Annual Enrollment

for Pre-Medicare Eligible Retired Agents and Other Pre-Medicare Eligible Individuals with Extended Group Medical Coverage

Date: November 2012

RE: Annual Enrollment

Dear Plan Member:

In this mailing you will find:

- Detailed information regarding Annual Enrollment and the Group Medical PPO Plan changes for 2013; **and**

EITHER

- A confirmation statement showing the 2013 insurance coverage for one or more persons in your household

OR

- A letter from State Farm if you or one or more persons in your household are currently Medicare eligible due to disability or end-stage renal disease.

If You Received a Confirmation Statement:

The enclosed confirmation statement provides the medical coverage and monthly cost for you and/or your covered dependent(s) beginning January 1, 2013, under the State Farm Group Medical PPO Plan Pre-Medicare Retiree Option. It will also provide confirmation of any retiree life insurance coverage, if applicable. **If you want to continue your current coverage, no action is required. However, if you would like to waive coverage or add/remove a dependent, contact the State Farm Benefits Center at Aon Hewitt by calling 1-866-935-4015.** Representatives are available from 7:00 a.m. to 6:00 p.m., Central Time, Monday through Friday. **Your changes must be provided to Aon Hewitt by November 30.**

If applicable, your contributions will continue to be deducted from your termination pay. If your termination pay will not cover your monthly contribution(s) or you would prefer not to have your contributions deducted from your termination pay, other payment options can be selected, such as direct billing or automatic withdrawal from a bank account. Contact the State Farm Benefits Center (1-866-935-4015) after January 1, 2013, to discuss payment options.

If You Received a Letter from State Farm:

Please refer to the enclosed letter for actions you must take if you would like to enroll in this Plan effective January 1, 2013.

Remember, you can view your State Farm group benefit information anytime, anywhere by visiting the My State Farm Benefits Resource website at www.resources.hewitt.com/statefarm. You are also able to complete address changes, add/remove dependents based on life events, and change beneficiaries whenever you'd like. See inside for details about accessing the website with a user ID and password.

Split-Family Coverage

Some families may find themselves in what is called a "split-family." A split-family simply means one or more family members are Medicare eligible, while one or more family members are not Medicare eligible. This can result in some family members being covered under individual Medicare supplemental plans with a retiree Health Reimbursement Account (HRA) or being covered under the temporary extension of the Group Medical PPO Plan, while other family members are covered under the State Farm Group Medical PPO Plan's Pre-Medicare Retiree Option.

For example, the State Farm retiree may be Medicare eligible, and his or her dependent adult and/or dependent child may not be. In this situation, the State Farm retiree could be receiving Company contributions to the Medicare-eligible retiree HRA or be covered under the temporary extension of the Group Medical PPO Plan, while his or her dependent adult and/or dependent child could be enrolled in the State Farm Group Medical PPO Plan's Pre-Medicare Retiree Option.

The reverse situation could occur as well. For example, the State Farm retiree may not yet be eligible for Medicare, so he or she could be enrolled in the State Farm Group Medical PPO Plan's Pre-Medicare Retiree Option. If his or her dependent adult or dependent child is Medicare eligible, they could be receiving Company contributions to the Medicare-eligible retiree HRA or be covered under the temporary extension of the Group Medical PPO Plan.

Therefore, you may be receiving this information because you or one or more of your family members are eligible for and/or are now enrolled in the State Farm Group Medical PPO Plan's Pre-Medicare Retiree Option with a $1,500 individual deductible and a $3,000 family deductible. See the enclosed confirmation statement, if applicable, to see who in your family is now enrolled in this option.

Medicare-Eligible Retiree Extended Group Medical Coverage

When you or your dependent adult or dependent child become eligible for Medicare due to age, coverage will end under the State Farm Group Medical PPO Plan's Pre-Medicare Retiree Option. At that time, you and/or your dependents may be eligible to receive a contribution from State Farm towards the cost of individual coverage under a Medicare Supplement, Medicare Advantage, and/or Medicare Prescription Drug Plan. Or, you and/or your dependents may be eligible for the temporary extension of the Group Medical PPO Plan (if still offered). You will receive a letter prior to the date you become eligible for Medicare explaining your coverage options. If you remain on the Group Medical PPO Plan, it is important to enroll in Medicare Parts A and B; otherwise, you could be paying over 80 percent of your medical bills as Medicare should be the primary carrier.

