

Medical Plan HealthSaver



ITW Medical Plan

HealthSaver

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

Summary of Benefits and Coverage



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, go to www.bcbsil.com/itw or call 1-800-325-0320. For prescription drugs, go to www.caremark.com or call 1-888-437-4926. 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 <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf> or call 1-800-325-0320 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u>?	<u>In-Network</u> : \$1,900 Individual/\$3,800 Family <u>Out-of-Network</u> : \$3,800 Individual/\$7,600 Family	Generally, you must pay all the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u>?	Yes. Certain <u>preventive care</u> is covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	<u>In-Network</u> : \$4,900 person /\$9,800 family <u>Out-of-Network</u> : \$9,800 person /\$19,600 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billed charges</u> , and exclusions of the <u>plan</u> .	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>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 provider's 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 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 <u>referral</u> .



All 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	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Coverage includes MDLive. Virtual visit: 20% <u>coinsurance</u> . See your benefit booklet for details.
	<u>Specialist</u> visit	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No Charge; <u>deductible</u> does not apply	20% <u>coinsurance</u> ; <u>deductible</u> does not apply	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Some tests subject to medical necessity. Pre-determination of benefits is recommended. <u>Out-of-network providers may balance bill.</u>
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.caremark.com	Generic drugs	20% <u>coinsurance</u> \$0 <u>copay</u> for generic preventive drugs identified by Caremark	You must pay for your prescription upfront and then request reimbursement.	\$20,000 lifetime maximum on fertility medications CVS Caremark Mail Service Pharmacy or Maintenance Choice (MC) required for maintenance medications after initial fill plus one refill at retail. Retail Pharmacy Network: Covers up to a 30-day supply CVS Caremark Mail Service: 31–90-day supply Maintenance Choice: 90-day supply Specialty Pharmacy: Covers up to a 30-day supply. Specialty Pharmacy required after initial fill plus one refill at Retail.
	Preferred brand drugs	20% <u>coinsurance</u>		
	Non-preferred brand drugs	20% <u>coinsurance</u>	Up to a 30-day supply will be reimbursed at contracted rate less <u>coinsurance</u> for initial fill plus one refill only.	
	<u>Specialty drugs</u>	20% <u>coinsurance</u>	You will pay more for your prescriptions filled at an out-of-network pharmacy.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None



All 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 need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Pre-certification required if admitted. <u>Out-of-network providers may balance bill.</u>
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Out-of-network providers may balance bill.</u>
	<u>Urgent care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-certification required for inpatient admission.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None.
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-certification required for inpatient admission.
If you are pregnant	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None.
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Notification required for inpatient admission.



All 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 need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-certification required.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Up to 60 visits combined per year per covered person for physical, speech, and occupational therapy.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Pre-certification required.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Benefits are limited to items used to serve a medical purpose. DME benefits are provided for both purchase and rental equipment (up to the purchase price).
	<u>Hospice service</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None.
If your child needs dental or eye care	Children's eye exam	No charge	20% <u>coinsurance</u>	Routine care only. <u>Out-of-network providers may balance bill.</u>
	Children's glasses	Not Covered	Not Covered	Discount program available.
	Children's dental check-up	Not Covered	Not Covered	Separate Dental Plan available.

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
• Cosmetic surgery • Drugs for cosmetic use only • Dental care (adult) • Acupuncture • Long-term care	• Custodial services • Hearing aids • Inpatient Private Duty Nursing Service • Routine foot care (exception for diabetes diagnosis)	• Weight loss programs • Vitamins or nutritional supplements • Over-the counter products or equivalents • Investigational or experimental medical services or prescription drugs for the treatment of any condition

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

- | | | |
|------------------------------|---|-------------------------|
| • Ambulance | • Casts & splints | • Chiropractic care |
| • Travel expense | • Routine eye care (adult and children) | • Infertility treatment |
| • Medical/surgical dressings | | |

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 ITW Benefits Service Center at 1-866-416-4931, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 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: Medical – Blue Cross Blue Shield of Illinois at 1-800-325-0320 or Prescription Drug – Caremark at 1-888-437-4926

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes employer-sponsored group 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 Standard? 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 1-800-325-0320

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-325-0320

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-325-0320

Navajo (Dine): Dine'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-325-0320

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf 1-800-325-0320 uff

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

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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 <u>deductible</u>	\$1,900
■ <u>Primary Care Physician coinsurance</u>	20%
■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Primary care physician 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:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,900
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,160
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$4,060

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall <u>deductible</u>	\$1,900
■ <u>Primary Care Physician coinsurance</u>	20%
■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

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:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,900
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$740
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$2,640

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall <u>deductible</u>	\$1,900
■ <u>Primary Care Physician coinsurance</u>	20%
■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

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:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,900
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$180
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,080