State Farm Insurance Companies
Health Reimbursement Arrangement Plan
Summary Plan Description

For United States Medicare-Eligible Retired Agents

Effective January 1, 2012

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

NAME OF PLAN

The name of the Plan is the State Farm Insurance Companies Health Reimbursement Arrangement Plan for United States Medicare-Eligible Retired Agents.

NAME, ADDRESS AND TELEPHONE NUMBER OF PLAN ADMINISTRATOR

State Farm Mutual Automobile Insurance Company
One State Farm Plaza
Bloomington, IL 61710-0001
(309) 766-6848

PLAN YEAR

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

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 ADMINISTRATOR

The Plan Administrator is the Welfare Benefit Administrative Committee, One State Farm Plaza, Bloomington, Illinois 61710 (1-309-766-6848). The Plan Administrator has the authority to control and manage the operation and administration of the Plan.

AGENT FOR THE SERVICE OF LEGAL PROCESS

Mary Schmidt, Vice President – Human Resources, has been designated as agent for service of legal process. Service of legal process may also be made upon the Plan Administrator.

HOW PLAN BENEFITS ARE PROVIDED

The purpose of the Plan is to contribute to the cost of coverage of individual Medicare Supplement, Medicare Advantage, and/or Medicare Prescription Drug Plans purchased through Aon Hewitt or other sources.

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

PLAN TERMINATION

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

AON HEWITT NAVIGATORS MEDICARE COORDINATOR SERVICES

Eligible Individuals

Eligible Individuals will receive personal support from specially trained Medicare coordinators prior to the date the Eligible Individual is Medicare-Eligible. The Aon Hewitt Navigators' Medicare coordinators will explain how to take advantage of the dollars available to an Eligible Individual and to choose the individual medical insurance that best fits the Eligible Individual's personal needs and budget and the advantages of enrolling in Aon Hewitt Navigators.

Enrollment Opportunities in Aon Hewitt Navigators

Eligible Individuals will have the following opportunities to enroll in Aon Hewitt Navigators.

(A) Initial enrollment – For Eligible Individuals who are Medicare-Eligible or who will become Medicare-Eligible prior to March 31, 2012, from the program's launch date (mid-September 2011) through March 31, 2012.

(B) Annual Enrollment – Beginning in 2012, annually from October 15 through December 31.

(C) Midyear changes - Centers for Medicare and Medicaid Services limitations apply.

Aon Hewitt Navigators will notify Eligible Individuals of their initial enrollment opportunity. The notification will provide an outline of the individual plans available to the Eligible Individual including a benefits overview and price quote for each individual policy.

Eligible Individuals may enroll in individual supplemental policies through Aon Hewitt Navigators:

(A) Through the individual health carrier's website,

(B) A three way conference call between the Eligible Individual, a Medicare coordinator, and the health carrier, or

(C) By paper.

Completing the Enrollment in Individual Medicare Policies

Once the Eligible Individual chooses an individual Medicare Supplement, Medicare Advantage, and/or Medicare Prescription Drug Plans available through Aon Hewitt Navigators, a Medicare coordinator will help him or her complete the enrollment application(s) prior to the date he or she becomes Medicare-Eligible and any other forms that are required to successfully enroll with the insurance provider(s) selected by the Eligible Individual. There is no cost to Eligible Individuals for the services of Navigators.

Other Medicare Coordinator Services

Eligible Individuals that enroll in individual Medicare Supplement, Medicare Advantage, and/or Medicare Prescription Drug Plans through Navigators may also receive:

(A) Automated reimbursement of Covered Expenses through the HRA;

(B) Special advocacy support for Medicare claims and coverage complexities.

OPTING OUT OF AON HEWITT NAVIGATORS

Eligible Individuals may opt out of using Aon Hewitt Navigators Medicare Coordinator Services and choose to purchase supplemental Medicare coverage on their own. However, these individuals will be responsible for submitting claims for 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)

General

The establishment of an HRA account by the Company is limited to Eligible Individuals.

Company Contributions

The Company shall make the following maximum annual contributions to the HRA accounts of the following individuals:

(A) For Medicare-Eligible Retirees as defined in (A), (C), and (E) of the "Medicare-Eligible Retiree" definition:
  (i) $2,400 for the Medicare-Eligible Retiree; and
  (ii) $2,400 for each covered Dependent.

