Coverage Period: 01/01/2026 – 12/31/2026
Coverage for: Single & Family | Plan Type: PPO

IBEW WU H and W Trust Fund Comprehensive 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, visit www.webaddress.com or call 1-000-000-0000. 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.healthcare.gov/sbc-glossary or call 1-000-000-0000 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network: **$300** person/**$900** family per calendar year. Out-of-Network: **$600** person/**$1,800** family per calendar year.	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 meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network preventive care, your drug card costs, in-network office services and services subject to copayments 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 example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?		
What is the out-of-pocket limit for this plan?	Health In-Network: **$6,600** person/ **$13,200** family per calendar year. Health Out-Of-Network: **$0** person/**$0** family per calendar year. Drug Card: **$0** person/**$0** family per calendar year. The In-Network health and drug card out-of-pocket maximum amounts accumulate together.	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?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.wellmark.com or call 1-000-000-0000 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 services.

Important Questions	Answers	Why this Matters:
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 In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) 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	$25 copay per provider per date of service	50% coinsurance	Primary Care Provider (PCP) types can be found in the What You Pay section of your plan document.
	Specialist visit	$50 copay per provider per date of service	50% coinsurance	Applies to Non-PCP providers. $25 copay per provider per date of service for in-network chiropractic services. Hearing exams are covered according to ACA guidelines.
	Preventive care/screening/ immunization	No charge	50% coinsurance	One preventive exam and one mammogram per calendar year. Well-child care is covered to age 7. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	50% coinsurance	For a test in a provider's office or clinic, your cost is included in the cost-share listed above.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	50% coinsurance	For a test in a provider's office or clinic, your cost is included in the cost-share listed above.

For more information about limitations and exceptions, see your plan document or call Group name at 1-000-000-0000.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) 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.webaddress.com/ prescriptions.	Generic drugs	Retail Pharmacy for 34-day supply: 10% coinsurance with a $10 minimum & $25 maximum payment per prescription; Mail Order for 90-day supply: $10 copayment per prescription. No charge for up to a month's supply of FDA-approved generic contraceptives (or 3-month supply of certain 90-day dosed contraceptives).	40% of the discounted drug cost.	• Medical Plan deductible does not apply; however, a separate drug deductible does apply. • If you purchase a brand drug when a generic drug is available, you pay the brand drug cost sharing plus the difference in cost between the brand drug and generic drug. • If the cost of the drug is less than the minimum payment, you pay just the drug cost. • Some prescriptions are subject to preauthorization (to avoid non-payment), quantity limits or step therapy requirements. • No charge for generic medication used for maintenance purposes when obtained at Mail Order. Maintenance drugs include those to treat chronic conditions like high blood pressure, cholesterol, thyroid, etc. • Certain over the counter (OTC) and prescription drugs are payable at no charge with a prescription. • If you fill a prescription at an Out-of-Network pharmacy, you will need to pay 100% for the drug at the time of purchase and file a claim with SavRx for reimbursement. Plan pays 60% of the discounted drug cost. • No coverage for prescriptions filled at Wal-Mart or Sam's Club Retail or Mail Order locations.
	Preferred brand drugs	Retail Pharmacy for 34-day supply: 20% coinsurance with a $20 minimum & $50 maximum payment per prescription; Mail Order for 90-day supply: $50 copayment per prescription. No charge for up to a month's supply of FDA-approved generic contraceptives (or 3-month supply of certain 90-day dosed contraceptives) if a	40% of the discounted drug cost.	

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
		generic is medically inappropriate or unavailable.		
	Non-preferred brand drugs	Retail Pharmacy for 34-day supply: 50% coinsurance with a $50 minimum (no maximum) payment per prescription. Mail order for 90-day supply: $100 copayment per prescription.	40% of the discounted drug cost.	
	Specialty drugs	You pay the same cost-sharing as retail or mail order for up to a 30-day supply.	Not covered.	Separate drug deductible does apply. Specialty drugs require preauthorization (to avoid non-payment) by calling SavRx at 1-866-233-4239.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	50% coinsurance	------None------
	Physician/surgeon fees	10% coinsurance	50% coinsurance	------None------
If you need immediate medical attention	Emergency room care	$250 copay per visit for facility and physician(s) combined	$250 copay per visit for facility and physician(s) combined	For emergency medical conditions treated out-of-network, it is likely you may not be balance billed pursuant to the federal rules developed for implementation of the No Surprises Act.
	Emergency medical transportation	10% coinsurance	10% coinsurance	For covered non-emergent situations, out-of-network ground ambulance services are NOT reimbursed at the in-network level. You may be balance billed for any out-of-network service as established under the rules developed for implementation of the No Surprises Act.
	Urgent care	$50 copay per provider per date of service for facility and physician(s) combined	50% coinsurance	------None------