If you, your dependent adult or your dependent child becomes eligible for Medicare due to disability or end-stage renal disease (ESRD) prior to becoming Medicare eligible due to age, please contact the State Farm Benefits Center at 1-866-935-4015. 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 percent of your medical bills when Medicare should be the primary carrier.

Accessing the My State Farm Benefits Resource Website

Here are a few tips to help you quickly access your benefit information on the My State Farm Benefits Resource website.

- Go to www.resources.hewitt.com/statefarm.
- At the Log On page, enter your already established user ID and password or click on the "Register as a new user" link.
  – If registering as a new user, you'll be asked to provide the last four digits of your Social Security Number, your date of birth (mmddyyyy), and home address zip code to establish your user ID and password.

The password you create on the website is the same password you will type into your telephone keypad to speak with the benefits center or review information.

Tips for Creating Your User ID & Password

User IDs are not assigned. You create your own user ID.

You cannot use your Social Security Number as your user ID. However, you can use any combination of letters and numbers you wish as long as your user ID is at least 8 characters in length and not more than 20, with no symbols. You are allowed up to three attempts to enter a user ID or Password before being asked to provide personal information for identification.

Medical Loss Ratio Information - The Affordable Care Act requires health insurers in the large group market to spend at least 85 percent of the premiums they receive on health care services and activities to improve health care quality. This is referred to as the Medical Loss Ratio (MLR) rule or the 85/15 rule. If a health insurer does not spend at least 85 percent of the premiums it receives on health care services and activities to improve health care quality, the insurer must rebate the difference.

A health insurer's Medical Loss Ratio is determined separately for each State's individual, small group and large group markets in which the health insurer offers health insurance. In some States, health insurers must meet a higher or lower Medical Loss Ratio. No later than August 1, 2012, health insurers must send any rebates due for 2011 and information to employers and individuals regarding any rebates due for 2011.

You are receiving this notice because your health insurer had a Medical Loss Ratio for 2011 that met or exceeded the required Medical Loss Ratio. For more information on Medical Loss Ratio and the State Farm Mutual Automobile Insurance Company's Medical Loss Ratio, visit www.HealthCare.gov.

Group Medical PPO Plan Changes for 2013

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. SBCs will help consumers better understand the coverage they have and, for the first time, allow them to easily compare different coverage options.

The SBC for the Group Medical PPO Plan's Pre-Medicare Retiree Option begins on page 8.

Eligibility of Inactive Agents and Dependents Eligible for Medicare Due to Disability or End-Stage Renal Disease

Inactive Agents and eligible Dependents of Inactive Agents who become eligible for Medicare due to disability or end-stage renal disease (ESRD) prior to becoming eligible for Medicare due to age will continue to be eligible for the Group Medical PPO Plan. Such individuals will be eligible for coverage under the Pre-Medicare Retiree Option.

Eligible individuals enrolled in the PPO Plan at the time of becoming eligible for Medicare due to disability or ESRD can remain enrolled in the Pre-Medicare Retiree Option. Eligible individuals not enrolled at the time of becoming eligible for Medicare due to disability or ESRD can enroll at a later date as a Special or Late Enrollee as defined in the Plan.

Coverage under the Plan will terminate at the end of month prior to the month in which Medicare becomes effective due to age; or the date such individual is no longer eligible for the Plan, whichever occurs first.

Eligible individuals who are currently eligible for Medicare due to disability or ESRD but not age and are enrolled in an individual Medicare Supplemental Plan will be provided a one-time opportunity to enroll in the Pre-Medicare Retiree Option during Annual Enrollment with an effective date of January 1, 2013. If the individual elects to enroll in the Pre-Medicare Retiree Option, his or her access to the State Farm Insurance Companies Health Reimbursement Arrangement Plan will remain in effect through December 31, 2012 while he or she continues to be enrolled in an individual Medicare Supplemental Plan.

This one-time offer ends with annual enrollment on November 30. Individuals wanting to enroll in the PPO Plan should contact the State Farm Benefits Center at 1-866-935-4015, Monday through Friday, 7:00 a.m. to 6:00 p.m. CT.

Changes under the Outpatient Prescription Drug Expense Benefit

Prior authorization will now be required for a select number of high cost Non-Preferred brand-name drugs due to the availability of other lower cost brand-name drugs. If a prior authorization is not approved, the participant must pay the entire cost of the drug or select an alternate lower cost brand-name drug.

