



State Farm Group Medical PPO Plan
Option 3E (features an HRA)
Benefits Summary

Benefits effective January 1, 2009

Related Internet Sites	www.bcbsil.com/statefarm www.caremark.com or www.caremark.com/statefarm www.goodneighborhealthyliving.com (Matria)	
Customer Service Numbers	Group Medical 1-888-652-4013 Caremark 1-800-388-2058 Good Neighbor Healthy Living (Matria) ¹ 1-866-549-5088 (toll free)	
Annual Deductible	\$2,500	
HRA allocation ²	\$1,000	
Deductible Gap	\$1,500 (The deductible gap may be less depending on any carryover HRA balance.)	
NOTE: This section applies to Employee <u>ONLY</u> coverage with no covered dependents		
Family Annual Aggregate Deductible	\$5,000	
Family HRA allocation ²	\$2,000	
Family Deductible Gap	\$3,000 (The deductible gap may be less depending on any carryover HRA balance.)	
NOTE: This section applies to <u>Employee plus one or more dependents</u>		
Lifetime Maximum Aggregate Benefit Per Individual	The maximum lifetime benefit per individual is \$2,000,000. The net cost of prescription drugs (the amount State Farm pays) applies toward the individual lifetime maximum of \$2,000,000.	
Annual Out-of-Pocket Expense Limit (includes the Annual Deductible) ³ for Employee <u>ONLY</u> coverage with no covered dependents	<i>PPO Provider</i>	<i>Non-PPO Provider</i>
	\$5,000	\$7,500
Family Annual Aggregate Out-of-Pocket Expense Limit (includes the Annual Family Deductible) ³ for <u>Employee plus one or more dependents</u>	\$10,000	\$15,000
	Prior to eligible charges being covered at 100%, the entire aggregate out-of-pocket expense limit must be satisfied. The full aggregate out-of-pocket expense limit may be satisfied by one or more family members. There are no "individual" out-of-pocket expense limits.	
Coinsurance Percentage	After the satisfaction of the deductible, 10% coinsurance required for charges from PPO Providers until the annual Out-of-Pocket Expense Limit is reached. Eligible charges are not subject to U&C limitations.	After the satisfaction of the deductible, 40% coinsurance required for charges from Non-PPO Providers until the annual Out-of-Pocket Expense Limit is reached. Eligible charges are subject to U&C limitations.
Physician Services	Eligible charges subject to deductible and 10% PPO Provider coinsurance.	Eligible charges subject to deductible, U&C and 40% Non-PPO Provider coinsurance.

Inpatient Hospitalization ⁴	Eligible charges subject to deductible and 10% PPO Provider coinsurance.	Eligible charges subject to deductible, U&C and 40% Non-PPO Provider coinsurance.
Emergency Care For each Visit to an Emergency Room, the member will be responsible for the first \$100 in Eligible Charges. If the patient is admitted to the hospital for at least 24 hours from the Emergency Room, this charge will be waived.	After the application of the Emergency Room Visit Charge, remaining eligible charges subject to deductible and 10% PPO Provider coinsurance.	After the application of the Emergency Room Visit Charge, remaining eligible charges subject to deductible, U&C and 10% PPO Provider coinsurance.
Ambulance	Eligible charges subject to deductible and 10% PPO Provider coinsurance.	Eligible charges subject to deductible and 10% coinsurance of billed charges.
Maternity Care: Pre-/Post-Natal Office Visit	Eligible charges subject to deductible and 10% PPO Provider coinsurance.	Eligible charges subject to deductible, U&C and 40% Non-PPO Provider coinsurance.
Maternity Care: Inpatient Delivery ⁴	Eligible charges subject to deductible and 10% PPO Provider coinsurance.	Eligible charges subject to deductible, U&C and 40% Non-PPO Provider coinsurance.
Well Child Care (Not subject to annual deductible) Sports and employment physicals are not eligible.	100% coverage for regularly scheduled check ups, immunizations, screening lab tests, and other associated diagnostic services from birth through age 16.	60% coverage subject to U&C allowance for regularly scheduled check ups, immunizations, screening lab tests, and other associated diagnostic services from birth through age 16. Coinsurance is not eligible for HRA reimbursement.
Preventive Care - adults (Not subject to annual deductible)	100% coverage for preventive diagnostic tests and services from age 17. Benefits are limited to \$1000 per individual per year.	60% coverage subject to U&C allowance for preventive diagnostic tests and services from age 17. Benefits are limited to \$1000 per individual per year. Coinsurance is not eligible for HRA reimbursement.
Colonoscopies and Sigmoidoscopies	Eligible charges subject to deductible and 10% PPO Provider coinsurance, paid as any other illness, regardless of the diagnosis. Not covered under the Preventive Care benefit.	Eligible charges subject to deductible and 40% Non-PPO Provider coinsurance, paid as any other illness, regardless of the diagnosis. Not covered under the Preventive Care benefit.
Mental Health, Substance Abuse, Alcohol Abuse: Inpatient Benefit and Maximum ⁴	Eligible charges subject to deductible and 10% PPO Provider coinsurance. Benefits are limited to annual maximum of 45 inpatient days for any combination of Mental Health and/or Substance Abuse and/or Alcohol Abuse treatment.	Eligible charges subject to deductible, U&C and 40% Non-PPO Provider coinsurance. Benefits are limited to annual maximum of 45 inpatient days for any combination of Mental Health and/or Substance Abuse and/or Alcohol Abuse treatment.
Mental Health, Substance Abuse, Alcohol Abuse: Outpatient Benefit and Maximum	Eligible charges subject to deductible and 10% PPO Provider coinsurance. 45 visit annual limit for any combination of Mental Health and/or Substance Abuse and/or Alcohol Abuse treatment.	Eligible charges subject to deductible, U&C and 40% Non-PPO Provider coinsurance. 45 visit annual limit for any combination of Mental Health and/or Substance Abuse and/or Alcohol Abuse treatment.
Mental Health: Partial Hospitalization	Eligible charges subject to deductible and 10% PPO Provider coinsurance. Limited to maximum of 120 days per calendar year.	Eligible charges subject to deductible, U&C and 40% Non-PPO Provider coinsurance. Limited to maximum of 120 days per calendar year.
Physical, Occupational and Speech Therapy Coverage	Eligible charges subject to deductible and 10% PPO Provider coinsurance with the following calendar year maximums per covered individual: Physical Therapy - \$2500 Occupational Therapy - \$1000 Speech Therapy - \$1000	Eligible charges subject to deductible, U&C and 40% Non-PPO Provider coinsurance with the following calendar year maximums per covered individual: Physical Therapy - \$2500 Occupational Therapy - \$1000 Speech Therapy - \$1000

