State Farm Insurance Companies
Health Care Flexible Spending Account Plan for U.S. Employees

Summary Plan Description

Effective January 1, 2023
# Table of Contents

Introduction .......................................................................................................................... 4

Eligibility ................................................................................................................................. 4
  Who Is Eligible ...................................................................................................................... 4
  Who Is Not Eligible ............................................................................................................ 4

Enrollment ............................................................................................................................. 5
  As a New Hire or Newly Eligible for Benefits ................................................................. 5
  As an Active Employee ...................................................................................................... 5
  Due to a Qualifying Event .................................................................................................. 5

When Coverage Begins ........................................................................................................ 7
  For a New Hire or Newly Eligible Employee .................................................................... 7
  For Active Employees ....................................................................................................... 7
  For Changes Due to a Qualifying Event ........................................................................... 7

How the Plan Works ............................................................................................................. 7
  Amount of Coverage ......................................................................................................... 7
  Eligible Health Care Expenses ....................................................................................... 8
  Dependent ......................................................................................................................... 8
  Reimbursement Period .................................................................................................... 8
  Carry-Over ......................................................................................................................... 9
  Effect on Taxes and Social Security Benefits .................................................................. 9
  Contribution Examples .................................................................................................... 9

Claiming Benefits ................................................................................................................. 10
  Payment of a Claim ........................................................................................................... 10

Claims and Appeals Procedures .......................................................................................... 11
  Claims Procedures .......................................................................................................... 11
  Denial of a Claim ............................................................................................................... 11
  How to Appeal a Denied Claim ....................................................................................... 12
  Review of Claim Appeals ................................................................................................. 12

When Coverage Ends ........................................................................................................... 12
  Termination of Employment ........................................................................................... 12

Continuing Coverage ......................................................................................................... 13
  During Family and Medical Leave Act (FMLA) ............................................................. 13
  During an Unpaid Leave of Absence (non-FMLA) ......................................................... 13
  During a Military Leave Protected by USERRA ............................................................. 13
  Consolidated Omnibus Budget Reconciliation Act (COBRA) ........................................ 13
Introduction

The State Farm Insurance Companies Health Care Flexible Spending Account Plan for U.S. Employees (“HCFSA” or “Plan”) is one of the benefit plan options offered under the State Farm Insurance Companies Group Health and Welfare Plan for United States Employees (Group Health and Welfare Plan). The Group Health and Welfare Plan together with all of the benefit plan options, including the HCFSA, constitute a welfare benefit plan under the Employee Retirement Income Security Act of 1974, as amended (“ERISA”). This Summary Plan Description describes the basic features of the HCFSA, how it operates, and how you can get the maximum advantage. The Plan described in this SPD is the Plan in effect as of January 1, 2023. Be sure to keep this SPD, along with notices of any Plan changes (summary of material modifications or SMM), in a safe and convenient place where you and your family can find and refer to them. It is provided for information purposes only and is not a contract of employment. It does not cover all provisions, limitations, and exclusions.

Under the HCFSA, you set aside funds from your before-tax pay to pay for eligible health care expenses that you otherwise would pay on an after-tax basis. State Farm does not contribute to the HCFSA.

In the case of a conflict between the information presented here and any of the benefit plans, the terms of the applicable plan shall govern. A complete copy of the State Farm benefit plans may be obtained from the State Farm Benefits Center.

Eligibility

Who Is Eligible

Eligible Active Employees

You are eligible to become a participant in the HCFSA if, based on the payroll records of State Farm Mutual Automobile Insurance Company (“State Farm” or the “Company”), you are employed by State Farm and you:

- Customarily work an average of 18 hours or more a week per pay period and work five continuous months or more during a year; or
- Are an Agent Intern.

If Both You and Your Spouse are State Farm Employees

If both you and your spouse are employed by State Farm and are eligible to enroll in the HCFSA, each of you can enroll and allocate up to the maximum amount allowed.