(B) For Medicare-Eligible Retirees as defined in (B), (D) and (F) of the "Medicare-Eligible Retiree" definition:
  (i) $2,400 for the Medicare-Eligible Retiree; however,
  (ii) **No contributions will be made for Dependent coverage**.

(C) For Medicare-Eligible Surviving Dependent Adults as identified in Exhibit A:
  (i) $2,400 for the Surviving Dependent Adult; and
  (ii) $2,400 for each covered Dependent.

(D) For Dependents as identified in (D) of the "Eligible Individual" definition:
  (i) $2,400 for each covered Dependent.

If an Eligible Individual becomes a Covered Individual mid-year, the annual contribution of $2,400 will be prorated at $200 per Month. For example, a Medicare-Eligible Retiree's Dependent Adult becomes a Covered Individual on April 7, 2012, an additional contribution of $1,800 (9 Months times $200) will be added to the HRA.

Medicare-Eligible Retirees may receive a prorated contribution retroactive to their Medicare eligibility date, which may or may not coincide with the date they became Covered Individuals.

On January 1 of each year, Covered Individuals will receive the maximum annual contribution of $2,400.

Contributions Subject to Change

The amounts described above may be changed at any time by the Plan Administrator or the Plan Sponsor.

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.

Establishment of HRA Account

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

(A) Crediting of Accounts – An HRA account will be credited as described above.

(B) Debiting of Accounts – An HRA account will be debited during each Plan Year for any reimbursement of Covered Expense incurred during a Plan Year.

(C) Available Amount – The amount available for reimbursement of Covered Expenses is the amount credited to the HRA account under subsection (A) above reduced by any reimbursements debited under subsection (B).

HRA ADMINISTRATIVE RULES

Subject to the sections entitled; “Company Contributions,” “Contributions Subject to Change,” and “HRA Account Balances,” the following rules apply:

Death of the Medicare-Eligible Retiree or Inactive Agent with Dependents that are Eligible Individuals

Any HRA account balance will transfer to the Medicare-Eligible Dependent Adult if he or she is receiving HRA contributions under the Plan. Reimbursement of Covered Expenses incurred by the Medicare-Eligible 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 Medicare-Eligible Retiree dies. In the event there is no Medicare-Eligible 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 Medicare-Eligible Retiree’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 a Medicare-Eligible Retiree adds a Medicare-Eligible Dependent Adult, the Medicare Eligible Dependent Adult will be treated as a Medicare-Eligible Surviving Dependent Adult upon the death of the Medicare-Eligible Retiree with respect to any remaining balance regardless of whether the Surviving Dependent Adult is eligible for the HRA contribution as described in Exhibit A. Such Surviving Dependent Adult may use the remaining balance for Covered Expenses until the balance is exhausted.

In the event the Medicare-Eligible Retiree’s Dependent Adult is covered under the Group Medical PPO Plan at the time of the Medicare-Eligible Retiree’s death, the Dependent Adult will be treated as a Medicare-Eligible Surviving Dependent Adult with respect to any remaining balance regardless of whether the Surviving Dependent Adult is eligible for the HRA contribution as described in Exhibit A when he or she becomes eligible for Medicare. Such Surviving Dependent Adult may use the remaining balance for Covered Expenses until the balance is exhausted.

In the event the Medicare-Eligible Retiree does not add his or her Medicare-Eligible Dependent Adult, and if the Dependent Adult is not covered under the Group Medical PPO Plan at the time

of the Medicare-Eligible Retirees death, the Dependent Adult will not be treated as a Medicare-Eligible Surviving Dependent Adult.

Death of the Medicare-Eligible Surviving Dependent Adult

In the event there is a covered Dependent child, reimbursements will terminate at the end of the Month in which the Medicare-Eligible 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.

Marriage/Domestic or Civil Union Partnership

Medicare-Eligible Dependent Adults are eligible for an HRA contribution (for reimbursement of their Covered Expenses), effective the first of the Month in which the marriage/domestic or civil union partnership occurs provided the Medicare-Eligible Dependent Adult is added within 31-days of the marriage or partnership. The amount of the contribution will be prorated based on the number of Months remaining in the Plan Year.

