

**State Farm Insurance Companies**  
**Group Medical Plan – Health Maintenance**  
**Organization Option**  
**Summary Plan Description**  
*For United States Employees*

*Effective January 1, 2012*

**Note:** This document plus the Summary Plan Description for the State Farm Insurance Companies Group Health and Welfare Plan for United States Employees and the certificate of coverage issued by the Health Maintenance Organization (HMO) constitutes the Summary Plan Description required by the Employee Retirement Income Security Act of 1974 (ERISA §102). Certificates of coverage are available under the “Health and Insurance” > “Overview” > “Plan Information” tab. You may also obtain a paper copy of your certificate of coverage, free of charge, by contacting your HMO.

The Compensation Committee of the Board of Directors of State Farm Mutual Automobile Insurance Company, as the Plan Sponsor of the State Farm Insurance Companies Group Health and Welfare Plan for United States Employees, fully intends to continue the Group Health and Welfare Plan and this component benefit program. Nevertheless, the Compensation Committee of the Board of Directors reserves the right, in its sole and unfettered discretion, to amend, modify or terminate the Group Health and Welfare Plan or this component benefit program at any time, in whole or in part, without the consent of plan participants and their beneficiaries. Only the Compensation Committee of the Board of Directors can modify or waive this reservation of rights.

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## INTRODUCTION

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State Farm offers medical coverage provided by a health maintenance organization (HMO) to eligible employees and their dependents in most locations. Each HMO offered is a fully insured group HMO and is operated independently from State Farm.

An HMO is an organization that contracts services with specific doctors and hospitals to manage costs. Members of HMOs must use physicians and hospitals in the network. If members go out of the network for non-emergency care, they may be responsible for the charges or pay a penalty.

Eligibility for HMO coverage is based on ZIP Code. All HMOs allow eligibility into their plan if your residential ZIP Code is in the HMO service area. Some plans allow eligibility based on your work ZIP Code.

HMO members generally have set copayments and/or coinsurance for doctor visits, hospital stays, and prescription drugs. Since every HMO is managed independently the benefits and out-of-pocket expenses differ from HMO to HMO. Review the information carefully to find out the HMOs available in your area and what services they offer.

This summary plan description (SPD) highlights provisions of the HMO option of the State Farm Insurance Companies Group Medical Plan. It explains who is eligible, when coverage begins and ends, and other important information. Words that have a specific meaning are capitalized and are defined in Appendix: Terms. This SPD should be used in conjunction with your certificate of coverage (evidence of coverage), which is distributed by the HMO that you elect.

**NOTE:** The Welfare Benefit Administrative Committee, as Plan Administrator, determines enrollment eligibility, effective date, and termination date of employees and their dependents. The HMO administers plan benefits, which includes the determination of eligible benefits, the computation of benefits, claim processing and appeal procedures.

If you have questions regarding eligibility, enrollment, or to report family status changes, call the State Farm Benefits Center at 1-866-935-4015, Monday – Friday, 7:00 a.m. - 6:00 p.m., CT.

Benefit or coverage questions should be directed to the HMO's customer service number.

## WHO IS ELIGIBLE

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### ELIGIBLE EMPLOYEES

Depending on the availability of an HMO, you are eligible if you are:

- An employee employed by the Company in the United States who customarily works an average of 18 or more hours per week per pay period and five continuous months or more during a year, or an employee residing in the State of Massachusetts who customarily averages 16 hours or more per week per pay period. These requirements do not apply if the employee is on an approved leave of absence.

**The term “Employee” as used throughout the rest of this summary plan description will include only those persons listed above.**

### WHO IS NOT ELIGIBLE FOR COVERAGE

#### ***Rehired Inactive Employees***

Effective January 1, 2012, Inactive Employees (as that term is defined in the Summary Plan Description for State Farm Group Medical PPO Plan) who are covered by the Pre-Medicare Retiree Option or Medicare eligible retirees who are receiving reimbursement under the State Farm Health Reimbursement Arrangement Plan on the date coverage would otherwise have been effective as an Active Employee (as that term is defined in the Summary Plan Description for State Farm Group Medical PPO Plan) will not be considered newly eligible Active Employees and will remain covered under the Pre-Medicare Retiree Option or the State Farm Health Reimbursement Arrangement Plan as applicable.

#### ***Non-Employees***

Persons who will not be considered employees and who will not be eligible for coverage include:

- Leased employees are not employees as defined herein and are not eligible for coverage. The term “leased employee” means an individual who is a “leased employee” within the meaning of section 414(n)(2) of the Internal Revenue Code and any other person who provides services to the Companies pursuant to an agreement between the Company and a leasing organization or similar organization, regardless of whether a court or administrative agency determines at any time that any such individual is a common law employee.
- Directors or officers of the Companies, unless such a person is otherwise eligible as a bona fide employee of the Company by performing services other than the usual duties of a director or officer.
- Persons performing the services of a recognized profession, including, but not limited to, an attorney-at-law or an accountant, who are paid on a basis other than a regular wage or salary by the Company.
- Agents

- Retirees
- Employees of agents

## **IF YOU AND YOUR DEPENDENT ADULT ARE BOTH ELIGIBLE FOR STATE FARM-SPONSORED GROUP MEDICAL PLANS**

If you and your Dependent Adult are both eligible for group medical coverage sponsored by State Farm, you cannot be covered as an Employee or as an agent (active or retired under the State Farm Insurance Companies Group Medical PPO Plan for United States Agents) if you are covered as a Dependent under your Spouse's plan.

A person can only be covered under **one** State Farm-sponsored group medical plan at any time.

## **ELIGIBLE DEPENDENTS**

You may be eligible to enroll any of the following as your dependents.

- A. A Dependent Adult who is not on active military duty.
- B. A child who is under 26 years of age, who is not on active military duty and who is
  - (1) the Employee's biological child;
  - (2) the Employee's legally adopted child (a child is considered 'legally adopted' on the earlier of the date the child is in the Employee's custody pursuant to an interim order of adoption or the date the child is lawfully placed in the Employee's home for purposes of adoption);
  - (3) the Employee's biological or adopted child who is an alternate recipient under a Qualified Medical Child Support Order until the earlier of the date specified in the Order or the date the alternate recipient ceases to be eligible under the terms of the Plan; (*See "Qualified Medical Child Support Order" under the Administrative Information section for more information on QMCSOs.*)
  - (4) the Employee's stepchild whose biological parent is also covered under the Plan;
  - (5) the Employee's foster child who is placed with the Employee or the Employee's Spouse by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction;
- C. a child for whom the Employee is the court-appointed legal guardian who is:
  - (1) in the care of the Employee pursuant to a court order of temporary custody;
  - (2) under 26 years of age;

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- (3) not on active military duty; and
- (4) meets the definition of dependent under Internal Revenue Code Section 152 (the Employee provides over one-half of the grandchild's support without regard to the earned income limit or the custodial rules applicable in divorce situations).

D. The Employee's unmarried grandchild who is:

- (5) in the care of the Employee pursuant to a court order of temporary custody;
- (6) under 26 years of age;
- (7) not on active military duty; and
- (8) meets the definition of dependent under Internal Revenue Code Section 152 (the Employee provides over one-half of the grandchild's support without regard to the earned income limit or the custodial rules applicable in divorce situations).

E. An Employee's child who has attained age 26, who is not married, provided the child meets the definition of dependent under Internal Revenue Code Section 152 (without regard to the earned income limit and without regard to the custodial rules applicable in divorce situations) and the child meets **all** of the following criteria:

- (1) incapable of self-sustaining employment and is dependent on his or her parents or Other Care Providers for lifetime care and supervision because of a handicapped condition that occurred before attaining age 26, **and**
- (2) actually receiving over one-half of his/her annual support from the Employee.

In order to be eligible, you must provide proof to the Plan Administer within 30 days before the day coverage would otherwise terminate due to age or within 30 days of the day you apply for the child's coverage. A child not covered under this Plan on the day coverage would otherwise have terminated due to age must have been continuously covered under a health plan since the time the child reached age 26.