Who Is Not Eligible

You are not eligible for coverage under the HCFSA and are excluded from participation if you fit any of the following descriptions, even in the instance where a court or administrative agency determines you are a common law employee:
• Any director, unless you are otherwise regularly employed by the Company;

• Any person whose terms and conditions of employment are determined by a collective bargaining agreement between the Company and a labor union which does not make the Plan applicable to them;

• Any State Farm independent contractor agent, or an employee of State Farm independent contract agent;

• Any individual performing services for the Companies who is classified as an external associate per the Companies’ records, including but not limited to any external claim resource, any external resource of any kind, any contingent worker, any leased employee or any person otherwise operating or performing under a service provider agreement. 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 Companies and a leasing organization or similar organization; or

• Any employee operating under a Staff Assistance Agreement.

**Enrollment**

**As a New Hire or Newly Eligible for Benefits**

To participate, you must enroll in the Plan within 60 days of the date you first become eligible.

**As an Active Employee**

Each Employee is eligible to become a participant in the Plan, effective January 1 of the following year. Participation is elected by making a proper salary reduction election pursuant to the terms of The State Farm Insurance Companies Flexible Compensation Plan for U.S. Employees. Beginning January 1, 2021, an Employee who has a carry-over balance from a prior year shall automatically be a participant in the Plan for that calendar year even if they do not make a salary reduction election. The enrollment procedures will be communicated prior to each annual enrollment period.

**Due to a Qualifying Event**

In general, the benefit elections you choose during annual enrollment remain in effect for the full Plan Year and cannot be changed. However, if you have a Qualifying Event and satisfy the Consistency Requirements or if you satisfy the Other Coverage Events rules, you may be able to change your elections outside of annual enrollment. You must contact the State Farm Benefits Center within 60 days following the Qualifying Event (60 days if the event is loss of Medicaid or CHIP coverage and start of eligibility for state premium assistance) to provide notice of the Qualifying Event.

A new election will be prospective in nature and cannot be less than the amount already contributed.

For more information please refer to the State Farm Insurance Companies Flexible Compensation Plan for U.S. Employees Summary Plan Description.
Qualifying Events

The following are qualifying events:

- **Legal marital status:** Any event that changes your legal marital status including marriage, divorce, death of a spouse, legal separation, and legal annulment.

- **Number of dependents:** Any event that changes the number of your dependents including birth, adoption, placement for adoption, legal guardianship, and death.

- **Employment status:** Any event that changes your, your spouse’s, or dependent’s employment status such that results in gaining or losing eligibility for coverage. Examples of these events are commencing or terminating employment, a strike or lockout, commencing or returning from a leave of absence, a change in worksite, or a change in benefit Plan eligibility.

- **Dependent status:** Any event that causes your dependents to become eligible or ineligible for coverage because of age, gain or loss of student status, or marriage.

- **Residence change:** A change in the place of residence for you, your spouse, or your dependent.

Consistency Requirements

The changes you make to your coverage must be *due to and consistent with* your Qualifying Event. This means you must meet the following requirements:

- **Eligibility effect:** You, your spouse, or your dependent must become newly eligible or lose eligibility for coverage under a comparable employer plan. Coverage for the impacted Plan will terminate at the end of the month in which the qualifying event has occurred.

- **Change in coverage:** The change in coverage must correspond with the Qualifying Event. To change HCFSA coverage, eligibility for participation in HCFSA or a similar health care flexible spending account must have been affected.
  - *Example:* If the Qualifying Event is the birth of a child, you may increase your HCFSA election and pay the increased contribution with pre-tax dollars because your child is newly eligible for the Plan.
  - *Example:* If the Qualifying Event is a change in your residence, you may be able to change your medical plan (e.g., HMO to Medical PPO) because you are newly eligible for a new medical plan. However, you may not be able to change your HCFSA election because eligibility for the HCFSA was not impacted.

Other Coverage Events

You may make changes to your benefit coverage for other Qualifying Events in some instances such as:

- **Health Insurance Portability and Accountability Act of 1996 (HIPAA) special enrollment events:**
  - *Medicaid:* You or your dependent become entitled to or lose coverage under Medicaid.
CHIP: You or your dependent become entitled to or lose coverage under CHIP.

- Judgments, Decrees, Orders, or QMCSO: An election may be changed due to an order that requires accident or health coverage for your dependent child.

- Medicare or Medicaid entitlement: You, your spouse, or your dependent become entitled to or lose entitlement to coverage under Medicare or Medicaid.

