# State Farm Insurance Companies Group Medical PPO Plan Summary Plan Description\*

For United States Employees

Effective January 1, 2012

#### **Notice for Massachusetts Residents**

This health plan meets Minimum Creditable Coverage Standards and will satisfy the individual mandate that a Massachusetts resident have health insurance. Please see page 8 for additional information.

\*This document plus the Summary Plan Description for the State Farm Insurance Companies Group Health and Welfare Plan for United States Employees constitutes the Summary Plan Description as required by the Employee Retirement Income Security Act of 1974 (ERISA §102).

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.

### **Table of Contents**

INTRO	DUCTION	7
No	otice Regarding Grandfathered Status	8
	assachusetts Notice	
	S ELIGIBLE	
El	ligible Employees	9
W	/ho Is Not Eligible For Coverage1	1
	ehired Inactive Employees1	
	on-Employees1	
lf '	You And Your Dependent Adult are Both Eligible For State Farm-Sponsored	
	Group Medical Plans 1	1
El	ligible Dependents1	2
Pr	roof of eligibility1	3
De	ependent Children of Eligible State Farm Parents1	3
De	ependents of a Surviving Dependent Adult1	3
WHEN	COVERAGE BEGINS	14
	hen Coverage Begins for Employees1	
	aiting Period1	
	ou Enroll Within 31 Days of Your Date of Hire1	
	ou Fail to Enroll Within 31 Days of Your Date of Hire1	
W	hen Coverage Begins for Retirees and Employees Who Terminate Due to Tota	al
	Disability or Illness Benefits Expired1	4
	ou Enroll Within 31 Days of Retiring or Terminating Due to Total Disability or	
III	Iness Benefits Expired1	4
	ou Fail to Enroll Within 31 Days of Retiring or Terminating Due to Total Disabili	
	r Illness Benefits Expired1	
	hen Coverage Begins Due to a Special Enrollment Period or Enrolling at Annu	
	nrollment1	_
	pecial Enrollment Period – Enrolled In Another Health Plan 1	6
	pecial Enrollment Period – Marriage, Birth, Adoption or Placement for	
	doption1	
	nrolling During Annual Enrollment1	
	hen Coverage Begins for Dependents of Employees1	
	ou Enroll Your Dependents When You First Become Eligible for Coverage 1	7
	ou Fail to Enroll Your Dependents When You First Become Eligible for	
	Coverage	7
	hen Coverage Begins For Dependents of Retirees and Employees Who	
	erminate Due to Total Disability or Illness Benefits Expired	7
	ou Enroll Your Dependents When You First Retire or Terminate Due to Total	
	Disability or Illness Benefits Expired	7
	ou Fail to Enroll Your Dependents When You First Retire or Terminate Due to	
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	otal Disability or Illness Benefits Expired	ıδ
	/hen Coverage Begins for Newly Acquired Dependents	
VV	hen Coverage Begins for Newly Born and Adopted Children 1	ıδ

	Other Newly Acquired Dependents	18
	When Coverage Begins Due to a Special Enrollment Period or Enrolling at Ann	ual
	Enrollment - Dependents	
	Special Enrollment Period – Dependents Enrolled In Another Health Plan	19
	Enrolling During Annual Enrollment	
	Changing Your Enrollment Decision During the Year	20
	Confirmation Statements	
	ID Cards	
	Associate Records	
MED	DICAL PLAN BENEFITS	
	Options under the Group Medical PPO Plan	
	Enrollment Options	
	Enrollment Option Eligibility	
	Lifetime Maximum Benefit	
	Specific Benefit Lifetime Maximums and Calendar Year Maximums	
	Your Payment Responsibilities	
	Plan Cost	
	Company Contributions To The Cost Of Coverage	
	Inactive Employees Hired Prior to January 1, 2007 and Their Dependents	
	Inactive Employees Hired On or After January 1, 2007 and Their Dependents	
	Employees Who Are Inactive Employees as of December 31, 2011 and Their	20
	Dependents	23
	Surviving Dependent Adults and Their Eligible Children	
	Wellness Incentive – Active Employees	
	Deductible	
	Deductible Types	
	Coinsurance Percentage (After Meeting the Deductible)	
	Out-Of-Pocket Expense Limit	
	HRA OPTION	
	General	
	Establishment of HRA Account	
	Company Contributions	
	Using HRA Account Balances	
	Change in Status – Active Employees	
	Change in Status – Inactive Employees and Surviving Dependent Adults	
	Change in Status – Dependent Child	
	Carryover	29
	Coordination of Benefits with State Farm Insurance Companies Health Care	
	Flexible Spending Account Plan for U.S. Employees (HCFSA)	
	When You Reach the Out-of-Pocket Expense Limit	
	Additional Charges	
	Emergency Room Visit Charge	
	Preadmission Utilization Management Review Charge	
	PPO providers	
	PPO Provider Benefits	
	Finding PPO Providers	30
	PPO Waiver Process	31

	Transitional Care	
	Utilization Management	32
	Preadmission Notification Requirements	32
	How To Pre-Notify Services and Inpatient Admissions	
LIVE	EWELL, BE WELL ÁND SPECIAL BEĠINNINGS PRENATAL PROGRAM	.32
	Live well, Be Well	32
	Good Neighbor Healthy Living Condition Management Program	33
	Information Sharing	
	Cost	
	Special Beginnings® Prenatal Program	
CLA	IM FILING AND APPEAL PROCEDURES	34
	Medical Records to Substantiate Claims	34
	Filing Claims	34
	How Claims Are Processed	34
	Payment of a Claim	
	Denial of a Claim	
	How to Appeal a Denied Claim	
	BlueCross BlueShield of IL Customer Service and Your Medical Claims	
COC	ORDINATION OF BENEFITS (COB)	
	Order of Benefit Determination rules	40
	Dependent or Non-Dependent	41
	Child Covered Under More Than One Plan	
	Active or Inactive Employee	
	Continuation Coverage	
	In Cases of Longer or Shorter Length of Coverage	
	Affect of COB Provisions on Plan Benefits	
	Right to Receive and Release Needed Information	
	Facility of Payment	
	Right of Recovery	
	Coordination When Medicare is Primary	
	Subrogation and Reimbursement	
PRE	SCRIPTION DRUG COVERAGE	
	Outpatient Prescription Drug Expense Benefit	
	Primary/Preferred Drug List	
	When You Use a CVS Caremark Participating Pharmacy (Retail Option)	
	Maintenance Medications Purchased at a Retail CVS/pharmacy	
	Value Priced Generics Program for Maintenance Medications	
	Maintenance Medications Purchased at a Retail Pharmacy Other Than a	
	CVS/pharmacy	45
	When You Use the CVS Caremark Mail-Order Pharmacy (Mail Order Option)	46
	When You Use a Non-Participating Pharmacy	
	Quantity Limitations	
	Pharmacy Services	
	Secure Care Program	
	CVS Caremark Resources	
	Covered Drugs	
	Diabetic Supplies	
		• •

Non-Covered Drugs	48
Controlled Substances - Quantity Limitations and Authorizations	48
Specialty Guideline Management Program	48
Filing Claims	
When You Use a Participating Pharmacy or the Mail-Order Pharmacy	
When You Use a Non-Participating Pharmacy	
Claim Appeals	
WHEN COVERAGE ENDS	49
When Coverage Ends for an Employee	
When Coverage Ends for a Dependent	
Coverage Termination Due to Fraud	
Termination of the Plan	
Certificate of Creditable Coverage	
CONTINUING COVERAGE	
Extension Of Coverage – Surviving Dependent Adults and Non-Medicare Eli	
Dependents	_
Surviving Dependent Adults	
Non-Medicare Eligible Dependents	
Company Contributions	
Continuation of Medical Coverage under COBRA	
Overview	
COBRA Qualifying Events and Length of Time Coverage Can Continue	
Applying For Continuation of Coverage	
60-Day Deadline To Elect COBRA	
Disability Extension	
Second Qualifying Events	
Adding Dependents After Continuation of Coverage Begins	
The Cost of Continued Coverage	
When Continued Coverage Ends	
WHO TO CONTACT	57
ADMINISTRATIVE INFORMATION	
Your Rights Under ERISA	
Qualified Medical Child Support Order	60
ERISA Administrative Information	
Plan Name	
Plan Administrator	
Plan and Employer Identification Numbers	
Additional Information	
PROTECTED HEALTH INFORMATION	
New York Orders of Protection	
APPENDIX A: COVERED SERVICES	
Services of Physicians and Hospitals	
Physicians and Hospitals	
Investigational or Experimental Procedures or Treatment	
Mental Health Conditions or Substance Use Disorders - Partial Hospitalization	
Program or Residential Treatment Facility	
Skilled Nursing Facility	70

Supplemental Health Care and Equipment	70
Ambulance	
Spinal Misalignment/Subluxation	70
Medical Supplies and Durable Medical Equipment	71
Diagnostic Services	
Home Health Care	
Hospice	72
Private Duty Nursing	72
Rehabilitation Therapy	
Preventive Care	
Well-Child Care	
Preventive Care and/or Services	
Cancer Prevention Screenings	
Other Services	
Allergies	74
Blue Distinction Centers for Transplants	
Christian Science Facility	
Contraceptive Coverage	75
Health Care Education	75
Mastectomy-Related Benefits	75
Maternity Care (Length of Stay Associated with Childbirth)	76
Metabolic Disorders	
Nutritional Counseling	77
Organ/Tissue Donation	77
Reconstructive Surgery	77
Scalp Hair Prostheses	77
Temporomandibular Joint Dysfunction (TMJ)	77
Transplants	
Transplant Lodging Expenses	78
Second Surgical Opinions	78
Dental-Related Benefits	78
APPENDIX B: EXCLUSIONS	
APPENDIX C: TERMS	
EXHIBIT A	
EXHIBIT B	
EXHIBIT C	
ADDENDUM	103

### INTRODUCTION

The State Farm Insurance Companies Group Medical PPO Plan for United States Employees (hereinafter referred to as the "Plan") offers eligible associates and their dependents comprehensive medical coverage. The Plan is a self-funded employee welfare benefit plan organized and operating under the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

Under the Plan, eligible active employees have the flexibility to choose from among two options including one with a Health Reimbursement Arrangement (HRA). Pre-Medicare Eligible Retirees who are eligible for extended benefits have one option, but this option does not include an HRA.

All Options provide the same benefits. However, they differ in the deductible, coinsurance percentage, out-of-pocket expense limits and monthly contribution amounts. Active Employees can save money by choosing an option with a higher out-of-pocket expense limit.

The Plan offers freedom to choose physicians, specialists, hospitals or other medical providers. In addition to the freedom of choice, all the Options include a PPO Provider benefit. If you use PPO Providers, your out-of-pocket expenses may be lower due to the discounted fees for services. However, you always have the option of choosing any provider whose services are covered under the Plan.

With the Plan, you can also take advantage of a prescription drug program that can save you money when you use CVS Caremark participating pharmacies or mail-order pharmacy.

This summary plan description (SPD) highlights provisions of the State Farm Group Medical PPO Plan. It explains when your coverage begins and ends, your medical options, and how the Plan works, including prescription drug coverage. Words that have a specific meaning are capitalized and are defined in Appendix C: Terms. Refer to the *Table of Contents* to see the section that contains the information you need.

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, or, visit them on the web at www.resources.hewitt.com/statefarm.

If you have benefit or coverage questions about the Group Medical PPO Plan, call BlueCross BlueShield of Illinois at 1-888-652-4013 during the hours of 7:00 a.m. – 7:00 p.m., CT.

#### NOTICE REGARDING GRANDFATHERED STATUS

We believe that the State Farm Group Medical PPO Plan for United States Employees is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage in effect when that law was enacted. Being a grandfathered health plan means that the plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of certain preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the State Farm Benefits Center at 1-866-935-4015. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

#### MASSACHUSETTS NOTICE

#### MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

This health plan **meets Minimum Creditable Coverage standards** that are effective January 1, 2012 as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you **will satisfy** the statutory requirement that you have health insurance meeting these standards.

### WHO IS ELIGIBLE

#### **ELIGIBLE EMPLOYEES**

You are eligible for the Group Medical PPO Plan if you are:

- A. 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.
- B. An employee hired prior to January 1, 2007 and employed by the Company in the United States on the day prior to retirement who, on the date of retirement, meets **all** of the following criteria:
  - Is at least 55 years of age,
  - > Has 5 or more years of Company Service,
  - > Is not eligible for Medicare, and
  - Receives immediate income from the State Farm Insurance Companies Retirement Plan for United States Employees upon retiring.
- C. An employee hired or rehired on or after January 1, 2007 and employed by the Company in the United States on the day prior to retirement who, on the date of retirement, meets **all** of the following criteria:
  - Is at least 55 years of age,
  - Has 15 or more years of Company Service,
  - > Is not eligible for Medicare, and
  - Receives immediate income from the State Farm Insurance Companies Retirement Plan for United States Employees upon retiring.
- D. An employee hired prior to January 1, 2007 and employed by the Company in the United States on the day prior to termination who:
  - a. terminates due to Illness Benefits Expired and;
    - (1) Is eligible to receive early retirement income under the State Farm Insurance Companies Retirement Plan for United States Employees, but chooses not to do so,
    - (2) Is not eligible for Medicare, and

- (3) Is certified by the Corporate Medical Director as Totally Disabled, or
- b. terminates due to Illness Benefits Expired and;
  - (1) Has at least 10 years of Company Service, or has five years or more of Company Service and whose age plus number of years of service equals or exceeds 55 on the date of termination,
  - (2) Is not eligible for Medicare, and
  - (3) Is certified by the Corporate Medical Director as Totally Disabled.
- E. An employee hired or rehired on or after January 1, 2007 by the Company in the United States who terminates due to Illness Benefits Expired, has 15 years or more of Company Service as of the date of termination, is not eligible for Medicare and is certified by the Corporate Medical Director as Totally Disabled.
- F. An employee hired prior to January 1, 2007 and employed by the Company in the United States on the day before the "Date of Disablement" who is a "Disabled Member" (as those terms are defined in the State Farm Insurance Companies Retirement Plan for United States Employee) and is not eligible for Medicare.
- G. An employee hired or rehired on or after January 1, 2007 and employed by the Company in the United States on the day before the "Date of Disablement" who is a "Disabled Member" (as those terms are defined in the State Farm Insurance Companies Retirement Plan for United States Employees) and has at least 15 years of Company Service as of the date of termination and is not eligible for Medicare.
- H. A retired Agency Manager employed by the Company in the United States on the day prior to retirement who was at least 55 years of age, had 5 years or more of Company Service, received immediate income from the State Farm Insurance Companies Retirement Plan for United States Employees upon retirement and who is not eligible for Medicare.
- I. An agency manager who meets **all** of the following criteria:
  - > Terminated due to Total Disability,
  - Had at least 5 years of Company Service preceding termination of the Agency Managers' Agreement,
  - Whose age plus the number of years of Company Service equaled or exceeded 55 when the Agency Managers' Agreement terminated, and
  - Who is not eligible for Medicare.
- J. An employee employed by the Company in the United States under the terms of a Staff Assistance Agreement provided the employee works 18 hours or more a week.

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 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 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 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 regular wage or salary by the Company.
- Employees of State Farm independent contractor 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 inactive under the State Farm Insurance Companies Group Medical PPO Plan for United States Agents) if you are covered as a Dependent under your Dependent Adult's plan. Additionally, no individual can be covered under a State Farm-sponsored Group Medical Plan and a State Farm Insurance Companies Health Reimbursement Arrangement Plan for United States Medicare-Eligible Retirees at the same time.

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;
  - 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 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) unmarried;
  - (2) under 26 years of age;
  - (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 child'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:
  - (1) in the care of the Employee pursuant to a court order of temporary custody;
  - (2) under 26 years of age;
  - (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).

- 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 (or the Employee and the Employee's ex-spouse).

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 medical plan at any time.

#### DEPENDENTS OF A SURVIVING DEPENDENT ADULT

Children of a deceased Employee or retired Employee who continue to meet the eligibility requirements of dependent children will remain eligible as long as a Surviving Dependent Adult remains covered and the children remain dependent on the Surviving Spouse or custodial parent for a majority of their support. Certain requirements must be met for a Surviving Dependent Adult to be eligible upon death of the Employee or retired Employee. For eligibility requirements see *Extension of Coverage* section.

A person extending his/her coverage as a Surviving Dependent Adult may add his/her newborn and/or never married, legally adopted child to the Plan provided notice is given to 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 within 31 days of the birth, adoption or placement for adoption and any required enrollment form is returned within 45 days of the date of birth, adoption, or placement for adoption. Any other newly acquired dependents are not eligible.

#### WHEN COVERAGE BEGINS

#### 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 the State Farm Group Medical PPO Plan. 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 day of the Month, a waiting period applies to you and your existing Dependents who are eligible for coverage under the State Farm Group Medical PPO Plan. 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 day of the Month and you enroll within 31 days of the date you were hired, your coverage will begin on the first day 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.

## WHEN COVERAGE BEGINS FOR RETIREES AND EMPLOYEES WHO TERMINATE DUE TO TOTAL DISABILITY OR ILLNESS BENEFITS EXPIRED

You Enroll Within 31 Days of Retiring or Terminating Due to Total Disability or Illness Benefits Expired

If you are an Employee who:

- is enrolled in a State Farm sponsored HMO at the time of retirement or termination due to Total Disability or Illness Benefits Expired, you may be eligible to enroll in the Group Medical PPO Plan at retirement or termination, or
- if you are already enrolled in the Group Medical PPO Plan at the time of retirement or termination due to Total Disability or Illness Benefits Expired, you may be eligible to extend your coverage.

If you are an eligible retired Employee or an Employee who terminates due to Total Disability or Illness Benefits Expired, you will need to complete an enrollment. You will receive enrollment information from the State Farm Benefits Center. You must complete the enrollment within 31 days of your retirement or termination date in order for coverage to begin on that date.

Eligible employees covered under an HMO option prior to retirement/termination can only continue their coverage under COBRA. If you choose to continue your coverage under an HMO after retirement/termination, you will be responsible for 102% of the applicable contribution.

If you are **not** enrolled in a State Farm sponsored group medical plan at the time of retirement or termination due to Total Disability or Illness Benefits Expired, you **are not** eligible to enroll in the Group Medical PPO Plan at the time of your retirement or termination. However, you do retain your Special and Late Enrollee rights as long as you remain eligible for the Group Medical PPO Plan.

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 within 31 days of a Special Enrollment Period and return any required enrollment form within 45 days of the Special Enrollment Period. To enroll as a Late Enrollee, you must notify the State Farm Benefits Center at Aon Hewitt and enroll 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.

### You Fail to Enroll Within 31 Days of Retiring or Terminating Due to Total Disability or Illness Benefits Expired

If you do not enroll or extend your coverage within 31 days after you retire or terminate due to Total Disability or Illness Benefits Expired or fail to return any required enrollment form, the next opportunity you will have to enroll (unless you experience a Special Enrollment Period) will be during any Annual Enrollment Period as a Late 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 within 31 days of a Special Enrollment Period or during any Annual Enrollment Period, as determined by the Plan Administrator, to enroll as a Late Enrollee. As a Late Enrollee, your coverage will begin January 1 following the Annual Enrollment Period year.

