



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. (800) 925-2272 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	For participating <u>providers</u> and non-participating <u>providers</u> : \$322 person / \$966 family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. For participating and non-participating <u>providers</u> : <u>Preventive care</u> , <u>emergency room care</u> (<u>emergency services</u> only), most facility charges and a portion of some professional services are covered before you meet your <u>deductible</u> . Refer to the individual benefit for further details.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	For participating and non-participating <u>providers</u> : \$1,288 person / \$3,863 family (<u>deductible</u> , <u>coinsurance</u> and medical <u>copays</u>) \$6,062 person / \$10,837 family (<u>prescription drug copays</u>)	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance billing</u> charges, certain specialty pharmacy drugs (those considered non-essential) and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.aetna.com/docfind/custom/mymeritain or call (800) 343-3140 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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 (<u>deductible</u> does not apply), thereafter 20% <u>coinsurance</u> after <u>deductible</u>	No charge for the first \$8 per visit (<u>deductible</u> does not apply), thereafter 20% <u>coinsurance</u> after <u>deductible</u>	There is no charge (<u>deductible</u> does not apply) to labs and x-rays in the office. There is no charge for the first \$10 per visit (<u>deductible</u> does not apply); thereafter 20% <u>coinsurance</u> after <u>deductible</u> for telemedicine from <u>providers</u> other than Teladoc. You pay a \$10 <u>copay</u> (<u>deductible</u> does not apply) if you receive consultation services through Teladoc.
	<u>Specialist</u> visit	No charge for the first \$8 per visit (<u>deductible</u> does not apply), thereafter 20% <u>coinsurance</u> after <u>deductible</u>	No charge for the first \$8 per visit (<u>deductible</u> does not apply), thereafter 20% <u>coinsurance</u> after <u>deductible</u>	
	<u>Preventive care</u> / <u>screening</u> / immunization	No Charge (<u>deductible</u> does not apply)	No Charge (<u>deductible</u> does not apply)	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Facility charges: No Charge (<u>deductible</u> does not apply)/ Professional/Interpretation fees: No charge for the first \$35 per visit (<u>deductible</u> does not apply), thereafter 20% <u>coinsurance</u> after <u>deductible</u>	Facility charges: No Charge (<u>deductible</u> does not apply)/ Professional/Interpretation fees: No charge for the first \$35 per visit (<u>deductible</u> does not apply), thereafter 20% <u>coinsurance</u> after <u>deductible</u>	There is no charge and the <u>deductible</u> does not apply to independent lab charges.
	Imaging (CT/PET scans, MRIs)	Facility charges: No Charge (<u>deductible</u> does not apply)/ Professional/Interpretation fees: No charge for the first \$35 per visit (<u>deductible</u> does not apply), thereafter 20% <u>coinsurance</u> after <u>deductible</u>	Facility charges: No Charge (<u>deductible</u> does not apply)/ Professional/Interpretation fees: No charge for the first \$35 per visit (<u>deductible</u> does not apply), thereafter 20% <u>coinsurance</u> after <u>deductible</u>	<u>Preauthorization</u> 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 <u>prescription drug coverage</u> is available at www.express-scripts.com	Generic drugs	Not Covered	Not Covered	Not Covered
	Preferred brand drugs	Not Covered	Not Covered	
	Non-preferred brand drugs	Not Covered	Not Covered	
	<u>Specialty drugs</u>	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge (<u>deductible</u> does not apply)	No Charge (<u>deductible</u> does not apply)	<u>Preauthorization</u> recommended for certain surgeries, including infusion therapy costing over \$2,000 per drug per month. See your <u>plan</u> document for a detailed listing. *See your <u>plan</u> for a list of specified surgeries. All other procedures may result in additional charges when received from a non-participating <u>provider</u> if a negotiated discount is not accepted and services are based/priced on <u>UCR (usual, customary and reasonable)</u> amounts.