Birth/Adoption

Medicare-Eligible Dependents are eligible for an HRA contribution, for reimbursement of their Covered Expenses, effective the first of the Month in which the birth/adoption occurs provided the Medicare-Eligible Dependent is added within 31-days of the birth/adoption. The amount of the contribution will be prorated based on the number of Months remaining in the Plan Year.

Divorce/Partnership Termination from Medicare-Eligible Retiree

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

Examples at the end of this Summary Plan Description illustrate the provisions of the HRA.

Other Coverage

A Medicare-Eligible Retiree covered as a dependent on his or her Dependent Adult's active plan with another employer is eligible for HRA contributions subject to the sections entitled "Company Contributions," "Contributions Subject to Change," and "HRA Account Balances." The Medicare-Eligible Retiree 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 Medicare-Eligible Retiree 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.

HOW TO FILE 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: PO Box 785040 Orlando, Florida 32878-5040. Claims will be reviewed and processed upon receipt. Eligible Individuals will receive an Explanation of Benefits (EOB) and payment (if applicable) via check.

Furnishing of Information

The Participant or other interested person shall provide to the Plan Administrator such pertinent information as the Plan Administrator may request, including proof or continued proof of eligibility, in such manner and form as the Plan Administrator may specify. No interested person shall be eligible for benefits under this Plan unless such information is provided by the Participant or on the Participant's behalf.

REVIEW OF CLAIM DENIAL

If a Participant's claim is denied by the Plan Administrator, he Plan Administrator will notify the Participant in writing. The written notice will provide:

(A) the specific reason or reasons for the denial,

(B) specific references to pertinent Plan provisions on which the denial is based,

(C) 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,

(D) 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

(E) 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.

Appeal Process

The Participant may submit his or her claim to the State Farm Group Medical Appeal Committee.

This written request must be submitted within 180 days of the receipt of notice of the denial of the claim for eligibility. If this written request is not submitted within 180 days, the Participant will be deemed to have waived his or her right to review by the State Farm Group Medical 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 State Farm Group Medical Appeal Committee will:

(A) 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

(B) decide the Participant's claim without deference to the initial claim denial.

The State Farm Group Medical Appeal Committee will give the Participant written notice of its decision within 30 days after receipt of the appeal. If the Participant's claim is denied by the State Farm Group Medical Appeal Committee, the following information will be provided in readily understandable language:

(A) the specific reason or reasons for the denial,

(B) specific reference to pertinent Plan provisions on which the denial is based,

(C) 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,

(D) a description of the Participant's right to file a lawsuit challenging the State Farm Group Medical Appeal Committee's decision,

(E) 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, and

(F) the following statement: "You and your plan may have other voluntary alternative dispute resolutions, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

If the State Farm Group Medical Appeal Committee fails to notify 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 as provided above under the section entitled "How To File A Claim," the claim has been denied, and the Participant has exhausted his or her appeal rights described above.

CONTACT INFORMATION

Reasons to Contact	Contact Name	Phone Number
• 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	Aon Hewitt Navigators	Aon Hewitt Navigators: 1-888-628-2397 Online at: www.resources.hewitt.com/statefarm Address for mailing claims: Your Spending Account P.O. Box 785040 Orlando, Florida 32878-5040

YOUR RIGHTS UNDER ERISA

Although State Farm agents are independent contractors and not Employees of State Farm, they will be treated for all purposes under the Plan as Plan participants.

As a participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to do the following.

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all Plan documents, including insurance contracts, and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan.

The people who operate your Plan are called "fiduciaries". Fiduciaries of the Plan have a duty to operate the Plan prudently and in the interest of you and other Plan participants and beneficiaries.

No one may discriminate against you in any way to prevent you from obtaining a welfare benefit, or exercising your rights under ERISA.

If your claim for a Plan benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials 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 Administrator.
If you have a claim for 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.

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 any assistance in obtaining documents from the Plan Administrator, you should contact the nearest area office of the U.S. Labor-Management Services Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline for the Pension and Welfare Benefits Administration.

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 Plan may disclose protected health information to the Plan Sponsor, provided the Plan Sponsor does not use or disclose such protected health information except for the following purposes:

- To perform administrative functions which the Plan Sponsor performs for the Plan; or
- Modifying, amending, or terminating the Plan.

