



**Roofers' Local 195 Health and Accident Fund**  
**7706 Maltlage Drive \* Liverpool, NY \* 13090**  
**Phone: (315) 699-1388**

**Coverage Period**  
**07/01/2025 – 06/30/2026**

**Summary of Benefits and Coverage:**  
**What Plan do you chose?**

What the Plan(s) Cover & What it Costs

**Coverage for:** Single; Employee + Spouse; Family \* **Plan Type:** Basic/Major Medical



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<u>General Information</u>		Option 1 - Plan A Single Monthly Premium - \$ 1,180.00 Employee+Spouse Monthly Premium \$ 1,925.00 Family Monthly Premium \$ 2,140.00		Option 2 - Plan B Single Monthly Premium - \$ 944.00 Employee+Spouse Monthly Premium \$ 1,694.00 Family Monthly Premium \$ 1,976.00	
		In Network	Out of Network	In Network	Out of Network
<u>What is the overall deductible?</u>	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan 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 deductible expenses paid by all family members meets the overall family deductible.	In and Out-of-Network		In and Out-of-Network	
<u>Are there services covered before you meet your deductible?</u>	This plan will generally pay 100% coverage once you have reached your out-of-pocket limit on your expenses.	Combined <b>\$ 500 Individual/ \$ 1000 Family</b> . Applies to the services after the copay is applied.		Combined <b>\$ 5000 Individual/ \$ 10,000 Family</b> . Applies to the services after the copay is applied.	
<u>Are there other deductibles for specific services?</u>		You will have to meet the deductible before the plan pays for any services with the exception of those items mandated under the Affordable Care Act, where the deductibles do not apply.		You will have to meet the deductible before the plan pays for any services with the exception of those items mandated under the Affordable Care Act, where the deductibles do not apply.	
<u>What is the out-of-pocket limit for this plan?</u>	This plan 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 these services.	\$7,700/15,400 medical	\$7,700/15,400 medical	\$7,700/15,400 medical	\$7,700/15,400 medical
		\$1,000/\$2,000 Rx	\$1,000/\$2,000 Rx	\$1,000/\$2,000 Rx	\$1,000/\$2,000 Rx
<u>Will you pay less if you use a network provider?</u>		Yes, see <a href="http://www.Aetna.com">www.Aetna.com</a> for a list of <u>network providers</u> .	Out-of Network providers may be subject to higher copays and higher coinsurance fees. See below for more detail. This plan is a \$ 15.00 copay plus 20% coinsurance.	Yes, see <a href="http://www.Aetna.com">www.Aetna.com</a> for a list of <u>network providers</u> .	Out-of Network providers may be subject to higher copays and higher coinsurance fees. See below for more detail. This plan is a 20% coinsurance.

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		In Network	Out of Network	In Network	Out of Network
		You can see the <u>specialist</u> you choose without a referral.		You can see the <u>specialist</u> you choose without a referral.	
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>		You can see the <u>specialist</u> you choose without a referral.		You can see the <u>specialist</u> you choose without a referral.	
<b>If you visit a health care provider's office or clinic.</b>	Primary care visit to treat an injury or illness	\$15 copay, then 0% coinsurance after deductible	\$15 copay, then 20% coinsurance after deductible	\$25 copay, then 0% coinsurance after deductible	\$25 copay, then 20% coinsurance after deductible
	<a href="#">Specialist visit</a>	\$15 copay, then 0% coinsurance after deductible	\$15 copay, then 20% coinsurance after deductible	\$25 copay, then 0% coinsurance after deductible	\$25 copay, then 20% coinsurance after deductible
	<u>Preventive care/screening/</u> and Immunizations.	Well Child: No charge  Adult: \$15 copay, then no charge after deductible. There are additional screenings for adults that may not be subject to the annual deductible.	Well Child: No charge  Adult: \$15 copay, 20% coinsurance; then no charge after deductible. There are additional screenings for adults that may not be subject to the annual deductible.	Well Child: No charge  Adult: \$15 copay, then no charge after deductible. There are additional screenings for adults that may not be subject to the annual deductible.	Well Child: No charge  Adult: \$15 copay, then 20% coinsurance, no charge after deductible. There are additional screenings for adults that may not be subject to the annual deductible.
<b>If you have a test</b>	<u>Diagnostic test (x-ray, blood work)</u>	10% coinsurance after deductible	20% coinsurance after deductible	10% coinsurance after deductible	20% coinsurance after deductible
<b>If you need drugs to treat your illness or condition</b>	Imaging (CT/PET scans, MRIs)	10% coinsurance after deductible	20% coinsurance after deductible	10% coinsurance after deductible	20% coinsurance after deductible
<b><u>More information about prescription drug coverage is available at <a href="http://www.Aetna.com">www.Aetna.com</a></u></b>	Generic drugs	\$10 copay per prescription (retail and mail order)		\$10 copay per prescription (retail and mail order)	
	Preferred brand drugs	\$15 copay per prescription (retail and mail order)		\$15 copay per prescription (retail and mail order)	
	Non-preferred brand drugs	\$15 copay per prescription (retail and mail order)		\$15 copay per prescription (retail and mail order)	
<b><u>Specialty drugs*</u></b>	<u>Specialty drugs*</u>	20% coinsurance		20% coinsurance	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% coinsurance after deductible	20% coinsurance after deductible	10% coinsurance after deductible	20% coinsurance after deductible
	Physician/surgeon fees	10% coinsurance after deductible	20% coinsurance after deductible	10% coinsurance after deductible	20% coinsurance after deductible
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	10% coinsurance after deductible	20% coinsurance after deductible	10% coinsurance after deductible	20% coinsurance after deductible
	<a href="#">Emergency medical transportation</a>	10% coinsurance after deductible	20% coinsurance after deductible	10% coinsurance after deductible	20% coinsurance after deductible
	<a href="#">Urgent care</a>	10% coinsurance after deductible	20% coinsurance after deductible	10% coinsurance after deductible	20% coinsurance after deductible
<b>If you have a hospital stay; precertification is required.</b>	Facility fee (e.g., hospital room)	No charge after deductible	20% coinsurance after deductible	No charge after deductible	20% coinsurance after deductible
	Physician/surgeon fees	\$15 copay, then 10% coinsurance after deductible	\$15 copay (per visit) then 20% coinsurance after deductible	\$25 copay, then 10% coinsurance after deductible	\$25 copay (per visit) then 20% coinsurance after deductible