### 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 or you cancel State Farm group medical coverage to enroll in another health plan, and

- 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 the State Farm Group Medical PPO Plan as Special Enrollees. As a Special Enrollee, you may elect to enroll in any medical plan offered to 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 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 for special enrollees 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 the State Farm Group Medical PPO Plan as Special Enrollees. As a Special Enrollee, you may elect to enroll in any medical plan offered to similarly situated Employees who enroll when first eligible.

To enroll as Special Enrollees, 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 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 the State Farm Group Medical PPO Plan 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.

#### 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 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.

## WHEN COVERAGE BEGINS FOR DEPENDENTS OF RETIREES AND EMPLOYEES WHO TERMINATE DUE TO TOTAL DISABILITY OR ILLNESS BENEFITS EXPIRED

### You Enroll Your Dependents When You First Retire or Terminate Due to Total Disability or Illness Benefits Expired

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

You may enroll your eligible Dependents in the State Farm Group Medical PPO Plan if they are covered under a State Farm sponsored HMO at the time of your retirement or termination due to Total Disability or Illness Benefits Expired.

If you and your eligible Dependents are already enrolled in the Group Medical PPO Plan at the time of retirement or termination due to Total Disability or Illness Benefits Expired, you may extend their Group Medical PPO coverage.

You must enroll or extend coverage for yourself and your eligible Dependents within 31 days of your retirement or termination date in order for coverage to begin on that date.

### You Fail to Enroll Your Dependents When You First Retire or Terminate Due to Total Disability or Illness Benefits Expired

If you do not enroll your Dependents covered under a State Farm sponsored HMO in the Group Medical PPO Plan or extend their Group Medical coverage within 31 days of your retirement or termination, 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.

#### WHEN COVERAGE BEGINS FOR NEWLY ACQUIRED DEPENDENTS

#### When Coverage Begins for Newly Born and Adopted Children

If one or more Dependents are already covered under the Plan, newly born or legally adopted children of the Employee will be covered free of charge for 31 days from the moment of birth or, the earlier of the date of adoption or the date the Employee assumes and retains a legal obligation for total or partial support in anticipation of adoption. Coverage will not continue beyond 31 days unless the Employee notifies the State Farm Benefits Center at Aon Hewitt (1-866-935-4015) or by accessing enrollment via My State Farm Benefits Resource at www.resources.hewitt.com/statefarm within 31 days of the date of birth or adoption, enrolls for coverage, and allocates Flex Dollars toward the payment of any additional contributions required after the 31<sup>st</sup> day or otherwise agrees in the form and manner designated by the Plan Administrator to contribute to the cost of coverage.

If one or more Dependents are not already covered under the Plan, and if the Employee notifies the State Farm Benefits Center at Aon Hewitt (1-866-935-4015) or by accessing enrollment via My State Farm Benefits Resource at www.resources.hewitt.com/statefarm within 31 days of the date of birth or adoption, enrolls for coverage, and allocates Flex Dollars toward the payment of any additional contributions required from the date of birth or adoption or otherwise agrees in the form and manner designated by the Plan Administrator to contribute to the cost of coverage, newly born children and legally adopted children will be covered from the moment of birth or adoption.

Any required enrollment form must be returned to the State Farm Benefits Center within 45 days of the date 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 coverage 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.

#### Other Newly Acquired Dependents

Any other newly acquired dependent will be covered on the date you acquire them (marriage, birth, adoption, etc.), provided you notify the State Farm Benefits Center at Aon Hewitt (1-866-935-4015) or by accessing enrollment via My State Farm Benefits Resource at

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 coverage 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.

## 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 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 the State Farm Group Medical PPO Plan as Special Enrollees. As a Special Enrollee, you may elect to enroll in any medical plan option offered to 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 (1-866-935-4015) or by accessing enrollment via My State Farm Benefits Resource at 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. Any required enrollment form must be returned within 45 days of 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, reaching the lifetime

limit on all benefits, exhaustion of continuation coverage, 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 PPO Plan at the time a Dependent loses coverage for one of the above reasons, you will also be eligible to enroll in the Group Medical PPO Plan 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 the State Farm Group Medical PPO Plan 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.

Inactive Employees must notify the State Farm Benefits Center during the Annual Enrollment Period. As a Late Enrollee, coverage will begin January 1 following the Annual Enrollment Period.

#### 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 or an eligible Dependent 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 you move and your new location makes you eligible for a different medical plan (for example, a new HMO).

You may change your Group Medical PPO Plan Option or your enrollment in an HMO (if you are eligible for an HMO) during the Annual Enrollment Period for an effective date of January 1 of the following year.

#### **Confirmation Statements**

When you enroll in the Group Medical PPO Plan, 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**

As a Group Medical PPO Plan enrollee, you will receive two ID cards. Each ID card identifies you as having group medical coverage. The ID card also provides important information such as:

- The BlueCross BlueShield Customer Service telephone number.
- The telephone number for precertification of services and inpatient admissions.
- The Plan's Group Number.
- Your unique Identification Number.

#### Associate Records

Enrollment records are maintained with 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.

#### **MEDICAL PLAN BENEFITS**

#### OPTIONS UNDER THE GROUP MEDICAL PPO PLAN

The State Farm Group Medical PPO Plan offers you a choice of medical care benefit options to cover yourself and your eligible dependents. Depending on your choice, your annual deductible, coinsurance percentage, out-of-pocket expense limit and monthly contributions will vary. All Options cover the same services and offer a PPO Provider benefit.

Non-Medicare eligible Inactive Employees and Surviving Dependent Adults have the Pre-Medicare Retiree Option.

If you obtain medical care through the PPO Provider network, your out-of-pocket expenses may be lower. However, the choice to use a participating provider each time you need medical care is yours.

Individuals who have questions about coverage eligibility can contact the State Farm Benefits Center at Aon Hewitt Monday – Friday, 7:00 a.m. to 6:00 p.m., CT by calling 1-866-935-4015. If you have questions about the benefits provided under the Group Medical PPO Plan, contact BlueCross BlueShield of Illinois at 1-888-652-4013.

#### **Enrollment Options**

Detailed information about the enrollment options available under this Plan are described in Exhibits A and B.

#### **Enrollment Option Eligibility**

Active Employees may elect Option 2E or Option 3E. Non-Medicare Inactive Employees and non-Medicare Surviving Dependent Adults and Non-Medicare Eligible Dependents, as described in the section entitled *Extension of Coverage*, are eligible for the Pre-Medicare Retiree Option.

#### LIFETIME MAXIMUM BENEFIT

Effective January 1, 2011, there is no lifetime maximum benefit.

#### Specific Benefit Lifetime Maximums and Calendar Year Maximums

Any benefits that have either a lifetime maximum or a calendar year maximum are aggregate benefits for all Options under this Plan, and they will be reduced by the amount of benefits paid, if any, under Group Policy Number HG00003 and/or Group Policy Number HG00004 regardless of whether the Individual was covered continuously.

#### YOUR PAYMENT RESPONSIBILITIES

#### 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.

For Inactive Employees and others eligible for extended medical benefits who receive a monthly retirement benefit, your contributions will be deducted from your retirement benefit. If you do not receive a retirement benefit, but are eligible for extended medical benefits, payment of your contributions will be handled on a "cash-pay" basis. Contact the State Farm Benefits Center at 1-866-935-4015 if you have questions regarding your contribution payments.

#### COMPANY CONTRIBUTIONS TO THE COST OF COVERAGE

#### Inactive Employees Hired Prior to January 1, 2007 and Their Dependents

The Company **will contribute** to the cost of coverage under the Plan for an Employee who, on or after January 1, 2012, meets the following requirements:

- a. becomes an Inactive Employee as defined in Section 1.2.25 (B), (D), and (F); and
- b. is 50 years of age or older.

The Company **will also contribute** to the cost of coverage under the Plan for such Inactive Employee's Dependents even in the event the Dependents become Non-Medicare Eligible Dependents.

However, for an Employee who becomes an Inactive Employee on or after January 1, 2012 as defined in the section entitled *Eligible Employees* items B., D., and F. who **is not** 50 years of age or older on or after January 1, 2012, the Company **will only contribute** to the cost of coverage under the Plan for the Inactive Employee and **not** the Inactive Employee's Dependents even in the event the Dependents become Non-Medicare Eligible Dependents.

The Inactive Employee's Dependents will only have **access** to coverage under the Plan and the Inactive Employee will be responsible for **100%** of the cost of any Dependent's coverage for the duration that they are covered under the Plan.

#### Inactive Employees Hired On or After January 1, 2007 and Their Dependents

The Company will **not** contribute to the cost of coverage under the Plan for an Employee as defined in in the section entitled *Eligible Employees* items C., E. and G. who becomes an Inactive Employee on or after January 1, 2012, or to the cost of coverage under the Plan for the Inactive Employee's Dependents even in the event the Dependents become Non-Medicare Eligible Dependents.

The Inactive Employee and any Dependents, even in the event the Dependents become Non-Medicare Eligible Dependents, will only have **access** to coverage under the Plan and the Inactive Employee will be responsible for **100**% of the cost of coverage for the duration that the Inactive Employee and any Dependents are covered under the Plan.

### Employees Who Are Inactive Employees as of December 31, 2011 and Their Dependents

The Company **will contribute** to the cost of coverage under the Plan for an Inactive Employee who is covered under the Plan as of December 31, 2011 and to the cost of coverage for the Inactive Employee's Dependents even in the event the Dependents become Non-Medicare Eligible Dependents. The Company **will** also contribute to the cost of coverage under the Plan for an Employee who has met the Inactive Employee eligibility requirements prior to December 31, 2011 (and to the cost of coverage for the Inactive Employee's Dependents) who later becomes enrolled as a Special or Late Enrollee.

#### Surviving Dependent Adults and Their Eligible Children

Coverage and Company contributions for Surviving Dependent Adults, as described in the section entitled Extension of Coverage – Surviving Dependent Adults, and their eligible children are provided in Exhibit C.

#### Wellness Incentive - Active Employees

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

Active Employees that do not complete the Wellness Assessment during the published completion period will not be eligible for the wellness incentive. Additionally, Active Employees hired after the published completion period will not be eligible for the wellness incentive. Active 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 contribution.

Active Employees who become Active 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 Active Employee or an Active Agent.

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

#### Deductible

The Deductible is a fixed amount of Eligible Charges incurred during a Benefit Period before benefits are paid. Deductibles apply to all Eligible Charges unless otherwise provided. Deductibles under each Option are described in Exhibits A and B.

If you incur Eligible Charges for a Hospital (or similar facility) inpatient confinement that begins during one calendar year and continues into the following year, those charges are not subject to the following year's Deductible. However, once you are discharged you will be required to meet the applicable Deductible for the year in which you are discharged.

#### **Deductible Types**

Two types of Deductibles are used:

(1) **Traditional Deductible** - When 2 or more members of a family have incurred Eligible Charges during a calendar year equal to or greater than their Individual Deductibles, no further Individual Deductible is required in connection with any member of that family.

The Family Deductible is satisfied when 2 or more members of a family have incurred Eligible Charges during a calendar year equal to or greater than their Individual Deductibles.

The Traditional Deductible is used for all options **except** Option 3E (HRA Option).

(2) **Aggregate Deductible** – All Eligible Charges incurred by members of the family are applied against the Deductible until it is satisfied. Since family members do not have Individual Deductibles, one family member may satisfy the entire Deductible applicable to Employee plus one or more Dependents.

#### The Aggregate Deductible is used for Option 3E (HRA Option).

Deductibles do not apply to eligible preventive diagnostic tests and procedures as outlined in *Appendix A: Covered Services, Preventive Care*. The type of Deductible, Traditional or Aggregate, also applies to the Out-of-Pocket Expense Limit in the same manner. Deductibles under each Option are described in Exhibits A and B.

#### Coinsurance Percentage (After Meeting the Deductible)

Coinsurance Percentage is the percentage of Eligible Charges that must be paid by the Employee for care and/or treatment after the applicable Deductible has been met. Coinsurance Percentages under each Option are described in Exhibits A and B.

#### Out-Of-Pocket Expense Limit

Out-of-Pocket Expense Limit includes the Deductible and the Coinsurance Percentage. In determining whether the Out-of-Pocket Expense Limit has been reached, only Eligible Charges will be considered. Eligible Charges billed by PPO Providers will be applied in satisfaction of the Non-PPO Provider Out-of-Pocket Expense Limit up to the PPO Provider Out-of-Pocket Expense Limit. Eligible Charges billed by Non-PPO Providers will be applied in satisfaction of the PPO Provider Out-of-Pocket Expense Limit. The following out-of-pocket expenses do not apply to the Out-of-Pocket Expense Limit:

- (A) the Emergency Room Visit Charge,
- (B) the Preadmission Utilization Management Review Charge,
- (C) the Coinsurance Percentage for Preventive Care services provided by Non-PPO Providers, and
- (D) the applicable Coinsurance Percentage or minimum and maximum amounts under the *Outpatient Prescription Drug Expense Benefit*.

Out-of-Pocket Expense Limits under each Option are described in Exhibits A and B.

#### **HRA OPTION**

#### General

The establishment of an HRA account is limited to Active Employees who enroll in Option 3E.

#### Establishment of HRA Account

The Company, in conjunction with the Claim Administrator, will establish and/or maintain an HRA account for each Active Employee enrolled in Option 3E and for each Inactive Employee or Surviving Dependent Adult (as described in the section entitled *Extension of Coverage - Surviving Dependent Adult*) with a residual HRA account enrolled in the Pre-Medicare Retiree Option. The Company will not create a separate fund or segregate assets for this purpose. The HRA account will be a recordkeeping account for tracking contributions and reimbursement amounts.

- (A) Crediting of Accounts An Active Employee's HRA account will be credited in accordance with the section below entitled *Company Contributions*.
- (B) Debiting of Accounts An Active Employee's HRA account will be debited during each Plan Year for any reimbursement of Covered Expense incurred during the Plan Year. Expenses incurred in prior years can only be paid from HRA funds that were available in the Plan Year in which the services were incurred.
- (C) Available Amount The amount available for reimbursement of Covered Expenses is the amount credited to the Active Employee's HRA account under subsection (A) above reduced by any reimbursements debited under subsection (B).

#### **Company Contributions**

Subject to the section below entitled *Change in Status*, the Company shall make the following maximum annual contributions to the Active Employee's HRA account:

- (A) Active Employee Only Coverage (no covered dependents) \$1,000
- (B) Active Employee Coverage Plus One or More Dependents \$2,000

An Active Employee with an Option 3E effective date between January 1 and March 31 inclusive will receive 100% of the applicable annual maximum Company Contribution (\$1,000 for (A) and \$2,000 for (B)).

An Active Employee with an Option 3E effective date between April 1 and June 30 inclusive will receive 75% of the applicable annual maximum Company Contribution (\$750 for (A) and \$1,500 for (B)).

An Active Employee with an Option 3E effective date between July 1 and September 30 inclusive will receive 50% of the applicable annual maximum Company Contribution (\$500 for (A) and \$1,000 for (B)).

An Active Employee with an Option 3E effective date between October 1 and December 31 inclusive will receive 25% of the applicable annual maximum Company Contribution (\$250 for (A) and \$500 for (B)).

Active Employees who change from Employee only coverage to Employee coverage plus one or more Dependents will receive a prorata portion of the difference between the Company Contribution for Employee only coverage and the Company Contribution for Employee coverage plus one or more Dependents. This prorata portion will be based on the schedule described above.

In no event will the Company Contributions exceed the annual maximum of \$2,000 for any Active Employee regardless of the number of Dependents added during a Plan Year.

For Active Employees who change from Employee coverage plus one or more Dependents to Employee only coverage, there will be no change in their Company Contributions for the Plan Year in which the change occurs.

#### Using HRA Account Balances

HRA account balances will be used to reimburse Covered Expenses incurred after the effective date of coverage under the HRA option (Option 3E) or for reimbursement of any residual HRA under the Pre-Medicare Retiree Option. No other expenses (including expenses incurred in connection with the *Outpatient Prescription Drug Expense Benefit*) are eligible for reimbursement.

HRA account balances will be applied automatically to the Covered Expenses identified as the Covered Individual's responsibility on the Explanation of Benefits form furnished by the Claim Administrator.

#### Change in Status – Active Employees

In the event an Active Employee changes from Option 3E to an HMO, or from Option 3E to Option 2E, or waives coverage altogether, the remaining HRA account balance (if any) will be used to reimburse Covered Expenses incurred prior to the effective date of the change. If no such Covered Expenses are incurred, the remaining HRA account balance (if any) will be forfeited.

In the event of a divorce, dissolution or termination of a marriage/partnership between an Active Employee who is enrolled in Option 3E and a covered Dependent Adult who is also eligible as an Active Employee, the HRA account balance as of the end of the Month in which

the divorce, dissolution or termination is final will be divided equally between the Active Employees provided:

- (A) the Dependent Adult elects Option 3E, and
- (B) the divorce decree, dissolution or termination does not provide otherwise.

In the event of a divorce, dissolution or termination of a marriage/partnership between an Active Employee who is enrolled in Option 3E and a covered Dependent Adult who is also eligible as an Inactive Employee, the HRA account balance as of the end of the Month in which the divorce, dissolution or termination is final will be divided equally between the Active Employee and the Inactive Employee provided:

- (A) the Dependent Adult elects the Pre-Medicare Retiree Option, and
- (B) the divorce decree, dissolution or termination does not provide otherwise.

In the event of a divorce between an Active Employee who is enrolled in Option 3E and a nonemployee Dependent Adult, a non-employee Dependent Adult who elects COBRA continuation coverage under Option 3E will have an HRA account with a balance equal to the balance in the Active Employee's HRA account as of the end of the Month in which the divorce, dissolution or termination is final.

For a Dependent Adult who continues Option 3E under COBRA continuation coverage, the Company will make a Company Contribution as determined by Section entitled *Company Contributions* coinciding with the next January 1. Company Contributions will continue for the balance of the COBRA continuation coverage period under the same terms and conditions as similarly situated Active Employees provided the Dependent Adult continues enrollment in Option 3E.

In the event an Active Employee is enrolled in Option 3E and covers his or her Dependent Adult as a Dependent, and if the Dependent Adult who is also eligible as an Active Employee, elects to enroll separately in Option 3E during the Annual Enrollment Period, the HRA account balance as of December 31st following the Annual Enrollment Period will be divided equally between the Active Employees as of the following January 1st.

In the event an Active Employee becomes an Inactive Employee, the HRA account balance will be carried over provided:

- (A) the Inactive Employee elects the Pre-Medicare Retiree Option, and
- (B) the account balance does not exceed the limits set forth in the section below entitled *Carryover*.

No additional Company Contributions will be made to an HRA account for an individual who is not an Active Employee.