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

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

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

- Make available to a Plan participant who requests an amendment, the participant's protected health information and incorporate any amendments to the participant's protected health information in accordance with HIPAA (45 CFR §164.526).
- Make available to a Plan participant who requests an accounting of disclosures of the participant's protected health information, the information required to provide an accounting of disclosures in accordance with HIPAA (45 CFR §164.528).
- Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA (45 CFR §164.504(f).
- If feasible, return or destroy all protected health information received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information feasible.
- Ensure that the adequate separation required by HIPAA (45 CFR §164.504(f)(2)(iii) between the Plan and the Plan Sponsor exists.

Certification of Plan Sponsor
The Plan shall disclose protected health information to the Plan Sponsor only upon the receipt of a Certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions of HIPAA (45 CFR §164.504(f)(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:

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

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

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

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

1. "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.

2. "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.

3. "Plan Sponsor" means State Farm Mutual Automobile Insurance Company, its affiliates and subsidiaries.

New York Orders of Protection
If State Farm Mutual Automobile Insurance Company as Plan Sponsor or John Hancock Life Insurance Company as Insurer receives a valid order of protection issued by a New York court with respect to a person covered by the group policy, the Plan Sponsor and the Insurer will be prohibited for the duration of the order from disclosing to the person against whom the order of protection was issued the address and telephone number of the insured person covered by the order of protection.

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

- Complete and submit the "New York Order of Protection Receipt Reporting Request" form found in State Farm Forms. To access the form, view the forms by Area and access the Administrative Services – Security forms file, and

- Send the paper copy of the Order of Protection to: Sheila Bury, Administrative Services, Concordville Operations Center AND to Total Rewards – Benefits at:

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

TERMS

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

Active Agent

"Active Agent" means a United States independent contractor agent of one or more of the Companies who is compensated for services rendered in the regular course of business of the Companies.

Aon Hewitt Navigators Insurance Services, Inc.

Aon Hewitt Navigators Insurance Services, Inc. ("Aon Hewitt Navigators") provides Medicare coordination services by contracting with medical carriers to offer Eligible Individuals individual Medicare Supplement, Medicare Advantage, and/or Medicare Prescription Drug Plans.

Companies

"Companies" means the Company and its participating affiliates and subsidiaries.

Company

"Company" means the State Farm Mutual Automobile Insurance Company of Bloomington, Illinois.

Company Service

"Company Service" means the combination of time spent as an Active Employee, as defined by the State Farm Insurance Companies Group Medical PPO Plan for United States Employees, or as an Active Agent.

Covered Expenses

"Covered Expenses" are limited to the premiums payable for individual Medicare Supplement, Medicare Advantage and/or Medicare Prescription Drug Plans.

Covered Individual

"Covered Individual" means an Eligible Individual who is receiving reimbursements for Covered Expenses under the Plan.

Dependent

"Dependent" means the following individuals who are eligible for Medicare:

(A) a Dependent Adult.

(B) a child who is under 26 years of age who is:

(i) the Medicare-Eligible Retiree's or Inactive Agent's biological child;

(ii) the Medicare-Eligible Retiree's or Inactive Agent's legally adopted child (a child is considered 'legally adopted' on the earlier of the date the child is in the Medicare-Eligible Retiree's or Inactive Agent's custody pursuant to an interim order of adoption or the date the child is lawfully placed in the Medicare-Eligible Retiree's or Inactive Agent's home for purposes of adoption);

(iii) the Medicare-Eligible Retiree's or Inactive Agent's stepchild whose biological parent is covered under the Plan or covered under the State Farm Insurance Companies Group Medical PPO Plan for United States Agent; or

(v) the Medicare-Eligible Retiree's or Inactive Agent's foster child who is placed with the Medicare-Eligible Retiree or Inactive Agent by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

(C) a child for whom the Medicare-Eligible Retiree or Inactive Agent is the court-appointed legal guardian who is:

(i) unmarried;

(ii) under 26 years of age;

(iii) meets the definition of dependent under Internal Revenue Code Section 152 (the Medicare-Eligible Retiree or Inactive Agent provides over one-half of the child's support without regard to the earned income limit or the custodial rules applicable in divorce situations).