- FMLA: You may terminate coverage when you begin an unpaid leave, subject to the provisions of FMLA. If your coverage terminates during the leave, upon your return, you will have the right to reinstate the same elections you had prior to the leave.

When Coverage Begins

For a New Hire or Newly Eligible Employee

Coverage generally begins the first day of the month following your date of hire. However, if you are hired on the first calendar day of the month, the effective date of coverage is your date of hire.

For Active Employees

For active employees who enroll during annual enrollment, coverage begins January 1.

For Changes Due to a Qualifying Event

Coverage is effective on the date of the Qualifying Event. However, any increase in coverage may only be used to reimburse expenses incurred on or after the date of the Qualifying Event.

How the Plan Works

Amount of Coverage

The amount you can contribute is subject to a minimum and a maximum.

<table>
<thead>
<tr>
<th>Year</th>
<th>Minimum</th>
<th>Maximum*</th>
</tr>
</thead>
<tbody>
<tr>
<td>2023</td>
<td>$120</td>
<td>$2,850</td>
</tr>
</tbody>
</table>

*The maximum is set by Human Resources and will not exceed the legally permitted maximum. The maximum does not include any permissible carry-over from a previous year. So, the maximum for 2023 would be $2,850 plus any permissible carry-over. (See Carry-Over provisions below.)

Your contributions will be made on a bi-monthly basis and taken out of your pay on a before-tax basis.
Eligible Health Care Expenses

To be eligible for reimbursement through the HCFSA, the expenses must meet all of the following conditions:

• They must be considered expenses for medical care under Internal Revenue Code Section 213(d), or be over-the-counter drugs, or menstrual products;
  
  o Group plan contributions, premiums, other payments for other insurance, a non-insurance health coverage or long-term care insurance, and payments for non-prescribed over-the-counter drugs are not eligible for reimbursement.

• They must not have not been reimbursed and must not be reimbursable under any other health plan coverage; and

• They must have been incurred on behalf of you or your dependents during the reimbursement period. A health care service is incurred on the date the care is provided or the date on which the prescribed medication is filled or device is received. The date on which the health care service is received is not based on the date the bill is received or the date on which the bill is paid.

Eligible expenses will only be reimbursed up to the amount of annual coverage elected for the Plan Year (reduced by prior reimbursements).

Dependent

A dependent is:

• Your spouse;

• Your child who, as of the end of the tax year, has not attained age 27. A child of divorced parents is treated as a dependent of both parents for this benefit; and

• In general, any person who is your dependent for tax purposes (more specifically, a dependent, as defined by Internal Revenue Code Section 152, but without regard to subsections (b)(1), (b)(2), and (d)(1)(B)).
  
  o This typically covers someone who is related to you if you provide over half of the individual’s support. Individuals who are related include: sons, daughters, stepsons, stepdaughters, brothers, sisters, stepbrothers, stepsisters, fathers, mothers, stepfathers, stepmothers, grandfathers, grandmothers, grandchildren, aunts, uncles, nephews, nieces, sons-in-law, daughters-in-law, fathers-in-law, mothers-in-law, brothers-in-law, sisters-in-law, or an individual who has the same principal place of abode and is a member of your household.

Reimbursement Period

To be eligible, health care expenses must be incurred during the reimbursement period. The reimbursement period begins on the first day for which you are enrolled and typically ends on the last day of the Plan Year. For a new hire or newly eligible employee, the reimbursement period may begin as early as the hire date or date of eligibility.
Carry-Over

If a participant has an outstanding credit in his/her Medical Reimbursement Account after the claim submission period has closed, such amounts will be carried forward for use in subsequent years. The maximum amount that may be carried forward shall be determined by the Vice President-Operations of Human Resources but will not exceed the applicable plan year limit established by the Internal Revenue Service.

Forfeiture

Following the end of the Plan Year and payment of all timely submitted eligible claims, amounts remaining in the Medical Reimbursement Accounts (in excess of the any carry over amount) may be used by the Company to offset expenses in administering the Plan.