In the event an Active Employee terminates employment and does not elect COBRA continuation coverage or terminates coverage under Option 3E, the remaining HRA account balance (if any) will be used to reimburse the Employee for Covered Expenses incurred prior to the effective date of termination. If no such Covered Expenses are incurred, the remaining

HRA account balance (if any) will be forfeited. Termination of employment does not include retirement.

In the event an Active Employee enrolled in Option 3E terminates coverage and enrolls as a Dependent in the same Plan Year of another Active Employee that is also enrolled in Option 3E, the Company will make no contribution to the HRA of the second Active Employee for the balance of the Plan Year. However, any remaining HRA account balance of the first Active Employee, up to the maximums listed in the section below entitled *Carryover*, will transfer to the HRA of the second Active Employee provided there is no gap in coverage.

In the event an Active Employee covered under Option 3E terminates employment and elects COBRA continuation coverage, Company Contributions will continue for the balance of the COBRA continuation coverage period under the same terms and conditions as similarly situated Active Employees, provided the individual in question continues enrollment in Option 3E.

#### Change in Status – Inactive Employees and Surviving Dependent Adults

In the event an Inactive Employee or Surviving Dependent Adult waives coverage, the remaining HRA account balance (if any) will be used to reimburse Covered Expenses incurred prior to the effective date of the change. If no such Covered Expenses are incurred, the remaining HRA account balance (if any) will be forfeited.

In the event of a divorce, dissolution or termination of a marriage/partnership between an Inactive Employee who is enrolled in the Pre-Medicare Retiree Option and a covered Spouse who is also eligible as an Active Employee, the HRA account balance as of the end of the Month in which the divorce, dissolution or termination is final will be divided equally between the Employees provided:

- (A) the Dependent Adult elects Option 3E, and
- (B) the divorce decree, dissolution or termination does not provide otherwise.

In the event of a divorce between an Inactive Employee who is enrolled in the Pre-Medicare Retiree Option and a covered Dependent Adult who is also eligible as an Inactive Employee, the HRA account balance as of the end of the Month in which the divorce, dissolution or termination is final will be divided equally between the Inactive Employees provided:

- (A) the Dependent Adult elects the Pre-Medicare Retiree Option, and
- (B) the divorce decree, dissolution or termination does not provide otherwise.

In the event of a divorce, dissolution or termination of a marriage/partnership between an Inactive Employee who is enrolled in the Pre-Medicare Retiree Option and a non-Employee Dependent Adult, a non-Employee Dependent Adult who elects COBRA continuation coverage under the Pre-Medicare Retiree Option will have an HRA account established with a balance equal to the balance in the Inactive Employee's HRA account as of the end of the Month in which the divorce, dissolution or termination is final.

In the event coverage terminate for an Inactive Employee, Surviving Dependent Adult or Non-Medicare Eligible Dependent under the Pre-Medicare Retiree Option, any balance remaining

in the HRA account will be used to reimburse the Covered Expenses incurred prior to the effective date of termination. If no such Covered Expenses are incurred, any remaining HRA account balance will be forfeited.

In the event an Inactive Employee, Surviving Dependent Adult or Non-Medicare Eligible Dependent enrolled in the Pre-Medicare Retiree Option terminates coverage and enrolls as a Dependent in the same Plan Year of an Active Employee that is enrolled in Option 3E, the Company will make a contribution to the HRA of the Active Employee as described in the section entitled *Company Contributions* only if the Active Employee has not already received the maximum Company Contribution of \$2,000 for the Plan Year. In addition, any remaining HRA account balance of the Inactive Employee, Surviving Dependent Adult, or Non-Medicare Eligible Dependent up to the maximums listed in the section below entitled *Carryover*, will transfer to the HRA of the Active Employee provided there is no gap in coverage.

In no event will the Company make a Company Contribution to an Inactive Employee's, Surviving Dependent Adult's or Non-Medicare Eligible Dependent's residual HRA account.

#### Change in Status - Dependent Child

In the event a Dependent child covered under Option 3E or the Pre-Medicare Retiree Option losses eligibility during the Plan Year and elects COBRA continuation coverage under Option 3E or the Pre-Medicare Retiree Option, an HRA account will be established for the child with a balance equal to the balance in the Employee's HRA account as of the end of the Month in which the child losses eligibility.

However, for a child who continues Option 3E under COBRA continuation coverage, the Company will make a Company Contribution as determined by the section entitled *Company Contributions* coinciding with the next January 1. Company Contributions will continue for the balance of the COBRA continuation coverage period under the same terms and conditions as similarly situated Active Employees provided the child continues enrollment in Option 3E.

In no event will the Company make a Company Contribution to a child who has continued coverage under the Pre-Medicare Retiree Option.

#### Carryover

The following HRA account balances may be carried over from year to year:

- (A) Employee Only Coverage \$10,000
- (B) Employee Coverage Plus One or More Dependents \$20,000

If an Active Employee changes from Employee coverage plus one or more Dependents to Employee only coverage, the HRA account balance in excess of \$10,000 will not be lost. However, for Active Employees, no additional Company Contributions will be made until the first day of year next following the year in which the HRA account balance drops below \$10,000.

### Coordination of Benefits with State Farm Insurance Companies Health Care Flexible Spending Account Plan for U.S. Employees (HCFSA)

Covered Expenses as determined by the Claim Administrator are automatically reimbursed under this Plan first and are not coordinated with benefits eligible under the HCFSA Plan.

#### When You Reach the Out-of-Pocket Expense Limit

Once you reach the applicable Out-of-Pocket Expense Limit, you may not be required to pay any additional Coinsurance Percentage for the remainder of the calendar year. For example, if you are a Covered Individual under Option 2E and you reach your PPO Provider Out-of-Pocket Expense Limit of \$3,000, your subsequent eligible PPO Provider medical expenses may be reimbursed at 100%.

#### Additional Charges

#### **Emergency Room Visit Charge**

For each Visit to an Emergency Room, you will be responsible for the first \$100 in Eligible Charges. This \$100 charge will not be applied toward the satisfaction of the calendar year Deductible or Out-of-Pocket Expense Limit.

#### **Preadmission Utilization Management Review Charge**

If the professional review organization is not notified in accordance with the requirements provided in the section entitled *Utilization Management – Preadmission Notification Requirements*, you will be responsible for the first \$100 of Eligible Charges. This \$100 charge will not be applied toward the satisfaction of the Deductible or Out-of-Pocket Expense Limit. There is no preadmission utilization management review charge for Private Duty Nursing, Home Health Care, or Skilled Nursing Facility admissions.

#### **PPO PROVIDERS**

PPO Provider means a Hospital (or other health care facility) or Physician (or other provider of professional services, medicines or supplies), that has a written agreement with the Claim Administrator at the time the Eligible Charges are incurred. The State Farm Group Medical PPO Plan utilizes the Blue Cross and Blue Shield PPO networks linked through the BlueCard® PPO Program.

#### PPO Provider Benefits

When you use PPO Providers, Plan benefits for Eligible Charges will be paid at the highest benefit level.

Eligible Charges for radiology, pathology, and anesthesiology incurred from Non-PPO providers will be paid at the PPO Provider Coinsurance Percentage of 90% subject to the Deductible and Usual and Customary (U&C) Charges if the care is provided as a result of a PPO Provider hospitalization, PPO Provider outpatient surgery or PPO Provider Physician office Visit.

#### Finding PPO Providers

For the names and addresses of Blue Cross and Blue Shield (BCBS) network providers, call BCBS of Illinois at 1-888-652-4013, or go online to access the BCBS directory at www.bcbsil.com/statefarm.

#### PPO Waiver Process

A PPO Waiver allows Eligible Charges that are provided by a Non-PPO Provider to be reimbursed at the PPO Provider Coinsurance Percentage.

There are two situations where a PPO Waiver may be granted:

- 1. A Geographic Waiver may be granted when no PPO Provider within the necessary field of medicine is within a 20 mile radius of the Covered Individual's home zip code. The 20 mile radius is determined by a straight line measurement from the center of the Covered Individual's home zip code to the PPO Provider. The 20 mile threshold applies to urban, suburban, and rural areas. Actual driving miles may be more or less than 20 miles.
- 2. A Clinical Waiver may be granted when a Covered Individual wants to use a specific Non-PPO Provider in lieu of available PPO Providers based on the Covered Individual's reasonable belief that the available PPO Providers are not able to treat the particular Illness in question.

A PPO Waiver request can be initiated by contacting BlueCross BlueShield of Illinois at 1-888-652-4013.

#### General Information:

- Typically, approvals for a PPO Waiver are valid for 6 months.
- PPO Waivers are specific to a certain provider and are not generalized to include all services, from all providers.
- Usual and Customary Charge limits will apply.

#### Transitional Care

Eligible Charges for Late Enrollees receiving care or treatment from Non-PPO Providers for the conditions described below prior to January 1, 2012 will be paid at the PPO Provider Coinsurance Percentage of 90% through March 31, 2012, or, in the case of Pregnancy, through delivery, post-partum care, and initial Hospital care for the newborn. The conditions are:

- Pregnancy (if confirmed prior to January 1, 2012),
- Cardiac Rehabilitation,
- Physical Therapy, Occupational Therapy, or Speech Therapy,
- radiation treatment or chemotherapy,
- post-surgical care for surgery performed prior to January 1, 2012,
- terminal Illness if the Covered individual's life expectancy is 6 months or less, or
- hospitalization if the confinement began prior to January 1, 2012 and continued on or after January 1, 2012.

To qualify for this benefit, you must call BCBS IL at 1-888-652-4013 before the covered individual receives care or treatment after December 31, 2011 for the conditions described above. Charges in excess of the Usual and Customary Charge will not be reimbursed.

#### UTILIZATION MANAGEMENT

Hospital, Residential Treatment Facility, or similar facility admissions and length of stays are subject to review by a professional review organization designated by the Plan Administrator.

#### Preadmission Notification Requirements

You, a family member, friend or the provider must notify the review organization;

- Within one business day for each non-emergency admission, admission to a Skilled Nursing Facility, Private Duty Nursing or Home Health Care services.
- Within two business days of an admission for an Emergency, maternity care, mental health or chemical dependency.

If the notification is not made as described above for non-emergency admissions, admissions for an Emergency, maternity care, mental health or chemical dependency, you will be responsible for the first \$100 of Eligible Charges.

 Notification is not required when you or your Dependent is covered by more than one health plan and the Group Medical PPO Plan is not the primary coverage.

Note: Notification to the review organization pursuant to the requirements stated above does not guarantee payment of any charges in connection with such admission. Such charges are subject to all other Plan provisions, Exclusions, Exceptions and Limitations.

#### How To Pre-Notify Services and Inpatient Admissions

To pre-notify services and inpatient admissions as described above, call BlueCross BlueShield of Illinois at 1-888-652-4013, Monday – Friday, 7:00 a.m. – 7:00 p.m., CT. This number is also on the back of your medical ID card.

## LIVE WELL, BE WELL AND SPECIAL BEGINNINGS PRENATAL PROGRAM

#### LIVE WELL, BE WELL

All Covered Individuals have access to Live Well, Be Well health information, tools, and programs administered by Alere® (formerly Matria Healthcare) that includes:

- Wellness Assessment
- Wellness Programs
- Healthy Living Programs
- Wellness Tools
- Personal Health Record
- Good Neighbor Healthy Living Condition Management Program

#### Good Neighbor Healthy Living Condition Management Program

The Good Neighbor Healthy Living Condition Management Program is a system of coordinated healthcare interventions and communications for people with asthma, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), coronary artery disease (CAD), diabetes and musculoskeletal & pain management. This program provides individuals with a better understanding of these conditions to help improve self-management skills.

For more information on the Live Well, Be Well programs, Covered Individuals can access the Live Well, Be Well website from home or work at www.SFLiveWell.com.

#### Information Sharing

BCBS IL and the Plan's Pharmacy Benefit Manager (CVS Caremark) will share claim data with Alere to identify Covered Individuals eligible for the Good Neighbor Healthy Living Condition Management Program. No identifying information will be shared with the Company or the Plan Administrator.

#### Cost

The contributions made by the Company and by the Employee to the Plan include the costs of the Good Neighbor Healthy Living Condition Management Program.

#### SPECIAL BEGINNINGS® PRENATAL PROGRAM

Special Beginnings is designed to provide expectant mothers with educational information and support throughout pregnancy.

Special Beginnings gives you:

- educational materials specific to your needs.
- access to a 24 hour, toll-free BabyLine<sup>®</sup> staffed by maternity nurses,
- an e-mail newsletter, and
- access to an online health information library.

You can enroll in Special Beginnings online, over the phone or through written materials sent to you through the mail. To participate in Special Beginnings, you must first notify BlueCross BlueShield of Illinois of your pregnancy by calling 1-888-652-4013. Once you notify BCBS, you will receive a welcome packet in the mail with instructions on how to enroll. You will be asked to complete an initial confidential health assessment and another one halfway through your pregnancy. Remember, there is no additional cost to taking advantage of this informative program.

### **CLAIM FILING AND APPEAL PROCEDURES**

#### Medical Records to Substantiate Claims

You must keep separate records of your expenses with respect to yourself and each of your dependents. Original copies of all itemized statements are necessary to support a claim when State Farm is the primary carrier. Itemized statements should always include **all** of the following information:

- Name of person or organization making the charge, e.g., doctor, hospital, nurse, drugstore, etc.
- Date of treatment or purchase
- Type of treatment performed or materials furnished
- Amount charged
- Name of patient
- Name and prescription number of drugs or medicine

A doctor's statement must be provided on request. Cash register receipts, canceled checks, money order stubs, etc., are not acceptable as bills for medical expenses when you submit claims.

#### Filing Claims

You or your medical provider can submit itemized bills to the following address:

Blue Cross and Blue Shield of Illinois P.O. Box 805107 Chicago, IL 60680-4112

All claims under this Plan must be submitted to the Claim Administrator on or before December 31st of the calendar year following the year in which the Eligible Charges were provided (For claim filing purposes, eligible charges incurred in the last Month of a calendar year shall be considered to have been incurred in the succeeding calendar year). Claims not filed within the required time period will not be eligible for payment unless it is shown that the claim was submitted as soon as was reasonably possible.

Claims cannot be filed for charges incurred prior to January 1, 2005 after June 30, 2006.

#### How Claims Are Processed

Blue Cross and Blue Shield of Illinois (BCBS IL) will determine if your claim meets the provisions of the Group Medical PPO Plan. This determination is usually made within 30 days from the date the claim is filed.

Special circumstances may require an extension of time for processing the claim. In these cases, written notice of the extension will be furnished to you prior to the termination of the initial 30-day period.

The extension notice will indicate 1) the special circumstances requiring an extension of time, and 2) the date which BCBS IL expects to render the final decision. This extension will not exceed 15 days from the end of the initial period.

If the extension is necessary due to your failure to submit information necessary to decide the claim, the extension notice will specifically describe the required information and you will be given 45 days from your receipt of the extension notice to provide the required information. BCBS IL may also attempt to obtain the required information from others on your behalf, but will not be required to do so. If the required information is not provided to BCBS IL within the 45 day period, your claim will be deemed denied. The 15 day period within which BCBS IL must decide your claim will be suspended pending receipt of the required information.

There is no requirement that any claim be approved prior to obtaining medical care as a condition of receiving payment of the claim.

The patient must submit to an examination if requested by BCBS IL when and as often as it may reasonably require during pendency of a claim. Any such examination will be at the expense of BCBS IL. BCBS IL will also have the right to request an autopsy where not prohibited by law.

#### Payment of a Claim

If payment is authorized, BCBS IL will release whatever benefits are payable. Claims are processed in the order received.

All payments by the Claim Administrator for the benefit of any employee may be made directly to any provider furnishing services for which payment is due, and the Claim Administrator is authorized by such employee to make payments directly to providers. However, the Claim Administrator reserves the right in its sole discretion to pay any benefits that are payable under the terms of the Plan directly to the employee or to the provider. All benefits payable to the employee that remain unpaid at the time of the death of the employee will be paid to the estate of the employee.

Once covered services are rendered by a provider, the employee has no right to request the Claim Administrator not to pay the claim submitted by such provider and no such request by an employee or his/her agent will be given effect. Furthermore, the Claim Administrator will have no liability to the employee or any other person because of its rejection of such request.

Neither the Plan nor an Employee's claim for payment of benefits under the Plan are assignable in whole or in part to any person or entity at any time. Coverage under the Plan is expressly non-assignable and non-transferable and will be forfeited if an employee attempts to assign or transfer coverage or aids or attempts to aid any other person in fraudulently obtaining coverage under the Plan. However, if the Claim Administrator makes payment because of a person's wrongful use of the identification card of an Employee, such payment will be considered a proper payment and the Claim Administrator will have no obligation to pursue recovery of such payment.

All claims payable under the terms of the Plan will be paid within 30 days following receipt by the Claim Administrator of due proof of loss. Failure to pay within such period will entitle the employee to interest at the rate of 9 percent per annum from the 30<sup>th</sup> day after receipt of such

proof of loss to the date of payment, provided that interest amounting to less than one dollar need not be paid.

#### Denial of a Claim

If a claim under the Outpatient Prescription Drug Expense Benefit is denied by the Prescription Benefit Manager (the "PBM") on grounds that the drug is not covered, or if a medical claim is denied by BCBS IL, the PBM or BCBS IL will give you written notice of the denial. The written notice provides the following information:

- The specific reason or reasons for the denial.
- Specific reference to pertinent Plan provisions on which the denial is based.
- A description of any additional material or information necessary to perfect the claim, and an explanation of why such material or information is necessary.
- A description of the Plan's review procedures, the time limits applicable to such procedures and a description of your right to file a lawsuit following conclusion of the appeal process.
- A description of any internal rule, guideline, protocol or similar criterion used in deciding to deny the claim, or a statement that such a criterion was used in deciding the claim and will be provided free of charge upon request.
- If the denial is based on restrictions involving medical necessity or experimental treatments, an explanation of the scientific or clinical judgment behind the denial or a statement that such explanation is available free of charge upon request.

Any reduction or termination of an on-going course of treatment prior to the end of the time period or number of treatments previously approved by the PBM or BCBS IL will be treated as a denied claim. The PBM or BCBS IL will give you the written notice described above in advance of the reduction or termination to allow you to initiate the Plan's review procedure and obtain a determination on review prior to reduction or termination of the benefit.

If you request extension of an on-going course of treatment beyond a previously-approved period of time or number of treatments, and delay in responding to your request could seriously jeopardize your life, health or ability to regain maximum function, or subject you to severe pain, the PBM or BCBS IL will notify you of its decision, whether adverse or not, within 24 hours after receipt of your request, provided you made your request at least 24 hours prior to the expiration of the previously approved period of time or number of treatments.

#### How to Appeal a Denied Claim

The Group Medical PPO Plan provides two levels of appeal. First level appeals are handled by the Blue Cross and Blue Shield of Illinois Appeal Committee or for claims under the Outpatient Prescription Drug Expense Benefit by the PBM. Second level appeals are handled by the State Farm Group Medical Appeal Committee. You may not submit your claim to the State Farm Group Medical Appeal Committee until after you have exhausted your first level of appeal.