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	50% coinsurance	------None------
	Physician/surgeon fees	10% coinsurance	50% coinsurance	------None------

For more information about limitations and exceptions, see your plan document or call Group name at 1-000-000-0000.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $25 copay per provider per date of service Facility: 10% coinsurance	50% coinsurance	------None------
	Inpatient services	10% coinsurance	50% coinsurance	------None------
If you are pregnant	Office visits	10% coinsurance	50% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply for preventive services. For any in-network services that fall outside of routine obstetric care, the office visit benefits shown above may apply.
	Childbirth/delivery professional services	10% coinsurance	50% coinsurance	Benefits shown reflect OB/GYN practitioner services which are typically globally billed at time of delivery for pre-natal, post-natal and delivery services.
	Childbirth/delivery facility services	10% coinsurance	50% coinsurance	------None------

For more information about limitations and exceptions, see your plan document or call Group name at 1-000-000-0000.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	10% coinsurance	50% coinsurance	------None------
	Rehabilitation services	Office: $25 PCP/$50 Non-PCP copay per provider per date of service Facility: 10% coinsurance	50% coinsurance	$25 copay per provider per date of service applies to in-network Physical and Occupational Therapists and Speech Pathologists.
	Habilitation services	Office: $25 PCP/$50 Non-PCP copay per provider per date of service Facility: 10% coinsurance	50% coinsurance	$25 copay per provider per date of service applies to in-network Physical and Occupational Therapists and Speech Pathologists.
	Skilled nursing care	10% coinsurance	50% coinsurance	------None------
	Durable medical equipment	10% coinsurance	50% coinsurance	------None------
	Hospice services	10% coinsurance	50% coinsurance	Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	------None------
	Children's glasses	Not covered	Not covered	------None------
	Children's dental check-up	Not covered	Not covered	------None------

For more information about limitations and exceptions, see your plan document or call Group name at 1-000-000-0000.

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.)	
• Bariatric surgery • Cosmetic surgery • Custodial care - in home or facility • Dental care - Adult • Dental check-up • Extended home skilled nursing • Eye exam	• Glasses • Infertility treatment • Long-term care • Routine eye care - Adult • Routine foot care • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
• Acupuncture ($500 per calendar year) • Applied Behavior Analysis therapy • Chiropractic care ($500 per calendar year) • Hearing aids ($500 every 3 years for adults $2,000 every 3 years for dependent children up to age 26) • Most coverage provided outside the U.S.	• Private-duty nursing - short term intermittent home skilled 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 Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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, you can contact: Group name at 1-000-000-0000 or Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes/No

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/No

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 page.

This contains only a partial description of the benefits, limitations, exclusions and other provisions of the health care plan. It is not a contract or policy. It is a general overview only. It does not provide all the details of coverage, including benefits, exclusions, and policy limitations. In the event there are discrepancies between this document and the Coverage Manual, Certificate, or Policy, the terms and conditions of the Coverage Manual, Certificate, or Policy will govern.

;01/01/2026;PL002945;NL000050;414659-18;414659-16;00057726;N;NGF

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	$300
PCP copayment	$25
Hospital(facility) coinsurance	10%
Other coinsurance	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	$300
Copayments	$100
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	**$70**
The total Peg would pay is	**$1,570**

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

The plan's overall deductible	$300
Specialist copayment	$50
Hospital(facility) coinsurance	10%
Other coinsurance	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	$50
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	**$4,300**
The total Joe would pay is	**$4,750**

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

The plan's overall deductible	$300
Specialist copayment	$50
Hospital(facility) copayment	$250
Other coinsurance	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	$300
Copayments	$500
Coinsurance	$90
What isn't covered	
Limits or exclusions	**$10**
The total Mia would pay is	**$900**

The amounts shown in the maternity claim example above are based on amounts using a single per person deductible. Some plans may actually apply a two-person or family deductible to maternity services for the mother and newborn baby.

