



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

07/01/2026 – 06/30/2027

PLAN B – HIGH-DEDUCTIBLE PLAN

Summary of Benefits and Coverage:

What this Plan Covers & What it Costs

Coverage for: Single; Family * **Plan Type:** Basic/Major Medical



Roofers Local 195 Health and Accident Fund Summary of Benefits and Coverage:

What this Plan Covers & What You Pay For Covered Services

OPTION 2 – Plan B

Coverage Period: 07/01/2026 – 06/30/2027
 Coverage for: Individual, Family | Plan Type: _PPO_




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, please contact The Fund office at 315-699-1388. 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.rooferslocal195.com or call 1-315-699-1388 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	In and Out-of-Network combined: \$5,000 Individual / \$10,000 Family. Applies to the services after the copay.	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 <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> ?	No	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 <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> ?	\$7,700/15,400 medical \$1,000/\$17,400 Rx	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 <u>out-of-pocket limit</u> ?	Even though you pay these expenses, they don't count toward the out-of-pocket limit.	Copayments for certain services, premiums, balance-billing charges, and health care this plan doesn't cover.
Will you pay less if you use a <u>network provider</u> ?	Yes, see www.Aetna.com for a list of network providers.	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 these 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 referral.

Roofers Local 195 Health and Accident Fund Summary of Benefits and Coverage:

What this Plan Covers & What You Pay for Covered Services

Coverage Period: 07/01/2026 – 06/30/2027
Coverage for: Medical and RX | Plan Type: _PPO_

 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
		Network Provider (You will pay the least)	Out-of-Network 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, then 0% coinsurance after deductible	\$25 copay, then 20% coinsurance after deductible	_____ none _____
	Specialist visit	\$25 copay, then 0% coinsurance after deductible	\$25 copay, then 20% coinsurance after deductible	_____ none _____
	Preventive care/screening/immunization	Child: No charge after deductible Adult: \$25 copay, then no charge after deductible	Child: No charge up to the allowed amount, after deductible Adult: \$25 copay, then 20% coinsurance after deductible	_____ none _____
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance after deductible	20% coinsurance after deductible	_____ none _____
	Imaging (CT/PET scans, MRIs)	10% coinsurance after deductible	20% coinsurance after deductible	Prior Authorization may be required
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.Aetna.com	Generic drugs	\$10 copay per prescription (retail and mail order)		Pharmacy benefits are limited to an annual benefit maximum of 100% of the first \$5,000 per family after applicable Copay, then payable at 80% with an applicable Copay of 20%, not subject to deductible. *Except for Specialty drugs which require a 20% copay. Retail: Limited to a one-month supply Mail: Limited to three months supply
	Preferred brand drugs	\$15 copay per prescription (retail and mail order)		
	Non-preferred brand drugs	\$15 copay per prescription (retail and mail order)		
	Specialty drugs *	20% coinsurance		

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance after deductible	20% coinsurance after deductible	_____none_____
	Physician/surgeon fees	10% coinsurance after deductible	20% coinsurance after deductible	_____none_____
If you need immediate medical attention	Emergency room care	10% coinsurance after deductible	10% coinsurance after deductible	_____none_____
	Emergency medical transportation	10% coinsurance after deductible	10% coinsurance after deductible	_____none_____
	Urgent care	10% coinsurance after deductible	10% coinsurance after deductible	_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after deductible	20% coinsurance after deductible	Limit: 70 days per disability Prior Authorization may be required.
	Physician/surgeon fees	\$25 copay, then 10% coinsurance after deductible	\$25 copay (per visit) then 20% coinsurance after deductible	_____none_____
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 copay, then 10% coinsurance after deductible	\$25 copay then 20% coinsurance after deductible	No Precertification is Required
	Inpatient services	No charge after deductible	20% coinsurance after deductible	Precertification required for all inpatient services, including mental health and substance abuse treatment. Limit: 70 days per disability
If you are pregnant	Office visits	\$25 copay, then 0% coinsurance after deductible	\$25 copay then 20% coinsurance after deductible	_____none_____
	Childbirth/delivery professional services	No charge after deductible	20% coinsurance after deductible	_____none_____
	Childbirth/delivery facility services	No charge after deductible	20% coinsurance after deductible	_____none_____

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge after deductible	20% coinsurance after deductible	Limit: 40 Visits per calendar year
	Rehabilitation services	Physical, Occupational and Speech Therapies: 20% coinsurance after Deductible	Physical, Occupational and Speech Therapies: 20% coinsurance after deductible	_____none_____
	Habilitation services	Rehabilitation Facility: No charge after deductible. See Rehabilitation	Rehabilitation facility: 20% coinsurance after deductible See Rehabilitation	Limit 70 days per disability combined with Hospital See Rehabilitation Services
	Skilled nursing care	No charge after deductible	20% coinsurance after deductible	Limit 70 days per disability combined with Hospital
	Durable medical equipment	20% coinsurance after deductible	20% coinsurance after deductible	The plan pays for rental not to exceed the purchase price
	Hospice services	No charge up to a maximum of \$200 per day after deductible	No charge up to a maximum of \$200 per day after deductible	Limit: 90 days per calendar year
If your child needs dental or eye care	Children’s eye exam	100% covered	20% coinsurance	Pediatric Vision and Dental coverage are based upon the Essential Health Benefits as established under the ADA.
	Children’s glasses	100% covered	20% coinsurance	
	Children’s dental check-up	100% covered	20% coinsurance	Pediatric Vision benefits include, an annual vision check-up, standard prescription lenses, and standard frames; covered once in any twelve-month period.

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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 .)		
<ul style="list-style-type: none">Acupuncture (except if performed in lieu of anesthesia)Biofeedback, Hypnosis or Hypnotherapy'Chiropractic careCosmetic surgery	<ul style="list-style-type: none">Dental care (Adult)Elective Abortion (unless life threatening to the mother)Infertility treatmentLong-term care	<ul style="list-style-type: none">Non-emergency care when traveling outside the U.S.Routine eye care (Adult)Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none">Bariatric surgery (Precertification required)Routine Foot care	<ul style="list-style-type: none">Hearing aids	<ul style="list-style-type: none">Private duty nursing

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 U.S. Department of Labor, Employee Benefits Administration at 1-866-444-3272 or www.dol.gov/ebsa or the U.S. Department of Health and Human Services at 1-877-267-2323 x 61565 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: Roofers Local 195 Health and Accident Fund at 315-699-1388 or the U.S. Department of Labor, Employee Benefits Administration at 1-866-444-3272 or www.dol.gov/ebsa or the U.S.

Does this plan provide Minimum Essential Coverage? Yes, this plan does provide minimum essential coverage

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes, this plan does meet the minimum value standards

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](#).

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



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](#) \$5000
- [Specialist](#) [co-pay] \$25
- Hospital (facility) [[Coinsurance](#)] 0%
- Other 10%

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$5,000
Copayments	\$40
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$5,100

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

- The [plan's](#) overall [deductible](#) \$5000
- [Specialist](#) [co-pay] \$25
- Hospital (facility) [[Coinsurance](#)] 0%
- Other 10%

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,900
Copayments	\$300
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$2,220

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

- The [plan's](#) overall [deductible](#) \$5000
- [Specialist](#) [co-pay] \$25
- Hospital (facility) [[Coinsurance](#)] 0%
- Other 10%

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:

Cost Sharing	
Deductibles	\$2,765
Copayments	\$35
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