If your claim is denied, and you wish to appeal that denial, you or your authorized representative may submit your appeal in writing to:

Blue Cross and Blue Shield of Illinois Claim Review Section

P.O. Box 2401 Chicago, Illinois 60690-1364

If a claim is denied under the Outpatient Prescription Drug Expense Benefit and the Covered Individual wishes to appeal that denial, the Covered Individual or his or her authorized representative may submit an appeal in writing within 180 days of the receipt of notice that the claim was denied to:

CVS Caremark, Inc. Appeals Department MC 109 P.O. Box 52084 Phoenix, AZ 85072-2084 FAX: 1-866-443-1172

ATTN: Appeals Department

Your written request must be submitted within 180 days of the receipt of notice of the denial of your claim. If your written request is not submitted within 180 days, you will be deemed to have waived your right to review by the applicable first level appeal committee and the State Farm Group Medical Appeal Committee.

Your appeal should include any written comments, documents, records, and any other information you wish to submit to support your position. You will also be provided, upon request and free of charge, copies of all documents, records and other information relevant to your claim.

In considering your appeal, the first level Appeal Committee will:

- Consider all comments, documents, records and other information submitted by you
  without regard to whether such information was submitted or considered when your
  claim was first denied.
- Decide your claim review without deference to the initial claim denial.
- Consult with an appropriate health care professional (who was not consulted, and is
  not subordinate to anyone consulted, in connection with the initial claim denial) in
  reviewing any denial based solely or partially on a medical judgment, including a
  judgment that an item was experimental, investigational or not medically necessary or
  appropriate.

The first level Appeal Committee will give you written notice of its decision within 30 days (72 hours if the claim involves urgent care) after receipt of your appeal. If your claim is denied on appeal, the Blue Cross and Blue Shield of Illinois Appeal Committee will provide you the following information in readily understandable language:

- The specific reason or reasons for the denial.
- Specific reference to pertinent plan provisions on which the denial is based.
- A statement that you are entitled to receive, upon request and free of charge, copies of all documents, records and other information relevant to your claim.

- A description of any internal rule, guideline, protocol or similar criterion used in deciding your claim or a statement that such a criterion was used in deciding your claim and that such criterion will be provided free of charge upon request.
- If the denial was based on restrictions involving medical necessity or experimental treatments, an explanation of the scientific or clinical judgment behind the denial or a statement that such explanation is available free of charge upon request.
- A description of your right to a second-level appeal by the State Farm Group Medical Appeal Committee and how to file your appeal.

If your claim is denied on appeal by the first level Appeal Committee, you have the right to request an appeal by the State Farm Group Medical Appeal Committee. You must submit your written request within 60 days after you receive notice that your claim has been denied on appeal by the first level Appeal Committee to:

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

The State Farm Group Medical Appeal Committee will:

- Consider all comments, documents, records and other information submitted by you
  without regard to whether such information was submitted or considered when your
  claim was first denied or denied on review.
- Decide your claim review without deference to the initial claim denial or the decision of the first level Appeal Committee.
- Consult with an appropriate health care professional (who was not consulted and is not subordinate to anyone consulted in connection with the initial claim denial or the denial of the claim on review) in reviewing any denial based solely or partially on a medical judgment, including a judgment that an item was experimental, investigational or was not medically necessary or appropriate.

The State Farm Group Medical Appeal Committee will give you written notice of its decision within 30 days (within 72 hours if the claim involves urgent care) after receipt of your appeal. If your claim is denied by the State Farm Group Medical Appeal Committee, the following information will be provided in readily understandable language:

- The specific reason or reasons for the denial.
- Specific reference to pertinent plan provisions on which the denial is based.
- A statement that you are entitled to receive, upon request and free of charge, copies of all documents, records and other information relevant to your claim.

- A description of your right to file a lawsuit challenging the Group Medical Appeal Committee's decision.
- A description of any internal rule, guideline, protocol or similar criterion used in deciding your claim or a statement that such a criterion was used in deciding your claim and that such criterion will be provided free of charge upon request.
- If the denial was based on restrictions involving medical necessity or experimental treatments, an explanation of the scientific or clinical judgment behind the denial or a statement that such explanation is available free of charge upon request.
- The following statement: "You and your plan may have other voluntary alternative dispute resolutions, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

If the State Farm Group Medical Appeal Committee fails to notify you of its decision within 30 days (within 72 hours if the claim involves urgent care), your claim will be deemed to have been denied on review.

### Legal Actions

You may not sue to recover on any claim unless you have first submitted your claim as provided above under "Filing Claims", your claim has been denied, and you have exhausted your appeal rights described above under "How to appeal a Denied Claim". You may not sue to recover on any claim after the expiration of thirty-six months from the last date the claim could have been submitted under this Plan.

### BlueCross BlueShield of IL Customer Service and Your Medical Claims

Covered individuals can call BlueCross BlueShield of Illinois at1-888-652-4013, Monday – Friday, during the hours of 7:00 a.m. – 7:00 p.m. CT to ask questions about:

- Benefits
- Claim status
- Usual and Customary Charges for Non-PPO Providers
- Eligibility of treatments, medical providers or facilities

### **COORDINATION OF BENEFITS (COB)**

When a person is covered under more than one health plan, the primary plan pays first without regard to the possibility that another plan may cover some expenses. However, if a person enrolled in the State Farm Group Medical PPO Plan is covered for medical care or treatment benefits under any other medical plan or plans, the benefits of the Group Medical PPO Plan may be reduced if the Group Medical PPO Plan is not primary so that during the calendar year up to, but not more than, 100% of the person's medical or dental expenses (at least a portion of which is covered under one or more of such plans) will be paid by all such plans.

The Group Medical PPO Plan is always secondary for the payment of medical expenses when a person enrolled in the Group Medical PPO Plan is covered under a no-fault insurance policy, regardless of the no-fault insurance coverage options chosen by the person. This includes all individual and group policies of no-fault insurance.

### (1) A plan includes:

- Group insurance, closed panel or other forms of group or group-type coverage, whether on an insured or uninsured basis.
- Medicare or any other governmental program.
- Hospital indemnity benefits in excess of \$200 per day and medical components of group long-term care contracts, such as skilled nursing care.
- Medical benefits under group or individual automobile contracts.
- Any group or individual policies of no-fault insurance.

Each contract for coverage under the plans above is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

#### (2) Plan does not include:

- Individual or family insurance.
- Closed panel or other individual coverage (except for group-type coverage).
- Amounts of hospital indemnity insurance of \$200 or less per day.
- School accident type coverage, benefits for nonmedical components of group longterm care policies.
- Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

### ORDER OF BENEFIT DETERMINATION RULES

If a person is covered for medical care or treatment under any other plan, as defined above, the order of benefit determination (primary vs. secondary) will be determined as follows:

The primary plan pays or provides its benefits as if the secondary plan did not exist.

- A plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary. There is one exception: Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. For example, major medical coverage that is superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
- A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.
- The first of the following rules that describes which plan pays its benefits before another plan is the rule that will be used.

### Dependent or Non-Dependent

The plan that covers the person as an employee, member, subscriber or retiree will be primary, and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (e.g., retiree), then the order of benefits between the two plans is reversed: The plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

#### Child Covered Under More Than One Plan

- Dependent Child (Parents Not Divorced or Separated)
  - The plan of the parent whose birthday (month and day) falls earliest in the year will be primary. This rule applies if:
    - The parents are married or they are not separated (whether or not they have ever been married), or
    - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
  - If both parents have the same date of birth, the plan that covered a parent the longest will be primary.
- Dependent Child (Parents Divorced, Separated or Not Married)
  - First, the plan of the parent with custody of the child.
  - Then, the plan of the spouse of the parent with custody of the child.
  - > Then, the plan of the parent not having custody of the child.
  - Finally, the plan of the spouse of the parent not having custody of the child.

There is an exception to the above criteria: If the specific terms of a court decree state that one of the parents is responsible for the health care expenses or health care coverage of the child and the individual obligated to pay or provide health care benefits or health care coverage has actual knowledge of that obligation, that parent's plan will be primary.

### Active or Inactive Employee

The plan that covers a person as an employee who is neither laid off nor retired is primary. The same would hold true if an individual is a dependent of a person covered as a retiree or an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply. Coverage provided to an individual as a retired worker and as a dependent of an actively working spouse will be determined under the rule for dependent or non-dependent.

### Continuation Coverage

If a person whose coverage is provided under a right of continuation provided by federal or state law is also covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule and, therefore, the plans do not agree on the order of benefits, this rule is not applicable.

### In Cases of Longer or Shorter Length of Coverage

The plan that has covered the person as an employee, member, subscriber or retiree the longest will be primary.

If the preceding rules do not determine the primary plan, allowable expenses will be shared equally between the plans meeting the definition of "plan" under this regulation. In addition, the State Farm Group Medical PPO Plan will not pay more than it would have paid had it been primary.

### AFFECT OF COB PROVISIONS ON PLAN BENEFITS

When the State Farm Group Medical PPO Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100% of the total allowable expenses. For all persons covered by the Group Medical PPO Plan other than those covered under Option 3E or Option 3T when there is a residual HRA balance available, the difference between the benefit payments that the Group Medical PPO Plan would have paid had it been the primary plan, and the benefit payments that it actually paid or provided are recorded as a benefit reserve for the covered person and used by the Group Medical PPO Plan to pay any allowable expenses not otherwise paid during the claim determination period. A benefit reserve will be recorded for Covered Individuals under Option 3T beginning the first of the Month following the Month in which the HRA account is exhausted. As each claim is submitted, the Group Medical PPO Plan will:

- Determine its obligation to pay or provide benefits under its contract,
- Determine whether a benefit reserve has been recorded for the covered person, and
- Determine whether there are any unpaid allowable expenses during that claim determination period.

If there is a benefit reserve, the secondary plan will use the covered person's reserve to pay up to 100% of the total allowable expenses incurred during the claim determination period. At the end of the claim determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new claim determination period.

If a covered person is enrolled in two or more closed panel plans and if, for any reason (including the provision of service by a non-panel provider), benefits are not payable by one closed panel plan, COB will not apply between that plan and other closed panel plans.

### Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under the Group Medical PPO Plan and other plans. The Claim Administrator and/or Plan Administrator may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under the Group Medical PPO Plan and other plans covering the person claiming benefits. The Claim Administrator and/or Plan Administrator need not tell or obtain consent from any person to do this. Each person claiming benefits under the Group Medical PPO Plan must give the Claim Administrator and/or Plan Administrator any facts it needs to apply those rules and determine benefits payable.

### Facility of Payment

A payment made under another plan may include an amount that should have been paid under the Group Medical PPO Plan. If it does, the Claim Administrator and/or Plan Administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under the Group Medical PPO Plan. The Claim Administrator and/or Plan Administrator will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

### Right of Recovery

If the amount of the payments made by State Farm is more than it should have paid under the COB provision, State Farm may recover the excess from one or more of the persons it has paid or for whom it has paid, or from any other person or organization that may be responsible for the benefits or services provided for the covered person. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

### Coordination When Medicare is Primary

When Medicare becomes primary, benefits for Covered Individuals who are eligible for coverage under Medicare Part A and B will be calculated as though they *are* covered for Medicare Part A and B regardless of whether or not they are, in fact, actually covered. Also, if the Covered Individual is Medicare eligible and chooses to seek treatment for services covered by Medicare from a provider who does not provide services through Medicare, the Group Medical PPO Plan will calculate benefits for Eligible Charges as though they are covered under Part A and B even if Medicare does not cover services provided by that provider. These provisions are not applicable to Dependents who are also enrolled for coverage as an active employee under another group hospital, surgical or medical expense plan.

Covered Individuals that do not enroll in Medicare when Medicare becomes primary will have greater out-of-pocket expenses as they will be responsible for the amount estimated that Medicare would have paid had they been enrolled.

### SUBROGATION AND REIMBURSEMENT

### Subrogation and Reimbursement

The Plan shall exclude from coverage any expenses incurred as a result of any injuries or sickness which give rise to a claim by a Covered Individual against a third party tortfeasor or against any person or entity as the result of the actions of a third party. This Plan also does not provide benefits to the extent that there is other coverage under non-group medical payments (including automobile insurance) or medical expense type coverage to the extent of that coverage.

In the event that benefits are provided under this Plan, the Plan shall be subrogated to all of the Covered Individual's rights of recovery against any person or organization to the extent of the benefits provided.

### PRESCRIPTION DRUG COVERAGE

#### OUTPATIENT PRESCRIPTION DRUG EXPENSE BENEFIT

The State Farm Group Medical PPO Plan has partnered with CVS Caremark, a prescription benefit manager, to provide medical plan enrollees with prescription drug coverage. The prescription drug program provides the same benefits to all enrollees under all Options.

The Group Medical PPO Plan's Deductible, Benefit Period, and coordination of benefits provisions do not apply to the prescription drug program. In no event will benefits be payable under both the prescription drug program and the Group Medical PPO Plan. All other Group Medical PPO Plan provisions apply to prescription drug coverage.

The Group Medical PPO Plan utilizes a three-tier prescription drug coverage structure. Under this structure, the prescription Coinsurance Percentage is determined by the category of the prescription drug. The three categories are; generic, primary brand and non-primary brand. Primary brands are those brand name drugs that are included on CVS Caremark's *Primary/Preferred Drug List*.

### Primary/Preferred Drug List

Primary brand drugs (may also be referred to as preferred or formulary drugs) listed on the *Primary/Preferred Drug List* are commonly prescribed, cost-effective medications that your physician may prescribe, when appropriate. The *List* is updated quarterly at which time medications may be added or deleted from the list based on the recommendations made by CVS Caremark's National Pharmacy & Therapeutic Committee.

Upon enrollment, you will receive an initial copy of the *List* with your CVS Caremark ID card. Thereafter, you can obtain the latest *List* by calling CVS Caremark's Customer Service at 1-800-388-2058, or online at: www.caremark.com

When you visit your doctor and you need a prescription, give him/her a copy of the *List*. By using the drugs listed on the *Primary/Preferred Drug List*, you can help control rising costs while maintaining high-quality care.

### When You Use a CVS Caremark Participating Pharmacy (Retail Option)

When you use a Participating Pharmacy to fill your prescription or obtain a refill, you present your prescription (unless you are getting a refill) and your CVS Caremark ID card. You pay the applicable Coinsurance Percentage (subject to the minimum and maximum limits) described below per prescription or refill (maximum 30-day supply):

Drug Class	Generic	Primary Brand**	Non-Primary Brand
Coinsurance			
Percentage	20%	30%	50%
Minimum*			
Amount	\$10	\$10	\$10
Maximum			
Amount	\$25	\$50	\$75

<sup>\*</sup>Minimum is either the cost of the drug or the minimum amount, whichever is less. For example, if a generic drug costs \$8.00 at retail, the Employee pays \$8.00. If a Primary Brand costs \$30, the Employee will pay the minimum of \$10, since 30% of \$30 is \$9, which is below the minimum amount. \*\*As listed on the CVS Caremark *Primary/Preferred Drug List*.

You only pay one Coinsurance Percentage listed above, subject to the minimum and maximum limits. There are no deductibles.

### Maintenance Medications Purchased at a Retail CVS/pharmacy

Instead of using the Mail Order Option, you may submit a written prescription to a retail CVS/pharmacy for Maintenance Medications for the applicable Coinsurance Percentage (subject to the minimum and maximum limits) described in the Mail Order Option per prescription or refill (maximum 90-day supply).

### Value Priced Generics Program for Maintenance Medications

Generic maintenance medications (maximum 90-day supply), as listed on the CVS Caremark *Value Priced Generics Drug List*, are only \$9.99\* per 90-day supply when purchased at a retail CVS/pharmacy or via the Mail Order Option. Neither the Coinsurance Percentage nor the minimum and maximum amounts apply to Value Generic Drugs purchased at a retail CVS/pharmacy or via Mail Order. To obtain a current *Value Priced Generics Drug List*, contact CVS Caremark at 1-800-388-2058 or log in to www.caremark.com. \* Not available in all states.

The Value Priced Generics Program does not apply to generic maintenance medications purchased at non-CVS/pharmacies. See below.

# Maintenance Medications Purchased at a Retail Pharmacy Other Than a CVS/pharmacy

You may fill Maintenance Medications under the Retail Option (maximum 30-day supply per fill unless filled at a retail CVS/pharmacy). However, after the third fill of the same medication during the same calendar year, you will be responsible for the applicable Coinsurance Percentage (subject to the minimum and maximum limits) described in the Mail Order Option

per 30-day supply. This does not apply to Maintenance Medications filled at a retail CVS/pharmacy.

### When You Use the CVS Caremark Mail-Order Pharmacy (Mail Order Option)

When you submit your written prescription or request for a refill to the CVS Caremark mailorder pharmacy, you pay the applicable Coinsurance Percentage (subject to the minimum and maximum limits) described below per prescription or refill (maximum 90-day supply):

Drug Class	Generic	Primary Brand**	Non-Primary Brand
Coinsurance	20%	30%	50%
Percentage			
Minimum*	\$20	\$20	\$20
Amount			
Maximum Amount	\$50	\$100	\$150

<sup>\*</sup>Minimum is either the cost of the drug or the minimum amount, whichever is less. For example, if a generic drug costs \$18.00 at mail order, the Employee pays \$18.00. If a Primary Brand costs \$60, the Employee will pay the minimum of \$20, since 30% of \$60 is \$18, which is below the minimum amount. \*\*As listed on the CVS Caremark *Primary/Preferred Drug List*.

You only pay one Coinsurance Percentage listed above, subject to the minimum and maximum limits. There are no deductibles.

After you have had a new prescription filled through the CVS Caremark mail-order pharmacy, refills can be obtained by mail, phone or online. If you request a refill by mail, you will need to complete a Mail Service Order Form. For a refill using your credit card, you can call CVS Caremark Customer Service at 1-800-388-2058 or go online to the CVS Caremark website at: www.caremark.com.

The address for the CVS Caremark mail-order pharmacy is:

CVS Caremark P.O. Box 94467 Palatine, IL 60094-4467

#### When You Use a Non-Participating Pharmacy

When you use a Non-Participating Pharmacy or you do not present your prescription drug program ID card when you use a Participating Pharmacy, you will need to pay for the prescription in full at the time of purchase and then submit a claim to CVS Caremark for reimbursement using a Prescription Drug Claim Form (see *Filing Claims* section below). You will be reimbursed based on the following formula: the dispensed drug's average wholesale price (AWP), minus the discount percentage and dispensing fee as determined by the applicable State Farm agreement with CVS Caremark, minus the appropriate Coinsurance Percentage (subject to the minimum or maximum amount).

### **Quantity Limitations**

For any and all drugs prescribed for the treatment of erectile dysfunction, the *Outpatient Prescription Drug Expense Benefit* is limited to eight (8) pills per 30-day supply and twenty-

four (24) pills per 90-day supply. However, Cialis<sup>®</sup> for daily use (2.5 mg and 5 mg dosages only) is limited to 30 pills per 30-day supply and 90 pills per 90-day supply.

### PHARMACY SERVICES

You are entitled to the following pharmacy services under the prescription drug program.

