State Farm Insurance Companies
Retiree Health Reimbursement Arrangement Plan
For United States Employees

Summary Plan Description

Effective January 1, 2018

Table of Contents

Introduction

The State Farm Insurance Companies Retiree Health Reimbursement Arrangement Plan for United States Employees (“Retiree HRA” 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 Retiree HRA, 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 Retiree HRA and how it operates.

The Plan described in this SPD is the Plan in effect as of January 1, 2018. 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.

The Plan offers Medicare coordination services and a Health Reimbursement Arrangement. The Medicare coordination services are provided through Aon Retiree Health Exchange. The Aon Retiree Health Exchange contracts with medical carriers to offer Eligible Individuals individual Medicare Supplement, Medicare Advantage, and/or Medicare Prescription Drug Plans. Eligible Individuals are provided a Health Reimbursement Arrangement (HRA) account for use in reimbursing Covered Expenses during retirement. Alight Solutions (Your Spending Account or YSA) is the Claim Administrator.

Words that have a specific meaning are capitalized and are defined in Appendix A: Terms.

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.

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

Eligibility

Who Is Eligible

Eligible Individuals

An Eligible Individual is one who is eligible for Medicare due to age and meets one of the following requirements:

- Is an Inactive Employee who is covered under the State Farm Insurance Companies Group Medical PPO Plan for United States Employees, or who is eligible for, but not covered under that Plan, as of December 31, 2011;
    - In addition, if the Inactive Employee was 50 years of age or older as of January 1, 2012, his or her Dependents.
- Is an Inactive Employee who is or becomes eligible for Medicare due to age on or after January 1, 2012;
    - In addition, if the Inactive Employee was 50 years of age or older as of January 1, 2012, his or her Dependents.
- Is a Surviving Dependent Adult (and any eligible Dependent child) if, at the time of the Active Employee's death, the Dependent Adult was covered under a State Farm sponsored group medical plan and the Active Employee:
    - Passed away prior to January 1, 2012; and
    - Satisfied one of the following:
        - Was hired prior to January 1, 2007 and the 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; or
        - Was hired on or after January 1, 2007 and the employee was at least age 55 years of age and had at least 15 years of Company service on the date of death;
- Is a Surviving Dependent Adult (and any eligible Dependent child) if, at the time of the Inactive Employee's death, the Dependent Adult is either covered under the State Farm Insurance Companies Group Medical PPO Plan for United States Employees or would have been eligible if the Inactive Employee had not died and the Inactive Employee satisfies one of the following:
    - Was hired prior to January 1, 2007; or
    - Was hired or rehired on or after January 1, 2007 but prior to January 1, 2012, and the employee had at least 15 years of Company service on the date of retirement.
- Is a Dependent of an Inactive Employee if the Inactive Employee:
    - Was age 50 or older as of January 1, 2012;

- Is not eligible for Medicare due to age; and
- Is covered under the State Farm Insurance Companies Group Medical PPO Plan for United States Employees.

Only Inactive Employees and Dependents who were eligible for Medicare due to disability or End Stage Renal Disease (and not due to age) who remained on the Plan under the Second Addendum are Eligible Individuals.

Who Is Not Eligible

Inactive Employees whose most recent date of hire is on or after January 1, 2012, and their Dependents are not eligible for the Plan.

A Dependent Adult who is neither enrolled in the Group Medical PPO Plan nor covered under this Plan at the time of the Employee's death will not be considered a Surviving Dependent Adult and may not enroll at a later date.

Also, you are not eligible for coverage under the Retiree HRA 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 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 an Eligible Individual

In general, Eligible Individuals do not have to take action to enroll in the Plan. Prior to the date on which the Eligible Individual becomes eligible for Medicare due to age, regardless of the Eligible Individual's decision regarding the Aon Retiree Health Exchange, the Company will establish the HRA account for the Eligible Individual.

Marriage/Domestic or Civil Union Partnership to an Inactive Employee who is an Eligible Individual

If an Inactive Employee marries or enters into a domestic or civil union partnership and the spouse/partner is eligible for coverage, the Inactive Employee must enroll the Dependent Adult within 31 days of the marriage or partnership. If timely enrolled, the Dependent Adult will have an HRA contribution made on the first of the month in which the marriage/domestic or civil union partnership occurs. The amount of the contribution will be determined as described in the *Contributions* section. If the Dependent Adult is not an Eligible Individual, no HRA contribution will be made.