The Plan Administrator may require proof of the incapacity and dependency of the child upon request, but not more than once a year after the two-year period immediately following the day coverage would otherwise have terminated due to age or the day of the Dependent's initial effective date.

## **PROOF OF ELIGIBILITY**

Proof of dependent eligibility will be required. Submission of the appropriate documentation needed for proving eligibility within the established timeframe is required or coverage will be terminated for lack of providing proof.

## **DEPENDENT CHILDREN OF ELIGIBLE STATE FARM PARENTS**

If both parents are eligible for State Farm-sponsored group medical coverage, either parent may cover the eligible dependent children. Dependent children can only be covered under **one** State Farm-sponsored group medical plan at any time.

## **WHEN COVERAGE BEGINS**

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### **WHEN COVERAGE BEGINS FOR EMPLOYEES**

#### ***Waiting Period***

A waiting period is the period of time that must pass before you and/or your existing dependents are eligible for coverage under an HMO. However, any period of time before a late or special enrollment is not considered a waiting period. The applicable waiting period must be satisfied before an individual is eligible as a Special or Late Enrollee.

If you are hired on the first day of the Month, there is no waiting period. If you are hired after the first of the Month, a waiting period applies to you and your existing dependents who are eligible for coverage under an HMO. The waiting period is the time between the date you are hired and the first day of the Month following the month in which you were hired.

#### ***You Enroll Within 31 Days of Your Date of Hire***

If you are hired on the first day of the Month and you enroll within 31 days of the date you were hired, your medical coverage will begin on your date of hire.

If you are hired after the first of the Month and you enroll within 31 days of the date you were hired, your coverage will begin on the first of the Month following the Month in which you were hired.

#### ***You Fail to Enroll Within 31 Days of Your Date of Hire***

If you do not enroll within 31 days of the date you were hired, the next opportunity you will have to enroll in medical coverage (unless you experience a Special Enrollment Period) will be as a Late Enrollee during any Annual Enrollment Period as determined by the Plan Administrator. As a Late Enrollee, your coverage will begin January 1 following the Annual Enrollment Period. Preexisting Condition exclusions may apply.

### **WHEN COVERAGE BEGINS DUE TO A SPECIAL ENROLLMENT PERIOD OR ENROLLING AT ANNUAL ENROLLMENT**

#### ***Special Enrollment Period – Enrolled In Another Health Plan***

If you waive State Farm group medical coverage because you are enrolled in coverage provided under another health plan (group plan, individual plan, governmental plan, etc), or you cancel State Farm group medical coverage to enroll in another health plan, and



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- You lose eligibility for that coverage due to reasons other than failure to pay premiums on a timely basis or termination due to cause, or
- You are covered under a coverage continuation provision (e.g. COBRA) and the coverage under such provision is exhausted, or
- You are covered under another health plan and you incur a claim that meets or exceeds a lifetime limit on all benefits, or
- You are covered by another employer's group plan and contributions toward such coverage are terminated by the employer,

you and your eligible Dependents may be eligible to enroll in an HMO as Special Enrollees. As a Special Enrollee, you may elect to enroll in any HMO or Group Medical PPO Plan option offered to newly hired, similarly situated Employees who enroll when first eligible.

To enroll as a Special Enrollee, you must notify the State Farm Benefits Center at Aon Hewitt (1-866-935-4015) or by accessing My State Farm Benefits Resource at [www.resources.hewitt.com/statefarm](http://www.resources.hewitt.com/statefarm) within 31 days of your loss of eligibility, exhaustion of continuation coverage, reaching the lifetime limit on all benefits or the termination of employer contributions and return any required enrollment form within 45 days of your loss of eligibility, exhaustion of continuation coverage, reaching the lifetime limit on all benefits, or the termination of employer contributions.

If these requirements are met, coverage will be effective on the calendar day following the termination date of the other health coverage due to loss of eligibility, exhaustion of continuation coverage, reaching the lifetime limit on all benefits, or the date the employer terminates employer contributions.

***Special Enrollment Period – Marriage, Birth, Adoption or Placement for Adoption***

If you previously waived or canceled State Farm group medical coverage and you acquire a new dependent through:

- Marriage,
- Birth,
- Adoption, or
- Placement for adoption,

you may be eligible to enroll yourself and/or your eligible Dependents under an HMO as Special Enrollees. As a Special Enrollee, you may elect to enroll in any HMO or Group Medical PPO Plan option offered to newly hired, similarly situated Employees who enroll when first eligible.

To enroll as Special Enrollees, you must notify State Farm Benefits Center at Aon Hewitt (1-866-935-4015) or by accessing My State Farm Benefits Resource at [www.resources.hewitt.com/statefarm](http://www.resources.hewitt.com/statefarm) within 31 days of the date of marriage, birth, adoption or placement for adoption and return any required enrollment form within 45 days of the date of marriage, birth, adoption or placement for adoption.

If these requirements are met, coverage will be effective on the date of marriage, birth, adoption or placement for adoption.

### ***Enrolling During Annual Enrollment***

If you previously waived or canceled State Farm group medical coverage for any reason, you may be eligible to enroll in an HMO as a Late Enrollee during any Annual Enrollment Period as determined by the Plan Administrator. As a Late Enrollee, your coverage will begin January 1 following the Annual Enrollment Period. Preexisting Condition exclusions may apply.

## **WHEN COVERAGE BEGINS FOR DEPENDENTS OF EMPLOYEES**

### ***You Enroll Your Dependents When You First Become Eligible for Coverage***

Coverage for your eligible dependents will begin when your coverage begins.

### ***You Fail to Enroll Your Dependents When You First Become Eligible for Coverage***

If you do not enroll your dependents within 31 days of first becoming eligible, the next opportunity you will have to enroll them (unless you or a Dependent experience an eligible Special Enrollment period) will be as Late Enrollees during any Annual Enrollment Period as determined by the Plan Administrator. As Late Enrollees, your Dependents' coverage will begin January 1 following the Annual Enrollment Period. Preexisting Condition exclusions may apply.

### ***Newly Born and Adopted Children***

Your newly born children may be covered automatically from the moment of birth. Legally adopted children may be covered automatically 1) on the date of adoption, or 2) the date you assume and retain a legal obligation for total or partial support in anticipation of adoption, whichever date comes first. **Refer to your HMO Certificate for detailed information on the effective date for newborns and adopted children.**

To ensure your Dependents are covered at the earliest date, you must notify the State Farm Benefits Center at Aon Hewitt (1-866-935-4015) or by accessing My State Farm Benefits Resource at [www.resources.hewitt.com/statefarm](http://www.resources.hewitt.com/statefarm) within 31 days of the date of birth, adoption or placement for adoption and return any required enrollment form within 45 days of the date of birth, adoption or placement for adoption. A newborn, adopted child or a child placed for adoption is not subject to preexisting condition exclusions when enrolled within 31 days of birth, adoption or placement for adoption.

If you fail to enroll a newly born or adopted child within 31 days of the date he/she first becomes eligible for insurance or fail to return any required enrollment forms within 45 days of becoming eligible, the next opportunity you will have to enroll him/her (unless you or a Dependent experience an eligible Special Enrollment Period) will be as a Late Enrollee during any Annual Enrollment Period as determined by the Plan Administrator. As a Late Enrollee, your dependent's coverage will begin January 1 following the Annual Enrollment Period. Preexisting condition exclusions may apply.

### ***Other Newly Acquired Dependents***

Any other newly acquired dependent will be covered on the date you acquire them, provided you notify the State Farm Benefits Center at Aon Hewitt (1-866-935-4015) or by accessing My State Farm Benefits Resource at [www.resources.hewitt.com/statefarm](http://www.resources.hewitt.com/statefarm) within 31 days of the

date the Dependent is acquired, enroll for coverage, and agree in the form and manner designated by the Plan Administrator to contribute to the cost of coverage. Any required enrollment form must be returned to the State Farm Benefits Center within 45 days of the date acquired.

