

**THE STATE FARM INSURANCE COMPANIES
GROUP HEALTH AND WELFARE PLAN FOR
UNITED STATES EMPLOYEES**

SUMMARY PLAN DESCRIPTION

**Effective
January 1, 2012**

This document, together with the attached documents listed in Section 2, constitutes the Summary Plan Description required by ERISA §102.

State Farm Insurance Companies Group Health & Welfare Plan
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INTRODUCTION

This document is the Summary Plan Description that identifies and describes the Options that comprise the State Farm Insurance Companies Group Health and Welfare Plan for United States Employees offered by State Farm Mutual Automobile Insurance Company, its affiliates and subsidiaries (the “Company”). The Plan consists of Options described in more detail in the Attachments to this document and the attachments to the State Farm Insurance Companies Group Health and Welfare Plan for United States Employees (the “Plan”). Some of the Options provide coverage only to employees and some provide coverage to employees and their eligible dependents identified in the Plan as being eligible for coverage. The Plan described in this SPD is the Plan in effect as of January 1, 2012. Be sure to keep this SPD, along with notices of any Plan changes, in a safe and convenient place where you and your family can find and refer to them.

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1. DEFINITIONS

“**Attachments**” means the documents attached hereto describing in more detail the terms of the available Options.

“**COBRA**” means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

“**COBRA Administrator**” means the vendor designated by the Plan Administrator to handle the administration of continuation coverage under federal law.

“**Code**” means the Internal Revenue Code of 1986, as amended.

“**Company**” means State Farm Mutual Automobile Insurance Company, its affiliates and subsidiaries.

“**Effective Date**” means January 1, 2012.

“**Employee**” means any employee of the Company who is eligible for any of the Options described in the Attachments. The terms of the applicable Option shall control with respect to eligibility and participation.

“**ERISA**” means the Employee Retirement Income Security Act of 1974, as amended.

“**FMLA**” means the Family and Medical Leave Act of 1993, as amended.

“**Group Health Plan**” means an employee welfare benefit plan providing medical care to participants or beneficiaries directly or through insurance, reimbursement, or otherwise.

“**HIPAA**” means the Health Insurance Portability and Accountability Act of 1996, as amended.

“**HRA**” means a health reimbursement arrangement under which the Company reimburses eligible employees for specified expenses up to a maximum amount. To participate in this arrangement, eligible employees must be enrolled in the qualifying HRA option.

“**MHPA**” means the Mental Health Parity Act on 1996, as amended.

“**MHPAEA**” means the Mental Health Parity and Addiction Equality Act of 2008.

“**Named Fiduciary**” means the Welfare Benefit Administrative Committee.

“**NMHPA**” means the Newborns' and Mothers' Health Protection Act of 1996, as amended.

“**Option**” means any of the component benefit options described in Section 2 below.

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“**Plan**” means the State Farm Insurance Companies Group Health and Welfare Plan for United States Employees.

“**Plan Administrator**” means the Welfare Benefit Administrative Committee.

“**Plan Sponsor**” means the Compensation Committee of the Board of Directors of the State Farm Mutual Automobile Insurance Company.

“**Plan Year**” means the 12-month period beginning on January 1 and ending on the next following December 31.

“**USERRA**” means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

“**WHCRA**” means the Women's Health and Cancer Rights Act of 1998, as amended.

2. BENEFIT OPTIONS

The Plan Sponsor hereby establishes the Plan for the exclusive benefit of its Employees and their eligible spouses and dependents, effective as of the Effective Date. The Plan provides benefits through the following component benefit options (collectively, the “Options”).

- **The State Farm Insurance Companies Group Medical PPO Plan for United States Employees (“Medical PPO Option”) (Attachment #1);**
- **The State Farm Insurance Companies Group Medical Plan - Health Maintenance Organization (HMO) Option for United States Employees (“HMO Option”) (Attachment #2);**
- **The State Farm Insurance Companies Group Dental Plan for United States Employees (“Dental Option”) (Attachment #3);**
- **The State Farm Insurance Companies Group Vision Plan for United States Employees (“Vision Option”) (Attachment #4);**
- **The State Farm Insurance Companies Group Long-Term Care Plan for United States Employees (“Long-Term Care Option”) (Attachment #5);**
- **The State Farm Insurance Companies Long Term Disability Plan for United States Employees (“Long Term Disability Option”) (Attachment #6);**
- **The State Farm Insurance Companies Group Life and Accidental Death & Dismemberment Insurance Plan for United States Employees (“Group Life and AD&D Option”) (Attachment #7);**
- **The State Farm Insurance Companies Group Voluntary Accidental Death and Dismemberment Insurance Plan for United States Employees (“Group Voluntary AD&D Option”) (Attachment #8);**