Provided, any provision of the Plan to the contrary notwithstanding, where a Participant has properly appealed the denial of a claim and the appeal has not been finally resolved or the appeal has been finally resolved in favor of the Participant, no forfeiture shall take place as to any such balance in dispute. If any such claim is denied on appeal, the amount held beyond the end of the Plan Year shall be forfeited and may be used by the Company to offset expenses of administering the Plan.

Any outstanding uncashed checks at the close of the year following the year the check was initially issued shall also be deemed forfeited and may be used by the Company to offset expenses of administering the Plan. If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited and may be used by the Company to offset expenses of administering the Plan following a reasonable time after the date any such payment first became due.

Effect on Taxes and Social Security Benefits

You receive a tax advantage by paying for eligible health care expenses through the HCFSA because your spending account contributions are taken on a before tax basis. As such you have less income subject to income and Social Security taxes. If your taxable pay is below the Social Security taxable wage base, your future Social Security benefits may also be reduced. You may wish to consult with a tax advisor.

Contribution Examples

If your annual contribution to the HCFSA is $600 and you incur $700 in eligible health care expenses, $600 of the expenses would be reimbursed upon the submission of your claim, assuming no other expenses had already been claimed.

Alternatively, if your annual contribution is $300, and you incur only $200 in eligible health care services during the reimbursement period, you will receive only $200 in reimbursement, and the remaining $100 of your contribution will be forfeited.
Claiming Benefits

Payment of a Claim

Eligible claims incurred in the Plan Year must be received in a form acceptable to the plan Administrator within three months of the end of the Plan Year (March 31).

In order to be reimbursed for a health care expenses you must submit to the Plan Administrator an itemized bill from the service provider. The Plan Administrator may also provide you with a debit card to use to pay for qualified medical expenses. The Plan Administrator will provide you with further details about the debit card. Amounts reimbursed from the Plan may not be claimed as a deduction on your personal income tax return. As required by law, reimbursement from the fund shall be paid at least once a month.

Debit and Credit Cards

Participants may, subject to a procedure established by the Plan Administrator, and applied in a uniform nondiscriminatory manner, use debit and/or credit (stored value) cards (“cards”) provided by the Plan Administrator and the Plan for payment of Medical Expenses, subject to the following terms:

a. Card only for medical expenses. Each Participant issued a card shall certify that such card shall only be used for Medical Expenses. The Participant shall also certify that any Medical Expense paid with the card has not already been reimbursed by any other plan covering health benefits and that the Participant will not seek reimbursement from any other plan covering health benefits.

b. Card issuance. Such card shall be issued upon the Participant’s Effective Date of Participation and reissued or remain in effect for each Plan Year the Participant remains a Participant in the Plan. Such card shall be automatically cancelled upon the Participant’s death or termination of employment, or if such Participant has a change in status that results in the Participant’s withdrawal from the Plan.

c. Maximum dollar amount available. The dollar amount of coverage available on the card shall be the amount elected by the Participant for the Plan Year plus any carry-over from the previous year. The maximum dollar amount of coverage available shall be the maximum amount for the Plan Year as set forth by the Vice-President-Operations of Human Resources for that Plan year.

d. Only available for use with certain service providers. The cards shall only be accepted by such merchants and service providers as have been approved by the Plan Administrator.

e. Card use. The cards shall only be used for Medical Expense purchases as defined in the Plan.

f. Substantiation. Such purchases by the cards shall be subject to confirmation by the Plan Administrator, usually by requiring the Participant to submit a receipt from a service provider describing the service, the date and the amount. The Plan Administrator shall also follow the requirements set forth in Revenue Ruling 2003-43 and Notice 2006-69. All charges shall be conditional pending confirmation by the Plan Administrator.

g. Correction methods. If such purchase is later determined by the Plan Administrator to not qualify as a Medical Expense, the Plan Administrator, in its discretion, shall use one of the following correction methods to make the Plan whole. Until the amount is repaid, the Plan
Administrator shall take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card.

1. Repayment of the improper amount by the Participant;
2. Withholding the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal and state law;
3. Claims substitution or offset of future claims until the amount is repaid; and
4. If subsections (1) through (3) fail to recover the amount, consistent with the Employer's business practices, the Employer may treat the amount as any other business indebtedness.

You may be asked to provide a physician's statement for a claim to prove medical necessity.