Organ Transplants ⁵	Eligible charges subject to deductible and 10% PPO Provider coinsurance.	Eligible charges subject to deductible, U&C and 40% Non-PPO Provider coinsurance.
Durable Medical Equipment	Eligible charges subject to deductible and 10% PPO Provider coinsurance.	Eligible charges subject to deductible, U&C and 40% Non-PPO Provider coinsurance.
Contraceptive Coverage	Oral contraceptives are covered under the Outpatient Prescription Drug Benefit; FDA approved prescription devices, procedures, and supplies and corresponding office visits subject to deductible and 10% PPO Provider coinsurance.	Oral contraceptives are covered under the Outpatient Prescription Drug Benefit; FDA approved prescription devices, procedures, and supplies and corresponding office visits subject to deductible, U&C and 40% Non-PPO Provider coinsurance.
Prescription Drug Coverage	Prescription Drug Coinsurance amounts do not apply toward the Out-of-Pocket Expense Limits nor eligible for HRA reimbursement.	
Retail <ul style="list-style-type: none"> • Generic • Preferred Brand-Name • Non-Preferred Brand-Name 	Maximum 30-Day Supply <ul style="list-style-type: none"> • 20% coinsurance for generics with a \$10 minimum and \$25 maximum • 30% coinsurance for medications included on the Preferred Drug List with a \$10 minimum and \$50 maximum • 50% coinsurance with a \$10 minimum and a \$75 maximum for medications not included on the Preferred Drug List 	
Mail Order or retail CVS/pharmacy <ul style="list-style-type: none"> • Generic • Preferred Brand-Name • Non-Preferred Brand-Name 	Maximum 90-Day Supply <ul style="list-style-type: none"> • 20% coinsurance for generics with a \$20 minimum and \$50 maximum • 30% coinsurance for medications included on the Preferred Drug List with a \$20 minimum and \$100 maximum • 50% coinsurance with a \$20 minimum and a \$150 maximum for brand name medications not included on the Preferred Drug List 	
Maintenance Medications at Retail	A maintenance medication can be filled at a retail pharmacy three times during the calendar year (maximum 30-day supply), however, for the 4 th and subsequent fills, you will receive each 30-day supply at the mail order cost. This does not apply to maintenance medications purchased at a retail CVS/pharmacy.	
Quantity Limitations	All drugs prescribed for the treatment of erectile dysfunction will be limited to 8 pills per 30-day supply and 24 pills per 90-day supply.	
Diabetic Supplies	Insulin, insulin syringes, lancets, lancing devices and glucagon emergency kits are eligible under the Outpatient Prescription Drug Expense Benefit through Caremark. A separate prescription is required for each item and each prescription will be subject to the applicable coinsurance. Test strips for glucose monitors will be provided free of charge when purchased at a Caremark participating pharmacy or through Caremark's Mail Order Pharmacy. Alcohol wipes and cotton balls are not eligible under the Plan.	

Disclaimer: This summary does not create a contract or binding agreement. This information is provided in summary for ease of comparison only. In the event there is a discrepancy between the information presented here and the actual plan document, the plan document or contract will prevail.

¹ Good Neighbor Healthy Living is a program available under the Group Medical PPO plan designed to help covered individuals better understand and manage certain chronic health conditions through the use of health coaches and other tools and resources. In addition, Good Neighbor Healthy Living provides a variety of on-line healthy living programs to promote healthier lifestyles among covered associates and their eligible dependents.

² This is the maximum amount that will be contributed in a calendar year. This amount may be prorated as determined by any mid-year enrollment. Refer to the Summary Plan Description for more information.

³ Eligible Charges incurred by PPO Providers will be used toward satisfying the Non-PPO Provider Out-of-Pocket Expense Limits up to the PPO Provider Out-of-Pocket Expense Limits and Eligible Charges incurred by Non-PPO Providers will be used to satisfy the PPO Provider Out-of-Pocket Expense Limits up to the PPO Provider Out-of-Pocket Expense Limits.

⁴ An additional **\$100** Pre-Admission Utilization Review Charge (per hospitalization) is applied if the Blue Cross Blue Shield Medical Services Advisor is not contacted within one business day prior to a scheduled hospital admission or within two business days of an emergency admission, maternity care, mental health or chemical dependency admission.

⁵ For transplants performed at a selected Blue Quality Centers for Transplant (BQCT), after the applicable annual deductible is satisfied, benefits will be increased 10% (not to exceed 100%) for the global fee for the transplant. For other benefits associated with this program, contact the Group Medical Customer Service Unit.