

Benefits Now *& Next*



2024 Annual Enrollment *Retiree Guide*
Eligible Retired Employees





It's Time to Think About Your Benefits

Annual Enrollment for 2024 benefits is **November 14** through **November 30**. Use the enclosed materials to learn about your benefits. **If you want to continue your current coverage, you don't need to take any action.** But it's a good idea to review these materials so you are aware of any changes.

Want More Details? You Got It.

See the *Summary of Benefits and Coverage* starting on page 12. Or visit the My State Farm® Benefits Resource website at www.statefarmbenefits.com.

What's in This Package?

1. A confirmation statement showing the 2024 medical coverage and monthly cost for you and your eligible covered dependents is provided. It also confirms your life insurance coverage, if applicable.
2. This booklet provides important information about the Group Medical Preferred Provider Organization (PPO) Plan, the costs for 2024, and much more.

This enrollment information was created for eligible retired employees and other eligible individuals with extended group medical coverage.

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Let Things Slide? Not You.

Things change all the time. Make sure your benefits fit the life you have now. Review your coverage and your needs, then take action by November 30.

Get to Know Your Health Benefits

Here's the slimmed down version of a benefits summary. Refer to the Summary of Benefits and Coverage starting on page 12 for more information.

Comprehensive medical coverage: Utilize in-network PPO providers to receive the highest level of benefits. After you satisfy the annual deductible, the plan pays a percentage of the cost (90% PPO providers, 60% non-PPO providers) of eligible medical expenses. Once you reach the out-of-pocket limit, the plan pays 100% of eligible expenses for the rest of the calendar year. Claim administration is provided by Blue Cross Blue Shield of Illinois (BCBSIL). Be sure to access your Blue Access for Members (BAM) online account for review of EOBs and more at www.bcbsil.com/statefarm.

Accolade — Healthcare Advocacy Program: Your Accolade Health Assistant® is available to help you with your health care needs throughout the year and at Annual Enrollment. Their assistance includes helping resolve billing disputes, finding a network provider, obtaining EOBs or ID cards, and even providing guidance with an upcoming outpatient/inpatient procedure. Your Health Assistant is there to take the hassle and pressure off of you so you can go back to doing things that matter more. Connecting with your Health Assistant is easy — you can call them at **1-844-287-3859** (8:00 a.m. to 8:00 p.m. Central Time), use your Accolade mobile app, or connect online at member.accolade.com.

Convenient prescription drug coverage: Your prescription drug benefits are administered by CVS Caremark. You can obtain your medications at any retail network pharmacy or CVS Caremark Mail Service Pharmacy.

The amount you pay for your prescription drug depends on the type of drug (generic, preferred brand, non-preferred brand, and specialty) and where it is filled — retail pharmacy or mail service. Be aware: Each pharmacy establishes its own prices, so that may make a difference in your cost, too.

See the Summary of Benefits and Coverage starting on page 12 for more information or visit the My State Farm Benefits Resource website at www.statefarmbenefits.com.

Value Generics Program: You can receive up to a 90-day supply of select generic medications for \$9.99 at a CVS Pharmacy or through the CVS Caremark Mail Service (mail order). The Value Generics Program doesn't apply to generic drugs purchased at non-CVS pharmacies.

Performance Drug List: Share the CVS Caremark Performance Drug List of preferred brand-name drugs with your doctor to see if a less expensive brand-name drug will work for you. The list is updated every three months. Visit www.caremark.com to download the most current list.

For information about changes to benefit terms and language, refer to **Plan Changes for 2024: Summary of Material Modifications** beginning on page 6.

Making a Change?

If you want to waive coverage or add or remove a dependent from your coverage, visit the My State Farm Benefits Resource website at www.statefarmbenefits.com or contact the State Farm Benefits Center at **1-866-935-4015** by November 30. Representatives are available between 7:00 a.m. and 6:00 p.m., Central Time, Monday through Friday. **Note:** In observation of the Thanksgiving holiday, the State Farm Benefits Center will be closed Thursday, November 23, and Friday, November 24, 2023.

