**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, go to www.meritain.com or call (315) 686-2615. For general 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.healthcare.gov/sbc-glossary or call Meritain Health, Inc. at (800) 925-2272 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | For participating providers:<br>$0 person / $0 family<br>For non-participating providers:<br>$483 person / $1,448 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. For participating providers: All services are covered before you meet a deductible. For non-participating providers: Emergency room care, emergency medical transportation (emergency services only), inpatient hospital facility charges (including mental health & substance abuse) and skilled nursing 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 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?** | For participating providers:<br>$7,350 person / $14,700 family<br>For non-participating providers:<br>$932 person / $2,763 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?** | Premiums, balance billing charges, preauthorization penalty amounts, certain specialty pharamacy drugs (those considered non-essential) 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.aetna.com/docfind/custom/mymeritain or call (800) 343-3140 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?** | No. | You can see the specialist you choose without a referral. |

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 |
|---|---|---|---|---|
| | | Participating Provider (You will pay the least) | Non-Participating 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 | $25 copay/visit (office visit)/ No Charge (all other services) | 20% coinsurance | Copay applies to the physician office visit only. Includes telemedicine from providers other than Teladoc. You pay a $10 copay (deductible does not apply) if you receive consultation services through Teladoc. |
| | Specialist visit | $25 copay/visit (office visit)/ No Charge (all other services) | 20% coinsurance | |
| | Preventive care/screening/ immunization | No Charge | 20% 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. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | Lab services & other diagnostic tests: No Charge / X-rays: No Charge (freestanding facility) / $35 copay/visit (all other outpatient) | 20% coinsurance | The copay is waived for interpretation fees. |
| | Imaging (CT/PET scans, MRIs) | No Charge (freestanding facility) / $35 copay/visit (all other outpatient) | 20% coinsurance | Preauthorization required for PET scans and non-orthopedic CT/MRI's. If you don't get preauthorization, benefits could be reduced by 50% up to $250 of the total cost of the service. The copay is waived for interpretation fees. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.express-scripts.com | Generic drugs | $15 copay (retail) / $30 copay (mail order) | Not Covered | Deductible does not apply. Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription); 30-day supply (specialty drugs). The copay applies per prescription. There is no charge for preventive drugs. Specialty drugs must be obtained directly from the specialty pharmacy. Step therapy provision applies. Preauthorization required for injectables costing over $2,000 per drug per month. Certain specialty drugs may be eligible for copay assistance programs through SaveOnSP; financial assistance provided does not apply to your out-of-pocket limit. |
| | Preferred brand drugs | $30 copay (retail)/ $60 copay (mail order) | Not Covered | |
| | Non-preferred brand drugs | $60 copay (retail)/ $95 copay (mail order) | Not Covered | |
| | Specialty drugs | Paid the same as generic, preferred and non-preferred drugs when not available through SaveOnSP. | Not Covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No Charge | 20% coinsurance | Preauthorization required for certain surgeries, including infusion therapy costing over $2,000 per drug per month. If you don't get preauthorization, benefits could be reduced by 50% up to $250 of the total cost of the service. See your plan document for a detailed listing. |
| | Physician/surgeon fees | No Charge | 20% coinsurance | |
| **If you need immediate medical attention** | Emergency room care | $75 copay/visit | $75 copay/visit | Non-participating providers paid at the participating provider level of benefits. |
| | Emergency medical transportation | $50 copay/trip (emergency services) / No Charge (non-emergency services) | $50 copay/trip (emergency services) / 20% coinsurance (non-emergency services) | Non-participating providers paid at the participating provider level of benefits for emergency services. |
| | Urgent care | $25 copay/visit | 20% coinsurance | Copay applies per visit regardless of what services are rendered. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $125 copay/admission | $125 copay/admission | Preauthorization required. If you don't get preauthorization, benefits could be reduced by 50% up to $250 of the total cost of the service. |
| | Physician/surgeon fees | No Charge | 20% coinsurance | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $25 copay/visit (office visits) / No Charge (all other outpatient) | 20% coinsurance | Includes telemedicine from providers other than Teladoc. You pay a $10 copay (deductible does not apply) if you receive behavioral health services through Teladoc. |
| | Inpatient services | Facility charges: $125 copay/admission / Professional fees: No Charge | Facility charges: $125 copay/admission / Professional fees: 20% coinsurance | Preauthorization required. If you don't get preauthorization, benefits could be reduced by 50% up to $250 of the total cost of the service. |
| **If you are pregnant** | Office visits | Prenatal: Office visits: $25 copay/visit / Labs, x-rays (at a freestanding facility) diagnostic tests: No Charge / X-rays at a hospital: $35 copay/visit All other outpatient: $35 copay/visit Postnatal: No Charge | 20% coinsurance | Preauthorization required for inpatient hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section). If you don't get preauthorization, benefits could be reduced by 50% up to $250 of the total cost of the service. Cost sharing does not apply to preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Baby does not count toward the mother's expense; therefore the family deductible amount may apply. Copay is waived for interpretation fees. |
| | Childbirth/delivery professional services | No Charge | 20% coinsurance | |
| | Childbirth/delivery facility services | $125 copay/admission | $125 copay/admission | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| **If you need help recovering or have other special health needs** | Home health care | No Charge | 20% coinsurance | Limited to 80 visits per year. Preauthorization required. If you don't get preauthorization, benefits could be reduced by 50% up to $250 of the total cost of the service. |
| | Rehabilitation services | Outpatient rehabilitation services: Physical, speech & occupational therapy: $35 copay/visit / Cardiac & respiratory/pulmonary rehab: No Charge (office)/ $35 copay/visit (all other outpatient) / Inpatient rehabilitation services: $125 copay/admission | Outpatient rehabilitation services: 20% coinsurance / Inpatient rehabilitation services: $125 copay/admission | Includes physical therapy. Outpatient speech, occupational, respiratory/ pulmonary therapies and cardiac rehab limited to a combined maximum of 80 visits per year. Inpatient rehabilitation services limited to 60 days per year and preauthorization is required. If you don't get preauthorization, benefits could be reduced by 50% up to $250 of the total cost of the service. |
| | Habilitation services | Office: $25 copay/visit / All other outpatient: $35 copay/visit | 20% coinsurance | Includes physical therapy. Speech, occupational, respiratory/pulmonary therapies and cardiac rehab limited to a combined maximum of 80 visits per year. |
| | Skilled nursing care | $125 copay/admission | $125 copay/admission | Limited to 60 days per year. Preauthorization required. If you don't get preauthorization, benefits could be reduced by 50% up to $250 of the total cost of the service. |
| | Durable medical equipment | No Charge | 20% coinsurance | Preauthorization required for electric/ motorized scooters or wheelchairs and pneumatic compression devices. If you don't get preauthorization, benefits could be reduced by 50% up to $250 of the total cost of the service. |
| | Hospice services | No Charge | 20% coinsurance | Bereavement counseling is covered if received within 12 months of death, limited to 5 visits per occurrence. Hospice services limited to 210 visits/days per year. |
| **If your child needs dental or eye care** | Children's eye exam | $20 copay/visit | No Charge (maximum of $61) | Coverage is provided through a stand-alone vision plan (refer to Davis Vision for further details). |
| | Children's glasses | No Charge | No Charge (maximum of $111 – frames, single vision lenses combined) | Coverage is provided through a stand-alone vision plan (refer to Davis Vision for further details). |
| | Children's dental check-up | Not Covered | Not Covered | Not Covered |