#### Secure Care Program

When you fill your prescriptions at a Participating Pharmacy or through CVS Caremark's mailorder pharmacy, your prescription information is entered into CVS Caremark's computerized database. This means each time you have a prescription filled, pharmacists at Participating Pharmacies and the mail-order pharmacy are alerted to potential drug interactions.

#### **CVS Caremark Resources**

- www.Caremark.com (ID and Password required) To check your prescription costs, review plan design, obtain forms, print a copy of the CVS Caremark *Primary/Preferred Drug List*, view your prescription history, order refills, check the status of your mail order claim, e-mail CVS Caremark and much, much more.
- <u>www.Caremark.com/statefarm</u> (no password required) To check your prescription costs and learn more about CVS Caremark.
- You can also contact a CVS Caremark Customer Care Representative at 1-800-388-2058 for any of the above information. They are available to assist you 24 hours a day, 7 days a week. For those participants requiring TTY assistance, please dial toll free 1-800-231-4403.

### COVERED DRUGS

Prescription drugs that are covered under the Outpatient Prescription Drug Expense Benefit include the following:

- All outpatient drugs and medicines which require a written prescription from a Physician and which must be dispensed by a licensed pharmacist or Physician
- All state-restricted drugs
- Compound medications that contain at least one prescription drug
- FDA-approved contraceptive drugs and devices

#### **Diabetic Supplies**

Eligible Charges for the following supplies will be covered at the applicable Coinsurance Percentage (subject to the minimum and maximum amounts):

- Insulin (prescriptions are required for mail-order pharmacy);
- syringes and needles (prescriptions are required for mail-order pharmacy);
- FDA approved oral agents used to control blood sugar; and
- glucagons emergency kits

Test strips for glucose monitors purchased from Participating Pharmacies will be provided free of charge and are not subject to the applicable Coinsurance Percentage.

### NON-COVERED DRUGS

Prescription drugs that are not covered under this program include the following:

- Over-the-counter contraceptive products
- Smoking deterrents
- All over-the-counter (non-prescription) drugs, except insulin
- Therapeutic devices/appliances
- Investigational/experimental drugs
- Anorexients/amphetamines
- Medications for which the cost is recoverable under any workers' compensation or occupational disease law or any state or governmental agency, or medications furnished by any other drug or medical service for which no charge is made to the member
- Allergy serum
- Allergy syringes
- Drugs provided by a home health care agency
- Retin-A, Renova or other drugs within this category for individuals age 36 or over\*; and
- Growth hormones\*

# CONTROLLED SUBSTANCES - QUANTITY LIMITATIONS AND AUTHORIZATIONS

This program assists in controlling waste and ensures appropriateness of therapy for medications that have a high potential for abuse and misuse. Fifteen specific medications as regulated under Schedule II (CII) of the Controlled Substances Act are subject to this limit.

Covered Individuals that exceed the quantity limit will be asked to have their physician submit additional medical documentation. If the documentation meets the requirements for medical necessity, additional medications will be dispensed above the quantity limit.

### SPECIALTY GUIDELINE MANAGEMENT PROGRAM

Specialty Guideline Management ensures appropriate utilization of specialty medications based on currently accepted evidence-based medicine guidelines and other national guidelines. This utilization management program is designed to ensure safety and efficacy, while preventing off-guideline utilization.

<sup>\*</sup> If these drugs are required to treat an Illness, you must provide a statement of medical necessity from your physician to the PBM for possible consideration. For more information, contact CVS Caremark at 1-800-626-3046, Monday – Friday, 8 a.m. to 6 p.m., CT. Regarding growth hormones, Illness does not include small for gestational age or short stature.

### FILING CLAIMS

### When You Use a Participating Pharmacy or the Mail-Order Pharmacy

You don't need to file a claim if you use a Participating Pharmacy or CVS Caremark's mailorder pharmacy.

### When You Use a Non-Participating Pharmacy

To file a claim, you must complete a *Prescription Drug Claim Form*. This form can be obtained from the CVS Caremark website at www.caremark.com or by calling the CVS Caremark Customer Service at 1-800-388-2058. You must fully complete the Participant and Patient Information sections of the claim form. The completed form, along with an itemized prescription receipt (cash register receipts are not acceptable), should be submitted to CVS Caremark.

The claim should be sent to:

CVS Caremark P.O. Box 52196 Phoenix, Arizona 85072-2196

The claim will be processed in four to six weeks.

### Claim Appeals

Prescription drug appeals are handled in the same manner as medical claim appeals. For more information, see "How to Appeal a Denied Claim" under the Claim Filing and Appeal Procedures section.

### WHEN COVERAGE ENDS

### WHEN COVERAGE ENDS FOR AN EMPLOYEE

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

- The date the State Farm Group Medical PPO 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.

- The last day of the Month in which an Employee who terminated employment due to Illness Benefits Expired is no longer Totally Disabled in the opinion of the Corporate Medical Director.
- 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.
- The last day of the Month prior to the Month the Inactive Employee initially becomes eligible for coverage under Medicare, regardless of whether or when the Inactive Employee actually enrolls in Medicare Part A, B, C and/or D.

### WHEN COVERAGE ENDS FOR A DEPENDENT

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

- the last day of the Month the Employee's coverage terminates under this Plan or the former Employee's coverage terminates under the State Farm Health Reimbursement Arrangement Plan.
- The date coverage for all Dependents is terminated under the State Farm Group Medical PPO Plan.
- The last day of the Month the Surviving Dependent Adult's coverage terminates under this Plan or under the State Farm Health Reimbursement Arrangement Plan.
- The last day of the Month 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 active military duty 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.
- 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.
- 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.

- For Dependents whose coverage has been extended under the section entitled
   *Extension of Coverage Non-Medicare Eligible Dependents*, the last day of the Month
   prior to the Month the Non-Medicare Eligible Dependent initially becomes eligible for
   coverage under Medicare, regardless of whether or when the Dependent actually
   enrolls in Medicare Part A, B, C and/or D.
- Regarding a covered child:
  - The last day of the calendar year during which the 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 remains unmarried and 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).
- Regarding Surviving Dependent Adults and their covered children the last day of the Month prior to the Month the Covered Individual becomes eligible for Medicare.
- Regarding the covered children of Surviving Dependent Adults the last day of the Month in which the Surviving Dependent Adult's coverage terminates either under this Plan or the State Farm Health Reimbursement Arrangement Plan.

### COVERAGE TERMINATION DUE TO FRAUD

An Employee's and/or Dependent's coverage may be terminated by the Plan Administrator if the Plan Administrator determines that the Employee and/or Dependent has submitted, or caused to be 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.

### TERMINATION OF THE PLAN

The Group Medical PPO Plan may be terminated at any time by the Compensation Committee of the Board of Directors of the State Farm Mutual Automobile Insurance Company with notice to participating affiliates and subsidiaries.

#### CERTIFICATE OF CREDITABLE COVERAGE

Whenever you or a covered dependent's coverage under the Group Medical PPO Plan (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 a State Farm group medical plan or plans. 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 preexisting condition exclusion or limitation that may be imposed when you or your dependent seek 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 before coverage terminates or within 24 months of losing coverage.

### CONTINUING COVERAGE

# EXTENSION OF COVERAGE – SURVIVING DEPENDENT ADULTS AND NON-MEDICARE ELIGIBLE DEPENDENTS

### Surviving Dependent Adults

- A. In the event a covered Inactive Employee dies, his or her Surviving Dependent Adult, who is not eligible for Medicare, may continue to be covered if the Surviving Dependent Adult was covered under the Plan on the date of the Inactive Employee's death. However, for Employees hired or rehired on or after January 1, 2007, the Employee must have had 15 years or more of Company Service as of the date of retirement in order for the Surviving Dependent Adult to be eligible for extended coverage.
- B. Coverage may be extended for the Surviving Dependent Adult of an Active Employee 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 A. and B. 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 Dependent Adult 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.

### Non-Medicare Eligible Dependents

In the event an Inactive Employee becomes eligible for Medicare prior to his or her Dependents becoming eligible for Medicare, coverage may be extended for the Non-Medicare Eligible Dependents until the earlier of the date the Dependent is no longer eligible under the terms of the Plan or the end of the Month prior to the Dependent becoming eligible for Medicare.

### **Company Contributions**

Company contributions for Surviving Dependent Adults and their eligible children are provided in Exhibit C.

### CONTINUATION OF MEDICAL COVERAGE UNDER COBRA

#### Overview

The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires health plans 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 health plan on the day before a qualifying event occurs. For information regarding the reduction of COBRA premiums under the American Recovery and Reinvestment Act of 2009 and it 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** 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).

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.

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

Qualifying Event	Qualified Beneficiary	Maximum Period of Continuation
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*  If you are on duty in the uniformed services for more than 31 days, your Spouse and Dependents may continue coverage for up to 18 months.
	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 medical plan	Dependent children	36 months
Death of employee	Dependent Spouse and children	36 months
Death of retiree if Spouse is not covered  Death of Surviving Spouse	Dependent children	36 months

- \* 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/statefarm, or by mailing to Aon Hewitt, c/o State Farm Benefits Center, 4 Overlook Point, P.O. Box 1413, Lincolnshire, IL 60069-1413. 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 covered Spouse or child, or the designated representative fails 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 qualifying event occurs; (3) the date on which 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 day 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) who are receiving an 18-month maximum period of continuation coverage (giving a total maximum period of **36 months** of continuation coverage from the date of the employment termination or reduction in hours) if the qualified beneficiaries experience a second qualifying event that is death of the covered Agent, divorce or legal separation of the covered Agent 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 cost 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. In the event your termination of employment is involuntary, the cost of continued coverage may be subsidized.

### 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 contributions are not paid on time. To be timely, a payment must be made 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 when an individual
  first becomes covered under another health care 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 provides 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.

### WHO TO CONTACT

<ul> <li>Information about plan eligibility, contributions, 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>	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 Monday – Friday, 7 a.m. – 6 p.m., CT  Aon Hewitt c/o State Farm Benefits Center 4 Overlook Point, P.O. Box 1413 Lincolnshire, IL 60069-1413
<ul> <li>To precertify prior to a hospital admission or within two days of an emergency admission</li> <li>Information about PPO Providers</li> <li>Usual and customary charge guidelines</li> <li>Questions about eligibility of services/treatment</li> <li>Questions about benefits</li> <li>Verification of medical coverage</li> <li>Status of claims</li> <li>Information about transplant centers</li> <li>Information about mastectomy-related benefits</li> <li>Information about the Special Beginnings Prenatal Program</li> </ul>	BlueCross BlueShield of Illinois 1-888-652-4013 Monday – Friday, 7 a.m 7 p.m., CT www.bcbsil.com/statefarm
Where to submit claims	Blue Cross and Blue Shield of Illinois P.O. Box 805107 Chicago, IL 60680-4112

<ul> <li>Prescription drug program information</li> <li>Order prescription refills by phone</li> <li>Check on the status of a refill order</li> <li>Locate Participating Pharmacies</li> <li>Request a Mail Service Order Form</li> <li>Request a Prescription Drug Claim Form</li> <li>Request a copy of the <i>Primary/Preferred Drug List</i> or <i>Value Generic Drug List</i></li> <li>Information about special non-covered drugs used to treat Illnesses</li> </ul>	CVS Caremark 1-800-388-2058 24 hours a day, 7 days a week
Mail-order pharmacy mailing address	CVS Caremark P.O. Box 94467 Palatine, IL 60094-4467
<ul> <li>To order prescription refills online</li> <li>View the status of a refill order</li> <li>View your prescription history</li> <li>Check drug coverage and cost</li> <li>View the Primary/Preferred Drug List or Value Generic Drug List</li> <li>Obtain forms</li> <li>Search for drug information</li> <li>Obtain health information</li> </ul>	CVS Caremark www.caremark.com (ID and password required); or www.caremark.com/statefarm (no ID and password required)
Where to submit a Prescription Drug Claim Form	CVS Caremark P.O. Box 52196 Phoenix, Arizona 85072-2196

### ADMINISTRATIVE INFORMATION

### YOUR RIGHTS UNDER ERISA

As a participant in the State Farm Group Medical PPO Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to the following.

#### Receive Information About Your Plans and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, 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 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 certain rules. 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.

The following are the State Farm Group Medical PPO 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 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 refiled 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 State Farm Benefits Center at Aon Hewitt, 4 Overlook Point, P.O. Box 1413, Lincolnshire, IL 60069-1413. 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 recognizes the existence of an alternate recipient's right to medical coverage under the Participant's medical plan.
- The order is made pursuant to a state's or administrative court's directive to provide medical coverage.
- The order relates to a claim for medical coverage for an eligible child within the meaning of ERISA.
- The order clearly specifies the name and last known mailing address of the Participant and the name and mailing address of each alternate recipient covered by the order.
   The alternate recipient's address can be the address of his or her designated representative.
- The order specifies the type and form of medical coverage.
- The order specifies the period to which such order applies.
- The order specifies each plan to which the order applies.
- The order requires that such coverage be paid by the Participant in accordance with the medical plan and federal law.
- 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.

### ERISA ADMINISTRATIVE INFORMATION

#### Plan Name

The name of the plan is the State Farm Group Medical PPO Plan for United States Employees referred to in this summary plan description as the "Group Medical PPO Plan" or "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 Plan Administrator is the Welfare Benefit Administrative Committee, 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. 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.

This comprehensive medical plan is administered by the Plan Administrator in accordance with the applicable contracts in force under the Group Medical PPO Plan. Benefits under this Plan will be paid only if the Plan Administrator decides in its discretion that the person is entitled to them. 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.

### 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 (EIN) 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.

### ADDITIONAL INFORMATION

Within this summary plan description, we have tried to describe the Group Medical PPO Plan in easy-to-understand terms. But, if this summary plan description contains any statements that disagree with the complete Group Medical PPO Plan document, the Plan document shall govern.

You or your Dependents may examine Plan documents during normal business hours at 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.

### PROTECTED HEALTH INFORMATION

# PROVISION OF PROTECTED HEALTH INFORMATION TO PLAN SPONSOR

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 Group Medical PPO Plan for United States Employees (Group Medical PPO 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 Group Medical PPO Plan.
- Obtaining premium bids from insurance companies, HMOs or other health plans for providing group coverage under the Group Medical PPO Plan; or
- Modifying, amending, or terminating the Group Medical PPO 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 Group Medical PPO 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 Group Medical PPO Plan or required by law.
- Ensure that any agent (including a subcontractor) who receives protected health information from the Group Medical PPO 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 Group Medical PPO Plan any use or disclosure of the information that is inconsistent with the uses or disclosures permitted herein.
- Make available to a Group Medical PPO Plan participant his or her protected health information in accordance with HIPAA (45 CFR §164.524).
- Make available to a Group Medical PPO 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 Group Medical PPO 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).
- Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Group Medical PPO 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 Group Medical PPO 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 Group Medical PPO Plan and the Plan Sponsor exists.

**Certification of Plan Sponsor.** The Group Medical PPO Plan shall disclose protected health information to the Plan Sponsor only upon the receipt of a Certification by the Plan Sponsor that the Group Medical PPO 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 Group Medical PPO 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 coverage under the Group Medical PPO Plan; or
- Modifying, amending, or terminating the Group Medical PPO Plan.

Permitted Uses and Disclosure of Enrollment and Disenrollment Information. The Group Medical PPO Plan may disclose enrollment and disenrollment information and information on whether individuals are participating in the Group Medical PPO 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 Group Medical PPO Plan.

Adequate Separation Between Plan and Plan Sponsor. The Plan Sponsor shall only allow members of the Group Medical PPO Plan Appeal Committee and 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 Group Medical PPO 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 Group Medical PPO 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 Group Medical PPO Plan:

- "Protected Health Information" means information that is created or received by the Group Medical PPO 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 PPO 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 Claim Administrator receives a valid order of protection issued by a New York court with respect to a person covered by the Plan, the Plan Sponsor and the Claim Administrator 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:

- 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 A: COVERED SERVICES**

This list includes medical services covered under the Plan. Benefits are payable if a Covered Individual incurs Eligible Charges, as described below, during a Benefit Period which exceed the applicable Deductible, the Emergency Room Visit Charge, and/or the Preadmission Utilization Management Review Charge and the minimum and maximum amounts under the *Outpatient Prescription Drug Expense Benefit* (if applicable). However, in no event shall any expense be payable under more than one of the benefits described below. An Eligible Charge can only be considered eligible once.

The charge for a service or a purchase is considered to be incurred on the date the service is performed or the purchase is made.

Coverage under these benefits is subject to the exclusions, exceptions and limitations of the State Farm Group Medical PPO Plan.

#### SERVICES OF PHYSICIANS AND HOSPITALS

### Physicians and Hospitals

See Appendix C: Terms for "Physician" and "Hospital" definitions.

- Room and Board Charges and routine services for confinement in a Hospital or Rehabilitation Facility. This excludes any charges for a private room that exceed the most common semiprivate room rate, unless the private room is considered part of the necessary treatment. Examples of illness requiring a private room include bacterial or viral encephalitis, active pulmonary tuberculosis and active viral hepatitis. If the hospital or Rehabilitation Facility does not have semiprivate rooms, the lowest private room charge will be considered eligible.
- Medical services and supplies provided by a Hospital or Rehabilitation Facility.
- Anesthetics and their administration.
- Outpatient medical care and treatment, including but not limited to, surgical operations provided by and in the physical presence of a Physician.
- X-ray and radiation therapy.
- Physician's diagnosis, consultation and treatment via electronic media. However, no benefits are payable for conversations between the provider and the Covered Individual via electronic media.
- Charges incurred by a Physician Assistant or Certified Surgical Assistant for assisting
  at surgery when an assistant surgeon is Medically Necessary. The Physician Assistant
  or Certified Surgical Assistant will be reimbursed up to 85% of the amount that would
  have been payable to an assistant surgeon providing the same service.

 Cardiac rehabilitation programs or treatment when provided by a Hospital or Physician beginning within 18 weeks following hospitalization due to a heart attack, open heart surgery or balloon angioplasty procedures. This benefit is limited to a maximum of 12 consecutive weeks. No benefits are payable for the maintenance phase of cardiac rehabilitation.

### Investigational or Experimental Procedures or Treatment

- Investigational or experimental procedures and treatment, only if all the following criteria are met:
  - ➤ The Physician must certify that accepted medical procedures have proven to be ineffective in the treatment of the diagnosed condition and that the condition, if not treated through investigational or experimental means, would be life threatening. Accepted medical procedures are those treatment modalities that meet the definition of Medical Necessity.
  - The investigational or experimental treatment must be performed at a facility that has been designated by the appropriate federal regulatory body to perform the procedure.
  - The investigational or experimental treatment must be under an active investigative protocol. Procedures that have been determined to be unproven under an active investigative protocol will not be eligible for payment. This provision does not apply if the diagnosed condition is so rare that an active investigative protocol is not practical.
  - The expenses must not have been reimbursed or be eligible for reimbursement under any State or federal grant, study, fund, endowment or other public or private funding mechanism.

