Roofers' Local 195 Health and Accident Fund

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Coverage Period

07/01/2024 – 06/30/2025

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

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 deductible?	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 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?	**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 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?	**$7,700/15,400 Medical** **$1,000/$2,000 Prescriptions**	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?	**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 network provider?	**Yes, see** www.Aetna.com **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 these 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
		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 a three month
	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		

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)	
				Supply
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

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)	
	Childbirth/delivery facility services	No charge after deductible	20% coinsurance after deductible	_____none_____
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. Pediatric Vision benefits include, an annual vision check-up, standard prescription lenses, and standard frames; covered once in any twelve-month period.
	Children's glasses	100% covered	20% coinsurance	
	Children's dental check-up	100% covered	20% coinsurance	

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 (except if performed in lieu of anesthesia)
- Biofeedback, Hypnosis or Hypnotherapy'
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Elective Abortion (unless life threatening to the mother)
- Infertility treatment
- Long-term care
- 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.)

- Bariatric surgery (Precertification required)
- Routine Foot care
- Hearing aids
- 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 Heath 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.

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	$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**

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**

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**

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**

Your Health Reimbursement Account (HRA) may be available for reimbursement for out-of-pocket expenses.
The plan would be responsible for the other costs of these EXAMPLE covered services.