Keeping your same benefits for next year? You don't have to do anything. Your current coverage will continue unless you become eligible for Medicare next year. See page 3 to learn more.

And the Rest of the Year?

Throughout the Year:

www.statefarmbenefits.com

The My State Farm Benefits Resource website (www.statefarmbenefits.com) is your “go to” place to manage your benefits anytime, anywhere, and from any device with Internet access. Keep your mailing address and phone numbers up to date, change your beneficiaries, add or remove a dependent from your coverage due to a life event change, and take other important benefit actions.

New to the site or haven't logged on in a while? You'll need to register first. Just click “Are you a new user?”

Forgot your user ID or password? Click on “Forgot User ID or Password?” Then follow the prompts.

Watch for Form 1095

Annually you receive a Form 1095 that shows the months of the year that you and/or your dependents were offered or enrolled in medical coverage. You'll receive this form in early February, and you'll need it to file your income taxes and prove that you have adequate medical coverage. This form is an Affordable Care Act (ACA) requirement and is very important so be sure to watch for it.

Additional Help Is Available From Accolade

Accolade Health Assistants can answer a wide range of benefits-related questions and can help resolve billing disputes and other claims issues. Think of them as an additional resource to help reduce frustration and save money. You can reach a Health Assistant at **1-844-287-3859**, Monday through Friday, 8:00 a.m. to 8:00 p.m. Central Time. You also can connect online at member.accolade.com or use the Accolade mobile app.



Download the Alight App

The Alight Mobile app gives you immediate and secure access to your benefit information anytime, anywhere. Download it from the App Store or Google Play.

Choose “State Farm Insurance Companies” as your employer and log on using your My State Farm Benefits Resource user ID and password (one time only) to “Sign In.” Then, enter the access code you'll receive via text. You also can enable biometric authentication.

Will You or a Dependent Become Eligible for Medicare in 2024?

When you or a covered dependent becomes Medicare-eligible due to age, Medicare will become the primary provider of your benefits and coverage will end under the State Farm Group Medical PPO Plan's Early Retiree Option. You will need to enroll in Medicare Parts A and B. It's important to enroll when you are first eligible; otherwise, you could pay more for coverage or your coverage could be delayed. Get help enrolling in a Medicare Supplement, Medicare Advantage, and/or Medicare prescription drug plans by calling Retiree Health Solutions at **1-888-628-2397**.

You (and/or your covered dependent) may be eligible for a Health Reimbursement Account (HRA) funded by State Farm. The HRA can be used to help offset the cost of these expenses:

- Premiums for individual coverage under a Medicare Supplement, Medicare Advantage, and/or Medicare Prescription Drug plans (also known as Medicare Part D),
- After-tax contributions for another employer's company-sponsored medical plan, such as through your spouse,
- Out-of-pocket prescription drug expenses, including deductibles, coinsurance, and copays, or
- Out-of-pocket expenses for charges eligible under a medical plan (e.g., doctor- or medical facility-related deductibles, coinsurance, and/or copays).

Medicare-Eligible Due to Disability or ESRD

If you or a covered dependent becomes eligible for Medicare due to a disability or end-stage renal disease (ESRD) before becoming eligible for Medicare due to age, Medicare will become the primary payer of benefits. It's important that you (or your covered dependent) enroll for Medicare Parts A and B when eligible to receive your full benefits. Participants eligible for Medicare under these scenarios remain enrolled in the State Farm Group Medical PPO Plan's Early Retiree Option and that coverage will be secondary to Medicare.

If you or your eligible dependent do not sign up for Medicare Parts A and B upon becoming eligible due to disability or ESRD, you will be responsible for the estimated amount Medicare would have paid. This means you could be paying over 80% of your medical bills when Medicare should be covering these expenses as the primary carrier.

Contact the State Farm Benefits Center at **1-866-935-4015** before you become Medicare-eligible to learn more.