If you fail to enroll your newly acquired Dependent within 31 days of the date he/she first becomes eligible for insurance or fail to return any required enrollment forms within 45 days of becoming eligible, the next opportunity you will have to enroll him/her (unless you or a Dependent experience an eligible Special Enrollment Period) will be as a Late Enrollee during any Annual Enrollment Period as determined by the Plan Administrator. As a Late Enrollee, your Dependent's coverage will begin January 1 following the Annual Enrollment Period. Preexisting Condition exclusions may apply.

## **WHEN COVERAGE BEGINS DUE TO A SPECIAL ENROLLMENT PERIOD OR ENROLLING AT ANNUAL ENROLLMENT - DEPENDENTS**

### ***Special Enrollment Period – Dependents Enrolled In Another Health Plan***

If you waive State Farm group medical coverage because your Dependents are enrolled in coverage provided under another health plan (group plan, individual plan, governmental plan, etc.), or you cancel State Farm group medical coverage to enroll your Dependents in another health plan, and

- They lose eligibility for that coverage due to reasons other than failure to pay premiums on a timely basis or termination due to cause, or
- They are covered under a coverage continuation provision (e.g. COBRA) and the coverage under such provision is exhausted, or
- They are covered by another health plan and they incur a claim that meets or exceeds a lifetime limit on all benefits, or
- They are covered by another employer's group plan and contributions toward such coverage are terminated by the employer,

you may be eligible to enroll your Dependents in an HMO as Special Enrollees. As a Special Enrollee, you may elect to enroll in any HMO or Group Medical PPO Plan option offered to newly hired, similarly situated Employees who enroll when first eligible.

To enroll them as Special Enrollees, you must notify the State Farm Benefits Center at Aon Hewitt Monday (1-866-935-4015) or by accessing enrollment via My State Farm Benefits Resource at [www.resources.hewitt.com/statefarm](http://www.resources.hewitt.com/statefarm) within 31 days of their coverage termination under the other health plan due to loss of eligibility, exhaustion of continuation coverage, reaching the lifetime limit on all benefits or the termination of employer contributions and return any required enrollment form within 45 days of your loss of eligibility, exhaustion of continuation coverage, reaching the lifetime limit on all benefits, or the termination of the employer's contributions.

If these requirements are met, coverage will be effective on the calendar day following the termination date of the other health coverage due to loss of eligibility, exhaustion of continuation

coverage, reaching the lifetime limit on all benefits, or the date the employer terminates employer contributions.

Note: In order for your eligible Dependents to be covered you must be covered. If you are not covered by a State Farm group medical plan at the time a Dependent loses coverage for one of the above reasons, you will also be eligible to enroll as a Special Enrollee. If you also lose coverage under the other medical plan, you may enroll any eligible Dependents. Otherwise, only dependents that have lost coverage as described above can be enrolled during the Special Enrollment Period.

### ***Enrolling During Annual Enrollment***

If you previously waived or canceled State Farm group medical coverage for your eligible Dependents for any reason, you may be eligible to enroll them in an HMO as Late Enrollees during any Annual Enrollment Period as determined by the Plan Administrator. As Late Enrollees, coverage will begin January 1 following the Annual Enrollment Period. Preexisting Condition exclusions may apply.

## **CHANGING YOUR ENROLLMENT DECISION DURING THE YEAR**

It is important to choose medical coverage carefully during the Annual Enrollment Period because the benefit election you make will be in effect for the entire calendar year unless you experience a Special Enrollment Period or a “Qualifying Event” as defined by the Flexible Compensation Plan, or you move and your new location makes you eligible for a different medical plan (for example, a new HMO).

If you are a new Employee, the benefit election you choose when you are hired will be in effect for the remaining portion of the year unless you or an eligible Dependent experience a Special Enrollment Period or a “Qualifying Event” as defined by the Flexible Compensation Plan or a “Qualifying Event” as defined by the Flexible Compensation Plan, or you move and your new location makes you eligible for a different medical plan (for example, a new HMO).

You may change your medical plan enrollment during the Annual Enrollment Period for an effective date of January 1 of the following year.

### ***Confirmation Statements***

If you enroll in an HMO, you will receive a confirmation statement after your elections or changes have been processed. **It is your responsibility to review your confirmation statement for accuracy. Immediately notify** the State Farm Benefits Center at Aon Hewitt by calling 1-866-935-4015 of any discrepancies or errors.

### ***ID Cards***

You will receive ID cards directly from the HMO. The ID card will provide important information such as:

- The HMO’s customer service telephone number.
- The telephone number for preauthorizations.
- Copayment/Coinsurance amounts.

### **Associate Records**

Enrollment records are maintained at Aon Hewitt. State Farm Benefits Center

Representatives may be contacted at Aon Hewitt Monday – Friday, 7:00 a.m. to 6:00 p.m., CT by calling 1-866-935-4015 or accessing the website at [www.resources.hewitt.com/statefarm](http://www.resources.hewitt.com/statefarm).

## **MEDICAL PLAN BENEFITS**

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You may be eligible for medical benefits under the HMO option. You may obtain information about eligibility without cost by contacting the Plan Administrator. The Plan Administrator will forward your request to the appropriate HMO or HMOs.

### **Plan Benefits**

In general, most major medical procedures are covered. There may be deductibles, coinsurance and/or copayments.

Most outpatient physician services are covered and may be subject to a copayment or coinsurance.

Hospitalization due to maternity care and/or general medical care is covered and may be subject to a deductible, coinsurance and/or copayment. HMOs generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, HMOs may not, under federal law, require that the provider obtain authorization from the HMO for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Treatment associated with alcoholism and drug abuse, mental health care, and emergency care is covered and may be subject to copayments, coinsurance, deductibles, maximum day limitations and/or dollar limitations.

Prescription drugs are covered and may be subject to deductibles, coinsurance and/or copayments.

Other major medical services are covered and may be subject to the various limitations mentioned above.

### **Notice: A Woman's Mastectomy Benefits Rights**

HMOs provide medical and surgical benefits for mastectomies and elective breast reconstruction. If a participant or dependent covered under the Plan has a mastectomy and elects to have breast reconstruction (in a manner determined through patient consultations with the attending physician), the HMO will cover:

- a. all stages of reconstruction of the breast on which the mastectomy has been performed,
- b. surgery and reconstruction of the other breast to produce a symmetrical appearance,

- c. prosthesis, and
- d. treatment of physical complications related to all stages of the mastectomy including lymphedema.

These mastectomy-related benefits are subject to the same deductible, coinsurance and copayment rules that apply to other medical and surgical benefits provided by the HMO.

### ***Benefit Limitations***

Detailed information regarding any cost-sharing provisions, including deductibles, coinsurance and copayment amounts for which the participant or beneficiary will be responsible; any annual or lifetime caps or other limits on benefits; the extent to which preventive services are covered; whether, and under what circumstances, existing and new drugs are covered; whether, and under what circumstances, coverage is provided for medical tests, devices and procedures; provisions governing the use of network providers, the composition of the provider network, and whether, and under what circumstances, coverage is provided for out-of-network services; any conditions or limits on the selection of primary care providers or providers of emergency medical care and any conditions requiring preauthorization or utilization review as a condition to obtaining a benefit or service may be obtained by contacting the HMO or the Plan Administrator. The Plan Administrator will forward your request to the appropriate HMO or HMOs.

**Refer to your HMO Certificate for detailed information on the HMO's benefits, exclusions, limitations, and definitions as used by the HMO Certificate.**

## **PREEXISTING CONDITION EXCLUSIONS**

**Refer to your HMO Certificate for detailed information on the HMO's preexisting condition exclusion limitations\*, if any.**

\* Under federal law, preexisting condition exclusions do not apply to Pregnancy, newborn children or adopted children under age 18, *if* the child is covered within 31 days of birth, adoption or placement for adoption.

