Roofers' Local 195 Health and Accident Fund
7706 Maltlage Drive * Liverpool, NY * 13090
Phone: (315) 699-1388
Coverage Period
01/01/2022 – 06/30/2022

Summary of Benefits and Coverage:

What this Plan Covers & What it Costs

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

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General Information		Option 1 - Plan A Monthly Premium - $ 1,442.00		Option 2 - Plan B Monthly Premium - $ 1,194.00	
		In Network	Out of Network	In Network	Out of Network
What is the overall deductible?	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.	**In and Out-of-Network**		**In and Out-of-Network**	
		Combined **$ 500 Individual/ $ 1000 Family**. Applies to the services after the copay is applied.		Combined **$ 5000 Individual/ $ 10,000 Family**. Applies to the services after the copay is applied.	
Are there services covered before you meet your deductible?		**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.**	
Are there other deductibles for specific services?					
What is the out-of-pocket limit for this plan?	This plan will generally pay 100% coverage once you have reached your out-of-pocket limit on your expenses.	**$7,700/15,400 medical** **$1,000/$2,000 Rx**	**$7,700/15,400 medical** **$1,000/$2,000 Rx**	**$7,700/15,400 medical** **$1,000/$2,000 Rx**	**$7,700/15,400 medical** **$1,000/$2,000 Rx**
Will you pay less if you use a network provider?	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.	Yes, see www.Aetna.com for a list of network providers.	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 www.Aetna.com for a list of network providers.	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.
Do you need a referral to see a specialist?		You can see the specialist you choose without a referral.		You can see the specialist you choose without a referral.	
	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
	Specialist visit	$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

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If you visit a health care provider's office or clinic.	Preventive care/screening/ 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 deductibel.	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 deductibel.	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 deductibel.	Well Child: No charge Adult: $15 copay, then 20% co insurance, no charge after deductible. There are additional screenings for adults that may not be subject to the annual deductibel.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance after deductible	20% coinsurance after deductible	10% coinsurance after deductible	20% coinsurance after deductible
If you need drugs to treat your illness or condition	Imaging (CT/PET scans, MRIs)	10% coinsurance after deductible	20% coinsurance after deductible	10% coinsurance after deductible	20% coinsurance after deductible
More information about prescription drug coverage is available at www.Aetna.com	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)	
Specialty drugs*	Specialty drugs*	20% coinsurance		20% coinsurance	
If you have outpatient surgery	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
If you need immediate medical attention	Emergency room care	10% coinsurance after deductible	20% coinsurance after deductible	10% coinsurance after deductible	20% coinsurance after deductible
	Emergency medical transportation	10% coinsurance after deductible	20% coinsurance after deductible	10% coinsurance after deductible	20% coinsurance after deductible
	Urgent care	10% coinsurance after deductible	20% coinsurance after deductible	10% coinsurance after deductible	20% coinsurance after deductible
If you have a hospital stay; precertification is required.	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
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	$25 copay, then 10% coinsurance after deductible	$25 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

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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
If you need help recovering or have other special health needs.					
Limit: 40 Visits per calendar year	Home health care	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.	Rehabilitation services	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.	Habilitation services	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	Skilled nursing care	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	Durable medical equipment	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Limit: 90 days per calendar year	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	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.