Split Family?

There's Something for Everyone

If you are Medicare-eligible due to age but your covered dependent is not, or vice versa, you have what is called a "split family." In this case, based on eligibility, medical benefits will be different for you and your dependent(s) as shown below:

Retirees and dependents who are eligible for Medicare due to age may be covered by:	Retirees and dependents who are NOT eligible for Medicare due to age may be covered by:
<ul style="list-style-type: none">• The State Farm-funded retiree HRA Plan• Individual supplemental Medicare coverage	The State Farm Group Medical PPO Plan's Early Retiree Option

Refer to the enclosed confirmation statement to see which eligible family members are enrolled in the State Farm Group Medical PPO Plan's Early Retiree Option.



Paying for Coverage

The following charts provide the possible rates you may pay depending upon your eligibility for the Company subsidy* and if you are in a “split family” situation. Please refer to your confirmation statement for your actual cost.

If you and your dependents qualify for the Company subsidy, then your monthly contribution for next year is shown below.

Coverage Level	Member Cost	State Farm	Total
Employee only (or Dependent Adult** only)	\$431.10	\$688.82	\$1,119.92
Employee + Dependent Adult	\$862.22	\$1,377.62	\$2,239.84
Employee (or Dependent Adult**) + Child(ren)	\$843.32	\$814.16	\$1,657.48
Employee + Dependent Adult + Child(ren)	\$1,255.28	\$1,522.12	\$2,777.40
Dependent Child(ren)**	\$431.46	\$106.10	\$537.56

If only you qualify for the Company subsidy*, but you must pay 100% of the cost to cover your dependents, then your monthly contribution for next year is shown below.

Coverage Level	Member Cost	State Farm	Total
Employee only	\$431.10	\$688.82	\$1,119.92
Dependent Adult** only	\$1,119.92	\$0	\$1,119.92
Employee + Dependent Adult	\$1,551.02	\$688.82	\$2,239.84
Employee + Child(ren)	\$968.66	\$688.82	\$1,657.48
Dependent Adult** + Child(ren)	\$1,657.48	\$0	\$1,657.48
Employee + Dependent Adult + Child(ren)	\$2,088.58	\$688.82	\$2,777.40
Dependent Child(ren)**	\$537.56	\$0	\$537.56

*Not all individuals will be eligible for a Company subsidy. Please refer to the Group Medical PPO Plan’s Summary Plan Description, found on the My State Farm Benefits Resource website (www.statefarmbenefits.com), to determine eligibility for a Company subsidy.

**Dependents may remain eligible for extended coverage after the retiree or surviving dependent adult becomes eligible for Medicare due to age and the retiree or surviving dependent adult is eligible for the retiree Health Reimbursement Account (HRA) Plan. If your dependent loses eligibility due to a qualifying status change and enrolls in COBRA, he or she must pay the full premium plus a 2% administration fee for coverage starting January 1.

If you do not qualify for any Company subsidy* (you have access only), you must pay 100% of the cost to cover you and your dependents, then your monthly contribution for next year is shown below.

Coverage Level	Member Cost	State Farm	Total
Employee only (or Dependent Adult** only)	\$1,119.92	\$0	\$1,119.92
Employee + Dependent Adult	\$2,239.84	\$0	\$2,239.84
Employee (or Dependent Adult**) + Child(ren)	\$1,657.48	\$0	\$1,657.48
Employee + Dependent Adult + Child(ren)	\$2,777.40	\$0	\$2,777.40
Dependent Child(ren)**	\$537.56	\$0	\$537.56

*Not all individuals will be eligible for a Company subsidy. Please refer to the Group Medical PPO Plan’s Summary Plan Description, found on the My State Farm Benefits Resource website (www.statefarmbenefits.com), to determine eligibility for a Company subsidy.

**Dependents may remain eligible for extended coverage after the retiree or surviving dependent adult becomes eligible for Medicare due to age and the retiree or surviving dependent adult is eligible for the retiree Health Reimbursement Account (HRA) Plan.