(D) the Medicare-Eligible Retiree's or Inactive Agent's unmarried grandchild who is:

(i) in the care of the Medicare-Eligible Retiree or Inactive Agent pursuant to a court order of temporary custody;

(ii) under 26 years of age;

(iii) meets the definition of dependent under Internal Revenue Code Section 152 (the Medicare-Eligible Retiree or Inactive Agent provides over one-half of the grandchild's support without regard to the earned income limit or the custodial rules applicable in divorce situations).

(E) a Medicare-Eligible Retiree's or Inactive Agent'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:

(i) 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

(ii) actually receiving over one-half of his or her annual support from the Medicare-Eligible Retiree or Inactive Agent (or the Medicare-Eligible Retiree's or Inactive Agent's ex-spouse).

In order to be eligible under (E) above, due proof that the Medicare-Eligible Retiree's or Inactive Agent's child qualifies as a Dependent must be furnished to the Plan Administrator upon request.

Dependent Adult

"Dependent Adult" means the Medicare-Eligible Retiree's or Inactive Agent's Spouse or Partner. A Medicare-Eligible Retiree or Inactive Agent can only have one Spouse or Partner enrolled in the Plan or the Group Medical PPO Plan for United States Agents at any one time.

Eligible Individual

"Eligible Individual" means the following persons who are eligible for HRA contributions:

(A) A Medicare-Eligible Retiree identified in (A), (C), and (E) of the "Medicare-Eligible Retiree" definition and his or her Dependents.

(B) A Medicare-Eligible Retiree identified in (B), (D), and (F) of the "Medicare-Eligible Retiree" definition.

(C) A Medicare-Eligible Surviving Dependent Adult of an Active or Inactive Agent as described in Exhibit A as eligible for HRA contributions and the deceased Active or Inactive Agent's eligible Dependents.

(D) A Dependent of an Inactive Agent when the Inactive Agent is:

(i) age 50 or older as of January 1, 2012,

(ii) not eligible for Medicare, and

(iii) covered under the State Farm Group Medical PPO Plan for United States Agents.

NOTE: Neither Active Agents appointed or reappointed on or after January 1, 2012 nor their Dependents are eligible for HRA contributions under the Plan. Dependent children will not be considered Eligible Individuals if a Medicare-Eligible Retiree, Inactive Agent, or Surviving Dependent Adult is not covered under either the Plan or the Group Medical PPO Plan for United States Agents.

Health Reimbursement Arrangement (HRA)

An "HRA" is an unfunded account established by the Company for Eligible Individuals. Insurance premiums for individual Medicare Supplement, individual Medicare Advantage, and/or individual Medicare Prescription Drug Plans are eligible for reimbursement.

Inactive Agent

"Inactive Agent" means:

(A) a retired United States independent contractor agent of the Company appointed prior to January 1, 2007 who, on the date the State Farm Agent's Agreement terminates, is at least fifty-five (55) years of age, has five (5) years or more of Company Service preceding the termination of the Agent's Agreement and is not eligible for Medicare,

(B) a retired United States independent contractor agent of the Company appointed or reappointed on or after January 1, 2007 who, on the date the State Farm Agent's Agreement terminates, is at least fifty-five (55) years of age and has fifteen (15) years or more of Company Service preceding the termination of the Agent's Agreement and is not eligible for Medicare,

(C) a United States independent contractor agent of the Company that was appointed prior to January 1, 2007 who terminates his or her State Farm Agent's Agreement due to Total Disability and:

(1) has at least ten (10) years of Company Service preceding the termination of the State Farm Agent's agreement, or has five (5) years or more of Company Service preceding termination of the State Farm Agent's Agreement and whose age plus the number of years of Company Service equals or exceeds 55 as of the date of termination,

(2) is approved for Long Term Disability Benefits under the Agent's Group Long Term Disability Income Policy or, if the agent is not insured under the Agent's Group Long Term Disability Income Policy, is approved for Social Security Disability benefits, or, if the Agent is not approved for Social Security benefits, is certified by the Corporate Medical Director as Totally Disabled, and

(3) is not eligible for Medicare.

(D) a United States independent contractor agent of the Company appointed or reappointed on or after January 1, 2007 who terminates his or her State Farm Agent's Agreement due to Total Disability and:

(1) has at least fifteen (15) years of Company Service preceding the termination of the State Farm Agent's agreement,

(2) is approved for Long Term Disability Benefits under the Agent's Group Long Term Disability Income Policy or, if the agent is not insured under the Agent's Group Long Term Disability Income Policy, is approved for Social Security Disability benefits, or, if the Agent is not approved for Social Security benefits, is certified by the Corporate Medical Director as Totally Disabled, and

(3) is not eligible for Medicare.