If a Dependent Adult is not enrolled within 31 days of the marriage or partnership, the next opportunity to have an HRA account established for the Dependent Adult, if eligible, will be January 1 following the Medicare open enrollment period, provided the Dependent Adult is enrolled in the Plan during the Medicare open enrollment period (generally October 15 through December 7). Otherwise, if the Dependent Adult is not an Eligible Individual, enrollment will be January 1 following the Medicare open enrollment period, provided the Dependent Adult is enrolled in the Plan during the Medicare open enrollment period.

How the Plan Works

The Plan offers Medicare coordination services (i.e., Aon Retiree Health Exchange) and a Health Reimbursement Arrangement. These are explained below.

Aon Retiree Health Exchange

Specially-trained Medicare coordinators provide Eligible Individuals with personal support to enroll on the Aon Retiree Health Exchange prior to the date the Eligible Individual is eligible for Medicare benefits. The Aon Retiree Health Exchange coordinators can explain how to take advantage of the dollars available and how to choose the individual medical insurance that best fits the Eligible Individual's personal needs and budget.

Enrollment Opportunities in the Aon Retiree Health Exchange

Eligible Individuals may enroll in individual supplemental policies on the Aon Retiree Health Exchange through the individual health carrier's website, on a three-way conference call between the Eligible Individual, a Medicare coordinator and the health carrier, or by paper.

Eligible Individuals will have the following opportunities to enroll with the Aon Retiree Health Exchange:

- Initial enrollment: Eligible Individuals will be notified of their initial enrollment opportunity with the Aon Retiree Health Exchange. The notification will provide an outline of the individual plans available including a benefits overview and price quote for each individual policy.
- Annual Enrollment: Eligible Individuals will have the opportunity to enroll annually as determined by the Centers for Medicare and Medicaid Services.
- Mid-year Changes: Eligible Individuals can make mid-year changes subject to the Centers for Medicare and Medicaid Services limitations.

Completing Enrollment in Individual Medicare Policies

Once the Eligible Individual chooses an individual Medicare Supplement, Medicare Advantage, and/or Medicare Prescription Drug Plan, a Medicare coordinator will assist with the enrollment application and any other forms that are required for the insurance provider(s) selected. There is no cost to Eligible Individuals for the Aon Retiree Health Exchange services.

Other Medicare Coordinator Services

Eligible Individuals that enroll in individual Medicare Supplement, Medicare Advantage, and/or Medicare Prescription Drug Plans through the Aon Retiree Health Exchange may also receive:

- Automated reimbursement of Covered Expenses through the HRA; and
- Special advocacy support for Medicare claims and coverage complexities.

Opting Not to Use the Aon Retiree Health Exchange

Eligible Individuals are not required to use the Aon Retiree Health Exchange Medicare coordinator services and may choose to purchase supplemental Medicare coverage on their own. In this case, individuals are responsible for submitting claims for HRA reimbursement of Covered Expenses. In addition, questions regarding Medicare claims and coverage complexities will be their responsibility and that of the agent and/or companies from whom coverage is purchased.

Health Reimbursement Arrangement (HRA) Account

The Company will establish and maintain an HRA account for Eligible Individuals. The HRA account will be a recordkeeping account for tracking contributions and reimbursement amounts.

- Crediting of Accounts: An HRA account will be credited based on the Company's determination of contributions, as detailed in the *Contributions* section.
- Debiting of Accounts: An HRA account will be debited during each Plan Year for any reimbursement of Covered Expense incurred during a Plan Year.
- Available Amount: The amount available for reimbursement of Covered Expenses is the amount credited to the HRA account reduced by any reimbursements that are debited.

Contributions

On January 1 of each year, the Company will make a maximum annual contribution of $2,400 per Eligible Individual to the HRA account. For Eligible Individuals that become covered mid-year, prorated contributions will be provided based on the number of months remaining in the year. The prorated contribution is based on $2,400 per year ($200 per month). For example, if a Dependent Adult becomes an Eligible Individual in April, a contribution of $1,800 will be added to the HRA ($200 monthly prorated contribution x 9 months remaining in the year = $1,800).

The Plan Sponsor reserves the right to change the benefits offered.