Paying for Coverage

Note regarding Medicare-eligible enrollees: Any retired employee (or eligible dependent) who becomes eligible for Medicare due to age, coverage terminates under the Group Medical PPO Plan Early Retiree Option on the day prior to the Medicare effective date. Medicare due to age is effective as follows: (1) born on the first of the month, Medicare is effective the first of the prior month; e.g., 65th birthday is August 1, Medicare effective July 1; (2) if 65th birthday is any other day than the first, Medicare is effective the first of the month age 65 is reached; e.g., turn age 65 on September 12, Medicare is effective September 1.

Qualified dependents, as defined in the Plan documents, may also be eligible for benefits if the retiree meets the eligibility requirements.



Plan Changes for 2024: Summary of Material Modifications

Group Medical PPO Plan

Plan Changes Effective January 1, 2024

Changes to the Bariatric Surgeries Coverage

- Bariatric Surgeries will only be covered when provided by SurgeryPlus™.
- Deductible and Coinsurance will be waived.
- The SurgeryPlus™ benefit is a comprehensive surgical program that provides a personalized concierge experience from dedicated Care Advocates and access to quality-centric health care through a network of credentialed surgeons.

For more information, call a SurgeryPlus™ Care Advocate at **1-833-469-2019**.

Orthoptic Therapy / Visual Therapy Coverage

- These services will be a covered service subject to the Deductible, Coinsurance Percentage, and the Major Medical Services' Out-of-Pocket Expense Limit.
- Orthoptic therapy is a program of eye exercises that aims to improve or correct eye problems such as lazy eye, crossed eyes, or poor eye condition.

Emergency Room Co-pay Change

- If the member is admitted, the \$200 Emergency Room Visit Co-pay will be waived.
- Emergency Room Visit Charge for each Visit to an Emergency Room, the first \$200 in Eligible Charges is the Covered Individual's responsibility. This \$200 charge will be applied toward the satisfaction of the applicable Out-of-Pocket Expense Limit. If admitted, this charge will be waived.
- HRA funds may not be used to reimburse this member Out-of-Pocket expense.

Prescription Drug Updates: Caremark Cost Saver

Starting January 1, 2024, Caremark will be offering the Caremark Cost Saver program to help members lower the pharmacy out-of-pocket drug costs. With this program, members will have automatic access to GoodRx's prescription pricing to allow them to pay lower prices, when available, on generic medications.

The amount paid will automatically be applied to members' deductible and out-of-pocket thresholds.

Plan members will utilize their existing benefit card at their preferred in-network pharmacy. No action is required by members.

Plan Changes for 2024: Summary of Material Modifications

Other Coverage Changes

- The plan will no longer cover expenses for educational, instructional, or vocational training and materials such as but not limited to books, tapes, videos, pamphlets, software, and self-management tools related to diabetes, asthma, or other conditions.
- Christian Science practitioner services will no longer be a covered service.



Important Information and Annual Notices

Information for Individuals Who Have Continued Coverage as Surviving Dependent Adults

Individuals who have continued their group medical coverage upon the death of an eligible active employee or retired employee may voluntarily cancel coverage at any time. However, those individuals who cancel their coverage will not be eligible to enroll in the Plan at a later date.

Enrollment Rights Under HIPAA

If you are declining enrollment for yourself or your dependents (including your dependent adult) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 60 days of the date your, or your dependents', other coverage ends (or the date the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, partnership, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days of the marriage, partnership, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the State Farm Benefits Center at **1-866-935-4015**.

Mastectomy Coverage

As required by the Women's Health and Cancer Rights Act of 1998, the Group Medical PPO Plan provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from a mastectomy, including lymphedema. Deductibles and coinsurance limitations may apply as set out in the plan. For more information on these benefits, contact the State Farm Benefits Center at **1-866-935-4015** from 7:00 a.m. to 6:00 p.m., Central Time, Monday through Friday or reach out to the health plan.