If a prior authorization is approved, the participant will pay 50% coinsurance of the cost of the drug for Non-Primary Brand Drugs up to a maximum of $75 for in-network retail pharmacies and up to a maximum of $150 through the CVS Caremark mail order.

Questions regarding the Non-Preferred brand-name drugs that will require a prior authorization can be directed to CVS Caremark at 1-800-388-2058. A list of the drugs requiring a prior authorization is located on the www.caremark.com/statefarm website under the "Save Me Money" tab; *Prior Authorization Formulary Exclusions Drug List.* Members who have registered a profile can also view the information under the "Understand My Plan & Benefits" tab at www.caremark.com which is a secured website for State Farm Associates.

Monthly Contributions

The following table provides the 2013 Group Medical monthly contributions for non-Medicare eligible individuals and individuals who are Medicare-eligible due to disability and end-stage renal disease. The member's, Company's, and total contribution is listed. You may notice the additional coverage descriptions due to "split-family" situations as described on page 2.

Note: The following information only applies to Agents who were appointed or reappointed on or after January 1, 2007 and their dependents.

Not all individuals eligible for coverage under the Group Medical PPO Plan receive a Company subsidy. Factors such as the Agent's appointment date or reappointment date, age and length of Company service at retirement and age as of January 1, 2012, determine if the Company will subsidize the cost of coverage. For some retired Agents, the Company will subsidize the cost only for the retiree and the retiree will have to pay the total cost of coverage for any eligible dependents. Some individuals will have access only to coverage, and will pay the total monthly contribution (100%).

Please review your confirmation statement or contact the State Farm Benefits Center at Aon Hewitt by calling 1-866-935-4015 for information about your monthly cost.

	Member	Company	Total
Single coverage for Retiree, Surviving Dependent Adult, or Dependent Adult	$140.06	$624.08	$764.14
Retiree + Dependent Adult	$280.12	$1,248.16	$1,528.28
Retiree/Surviving Dependent Adult/ Dependent Adult + Dependent child/children	$307.80	$823.14	$1,130.94
Retiree + all Dependents (Dependent Adult + one or more Dependent children)	$447.86	$1,447.22	$1,895.08
Dependent child/children	$167.76	$199.02	$366.78

Group Medical PPO Plan Prescription Drug Benefit

The Group Medical PPO Plan has partnered with CVS Caremark, a pharmacy benefit manager, to provide Plan members with prescription drug coverage.

The Plan utilizes a three-tier prescription drug structure as a means to control costs for you and State Farm. More information regarding the three tiers is provided on the Summary of Benefits and Coverage beginning on page 8.

It's important to note that prescription drug coinsurance may fluctuate from month to month and pharmacies may also have different prices for the same medication.

Prescription Benefit Restrictions and Limitations:

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 4th 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 – 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. However, Cialis® for daily use (2.5 mg and 5 mg dosages only) is limited to 30 pills per 30-day supply or 90 pills per 90-day supply.

Use your Group Medical PPO Plan Prescription Drug Card to maximize savings:

- **Ask for a generic! –** They're FDA approved and contain the same active ingredients and dosage requirements as the brand- name drug.
- Check out the CVS Caremark Value Generic List to see if you can obtain additional savings on your generic maintenance medication! The CVS Caremark Value Generics Program offers access to a 90-day supply of select maintenance generic medications that can be either filled through a retail CVS/pharmacy or through CVS Caremark Mail Service Pharmacy at a cost of $9.99.

  The Value Generics Program does not apply to generic maintenance medications purchased at non-CVS/pharmacies.
- Share the CVS Caremark Primary/Preferred Drug List with your doctor to see if a less-expensive brand-name medicine will work for you.
- For maintenance medications (up to a 90-day supply) use CVS Caremark's Mail Service or a retail CVS/pharmacy.

CVS Caremark Resources:
You may obtain an estimate on what your drug costs may be for 2013 by contacting CVS Caremark through the following options:

- **www.Caremark.com** (ID and password required) – Once you've logged in to the CVS Caremark Home page, click the "Find Savings and Opportunities" tab at the top. Then select the "Search for a Drug" link and follow the instructions.
- Call a CVS Caremark Customer Care Representative at 1-800-388-2058. They are available to assist you 24 hours a day, seven days a week. For those participants with hearing loss requiring TTY assistance, please dial toll-free 1-800-231-4403.