If the above criteria are met, the investigational or experimental treatment will be eligible for reimbursement or payment subject to all other provisions of the Plan and a maximum lifetime benefit of \$250,000 per Covered Individual, except that charges incurred prior to January 1, 2005, will not be applied to the lifetime maximum amount. This maximum does not apply to transplants performed at Blue Distinction Centers for Transplants.

### Mental Health Conditions or Substance Use Disorders - Partial Hospitalization Program or Residential Treatment Facility

Treatment of Mental Health Conditions or Substance Use Disorders provided in a Partial Hospitalization Program or Residential Treatment Facility.

The treatment in a Partial Hospitalization Program must be provided:

- As a transition from, or an alternative to, inpatient hospitalization,
- On a planned and regularly scheduled basis, and
- Involve a minimum of four hours of care in any one day.

No benefits are payable for Residential Treatment Facility charges incurred for educational, instructional or vocational training.

### Skilled Nursing Facility

Semiprivate Room and Board Charges and routine nursing services in a Skilled Nursing Facility (approved as such by Medicare) up to a maximum of 100 days during each benefit period.\* Benefits are reduced by the amount, if any, which is paid or payable for such confinement by Medicare. An eligible confinement in a Skilled Nursing Facility must:

- Be for treatment of an Illness.
- ➤ Include at least one Visit to the Covered Individual made by the Physician or surgeon per 30 consecutive days of confinement.
- > Not primarily involve routine custodial care.
- \* "Benefit period" means any one continuous period of confinement, whether due to one or more causes, and all successive periods of confinement due to the same or related causes. A successive confinement is considered a new Skilled Nursing Facility benefits period (regardless of its cause) only if it occurs after a period of 60 days or longer during which the Covered Individual has not been confined in a Hospital or Skilled Nursing Facility.

### SUPPLEMENTAL HEALTH CARE AND EQUIPMENT

#### **Ambulance**

Transportation necessary for the treatment of a Covered Individual's Illness is limited to:

- Emergency transportation of the patient by a professional ambulance service to the nearest Hospital equipped to provide the necessary care.
- Transportation of the Covered Individual from one Hospital to another if the Hospital
  from which the patient is being transferred lacks the facilities necessary to treat the
  Covered Individual. Only transportation to the nearest Hospital capable of treating the
  Covered Individual will be eligible for payment.
- Transportation of the patient to a Hospital via regularly scheduled airline if such transportation is in connection with an Emergency or an Emergency Medical Condition related to an Illness, is recommended by a Physician and not solely for the convenience of the Covered Individual.

### Spinal Misalignment/Subluxation

Charges for care and/or treatment in connection with the detection and correction by manual or mechanical means (including the application of treatment modalities such as, but not limited to Physical Therapy, diathermy, ultrasound, heat and cold, etc.) of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of, or in the vertebral column are limited to 30 Visits per calendar year.

These limitations are not applicable if such services are provided during general anesthesia, during a cutting operation or while the Covered Individual is confined in a Hospital.

### Medical Supplies and Durable Medical Equipment

See Appendix C: Terms for "Durable Medical Equipment" definition.

The following medical supplies and equipment are covered if prescribed by a Physician:

- Blood and other fluids (except insulin and associated syringes) to be injected into the circulatory system.
- Artificial limbs and eyes for loss of natural limbs and eyes up to an amount determined by the Claim Administrator and/or Plan Administrator to be sufficient to meet the basic needs of the Covered Individual.
- Intraocular prosthetic lens implanted during cataract surgery, and contact lenses when required for the treatment of keratoconus.
- Casts, splints, trusses, braces, crutches and surgical dressings.
- Colostomy supplies.
- Prosthetic and customized orthotic devices designed for a specific individual, stump socks, corrective or special shoes attached to a brace.
- Rental or, at the option of the Claim Administrator and/or Plan Administrator, purchase of Durable Medical Equipment up to an amount determined by the Claim Administrator and/or Plan Administrator to be sufficient to meet the basic needs of the Covered Individual provided the treating Physician submits to the Claim Administrator documentation regarding Medical Necessity. The Claim Administrator and/or Plan Administrator will consider as eligible all charges for supplies, materials and repairs necessary for the proper operation of such equipment, and the Usual and Customary (U&C) Charges and necessary expenses for the training of a person to operate and maintain the equipment for the sole benefit of the Covered Individual.
- Drugs and medicines that require a written prescription from a Physician, are dispensed by a licensed pharmacist or Physician and are specifically supplied and billed by a Home Health Care program.
- Diabetic equipment and supplies, including but not limited to, blood glucose monitors (including monitors and cartridges for the legally blind), lancets and lancing devices.

### Diagnostic Services

X-ray examinations (other than dental), microscopic examinations and laboratory tests, including but not limited to prenatal HIV testing, and other diagnostic services.

#### Home Health Care

Home Health Care must be prescribed by a Physician. Four hours of home health service is considered one home health care Visit. Each Visit by a member of a home health care team is

considered one Home Health Care Visit. The maximum benefit for Home Health Care is limited to a maximum benefit of \$8,500 per calendar year.

- No benefits are payable for Home Health Care incurred for:
  - Services of a person who ordinarily resides in the Covered Individual's home or who is a member of the Covered Individual's family.
  - Custodial care.
  - Transportation services.
  - Any period during which the Covered Individual is not under the care of a Physician.
  - Full-time Private Duty Nursing services.
  - Homemaker services.
  - Meals delivered to the home.

### Hospice

See Appendix C: Terms for "Hospice" definition.

- Inpatient Respite Care limited to a maximum of five days per confinement.
  Bereavement counseling benefits for family members covered under the Plan are
  limited to a maximum of five Visits and up to a maximum benefit of \$40 per Visit per
  Covered Individual. This counseling may occur before, but no later than three months,
  following the death of the Covered Individual who received Hospice care.
- No benefits are payable for hospice charges incurred for:
  - Financial and legal planning.
  - > Funeral arrangements.
  - > Homemaker services.
  - > Services provided by volunteers or individuals who do not regularly charge for their services.
  - Services provided by a licensed pastoral counselor to a member of his/her congregation, unless the pastoral counselor is an employee of the Hospice agency rendering these services.
  - Services incurred following the Covered Individual's death, except for bereavement counseling.

#### Private Duty Nursing

Services provided by a registered nurse (RN) or licensed practical nurse (LPN) for full-time, private duty nursing services provided to a Covered Individual who is confined to a Hospital as a registered bed patient.

Charges for full-time, Private Duty Nursing services provided to a Covered Individual who is not confined to a Hospital as a registered bed patient are limited to a maximum benefit of \$10,000 per calendar year. A Physician must prescribe these services and certify that the services are 1) being provided in lieu of hospital confinement, 2) cannot be provided through intermittent home nursing visits, and 3) cannot be provided by non-professional personnel such as an attendant, aide or the Covered Individual's family members.

### Rehabilitation Therapy

### **Occupational Therapy**

Services performed by a Physician or licensed occupational therapist at the direction of a Physician for Occupational Therapy are limited to 25 Visits per Covered Individual per calendar year.

### Physical Therapy

Services provided by a Physician or licensed physiotherapist at the direction of a Physician for Physical Therapy are limited to 50 Visits per Covered Individual per calendar year.

## Speech Therapy

Services performed by a Physician or Qualified Speech Therapist for Speech Therapy are limited to 25 Visits per Covered Individual per calendar year.

### PREVENTIVE CARE

#### Well-Child Care

Well-child care includes services provided by a Physician during the first 16 years of a child's life. Services are limited to regularly scheduled checkups (including the initial inpatient newborn checkup), immunizations, laboratory tests and other associated screening or diagnostic services as recommended by the American Academy of Pediatrics and the American Academy of Family Physicians following the child's initial Hospital stay at birth. Eligible well-child care services will be reimbursed at 100% of the Eligible Charge when provided by PPO Providers and 60% of the Eligible Charge when provided by Non-PPO Providers. This benefit is not subject to the Deductible nor is any applicable Coinsurance Percentage applied to the Out-of-Pocket Expense Limit. No benefits are payable for sports and employment physicals.

#### Preventive Care and/or Services

Preventive care and/or services for Covered Individuals age 17 and older will be reimbursed at 100% of the Eligible Charge when provided by PPO Providers and 60% of the Eligible Charge when provided by the Non-PPO Providers. This benefit is not subject to the Deductible nor is any applicable Coinsurance Percentage applied to the Out-of-Pocket Expense Limit. Examples of preventive diagnostic tests and services include, but are not limited to, bone mineral density screenings; serum cholesterol test; resting electrocardiogram (EKG); immunizations for tetanus, influenza, human papillomavirus (HPV), meningococcal, pneumococcal and shingles.

### Cancer Prevention Screenings

Charges for the following cancer prevention screenings will be reimbursed at 100% of the Eligible Charge when provided by PPO Providers and 60% of the Eligible Charge when provided by Non-PPO Providers. This benefit is in addition to the benefits provided above under *Preventive Care and/or Services* and is not subject to the Deductible nor is any applicable Coinsurance Percentage applied to the Out-of-Pocket Expense Limit.

#### **Breast Cancer**

Coverage will be provided for one mammogram and one clinical breast exam (CBE) for women every calendar year.

#### Colon and Rectal Cancer

A Covered Individual, age 50 or older, will be eligible for one of the following screening tests in any calendar year at the prescribed screening interval:

- a. flexible sigmoidoscopy (one preventive screening every 5 years), or
- b. colonoscopy (one preventive screening every 10 years).

Preventive sigmoidoscopies and colonoscopies for high risk individuals will be covered at intervals as determined by the attending Physician in accordance with the published American Cancer Society guidelines on colorectal cancer screening or other existing colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology.

Regardless of age, one of the following preventive screenings will be provided every calendar year:

- a. fecal occult blood test (FOBT\*),
- b. fecal immunochemical test (FIT\*), or
- c. double contrast barium enema.
- \* For FOBT or FIT used as a screening test, the take-home multiple sample method should be used. A FOBT or FIT done during a digital rectal exam in the Physician's office is not adequate for screening.

#### **Cervical Cancer**

Coverage will be provided for one conventional or one liquid-based Pap test every calendar year.

#### **Prostate Cancer**

Coverage will be provided for a preventive prostate-specific antigen (PSA) blood test and digital rectal examination (DRE) for men every calendar year.

## **OTHER SERVICES**

#### **Allergies**

Benefits are payable for allergy serum and allergy syringes.

## Blue Distinction Centers for Transplants

Eligible Charges incurred for a Covered Transplant performed at Blue Distinction Centers for Transplants are subject to the Deductible. After satisfaction of the Deductible, benefits will be

increased 10% (not to exceed 100%) for global transplant care and/or treatment performed at a Blue Distinction Center for Transplants. Ancillary care and/or treatment not included in the global transplant fee but related to a Covered Transplant are eligible for reimbursement at the standard PPO Provider/Non-PPO Provider Coinsurance Percentages. Blue Distinction Centers for Transplants will be determined by Blue Cross Blue Shield.

Charges for transportation to a Blue Distinction Center for Transplants and lodging expenses away from home, as defined by Internal Revenue Code 213(d)(2), that are incurred in conjunction with a Covered Transplant for a Covered Individual will be covered up to \$10,000 per Covered Transplant. The lodging benefit is limited to \$50 per night for the Covered Individual receiving the transplant and one companion. If the Covered Individual is a minor, lodging for two companions traveling with the minor will be considered eligible, subject to the \$50 limitation per night, per individual and the \$10,000 maximum.

## Christian Science Facility

- Confinement in a Christian Science sanitarium only with respect to those Covered Individuals who are admitted for healing (not for rest or study) and who are under the care of an authorized practitioner. Christian Science sanitarium charges will be considered Hospital Room and Board Charges.
- Services provided by a Christian Science practitioner in the physical presence of a Covered Individual and given in accordance with the healing practices of Christian Science.
- Professional nursing services provided by a Christian Science nurse in the physical presence of a Covered Individual and given in accordance with the healing practices of Christian Science.

### Contraceptive Coverage

- Charges for FDA-approved contraceptive drugs and devices when prescribed for contraception. Oral contraceptives are covered under the prescription drug program.
- Outpatient contraceptive services (consultations, examinations, procedures and other medical services) relating to contraceptive management, including natural family planning.
- Over-the-counter contraceptive products are ineligible.

#### Health Care Education

Educational or instructional care provided to a Covered Individual for the purpose of self-care, administration and management of his/her diabetic or asthmatic condition.

### Mastectomy-Related Benefits

The Plan provides benefits as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA). Coverage will be provided in a manner determined in consultation with the attending Physician and the Covered Individual for the surgical removal of all or any portion of the breast as a result of or in connection with infection or disease and for breast reconstruction in connection with a mastectomy, including:

a. All stages of reconstruction of the breast on which the mastectomy was performed;

- b. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- c. Prostheses; and
- d. Treatment for physical complications of the mastectomy, including lymphedema.

Inpatient care following a mastectomy will be eligible for a length of time determined by the attending Physician to be medically necessary in accordance with protocols and guidelines based on sound scientific evidence.

## Maternity Care (Length of Stay Associated with Childbirth)

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/preadmission, contact the BlueCross BlueShield of Illinois at 1-888-652-4013, Monday – Friday, 7:00 a.m. – 7:00 p.m., CT. This number is also on the back of your medical ID card.

If a shorter length of stay is determined appropriate by the attending provider, coverage will be provided for one of the following to verify the condition of the infant:

- a. a single Home Health Care Visit within 48 hours after discharge, or
- b. a Physician's office Visit within 48 hours after discharge.

A Home Health Care Visit provided above does not count towards the Home Health Care benefit limit of \$8,500 per calendar year.

Note: This provision does not eliminate the Preadmission Notification Requirements described in the *Medical Plan Benefits – Utilization Management* section.

#### Metabolic Disorders

Benefits are payable for infant formula required for the treatment or amelioration of metabolic disorders when prescribed by a Physician for infants younger than 2 years of age.

### Nutritional Counseling

Nutritional or dietetic instruction when provided by a Physician or Registered Dietitian who is under the direct supervision of the prescribing Physician for the therapeutic treatment of an Illness.

No benefits are payable for dietary supplements (liquid, solids or pills) or dietary counseling specifically for the purpose of weight loss.

## Organ/Tissue Donation

Benefits are payable for tests administered to prospective organ/tissue donors.

If a Covered Individual is a prospective organ/tissue donor, charges for tests to determine organ/tissue donor compatibility will be considered eligible.

If the recipient is a Covered Individual, charges for tests to determine organ/tissue donor compatibility for immediate family members of the recipient will be considered eligible. Immediate family member means the recipient's spouse/partner, father, mother, brother, sister, son, or daughter.

If the prospective organ/tissue donor is not an immediate family member of the recipient, this benefit is subject to a lifetime limitation of \$5,000 regardless of the number of individuals tested. Again, the recipient must be a Covered Individual. Charges incurred prior to January 1, 2005, under Policy Number HG00003 or Policy Number HG00004 will not be applied against the \$5,000 lifetime limitation.

## Reconstructive Surgery

Reconstructive surgery when the surgery is:

- The result of an accident.
- For the correction of a congenital defect for a dependent child.
- For the correction of marked asymmetry following the surgical treatment of an Illness.

#### Scalp Hair Prostheses

Benefits are payable in connection with scalp hair prostheses (wigs) or hair transplants for the treatment of hair loss due to cancer treatment, alopecia areata and alopecia totalis. The supply or treatment must be prescribed by a Physician and the hair transplant treatment must be performed by a Physician. The maximum payment under this benefit is limited to \$350 per calendar year.

## Temporomandibular Joint Dysfunction (TMJ)

Benefits are payable for the diagnosis, care, and/or treatment of temporomandibular joint (TMJ) dysfunction. Coverage includes Medically Necessary surgical procedures and custom made oral appliances (intra-oral splint or occlusal splint). However, orthodontics, dentures (full and partial), crowns, bridgework, dental splints, dental implants or other dental appliances or procedures to treat dental conditions related to TMJ disorders are not covered.

### **Transplants**

The following human organ/tissue transplant procedures are Covered Transplants:

- a. heart,
- b. lung,
- c. combination heart/lung,
- d. liver.
- e. simultaneous pancreas kidney (SPK).
- f. pancreas (PAK/PTA), or
- g. bone marrow/stem cell (autologous and allogeneic).

## Transplant Lodging Expenses

Lodging expenses away from home as defined by Internal Revenue Code 213(d)(2) that are incurred in conjunction with a Covered Transplant by a Covered Individual who is not enrolled in the Blue Distinction Centers for Transplants program will be considered eligible. This benefit is limited to \$50 per night, per individual for the Covered Individual receiving the transplant and one companion up to a maximum of \$5,000 per Covered Transplant. If the Covered Individual is a minor, lodging for two companions traveling with the minor will be considered eligible, subject to the \$50 limitation per night, per individual and the \$5,000 maximum.

## Second Surgical Opinions

A second surgical opinion and associated ancillary diagnostic services performed by a board-certified specialist other than the Physician who initially recommended the surgery or who is associated with the Physician who recommended the surgery.

#### Dental-Related Benefits

Charges for the treatment of teeth, gums or alveolar process, or for dental appliances or supplies used in such treatment are specifically limited to the following:

- Hospital and ambulatory surgery center expenses.
- Expenses incurred as a result of and within 24 months after an accident for treatment
  of injury to sound natural teeth, including the replacement of such teeth or setting of a
  jaw fracture or dislocation.

The time period for dental accidents for children under age 16 may be extended beyond 24 months, provided the dentist presents a treatment plan within 24 months following the accident to the Claim Administrator and/or Plan Administrator. Benefits will be payable only if the child is covered on the date service is finally provided. The extension of benefits beyond 24 months does not apply to any Covered Individual whose accident occurs on or after he/she reaches age 16. Accidental injury does not include injury caused by or occurring out of the act of chewing.

- Treatment of active periodontal disease, except physician services for:
  - Periodontal maintenance procedures (periodontal prophylaxis).
  - > Periodontal root scaling/planning.
  - Surgical extraction of the teeth.
  - Osseous surgery.
- Treatment resulting from cancerous growths or osteomyelitis.

## **APPENDIX B: EXCLUSIONS**

The following providers, conditions, treatments and supplies are not covered charges under the State Farm Group Medical PPO Plan. Terms that are capitalized have specific meanings and are defined in *Appendix C: Terms*.

