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 and non-participating providers: $322 person / $966 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 and non-participating providers: Preventive care, emergency room care (emergency services only), most facility charges and a portion of some professional services are covered before you meet your deductible. Refer to the individual benefit for further details.	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 and non-participating providers: $1,288 person / $3,863 family (deductible, coinsurance and medical copays) $6,062 person / $10,837 family (prescription drug copays)	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, 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/meritain 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	No charge for the first $8 per visit (deductible does not apply), thereafter 20% coinsurance after deductible	No charge for the first $8 per visit (deductible does not apply), thereafter 20% coinsurance after deductible	There is no charge (deductible does not apply) to labs and x-rays in the office. There is no charge for the first $10 per visit (deductible does not apply); thereafter 20% coinsurance after deductible for telemedicine from providers other than Teladoc. You pay a $10 copay (deductible does not apply) if you receive consultation services through Teladoc.
	Specialist visit	No charge for the first $8 per visit (deductible does not apply), thereafter 20% coinsurance after deductible	No charge for the first $8 per visit (deductible does not apply), thereafter 20% coinsurance after deductible	
	Preventive care/ screening/ immunization	No Charge (deductible does not apply)	No Charge (deductible does not apply)	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)	Facility charges: No Charge (deductible does not apply)/ Professional/Interpretation fees: No charge for the first $35 per visit (deductible does not apply), thereafter 20% coinsurance after deductible	Facility charges: No Charge (deductible does not apply)/ Professional/Interpretation fees: No charge for the first $35 per visit (deductible does not apply), thereafter 20% coinsurance after deductible	There is no charge and the deductible does not apply to independent lab charges.
	Imaging (CT/PET scans, MRIs)	Facility charges: No Charge (deductible does not apply)/ Professional/Interpretation fees: No charge for the first $35 per visit (deductible does not apply), thereafter 20% coinsurance after deductible	Facility charges: No Charge (deductible does not apply)/ Professional/Interpretation fees: No charge for the first $35 per visit (deductible does not apply), thereafter 20% coinsurance after deductible	Preauthorization recommended for PET scans and non-orthopedic CT/MRI's.

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 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 recommended 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	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge (deductible does not apply)	No Charge (deductible does not apply)	Preauthorization recommended for certain surgeries, including infusion therapy costing over $2,000 per drug per month. See your plan document for a detailed listing. *See your plan for a list of specified surgeries. All other procedures may result in additional charges when received from a non-participating provider if a negotiated discount is not accepted and services are based/priced on UCR (usual, customary and reasonable) amounts.
	Physician/surgeon fees	No Charge (deductible does not apply)	Specific surgeries: No Charge* (deductible does not apply)/ All other surgeries: No Charge, deductible does not apply (when a negotiated discount is accepted) / No charge up to the UCR amount (deductible does not apply); 20% coinsurance after deductible for amounts over UCR (when UCR is used)	
If you need immediate medical attention	Emergency room care	Emergency services: No Charge (deductible does not apply) / Non-emergency services: 20% coinsurance after deductible	Emergency services: No Charge (deductible does not apply) / Non-emergency services: 20% coinsurance after deductible	Non-participating providers paid at the participating provider level of benefits for emergency services.
	Emergency medical transportation	No charge for the first $50 per trip (deductible does not apply), thereafter 20% coinsurance after deductible	No charge for the first $50 per trip (deductible does not apply), thereafter 20% coinsurance after deductible	Non-participating providers paid at the participating provider level of benefits.

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)	
	Urgent care	Facility charges: No Charge (deductible does not apply)/ Professional fees: No charge for the first $8 per visit (deductible does not apply), thereafter 20% coinsurance after deductible	Facility charges: No Charge (deductible does not apply)/ Professional fees: No charge for the first $8 per visit (deductible does not apply), thereafter 20% coinsurance after deductible	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge for the first 365 days per admission (deductible does not apply), thereafter 20% coinsurance after deductible	No charge for the first 365 days per admission (deductible does not apply), thereafter 20% coinsurance after deductible	Preauthorization recommended. You will pay 20% coinsurance after deductible for additional consultations or same days visits within the same hospital stay.
	Physician/surgeon fees	Days 1 – 59: No charge for the first $25 per visit (deductible does not apply); thereafter 20% coinsurance after deductible / Days 60 – 365: No charge for the first $10 per visit (deductible does not apply); thereafter 20% coinsurance after deductible	Days 1 – 59: No charge for the first $25 per visit (deductible does not apply); thereafter 20% coinsurance after deductible / Days 60 – 365: No charge for the first $10 per visit (deductible does not apply); thereafter 20% coinsurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits: No charge for the first $8 per visit (deductible does not apply), thereafter 20% coinsurance after deductible / All other outpatient: No Charge (deductible does not apply)	Office visits: No charge for the first $8 per visit (deductible does not apply), thereafter 20% coinsurance after deductible / All other outpatient: No Charge (deductible does not apply)	There is no charge for the first $10 per visit (deductible does not apply); thereafter 20% coinsurance after deductible for 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: No charge for the first 365 days per admission (deductible does not apply), thereafter 20% coinsurance after deductible/	Facility charges: No charge for the first 365 days per admission (deductible does not apply), thereafter 20% coinsurance after deductible/	Preauthorization recommended. You will pay 20% coinsurance after deductible for additional consultations or same days visits within the same hospital stay.

