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, contact Accolade customer service at **1-844-287-3859** or visit the BlueCross BlueShield of Illinois website at **www.bcbsil.com/statefarm**. 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.healthcare.gov/sbc-glossary or call 1-844-287-3859 to request a copy. BlueCross BlueShield of Illinois is the Claim Administrator for the Plan.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$2,500** individual **$5,000** family Doesn't apply to preventive care or outpatient prescription drugs. Plan provides a $2,000 Health Reimbursement Account (HRA) that can reduce the deductible.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members in this 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. Preventive care and outpatient prescription drugs are 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?	Yes. **$200** for each emergency room visit and **$100** for each non-notification of an inpatient hospitalization or admission to a Skilled Nursing Facility. 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.
What is the out-of-pocket limit for this plan?	**Medical services**: For PPO Providers **$5,000** individual / **$10,000** family; For Non-PPO Providers **$7,500** individual / **$15,000** family; Medical out-of-pocket limit can be reduced by available HRA. **Outpatient prescription drugs**: **$1,600** individual / **$3,200** family; aggregate out-of-pocket limit for both participating and non-participating pharmacies; HRA does not apply to outpatient prescription drugs.	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 have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

What is not included in the out-of-pocket limit?	Coinsurance for Non-PPO Providers for preventive care, premiums, balance billing 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.
Will you pay less if you use a network provider?	Yes. See **www.bcbsil.com/statefarm** or call 1-844-287-3859 for a list of network providers.	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. The plan refers to network providers as "PPO-Providers" and out-of-network providers as "Non-PPO Providers".
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 For more exclusions, see Appendix C.*
		Network Provider (PPO Provider) You will pay the least	Out-of-Network Provider (Non-PPO 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	10% coinsurance	40% coinsurance	All eligible services provided by Non-PPO Providers are subject to Usual & Customary (U&C or UCR) allowances. Charges in excess of U&C are not applied to the out-of-pocket limits.
	Specialist visit	10% coinsurance	40% coinsurance	See above regarding U&C.
	Preventive care/screening/ immunization	No charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. U&C applies for Non-PPO providers. Charges in excess of U&C are not applied to the out-of-pocket limits.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	40% coinsurance	U&C applies for Non-PPO Providers. Charges in excess of U&C are not applied to the out-of-pocket limits. Preauthorization is required for imaging.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	40% coinsurance	

*For more information about limitations and exceptions, see the summary plan description (SPD) at www.statefarmbenefits.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information For more exclusions, see Appendix C.*
		Network Provider (PPO Provider) You will pay the least	Out-of-Network Provider (Non-PPO Provider) You will pay the most	
If you need drugs to treat your illness or condition Prescription drug coverage is provided by CVS Caremark. More information about prescription drug coverage, including all drug lists used by the plan, is available at www.caremark.com (member registration is required to access your personalized benefit information) or by phone at 1-800-388-2058.	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/ $75 maximum Mail: 30% coinsurance with a $20 min/ $150 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/ $100 maximum Mail: 50% coinsurance with a $20 min/ $200 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). May require use of generic or preferred brand drug prior to eligibility. Some non-preferred brand drugs require a preauthorization or the member's cost is 100%.
	Specialty drugs	30% coinsurance; $0 out-of-pocket for participants enrolled in PrudentRx Copay Program	No coverage	Specialty drugs must be filled through CVS Specialty Pharmacy. Preauthorization is required among other utilization management tools may also apply. 30 days max. Call PrudentRx at 1-800-578-4403 for questions or to enroll in or opt-out of the Copay Program.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40% coinsurance	U&C applies for Non-PPO Providers. Charges in excess of U&C are not applied to the out-of-pocket limits.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	
If you need immediate	Emergency room care	10% coinsurance	10% coinsurance	$200 fee for each emergency room visit. U&C