Good Neighbor Healthy Living Condition Management Program

Group Medical PPO Plan members and eligible dependents have access to a chronic health condition program, Good Neighbor Healthy Living Condition Management Program, that provides personalized health support to help individuals modify their behaviors, change unhealthy lifestyles and better adhere to their physician's evidence-based treatment plan.

Individuals identified as having any one of the conditions listed below can partner with a nurse from Alere®, an industry-leading wellness services provider, for personalized and confidential telephonic support and guidance in understanding and living with a chronic health condition.

The health conditions managed within Good Neighbor Healthy Living Condition Management Program are:

- Asthma
- Chronic obstructive pulmonary disease (COPD)
- Congestive heart failure (CHF)
- Coronary artery disease (CAD)
- Diabetes
- Musculoskeletal and Pain Management (MSP)

Participants are identified for any one of the above programs through medical and pharmacy claims data, wellness assessment data, physician referrals, and self referrals. If you have one of the above conditions and have not heard from an Alere representative, **call 1-800-698-8546** to speak with a nurse about your condition and the available programs. Program participation is always voluntary, however, in an effort to provide care management assistance to covered individuals identified as candidates for this Program, individuals may receive unsolicited information directly from Alere.

Confidentiality – Participation in any of the Good Neighbor Healthy Living programs is completely confidential. At no time is State Farm advised of any one individual's enrollment or health condition.

For more information on this Program plus other information on health and wellness, visit the www.SFLiveWell.com website.

Important Information and Annual Notices

Important Information for Individuals Who Have Continued Coverage as Surviving Dependent Adults – Individuals that have continued their Group Medical coverage upon the death of an eligible active agent or retired agent may voluntarily cancel coverage at any time. However, those individuals that 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 31 days after your or your dependents' other coverage ends (or after 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 31 days after 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. For more information on these benefits, contact BlueCross BlueShield of Illinois at 1-888-652-4013.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact BlueCross BlueShield of Illinois at 1-888-652-4013 Monday – Friday, 7:00 a.m. – 7:00 p.m., CT.

Important Information About Your Privacy

The Group Medical PPO Plan's Notice of Health Insurance Portability and Accountability Act of 1996 (HIPAA) 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 this Notice by contacting the Group Medical PPO Plan at 1-309-766-6459 or by mailing your request to State Farm Insurance Companies, Total Rewards – Benefits, C-1, One State Farm Plaza, Bloomington, IL 61710-0001.

Children's Health Insurance Program (CHIP)

Under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), group health plans and group health insurance issuers must offer new special enrollment opportunities. Plans and issuers must permit members and dependents who are eligible for but not enrolled in a group health plan to enroll in the plan upon –

- losing eligibility for coverage under a State Medicaid or CHIP program, or
- becoming eligible for State premium assistance under Medicaid or CHIP.

The member or dependent must request coverage within 60 days of being terminated from Medicaid or CHIP coverage or within 60 days of being determined to be eligible for premium assistance.

Group health plans offered in a State that provides premium assistance under Medicaid or CHIP must notify all members of potential opportunities for premium assistance in the State in which the member resides. Please review the notice on page 16 to determine if your State provides such assistance.

COBRA Notice

Under the Consolidation Omnibus Budget Reconciliation Act of 1985 (COBRA), it is the responsibility of the associate 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.

Transitional Care

Individuals who enroll in the Plan as "late enrollees" (individuals not covered under the Group Medical PPO Plan on December 31 of the current year), who are currently receiving treatment from a provider that is not a BlueCard PPO provider, the individual may be eligible to continue treatment with that provider temporarily at the PPO Provider benefit level.

Eligible services for individuals qualifying for Transitional Care will be considered at the PPO Provider coinsurance level of 90% for medical care incurred through March 31, 2013, or in the case of pregnancy, through delivery and postpartum care (including the initial hospital care for the newborn). Usual and Customary limits will apply.

The following conditions qualify for Transitional Care:

- pregnancy, if confirmed before January 1, 2013,
- cardiac rehabilitation,
- physical, occupational, or speech therapy,
- radiation therapy or chemotherapy,
- post-surgical care for surgery performed prior to January 1, 2013,
- terminal illness when life expectancy is less than six months, or
- hospitalization beginning in 2012 and continuing into 2013.