## **CLAIM FILING AND APPEAL PROCEDURES**

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**Refer to your HMO Certificate for detailed information on the HMO's claim filing and appeal procedures, or call the HMO's customer service number.**

## **COORDINATION OF BENEFITS**

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When a person is covered under more than one health plan, a health plan will follow its coordination of benefits (COB) provisions to determine the order coverage will apply (primary vs. secondary). **Please refer to your HMO Certificate for detailed information on the HMO's coordination of benefits (COB) provisions, or call the HMO's customer service number.**

## **WHEN COVERAGE ENDS**

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### **WHEN COVERAGE ENDS FOR AN EMPLOYEE**

Your coverage will automatically terminate on the earliest of the following dates:

- The date the HMO plan terminates.
- The last day of the calendar Month in which your employment terminates.
- The date of the expiration of the last period for which you have made a contribution.
- The last day of the Month in which you cease to be eligible.
- The last day of the Month in which your Reemployment Rights Expire.
- In the event an Employee changes coverage during a Special Enrollment Period, the calendar day preceding the date of marriage, birth, adoption or placement for adoption; or in the event of the termination of other health coverage, employer contributions, denial of a claim for other health coverage due to meeting a lifetime limit for all benefits, or exhaustion of COBRA continuation coverage, the calendar day coinciding with the termination of other health coverage, employer contributions, denial of a claim for other health coverage due to meeting a lifetime limit for all benefits, or exhaustion of COBRA continuation coverage.

### **WHEN COVERAGE ENDS FOR A DEPENDENT**

A Dependent's coverage automatically terminates on the earliest of the following dates:

- The date coverage for all Dependents is terminated under the HMO Plan.
- The date the Employee's coverage terminates.
- The last day for which the Employee's Dependent contribution has been paid.
- The last day of the Month in which he/she ceases to be an eligible Dependent.
- The last day of the Month in which the Dependent enlists or is drafted into the armed services of any country, if the service is expected to continue for two or more years.
- The end of the Month in which 45 days of military service is completed, however, coverage can be reinstated on the day the Dependent returns to civilian status provided he or she meets the requirements of a Dependent and the Employee is still a plan member.
- In the event an Employee changes coverage during a Special Enrollment Period, the dependent's coverage will terminate on the calendar day preceding the date of marriage, birth, adoption or placement for adoption; or in the event of the termination of other

health coverage, employer contributions, denial of a claim for other health coverage due to meeting a lifetime limit for all benefits, or exhaustion of COBRA continuation coverage, the calendar day coinciding with the termination of other health coverage, employer contributions, denial of a claim for other health coverage due to meeting a lifetime limit for all benefits, or exhaustion of COBRA continuation coverage.

- Regarding a Dependent Adult, the last day of the Month in which the divorce, dissolution or termination of a marriage/partnership from the Employee is final.
- With respect to a covered child:
  - The last day of the calendar year during which a child, as described in B. of *Eligible Dependents*, reaches age 26.
  - The last day of the calendar year during which the child, as described in C. and D. of *Eligible Dependents*, reaches age 26 provided the child continues to meet the definition of dependent under Section 152 of the Internal Revenue Code (without regard to the earned income limit or the custodial rules applicable in divorce situations).

## **COVERAGE TERMINATION DUE TO FRAUD**

An Employee's and/or Dependent's coverage may be terminated by State Farm if State Farm determines that the Employee and/or Dependent has submitted, or caused to have been submitted, a claim or claims containing a material misrepresentation, or that the Employee and/or Dependent has committed any other fraudulent, wrongful or illegal act in connection with the payment of a claim.

## **COVERAGE TERMINATION BY THE HMO**

Employee and Dependent coverage under an HMO may be immediately terminated for any of the following reasons:

- Nonpayment of monthly contributions, coinsurance or copayments.
- Fraud or deception knowingly committed by an enrollee.
- Misuse of the HMO identification card.
- Disruptive, threatening, unruly, abusive, and/or uncooperative behavior.
- The date the certificate of coverage terminates
- The date of the expiration of the last period of time for which any required contribution has been made.

## **CERTIFICATE OF CREDITABLE COVERAGE**

Whenever you or a covered Dependent's coverage under an HMO (including continued coverage) terminates, you will automatically receive a certificate from the State Farm Benefits Center documenting the length of coverage you or your dependents had under the State Farm Group Medical Plan. Additionally, this certificate will indicate either the length of your coverage (if less than 18 months) or certify that you or your dependents had at least eighteen months of coverage. However, any period of State Farm group medical coverage prior to any break in



coverage of 63 days or more will not be counted as creditable coverage and will not be reflected on the certificate.

You should retain a copy of the certificate for your records, as it may be needed to offset any exclusion of coverage for a preexisting condition that may be imposed when you or your dependent seeks coverage under another group health plan.

In addition to automatically receiving a certificate upon coverage termination, you or your covered dependents may also request a certificate of creditable coverage from the State Farm Benefits Center any time before coverage terminates or within 24 months of losing coverage.

## **CONTINUING COVERAGE**

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### **EXTENSION OF COVERAGE UPON TERMINATION**

#### ***Extension of Coverage For Surviving Dependent Adults***

Coverage may be extended for the Surviving Dependent Adult of an Active Employee (as that term is defined in the SPD for the Group Medical PPO Plan) who dies prior to retirement if the Active Employee and the Surviving Dependent Adult were participating in a State Farm sponsored group health plan and the Active Employee had at least 10 years of Company Service, or who had at least 5 years of Company Service and whose age plus years of Company Service equaled or exceeded 55 on the date of death. However, for Employees hired or rehired on or after January 1, 2007, the Employee must have had at least 15 years of Company Service as of the date of death in order for the Surviving Dependent Adult to be eligible for extended coverage.

With respect to the above, if the Employee's Surviving Dependent Adult is covered, the Employee's Dependents may also be covered.

Surviving Dependent Adults not covered by the Plan on the date of the Employee's death are not eligible for coverage.

**Note: An eligible Surviving Dependent Adult who is covered by a State Farm sponsored HMO at the time of the Employee's death who fails to enroll in the State Farm Group Medical PPO Plan when offered, or a Surviving Spouse who is covered by the State Farm Group Medical PPO Plan who fails to extend his/her coverage upon the death of an Active Employee/Inactive Employee, is not eligible for coverage at a later date. Additionally, if a Surviving Dependent Adult who has elected to extend coverage ever cancels the coverage, he or she will not be eligible to reinstate the coverage at a later date. Continuation under COBRA may be available.**

### **CONTINUATION OF MEDICAL COVERAGE UNDER COBRA**

#### ***Overview***

The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires employers to offer continued health care coverage to **qualified beneficiaries**. Qualified beneficiaries are those individuals (Employee, Employee's Spouse and Dependents) who are covered under a group

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health plan on the day a qualifying event occurs. For information regarding the reduction of COBRA premiums under the American Recovery and Reinvestment Act of 2009 and its amendments, see the Summary Plan Description for the State Farm Insurance Companies Group Health and Welfare Plan for United States Employees.

Note: Although COBRA does not apply to Covered Individuals that are not the Employee's dependents under the IRS Code (in general, a same-sex Spouse/Partner and/or the Spouse's/Partner's child/children), such individuals will be offered "COBRA-like" continuation coverage in a manner similar to COBRA.

COBRA participants must pay the **entire** premium cost (employee and Company contributions) plus a 2% administration fee (higher fees may be charged in special cases such as an extension of benefits due to disability).

In order to protect your and your family's rights, you should inform the State Farm Benefits Center at Aon Hewitt (1-866-935-4015), of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

### ***Eligibility***

Qualified Beneficiaries do not have to provide evidence of insurability to continue coverage. All provisions of the plan will continue during the continuation period. Each qualified beneficiary has independent election rights under COBRA and may elect to continue coverage on their own (separate from the other qualified beneficiaries).

The following chart shows the qualifying events that may entitle you (or your dependent) to COBRA coverage. The chart also shows the length of time coverage may continue. Rights to continued coverage apply separately to each qualified beneficiary.