Covered Expenses

Covered expenses are limited to:

- Premiums that are paid for individual policies for:
    - Medicare Supplement;
    - Medicare Advantage; and/or,
    - Medicare Prescription Drug Plans.
- Out-of-pocket prescription drug costs (e.g., prescription drug deductibles, coinsurance and copays); and
- Contributions that are paid on an after-tax basis for group medical coverage provided by another employer (e.g., contributions paid by your Dependent Adult for coverage provided by his or her employer) or individual policies purchased as a bridge between Medicare eligibility and the effective date of Medicare enrollment.

HRA Account Balances

HRA account balances can only be used to reimburse Covered Expenses incurred after the establishment of the HRA account. No other expenses are eligible for reimbursement. Claims for reimbursement of expenses incurred during the year must be made by March 31st of the following year.

Example: Inactive Employee becomes an Eligible Individual on May 1

HRA Activity	Account Balance
May 1: The Inactive Employee becomes an Eligible Individual. A prorated contribution is made to the HRA ($200 x 8 months remaining in the year = $1,600)	On May 1, the available balance is $1,600.

Example: Dependent Adult Becomes an Eligible Individual Mid-Year

Inactive Employee that is an Eligible Individual has a Dependent Adult who becomes an Eligible Individual mid-year:

HRA Activity	Account Balance
January 1: On January 1, the annual allocation of $2,400 per Eligible Individual is made.	On January 1, the available balance is $2,400.
January 1 – May 31: Reimbursements are paid for Covered Expenses, totaling $500.	On May 31, the available balance is $1,900.
June 1: The Dependent Adult becomes an Eligible Individual on June 1. An additional allocation is made to the HRA, based on the number of months remaining in the year ($200 x 7 months = $1,400).	On June 1, the available balance is $3,300 ($1,900+$1,400).

Example: Inactive Employee Dies Mid-Year

Two Eligible Individuals and the Inactive Employee that is an Eligible Individual dies mid-year, the account balance will be as follows:

HRA Activity	Account Balance
January 1: On January 1, the annual allocation of $2,400 per Eligible Individual is made, for a total balance of $4,800.	On January 1, the available balance is $4,800.
January 1 – May 31: Claim reimbursements are paid for Covered Expenses, totaling $1,000.	On May 31, the available balance is $3,800.
June 3: The Eligible Individual who was the employee dies on June 3 and the account is transferred to the Surviving Dependent Adult's account.	On June 3, the account balance of $3,800 is transferred to the Surviving Dependent Adult.
June 3 – December 31: Claim reimbursements total $1,000.	On December 31, the year-end balance is $2,800.
January 1: The $2,800 balance from the previous year is carried over to the Surviving Dependent Adult's account and the new year's allocation of $2,400 is received.	On January 1 of the next year, the Surviving Dependent Adult's account has a balance of $5,200.

HRA Administrative Rules

Death of an Inactive Employee who is an Eligible Individual with Dependents

Any HRA account balance will transfer to the Dependent Adult if he or she is receiving HRA contributions under the Plan. Reimbursement of Covered Expenses incurred by the Dependent Adult and covered Dependents, if any, may continue. The amount of the HRA contribution will not be reduced in the year in which the Inactive Employee dies.

In the event there is no Surviving Dependent Adult, but there is a covered Dependent child, reimbursements for Covered Expenses will terminate at the end of the month in which the

Inactive Employee's death occurs, the remaining HRA balance (if any) will be forfeited, and no new contributions will be made on behalf of the Dependent child.

In the event an Inactive Employee enrolls a Dependent Adult, the Dependent Adult will be treated as a Surviving Dependent Adult upon the death of the Inactive Employee with respect to any remaining balance regardless of whether the Surviving Dependent Adult qualifies as an Eligible Individual. Such Surviving Dependent Adult may use the remaining balance for Covered Expenses until the balance is exhausted.

In the event the Inactive Employee's Dependent Adult is covered under the Group Medical PPO Plan at the time of Inactive Employee's death, the Dependent Adult will be treated as a Surviving Dependent Adult with respect to any remaining balance regardless of whether the Surviving Dependent Adult qualifies as an Eligible Individual when he or she becomes eligible for Medicare due to age. Such Surviving Dependent Adult may use the remaining balance for Covered Expenses until the balance is exhausted.