NOTE: In order to qualify for this benefit, BlueCross BlueShield of Illinois must be contacted before December 31, 2012. Group Medical coverage must be in force at the time the approved Transitional Care is provided. Call BCBS IL at 1-888-652-4013 Monday – Friday, 7 a.m. to 7 p.m., CT to initiate this benefit.

NOTICE FOR LOUISIANA RESIDENTS: HEALTH CARE SERVICES MAY BE PROVIDED TO YOU AT A NETWORK HEALTH CARE FACILITY BY FACILITY-BASED PHYSICIANS WHO ARE NOT IN YOUR HEALTH PLAN. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE OUT-OF-NETWORK SERVICES, IN ADDITION TO APPLICABLE AMOUNTS DUE FOR CO-PAYMENTS, COINSURANCE, DEDUCTIBLES, AND NON-COVERED SERVICES. SPECIFIC INFORMATION ABOUT IN-NETWORK AND OUT-OF NETWORK FACILITY-BASED PHYSICIANS CAN BE FOUND AT THE BLUE CROSS BLUE SHIELD WEBSITE AT www.bcbsil.com/statefarm OR BY CALLING BCBS IL AT 1-888-652-4013.

State Farm Group Medical PPO Plan: Pre-Medicare Retirees **Coverage Period: 01/01/2013 – 12/31/2013**

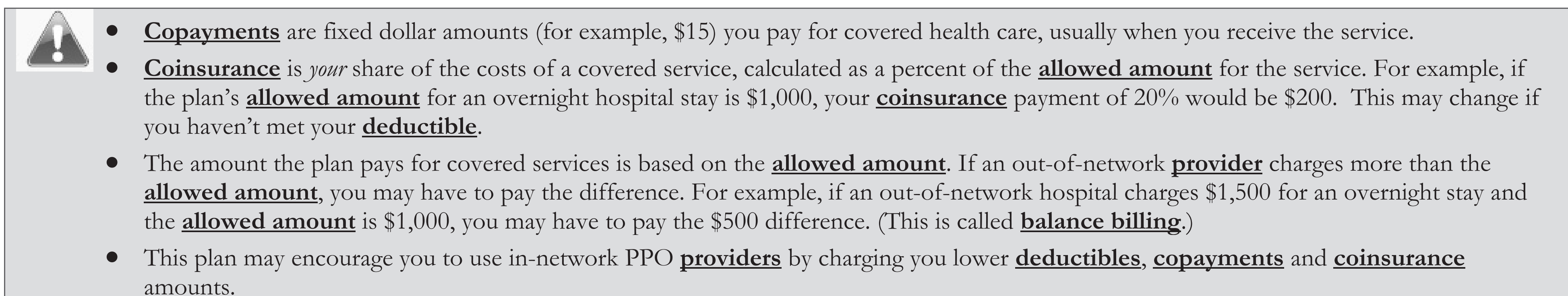
Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for: All Coverage Tiers | Plan Type: PPO**

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.	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, co-insurance 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 bolded 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 PPO **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% co-insurance	40% co-insurance	Note: All eligible services provided by Non-PPO Providers are subject to Usual & Customary (U&C) allowances.
	Specialist visit	10% co-insurance	40% co-insurance	
	Other practitioner office visit	10% co-insurance	40% co-insurance	Charges for chiropractic services are limited to 30 visits per year. See above re: U&C.
	Preventive care/screening/ immunization	No Charge	40% co-insurance	U&C applies for non-PPO providers.
If you have a test	Diagnostic test (x-ray, blood work)	10% co-insurance	40% co-insurance	U&C applies for non-PPO providers.
	Imaging (CT/PET scans, MRIs)	10% co-insurance	40% co-insurance	

Common Medical Event	Services You May Need	Your Cost If You Use an:		Limitations & Exceptions
		In-network PPO Provider	Out-of-network (non-PPO) Provider	
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% co-insurance with a $10 minimum/ $25 maximum Mail: 20% co-insurance with a $20 min/$50 max	Reimbursement will be based on the average wholesale price of the drug and other factors, less 20% co-insurance.	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% co-insurance with a $10 minimum/ $50 maximum Mail: 30% co-insurance with a $20 min/$100 max	Reimbursement will be based on the average wholesale price of the drug and other factors, less 30% co-insurance.	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% co-insurance with a $10 minimum/ $75 maximum Mail: 50% co-insurance with a $20 min/$150 max	Reimbursement will be based on the average wholesale price of the drug and other factors, less 50% co-insurance.	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	Pre-authorizations 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% co-insurance	40% co-insurance	U&C applies for non-PPO providers.
	Physician/surgeon fees	10% co-insurance	40% co-insurance	