### ***COBRA Qualifying Events and Length of Time Coverage Can Continue***

<b>Qualifying Event</b>	<b>Qualified Beneficiary</b>	<b>Maximum Period of Continuation</b>
Your employment stops for any reason other than gross misconduct or you have a reduction in work hours	You and your covered dependents	18 months  Up to 29 months if you or a qualified beneficiary is disabled within 60 days of beginning COBRA coverage*
	Dependent(s)	Up to 36 months if you are enrolled in Medicare**
Divorce/legal separation	Ex-spouse or legally separated spouse and/or your dependent children	36 months
Dependent child no longer eligible under terms of the Plan	Dependent children	36 months

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Death of employee	Dependent spouse and children	36 months
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- \* If the disabled individual (as determined by the Social Security Administration) entitled to the extension has non-disabled family members who are entitled to COBRA coverage, the non-disabled family members may continue coverage for up to 29 months as well.
- \*\* If you enroll for Medicare before you terminate employment or before you lose full-time status, your dependents may continue coverage up to the later of 36 months from the date you enroll for Medicare, or 18 months from the date of your termination or reduction in hours. For example, if you enroll for Medicare on January 1, and terminate employment a month later on February 1, your spouse and children may continue coverage for up to 36 months, counting from January 1.

### ***Applying For Continuation of Coverage***

When you lose eligibility for coverage, you will be notified if you are eligible for COBRA continuation coverage. **However, you or a covered family member (or a designated representative) must notify the State Farm Benefits Center in the event of divorce, legal separation or when a dependent child is no longer eligible for coverage.** You must provide this notice **within 60 days of the divorce, legal separation, or Dependent losing dependent status** to the State Farm Benefits Center at Aon Hewitt (1-866-935-4015), by accessing My State Farm Benefits Resource at [www.resources.hewitt.com/state](http://www.resources.hewitt.com/state), or by mailing to Aon Hewitt, c/o State Farm Benefits Center, 100 Half Day Road, P.O. Box 1495, Lincolnshire, IL 60069-1495. You may be required to provide additional documentation such as a copy of the divorce decree or proof that a child is no longer a “dependent” under the Plan. When the appropriate department receives your notice, it must in turn notify you, your Spouse and children (individually or jointly) of your right to elect COBRA coverage.

If you, a your covered Spouse or child, or designated representative fail to provide the appropriate department with timely notice when one of these qualifying events occurs, the right to COBRA coverage will be waived.

If you elect COBRA coverage, you have the same annual enrollment rights that apply to active Employees.

### ***60-Day Deadline To Elect COBRA***

You will have 60 days from the time coverage stops or the date you are notified, whichever is later, to apply for COBRA coverage. You and each eligible dependent have the right to make an individual election. If you or your dependents do not file your application for continued coverage during that period, you will lose the opportunity to continue your coverage.

### ***Disability Extension***

If a qualified beneficiary is disabled and meets certain requirements, all of the qualified beneficiaries in the family may extend the continuation coverage period an additional 11 months for a total of up to 29 months.

The requirements are, first, that the disabled qualified beneficiary must be determined by the Social Security Administration (SSA) to be disabled at some time before the 60th day of continuation coverage and, second, that the disability must continue during the rest of the initial 18-month period of continuation coverage.

To extend coverage beyond the 18-month period, you or the disabled qualified beneficiary (or another person on his or her behalf) must show that you are entitled to Social Security disability

benefits by providing a letter of determination (Social Security award letter) to the COBRA Administrator within 60 days from the later of: (1) the date on which SSA issues the disability determination; (2) the date on which the qualifying event occurs; (3) the date on which the qualified beneficiary loses (or would lose) coverage under the plan as a result of the qualifying event; or (4) the date on which the qualified beneficiary is informed, through the furnishing of either the SPD or the COBRA general notice, of the responsibility to notify the plan and the procedures for doing so.

If Social Security determination of disability stops, you must notify the COBRA Administrator within 31 days of the final Social Security determination. COBRA coverage will stop on the first of the month following 31 days after the determination that you or a dependent is no longer disabled.

### ***Second Qualifying Events***

An 18-month extension may be available to qualified beneficiaries (Spouse and/or Dependents) receiving an 18-month maximum period of continuation coverage (giving a total maximum period of **36 months** of continuation coverage) if the qualified beneficiaries experience a second qualifying event that is death of the covered employee, divorce or legal separation of the covered employee and spouse, or loss of dependent child status under the plan. The second event can be a second qualifying event only if it would have caused the qualified beneficiary to lose coverage under the plan in the absence of the first qualifying event. Notification must be provided to the COBRA Administrator within 60 days from the later of: (1) the date on which the qualifying event occurs; (2) the date on which the qualified beneficiary loses (or would lose) coverage under the plan as a result of the qualifying event; or (3) the date on which the qualified beneficiary is informed, through the furnishing of either the SPD or the COBRA general notice, of the responsibility to notify the plan and the procedures for doing so.

### ***Adding Dependents After Continuation of Coverage Begins***

If you elect to continue coverage, you may add newly acquired, eligible dependents to your COBRA coverage, by complying with the same requirements as that of an active employee. You must notify the COBRA Administrator, Benefit Concepts, to add newly acquired dependents.

### ***The Cost of Continued Coverage***

Any person who elects to continue coverage under the Plan must pay the full cost (your share and your employer's share), plus 2% for administrative expenses. A disabled person (and covered family members) who extends coverage for more than 18 months may be required to pay 150% of the premium for months 19 through 29. However, if only the non-disabled family members elect to continue coverage under COBRA, then the cost will be 102% (full cost plus 2% for administrative expenses). Payments for continued coverage must be made no later than the first day of coverage in each month.

### ***When Continued Coverage Ends***

COBRA coverage will be canceled in less than 18 months (or, if applicable, 36 months) if one of the following situations occurs:

- Required premiums are not paid on time. To be timely, a payment must be paid within 30 days of its due date (or 45 days of the due date for the initial payment).
- After electing continuation coverage, the end of the Month an individual already covered by COBRA coverage first becomes covered under another health care

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plan as an employee or dependent — unless the other plan contains a preexisting condition exclusion or limitation. Continued coverage will not terminate until the individual is no longer affected by a preexisting condition exclusion or limitation under the other group health plan. An individual can be dropped from COBRA coverage if he/she becomes covered under a new health care plan and the new plan gives credit for prior coverage that serves to eliminate the preexisting condition exclusion period.

- After electing continuation coverage, the end of the Month the Employee becomes entitled to Medicare (Part A, Part B, or both), in which case the Employee's continuation coverage will cease but the continuation coverage for his or her Dependents may continue for up to 36 months from the date of the Employee's reduction in hours or termination of employment.
- After electing continuation coverage, the end of the Month the Dependent first becomes entitled to Medicare benefits (Part A, Part B, or both).
- It is determined that the individual is no longer disabled under the Social Security laws, if that person is eligible because of the special extended coverage period for disabled individuals.
- The Company no longer offers group medical coverage to any Employees.

Once COBRA coverage is cancelled, it will not be reinstated. If, during the 18-month or 29-month period, a second event occurs that would require continued coverage, coverage may be extended — but not beyond a total period of 36 months. No one may continue COBRA coverage for more than 36 months for any reason.

