Medical Plan PPO Option 2

Summary of Benefits and Coverage

ITW Medical Plan

PPO Option 2

Coverage Period: 1/1/2024 – 12/31/2024

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 deductible?	$1,000 person / $2,000 family Doesn't apply to preventive care	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. Certain preventive care, services that charge a copay, and prescription drugs 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 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?	In-Network: $4,100 person /$8,200 family Out-of-Network: $7,500 person /$15,000 family Prescription Drug: $2,500 person /$5,000 family	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 must meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. There is a separate prescription drug out-of-pocket limit. Out-of-pocket limits help you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, penalty for no pre-certification of care, and exclusions of the plan.	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.	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.
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	$35 copay/visit; deductible does not apply	40% coinsurance	Copay applies to the office visit service only. All other services rendered in office setting are subject to general plan payment level (deductible and coinsurance). 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.
	Specialist visit	$50 copay/visit; deductible does not apply	40% coinsurance	
	Preventive care/screening/ immunization	No Charge; deductible does not apply	20% coinsurance; deductible does not apply	
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Some tests subject to medical necessity. Pre-determination of benefits is recommended. Out-of-network providers may balance bill.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	$20 copay/Rx for Retail; $40 copay/Rx for Mail or MC $0 copay for generic preventive drugs identified by Caremark	You must pay for your prescription upfront and then request reimbursement. Up to a 30-day supply will be reimbursed at contracted rate less copay or coinsurance for initial fill plus one refill only. You will pay more for your prescriptions filled at an out-of-network pharmacy.	$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
	Preferred brand drugs	25% coinsurance; up to $125 max for Retail & $300 max for Mail or MC		
	Non-preferred brand drugs	40% coinsurance; up to $275 max for Retail & $600 max for Mail or MC		
	Specialty drugs	30% coinsurance $0 if enrolled in PrudentRx		**Specialty Pharmacy:** Covers up to a 30-day supply. Specialty Pharmacy required after initial fill plus one refill at Retail.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None

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 need immediate medical attention	Emergency room care	$150 ER copay & 20% coinsurance	$150 ER copay & 20% coinsurance	Non-emergency use of the ER subject to plan deductible and coinsurance specific to network status. Pre-certification required if admitted. Out-of-network providers may balance bill. Copay waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Out-of-network providers may balance bill.
	Urgent care	Office: $35/$50 copay Outpatient Facility: $150 copay & 20% coinsurance	Office: 40% coinsurance Outpatient Facility: $150 copay & 20% coinsurance	Office visit copay applies to the office visit service only. All other services rendered in office setting are subject to general plan payment level (deductible and coinsurance).
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 inpatient copay & 20% coinsurance	$250 inpatient copay & 40% coinsurance	Pre-certification required for inpatient admission.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	Office visit subject to copay for in-network care.
	Inpatient services	$250 inpatient copay & 20% coinsurance	$250 inpatient copay & 40% coinsurance	Pre-certification required for inpatient admission.
If you are pregnant	Office visits	$35 copay/visit; deductible does not apply	40% coinsurance	Notification required for inpatient treatment. Office visit copay applies to the office visit service only. All other services rendered in office setting are subject to general plan payment level (deductible and coinsurance).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	$250 inpatient copay & 20% coinsurance	$250 inpatient copay & 40% coinsurance	

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 need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Pre-certification required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Up to 60 visits combined per year per covered person for physical, speech, and occupational therapy.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Pre-certification required.
	Durable medical equipment	20% coinsurance	40% coinsurance	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).
	Hospice service	20% coinsurance	40% coinsurance	None.
If your child needs dental or eye care	Children's eye exam	No charge	20% coinsurance	Routine care only. Out-of-network providers may balance bill.
	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 Plan Generally Does NOT Cover (Check your plan document for more information and a list of any other excluded services.)

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

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): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-325-0320

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

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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. 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	**$1,000**
Primary Care Physician copay	**$35**
Specialist copay	**$50**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**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:

Cost Sharing	
Deductibles	$1,000
Copayments	$285
Coinsurance	$2,283
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,568**

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

The plan's overall deductible	**$1,000**
Primary Care Physician copay	**$35**
Specialist copay	**$50**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**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:

Cost Sharing	
Deductibles	$1,000
Copayments	$380
Coinsurance	$844
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,224**

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

The plan's overall deductible	**$1,000**
Primary Care Physician copay	**$35**
Specialist copay	**$50**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**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:

Cost Sharing	
Deductibles	$1,000
Copayments	$300
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,600**

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