Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period:1/1/2026- 12/31/2026

New England Health Care Employees Welfare Fund: Wage Class II

Coverage for: Individual, Family/Plan Type: Taft Hartley Trust Fund

The Summary of Benefits and Coverage (SBC) document shows you how you and the plan would share the cost for covered health care services. NOTE: This SBC applies to Wage Class II Eligible Participants. If you are not sure what your wage classification is, reach out to the Fund Office Toll Free 1-800-227-4744 or Local 1-860-728-1100. Information about the cost of this plan (called the premium) including eligible spouse premium will be provided separately. This SBC is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.1199nefunds.org or call the Fund Office. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary included in this packet. You can also view the Glossary at www.1199nefunds.org or call the Fund Office to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$900/Individual or $1800 Family**	Generally, you must pay all 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 meet the overall family deductible.
Are there services covered before you meet your deductible?	**Yes. Preventive care, prescription drugs and primary care services are covered before you meet your deductible**	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 some services even if you did not meet the deductible amount. You can access a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	**No.**	
What is the out-of-pocket limit for this plan?	**$3,700/Individual/$7,400/Family for Medical**	The out-of-pocket limit is the most you would pay in a year for covered services. If you have other family members in this plan, they must 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?	**Spousal Premiums, balance billing, penalty fees and healthcare not covered by this plan**	These types of expenses, while considered out of pocket, do not count toward the out-of- pocket limit.
Will you pay less if you use a network provider?	**Yes. For network providers go to www.whyuhc.com/uhss or call Fund Office 1-800-227-4744 or 860-728-1100**	Services provided by an out-of-network provider are not covered by this plan. Always check to see if your provider is in the UnitedHealthcare services network including any other providers and/or lab facilities you are referred to for services.
Do you need a referral to see a specialist?	**No.**	You can see the specialist you choose without a referral if they are in the network. Otherwise, you will pay out of pocket for any expenses incurred by an out-of-network provider.

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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 Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay	Not Covered	Out of network providers are not covered except in case of medical emergency.
	Specialist visit	$30 copay* 15% coins	Not Covered	You can choose any Network Specialist without a referral – Out of network providers are not covered.
	Preventive care/screening/ immunization	No Charge	Not Covered	Ask your provider to make sure the services being provided are preventive; if they are not preventive, check your plan to understand your cost and what the plan pays.
	Other Provider Services	$30 copay* 15% coins	Not Covered	Coverage is limited to a maximum of 30 visits per calendar year for Physical Therapy, Chiropractic services, and Acupuncture. Occupational and Speech Therapy combined are limited to 30 visits max per calendar year.
If you have a test	Diagnostic test (x-ray, blood work)	15% coins	Not Covered	Some services for Genetic Testing, and Sleep Study require pre-authorization. Your provider must call UnitedHealth services at 1-800-897-2187 to pre-authorize these services.
	Imaging (CT/PET scans, MRIs)	15% coins	Not Covered	

*Specialist copay applies to Office Visit only. All other services are subject to deductible and coinsurance) For more information about limitation and exclusions, see the plan or policy document at (www.1199nefunds.org)

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Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.EmpiRxhealth.com	**Tier 1** Generic drugs	Not Covered	Not Covered	
	Tier 2 Formulary brand drugs	Not Covered	Not Covered	
	Tier 3 Non-formulary brand drugs	Not Covered	Not Covered	
	Specialty drugs	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200 copay 15% coins	Not Covered	Certain out-patient surgery requires prior authorization. Your provider must call UnitedHealthcare services at 1-800-897-2187 to pre-authorize these services.
	Physician/surgeon fees	15% coins	Not Covered	

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Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	Emergency room care	$250 copay 15% coins	**Treated In-Network** $250 copay 15% coins	**Emergency services** mean screening (to evaluate a medical condition) and stabilization (medical examination and treatment needed to stabilize the patient) services with respect to a medical condition that is characterized by acute symptoms of sufficient severity (including severe pain) that a reasonable layperson would expect the absence of medical attention to place the health of the individual in serious jeopardy.
	Emergency medical transportation	15% coins	**Treated as In-Network** 15% coins	
	Urgent care	$50 copay	Not Covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay 15% coins	Not Covered	If admitted inpatient because of an emergency room visit, $250 copay that applies to emergency room visits will be waived.
	Physician/surgeon fees	15% coins	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	15% coins	Not Covered	Certain outpatient and in-patient services require prior authorization. Your provider must call UnitedHealthcare services at 1-800-897-2187 to pre-authorize these services
	Inpatient services	15% coins	Not Covered	