## 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<br>• Cosmetic surgery<br>• Dental care (Adult & Child)<br>• Long-term care | • Non-emergency care when traveling outside the U.S.<br>• Private-duty nursing (except for home health care & hospice) | • Routine foot care (except for metabolic or peripheral vascular disease)<br>• 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 (for morbid obesity only)<br>• Chiropractic care | • Glasses (Adult & Child – through a stand-alone vision plan with Davis Vision)<br>• Hearing aids (1 hearing aid per hearing impaired ear every 3 years) | • Infertility treatment (3 cycles per lifetime)<br>• Routine eye care (Adult & Child – through a stand-alone vision plan with Davis Vision) |

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at (877) 267-2323 x 61565 or www.cciio.cms.gov, or Jefferson-Lewis et. al. School Employees' Healthcare Plan at (315) 686-2615. 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 on how 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 Jefferson-Lewis et. al. School Employees' Healthcare Plan at (315) 686-2615 or Meritain Health, Inc. at (800) 925-2272.

Additionally, a consumer assistance program can help you file your appeal. Contact the Community Service Society of New York, Community Health Advocates at (888) 614-5400.

**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 1-800-378-1179.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-378-1179.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-800-378-1179.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-378-1179.

*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** | **$0** |
| **Primary care physician copayment** | **$25** |
| **Hospital (facility) coinsurance** | **$125** |
| **Other coinsurance** | **0%** |

**This EXAMPLE event includes services like:**
Primary care physician 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 | $0 |
| Copayments | $200 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | $260 |

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

| | |
|---|---|
| **The plan's overall deductible** | **$0** |
| **Specialist copayment** | **$25** |
| **Hospital (facility) coinsurance** | **0%** |
| **Other coinsurance** | **0%** |

**This EXAMPLE event includes services like:**
Specialist 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 | $0 |
| Copayments | $800 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | $820 |

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

| | |
|---|---|
| **The plan's overall deductible** | **$0** |
| **Specialist copayment** | **$25** |
| **Hospital (facility) copayment** | **$75** |
| **Other coinsurance** | **0%** |

**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 | $0 |
| Copayments | $400 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | $400 |

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