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- **LifeWorks (Employee Assistance Program) for United States Employees (“Employee Assistance Option”)** (Attachment #9);
- **The State Farm Insurance Companies Flexible Compensation Plan for U.S. Employees (“Flexible Compensation Option”)** (Attachment #10);
- **The State Farm Insurance Companies Dependent Care Flexible Spending Account Plan for U.S. Employees (“DCFSA Option”)** (Attachment #11);
- **The State Farm Insurance Companies Health Care Flexible Spending Account Plan for U.S. Employees (“HCFSA Option”)** (Attachment #12);
- **The State Farm Insurance Companies Involuntary Severance Payment Plan (“Involuntary Severance Option”)** (Attachment #13);
- **The State Farm Insurance Companies Voluntary Severance Payment Plan (“Voluntary Severance Option”)** (Attachment #14);
- **The State Farm Insurance Companies Involuntary Severance Payment Plan for Florida Employees (“Florida Involuntary Severance Option”)** (Attachment #15);
- **The State Farm Insurance Companies Voluntary Severance Payment Plan for Florida Employees (“Florida Voluntary Severance Option”)** (Attachment #16);
- **The State Farm Insurance Companies Involuntary Severance Payment Plan for New Jersey Employees (“New Jersey Involuntary Severance Option”)** (Attachment #17); and
- **The State Farm Insurance Companies Health Reimbursement Arrangement Plan (“Retiree HRA Option”)** (Attachment #18).

Some of these Options require you to make an annual election to enroll for coverage. The details of such annual elections are described in the Attachments.

This document and its Attachments constitute the SPD for each of the Options to the extent required by ERISA §102.

3. GENERAL INFORMATION ABOUT THE PLAN

Plan Name: The State Farm Insurance Companies Group Health and Welfare Plan for United States Employees

Type of Plan: Welfare plan providing benefits under the following Options: Medical PPO Option (including an HRA option), HMO Option, Dental Option, Vision Option, Long-Term Care Option, Long Term Disability Option, Group Life and AD&D Option, Group Voluntary AD&D Option, Employee Assistance Option, Flexible Compensation Option, DCFSA Option, HCFSA Option, Involuntary Severance

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Option, Voluntary Severance Option, Florida Involuntary Severance Option, Florida Voluntary Severance Option, New Jersey Involuntary Severance Option, and the Retiree HRA Option.

Plan Year: January 1 - December 31

Plan Number: 524

Effective Date: January 1, 2012

**Funding Medium
And Plan**

Administration: Some benefits under the Plan are self-funded and some are fully insured. Below is a general description of the funding mechanisms for each Option. Please refer to the Attachments for more details.

Self-Funded: The Medical PPO Option, the Dental Option, the DCFSA Option, the HCFSA Option, the Involuntary Severance Option, the Voluntary Severance Option, the Florida Involuntary Severance Option, the Florida Voluntary Severance Option, the New Jersey Involuntary Severance Option, and the Retiree HRA Option are self-funded by the Company.

Fully Insured: The HMO Option, the Vision Option, the Long Term Disability Option, the Group Life and AD&D Option, the Group Voluntary AD&D Option, the Employee Assistance Option, and the Long-Term Care Option are fully insured by the HMO, the provider, or the insurer. The Company shares responsibility with the HMOs, the providers, and the insurers for administering these Options, as described in Section 7.

The cost of many of the benefits provided under the Options will be funded in part by Company contributions and in part by either pre-tax Employee contributions through the Flexible Compensation Option or by after-tax Employee contributions. The Company will determine and periodically communicate the Employee's share of the cost of the benefits provided under each Option, and it may change that determination at any time.

Note: Under some Options, the Company does not contribute to the cost of coverage. The Employee is responsible for the entire cost of coverage.

Contributions to the cost of coverage will be made by the Company and by the Employee in accordance with the terms of the applicable Attachment.

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Plan Sponsor: Compensation Committee of the Board of Directors of State Farm Mutual
Automobile Insurance Company
One State Farm Plaza
Bloomington, IL 61710
(309) 766-6848

**Plan Sponsor's
Employer
Identification
Number:**

37-0533100

**Insurance
Companies:**

Please refer to the Attachments for more information.