To submit a claim or if you have questions regarding claims submissions, please contact:

Claims Department
P.O. Box 622317
Orlando, FL 32862-2317
1-800-380-6484

**Claims and Appeals Procedures**

**Claims Procedures**

Eligible claims incurred in the Plan Year must be submitted within three months of the end of the Plan Year (March 31).

Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that you are entitled to them. The determination process usually takes 5-7 business days but no longer than 60 days after receipt of the claim. This 60-day period may be extended one time for up to 15 days if the Plan Administrator determines that an extension is necessary due to matters beyond the control of the Plan. You will be notified within the 60 days of the circumstances requiring the extension and the date by which the decision will be rendered. If the extension is needed due to a failure to submit all necessary information, the notice will specifically describe the information needed, and you will have 45 days from receipt of notice to provide the information.

**Denial of a Claim**

The Plan Administrator will provide written or electronic notification of any claim denial. The notice will state:

- The reason or reasons for the denial;
- A reference to the specific Plan provisions on which the denial was based;
• A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; and
• A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of your right to bring a civil action under Section 502(a) of ERISA following a denial on review.

How to Appeal a Denied Claim

If your claim is denied, you will have a period of 180 days after receipt of notification of denial in which to appeal the decision. Your request must be in writing and submitted to:

State Farm
Flex Appeals Committee
One State Farm Plaza C-1
Bloomington, IL 61710-0001

The request must include documents, reports, or other evidence relied upon by you to support your position. To help you prepare a request, you may examine any pertinent Plan documents. If you do not request a review, you may not challenge the denial of your claim in any subsequent judicial or administrative proceeding.

Review of Claim Appeals

Upon receipt of your appeal, the Plan Administrator will make a decision after the request for review is submitted.

The decision on review will be provided in writing in a manner calculated to be readily understood and will include specific reasons for the decisions, as well as specific references to pertinent Plan provisions on which the decision is based. If the decision on review is not furnished within the time limits described in the preceding paragraph, the claim shall be deemed to be denied on review.

When Coverage Ends

Your coverage under the HCFSA will cease on the earliest of the following dates:

• The last day of the month in which your employment is terminated;
• The last day of the month in which the status change occurred or the last day of the prior month if status is on the first.
• The last day of the month in which you cease to be eligible;
• The last day of the Plan Year; or
• The date the Plan is terminated.

Termination of Employment

Any funds remaining in your HCFSA upon termination of employment can only be used to reimburse those health care expenses which were incurred before the end of the month in
which the termination occurred unless you elect after-tax continuation coverage (see Continuing Coverage).

HCFSA claims must be submitted by the terminating employee within three months after the end of the current Plan Year (March 31).

Rehire

If employment terminates and you are rehired within the same year, you will automatically be reinstated in the HCFSA as of the first of the month coincident with or following your date of rehire. Any missed contributions will be collected from the remaining pay periods.

If you are rehired in a Plan Year following your termination, you may enroll within 60 calendar days of your eligibility date.

**Continuing Coverage**

**During Family and Medical Leave Act (FMLA)**

FMLA entitles an eligible employee to take a job-protected leave for specified family and medical reasons such as for your own serious health condition, to care for a spouse, child, or parent who has a serious health condition, or the birth, adoption or foster care placement of your child.

If you are eligible for an FMLA leave, you may take up to a total of 12 weeks of leave each year, except where state law mandates a different leave period. If you take a leave of absence that qualifies under the FMLA your coverage in the HCFSA will continue, whether your leave is paid or unpaid. Any missed contributions will be collected from the remaining pay periods in the calendar year.

If you do not return to work at the end of your FMLA leave, you will be entitled to enroll in COBRA to continue your coverage.

**During an Unpaid Leave of Absence (non-FMLA)**

If you are an unpaid leave of absence (non-FMLA), your HCFSA coverage continues. If you return from leave within the same calendar year, your coverage will be reinstated and any missed contributions will be collected from the remaining pay periods of the year.

**During a Military Leave Protected by USERRA**

If you are on a paid or unpaid military leave that is protected by USERRA, your HCFSA coverage will continue. If you return from leave within the same calendar year, your coverage will be reinstated and any missed contributions will be collected from the remaining pay periods of the year.