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% co-insurance	10% co-insurance	$100 fee for each emergency room visit. U&C applies for non-PPO providers.
	Emergency medical transportation	10% co-insurance	10% co-insurance	
	Urgent care	10% co-insurance	40% co-insurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-insurance	40% co-insurance	Pre-admission notification required or $100 fee assessed. See above re: U&C.
	Physician/surgeon fee	10% co-insurance	40% co-insurance	U&C applies for non-PPO providers.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% co-insurance	40% co-insurance	U&C applies for non-PPO providers.
	Mental/Behavioral health inpatient services	10% co-insurance	40% co-insurance	Pre-admission notification required or $100 fee assessed. See above re: U&C.
	Substance use disorder outpatient services	10% co-insurance	40% co-insurance	U&C applies for non-PPO providers.
	Substance use disorder inpatient services	10% co-insurance	40% co-insurance	Pre-admission notification required or $100 fee assessed. See above re: U&C.
If you are pregnant	Prenatal and postnatal care	10% co-insurance	40% co-insurance	U&C applies for non-PPO providers.
	Delivery and all inpatient services	10% co-insurance	40% co-insurance	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% co-insurance	40% co-insurance	Maximum benefit of $8,500 per year. U&C applies for non-PPO providers.
	Rehabilitation services	10% co-insurance	40% co-insurance	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% co-insurance	40% co-insurance	

Common Medical Event	Services You May Need	Your Cost If You Use an:		Limitations & Exceptions
		In-network PPO Provider	Out-of-network (non-PPO) Provider	
If you need help recovering or have other special health needs, continued	Skilled nursing care	10% co-insurance	40% co-insurance	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% co-insurance	40% co-insurance	U&C applies for non-PPO providers.
	Hospice service	10% co-insurance	40% co-insurance	U&C applies for non-PPO providers.
If your child needs dental or eye care	Eye exam	10% co-insurance	40% co-insurance	Must be part of a preventive pediatric exam to be eligible.
	Glasses	Not Covered	Not Covered	
	Dental check-up	Not Covered	Not Covered	

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)
- Infertility treatment (Only those services for the diagnosis and treatment of infertility; coverage **does not** include charges resulting
- Most coverage provided outside the United States. See www.bcbsil.com/statefarm
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (limited to a maximum benefit of $10,000 per year when prescribed by a doctor)

from or incurred in connection with in vitro fertilization or other forms of artificial insemination.)

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.

Language Access Services:

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

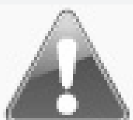
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-888-652-4013.

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.

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. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to group health coverage. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible or these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can 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, you can 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, you can ask the 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 permit 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, you can contact the Department of Labor electroically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3373).

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, 2012. You should contact your State for further information on eligibility.

ALABAMA – Medicaid	**GEORGIA – Medicaid**
Website: http://www.medicaid.alabama.gov Phone: 1-800-362-1504	Website: http://dch.georgia.gov/ Click on Programs, then Medicaid, then Health Insurance Premium Payments (HIPP) Phone: 1-800-869-1150
ALASKA – Medicaid	**IDAHO – Medicaid and CHIP**
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588
ARIZONA – CHIP	**INDIANA – Medicaid**
Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Website: http://www.in.gov/fssa Phone: 1-800-889-9948
COLORADO – Medicaid	**IOWA - Medicaid**
Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943	Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
FLORIDA – Medicaid	**KANSAS - Medicaid**
Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268	Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884