	Physician/surgeon fees	No Charge (<u>deductible</u> does not apply)	Specific surgeries: No Charge* (<u>deductible</u> does not apply) / All other surgeries: No Charge, <u>deductible</u> does not apply (when a negotiated discount is accepted) / No charge up to the <u>UCR</u> amount (<u>deductible</u> does not apply); 20% <u>coinsurance</u> after <u>deductible</u> for amounts over <u>UCR</u> (when <u>UCR</u> is used)	
If you need immediate medical attention	<u>Emergency room care</u>	<u>Emergency services</u> : No Charge (<u>deductible</u> does not apply) / <u>Non-emergency services</u> : 20% <u>coinsurance</u> after <u>deductible</u>	<u>Emergency services</u> : No Charge (<u>deductible</u> does not apply) / <u>Non-emergency services</u> : 20% <u>coinsurance</u> after <u>deductible</u>	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits for <u>emergency services</u> .
	<u>Emergency medical transportation</u>	No charge for the first \$50 per trip (<u>deductible</u> does not apply), thereafter 20% <u>coinsurance</u> after <u>deductible</u>	No charge for the first \$50 per trip (<u>deductible</u> does not apply), thereafter 20% <u>coinsurance</u> after <u>deductible</u>	Non-participating <u>providers</u> paid at the participating <u>provider</u> level of benefits.
	<u>Urgent care</u>	Facility charges: No Charge (<u>deductible</u> does not apply) / Professional fees: No charge for the first \$8 per visit (<u>deductible</u> does not apply), thereafter 20% <u>coinsurance</u> after <u>deductible</u>	Facility charges: No Charge (<u>deductible</u> does not apply) / Professional fees: No charge for the first \$8 per visit (<u>deductible</u> does not apply), thereafter 20% <u>coinsurance</u> after <u>deductible</u>	-----none-----

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 a hospital stay	Facility fee (e.g., hospital room)	No charge for the first 365 days per admission (<u>deductible</u> does not apply), thereafter 20% <u>coinsurance</u> after <u>deductible</u>	No charge for the first 365 days per admission (<u>deductible</u> does not apply), thereafter 20% <u>coinsurance</u> after <u>deductible</u>	<u>Preauthorization</u> recommended. You will pay 20% <u>coinsurance</u> after <u>deductible</u> 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 (<u>deductible</u> does not apply); thereafter 20% <u>coinsurance</u> after <u>deductible</u> / Days 60 – 365: No charge for the first \$10 per visit (<u>deductible</u> does not apply); thereafter 20% <u>coinsurance</u> after <u>deductible</u>	Days 1 – 59: No charge for the first \$25 per visit (<u>deductible</u> does not apply); thereafter 20% <u>coinsurance</u> after <u>deductible</u> / Days 60 – 365: No charge for the first \$10 per visit (<u>deductible</u> does not apply); thereafter 20% <u>coinsurance</u> after <u>deductible</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits: No charge for the first \$8 per visit (<u>deductible</u> does not apply), thereafter 20% <u>coinsurance</u> after <u>deductible</u> / All other outpatient: No Charge (<u>deductible</u> does not apply)	Office visits: No charge for the first \$8 per visit (<u>deductible</u> does not apply), thereafter 20% <u>coinsurance</u> after <u>deductible</u> / All other outpatient: No Charge (<u>deductible</u> does not apply)	There is no charge for the first \$10 per visit (<u>deductible</u> does not apply); thereafter 20% <u>coinsurance</u> after <u>deductible</u> for telemedicine from <u>providers</u> other than Teladoc. You pay a \$10 <u>copay</u> (<u>deductible</u> does not apply) if you receive behavioral health services through Teladoc.