Medicare

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

Medicare-Eligible Retiree

"Medicare-Eligible Retiree" mean the following persons:

(A) An Inactive Employee who is 50 years of age or older as of January 1, 2012, is Medicare eligible and who is covered under the State Farm Insurance Companies Group Medical PPO Plan for United States Agents, or who is eligible for, but not covered under that Plan, as of December 31, 2011.

(B) An Inactive Agent who is less than 50 years of age as of January 1, 2012, is Medicare eligible and who is covered under the State Farm Insurance Companies Group Medical PPO Plan for United States Agents, or who is eligible for, but not covered under that Plan, as of December 31, 2011.

(C) An Inactive Agent who becomes eligible for Medicare on or after January 1, 2012 and who is 50 years of age or older as of January 1, 2012.

(D) An Inactive Agent who becomes eligible for Medicare on or after January 1, 2012 and who is less than 50 years of age as of January 1, 2012.

(E) An Active Agent who is eligible for Medicare at the time of becoming an Inactive Agent who is 50 years of age or older as of January 1, 2012.

(F) An Active Agent who is eligible for Medicare at the time of becoming an Inactive Agent who is less than 50 years of age or older as of January 1, 2012.

Month

"Month" means one of the 12 months represented in a given calendar year.

Other Care Providers

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

Participant

"Participant" means a person who may be eligible to receive benefits under the Plan.

Partner

"Partner" means the person to whom the Medicare-Eligible Retiree or Inactive Agent 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

"Spouse" means the person to whom the Medicare-Eligible Retiree or Inactive Agent is legally married under the laws of the State in which the marriage is registered.

State

"State" means any of the 50 states of the United States of America, the District of Columbia or any similar unit of government in any other country.

Total Disability and Totally Disabled

"Total Disability" and "Totally Disabled" mean:

(A) with respect to an Active Agent, as a result of Illness (as defined by the Group Medical PPO Plan for United States Agents),

(i) during the first 24 Months, the inability to engage in the Active Agent's normal occupation with the Company; and

(ii) after 24 Months, the inability to perform the duties of any occupation for which the Active Agent is or becomes qualified for based on education, training, or experience.

(B) with respect to an Inactive Agent or a Dependent, the inability to perform the usual and customary duties or activities of a person in good health and the same age and sex.

EXAMPLES

All Examples Assume Eligibility Under the sections entitled "Company Contributions," "Contributions Subject to Change," and "HRA Account Balances."

Example 1:

For accounts beginning in 2012 with a Medicare-Eligible Retiree and a Medicare-Eligible Dependent Adult, if the Medicare-Eligible Retiree dies mid-year:

1/1/2012 - Allocation is $4800. ($2400 per Covered Individual)
Reimbursements paid 1/1 through 5/31 = $1000
Available balance is $3800.
Medicare-Eligible Retiree dies 6/3 - Account moves to survivor account with an available balance of $3800.
Reimbursements filed from 6/3 - 12/31 = $1000
Amount available to carryover to 2013 is $2800
2013 Survivor Account
1/1/2013 - carryover $2800
1/1/2013 - Allocation is $2400
Total available balance is $5200

Example 2:

For accounts with a single Medicare-Eligible Retiree who joins on May 1, 2012:

5/1/2012 – Allocation is $2400 prorated
$2400/12 months = $200
$200x8 months = $1600 Available balance

Example 3:

For accounts beginning in 2012 when a Medicare-Eligible Retiree adds a Medicare-Eligible Dependent Adult mid-year:

1/1/2012 - Allocation is $2400 for Medicare-Eligible Retiree
Reimbursements paid 1/1 through 5/31 = $500
Available balance is $1900.
Dependent Adult becomes Medicare-Eligible on 6/1/2012 – Allocation is $1400
($2400/12 months = $200
$200x7 months = $1400)
Available family balance on 6/1/2012 is $1900+$1400 = $3300

Example 4:

For accounts beginning 2012, when a Dependent child is covered under the Plan prior to the Medicare-Eligible Retiree and the Medicare-Eligible Retiree's Dependent Adult and the retiree and Dependent Adult become Medicare-Eligible mid-year:

1/1/2012 - Allocation is $2400 for child
Reimbursements paid 1/1 through 5/31 = $500
Available balance is $1900.
Dependent Adult becomes Medicare-Eligible on 6/1/2012 – Allocation is $1400
($2400/12 months = $200
$200x7 months = $1400)
Available family balance on 6/1/2012 is $1900+$1400 = $3300
Reimbursements paid 6/1 through 7/31 = $200
Available balance is $3100.
Retiree becomes Medicare-Eligible on 8/1/2012 – Allocation is $1000
($2400/12 months = $200
$200x5 months = $1000)
Available family balance on 8/1/2012 is $3100+$1000 = $4100

EXHIBIT A: ELIGIBILITY OF SURVIVING DEPENDENT ADULTS AND THEIR DEPENDENTS

Death of an Active Agent	
A Surviving Dependent Adult may be eligible if the Agent, upon death meets these requirements:	**And the Surviving Dependent Adult is Medicare Eligible; THEN**
Death prior to 1/1/2012 An **Active Agent** passes away prior to 1/1/2012 who meets the following requirements: • Appointed/reappointed prior to January 1, 2007 and the Agent 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.	• The Company will make a contribution to a Health Reimbursement Account (HRA) for the Surviving Dependent Adult and any Medicare-eligible dependents. • The Surviving Dependent Adult and any Medicare-eligible dependents can use the HRA for Covered Expenses.
Death prior to 1/1/2012 An **Active Agent** passes away prior to 1/1/2012 who meets the following requirements: • Appointed/reappointed on or after January 1, 2007 and the Agent **was at least 55 years of age** and had at least 15 years of Company service on the date of death.	• The Company will make a contribution to a Health Reimbursement Account (HRA) for the Surviving Dependent Adult and any Medicare-eligible dependents. • The Surviving Dependent Adult and any Medicare-eligible dependents can use the HRA for Covered Expenses.
Death prior to 1/1/2012 An **Active Agent** passes away prior to 1/1/2012 who meets the following requirements: • Appointed/reappointed on or after January 1, 2007 and the Agent **was under 55 years of age** and had at least 15 years of Company service on the date of death.	• The Surviving Dependent Adult and any Medicare-eligible dependents **are not eligible** for the Company contribution to a Health Reimbursement Account (HRA).
Death on or after 1/1/2012 An **Active Agent** passes away on or after 1/1/2012	• The Surviving Dependent Adult and any Medicare-eligible dependents **are not eligible** for the Company contribution to a Health Reimbursement Account (HRA).
Death of an Inactive Agent	
A Surviving Dependent Adult may be eligible if the Agent, upon death meets these requirements:	**And the Surviving Dependent Adult is Medicare Eligible; THEN**
An **Inactive Agent** appointed **prior to January 1, 2007**	• The Company will make a contribution to a Health Reimbursement Account (HRA) for the Surviving Dependent Adult and any Medicare-eligible dependents. • The Surviving Dependent Adult and any Medicare-eligible dependents can use the HRA for Covered Expenses.
An **Inactive Agent** appointed/reappointed **on or after January 1, 2007, but prior to January 1, 2012** who had at least 15 years of Company service on the date of retirement	• The Company will make a contribution to a Health Reimbursement Account (HRA) for the Surviving Dependent Adult and any Medicare-eligible dependents. • The Surviving Dependent Adult and any Medicare-eligible dependents can use the HRA for Covered Expenses.
An **Inactive Agent** appointed/reappointed **on or after January 1, 2012**	• The Surviving Dependent Adult and any Medicare-eligible dependents **are not eligible** for the Company contribution to a Health Reimbursement Account (HRA).

ADDENDUM

Any provision to the contrary notwithstanding, the State Farm Insurance Companies Health Reimbursement Arrangement Plan (the "HRA") is hereby amended as follows:

Under the section entitled "Company Contributions," for those individuals with coverage under individual Medicare Supplement or Medicare Advantage Plans with an effective date of coverage of January 1, 2012 who notify the Plan Administrator accordingly, the Company will add an additional $400 on a one time basis to the HRA accounts of those individuals who would otherwise be entitled to an annual contribution of $2,400 as of January 1, 2012 under the terms of the HRA.

This addendum is effective January 1, 2012.