Plan Administrator: Welfare Benefit Administrative Committee
One State Farm Plaza
Bloomington, IL 61710
(309) 766-6848

Named Fiduciary: Welfare Benefit Administrative Committee
One State Farm Plaza
Bloomington, IL 61710
(309) 766-6848

For certain benefit claims, the HMO, the provider, or the insurer will act as the fiduciary in deciding claims. Please see Attachments for more details.

**Agent for Service
of Process:**

Mary Schmidt
Vice President-Human Resources
State Farm Mutual Automobile Insurance Company
One State Farm Plaza
Bloomington, IL 61710

Service for legal process may also be made on the Plan Administrator.

Contact Numbers: Contact numbers for each Option are listed in the applicable Attachment.

4. ELIGIBILITY AND PARTICIPATION REQUIREMENTS

An eligible employee with respect to the Plan will be any employee or former employee of the Company who is eligible to participate in and receive benefits under one or more of the Options described in the applicable Attachment.

Certain Options require that you make an annual election to enroll for coverage. Information about enrollment procedures, including when coverage begins and ends for the various Options is found within the Attachments. If you are an eligible employee, you may begin participating in the Plan upon your election to participate in an Option in accordance with the terms and conditions of that Option.

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Again, you should consult the enrollment procedures located within the Attachments for additional information.

Termination of Participation

The rules governing termination of coverage for each Option are set forth in the applicable Attachment.

Important Information About Your COBRA Continuation Coverage Rights

What is continuation coverage?

Federal law requires that most Group Health Plans give employees and their families the opportunity to continue their health care coverage when there is a “qualifying event” that would result in a loss of coverage under an employer’s plan. Depending on the type of qualifying event, “qualified beneficiaries” can include the employee (or retired employee) covered under a Group Health Plan, the covered employee’s spouse, and the dependent children of the covered employee.

Continuation coverage is the same coverage that is offered to other participants or beneficiaries who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights as other participants or beneficiaries.

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months. In the case of losses of coverage due to an employee’s death, divorce or legal separation, the employee’s becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement.

Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to USERRA. More information about coverage available pursuant to USERRA is included in the applicable Attachments.

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary first becomes covered, after electing continuation coverage, under another Group Health Plan that does not impose any preexisting condition exclusion for a preexisting condition of the qualified beneficiary,
- a qualified beneficiary first becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the employer ceases to provide any Group Health Plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of participant or beneficiary not receiving continuation coverage (such as fraud).

How can you extend the length of COBRA continuation coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the COBRA Administrator of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined under the Social Security Act (SSA) to be disabled. The disability has to have started at some time on or before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined to no longer be disabled under the SSA, you must notify the Plan of that fact within 30 days after that determination.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

How can you elect COBRA continuation coverage?

To elect continuation coverage, you must complete the Election Form provided by the COBRA Administrator, and furnish it according to the directions on the Form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have a 63-day gap in health coverage, and election of continuation coverage may help prevent such a gap. Second, you will lose the guaranteed right to purchase individual health coverage that does not impose a preexisting condition exclusion if you do not elect continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage.

Note that if you or your eligible family members qualify for COBRA continuation coverage, each Option is a separate option. Thus, for example, if you had coverage on the date of the qualifying event under the Medical PPO Option, the Dental Option, and Vision Option, and you elect COBRA, you can elect medical-only, dental-only or vision-only coverage, or any combination of these options.

The American Recovery and Reinvestment Act of 2009, as amended by the Department of Defense Appropriations Act, 2010, the Temporary Extension Act of 2010, and the Continuing Extension Act of 2010 (CEA), reduces the COBRA premium in some cases. The premium reduction is available to certain individuals who experience a qualifying event relating to COBRA continuation coverage that is an involuntary termination of employment during the period beginning with September 1, 2008 and ending with May 31, 2010 or a reduction of hours during the period beginning with September 1, 2008 and ending with May 31, 2010 that is followed by an involuntary termination of employment on or after March 2, 2010 and

by May 31, 2010. If you qualify for the premium reduction, you need only pay 35 percent of the COBRA premium otherwise due to the plan. This premium reduction is available for up to 15 months. If your COBRA continuation coverage lasts for more than 15 months, you will have to pay the full amount to continue your COBRA continuation coverage. See the section “Summary of the COBRA Premium Reduction Provisions under ARRA” for more details, restrictions, and obligations.