**Consolidated Omnibus Budget Reconciliation Act (COBRA)**

In certain legally required situations, you and/or your qualified beneficiaries may request continuation of your coverage under COBRA if your coverage would otherwise end because of
a qualifying event. Qualified beneficiaries are those individuals who are covered under the Plan on the day before a qualifying event occurs.

**COBRA Qualifying Events**

If you are an employee of State Farm, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following events happen:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than gross misconduct.

If you are the spouse of an employee of State Farm, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following events happen:

- The employee dies;
- The employee’s hours of employment are reduced;
- The employee’s employment ends for any reason other than his or her gross misconduct; or
- You become divorced or legally separated from the employee.

If you are another eligible dependent of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following events happen:

- The employee dies;
- The employee’s hours of employment are reduced;
- The employee’s employment ends for any reason other than his or her gross misconduct;
- The employee becomes divorced; or
- The dependent stops being eligible for coverage under the Plan as a dependent.

For qualifying events such as the divorce or legal separation of the employee and spouse or a dependent losing eligibility for coverage as a dependent, it is your responsibility to notify the State Farm Benefits Center at 1-866-935-4015.

**Electing COBRA**

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the State Farm Benefits Center has been notified that a qualifying event has occurred.

When the qualifying event is the end of employment or reduction of hours of employment, death of the eligible employee, or the employee’s becoming entitled to Medicare, State Farm will notify the Benefits Center of the qualifying event.

It is your responsibility to notify the State Farm Benefits Center within 60 days following other events causing the loss of coverage and/or the date coverage ceases. Once you have notified the State Farm Benefits Center of your request, the continuation election and contribution payment procedures will be provided.
Duration of COBRA

HCFSA participants will be eligible for COBRA continuation coverage if they have positive account balances at the time of a qualifying event, taking into account all claims submitted before the date of the qualifying event. Generally, unless required by law, continuation coverage will not be available beyond the end of the year in which the qualifying event occurs.

Cost of and Payments for COBRA

Generally, you may be required to pay up to 102% of your monthly prorated annual election on an after-tax basis.

You must make your first payment for COBRA no later than 45 calendar days after the date of your election, the date the election notice is post-marked. If you do not make your first payment in full within 45 calendar days after the date of your election, you will lose all COBRA continuation coverage rights under the Plan.

Thereafter, you must pay for coverage on a monthly basis with payments due on the first day of each month for the coverage period.

Payments for COBRA continuation coverage must be sent to:

State Farm Benefits Center
4 Overlook Point
P.O. Box 1413
Lincolnshire, IL 60069-1413
1-866-935-4015

Grace Period for COBRA Payments

Although payments are due on the dates shown above, you will be given a grace period of 30 calendar days after the first day of the coverage period to make each periodic payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment.

Questions about COBRA

Questions concerning your COBRA continuation coverage rights must be addressed the State Farm Benefits Center.

Termination of Continuation Coverage

Continuation of the HCFSA benefits shall not be provided beyond whichever of the following dates is first to occur:

- The last day of the Plan Year in which the qualifying event occurs.
- The date the eligible employee or qualified beneficiary fails to pay the applicable HCFSA contribution on time.
- The date State Farm terminates the Plan.

COBRA continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA continuation coverage, such as fraud.
Administrative Information

Official Plan Document

This summary provides general information about the HCFSA, who is eligible to receive benefits under the Plan, what those benefits are, and how to obtain benefits. It is provided for information purposes only and is not a contract of employment. In the event of a conflict between this summary and the terms of the plan, the terms of the plan control. A copy of the Plan Document is available upon request to the State Farm Benefits Center.

Nondiscrimination Provisions

The HCFSA will not discriminate in favor of highly-compensated individuals with regard to eligibility, contributions, or benefits. To comply with IRS guidelines on nondiscrimination requirements, the Plan Administrator may impose a pro rata reduction of the benefit elections of all highly compensated employees in a uniform and non-discretionary manner. However, in no event shall such actions by the Plan Administrator result in a refund of elective contributions not used during a Plan Year which otherwise would have been forfeited.