- Any Illness arising out of or in the course of any employment for which the Covered Individual is entitled to make a claim for benefits under any workers' compensation, occupational disease or similar law, or for which he/she receives any settlement from a workers' compensation carrier or employer related to such law.
- Charges due to war or any act of war, whether declared or undeclared.
- Charges incurred when the Covered Individual is not under the direct care of a Physician.
- Charges which the Covered Individual is not legally obligated to pay.
- Expenses in excess of Usual and Customary (U&C) Charges for services performed and materials furnished. This exclusion does not apply to services performed or materials furnished by a PPO Provider.
- Any services, supplies or Hospital confinements that are not considered Medically Necessary treatment of an Illness.
- Charges for losses incurred while the Covered Individual is in the military, naval, air force or other armed services of any country.
- Charges for which benefits are not specifically provided under the State Farm Group Medical PPO Plan.
- Treatment of teeth, gums or alveolar process, or for dental appliances or supplies used in such treatment, including but not limited to dental implants and related procedures. This exclusion does not apply to those services listed under *Appendix A: Covered Services, Dental-Related Benefits* in this summary plan description (provided the services are not covered expenses under the State Farm Group Dental Plan, regardless of whether the individual is covered under such plan).
- Hearing aids or examinations to determine the need for or the proper adjustment of hearing aids.
- No benefits are payable for:
  - a. radial keratotomy or any other refractive keratoplasty procedures,
  - b. eveglasses or contact lenses,
  - c. vision therapy,

- d. Physicians' services in connection with a., b., and c. above, or
- e. examinations to determine the need for or proper adjustment of eyeglasses and/or contact lenses.

This exclusion does not apply to expenses incurred for intraocular prosthetic lens implanted during cataract surgery and contact lenses when required for the treatment of keratoconus.

- Acupuncture (including, but not limited to, acupuncture by needle, electrical stimulation, ultrasound, acupressure, laser and articular therapy) or thermography.
- Treatment performed for cosmetic reasons and charges in connection with Cosmetic Surgery. This exclusion does not apply to expenses for:
  - Surgical removal of all or a portion of the breast made necessary by infection or disease and any subsequent implantation or injection of substances foreign to the body and for breast reconstruction in connection with a mastectomy.
  - Reconstructive surgery when the surgery is 1) the result of an accident, 2) for the correction of a congenital defect for a Dependent child, or 3) for the correction of marked asymmetry following the surgical treatment of an Illness.
- Hospitalization, services, treatments or supplies furnished by the United States or a foreign governmental agency, unless otherwise prohibited by law.
- Medical treatment by a Physician or Qualified Speech Therapist for any treatment
  which is not provided by or in the physical presence of the Physician or Speech
  Therapist, including charges for refilling prescription medication over the telephone.
  This exclusion does not apply to charges by a Physician for diagnosis, consultation,
  and treatment via electronic media.
- Treatment provided by a Social Worker is not covered unless the Social Worker is licensed or registered by the State in which these services are performed or is certified by the National Academy of Certified Social Workers.
- Services provided by a family member\* unless all of the following is applicable:
  - > The family member is a regular employee of the organization providing the service.
  - > The organization receives the payment for the services, and
  - ➤ The family member receives no compensation other than the normal compensation for employees in his/her job category.
  - \* "Family member" means your Dependent Adult and anyone who is related to you or your Dependent Adult by blood, marriage or legal adoption as a parent, grandparent, child or grandchild, brother or sister, aunt or uncle, first cousin, nephew or niece.

- Charges resulting from or incurred in connection with reversal of sterilization procedures, either male or female.
- Custodial Care or care that is primarily for custodial or domiciliary purposes. This exclusion does not apply to charges for Hospice care.
- Any and all expenses incurred beyond the termination date of coverage, unless specifically allowed for the extension of certain benefits upon termination of coverage provision.
- Educational, instructional or vocational training and materials, such as, but not limited to books, tapes, videos, pamphlets, and software.\*
  - \* This exclusion does not apply to educational or instructional care provided for self-care, administration and management of a diabetic or asthmatic condition, or to nutritional or dietetic instruction provided by a Physician or Registered Dietician under a Physician's supervision for the treatment of an Illness.
- Treatment, therapy or related services provided in order to maintain a restored level of functioning when no further significant improvement can be expected, or when no improvement is supported by objective findings.
- Expenses resulting from modifications made to a home, vehicle or other real or
  personal property and testing of such property, including, but not limited to,
  environmental testing. This includes, but is not limited to the purchase and installation
  of ramps, stair lifts, elevators, spas, air cleaning or filtration systems, and car hand
  controls.
- Any drug or medicine that is not approved by the Food and Drug Administration (FDA).
- Exercise, diet or weight loss programs, surgical procedures or other treatments, nutritional evaluations, food supplements, or providers or facilities providing such programs, surgical procedures, treatments, evaluations, or supplements, regardless of the reason for such programs, surgical procedures, treatments, evaluations or supplements. This exclusion does not apply to charges described in *Appendix A: Other Covered Services, Metabolic Disorders*.
- Routine, periodic or annual examinations or diagnostic tests that are performed primarily for preventive or health screening purposes, except those services which are listed under *Appendix A: Covered Services, Preventive Care*.
- Any smoking cessation program or any treatment for tobacco, nicotine or caffeine dependence.
- Diagnosis, care or treatment of Developmental Disorders or learning disturbances, regardless of age.
- Any charges resulting from or incurred in connection with surrogate Pregnancy.

- Exercise programs, exercise equipment and spa, exercise or health club memberships.
- Purchase or rental of equipment for use in the home 1) that cannot withstand repeated use, 2) is not primarily and customarily used to serve a medical purpose, 3) is useful in the absence of an Illness, 4) and is used solely for comfort and convenience.
- Charges resulting from or incurred in connection with in vitro fertilization or other forms
  of artificial insemination. This exclusion does not apply to charges for the treatment of
  infertility that would have been incurred even in the absence of in vitro fertilization or
  other forms of artificial insemination.
- Charges resulting from or incurred in connection with chelation therapy except in the case of heavy metal poisoning.
- Charges resulting from or incurred in connection with Concurrent Medical Care.
- Charges incurred for items purchased without a prescription including but not limited to sterile gloves, cotton balls, alcohol wipes, and lubricants.
- Charges incurred for food, including but not limited to food formulated to be consumed
  or administered enterally or orally under the supervision of a Physician and intended
  for the specific dietary management of a disease or condition for which distinctive
  nutritional requirements, based on recognized scientific principles, are established by
  medical evaluations. This exclusion does not apply to charges described in *Appendix*A: Other Covered Services, Metabolic Disorders.
- Benefits are not payable for any "never event" or "hospital-acquired condition" as determined by the Claim Administrator.

"Never events" or "hospital-acquired conditions" include but are not limited to:

- Surgery performed on a wrong body part.
- Surgery performed on the wrong patient.
- > The wrong surgical procedure performed on a patient.
- Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a facility.
- An infant discharged to the wrong person.
- Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products (transfusion with the wrong blood type).
- Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia (jaundice) in neonates during the first 28 days of life.
- > Patient death or serious disability associated with a burn incurred from any source while being cared for in a facility.

## APPENDIX C: TERMS

The following are definitions for words and phrases used in this summary plan description. Additional terms may be defined in the Plan Document, which is available for review by request to the Human Resources Department Total Rewards – Benefits Department, Corporate Headquarters. Terms defined in this section are capitalized throughout the Summary Plan Description.

## **Active Employee**

Active Employees are described in A. and J. in the section entitled *Eligible Employees*.

#### **Annual Enrollment Period**

Is 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.

#### **Benefit Period**

A benefit period is a calendar year (January 1 – December 31) or that portion of a calendar year during which you and/or your Dependents are covered under this Plan. A benefit period terminates on the last day of the calendar year, the last day of the month in which the Covered Individual ceases to be eligible for coverage, or the day the maximum benefit is reached, whichever occurs first. All Eligible Charges incurred during a benefit period for all Illnesses are used in computing benefit payments.

When Eligible Charges are incurred while the Covered Individual is confined in a Hospital, Residential Treatment Facility, Skilled Nursing Facility, or Rehabilitation Facility, and if the confinement begins in one calendar year and continues into the next calendar year, the Eligible Charges incurred for the confinement will be considered and applied in satisfaction of the Deductible, Coinsurance Percentage, and Out-of-Pocket Expense Limit for the calendar year in which the confinement began. The Covered Individual will not have to satisfy a new Deductible, Coinsurance Percentage or Out-of-Pocket Expense Limit for the Eligible Charges incurred in the next calendar year for the confinement that began in the preceding calendar year. Eligible Charges incurred after discharge will be subject to satisfaction of the calendar year Deductible, Coinsurance Percentage, and Out-of-Pocket Expense Limit.

#### **BCBS IL**

Blue Cross and Blue Shield of Illinois

### **Certified Surgical Assistant**

A person who is licensed, certified or registered as a Surgical Assistant by the State in which services are provided. If the State does not require or provide licensing, certification or registration, a Certified Surgical Assistant means someone who is certified by the by the National Surgical Assistant Association on the Certification of Surgical Assistants, the Liaison Council on Certification of Surgical Technologists, or the American Board of Surgical Assistants.

#### Christian Science

Christian Science means a sanatorium accredited by the Department of Care of the First Church of Christ, Scientist, Boston, Massachusetts. Physician, R.N. and L.P.N. will include a Christian Science practitioner of the First Church of Christ, Scientist, Boston, Massachusetts listed in the current issue of the *Christian Science Journal* at the time the service is provided.

#### Claim Administrator

Blue Cross and Blue Shield of Illinois (BCBS IL)

#### **Claim Determination Period**

Claim determination period means a calendar year. However, it does not include any part of a year during which a person has no coverage under the State Farm Group Medical PPO Plan, or before the date the State Farm coordination of benefits provisions or similar provisions become effective.

## **Coinsurance Percentage**

The percentage of Eligible Charges that must be paid by the Employee for care and/or treatment after the applicable Deductible has been met.

### 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.

## **Company Service**

The combination of time spent as an employee of State Farm or as an independent contractor insurance agent for State Farm.

#### **Concurrent Medical Care**

Includes:

- a. therapy care when the same Physician provides both therapy care and medical care on the same day, or
- b. medical care when the same Physician provides both mental health services and medical care on the same day, or
- c. anesthesia when administered by the same Physician who delivered the child. or
- d. consultation when the same Physician provides both consultation and medical care on the same day, or
- e. consultation when the same Physician provides both consultation and surgical assistant services on the same day, or

- f. surgical assistant services when performed by the same Physician who performed the surgery or administered the anesthesia, or
- g. anesthesia when administered by the same Physician who performed or assisted in the surgery.

### **Cosmetic Surgery**

The surgical alteration of tissue for the improvement of the Covered Individual's appearance rather than improvement or restoration of bodily function.

## **Covered Expenses**

For purposes of the HRA compatible options (Option 3E or the Pre-Medicare Retiree Option), "Covered Expenses" mean Eligible Charges that would be paid or reimbursed by the Plan but for the applicable Deductible and Coinsurance Percentage. Covered Expenses do not include:

- a. the Emergency Room Visit Charge,
- b. the Preadmission Utilization Management Review Charge,
- the Coinsurance Percentage for Preventive Care services provided by Non-PPO Providers, and
- d. the applicable Coinsurance Percentage or minimum and maximum amounts under the *Outpatient Prescription Drug Expense Benefit*.

#### Covered Individual

The following persons who are enrolled in the Plan:

- a. an Employee,
- b. an Employee's Dependent,
- c. a newborn or legally adopted child of a Surviving Dependent Adult,
- d. or a Non-Medicare Eligible Dependent.

#### **Custodial Care**

Services for personal, family or domestic needs primarily designed to assist with the activities of daily living and can be provided by persons without professional skills or training. Custodial care includes, but is not limited to, help in walking, assistance with bathing, dressing and eating.

#### **Custodial Parent** (pertains to Coordination of Benefits)

This is a parent who is awarded custody by court decree. In the absence of a court decree, it is the parent with whom the child resides more than one-half of the calendar year without regard to any temporary visitation.

#### **Deductible**

The fixed amount of Eligible Charges incurred during a Benefit Period before benefits are paid. Deductibles apply to all Eligible Charges unless otherwise provided.

## Dependent

For purposes of this SPD, 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.

## **Developmental Disorders**

Disorders characterized by or whose manifestations include delays in development of specific academic, language, speech and motor skills, but are not due to specific, identifiable, physical or neurological disorders.

### **Durable Medical Equipment**

Equipment which meets all of the following criteria:

- Can withstand repeated use,
- Is primarily and customarily used to serve a medical purpose
- Generally is not useful to a person in the absence of an Illness, and
- Is appropriate for use in the home.

## **Eligible Charges**

Charges incurred by a Covered Individual that include all of the following criteria:

- A result of an Illness for which the Covered Individual is not entitled to benefits under any workers' compensation or occupational disease law,
- Medically Necessary for the treatment of an Illness,
- Are not in excess of Usual and Customary (U&C) Charges for the services performed or the materials furnished,
- Are not in excess of any of the Plan's dollar limits, number of days limits, or number of Visit limits,
- Are not for Concurrent Medical Care,
- Except as provided in Appendix A: Covered Services, Investigational and Experimental Procedures or Treatment, are not for experimental or investigational medical, surgical, or other experimental health care procedures, services, or supplies. Such procedures, services, or supplies are those that in the judgment of the Claim Administrator or the Plan Administrator
  - (1) are in a testing stage or in early field trials on animals or humans;

- do not have required final federal regulatory approval for commercial distribution for the specific indications and methods of use assessed;
- (3) are not generally recognized as acceptable medical practice; or
- (4) have not yet been shown in recognized medical journals to be consistently effective for the diagnosis or treatment of the Covered Individual's condition, **and**
- With respect to Medicare participants, are not in excess of the balance billing limit for charges allowed by Medicare on physician fees incurred by Medicare participants.

### **Emergency or Emergency Medical Condition**

An accidental bodily injury or a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or with respect to a pregnant women, the health of the woman or her unborn child) in serious jeopardy,
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part.

### **Emergency Room**

The area of a Hospital where Emergency Medical Conditions are treated.

### **Emergency Room Visit Charge**

For each Visit to an Emergency Room, the first \$100 in Eligible Charges is the Covered Individual's responsibility. This \$100 charge will not be applied toward the satisfaction of the applicable Deductible, Coinsurance Percentage, or Out-of-Pocket Expense Limit.

#### **Employee**

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

## 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 United States Employees.

## **Health Reimbursement Arrangement (HRA)**

Is an arrangement under which the Company reimburses eligible Employees for Covered Expenses up to a maximum dollar amount. To participate in this arrangement, eligible Employees must be enrolled in the qualifying HRA option. This arrangement is described in more detail in the section entitled "HRA Option".

#### **Home Health Care**

A formal program of part-time or intermittent care and treatment that is performed in the home of a Covered Individual for an Illness. It must be provided by a Hospital or home health service or agency and must meet **all** of the following criteria:

- Be established and operated in accordance with the applicable laws in the
  jurisdiction in which it is located and, where licensing is required, be
  licensed and approved by the regulatory authority having responsibility for
  licensing under the law,
- Be under the direct supervision of a Physician,
- Be coordinated by a graduate registered nurse (R.N.), and
- Maintain medical records on each patient.

## **Hospice**

An agency that provides a coordinated program of home and inpatient care for the special physical, psychological and social needs of terminally ill persons and their families. A terminally ill person is one who has been diagnosed by a Physician as having a life expectancy of six months or less. The hospice agency must meet **all** of the following criteria:

- Be established and operated in accordance with the applicable laws in the
  jurisdiction in which it is located and, where licensing is required, be
  licensed and approved by the regulatory authority having responsibility for
  licensing under the law,
- Be under the direct supervision of a Physician,
- Be coordinated by a graduate registered nurse (R.N.),
- Provide continuous 24-hour nursing service, and
- Maintain medical records on each patient.

#### Hospital

A legally operated institution with accommodations for the care and treatment of sick or injured resident inpatients that is:

- Licensed as a hospital under the hospital licensing laws of the State in which it is situated, or
- Accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations.

This definition does not include any institution operating as a clinic, nursing home, rest home, home for the aged, convalescent home, group home, halfway house, Residential Treatment Facility or similar establishment.

#### Illness

A bodily disorder or disease, Mental Health Condition or Substance Use Disorder, Pregnancy or bodily injury. With respect to the transplant of a natural organ or organs or other natural tissue from one living person to another, the medical expenses of the donor will be considered Eligible Charges as an Illness of the Covered Individual, subject to the other provisions of this Plan.

#### **Illness Benefits Expired**

When employment is terminated and an Employee meets all of the following criteria:

- Has used all paid sick leave, medical leave and any leave for personal illness made available,
- Has not been released to return to work by his/her own doctor and the Corporate Medical Director,
- Has not qualified for retirement disability under the State Farm Insurance Companies Retirement Plan for United States Employees, and
- Is not eligible for early retirement under the State Farm Insurance Companies Retirement Plan for United States Employees, or if eligible chooses to delay receiving income from the Employees' Retirement Plan.

### **Inactive Employee**

Inactive Employees are described in B., C., D., E., F., G., H., and I. in the section entitled *Eligible Employees*.

#### 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.

#### **Maintenance Medications**

Drugs or medicines taken on a regular or continuing basis for chronic or long term conditions including but not limited to diabetes, arthritis, high blood pressure, cardiovascular problems, high cholesterol, asthma, allergies, ulcers, or depression.

#### **Medically Necessary/Medical Necessity**

Medically Necessary or Medical Necessity means health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an Illness or its symptoms, and that are: (a) in accordance with Generally Accepted Standards of Medical Practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's Illness; and (c) not primarily for the convenience of the patient, Physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness. For these purposes, "Generally Accepted Standards of Medical

Practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors. The fact that your Physician may prescribe, order, recommend, approve or view hospitalization or other health care services and supplies as Medically Necessary does not make the hospitalization, services or supplies Medically Necessary and does not mean that the Claim Administrator and/or Plan Administrator will pay the cost of the hospitalization, services, or supplies.

For a Hospital confinement on an inpatient or outpatient basis, the length of confinement and medical services and supplies furnished by the Hospital will be considered Medically Necessary only to the extent they are determined by the Claim Administrator and/or the Plan Administrator to be related to the Medically Necessary treatment of the diagnosed Illness.

#### Medicare

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

#### **Mental Health Conditions**

Those psychiatric illnesses as defined in the most current edition of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association.

#### Month

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

### National Scientific Organization

An entity composed of medical specialists recognized by the American Medical Association or the Council on Medical Specialty Societies that evaluates diagnostic and therapeutic procedures to determine whether such procedures are clinically acceptable.

### Non-Medicare Eligible Dependent

In regards to the section entitle *Extension of Coverage – Non-Medicare Eligible Dependents*, a Dependent of a Medicare eligible Inactive Employee or an eligible child of a Medicare eligible Surviving Dependent Adult, whose coverage under the Plan has been extended due to the fact the Dependent is not eligible for Medicare.

#### Non-PPO Provider

A Hospital (or other health care facility) or Physician (or other provider of professional services, medicines or supplies) that does not have a written PPO-Provider agreement with the Claim Administrator at the time the Eligible Charges are incurred.

#### Non-Solicited Provider

Providers of services that are not approached by the Blue Cross Blue Shield network to enter into a contractual relationship. Examples of Non-Solicited Providers include but are not limited to providers of blood and blood compounds, prosthetic appliances, ambulance transportation (local ground or air transportation to the nearest appropriately equipped facility), eligible dental accident care, durable medical

equipment, private duty nursing, oxygen and its administration, leg, back, arm and neck braces, medical and surgical dressings, supplies, casts and splints.