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)	
		Professional fees: Days 1 – 59: No charge for the first $25 per visit (deductible does not apply); thereafter 20% coinsurance after deductible / Days 60 – 365: No charge for the first $10 per visit (deductible does not apply); thereafter 20% coinsurance after deductible	Professional fees: Days 1 – 59: No charge for the first $25 per visit (deductible does not apply); thereafter 20% coinsurance after deductible / Days 60 – 365: No charge for the first $10 per visit (deductible does not apply); thereafter 20% coinsurance after deductible	
If you are pregnant	Office visits	Office visits: No charge for the first $8 per visit (deductible does not apply), thereafter 20% coinsurance after deductible / Diagnostic tests: Facility charges: No Charge (deductible does not apply)/Professional/Interpretation fees: No charge for the first $35 per visit (deductible does not apply), thereafter 20% coinsurance after deductible / All other outpatient: 20% coinsurance after deductible	Office visits: No charge for the first $8 per visit (deductible does not apply), thereafter 20% coinsurance after deductible / Diagnostic tests: Facility charges: No Charge (deductible does not apply)/Professional/Interpretation fees: No charge for the first $35 per visit (deductible does not apply), thereafter 20% coinsurance after deductible / All other outpatient: 20% coinsurance after deductible	Preauthorization recommended for inpatient hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section). 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. *Delivery services from a non-participating provider may result in additional charges if a negotiated discount is not accepted and services are based/priced on UCR (usual, customary and reasonable) amounts.
	Childbirth/delivery professional services	No Charge (deductible does not apply)	*No Charge, deductible does not apply (when a negotiated discount is accepted) / No charge up to the UCR amount (deductible does not apply); 20% coinsurance after deductible for amounts over UCR (when UCR is used)	
	Childbirth/delivery facility services	No Charge (deductible does not apply)	No Charge (deductible does not apply)	

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 (deductible does not apply)	No Charge (deductible does not apply)	Limited to 80 visits per year. Preauthorization recommended.
	Rehabilitation services	20% coinsurance after deductible (outpatient rehabilitation services) / No Charge, deductible does not apply (inpatient rehabilitation services)	20% coinsurance after deductible (outpatient rehabilitation services) / No Charge, deductible does not apply (inpatient rehabilitation services)	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 100 days per year and preauthorization is recommended.
	Habilitation services	20% coinsurance after deductible	20% coinsurance after deductible	Includes physical therapy. Speech, occupational, respiratory/pulmonary therapies and cardiac rehab limited to a combined maximum of 80 visits per year.
	Skilled nursing care	No Charge (deductible does not apply)	No Charge (deductible does not apply)	Limited to 100 days per year. Preauthorization recommended.
	Durable medical equipment	20% coinsurance after deductible	20% coinsurance after deductible	Preauthorization recommended for electric/motorized scooters or wheelchairs and pneumatic compression devices.
	Hospice services	No Charge (deductible does not apply)	No Charge (deductible does not apply)	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	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	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 • Cosmetic surgery • Dental care (Adult & Child) • Glasses (Adult & Child)	• Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty nursing (except for home health care & hospice)	• Routine eye care (Adult & Child) • Routine foot care (except for metabolic or peripheral vascular disease) • 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) • Chiropractic care	• Hearing aids (1 hearing aid per hearing impaired ear every 3 years)	• Infertility treatment (3 cycles per lifetime)

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	$322
Primary care physician coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$322
Copayments	$10
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1,392

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

The plan's overall deductible	$322
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$322
Copayments	$500
Coinsurance	$300
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$1,142

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

The plan's overall deductible	$322
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$322
Copayments	$10
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$832

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