State Farm Group Medical PPO Plan: Eligible Retired Agents Coverage Period: 01/01/2015 – 12/31/2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for: All Coverage Tiers | Plan Type: PPO**

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.bcbsil.com/statefarm** or by calling Blue Cross Blue Shield of Illinois at **1-888-652-4013**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,500** individual **$3,000** family Doesn't apply to preventive care or outpatient prescription drugs.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$100** for each emergency room visit and **$100** for each non-notification of an inpatient hospitalization. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. For PPO providers: **$5,000** individual / **$10,000** family For non-PPO providers: **$7,500** individual / **$15,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	The "other" deductibles, coinsurance for non-PPO providers for preventive care, out-of-pocket expenses for prescription drugs, premiums, balanced-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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network PPO providers see **www.bcbsil.com/statefarm** or call **1-888-652-4013**.	If you use an in-network doctor or other in-network health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

Questions: Call BCBS of IL at **1-888-652-4013** or visit us at **www.bcbsil.com/statefarm.**
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.dol.gov/ebsa/healthreform** or **www.cciio.cms.gov**; or call 1-866-935-4015 to request a copy.

Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an: In-network PPO Provider	Your Cost If You Use an: Out-of-network (non-PPO) Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	40% coinsurance	Note: All eligible services provided by Non-PPO Providers are subject to Usual & Customary (U&C) allowances.
	Specialist visit	10% coinsurance	40% coinsurance	
	Other practitioner office visit	10% coinsurance	40% coinsurance	Charges for chiropractic services are limited to 30 visits per year. See above re: U&C.
	Preventive care/screening/ immunization	No charge	40% coinsurance	U&C applies for non-PPO providers.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	40% coinsurance	U&C applies for non-PPO providers.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	Your Cost If You Use an: In-network PPO Provider	Your Cost If You Use an: Out-of-network (non-PPO) Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com or by phone at 1-800-388-2058. The Prescription Drug carrier is CVS Caremark.	Generic drugs	Retail: 20% coinsurance with a $10 minimum/ $25 maximum Mail: 20% coinsurance with a $20 min/$50 max	Reimbursement will be based on the average wholesale price of the drug and other factors, less 20% coinsurance.	Retail maximum is 30-day supply; Mail order maximum is 90-day supply; You may use a CVS/pharmacy in lieu of mail order for maintenance medications (90-day supply).
	Preferred brand drugs	Retail: 30% coinsurance with a $10 minimum/ $50 maximum Mail: 30% coinsurance with a $20 min/$100 max	Reimbursement will be based on the average wholesale price of the drug and other factors, less 30% coinsurance.	Retail maximum is 30-day supply; Mail order maximum is 90-day supply; You may use a CVS/pharmacy in lieu of mail order for maintenance medications (90-day supply).
	Non-preferred brand drugs	Retail: 50% coinsurance with a $10 minimum/ $75 maximum Mail: 50% coinsurance with a $20 min/$150 max	Reimbursement will be based on the average wholesale price of the drug and other factors, less 50% coinsurance.	Retail maximum is 30-day supply; Mail order maximum is 90-day supply; You may use a CVS/pharmacy in lieu of mail order for maintenance medications (90-day supply). Some non-preferred brand drugs require a preauthorization; if not obtained the member's cost is 100%.
	Specialty drugs	Contact the Prescription Drug carrier for details	Contact the Prescription Drug carrier for details	Preauthorizations are required for all specialty drugs. Contact the Prescription Drug carrier for details.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40% coinsurance	U&C applies for non-PPO providers.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	Your Cost If You Use an: In-network PPO Provider	Your Cost If You Use an: Out-of-network (non-PPO) Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	10% coinsurance	10% coinsurance	$100 fee for each emergency room visit. U&C applies for non-PPO providers.
	Emergency medical transportation	10% coinsurance	10% coinsurance	
	Urgent care	10% coinsurance	40% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	40% coinsurance	Pre-admission notification required or $100 fee assessed. See above re: U&C.
	Physician/surgeon fee	10% coinsurance	40% coinsurance	U&C applies for non-PPO providers.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% coinsurance	40% coinsurance	U&C applies for non-PPO providers.
	Mental/Behavioral health inpatient services	10% coinsurance	40% coinsurance	Pre-admission notification required or $100 fee assessed. See above re: U&C.
	Substance use disorder outpatient services	10% coinsurance	40% coinsurance	U&C applies for non-PPO providers.
	Substance use disorder inpatient services	10% coinsurance	40% coinsurance	Pre-admission notification required or $100 fee assessed. See above re: U&C.
If you are pregnant	Prenatal and postnatal care	10% coinsurance	40% coinsurance	U&C applies for non-PPO providers.
	Delivery and all inpatient services	10% coinsurance	40% coinsurance	Pre-admission notification required or $100 fee assessed. See above re: U&C.
If you need help recovering or have other special health needs	Home health care	10% coinsurance	40% coinsurance	Maximum benefit of $8,500 per year. U&C applies for non-PPO providers.
	Rehabilitation services	10% coinsurance	40% coinsurance	Coverage is limited for the following: Physical therapy: 50 visits a year Speech therapy: 25 visits a year Occupational therapy: 25 visits a year U&C applies for non-PPO providers.
	Habilitation services	10% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	Your Cost If You Use an: In-network PPO Provider	Your Cost If You Use an: Out-of-network (non-PPO) Provider	Limitations & Exceptions
If you need help recovering or have other special health needs, continued	Skilled nursing care	10% coinsurance	40% coinsurance	Coverage up to 100 days of confinement during each Skilled Nursing Facility Benefit Period as defined by the plan. U&C applies for non-PPO providers.
	Durable medical equipment	10% coinsurance	40% coinsurance	U&C applies for non-PPO providers.
	Hospice service	10% coinsurance	40% coinsurance	U&C applies for non-PPO providers.
If your child needs dental or eye care	Eye exam	No charge	40% coinsurance	Must be part of a pediatric wellness exam to be eligible. U&C applies for non-PPO providers.
	Glasses	Not covered	Not covered	
	Dental check-up	No charge	40% coinsurance	Oral health risk assessments provided to children through age 10 when part of a pediatric wellness exam. See above re: U&C.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Chiropractic care (30 visits per year)
- Most coverage provided outside the United States. See www.bcbsil.com/statefarm
- Non-emergency care when traveling outside the U.S.
- Infertility treatment (Only those services for the diagnosis and treatment of infertility; coverage **does not** include charges resulting from or incurred in connection with in vitro fertilization or other forms of artificial insemination.)
- Private-duty nursing (limited to a maximum benefit of $10,000 per year when prescribed by a doctor)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-935-4015. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Blue Cross Blue Shield of Illinois at 1-888-652-4013 for medical claims and for prescription drug claims; CVS Caremark at 1-800-388-2058. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the "minimum value standard." **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-652-4013.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-888-652-4013.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-652-4013.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $5,420
- **Patient pays:** $2,120

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions - generic	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,500
Copays	$0
Coinsurance ($580 medical; $40 Rx)	$620
Limits or exclusions	$0
Total	**$2,120**

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your costs may be higher. For more information, please contact BCBS of IL at 1-888-652-4013.

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,230
- **Patient pays:** $2,170

Sample care costs:

Prescriptions - generic	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,500
Copays	$0
Coinsurance ($90 medical; $580 Rx)	$670
Limits or exclusions	$0
Total	**$2,170**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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