Adding a Dependent

Eligible retirees may enroll themselves and their eligible dependents in the Group Medical PPO Plan Early Retiree Option during Annual Enrollment for an effective date of January 1 of the following plan year. If you waive or cancel coverage, you must wait until the next Annual Enrollment period to enroll unless you acquire a new dependent due to the enrollment rights under HIPAA outlined in the "Enrollment Rights Under HIPAA" section. Loss of coverage must be due to reasons other than failure to pay premiums on a timely basis or termination due to cause. *Enrollment must be requested within 60 days of the dependent becoming eligible.* You may also be required to verify your dependent is eligible for coverage. Watch for that packet and take action before the communicated deadline. If you don't provide the required documentation within the deadline provided (generally about 60 days), your dependent will be dropped from coverage. You must also provide the dependent's Social Security Number (SSN) unless the dependent is a child less than six months old as of January 1 of the new plan year or a foreign born individual who has not obtained an SSN.



Important Information and Annual Notices

Important Information About Your Privacy

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Notice of Privacy Practices describes how medical information about you may be used and disclosed and how you can get access to this information.

You may obtain a copy of the Notice by accessing the State Farm Benefits Resource website at www.statefarmbenefits.com, by contacting the State Farm Benefits Center at **1-866-935-4015** from 7:00 a.m. to 6:00 p.m., Central Time, Monday through Friday, or by mailing your request to State Farm Insurance Companies, Total Rewards - Benefits, C1, One State Farm Plaza, Bloomington, IL 61710-0001.

COBRA Notice

Under the Consolidation Omnibus Budget Reconciliation Act of 1985 (COBRA), it is the responsibility of the retiree or the dependent to notify the health plan when a covered dependent loses eligibility for the health plan due to divorce, legal separation, or the dependent child ceasing to be a dependent under the rules of the health plan.

Notice of the loss of eligibility must be provided to the State Farm Benefits Center at **1-866-935-4015** within 60 days from the later of:

- The date of the event, or
- The date on which the dependent would lose coverage on account of the event.

Failure to provide the State Farm Benefits Center with timely notice may result in the loss of the dependent's COBRA continuation rights.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for group health coverage your State may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your State if it has a program that might help you pay the premiums for a group health plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your group health plan, your group health plan must allow you to enroll in your group health plan if you are not already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your group health plan, contact the Department of Labor at www.askebsa.dol.gov or call toll-free **1-866-444-EBSA (3272)**.

If you live in one of the following States, you may be eligible for assistance paying your group health plan premiums. The following list of States is current as of July 31, 2023. Contact your State for further information on eligibility.

ALABAMA Medicaid	Website: http://myalhipp.com/ Phone: 1-855-692-5447
ALASKA Medicaid	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS Medicaid	Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA Medicaid	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 1-916-445-8322 Fax: 1-916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO Health First Colorado (Colorado's Medicaid Program) and Child Health Plan Plus (CHP+)	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+ Website: https://www.hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com HIBI Customer Service: 1-855-692-6442
FLORIDA Medicaid	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA Medicaid	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 1-678-564-1162 , Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 1-678-564-1162 , Press 2
INDIANA Medicaid	Healthy Indiana Plan for low-income adults 19 – 64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA Medicaid and CHIP (Hawki)	Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562
KANSAS Medicaid	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-697-4660
KENTUCKY Medicaid	Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms
LOUISIANA Medicaid	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE Medicaid	Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711
MASSACHUSETTS Medicaid and CHIP	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA Medicaid	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
MISSOURI Medicaid	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 1-573-751-2005