## **Occupational Therapy**

Treatment to increase a patient's use of fine motor skills to enable the patient to apply such skills to the tasks required in daily living, after those skills have been impaired by Illness or injury.

#### Other Care Providers

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

## **Out-of-Pocket Expense Limit**

Out-of-Pocket Expense Limit includes the Deductible and the Coinsurance Percentage. In determining whether the Out-of-Pocket Expense Limit has been reached, only Eligible Charges will be considered. Eligible charges billed by PPO Providers will be applied in satisfaction of the Non-PPO Provider Out-of-Pocket Expense Limit up to the PPO Provider Out-of-Pocket Expense Limit. Eligible charges billed by Non-PPO Providers will be applied in satisfaction of the PPO Provider Out-of-Pocket Expense Limit. The following out-of-pocket expenses do not apply to the Out-of-Pocket Expense Limit:

- the Emergency Room Visit Charge,
- the Preadmission Utilization Management Review Charge,
- the Coinsurance Percentage for Preventive Care services provided by Non-PPO Providers, and
- the applicable Coinsurance Percentage or minimum and maximum amounts under the *Outpatient Prescription Drug Expense Benefit*.

## **Partial Hospitalization Program**

A program which provides an integrated and comprehensive schedule of recognized psychiatric treatment under the direct supervision of a Physician. The program must be:

- Part of a Hospital complex, a component of a community mental health center or a free-standing unit, and
- Established and operated in accordance with the applicable laws in the jurisdiction in which it is located, and, where licensing is required, is licensed and approved by the regulatory authority having responsibility for licensing under the law.

#### **Participant**

An Employee who is or may become eligible to receive benefits under the Plan.

## **Participating Pharmacy**

A retail pharmacy recognized as such under its agreement with CVS Caremark Corp.

#### **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.

## **Physical Therapy**

Therapeutic interventions concerned with restoration of function and prevention of disability following an Illness. Such interventions include therapeutic exercise programs to increase strength and endurance, as well as the application of various other modalities including, but not limited to, heat, cold, electrical stimulation, ultrasound, hydrotherapy, and massage or mobilization techniques that are tailored to the specific needs of the Covered Individual.

### **Physician**

A health care provider licensed by the State, and performing services within the scope of his/her license under the laws of the State in which these services are provided.

## **Physician Assistant**

A person who is licensed, certified or registered as a physician assistant by the State in which services are provided. If the State does not require or provide licensing, certification or registration, physician assistant means a graduate of a physician assistant or surgeon assistant training program (accredited by the American Medical Association's Commission of Accreditation of Allied Health Education Programs) who passed the certifying examination administered by the National Commission on the Certification of Physician Assistants.

#### Plan Administrator

The Welfare Benefit Administrative Committee.

#### Plan Year

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

#### **PPO Provider**

A Hospital (or other health care facility) or, Physician (or other provider of professional services, medicines or supplies) that has a written agreement with the Claim Administrator at the time the Eligible Charges are incurred.

#### **Preadmission Utilization Management Review Charge**

If the professional review organization is not notified in accordance with the requirements provided in the section entitled *Utilization Management – Preadmission Notification Requirements*, the Employee will be responsible for the first \$100 of Eligible Charges. This \$100 charge will not be applied toward the satisfaction of the Deductible or Out-of-Pocket Expense Limit and will not apply to calls not made for private duty nursing. Home Health Care, or Skilled Nursing Facility Admissions.

### **Pregnancy**

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

## **Qualified Speech Therapist**

A qualified speech therapist has a master's degree in speech pathology, has completed a supervised internship and is licensed by the State in which the services are performed, if required by the State.

### Reemployment Rights

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

## **Registered Dietitian**

A dietitian who is registered with the Commission on Dietetic Registration of the American Dietetic Association and is licensed by the State in which the services are performed if required by the State.

#### **Rehabilitation Facility**

A legally operated institution that provides coordinated multidisciplinary physical restorative services for the care and treatment of sick or injured resident inpatients and is:

- Established and operated in accordance with the applicable laws of the State in which it is situated, and
- Accredited by either the Joint Commission on Accreditation of Healthcare Organizations or the Commission on Accreditation of Rehabilitation Facilities.

This definition does not include any institution (including a rehabilitation facility or any part of a rehabilitation facility) operated primarily as a clinic, nursing home, rest home, home for the aged, convalescent home, group home, halfway house, Residential Treatment Facility or similar establishment.

#### **Residential Treatment Facility**

An institution that is licensed to provide 24-hour a day residential programs for the care and treatment of Mental Health Conditions or Substance Use Disorders. The institution must be licensed to provide 24-hour a day residential programs for the care and treatment of Mental Health Conditions or Substance Use Disorders by the State in which the care and treatment is provided.

#### **Respite Care**

A short-term inpatient stay for the Hospice care patient, which may be necessary in order to give temporary relief to the person who regularly assists with home care.

#### **Room and Board Charges**

Charges made by a Hospital or Skilled Nursing Facility for the cost of the room, meals and services (such as general nursing services) routinely provided to all inpatients.

## **Skilled Nursing Facility**

An institution that is approved as such by Medicare.

#### Social Worker

A health care provider licensed or registered by the State in which these services are performed or is certified by the National Academy of Certified Social Workers.

### **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 PPO Plan 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, but are not enrolled, may enroll for coverage under 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 this Plan, Policy Number HG00003, or Policy Number HG00004,
  - 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 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 existing 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 PPO Plan, provided:
  - a. The Employee acquires a new Dependent through marriage, birth, adoption or placement for adoption, **and**
  - b. The Employee 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 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.

## Speech Therapy

Therapy services that assist in the restoration of the ability to communicate orally, when such ability has been acutely impaired by Illness, injury or birth defect.

#### **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.

#### **Substance Use Disorders**

Those psychiatric illnesses as defined in the most current edition of the Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association including, but not limited to, alcohol dependence and other substance dependence that are not excluded from coverage in Part V; Exclusions, Exceptions and Limitations.

## **Total Disability or Totally Disabled**

The Employee's inability, as a result of Illness, to engage in the normal occupation with the employer during the first 24 months after disability starts. After 24 months of disability, the Employee's inability to perform the duties of any occupation for which the Employee is or becomes qualified for based on education, training or experience. The Dependent's or retired Employee's inability to perform the usual and customary duties or activities of a person in good health and of the same age and sex.

### **Usual and Customary (U&C) Charge**

For fees charged by a Hospital or other health care facility, Physician, or other provider of professional services, medicines or supplies, the lesser of:

- The actual charge, or
- 300% of the base Medicare reimbursement rate excluding any Medicare adjustments which are based on information on the claim, **or**
- the diagnostic related group charge.

When a Medicare reimbursement rate is not available for an Eligible Charge or is unable to be determined from the information submitted on the claim, the amount considered for Non-PPO Providers will be 50-90% of the Non-PPO Provider's standard billed charge for such Eligible Charge.

The Claim Administrator will utilize the same claim processing rules and/or edits that it utilizes in processing PPO Provider claims for processing claims submitted by Non-PPO Providers or Non-Solicited Providers which may also alter the amount considered for a particular service. In the event the Claim Administrator does not have any claim edits or rules, the Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the claims. The amount considered will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific claim, including, but not limited to, disproportionate share payments and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by the Claim Administrator within 90-145 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor. Usual and Customary Charges do not apply to services performed or materials furnished by a PPO Provider or Non-Solicited Provider.

The Claim Administrator and/or the Plan Administrator in determining if a charge is usual and customary may consider one or more of the following factors:

- The level of skill, extent of training and experience required to perform the procedure or service.
- The length of time required to perform the procedure or service compared to the length of time required to perform other similar procedures or services.
- The severity or nature of the Illness or injury being treated.
- The cost to the provider of providing the service or performing the procedure.
- The cost and availability of alternative modes of treatment.
- Whether the amount that would otherwise be payable to a Non-PPO Provider under the terms of the Plan exceed the amounts payable to a PPO Provider; and
- Such other factors as the Claim Administrator and/or the Plan Administrator, in the reasonable exercise of discretion determine are appropriate.

When multiple or bilateral procedures, which add significant time or complexity to patient care, are performed during the same operative session, the maximum limit for the procedures is the lesser of:

- The actual charges, or
- The U&C charge for the primary procedure plus the lesser of the actual charges for the secondary or bilateral procedures, or 50% of the U&C charges for the secondary and subsequent procedures.

When incidental procedures (e.g., incidental appendectomy, lysis of adhesions, excision of previous scar) are performed during the same operative session, the maximum limit for the procedures will be the lesser of the actual charges for the incidental procedures **or** the U&C charge for the primary procedure only.

When an inherent procedure is performed at the same operative session, the maximum limit for the procedures will be the lesser of the actual charge for the inherent procedure or the U&C charge for the primary procedure only.

When an assistant surgeon is Medically Necessary, the U&C charge for the assistant surgeon will be 20% of the U&C charge for the surgical procedure. If the actual charge for the surgical procedure is less than the U&C charge for the surgical procedure, the Eligible Charge for the assistant surgeon will be 20% of the actual charge for the surgical procedure.

#### Visit

Each personal attendance of a Covered Individual by a Physician or other eligible practitioner regardless of the type of professional service provided, whether termed as a consultation, treatment, or some other name, and regardless of whether the Deductible has been satisfied.

### **Waiting Period**

The period that must pass before an individual is eligible to be covered for benefits under the State Farm Group Medical PPO Plan. 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. Any period preceding a late or special enrollment is not a waiting period.

#### Wellness Assessment

A voluntary survey for Active 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.

## **EXHIBIT A**

# Active Employees as described in the section entitled *Eligible Employees*, items A.and J.

Definitions of capitalized terms may be found in Appendix C: Terms.

Plan Option	Option 2E		Option 3E - HRA		
Deductible Type	Traditional <sup>(1)</sup>		Aggregate <sup>(2)</sup>		
Deductible	All Providers		All Providers		
Individual	\$1,0	000	Employee Only		
Family	\$2,0	000	(no covered Dependents)		
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		` \$2,500		
			Employee plus one or more		
			Dependents		
			\$5,000		
HRA (a)			Employee Only		
Account <sup>(3)</sup>	Not Applicable		(no covered Dependents)		
			\$1,000 <sup>(4)</sup>		
			Employee plus one or more		
			Dependents		
Cainaviranaa	\$2,000 <sup>(4)</sup>				
Coinsurance	Services provided by PPO Providers: 10%				
Percentage Both	Emergency services provided by Non-PPO Providers: 10%				
Options	Services provided outside the United States: 10%				
Optiono	Services provided by Non-PPO Providers <sup>(5)</sup> : 40%				
	Services provided by Non-Solicited Providers: 10%  Preventive Care, Well-Child Care and Cancer Prevention Screenings (not subject to the Deductible)				
			ere: No	one (Paid at 100%)	
Plan Option	Option 2E		roviders: 40% Option 3E		
Out-of-	PPO Providers	Non-PPO	PPO Providers	Non-PPO	
Pocket	11 O I Toviders	Providers	11 O I Iovideis	Providers	
Expense		1 10 110010	Employee Only	Employee Only	
Limit			\$5,000 <sup>(2)(6)</sup>	\$7,500 <sup>(2)(6)</sup>	
Individual	\$3,000	\$5,000	Employee + 1 or	Employee + 1 or	
Family	\$6,000	\$10,000	more Dependents	more Dependents	
			\$10,000 <sup>(2)(6)</sup>	\$15,000 <sup>(2)(6)</sup>	
Prescription	Class of Drug	Generic	Primary Brand	Non-Primary	
Drug	Ü		(as approved by	Brand	
Coverage			CVS Caremark)		
Both	Coinsurance	20%	30%	50%	
Options	Percentage				
(not subject	Min <sup>(7)</sup> /Max: Retail	\$10 / \$25	\$10 / \$50	\$10 / \$75	
to	Min <sup>(7)</sup> /Max:	\$20 / \$50	\$20 / \$100	\$20 / \$150	
Deductible)	Mail Order	•			

#### **Endnotes:**

- (1) Traditional Deductible See Plan Document for more information.
- (2) Aggregate Deductible/Out-of-Pocket Expense Limit There are no "Individual" Deductible/Out-of-Pocket Expense Limits. See Plan Document for more information.
- (3) No part of the Active Employee's pre-tax or after-tax contribution will be used to fund the Health Reimbursement Arrangement (HRA).
- (4) Maximum amount of Company contributions per calendar year. This amount is prorated based on effective date of coverage. See Plan Document for more information.
- (5) Eligible Charges for radiology, pathology, and anesthesiology incurred from Non-PPO Providers will be paid at the PPO Provider Coinsurance rate of 90% subject to Usual and Customary Charges if the care is provided as a result of a PPO Provider hospitalization, PPO Provider outpatient surgery or PPO Provider Physician office Visit. Additionally, if Medicare is primary, Eligible Charges from Non-PPO Providers will be reimbursed at the PPO-Provider Coinsurance rate of 90%.
- (6) The Out-of-Pocket Expense Limit will be reduced by the amount of any HRA reimbursement for Covered Expenses within a calendar year.
- (7) If the actual cost of the drug is less than the minimum amount, the cost of the drug will be considered the minimum.

## **EXHIBIT B**

Inactive Employees as described in the section entitled *Eligible Employees*, items B., C., D., E., F., G., H., and I., Surviving Dependent Adults and Non-Medicare Eligible Dependents as described in the section entitled *Extension of Coverage*.

Definitions for capitalized terms may be found in *Appendix C: Terms*.

Plan Option	Pre-Medicare Retiree Option				
Deductible <sup>(1)</sup>	All Providers				
Individual	\$1,500				
Family	\$3,000				
Coinsurance	Services provided by PPO Providers: 10%				
<u>Percentage</u>	Emergency services provided by Non-PPO Providers: 10%				
	Services provided outside the United States: 10%			10%	
	Services provided by Non-PPO Providers <sup>(2)</sup> :			40%	
	Services provided by Non-Solicited Providers:			10%	
	Preventive Care, Well-Child Care and Cancer Prevention Screenings				
	(not subject to the Deductible)				
	Services provided by PPO Providers: None (Paid at 100%)				
		vided by Non-PPO F		40%	
Out-of-	PPO Providers		Non-PPO Providers		
Pocket					
Expense					
<u>Limit</u> Individual	<b>#5.000</b>		¢7.500		
Family	\$5,000 \$10,000		\$7,500 \$15,000		
<u>Prescription</u>	Class of Drug	Generic	Primary Brand	Non-Primary	
<u>Drug</u>			(as approved by	Brand	
Coverage (not subject	Coinsurance	20%	CVS Caremark) 30%	50%	
to	Percentage	20 /0	JU /0	3U /0	
Deductible)	Min <sup>(3)</sup> /Max: Retail	\$10 / \$25	\$10 / \$50	\$10 / \$75	
	Min <sup>(3)</sup> /Max: Mail Order	\$20 / \$50	\$20 / \$100	\$20 / \$150	

#### **Endnotes:**

<sup>(1)</sup> Traditional Deductible – See Plan Document for more information.

<sup>&</sup>lt;sup>(2)</sup> Eligible Charges for radiology, pathology, and anesthesiology incurred from Non-PPO Providers will be paid at the PPO Provider Coinsurance rate of 90% subject to Usual and Customary Charges if the care is provided as a result of a PPO Provider hospitalization, PPO Provider outpatient surgery or PPO Provider Physician office Visit. Additionally, if Medicare is primary, Eligible Charges from Non-PPO Providers will be reimbursed at the PPO-Provider Coinsurance rate of 90%.

<sup>(3)</sup> If the actual cost of the drug is less than the minimum amount, the cost of the drug will be considered the minimum.

## **EXHIBIT C**

Extension of Coverage and Company Contributions for Surviving Dependent Adults as described in the section entitled *Extension of Coverage - Surviving Dependent Adults*.

Death of an Active Employee					
If the Surviving Dependent Adult is covered under the Plan at the time of the Active Employee's death and:	And the Surviving Dependent Adult is Pre-Medicare Eligible; THEN				
The Active Employee passes away who meets the following requirements:  • Hired/rehired prior to January 1, 2007 and the Active Employee had at least 10 years of Company Service; or had at least 5 years of Company Service and whose age plus years of service equal or exceed 55 on the date of death	<ul> <li>The Surviving Dependent Adult and any eligible dependent child may extend coverage under the Plan,</li> <li>The Company will share in the cost of the coverage for the Surviving Dependent Adult and any eligible dependent child even in the event the child later becomes a Non-Medicare Eligible Dependent.</li> </ul>				
The Active Employee passes away who meets the following requirements:  • Hired/rehired on or after January 1, 2007 and the Active Employee had at least 15 years of Company Service on the date of death	<ul> <li>The Surviving Dependent Adult and any eligible dependent child may extend coverage under the Plan,</li> <li>The Company will not share in the cost of the coverage and the Surviving Dependent Adult will pay 100% of the cost of the coverage for the Surviving Dependent Adult and any eligible dependent child even in the event the child later becomes a Non-Medicare Eligible Dependent.</li> </ul>				
Death of an Inactive Employee	5 1				
If Surviving Dependent Adult is covered under the Plan at the time of the Inactive Employee's	And the Surviving Dependent Adult is				
death and:	Pre-Medicare Eligible; THEN				
<u> </u>					

## **ADDENDUM**

# ADDENDUM TO THE STATE FARM INSURANCE COMPANIES GROUP MEDICAL PPO PLAN FOR UNITED STATES EMPLOYEES

Any provision to the contrary notwithstanding, the State Farm Insurance Companies Group Medical PPO Plan for United States Employees (the "Plan") is hereby amended:

- To automatically re-enroll in Option 2T Medicare-Eligible Individuals ("Eligible Individuals" as defined in the State Farm Insurance Companies Health Reimbursement Arrangement Plan) who were covered under the Plan as of December 31, 2011, and who do not have coverage under individual Medicare Supplement or Medicare Advantage Plans with an effective date of coverage of January 1, 2012.
- 2. To provide coverage at no cost to those Eligible Individuals identified above for the first two months of 2012 and those Eligible Individuals who previously waived coverage under the Plan, do not have coverage under individual Medicare Supplement or Medicare Advantage Plans with an effective date of coverage of January 1, 2012, and elect to enroll in the Plan with an effective date of January 1, 2012.
- 3. To charge no more than \$75 for individual coverage, \$150 for two person coverage, and \$187.50 for three or more person coverage per month beginning March 1, 2012 for those Eligible Individuals identified in number 2 above.
- 4. To continue coverage for those Eligible Individuals identified in number 2 beginning on January 1, 2012 and ending on a date determined by the Welfare Benefit Administrative Committee based on Aon Hewitt Navigator's ability to complete the enrollment process.

This addendum is effective January 1, 2012.

Option 2T – Deductible and Out-of-Pocket Amounts – All other Plan provisions apply equally to this Option for the duration this Addendum is in effect.

<b>Deductible -</b> Traditional	Out-of-Pocket Expense Limit		
\$1,000 per individual	PPO Providers perform the	Non-PPO Providers perform	
\$2,000 per family	services:	the services:	
	\$3,000 per individual	\$5,000 per individual	
	\$6,000 per family	\$10,000 per family	