In the event the Inactive Employee has not enrolled his or her Dependent Adult in the Plan, or if the Dependent Adult is not covered under the Group Medical PPO Plan at the time of the Inactive Employee's death, the Dependent Adult will not be treated as a Surviving Dependent Adult or as an Eligible Individual.

Death of the Surviving Dependent Adult

In the event there is a covered Dependent child, reimbursements will terminate at the end of the month in which the Surviving Dependent Adult's death occurs, the remaining HRA balance (if any) will be forfeited, and no new contributions will be made on behalf of the Dependent child.

Divorce/Partnership Termination from an Inactive Employee who is an Eligible Individual

The balance in the HRA account will not be reduced for the year in which the divorce or partnership termination occurs. Covered Expenses for the Dependent Adult are reimbursable through the end of the month in which the divorce or partnership is final. Beginning in the new Plan Year after the divorce or partnership termination, the HRA contribution will be based on the number of Eligible Individuals remaining covered under the Plan. Any remaining HRA balance may be used by the Inactive Employee for reimbursement of his or her Covered Expenses.

Loss of Dependent Status

The balance in the HRA account will not be reduced for the year in which the loss of dependent status occurs. Covered Expenses for the Dependent are reimbursable through the end of the month in which the Dependent loses Dependent status. Beginning in the new Plan Year after the loss of Dependent status, the HRA contribution will be based on the number of Eligible Individuals remaining covered under the Plan. Any remaining HRA balance may be used by remaining Eligible Individuals for reimbursement of their Covered Expenses.

Death of a Dependent

The balance in the HRA account will not be reduced for the year in which the death of the Dependent occurs. Covered Expenses for the Dependent are reimbursable through the end of the month in which the Dependent's death occurs. Beginning in the new Plan Year after the death of the Dependent, the HRA contribution will be based on the number of Eligible

Individuals remaining covered under the Plan. Any remaining HRA balance may be used by remaining Eligible Individuals for reimbursement of their Covered Expenses.

Other Coverage

An Inactive Employee covered as a dependent on his or her Dependent Adult's active plan with another employer is eligible for HRA contributions subject to the *Contributions* section. The Inactive Employee cannot use HRA contributions to receive reimbursement for premiums paid for coverage under the Dependent Adult's group plan. However, the HRA account will be funded and available for use if the Inactive Employee decides to leave the Dependent Adult's group plan and purchase individual Medicare Supplement, Medicare Advantage, and/or Medicare Prescription Drug plans.

Carryover

Funds that are not used by the end of the Plan Year will rollover to the following Plan Year.

Claiming Benefits

Filing a Claim

Eligible Individuals may choose to file their claim online on the My State Farm Benefits Resource website at www.resources.hewitt.com/statefarm, or mail their claim. Online, Eligible Individuals will be asked to enter their claim information then fax, mail or upload claim documentation. Eligible Individuals, who prefer to file a claim on a paper form, may request a claim form from the benefits center and mail the claim documentation to: Your Spending Account, P.O. Box 64030, The Woodlands, TX 77387-4030.

Claims will be reviewed and processed upon receipt. Eligible Individuals will receive an Explanation of Benefits (EOB) and payment (if applicable) via check.

Deadline for Submitting Claims for Reimbursement

The deadline for submitting claims for reimbursement for the prior Plan Year is March 31.

Claims and Appeals Procedures

Denial of a Claim

If a Participant's claim is denied, the Claim Administrator will send notice in writing. The written notice will provide the following information:

- The specific reason or reasons for the denial;
- Specific references 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 as to why such material or information is necessary;
- The time limits applicable to such procedures and a description of the Participant's right to file a lawsuit following conclusion of the appeal process; and
- 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.

How to Appeal a Denied Claim

If a Participant's claim is denied, he or she may request a review of the claim. The written request should be sent to:

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

The request must be submitted within 180 days of the receipt of notice of the denial of your claim. If your request is not submitted within 180 days, the Participant will be deemed to have waived his or her right to review by the Welfare Benefit Appeal Committee.

The appeal should include any written comments, documents, records, and any other information the Participant wishes to submit to support his or her position. The Participant will also be provided, upon request and free of charge, copies of all documents, records and other information relevant to the Participant's claim.