### ***Converting Your Coverage***

You or your dependents may be eligible to convert the HMO coverage to an individual policy, provided you and your dependents were covered on the date of coverage termination. **Refer to your HMO Certificate for detailed information on the HMO's conversion policy, if any.**

## WHO TO CONTACT

<ul style="list-style-type: none"><li>• Information about eligibility, premiums, enrollment procedures, address changes</li><li>• Special or late enrollment</li><li>• Enroll dependents after your coverage effective date</li><li>• Report a marital or dependent status change</li><li>• Information about COBRA eligibility, questions, billing or to request COBRA coverage</li><li>• Enrollment records</li></ul>	<p>State Farm Benefits Center at Aon Hewitt 1-866-935-4015 or by accessing My State Farm Benefits Resource at <a href="http://www.resources.hewitt.com/statefarm">www.resources.hewitt.com/statefarm</a> Monday – Friday, 7 a.m. – 6 p.m., CT</p> <p>Aon Hewitt c/o State Farm Benefits Center 100 Half Day Road, P.O. Box 1495 Lincolnshire, IL 60069-1495</p>
<ul style="list-style-type: none"><li>• Questions about eligibility of services/treatment</li><li>• Questions about the benefits provided under the HMO</li><li>• Verification of medical coverage</li></ul>	<p><b>Contact the HMO's customer service number located on the HMO's ID card</b></p>

## ADMINISTRATIVE INFORMATION

### ERISA ADMINISTRATIVE INFORMATION

#### **Plan Name**

The name of the plan is the State Farm Insurance Companies Group Medical Plan - HMO Option for United States Employees, referred to in this summary plan description as the "Plan." The Plan is a group health plan and is a component benefit Option (as that term is defined in the State Farm Insurance Companies Group Health and Welfare Plan for United States Employees) of the State Farm Insurance Companies Group Health and Welfare Plan for United States Employees.

#### **Plan Administrator**

The Welfare Benefit Administrative Committee is the Plan Administrator; One State Farm Plaza, Bloomington, Illinois 61710 (1-309-766-6848). Mary Schmidt, Vice President – Human Resources, has been designated as agent for service of legal process. Service of legal process may also be made upon the Plan Administrator.

The Plan provides medical benefits to Employees (as defined in the Plan) of State Farm Mutual Automobile Insurance Company and its affiliates and subsidiaries. A complete list of the participating employers may be obtained upon written request to the Plan Administrator.

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Participants and beneficiaries may also receive upon written request information as to whether a particular employer is a plan sponsor, and, if the employer is a plan sponsor, the sponsor's address.

The Plan Administrator shall have the power to make all reasonable rules and regulations required in the administration of the Plan and for the conduct of its affairs, to make all determinations that the Plan requires for its administration, and to construe and interpret the Plan whenever necessary to carry out its intent and purpose and to facilitate its administration. All such rules, regulations, determinations, constructions and interpretations made by the Plan Administrator shall be binding upon the Companies, all Employees and their Dependents, and all other interested parties.

### ***Discretionary Authority***

The Plan Administrator delegates to the HMO the discretionary authority to interpret and apply plan terms and to make factual determinations in connection with its review of claims under the Plan. Such discretionary authority is intended to include, but is not limited to, the determination that a person is or is not entitled to benefits under the plan, and the computation of any and all benefit payments. The Plan Administrator also delegates to the HMO the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial, which has been appealed by the claimant or his duly authorized representative. Benefits under this Plan will be paid only if the HMO decides in its discretion that the person is entitled to them.

### ***Plan Cost***

You and State Farm share the cost of your medical coverage. For active Employees, your share of the cost is paid with pre-tax Flex Dollars. Your monthly contribution will be deducted equally from your first and second paycheck of the month.

### ***Wellness Incentive***

If an Employee satisfactorily completes the Wellness Assessment during the completion period, as determined by the Plan Administrator, said Employee will receive a wellness incentive of \$15.00 towards the Employee's monthly premium for the 2012 Plan Year. The \$15.00 monthly wellness incentive applies regardless of the Option the Employee elects or the number of Dependents the Employee enrolls.

Employees that do not complete the Wellness Assessment during the published completion period will not be eligible for the wellness incentive. Additionally, Employees hired after the published completion period will not be eligible for the wellness incentive. Employees rehired during the 2012 Plan Year who were previously eligible for the wellness incentive will retain eligibility and begin receiving the incentive upon the reinstatement of their monthly premium.

Employees who become Agents (as defined in the Group Medical PPO Plan for United States Agents) will retain the incentive. However, no wellness incentive will be given during any period in which an individual is not an Employee or an Agent.

In all other cases, the wellness incentive will terminate at the end of the Month the Employee is no longer an Employee. For all eligible individuals, the incentive will expire on December 31, 2012.

### **Plan and Employer Identification Numbers**

For purposes of identification, the number 524 has been assigned to the State Farm Insurance Companies Group Health and Welfare Plan for United States Employees. The Internal Revenue Service has assigned State Farm Mutual Automobile Insurance Company the employer identification number 37-0533100. When writing about this component benefit Option, please identify the Group Health and Welfare Plan both by name and by the above two numbers.

## **YOUR RIGHTS UNDER ERISA**

As a participant in any State Farm sponsored HMO, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). These rights are also provided in the Summary Plan Description for the State Farm Insurance Companies Group Health and Welfare Plan for United States Employees. ERISA provides that all Plan participants shall be entitled to the following.

### **Receive Information About Your Plan and Benefits**

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and an updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

### **Continue Group Health Plan Coverage**

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

### **Prudent Actions By Plan Fiduciaries**

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, or any other



person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit, or exercising your rights under ERISA.

### **Enforce Your Rights**

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal to any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim of benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

### **Assistance With Your Questions**

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

## **QUALIFIED MEDICAL CHILD SUPPORT ORDER**

The Employee Retirement Income Security Act of 1974 (ERISA) requires the Plan Administrator to honor court orders or administrative court directives (i.e., medical child support decrees) to provide medical plan coverage to dependent children of divorced parties, and to begin such coverage while you are working. A child provided coverage due to a court judgment or decree is referred to as an "alternate recipient".

These orders must meet the Qualified Medical Child Support Order (QMCSO) rules, which require that certain federal standards be satisfied. The Plan Administrator will deny medical plan coverage under any judgment, decree or order as a QMCSO unless it satisfies all of the requirements set forth below. Assuming such an order meets these federal requirements, the Plan Administrator will follow the terms of the order if the medical plan is the proper party to the legal proceeding from which the order has been issued.

The following are the Plan's procedures as required under Section 609 of ERISA. The Plan may provide coverage under a Medical Child Support Order (MCSO) only if the MCSO has been

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determined by the Plan Administrator to be a QMCSO. Upon receipt of an MCSO, the following procedure will be followed in determining whether or not it is a QMCSO.

- Any Employee affected and any other person (e.g., alternate recipient or their designated representative) specified in the MCSO as being entitled to medical coverage under the plan will be notified of the receipt of the proposed order. The notification will be sent to the address set forth in the MCSO. If no address is indicated, any other address of the individual that the Plan Administrator has on record will be used.
- The Plan will refer the MCSO to legal counsel for advice as to whether the MCSO satisfies the requirements of a QMCSO under Section 609 of ERISA and regulations, if any are issued.
- When counsel notifies the Plan as to the status of the MCSO, the Plan will notify the Employee and alternate recipient(s) or their representative of the Plan Administrator's determination within a reasonable time period. If the MCSO is determined to be a QMCSO, notification will also include the terms of benefits and instructions for medical coverage.
- During the time the status of the MCSO is being determined, the Plan Administrator will, record the potential alternate recipient's claim. At this stage the alternate recipient is not entitled to medical plan coverage.
- If coverage is immediate, the Employee will be required to make payment in accordance with the terms of the Plan and federal law. The period commences on the date the coverage is approved by the Plan and required under the MCSO. If the MCSO is determined not to be a QMCSO within a reasonable period, or the issue is not resolved, the Plan will not be able to provide medical coverage to any named recipient under the order. If the MCSO is determined not to be a QMCSO before a reasonable period expires, and the Plan Administrator receives no written notice that one of the parties is attempting to rectify the order, the Plan will consider the matter resolved outside of the Plan and not provide coverage until a QMCSO has been re-filed with the Plan.

You have the right to designate a representative to receive copies of notices that are sent with respect to the MCSO. If you wish to designate such a representative, the Plan Administrator should be notified in writing immediately by writing the Human Resources Services Center at State Farm Insurance Companies, Human Resources Services Center, Three State Farm Plaza South, Bloomington, IL 61791-001. If no designation is received by the Plan, notifications regarding the MCSO will be sent to the custodian parent at the address included in the MCSO, or if no address is indicated, at any address otherwise known to the Plan Administrator.