MONTANA Medicaid	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov
NEBRASKA Medicaid	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 1-402-473-7000 Omaha: 1-402-595-1178
NEVADA Medicaid	Website: https://dhcfp.nv.gov Phone: 1-800-992-0900
NEW HAMPSHIRE Medicaid	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY Medicaid and CHIP	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
NEW YORK Medicaid	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA Medicaid	Website: https://medicaid.ncdhhs.gov/ Phone: 1-919-855-4100
NORTH DAKOTA Medicaid	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA Medicaid and CHIP	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON Medicaid	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA Medicaid and CHIP	Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx CHIP Phone: 1-800-986-KIDS (5437)
RHODE ISLAND Medicaid and CHIP	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 1-401-462-0311 (Direct Rlte Share Line)
SOUTH CAROLINA Medicaid	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA Medicaid	Website: http://dss.sd.gov/ Phone: 1-888-828-0059
TEXAS Medicaid	Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program Phone: 1-800-440-0493
UTAH Medicaid and CHIP	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT Medicaid	Website: http://www.dvha.vermont.gov/members/medicaid/hipp-program Phone: 1-800-250-8427
VIRGINIA Medicaid and CHIP	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON Medicaid	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA Medicaid and CHIP	Website: https://dhr.wv.gov.bms/ http://mywvhipp.com/ Medicaid Phone: 1-304-558-1700 CHIP Phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN Medicaid and CHIP	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING Medicaid	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any more states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Summary of Benefits and Coverage (SBC)

Under the Patient Protection and Affordable Care Act (PPACA or ACA for short) insurers and group health plans are required to provide standardized documents about health plan benefits and coverage called a Summary of Benefits and Coverage (SBC).

The SBC provides a consistent format for all employers and plans to summarize the key features of the plan or coverage, such as the covered benefits, cost-sharing provisions, and coverage limitations and exceptions. SBC will help consumers better understand the coverage they have and allow them to easily compare different coverage options.

The SBC for the Group Medical PPO Plan's Early Retiree Option follows on the next page.



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, call 1-844-287-3859 or 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 www.healthcare.gov/sbc-glossary/ or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$1,500 Individual / \$3,000 Family	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 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 is 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.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For In-Network: \$5,000 Individual / \$10,000 Family For Out-of-Network: \$7,500 Individual / \$15,000 Family Prescription drug expense limit: Outpatient prescription drugs \$1,600 Individual/\$3,200 Family; aggregate out-of-pocket limit for both participating and non-participating pharmacies.	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?	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.
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
		In-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	10% coinsurance	40% coinsurance	None
	Specialist visit	10% coinsurance	40% coinsurance	None
	Preventive care/screening/immunization	No Charge; deductible does not apply	40% 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.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	40% coinsurance	Preauthorization may be required; see your benefit booklet* for details.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	40% coinsurance	

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com/statefarm.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.Caremark.com	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). 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%.
	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.	
	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.	
	<u>Specialty drugs</u>	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% <u>coinsurance</u>	40% <u>coinsurance</u>	Preauthorization may be required.
	Physician/surgeon fees	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$200 copay/visit plus 10% <u>coinsurance</u>	\$200 copay/visit plus 10% <u>coinsurance</u>	Copay waived if admitted.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Preauthorization may be required for non-emergency transportation; see your benefit booklet* for details.
	<u>Urgent care</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Preauthorization required.
	Physician/surgeon fees	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None

* For more information about limitations and exceptions, see the [plan](http://www.bcbsil.com/statefarm) or policy document at www.bcbsil.com/statefarm.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> may be required; see your benefit booklet* for details.
	Inpatient services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> required.
	Office visits	10% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>coinsurance</u> or <u>deductible</u> may apply.
If you are pregnant	Childbirth/delivery professional services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need help recovering or have other special health needs	<u>Home health care</u>	No Charge after <u>deductible</u>	No Charge after <u>deductible</u>	Limited to 50 visits per benefit period. <u>Preauthorization</u> may be required.
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 100 visits combined per benefit period for occupational therapy, speech therapy and physical therapy.
	<u>Habilitation services</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> may be required.
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 100 days per occurrence. <u>Preauthorization</u> may be required.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Benefits are limited to items used to serve a medical purpose. Durable Medical Equipment benefits are provided for both purchase and rental equipment (up to the purchase price).
	<u>Hospice services</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> may be required.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com/statefarm.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