*For more information about limitations and exceptions, see the summary plan description (SPD) at www.statefarmbenefits.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information For more exclusions, see Appendix C.*
		Network Provider (PPO Provider) You will pay the least	Out-of-Network Provider (Non-PPO Provider) You will pay the most	
medical attention	Emergency medical transportation	10% coinsurance	10% coinsurance	applies for Non-PPO Providers. Charges in excess of U&C are not applied to the out-of-pocket limits.
	Urgent care	10% coinsurance	40% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	40% coinsurance	Preadmission notification required or $100 fee assessed. U&C applies for Non-PPO Providers. Charges in excess of U&C are not applied to the out-of-pocket limits.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	See above regarding U&C.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	40% coinsurance	U&C applies for Non-PPO Providers. Charges in excess of U&C are not applied to the out-of-pocket limits.
	Inpatient services	10% coinsurance	40% coinsurance	Preadmission notification required or $100 fee assessed. See above regarding U&C.
If you are pregnant	Office visits	10% coinsurance	40% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Preadmission notification required for inpatient stays or $100 fee assessed. See above regarding U&C.
	Childbirth/delivery professional services	10% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	40% coinsurance	Preauthorization is required. Coverage is limited to 50 visits a year. See above regarding U&C.
	Rehabilitation services	10% coinsurance	40% coinsurance	Maximum of 100 visits a year combined for physical therapy, speech therapy, and occupational therapy. See above regarding U&C.
	Habilitation services	10% coinsurance	40% coinsurance	
	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. Preadmission notification required or $100 fee assessed. U&C applies for Non-PPO Providers. Charges in excess of U&C are not applied to the out-of-pocket limits.

*For more information about limitations and exceptions, see the summary plan description (SPD) at www.statefarmbenefits.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information For more exclusions, see Appendix C.*
		Network Provider (PPO Provider) You will pay the least	Out-of-Network Provider (Non-PPO Provider) You will pay the most	
	Durable medical equipment	10% coinsurance	40% coinsurance	Excludes modifications to a home, vehicle, or other personal property, exercise equipment or programs. See above regarding U&C.
	Hospice services	10% coinsurance	40% coinsurance	Preauthorization is required. See above regarding U&C.
If your child needs dental or eye care	Children's eye exam	No charge	40% coinsurance	Must be part of a preventive pediatric exam to be eligible. U&C applies for Non-PPO Providers. Charges in excess of U&C are not applied to the out-of-pocket limits.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	No charge	40% coinsurance	Must be part of a preventive pediatric exam to be eligible. See above regarding U&C.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Long Term Care
- Routine eye care (Adult)
- Routine Foot Care
- Weight Loss Programs - However, weight loss management and anti-obesity medications will be eligible provided preauthorization is obtained prior to dispensing the medication

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

- Bariatric Surgery when performed at Blue Distinction Centers of Excellence for Bariatric Surgery
- Chiropractic care (30 visits per year)
- 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.)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (limited to a maximum benefit of 40 visits per year when prescribed by a doctor)

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 Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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

*For more information about limitations and exceptions, see the summary plan description (SPD) at www.statefarmbenefits.com.

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: BlueCross BlueShield of Illinois at 1-800-538-8833 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 plan provide Minimum Essential Coverage? **Yes**.
Minimum Essential Coverage generally includes 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 Minimum Value Standards? **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 1-855-710-6984.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-855-710-6984.

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

*For more information about limitations and exceptions, see the summary plan description (SPD) at www.statefarmbenefits.com.

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	$2,500
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:
Specialist 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 (reduced by HRA**)	$500
Copayments	$0
Coinsurance (prescription drugs = $60)	$1,070
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$1,570**

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

The plan's overall deductible	$2,500
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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 (reduced by HRA**) ^	$0
Copayments	$0
Coinsurance (prescription drugs)	$1,300
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,300**

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

The plan's overall deductible	$2,500
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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* (reduced by HRA**)	$800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$800**

*Note: This plan has other deductibles for specific services included in this coverage example. Simple fracture example includes $200 fee for each emergency room visit. See "Are there other deductibles for specific services?" row above. **These figures illustrate the reduction of the $2,500 deductible by the $2,000 HRA that covers eligible medical expenses on a first dollar basis. The HRA does not apply to outpatient prescription drugs. ^ In this example, not enough eligible charges were incurred to satisfy the $2,500 individual deductible. $2,000 is the maximum annual contribution of the HRA for an employee with one or more dependents. The HRA is prorated depending on the effective date for mid-year entrants to the plan.

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