The Plan Administrator will follow court orders or administrative court orders that meet all of the following requirements:

- The order relates to the provision of a medical child support order.
- The order creates or recognizes the existence of an alternate recipient's right to medical coverage under the participant's medical benefits.
- The order specifies the Social Security number, name, birth date and last known mailing address of the participant and each alternate recipient covered by the order.

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- The order specifies the type and period of medical coverage and requires that such coverage be paid by the participant in accordance with the medical plan and federal law.
- The order specifically names the State Farm Group Medical Plan – HMO Option as the plan to which the order applies.
- The order does not require the medical plan to provide any type of medical coverage, benefit(s), form of coverage or option(s) not otherwise provided under this Plan.

## **ADDITIONAL INFORMATION**

Within this summary plan description, we have tried to describe the HMO option in easy-to-understand terms. But, if this summary plan description contains any statements that disagree with the certificate of coverage issued by the HMO, the terms of the certificate shall govern.

You or your Dependents may examine the Plan documents during normal business hours at the following location:

- The Human Resources Department, Corporate Headquarters

Upon written request to the Human Resources Department – Total Rewards – Benefits, State Farm Insurance Companies, One State Farm Plaza, Bloomington, Illinois 61710-0001, copies of any or all of the documents will be furnished to you at a reasonable charge. The Plan's records are maintained on a calendar year basis, ending on December 31.

You may also obtain additional information by contacting the HMO's customer service or by accessing the HMO's website, if available.

## YOUR HEALTH INFORMATION

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### PROVISION OF PROTECTED HEALTH INFORMATION TO PLAN SPONSOR (Effective April 14, 2003)

**Permitted and Required Uses and Disclosure of Protected Health Information.** Subject to obtaining written certification as required in the “Certification of Plan Sponsor” section below, the State Farm Insurance Companies Group Medical Plan - HMO Option for United States Employees (the Plan) may disclose protected health information to the Plan Sponsor, provided the Plan Sponsor does not use or disclose such protected health information except for the following purposes:

- To perform administrative functions which the Plan Sponsor performs for the Plan.
- Obtaining premium bids from insurance companies, HMOs or other health plans for providing group insurance coverage under the Plan; or
- Modifying, amending, or terminating the Plan.

In no event shall the Plan Sponsor be permitted to use or disclose protected health information in a manner that is inconsistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (45 CFR §164.504(f)).

**Conditions of Disclosure.** The Plan shall not disclose protected health information to the Plan Sponsor unless the Plan Sponsor agrees to:

- Not use or further disclose the protected health information other than as permitted by the Plan or required by law.
- Ensure that any agent (including a subcontractor) who receives protected health information from the Plan, agrees in advance to the same restrictions and conditions that apply to the Plan Sponsor with respect to the protected health information.
- Not use or disclose the protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual.
- Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures permitted herein.
- Make available to a Plan participant his or her protected health information in accordance with HIPAA (45 CFR §164.524).
- Make available to a Plan participant who requests an amendment, the participant's protected health information and incorporate any amendments to the participant's protected health information in accordance with HIPAA (45 CFR §164.526).
- Make available to a Plan participant who requests an accounting of disclosures of the participant's protected health information, the information required to provide an accounting of disclosures in accordance with HIPAA (45 CFR §164.528).

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- Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA (45 CFR §164.504(f)).
- If feasible, return or destroy all protected health information received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information feasible.
- Ensure that the adequate separation required by HIPAA (45 CFR §164.504(f)(2)(iii)) between the Plan and the Plan Sponsor exists.

**Certification of Plan Sponsor.** The Plan shall disclose protected health information to the Plan Sponsor only upon the receipt of a Certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions of HIPAA (45 CFR §164.504(f)(2)(ii)), and that the Plan Sponsor agrees to the conditions of disclosure described above.

**Permitted Uses and Disclosure of Summary Health Information.** The Plan may disclose Summary Health Information to the Plan Sponsor, provided such Summary Health Information is only used by the Plan Sponsor for the purpose of:

- Obtaining premium bids from health plan providers for providing health insurance coverage under the Plan; or
- Modifying, amending, or terminating the Plan.

**Permitted Uses and Disclosure of Enrollment and Disenrollment Information.** The Plan may disclose enrollment and disenrollment information and information on whether individuals are participating in the Plan to the Plan Sponsor, provided such enrollment and disenrollment is only used by the Plan Sponsor for the purpose of performing administrative functions that the Plan Sponsor performs for the Plan.

**Adequate Separation Between Plan and Plan Sponsor.** The Plan Sponsor shall only allow those members of the Corporate Law Department, Financial Operations, the Human Resources Services Center, Total Rewards - Benefits and other supporting departments with responsibility for supporting and performing administrative functions for the Plan with access to protected health information. Such employees shall only have access to and use such protected health information to the extent necessary to perform the supporting and administrative functions that the Plan Sponsor performs for the Plan. In the event that any such employees do not comply with the provisions of this Section, the employee shall be subject to disciplinary action by the Plan Sponsor for non-compliance pursuant to Plan Sponsor's employee discipline and termination procedures.

**Definitions.** For purposes of this provision, the following terms shall have the meaning described below unless otherwise provided by the Plan:

- “Protected Health Information” means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a member; the provision of health care to a member; or the past, present, or future

payment for the provision of health care to a member, and that identifies the member or for which there is a reasonable basis to believe the information can be used to identify the member. Personal health information includes information of persons living or deceased. The following components of a member's information also are considered personal health information: 1) names; b) street address, city, county, precinct, zip code; c) dates directly related to a member, including birth date, health facility admission and discharge date, and date of death; d) telephone numbers, fax numbers, and electronic mail addresses; e) Social Security numbers; f) medical record numbers; g) health plan beneficiary numbers; h) account numbers; i) certificate/license numbers; j) vehicle identifiers and serial numbers, including license plate numbers; k) device identifiers and serial numbers; l) Web Universal Resource Locators (URLs) and Internet Protocol (IP) address numbers; m) biometric identifiers, including finger and voice prints; n) full face photographic images and any comparable images; and o) any other unique identifying number, characteristic, or code.

- “Summary Health Information” means information that may be individually identifiable health information, and a) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and b) from which the information listed above as components of personal health information has been deleted, except that the geographic information need only be aggregated to the level of a five digit zip code.
- “Plan Sponsor” means the Compensation Committee of the Board of Directors of State Farm Mutual Automobile Insurance Company.

**Electronic Protected Health Information.** The Plan Sponsor shall:

- (a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that they create, receive, maintain, or transmit on behalf of the Group Medical Plan;
- (b) Ensure that the adequate separation required by § 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;
- (c) Ensure that any agent, including a subcontractor, to whom they provide this information agrees to implement reasonable and appropriate security measures to protect the information; and
- (d) Report to the group health plan any security incident of which it becomes aware.

## **NEW YORK ORDERS OF PROTECTION**

If the Plan Sponsor or the HMO, as insurer, receive a valid order of protection issued by a New York court with respect to a person covered by the group policy, the Plan Sponsor and the insurer will be prohibited for the duration of the order from disclosing to the person against whom the order of protection was issued the address and telephone number of the insured person covered by the order of protection.

If you receive an Order of Protection, the following steps should be taken:

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- Complete and submit the “Order of Protection Receipt Reporting Request - NY” form found in State Farm Forms. To access the form, view the forms by Area and access the Administrative Services > Security forms file, and
- Send the paper copy of the Order of Protection to: Sheila Bury, Administrative Services, Concordville Operations Center AND to Total Rewards – Benefits at:

State Farm Insurance Companies  
Total Rewards - Benefits, C-1  
One State Farm Plaza  
Bloomington, IL 61710-0001

## **APPENDIX: TERMS**

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The following are definitions for words and phrases used in this summary plan description. Additional terms as used by the HMO are defined in the HMO's certificate of coverage. Terms defined in this section are capitalized throughout the Summary Plan Description.