When and how must payment for COBRA continuation coverage be made?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the COBRA Administrator to confirm the correct amount of your first payment or to discuss payment issues related to the ARRA premium reduction.

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary and the timing of each payment will be provided to you. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage will continue for that coverage period without any break. The COBRA Administrator may send periodic notices of payments due for these coverage periods.

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Grace periods for periodic payments

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

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

For More Information

This information is only a summary of the continuation coverage provisions under the Plan. More information about continuation coverage and your rights under the Plan is available in the applicable Attachments or from the Plan Administrator.

Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you should keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Summary of the COBRA Premium Reduction Provisions under ARRA, as Amended

President Obama signed the American Recovery and Reinvestment Act (ARRA) on February 17, 2009. ARRA has been amended three times: on December 19, 2009 by the Department of Defense Appropriations Act, 2010, on March 2, 2010 by the Temporary Extension Act of 2010, and on April 15, 2010 by the Continuing Extension Act of 2010. These laws give "Assistance Eligible Individuals" the right to pay reduced COBRA premiums for periods of coverage beginning on or after February 17, 2009 and can last up to 15 months.

To be considered an "Assistance Eligible Individual" and get reduced premiums you:

- MUST have a continuation coverage election opportunity related to an involuntary termination of employment that occurred at some time from September 1, 2008 through May 31, 2010; #
- MUST elect the coverage;
- MUST NOT be eligible for Medicare; AND
- MUST NOT be eligible for coverage under any other Group Health Plan, such as a plan sponsored by a successor employer or a spouse's employer.*

The involuntary termination must occur on or after March 2, 2010 but by May 31, 2010 if it is preceded by a qualifying event that was a reduction of hours occurring at any time from September 1, 2008 through May 31, 2010.

◆ IMPORTANT ◆

- ◇ If, after you elect COBRA and while you are paying the reduced premium, you become eligible for other Group Health Plan coverage or Medicare you MUST notify the plan in writing. If you do not, you may be subject to a tax penalty.

* Generally, this does not include coverage for only dental, vision, counseling, or referral services; coverage under a health flexible spending arrangement; or treatment that is furnished in an on-site medical facility maintained by the employer.

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- ◇ Electing the premium reduction disqualifies you for the Health Coverage Tax Credit. If you are eligible for the Health Coverage Tax Credit, which could be more valuable than the premium reduction, you will have received a notification from the IRS.
- ◇ The amount of the premium reduction is recaptured for certain high income individuals. If the amount you earn for the year is more than \$125,000 (or \$250,000 for married couples filing a joint Federal income tax return) all or part of the premium reduction may be recaptured by an increase in your income tax liability for the year. If you think that your income may exceed the amounts above, you may wish to consider waiving your right to the premium reduction. For more information, consult your tax preparer or visit the IRS webpage on ARRA at www.irs.gov.

For general information regarding your plan's COBRA coverage and for specific information related to your plan's administration of the ARRA Premium Reduction or to notify the plan of your ineligibility to continue paying reduced premiums, contact the Plan Administrator or COBRA Administrator.

If you are denied treatment as an "Assistance Eligible Individual" you may have the right to have the denial reviewed. For more information regarding reviews or for general information about the ARRA Premium Reduction go to:

www.dol.gov/COBRA or call 1-866-444-EBSA (3272)

5. **SUMMARY OF PLAN BENEFITS**

The Plan may provide you and your eligible dependents with the opportunity to elect medical, dental, vision, long-term care, long term disability (employees only), accidental death and dismemberment insurance, and group term life insurance benefits. The Plan may also provide you with the opportunity to participate in the Flexible Compensation Option, the DCFSA Option, and the HCFSA Option. In addition, you may be eligible to receive severance, employee assistance benefits, and reimbursement for individual Medicare supplemental premiums in retirement. A summary of benefits and eligibility requirements for each Option provided under the Plan is set forth in the applicable Attachment.

Qualified Medical Child Support Orders

With respect to Options that are Group Health Plans, the Plan will also provide benefits as required by any qualified medical child support order (QMCSO) (defined in ERISA § 609(a)). The Plan has procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

Special Rights on Childbirth

Group Health Plans and health insurance issuers offering group insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than the above periods. In any case, such plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods.

6. HOW THE PLAN IS ADMINISTERED

Plan Administration

The administration of the Plan is under the supervision of the Plan Administrator.