The Welfare Benefit Appeal Committee will:

- Consider all comments, documents, records and other information submitted by the Participant without regard to whether such information was submitted or considered when the Participant's claim was first denied; and
- Decide the Participant's claim without deference to the initial claim denial.

The Welfare Benefit Appeal Committee will provide written notice of its decision within 30 days after receipt of the appeal. If the claim is denied by the Welfare Benefit 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 the Participant is entitled to receive, upon request and free of charge, copies of all documents, records and other information relevant to the claim;
- A description of the Participant's right to file a lawsuit challenging the Welfare Benefit Appeal Committee's decision; and
- A description of any internal rule, guideline, protocol or similar criterion used in deciding the claim or a statement that such a criterion was used in deciding the claim and that such criterion will be provided free of charge upon request.

If the Welfare Benefit Appeal Committee fails to notify the Participant of its decision within 30 days, the Participant's claim will be deemed to have been denied on review.

Legal Actions

The Participant may not sue to recover on any claim unless the Participant has first submitted a claim, the claim has been denied, and the Participant has exhausted his or her appeal rights described above. The Participant may not sue to recover on any claim after the expiration of 36 months from the last date the claim could have been submitted under this Plan.

Administrative Information

Official Plan Document

This summary provides general information about the Retiree HRA, including who is eligible to receive benefits under the Plan 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 benefits provided by the Plan, the Plan will control.

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

representative. Benefits under this Plan will be paid only if the Claim Administrator decides in its discretion that the person is entitled to them.

On non-claims issues, the Plan Administrator retains 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

Who to Contact	Additional Information Topic
Aon Retiree Health Exchange 1-888-628-2397 or online at www.resources.hewitt.com/statefarm **Your Spending Account** P.O. Box 64030 The Woodlands, TX 77387-4030 1-866-935-4015	• Questions about HRA reimbursement, balance or submission of claims • Speak with a benefits advisor to discuss options for individual Medicare supplemental coverage and/or to change plans • Advocacy services: assistance with Medicare claims/denials, carrier questions

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 State Farm Insurance Companies Retiree Health Reimbursement Arrangement Plan for United States Employees (the Plan) 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 Plan; or
- Modifying, amending, or terminating the Plan.

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

Conditions of Disclosure

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

- Not use or further disclose the PHI other than as permitted by the Plan or required by law.
- Ensure that any agent (including a subcontractor) who receives PHI from the Plan, 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 Plan any use or disclosure of the information that is inconsistent with the uses or disclosures permitted herein.
- Make available to the Plan participant his or her PHI in accordance with HIPAA (45 CFR §164.524).
- Make available to the Plan 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 a Plan 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 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 PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information feasible.
- Ensure that the adequate separation required by HIPAA (45 CFR §164.504(f)(2)(iii)) between the Plan and the Plan Sponsor exists.

Certification of Plan Sponsor

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

Permitted Uses and Disclosure of Summary Health Information

The Plan may disclose Summary Health Information to the Plan Sponsor, provided such Summary Health Information is only used by the Plan Sponsor for the purpose of:

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

Permitted Uses and Disclosure of Enrollment and Disenrollment Information

The Plan may disclose information on enrollment, disenrollment, and/or details on whether individuals are participating in the Plan to the Plan Sponsor, provided such enrollment and disenrollment is only used by the Plan Sponsor for the purpose of performing administrative functions that the Plan Sponsor performs for the Plan.

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 Plan;
- 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 Plan any security incident of which it becomes aware.

Adequate Separation Between Plan and Plan Sponsor

The Plan Sponsor shall only allow those members of the Total Rewards – Benefits and other supporting departments with responsibility for supporting and performing administrative functions for the Plan 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 Plan. 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 Plan:

- **Protected Health Information**: means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a member; the provision of health care to a member; or the past, present, or future payment for the provision of health care to a member, and that identifies the member or for which there is a reasonable basis to believe the information can be used to identify the member. Personal health information includes information of persons living or deceased. The following components of a member's information also are considered personal health information: 1) names; b) street address, city, county, precinct, zip code; c) dates directly related to a member, including birth date, health facility admission and discharge date, and date of death; d) telephone numbers, fax numbers, and electronic mail addresses; e) Social Security numbers; f) medical record numbers; g) health plan beneficiary numbers; h) account numbers; i) certificate/license numbers; j) vehicle identifiers and serial numbers, including license plate numbers; k) device identifiers and serial numbers; l) Web Universal Resource Locators (URLs) and Internet Protocol (IP) address numbers; m) biometric identifiers, including finger and voice prints; n) full face photographic images and any comparable images; and o) any other unique identifying number, characteristic, or code.
- **Summary Health Information**: means information that may be individually identifiable health information, and a) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and b) from which the information listed above as components of personal health information has been deleted, except that the geographic information need only be aggregated to the level of a five digit zip code.

