PET scans, MRIs)	Not available	Deductible + 5% coinsurance	Deductible + 20% coinsurance	May require preauthorization.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.aetna.com/individuals-families/find-a-medication/2024-aetna-advanced-control-plan.html	Preferred generic drugs	$10 copay (30-day supply) / $20 copay (90-day supply) Deductible does not apply.			You are required to use generic if available. If brand is chosen, you must pay 100% of the difference between generic and brand. Limited to 30-day retail supply & 90-day retail supply. In-network pharmacy and CVS Caremark are subject to In-network out-of-pocket limit. Out of Network pharmacy is subject to Out of Network out-of-pocket limit. Certain specialty pharmacy drugs are considered non-essential health benefits and fall outside the out-of-pocket limits. The cost of these drugs (though reimbursed by the manufacturer at no cost to you) will not be applied towards satisfying your out-of-pocket maximums.
	Preferred brand drugs	$30 copay (30-day supply) / $60 copay (90-day supply) Deductible does not apply.			
	Non-preferred brand drugs	$60 copay (30-day supply) / $120 copay (90-day supply) Deductible does not apply.			
	Preferred and non-preferred Specialty drugs	$75 copay Deductible does not apply.		Not Covered	Limited to 30-day supply. Prior authorization required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not available	Deductible + 5% coinsurance	Deductible + 20% coinsurance	Pre-certification required for Hospital Observations.
	Physician/surgeon fees	Not available	No charge	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay: MSU Student Health Services at Olin Health Center	What You Will Pay: In-Network Coverage	What You Will Pay: Out-of-Network Coverage	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	Emergency room care	Not available	$50 copay + 5% coinsurance Deductible does not apply.	$50 copay + 5% coinsurance Deductible does not apply.	Non-emergency services are covered but are subject to deductible and coinsurance.
	Emergency medical transportation	Not available	5% coinsurance Deductible does not apply.	5% coinsurance Deductible does not apply.	
	Urgent care	Not available	Deductible + 5% coinsurance	Deductible + 20% coinsurance	Copay includes all related charges provided at the urgent care facility.
If you have a hospital stay	Facility fee (e.g., hospital room)	Not available	Deductible + 5% coinsurance	Deductible + 20% coinsurance	Pre-certification required.
	Physician/surgeon fees	Not available	No Charge	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay Deductible does not apply.	Office visits: $15 copay All other outpatient services: Deductible + 5% coinsurance	Mental health & behavioral health office visits: $15 copay after deductible All other outpatient services to include substance abuse services: Deductible + 20% coinsurance	Some services may require prior authorization.
	Inpatient services	Not available	Deductible + 5% coinsurance	Deductible + 20% coinsurance	Pre-certification required.

Common Medical Event	Services You May Need	What You Will Pay: MSU Student Health Services at Olin Health Center	What You Will Pay: In-Network Coverage	What You Will Pay: Out-of-Network Coverage	Limitations, Exceptions, & Other Important Information
If you are pregnant	Office visits	Not available	Covered Deductible does not apply.	Deductible + 20% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of service, a copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Pre-certification is required for vaginal deliveries requiring more than a 48-hour stay and for cesarean section deliveries requiring more than a 96-hour stay, or no benefits are paid.
	Childbirth/delivery professional services	Not available	Deductible + 5% coinsurance	Deductible + 20% coinsurance	
	Childbirth/delivery facility services	Not available	Deductible + 5% coinsurance	Deductible + 20% coinsurance	
If you need help recovering or have other special health needs	Home health care	Not available	Deductible + 5% coinsurance	Deductible + 20% coinsurance	Pre-certification required.
	Rehabilitation services	$15 copay Deductible does not apply.	$15 copay + 5% coinsurance	Deductible + 20% coinsurance	Only physical therapy services are available at Olin Health Center. Olin Health Center does not offer speech or occupational therapy.
	Habilitation services	Physical Therapy: $15 copay Deductible does not apply.	Applied Behavior Analysis (ABA) - $15 copay Physical, Occupational, Speech Therapy (PT/OT/ST - $15 copay + 5% coinsurance	Deductible + 20% coinsurance	
	Skilled nursing care	Not available	Deductible + 5% coinsurance	Deductible + 20% coinsurance	Services require prior authorization.

Common Medical Event	Services You May Need	What You Will Pay MSU Student Health Services at Olin Health Center	In-Network Coverage	Out-of-Network Coverage	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Durable medical equipment	Olin Health Center has certain DME items available. Member out-of-pocket costs apply.	Deductible + 5% coinsurance	Not covered	Certain exclusions apply.
	Hospice services	Not available	Deductible + 5% coinsurance	Deductible + 20% coinsurance	None.
If your child needs dental or eye care	Children's eye exam	Not available	Covered Deductible does not apply.	Difference between the Aetna approved amount and the amount charged by the provider	Limited to covered dependent children of the student once in a calendar year through the end of the year in which they turn 19. 1 routine eye exam/plan year to age 19. 1 pair of glasses or lenses/plan year to age 19.
	Children's glasses	Not available	Covered Deductible does not apply.	Difference between the Aetna approved amount and the amount charged by the provider	
	Children's dental check-up	Not available	Contact your benefit administrator for coverage information	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (adult)
- Gene-based, cellular, and other innovative therapies
- Hearing aids, unless due to covered injury or illness
- Long-term Care
- Non-emergency care when travelling outside the U.S.
- Private Duty Nursing
- Routine eye care (adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery (medical necessity only)
- Chiropractic care
- Gender affirming treatment
- Infertility (For more information & exceptions, see policy document)
- Weight loss programs

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the plan at 1-833-239-1273. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the plan at 1-833-239-1273. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. You may be able to contact your state department of insurance for assistance. A list of states with Consumer Assistance Programs is available at: https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers and http://www.cms.gov/CCIIO/Resources/Consumer- Assistance-Grants/

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-833-239-1273.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-239-1273.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-833-239-1273.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-833-239-1273.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$125
Specialist copayment	$15
Hospital (facility) coinsurance	5%
Other coinsurance	5%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$100
Copayments	$30
Coinsurance	$400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$590**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$125
Specialist copayment	$15
Hospital (facility) coinsurance	5%
Other coinsurance	5%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$100
Copayments	$600
Coinsurance	$30
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$750**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$125
Specialist copayment	$15
Hospital (facility) coinsurance	5%
Other coinsurance	5%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$100
Copayments	$100
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$270**

The plan would be responsible for the other costs of these EXAMPLE covered services.