Duties of the Plan Administrator

The principal duties of the Plan Administrator include, but are not limited to the following:

- (a) To make all reasonable rules and regulations required in the administration of the Plan and for the conduct of its affairs;
- (b) To administer the Plan in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan;
- (c) To appoint the members of the Group Medical Appeal Committee, the Severance Appeal Committee and the Flex Appeal Committee. The appointment of these members shall be in writing, shall expressly identify the delegate(s), and shall expressly describe the nature and scope of the delegated responsibility;
- (d) To keep and maintain the Plan documents and all other records pertaining to the Plan;
- (e) To appoint one or more claim administrators;
- (f) To perform all necessary tasks as required by ERISA; and
- (g) To establish and communicate procedures to determine whether a medical child support order is acceptable.

The Plan Administrator and its delegates have the discretionary authority to interpret the Plan in order to make eligibility and benefit determinations under the Medical PPO Option, the Group Life and AD&D Option, the Group Voluntary AD&D Option, the Flexible Compensation Option, the DCFSA Option, the HCFSA Option, the Voluntary Severance Option, the Involuntary Severance Option, the Florida Involuntary Severance Option, the Florida Voluntary Severance Option, the New Jersey Involuntary Severance Option and the Retiree HRA Option. In its administration of the Plan, the Plan Administrator and its delegates 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 or its delegates with respect to these Options shall be binding on Employees, their eligible dependents and all other interested parties. Benefits under these Options will be paid only if the Plan Administrator or its delegates decide in their discretion that the applicant is entitled to them.

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The Plan Administrator may delegate any of the duties outlined above among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegates, and expressly describes the nature and scope of the delegated responsibility.

The Company will bear the costs of administering the Plan.

7. **POWER AND AUTHORITY OF HMOs, INSURANCE COMPANIES, AND OTHER PROVIDERS**

The following Options are fully insured by a company other than the Company:

HMO Option

The HMO provider will depend upon the Employee's particular geographic location.

Vision Option

Vision Service Plan

Long-Term Care Option

John Hancock Life Insurance Company

Long Term Disability Option

Life Insurance Company of North America

Services under the following Options are provided by contract:

Dental Option

Connecticut General Insurance Company, a CIGNA company

Employee Assistance Option

Ceridian

The HMOs, the insurance companies, and other providers are responsible for determining eligibility and the amount of any benefits payable, prescribing the claims procedures to be followed and the claims forms to be used pursuant to the HMO Option, the Dental Option, the Long-Term Care Option, the Long Term Disability Option, the Vision Option, and the Employee Assistance Option. The HMOs, the insurance companies, and other providers and not the Company are responsible for paying claims with respect to these Options. The Company shares responsibility with the HMOs, the insurance companies, and other providers for the general administration of these Options.

8. **CIRCUMSTANCES THAT MAY AFFECT BENEFITS**

Benefits will cease in accordance with the terms of the applicable Attachment.

9. **AMENDMENT OR TERMINATION OF THE PLAN**

The Plan Sponsor has the right to amend or terminate the Plan at any time. The Plan may be amended or terminated by a written instrument duly adopted by the Plan Sponsor.

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The Plan Sponsor or its delegate may sign insurance contracts for this Plan on behalf of the Company, including amendments to those contracts, and may adopt (by a written instrument) amendments to the Plan.

10. CLAIMS PROCEDURES

Claims for Benefits – Options insured by companies other than the Company

Long-Term Care Option - John Hancock Life Insurance Company is responsible for reviewing claims for benefits and for deciding appeals of denied claims.

Long Term Disability Option - The Life Insurance Company of North America is responsible for reviewing claims for benefits and for deciding appeals of denied claims.

Vision Option - Vision Service Plan of Illinois is responsible for reviewing claims for benefits and for deciding appeals of denied claims.

If your claim for benefits is denied, you will receive a written notification setting forth the reasons for the denial. You may then file an appeal with the respective insurer for a review of the denied claim. The insurer or its delegate will decide the appeal in accordance with its reasonable claims procedures, as required by ERISA. If you do not appeal in a timely fashion, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court).

For purposes of determining the amount of and entitlement to benefits under these Options, the respective insurer is a fiduciary with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable policy of insurance.

More information regarding the claims procedures for these Options can be found in the applicable Attachment.

Claims for Benefits – HMOs

HMO Options – Your HMO is responsible for reviewing claims for benefits and for deciding appeals of denied claims.