For more information on the Plan’s privacy practices, please refer to the Health Insurance Portability and Accountability Act Notice of 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 the State Farm intranet, accessible on the My State Farm Benefits Resource website at www.resources.hewitt.com/statefarm. You may also mail a request to:

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

Summary Plan Description

The information contained in this document and the Summary Plan Description for the Group Health and Welfare Plan for United States Employees constitute a Summary Plan Description recognized by the Employee Retirement Income Security Act of 1974 (ERISA §102).

Plan Information	Details
Name of Plan	State Farm Insurance Companies Group Health and Welfare Plan for United States Employees
Name of Component Benefit Option	The State Farm Insurance Retiree Health Reimbursement Arrangement Plan for United States Employees
Employer I.D. Number	37-0533100
Plan Number	524
Plan Sponsor	Compensation Committee State Farm Mutual Automobile Insurance Company One State Farm Plaza, C-1 Bloomington, Illinois 61710
Type of Plan	Employee welfare benefit plan
Effective Date	January 1, 2018
Plan Year Ends	A calendar year beginning on January 1 and ending on December 31
Plan Administrator	The Plan Administrator 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 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
Plan Funding	The benefits payable under the Plan and the costs of administration will be paid from the general assets of State Farm Mutual Automobile Insurance Company and allocated to participating affiliates and subsidiaries through cost sharing agreements.

Plan Information	Details
Agent for Service of Legal Process	Service of legal process may be made upon the Plan Administrator or the designated agent: Michael Trout Vice President-Human Resources One State Farm Plaza Bloomington, Illinois 61710
Participating Companies	1. State Farm Mutual Automobile Insurance Company 2. State Farm Life Insurance Company 3. State Farm Life and Accident Assurance Company 4. State Farm Fire and Casualty Company 5. State Farm General Insurance Company 6. State Farm Indemnity Company 7. State Farm VP Management Corp. 8. State Farm Florida Insurance Company 9. State Farm International Holding Company

Your Rights Under ERISA

As a participant in the Group Health and Welfare Plan and its component benefit options, including the Retiree HRA, 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 description. 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 group health plan coverage.
- 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.

Appendix A: Terms

The following are definitions for words and phrases used in this summary plan description. Terms defined in this section are capitalized throughout the Summary Plan Description.

Active Employee
Active Employee means a person who, based on the payroll records of State Farm Mutual Automobile Insurance Company ("State Farm" or the "Company"), is or was employed by State Farm (or one of the participating Companies) and is or was eligible for the State Farm Insurance Companies Group Medical PPO Plan.

Aon Retiree Health Exchange
Aon Retiree Health Exchange provides Medicare coordination services by contracting with medical carriers to offer Eligible Individuals individual Medicare Supplement, Medicare Advantage, and/or Medicare Prescription Drug Plans.

Company Service
Company Service is the combination of time spent as an Active Employee or as a State Farm Agent.

Dependent
Dependents are those individuals who meet the following requirements, are eligible for Medicare due to age and have a Social Security Number (SSN) on file with the State Farm Benefits Center. This requirement is waived for foreign-born individuals that have not obtained an SSN. Dependent children will not be eligible unless an Inactive Employee or Surviving Dependent Adult is covered under either the Plan or the Group Medical PPO Plan for United States Employees.:

- An Inactive Employee's Spouse or Partner (Dependent Adult);
- An Inactive Employee's child who has attained 26 years of age, 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 or the custodial rules applicable in divorce situations), and the child is:
    - 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
    - Receiving over one-half of his or her annual support from the Inactive Employee (or the Inactive Employee's ex-spouse).

The Plan Administrator may require proof that the Inactive Employee's child qualifies as a Dependent.

Dependent Adult
Dependent Adult means the Employee's Spouse or Partner. An Inactive Employee can only have one Spouse or Partner enrolled in the Plan or the Group Medical PPO Plan for United States Employees at any one time.