<table>
<tr><th>KENTUCKY – Medicaid</th><th>NEW JERSEY – Medicaid and CHIP</th></tr>
<tr><td>Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570</td><td>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 1-800-356-1561
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710</td></tr>
<tr><th>LOUISIANA – Medicaid</th><th>NEW YORK – Medicaid</th></tr>
<tr><td>Website: http://www.lahipp.dhh.louisiana.gov
Phone: 1-888-695-2447</td><td>Website: http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831</td></tr>
<tr><th>MAINE – Medicaid</th><th>NORTH CAROLINA – Medicaid</th></tr>
<tr><td>Website: http://www.maine.gov/dhhs/Ofi/public-assistance/index.html
Phone: 1-800-977-6740
TTY 1-800-977-6741</td><td>Website: http://www.nc.gov
Phone: 919-855-4100</td></tr>
<tr><th>MASSACHUSETTS – Medicaid and CHIP</th><th>NORTH DAKOTA – Medicaid</th></tr>
<tr><td>Website: http://www.mass.gov/MassHealth
Phone: 1-800-462-1120</td><td>Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-800-755-2604</td></tr>
<tr><th>MINNESOTA – Medicaid</th><th>OKLAHOMA – Medicaid and CHIP</th></tr>
<tr><td>Website: http://www.dhs.state.mn.us/
• Click on Health Care, then Medical Assistance
Phone: 800-657-3629</td><td>Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742</td></tr>
<tr><th>MISSOURI – Medicaid</th><th>OREGON – Medicaid and CHIP</th></tr>
<tr><td>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005</td><td>Website: http://www.oregonhealthykids.gov
http://www.hijossaludablesoregon.gov
Phone: 1-888-564-9669</td></tr>
<tr><th>MONTANA – Medicaid</th><th>PENNSYLVANIA – Medicaid</th></tr>
<tr><td>Website:
http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml
Telephone: 1-800-694-3084</td><td>Website: http://www.dpw.state.pa.us/hipp
Phone: 1-800-692-7462</td></tr>
<tr><th>NEBRASKA – Medicaid</th><th>RHODE ISLAND– Medicaid</th></tr>
<tr><td>Website: www.ACCESSNebraska.ne.gov
Phone: 1-877-255-3092</td><td>Website: www.ohhs.ri.gov
Phone: 401-462-5300</td></tr>
<tr><th>NEVADA – Medicaid</th><th>SOUTH CAROLINA– Medicaid</th></tr>
<tr><td>Medicaid Website: http://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900</td><td>Website: http://www.scdhhs.gov
Phone: 1-888-549-0820</td></tr>
<tr><th>NEW HAMPSHIRE – Medicaid</th><th>TEXAS – Medicaid</th></tr>
<tr><td>Website: www.dhhs.nh.gov/ombp/index.htm
Phone: 603-271-8183</td><td>Website: https://www.gethipptexas.com/
Phone: 1-800-440-0493</td></tr>
</table>

UTAH – Medicaid	WEST VIRGINIA – Medicaid
Website: http://health.utah.gov/upp Phone: 1-866-435-7414	Website: www.dhhr.wv.gov/bms/ Phone: 1-800-562-3022 ext 15473
VERMONT – Medicaid	**WISCONSIN – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
VIRGINIA – Medicaid and CHIP	**WYOMING – Medicaid**
Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647	Website: http://www.health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531
WASHINGTON – Medicaid	
Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473	

To see if any more States have added a premium assistance program since July 31, 2012, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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, Ext. 61565

Notes:

Contact Information

Contact Name	Phone Number	Reasons to Contact:
State Farm Benefits Center	Aon Hewitt: 1-866-935-4015 www.resources.hewitt.com/statefarm	**Report a death** **Change your address** **Group Medical Coverage:** • Determine eligibility for Group Medical coverage as a special or late enrollee • Add or delete a dependent from medical coverage **Group Life Insurance:** • Check amount of coverage • Change beneficiary
Agency Sales Resource	State Farm: 1-877-277-9698	• 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 or www.caremark.com/statefarm	• Questions about prescription drug coverage • Obtain a copy of the approved drug list • Request forms • Request a CVS Caremark prescription drug card
Good Neighbor Healthy Living	1-800-698-8546 www.SFLiveWell.com	• Enroll in a Good Neighbor Healthy Living Condition Management program for patients with chronic health conditions • Complete a Health Risk Assessment
Group Medical Customer Service	BlueCross BlueShield 1-888-652-4013 www.bcbsil.com/statefarm	• Ask claim questions • Request copies of EOBs • Find PPO provider • Request a Group Medical ID card
Human Resources Services Center	State Farm: 1-877-272-1999	• Change your Federal or State Tax withholding from your retired employee pension payment (if applicable) • Questions about your 1099 or pension payment as a retired employee • Change your direct deposit for your retired employee pension payment • Change your address
Long-Term Care (LTC)	1-800-858-4933 John Hancock	• Questions regarding Long-Term Care
Social Security	1-800-772-1213 or www.ssa.gov	• Questions about Social Security or Medicare

State Farm
Home Office, Bloomington, IL

statefarm.com®   10-2012   PREH000105224AG