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Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you are pregnant	Office visits	$15 copay	Not Covered	There may be some services where a copay, deductible may apply. **Maternity expenses for dependent children are not covered.**
	Childbirth/delivery professional services (Global Charge)	15% coins	Not Covered	
	Childbirth/delivery facility services	15% coins	Not Covered	
If you need help recovering or have other special health needs	Home health care	15% coins	Not Covered	Specific services related to skilled nursing, home health care and hospice require pre-authorization. Your provider must call UnitedHealthcare services at 1-800-897-2187 to pre-authorize these services.
	Rehabilitation services	15% coins	Not Covered	
	Habilitation services	15% coins	Not Covered	
	Skilled nursing care	15% coins	Not Covered	
	Durable medical equipment	15% coins	Not Covered	
	Hospice services	15% coins	Not Covered	

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Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If your child needs dental or eye care	Children's eye exam	$0 copay	Services are paid by you when rendered – with limited allowable amounts for the services	When you use out of network providers you submit the claim directly to the vision carrier after you have directly paid the provider. For more detailed plan information call Davis Vision at 1-877-923-2847.
	Children's glasses	$0 copay	Services are paid by you when rendered – with limited allowable amounts for the services	When you use out of network providers you submit the claim directly to the vision carrier after you have directly paid the provider. For more detailed plan information call Davis Vision at 1-877-923-2847.
	Children's dental check-up	Not Covered	Not Covered	No Dental Coverage with this Plan

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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 comprehensive list of any other excluded services.)

- Convalescent facilities, group homes, halfway houses, nursing homes, rest homes
- Custodial care
- Cosmetic surgery (Refer to Plan Document for more details)
- Dietician services
- Dental Care
- Infertility treatment
- Long Term care
- Non-Emergency care when traveling outside the U.S.
- Nutritionists unless done in conjunction with a covered diagnosis
- Organ transplant (Refer to Plan Document for more details)
- Over the counter drugs
- Prescription drug coverage
- Private duty nursing
- Services not medically necessary
- Weight loss programs
- Wigs – unless due to chemotherapy or radiation therapy in which case coverage is limited to two wigs per calendar year

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture treatment performed by a licensed Medical Doctor, Doctor of Osteopathy or Licensed Acupuncturist
- Skilled nursing facilities for short term rehabilitation and pre-authorization
- Bariatric surgery with pre-authorization
- Genetic testing with pre-authorization and meets plan criteria
- Chiropractic care services limited to 30 visits per calendar year
- Speech Therapy/Occupational Therapy combines
- limited to 30 visits per calendar year
- Physical Therapy limited to 30 visits per calendar year
- Hearing aids – limited to one appliance every 3 years up to $2,500 for each appliance for each ear
- Out of Network medical providers only in case of medical emergency
- Routine eye care (Administered through Davis Vision)
  - **Up to age 13** – 1 exam/1 pair of glasses per year
  - **13 & Over** – 1 exam/1 pair of glasses every two years.
  - Fore eye care services, If you choose an out-of-network provider for vision services, you must pay the provider directly for all charges and then submit a claim to Davis Vision after services are rendered to be reimbursed directly.

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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: [Your State Insurance Department, the US Department of Health and Human Services(HHS) at 1-877-696-6775, Department of Labor(DOL) Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa. Other coverage options may be available to you, 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 the Fund Office Toll Free at 1-800-227-4744 or Local at 1-860-728-1100.

Additionally, a consumer assistance program can help you file your appeal by contacting the Connecticut Office of the Healthcare Advocate at www.ct.gov/oha, healthcare.advocate@ct.gov or Toll free at 1-866-466-4446. You can also write to them at:

Connecticut Office of the Healthcare Advocate
P.O.Box 1543
Hartford, CT 06144

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 [insert telephone number 1-804-673-1177].] [Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [1-804-673-1177].]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码[1-804-673-1177].] [Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [1-804-673-1177].]

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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. 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	$900
Specialist copay	$30
Hospital (facility) coinsurance	15%
Other coinsurance	15%

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	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$900
Copayments	$30
Coinsurance	$1785
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,715**

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

The plan's overall deductible	$900
Primary Care copayment	$15
Hospital (facility) coinsurance	15%
Other coinsurance	15%

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	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductible	$900
Copayment	$15
Coinsurance	$975
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,890**

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

The plan's overall deductible	$900
Specialist coinsurance	15%
Emergency room copayment	$250
Other coinsurance]	15%

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	$900
Copayments	$250
Coinsurance	$285
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,435**

The plan would be responsible for the other costs of these EXAMPLE covered services

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