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

Wellmark Language Assistance

Discrimination is against the law

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Wellmark

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call 800-524-9242.

If you believe that Wellmark has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Wellmark Civil Rights Coordinator, 1331 Grand Avenue, Station 3E417, Des Moines, IA 50309-2901, 515-376-6500, TTY 888-781-4262, Fax 515-376-9055, Email **CRC@Wellmark.com**. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Wellmark Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

ATENCIÓN: Si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Comuníquese al 800-524-9242 o al (TTY: 888-781-4262).

注意： 如果您说普通话， 我们可免费为您提供语言协助服务。 请拨打 800-524-9242 或 （听障专线： 888-781-4262）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí có qJ;us
sẵn cho quý vị. Xin hãy liên hệ 800-524-9242 hoặc (TTY: 888-781-4262).

NAPOMENA: Ako govorite hrvatski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte 800-524-9242 ili (tekstualni telefon za osobe oštećena sluha: 888-781-4262).

ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen kostenlose sprachliche Assistenzdienste zur Verfügung. Rufnummer: 800-524-9242 oder (TTY: 888-781-4262).

تنبيه: إذا كنت تتحدث اللغة العربية, فإننا نوفر لك خدمات المساعدة اللغوية، المجانية. اتصل بالرقم 2429-425-008 أو (خدمة الهاتف النصي: 888-187-2624).

ສຶດວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານ ໂດຍບໍ່ເສັຍຄ່າ ຫຼື 800-524-9242 ຕິດຕໍ່. (TTY: 888-781-4262.)

주의: 한국어 를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-524-9242번 또는 (TTY: 888-781-4262)번으로 연락해 주십시오.

ध्यान रखें : अगर आपकी भाषा ह⌧न्दी ⌧ै, तो आपकी ह⌧ए भाषा स⌧ायाता सेवाएँ, हन:शुल्की उप⌧ब्ध ⌧ं। 800-524-9242 पर संपकीक कीरं या (TTY: 888-781-4262)।

ATTENTION: Si vous parlez français, des services d’assistance dans votre langue sont à votre disposition gratuitement. Appelez le 800 524 9242 (ou la ligne ATS au 888 781 4262).

Geb Acht: Wann du Deitsch schwetze duscht, kannscht du Hilf in dei eegni Schprooch koschdefrei griege. Ruf 800-524-9242 odder (TTY: 888-781-4262) uff.

โปรดทราบ: หากคุณพูด ไทย เรามีบริการช่วยเหลือด้านภาษาสำหรับคุณโดยไม่คิดค่าใช้จ่าย ติดต่อ 800-524-9242 หรือ (TTY: 888-781-4262)

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad. Makipag-ugnayan sa 800-524-9242 o (TTY: 888-781-4262).

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ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь 800-524-9242 (телетайп: 888-781-4262).

सावधान: याददी तोपाईं नेपा⌧ी बोल्नुहुन्छ भाने, तोपाईंकी ⌧ाहग हन:शुल्की रूपमा भाषा स⌧ायातो सेवा⌧रू उप⌧ब्ध गराइन्छ । 800-524-9242 वा (TTY: 888-781-4262) मा सम्पकीक गनुक⌧ोस् ।

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HEETINA To a wolwa Fulfulde laabi walliinde dow wolde, naa e njobdi, ene ngoodi ngam maaɗa. Heɓir 800-524-9242 malla (TTY: 888-781-4262).

FUULEFFANNAA: Yo isin Oromiffaa, kan dubbattan taatan, tajaajiloonni gargaarsa afaanii, kaffaltii malee, isiniif ni jiru. 800-524-9242 yookin (TTY: 888-781-4262) quunnamaa.

УВАГА! Якщо ви розмовляєте українською мовою, для вас доступні безкоштовні послуги мовної підтримки. Зателефонуйте за номером 800-524-9242 або (телетайп: 888-781-4262).

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