Health Reimbursement Arrangement (HRA)
An unfunded account established by the Company for Eligible Individuals. Only Covered Expenses are eligible for reimbursement.

Illness Benefits Expired
"Illness Benefits Expired" is a term used when an Active Employee terminates employment with the Company who satisfies both of the following criteria:

- the Active Employee's absence:
  - begins prior to September 24, 2016, has exhausted all available paid sick leave, medical leave, and any leave for personal illness made available under federal, state or municipal law, or
  - begins on or after September 24, 2016, has exhausted all short-term disability benefits under the State Farm Short-Term Disability Plan, and any leave for personal illness made available under federal, state or municipal law, and
- is not released to return to work by his or her doctor and the Corporate Medical Director.

Inactive Employee
Inactive Employee means a person who meets one of the following requirements:

- An employee hired prior to January 1, 2007, who was an Active Employee on the day prior to retirement; was at least 55 years of age with 5 years or more of Company Service on the date of retirement, and elected to receive immediate income from the State Farm Insurance Companies Retirement Plan for United States Employees upon retiring;
- An employee whose most recent date of hire is on or after January 1, 2007, but prior to January 1, 2012, who was an Active Employee on the day prior to retirement; was at least 55 years of age with 15 years or more of Company Service on the date of retirement; and elected to receive immediate income from the State Farm Insurance Companies Retirement Plan for United States Employees upon retiring;
- An employee hired prior to January 1, 2007, who was an Active Employee on the day prior to termination who:
  - Terminated prior to January 1, 2018 due to Illness Benefits Expired and;
    - Was eligible to receive early retirement income under the State Farm Insurance Companies Retirement Plan for United States Employees, but chooses not to do so; and
    - Was and continues to be certified by the Corporate Medical Director, or the Director's designee, as Totally Disabled, or
  - Terminated prior to January 1, 2018 due to Illness Benefits Expired and;
    - Has at least 10 years of Company Service, or has 5 years or more of Company Service and whose age plus the number of years of Company Service equals or exceeds 55 on the date of termination; and
    - Was, and continues to be, certified by the Corporate Medical Director, or the Director's designee, as Totally Disabled, or

- An employee whose most recent date of hire is on or after January 1, 2007, but prior to January 1, 2012, who was an Active Employee on the day before termination and who:
    - Terminated prior to January 1, 2018 due to Illness Benefits Expired;
    - Was at least 55 years of age with 15 years or more of Company Service as of the date of termination; and
    - Was and continues to be certified by the Corporate Medical Director, or the Director's designee, as Totally Disabled;
- An employee hired prior to January 1, 2007, who was an Active Employee on the day before the "Date of Disablement" and who is a "Disabled Member" (as defined in the State Farm Insurance Companies Retirement Plan for United States Employees);
- An employee whose most recent date of hire is on or after January 1, 2007, but prior to January 1, 2012, who was an Active Employee on the day before the "Date of Disablement" and who is a "Disabled Member" (as defined in the State Farm Insurance Companies Retirement Plan for United States Employees) and was at least 55 years of age with at least 15 years of Company Service as of the date of termination;
- A retired Agency Manager who was an Active Employee 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; or
- An Agency Manager who was an Active Employee on the day prior to termination who terminated due to Total Disability, who 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.

Medicare
The medical benefits provided by Title XVIII of the Social Security Act as amended from time to time.

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

Participant
Any Employee who is or may become eligible to receive benefits under the Plan or whose Dependents may be eligible to receive any such benefit.

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.

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

Surviving Dependent Adult
The Spouse or Partner of a deceased Active or Inactive Employee.

Total Disability and Totally Disabled
Total Disability and Totally Disabled mean, as a result of Illness (as defined by the Group Medical PPO Plan for United States Employees) that:

- An Active Employee:
    - During the first 24 months, has the inability to engage in the Active Employee's normal occupation with the Company; and
    - After 24 months, has the inability to perform the duties of any occupation for which the Active Employee is or becomes qualified for based on education, training, or experience.
- An Inactive Employee or a Dependent, has the inability to perform the usual and customary duties or activities of a person in good health and the same age and sex.

The determination as to whether someone is Totally Disabled shall be made in accordance with procedures established by the Plan Administrator.