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		If you need mental health, behavioral health, or substance abuse services; precertification is required.	Outpatient services	\$15 copay, then 10% coinsurance after deductible	\$15 copay, then 20% coinsurance after deductible
	Inpatient services (Facility)	No charge after deductible	20% coinsurance after deductible	No charge after deductible	20% coinsurance after deductible
If you are pregnant	Office visits	\$15 copay, then 100% after deductible	\$15 copay then 20% coinsurance after deductible	\$25 copay, then 100% after deductible	\$25 copay then 20% coinsurance after deductible
	Childbirth/delivery professional services	No charge after deductible	20% coinsurance after deductible	No charge after deductible	20% coinsurance after deductible
	Childbirth/delivery facility services	No charge after deductible	20% coinsurance after deductible	No charge after deductible	20% coinsurance after deductible
<u>If you need help recovering or have other special health needs.</u>					
Limit: 40 Visits per calendar year	<a href="#">Home health care</a>	No charge after deductible	20% coinsurance after deductible	No charge after deductible	20% coinsurance after deductible
Limit 70 days per disability combined with Hospital Benefit.	<a href="#">Rehabilitation services</a>	Physical, Occupational and Speech Therapies: 20% coinsurance after deductible	Physical, Occupational and Speech Therapies: 20% coinsurance after deductible	Physical, Occupational and Speech Therapies: 20% coinsurance after deductible	Physical, Occupational and Speech Therapies: 20% coinsurance after deductible
Limit 70 days per disability combined with Hospital Benefit. See Rehabilitation services.	<a href="#">Habilitation services</a>	Rehabilitation Facility: No charge after deductible. See Rehabilitation	Rehabilitation facility: 20% coinsurance after deductible See Rehabilitation	Rehabilitation Facility: No charge after deductible. See Rehabilitation	Rehabilitation facility: 20% coinsurance after deductible See Rehabilitation
Limit 70 days per disability combined with Hospital	<a href="#">Skilled nursing care</a>	No charge after deductible	20% coinsurance after deductible	No charge after deductible	20% coinsurance after deductible
The plan pays for rental not to exceed the purchase price	<a href="#">Durable medical equipment</a>	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Limit: 90 days per calendar year	<a href="#">Hospice services</a>	No charge up to a maximum of \$200 per day after deductible	No charge up to a maximum of \$200 per day after deductible	No charge up to a maximum of \$200 per day after deductible	No charge up to a maximum of \$200 per day after deductible
Treatment for diseases of the eye may be covered under the medical benefit portion of the plan. If your child needs dental or eye care, only those services required under the ACA will be covered.	Children's eye exam	As required under the ACA.	As required under the ACA.	As required under the ACA.	As required under the ACA.
	Children's glasses	Not covered	Not covered	Not covered	Not covered
	Children's dental check-up	As required under the ACA.	As required under the ACA.	As required under the ACA.	As required under the ACA.