	Inpatient services	Facility charges: No charge for the first 365 days per admission (<u>deductible</u> does not apply), thereafter 20% <u>coinsurance</u> after <u>deductible</u> / Professional fees: Days 1 – 59: No charge for the first \$25 per visit (<u>deductible</u> does not apply); thereafter 20% <u>coinsurance</u> after <u>deductible</u> / Days 60 – 365: No charge for the first \$10 per visit (<u>deductible</u> does not apply); thereafter 20% <u>coinsurance</u> after <u>deductible</u>	Facility charges: No charge for the first 365 days per admission (<u>deductible</u> does not apply), thereafter 20% <u>coinsurance</u> after <u>deductible</u> / Professional fees: Days 1 – 59: No charge for the first \$25 per visit (<u>deductible</u> does not apply); thereafter 20% <u>coinsurance</u> after <u>deductible</u> / Days 60 – 365: No charge for the first \$10 per visit (<u>deductible</u> does not apply); thereafter 20% <u>coinsurance</u> after <u>deductible</u>	<u>Preauthorization</u> recommended. You will pay 20% <u>coinsurance</u> after <u>deductible</u> 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)	
If you are pregnant	Office visits	No Charge (<u>deductible</u> does not apply)	Office visits: No charge for the first \$8 per visit (<u>deductible</u> does not apply), thereafter 20% <u>coinsurance</u> after <u>deductible</u> / <u>Diagnostic tests</u> : Facility charges: No Charge (<u>deductible</u> does not apply)/Professional/Interpretation fees: No charge for the first \$35 per visit (<u>deductible</u> does not apply), thereafter 20% <u>coinsurance</u> after <u>deductible</u> / All other outpatient: 20% <u>coinsurance</u> after <u>deductible</u>	<u>Preauthorization</u> recommended for inpatient hospital stays in excess of 48 hrs (vaginal delivery) or 96 hrs (c-section). <u>Cost sharing</u> does not apply to <u>preventive services</u> . 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 <u>deductible</u> amount may apply. *Delivery services from a non-participating <u>provider</u> may result in additional charges if a negotiated discount is not accepted and services are based/priced on <u>UCR</u> (<u>usual, customary and reasonable</u>) amounts.
	Childbirth/delivery professional services	No Charge (<u>deductible</u> does not apply)	*No Charge, <u>deductible</u> does not apply (when a negotiated discount is accepted) / No charge up to the <u>UCR</u> amount (<u>deductible</u> does not apply); 20% <u>coinsurance</u> after <u>deductible</u> for amounts over <u>UCR</u> (when <u>UCR</u> is used)	
	Childbirth/delivery facility services	No Charge (<u>deductible</u> does not apply)	No Charge (<u>deductible</u> does not apply)	
If you need help recovering or have other special health needs	<u>Home health care</u>	No Charge (<u>deductible</u> does not apply)	No Charge (<u>deductible</u> does not apply)	Limited to 80 visits per year. <u>Preauthorization</u> recommended.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u> after <u>deductible</u> (outpatient <u>rehabilitation services</u>) / No Charge, <u>deductible</u> does not apply (inpatient <u>rehabilitation services</u>)	20% <u>coinsurance</u> after <u>deductible</u> (outpatient <u>rehabilitation services</u>) / No Charge, <u>deductible</u> does not apply (inpatient <u>rehabilitation services</u>)	Includes physical therapy. Outpatient speech/hearing, occupational, respiratory/ pulmonary therapies and cardiac rehab limited to a combined maximum of 80 visits per year. Inpatient <u>rehabilitation services</u> limited to 100 days per year and <u>preauthorization</u> is recommended.

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)	
	<u>Habilitation services</u>	20% <u>coinsurance</u> after <u>deductible</u>	20% <u>coinsurance</u> after <u>deductible</u>	Includes physical therapy. Speech/hearing, occupational, respiratory/pulmonary therapies and cardiac rehab limited to a combined maximum of 80 visits per year.
	<u>Skilled nursing care</u>	No Charge (<u>deductible</u> does not apply)	No Charge (<u>deductible</u> does not apply)	Limited to 100 days per year. <u>Preauthorization</u> recommended.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u> after <u>deductible</u>	20% <u>coinsurance</u> after <u>deductible</u>	<u>Preauthorization</u> recommended for electric/motorized scooters or wheelchairs and pneumatic compression devices.
	<u>Hospice services</u>	No Charge (<u>deductible</u> does not apply)	No Charge (<u>deductible</u> does not apply)	Bereavement counseling is covered if received within 12 months of death, limited to 5 visits per occurrence. <u>Hospice services</u> 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 <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u>.)		
• 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 <u>plan</u> 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 Health Advocates, Community Service Society of New York 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, kwíijigo 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 <u>plan's</u> overall <u>deductible</u>	\$322
■ <u>Primary care physician coinsurance</u>	0%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$322
Copayments	\$10
Coinsurance	\$1,000
<i>What isn't covered</i>	
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 <u>plan's</u> overall <u>deductible</u>	\$322
■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$322
Copayments	\$500
Coinsurance	\$300
<i>What isn't covered</i>	
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 <u>plan's</u> overall <u>deductible</u>	\$322
■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$322
Copayments	\$10
Coinsurance	\$500
<i>What isn't covered</i>	
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.