### **Annual Enrollment Period**

The period designated by the Plan Administrator for Employees to enroll themselves and their Dependents as of the first day of the following Plan Year.

### **Company**

The State Farm Mutual Automobile Insurance Company, State Farm Fire and Casualty Company, State Farm General Insurance Company, State Farm Florida Insurance Company, State Farm Indemnity Company, State Farm Life Insurance Company, State Farm Life and Accident Assurance Company, State Farm VP Management Corp., and such other affiliated companies as may elect to offer the Plan for the benefit of its Employees and their Dependents.

### **Dependent**

For purposes of this summary plan description, persons who are eligible as Dependents are described in the section entitled *Eligible Dependents*.

### **Dependent Adult**

Dependent Adult means the Employee's Spouse or Partner. An Employee can only have one Spouse or Dependent Adult at any one time.

### **Employee**

For purposes of this summary plan description, persons who are eligible as Employees are described in the section entitled *Eligible Employees*.

### **Enrollment Date**

The first day of coverage or the first day of a Waiting Period, whichever is earlier.

**Flex Dollars**

Flex Dollars credited to an Employee's Flex Dollar Account according to the provisions of the State Farm Insurance Companies' Flexible Compensation Plan for U.S. Employees.

**Individual**

Where noted or capitalized means an Employee or a Dependent of an Employee.

**Late Enrollee**

Employees and/or Dependents who enroll any time other than the first period in which they are eligible to enroll or who have enrolled during a Special Enrollment Period. Enrollment can be made during any Annual Enrollment Period as determined by the Plan Administrator. Coverage will be effective January 1 following the Annual Enrollment Period.

**Medicare**

Medical benefits provided by Title XVIII of the Social Security Act.

**Month**

One of the 12 months represented in a given calendar year.

**Other Care Providers**

A community-integrated living arrangement, group home, supervised apartment or other residential services licensed or certified by the State.

**Partner**

The person to whom the Employee has legally entered into a relationship under the laws of the State in which the relationship is registered whether referred to as a civil union, domestic partnership or substantially similar legal relationship. In the event of a discrepancy between the definition of Partner under the laws of another State and the definition of Partner under the Illinois Religious Freedom Protection and Civil Union Act (the Illinois "Civil Union Law"), the Illinois Civil Union Law will control. An Employee may only have one Spouse or Partner enrolled in the Plan at one time.

**Plan Year**

The Plan Year is the 12-month period beginning on January 1 and ending on the next following December 31.

**Preexisting Condition**

Preexisting condition means a limitation or exclusion of benefits relating to a condition for which medical advice, diagnosis, care or treatment was recommended by or received from a physician within six months prior to the individual's Enrollment Date.

**Pregnancy**

Pregnancy means the physical state that results in childbirth, abortion or miscarriage. This definition includes medical complications of the physical state of pregnancy.

**Reemployment Rights**

The rights set forth in the Uniformed Services Employment and Reemployment Rights Act.



### **Special Enrollee**

Employees and/or their Dependents who previously waived State Farm group medical coverage because they were covered under another plan and who lose eligibility for that coverage, or those who become eligible for coverage under the State Farm Group Medical Plan - HMO Option because of marriage, birth, adoption, placement for adoption, legal guardianship or legal custody of a dependent.

### **Special Enrollment Period**

The 31-day period during which:

- Employees and their Dependents who are eligible for medical coverage, may enroll for coverage under the State Farm Group Medical Plan - HMO Option or the State Farm Group Medical PPO Plan, provided:
  - a. The Employee or Dependent was covered under another group health plan or had health insurance coverage at the time coverage was previously offered under State Farm group medical,
  - b. in the case of an Employee or Dependent who has coverage that is not COBRA continuation coverage and the Employee or Dependent loses eligibility for the other coverage due to one of the following events
    - (1) the Employee's or Dependent's coverage is terminated as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, dependent losing dependent status, or the employer terminates contributions toward such Employee's or Dependent's coverage;
    - (2) in the case of an Employee or Dependent who has coverage through an HMO or other arrangement in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loses coverage because the Employee or Dependent no longer resides, lives, or works in the service area (whether or not within the choice of the Employee or Dependent);
    - (3) in the case of an Employee or Dependent who has coverage through an HMO or other arrangement in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loses coverage because the Employee or Dependent no longer resides, lives, or works in the service area (whether or not within the choice of the Employee or Dependent), and no other benefit package is available to the Employee or Dependent;
    - (4) the Employee or Dependent incurs a claim that would meet or exceed a lifetime limit on all benefits;
    - (5) the plan no longer offers any benefits to the class of similarly situated individuals that includes the Employee or Dependent; or
    - (6) in the case of an Employee or Dependent who has COBRA continuation coverage and the Employee or Dependent has exhausted such

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continuation coverage. Exhaustion means that coverage ceases for any reason, including events (2), (3), and (4) above when there is no other COBRA continuation coverage available to the individual, but does not include either the failure of the Employee or Dependent to pay premiums on a timely basis or termination due to cause, and

- c. The Employee requests State Farm group medical coverage not later than 31 days after the coverage described above is terminated due to loss of eligibility, employer contributions are terminated, a claim is denied due to meeting a lifetime limit for all benefits, or COBRA continuation coverage is exhausted and the Employee completes and returns any required enrollment form or documentation within 14 days after the end of the 31-day Special Enrollment Period.

Only Dependents (and the Employee if not already enrolled) who lose eligibility for coverage as described in (1) through (6) above are eligible for enrollment. If the Employee loses eligibility, however, the Employee and any eligible Dependents are eligible to enroll.

**Note:** Loss of eligibility does not include loss due to failure to pay premiums on a timely basis or termination due to cause.

- Employees and their Dependents who are eligible for coverage, but not enrolled, and/or their newly acquired Dependents may be eligible to enroll for coverage under the State Farm Group Medical Plan - HMO Option or the State Farm Group Medical PPO Plan, provided:
  - a. The Employee acquires a new Dependent through marriage, birth, adoption or placement for adoption, **and**
  - b. He/she requests coverage not later than 31 days after the date of the marriage, birth, adoption or placement for adoption and returns any required enrollment form or documentation within 14 days after the end of the 31-day Special Enrollment Period.
- Special Enrollment Rules Due to Medicaid and Children's Health Insurance Program (CHIP)

Effective April 1, 2009, Employees and their Dependents who are otherwise eligible to enroll, but are not enrolled, may enroll for coverage under any option offered by the Plan provided:

- a. The Employee or Dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act (CHIP) and coverage of the Employee or Dependent under such a plan is terminated as a result of loss of eligibility for such coverage and the Employee requests coverage not later than 60 days after the date of termination of such Medicaid or CHIP coverage, or
- b. The Employee or Dependent becomes eligible for assistance under a Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan), if the Employee requests

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coverage not later than 60 days after the date the Employee or Dependent is determined to be eligible for such assistance.

Any required enrollment form or documentation must be returned within 75 days of either a. or b. above.

**Spouse**

The person to whom the Employee is legally married under the laws of the State in which the marriage is registered.

**State**

Any of the fifty states of the United States of America, the District of Columbia or any similar unit of government in any other country.

**Waiting Period**

The period that must pass before an Individual is eligible to be covered for benefits under the State Farm Group Medical Plan - HMO Option. For Employees hired on the first calendar day of the month, there is no waiting period. For Employees hired after the first calendar day of the month, the waiting period is the period of time between the date of hire and the first calendar day of the following month. A period preceding a late or special enrollment is not a waiting period.

**Wellness Assessment**

A voluntary survey for Employees that can provide the participant with a comprehensive summary of his or her health risks. The Wellness Assessment vendor will share information with the Plan Administrator in aggregate form and may help determine future benefit design and wellness initiatives. No personally identifiable health information will be shared. The content of the Wellness Assessment will be determined by the Plan Administrator.