Qualified Medical Child Support Order (QMCSO)

The components of this Plan that are group health plans extend benefits to a Participant’s noncustodial child, as required by any QMCSO, as defined in ERISA Section 609(a). If the Plan Administrator receives a judgment, decree, or order creating or recognizing the right of an Employee’s child or children to enroll in the Plan, the Plan Administrator will notify the Employee and the child (or the child’s designated representative) accordingly. The Plan Administrator has detailed procedures for determining whether an order qualifies as a QMCSO. If the judgment, decree, or order is determined to be a qualified medical child support order, the Plan Administrator will comply with such order.

Qualified Reservist Distribution (QRD)

Effective January 1, 2009, a Plan participant may request a QRD if they are a member of a reserve component (as defined in title 37 U.S.C. 101)* who is called to active duty for a period of 180 days or more or for an indefinite period. A QRD is a distribution to an individual of the balance in their HCFSA. The balance is the amount contributed to the HCFSA as of the date of the QRD request, less any reimbursements as of the date of the QRD request. A request for distribution must be made during the period beginning with the order or call to active duty and ending on the last day of the Plan Year that includes the date of the order or call to active duty.

*Paragraph 24 of section 101 of title 37 of the United States Code defines the term “reserve component” to mean: The Army National Guard of the United States; the Army Reserve; the Navy Reserve; the Marine Corps Reserve; the Air National Guard of the United States; the Air Force Reserve; the Coast Guard Reserve; or the Reserve Corps of the Public Health Service.

Modification or Termination of the Plan

The Compensation Committee of the Board of Directors of State Farm Mutual Automobile Insurance Company, as Plan Sponsor fully intends to continue the Group Health and Welfare Plan and its component benefit programs, including the HCFSA. 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 its component benefit options at any time, in whole or in part, without the consent of Plan participants and their beneficiaries.

Rules and Regulations

The Plan Administrator has 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 and the employees and their beneficiaries, and all other interested parties.

Additional Information

For general questions about the HCFSA, please contact the State Farm Benefits Center at 1-866-935-4015.

For specific information regarding account balances and the status of reimbursement requests, contact:

Claims Department
P.O. Box 622317
Orlando, FL 32862-2317
1-800-380-6484

If this summary plan description contains any statements that disagree with the complete HCFSA Plan document, the Plan document shall govern.

You may examine Plan documents during normal business hours at the Human Resources Department, Corporate Headquarters. Upon written request to the State Farm Benefits Center at 4 Overlook Point, P.O. Box 1413, Lincolnshire, IL 60069-1413, 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.

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 HCFSA may disclose protected health information (PHI) 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 HCFSA; or
• Modifying, amending, or terminating the HCFSA.

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 HCFSA shall not disclose protected health information to the Plan Sponsor unless the Plan Sponsor agrees to:

• Not use or further disclose the PHI other than as permitted by the Plan or required by law.
• Ensure that any agent (including a subcontractor) who receives PHI from the HCFSA, agrees in advance to the same restrictions and conditions that apply to the Plan Sponsor with respect to the PHI.
• Not use or disclose the PHI 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 HCFSA any use or disclosure of the information that is inconsistent with the uses or disclosures permitted herein.
• Make available to an HCFSA participant his or her PHI in accordance with HIPAA (45 CFR §164.524).
• Make available to an HCFSA participant who requests an amendment, the participant's protected health information and incorporate any amendments to the participant's PHI in accordance with HIPAA (45 CFR §164.526).
• Make available to an HCFSA participant who requests an accounting of disclosures of the participant's PHI, 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 HCFSA 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 PHI received from the HCFSA 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 HCFSA and the Plan Sponsor exists.

Certification of Plan Sponsor

The HCFSA shall disclose PHI to the Plan Sponsor only upon the receipt of a Certification by the Plan Sponsor that the HCFSA has been amended to incorporate the provisions of HIPAA (45 CFR §164.504(f)(s)(ii)), and that the Plan Sponsor agrees to the conditions of disclosure described above.
Permitted Uses and Disclosure of Summary Health Information

The HCFSA 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:

- Performing administrative functions which the Plan Sponsor performs for the HCFSA.
- Modifying, amending, or terminating the HCFSA.

Permitted Uses and Disclosure of Enrollment and Disenrollment Information

The HCFSA may disclose information on enrollment, disenrollment, and/or details on whether individuals are participating in the HCFSA 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 HCFSA.

