

Medical Plan PPO Option 2



ITW Medical Plan

PPO Option 2

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>?	\$1,000 person / \$2,000 family Doesn't apply to <u>preventive care</u>	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> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. Certain <u>preventive care</u> , services that charge a <u>copay</u> , and prescription drugs 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 a <u>copayment</u> or <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>?	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 <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they must meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. There is a separate prescription drug <u>out-of-pocket limit</u> . <u>Out-of-pocket limits</u> help you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billed charges</u> , penalty for no pre-certification of care, 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 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 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	<u>Copay</u> applies to the office visit service only. All other services rendered in office setting are subject to general <u>plan</u> payment level (<u>deductible</u> and <u>coinsurance</u>). 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.
	<u>Specialist</u> visit	\$50 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	
	<u>Preventive care/screening/immunization</u>	No Charge; <u>deductible</u> does not apply	20% <u>coinsurance</u> ; <u>deductible</u> does not apply	
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</u> may <u>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>copay</u> /Rx for Retail; \$40 <u>copay</u> /Rx for Mail or MC \$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	25% <u>coinsurance</u> ; up to \$125 max for Retail & \$300 max for Mail or MC	Up to a 30-day supply will be reimbursed at contracted rate less <u>copay</u> or <u>coinsurance</u> for initial fill plus one refill only.	
	Non-preferred brand drugs	40% <u>coinsurance</u> ; up to \$275 max for Retail & \$600 max for Mail or MC		
	<u>Specialty drugs</u>	30% <u>coinsurance</u> \$0 if enrolled in PrudentRx	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 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	<u>Emergency room care</u>	\$150 ER <u>copay</u> & 20% <u>coinsurance</u>	\$150 ER <u>copay</u> & 20% <u>coinsurance</u>	Non-emergency use of the ER subject to <u>plan deductible</u> and <u>coinsurance</u> specific to network status. Pre-certification required if admitted. <u>Out-of-network providers</u> may <u>balance bill</u> . <u>Copay</u> waived if admitted.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Out-of-network providers</u> may <u>balance bill</u> .
	<u>Urgent care</u>	Office: \$35/\$50 <u>copay</u> Outpatient Facility: \$150 <u>copay</u> & 20% <u>coinsurance</u>	Office: 40% <u>coinsurance</u> Outpatient Facility: \$150 <u>copay</u> & 20% <u>coinsurance</u>	Office visit <u>copay</u> applies to the office visit service only. All other services rendered in office setting are subject to general <u>plan</u> payment level (<u>deductible</u> and <u>coinsurance</u>).
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 inpatient <u>copay</u> & 20% <u>coinsurance</u>	\$250 inpatient <u>copay</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>	Office visit subject to <u>copay</u> for in-network care.
	Inpatient services	\$250 inpatient <u>copay</u> & 20% <u>coinsurance</u>	\$250 inpatient <u>copay</u> & 40% <u>coinsurance</u>	Pre-certification required for inpatient admission.
If you are pregnant	Office visits	\$35 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	Notification required for inpatient treatment. Office visit <u>copay</u> applies to the office visit service only. All other services rendered in office setting are subject to general <u>plan</u> payment level (<u>deductible</u> and <u>coinsurance</u>).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$250 inpatient <u>copay</u> & 20% <u>coinsurance</u>	\$250 inpatient <u>copay</u> & 40% <u>coinsurance</u>	



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	<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.)

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|---|---|---|
| <ul style="list-style-type: none">• Ambulance• Travel expense• Medical/surgical dressings | <ul style="list-style-type: none">• Casts & splints• Routine eye care (adult and children) | <ul style="list-style-type: none">• 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): 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.—————

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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 <u>deductible</u>	\$1,000
■ <u>Primary Care Physician copay</u>	\$35
■ <u>Specialist copay</u>	\$50
■ 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
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$285
<u>Coinsurance</u>	\$2,283
<i>What isn't covered</i>	
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 <u>deductible</u>	\$1,000
■ <u>Primary Care Physician copay</u>	\$35
■ <u>Specialist copay</u>	\$50
■ 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
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$380
<u>Coinsurance</u>	\$844
<i>What isn't covered</i>	
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 <u>deductible</u>	\$1,000
■ <u>Primary Care Physician copay</u>	\$35
■ <u>Specialist copay</u>	\$50
■ 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
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,600