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.)
<ul style="list-style-type: none"> • Acupuncture • Dental care (Adult) • Hearing aids
<ul style="list-style-type: none"> • Long term care • Non-emergency care when traveling outside the U.S. • Routine eye care (Adult) • Routine foot care (with the exception of person with diagnosis of diabetes) • Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)
<ul style="list-style-type: none"> • Bariatric surgery • Chiropractic care (Chiropractic and Osteopathic manipulation limited to 30 visits per calendar year) • Cosmetic surgery (only for correcting congenital deformities or conditions resulting from accidental injuries, scars, tumors, or diseases) • 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) • Most coverage provided outside the United States. See www.bcbsil.com/statefarm • Private-duty nursing (with the exception of inpatient private duty nursing) (limited to 40 visits per calendar year)

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com/statefarm.

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 [plan](tel:1-844-287-3859) at 1-844-287-3859, 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.ccijio.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: Blue Cross and Blue Shield of Illinois at 1-844-287-3859 or visit www.bcbsil.com/statefarm, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your [appeal](#). Contact the Illinois Department of Insurance at (877) 527-9431 or visit <http://insurance.illinois.gov>.

[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 the 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 1-844-287-3859.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-287-3859.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-844-287-3859.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-844-287-3859.

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

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 \$1,500
- 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:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,100
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,660

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$1,500
- 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:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$700
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,220

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible \$1,500
- 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:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$100
<i>What isn't covered</i>	
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.

Have Questions? Get Answers

Contact Name	Phone Number	Reasons to Contact:
State Farm Benefits Center	1-866-935-4015 www.statefarmbenefits.com	Report a death Change your address Group medical coverage: <ul style="list-style-type: none"> • Determine eligibility for group medical coverage as a special or late enrollee • Add or delete a dependent from medical coverage Group life insurance: <ul style="list-style-type: none"> • Check amount of coverage • Change beneficiary Retired employee pension payment (if applicable) <ul style="list-style-type: none"> • Questions about your 1099 or pension payment as a retired employee • Change your direct deposit for payment • Change your federal or state withholding • Change your address
Accolade Healthcare Advocacy Services	Health Assistants 1-844-287-3859 member.accolade.com	<ul style="list-style-type: none"> • Questions about benefits and health care providers • Resolve billing disputes and claim-related issues • Administrative support (e.g., ID cards, Explanation of Benefits, etc.) • Assist with upcoming inpatient/outpatient treatment
Accolade – Utilization Management Services	1-844-287-3859 member.accolade.com	<ul style="list-style-type: none"> • Case Management • Complex Case Management • Condition Management • Maternity Management • 24/7 Nurse Line
Agency Sales Resources (ASR) Agency Benefits	State Farm 1-877-889-2294	<ul style="list-style-type: none"> • Change your address • Questions about your term pay • Change your federal or state tax withholdings
CVS Caremark	1-800-388-2058 or www.caremark.com	<ul style="list-style-type: none"> • Questions about prescription drug coverage • Obtain a copy of the approved drug list • Request forms • Request a CVS Caremark prescription drug card
Group Medical Customer Service Blue Access for Member (BAM) – Group Medical PPO Member Portal	Blue Cross Blue Shield of Illinois www.bcbsil.com/statefarm	<ul style="list-style-type: none"> • Access member profile • Review claims history • Review/request copies of EOBs • Request a Group Medical PPO ID card
Human Resources & Development – Talent Operations	State Farm 1-877-272-1999	<ul style="list-style-type: none"> • U.S. Discount Program
Long-Term Care (LTC)	John Hancock 1-888-321-4582	<ul style="list-style-type: none"> • Questions regarding long-term care
Social Security	1-800-772-1213 or www.ssa.gov	<ul style="list-style-type: none"> • Questions about Social Security or Medicare



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