Electronic Protected Health Information

The Plan Sponsor shall:

- 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 HCFSA;
- Ensure that the adequate separation required by 45 CFR §164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;
- 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
- Report to the HCFSA any security incident of which it becomes aware.

Adequate Separation Between Plan and Plan Sponsor

The Plan Sponsor shall only allow members of the Flex Appeals Committee and those members of the Corporate Law Department, the Accounting Department, the Human Resources Services Center, Total Rewards – Benefits and other supporting departments with responsibility for supporting and performing administrative functions for the HCFSA with access to PHI. Such employees shall only have access to and use PHI to the extent necessary to perform the supporting and administrative functions that the Plan Sponsor performs for the HCFSA. In the event that any 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.

Privacy Terms

For purposes of this provision, the following terms shall have the meaning described below unless otherwise provided by the HCFSA:

- **Protected Health Information**: means information that is created or received by the HCFSA 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.

For more information on the HCFSA’s privacy practices, please refer to the Notice of Health Insurance Portability and Accountability Act of 1996 Privacy Practices. This notice describes how medical information about plan participants may be used and disclosed and how you can get access to this information.

The Notice is located in the U.S. HR Policy Manual located on State Farm's intranet, accessible on the My State Farm Benefits Resource website at www.statefarmbenefits.com. You may also mail a request to:

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

**Summary Plan Description**


<table>
<thead>
<tr>
<th>Plan Information</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name of Plan</strong></td>
<td>State Farm Insurance Companies Group Health and Welfare Plan for United States Employees</td>
</tr>
<tr>
<td><strong>Name of Component Benefit Option</strong></td>
<td>The State Farm Insurance Companies Health Care Flexible Spending Account Plan for U.S. Employees</td>
</tr>
</tbody>
</table>
## Plan Information

<table>
<thead>
<tr>
<th>Plan Information</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Employer I.D. Number</strong></td>
<td>37-0533100</td>
</tr>
<tr>
<td><strong>Plan Number</strong></td>
<td>524</td>
</tr>
</tbody>
</table>
| **Plan Sponsor**       | Compensation Committee  
                         | State Farm Mutual Automobile Insurance Company  
                         | One State Farm Plaza, C-1  
                         | Bloomington, Illinois 61710 |
| **Type of Plan**       | Self-insured medical reimbursement plan |
| **Effective Date**     | The Plan is effective January 1, 2023 |
| **Plan Year Ends**     | A calendar year beginning on January 1 and ending on December 31 |
| **Plan Administrator** | The Plan Administrator and Named Fiduciary is the Welfare Benefit Administrative Committee.  
                         | Questions regarding participation should be directed to:  
                         | State Farm Benefits Center  
                         | 4 Overlook Point  
                         | P.O. Box 1413  
                         | Lincolnshire, IL 60069-1413  
                         | 1-866-935-4015  
                         | Claim administration is performed by a third party administrator. Questions regarding benefits or claims can be directed to:  
                         | Claims Department  
                         | P.O. Box 622317  
                         | Orlando, FL 32862-2317  
                         | 1-800-380-6484  
                         | All communication concerning the Plan can be directed to:  
                         | Welfare Benefit Administrative Committee  
                         | State Farm Mutual Automobile Insurance Company  
                         | One State Farm Plaza, C-1  
                         | Bloomington, IL 61710  
                         | 1-309-766-2623 |
| **Type of Administration** | Employer Administration |
| **Plan Funding**       | General assets of State Farm |
Your Rights Under ERISA

As a participant in the Group Health and Welfare Plan and its component benefit options, including the HCFSA, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants shall be entitled to the following.

**Receive Information About Your Plans and Benefits**

You may:

- Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites, all documents governing the benefit plans and a copy of the latest annual report (Form 5500 Series) filed for the Group Health and Welfare Plan and its component benefit options with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

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

- Receive a summary of the annual financial report for the Group Health and Welfare Plan and its component benefit options. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plans 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 plans on the rules governing your COBRA continuation coverage rights.

**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 plans, called “fiduciaries” of the plans, 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 Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, U.S. Employee Benefits Security Administration, 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 Employee Benefits Security Administration.