If your claim is denied, you will receive a written notification setting forth the reasons for the denial. You may then file an appeal with your HMO for a review of the denied claim. The HMO or its delegate will decide the appeal in accordance with its reasonable claims procedures, as required by ERISA. If you do not appeal in a timely fashion, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court).

For purposes of determining the amount of and entitlement to benefits under this Option, your HMO is a fiduciary with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided by the HMO.

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More information regarding the claims procedures for the HMO Option can be found in the applicable Attachment.

Claims for Self-Funded Benefits

Medical PPO Option – Blue Cross and Blue Shield of Illinois (BCBSIL) is responsible for reviewing claims for benefits and for deciding appeals of denied claims. If your claim is denied on appeal, you may file an appeal with the Group Medical Appeal Committee.

If your claim is denied, you will receive a written notification setting forth the reasons for the denial. You may then file an appeal with BCBSIL for a review of the denied claim, and, if your claim is denied on appeal, with the Group Medical Appeal Committee. BCBSIL and the Group Medical Appeal Committee will decide the appeal in accordance with their reasonable claims procedures, as required by ERISA. If you do not appeal in a timely fashion, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court).

For purposes of determining the amount of and entitlement to benefits under this Option, BCBSIL and the Group Medical Appeal Committee (as a fiduciary) have the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided under the Medical PPO Option.

More information regarding the claims procedures for this Option can be found in the applicable Attachment.

Voluntary Severance Option, Involuntary Severance Option, Florida Voluntary Severance Option, Florida Involuntary Severance Option, and New Jersey Involuntary Severance Option – The Company is responsible for reviewing claims for benefits. If your claim is denied on appeal, you may file an appeal with the Severance Appeal Committee.

If your claim is denied, you will receive a written notification setting forth the reasons for the denial. You may then file an appeal with the Severance Appeal Committee for a review of the denied claim. The Severance Appeal Committee will decide the appeal in accordance with its reasonable claims procedures, as required by ERISA. If you do not appeal in a timely fashion, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court).

For purposes of determining the amount of and entitlement to benefits under these Options, the Severance Appeal Committee is a fiduciary with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided under these Options.

More information regarding the claims procedures for these Options can be found in the applicable Attachment.

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Retiree HRA Option – If your claim is denied by Aon Hewitt (the State Farm Insurance Companies Group Health and Welfare Plan’s benefit service provider), you may file an appeal with the Group Medical Appeal Committee.

The Group Medical Appeal Committee will decide the appeal in accordance with their reasonable claims procedures, as required by ERISA. If you do not appeal in a timely fashion, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court).

For purposes of determining the amount of and entitlement to benefits under this Option, the Group Medical Appeal Committee is a fiduciary with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided under this Option.

More information regarding the claims procedures for this Option can be found in the applicable Attachment.

Flexible Compensation Option - The Company is responsible for reviewing claims for benefits. If your claim is denied, you may file an appeal with the Flex Appeal Committee.

If your claim is denied, you will receive a written notification setting forth the reasons for the denial. You may then file an appeal with the Flex Appeal Committee for a review of the denied claim. The Flex Appeal Committee will decide the appeal in accordance with its reasonable claims procedures, as required by ERISA. If you do not appeal in a timely fashion, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court).

For purposes of determining the amount of and entitlement to benefits under this Option, the Flex Appeal Committee is a fiduciary with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided under this Option.

More information regarding the claims procedures for these Options can be found in the applicable Attachment.

DCFSA and HCFSA Options – If your claim is denied by Aon Hewitt (the State Farm Insurance Companies Group Health and Welfare Plan’s benefit service provider whose duties include claim administration for the Dependent Care Flexible Spending Account and the Health Care Flexible Spending Account Plan), you may file an appeal with the DCFSA/HCFSA Plan Appeals Committee.

If your claim is denied, you will receive a written notification setting forth the reasons for the denial. You may then file an appeal with the Appeals Committee for a review of the denied claim. The Appeals Committee will decide the appeal in accordance with its reasonable claims procedures, as required by ERISA, if applicable. If you do not appeal in a timely fashion, you will lose your right to file suit in a state or federal court, as you will not

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have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court).

For purposes of determining the amount of and entitlement to benefits under these Options, the Appeals Committee is a fiduciary with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided under these Options.

More information regarding the claims procedures for these Options can be found in the applicable Attachments.

Claims for Benefits - Policies of Insurance issued by the Company

Group Life and AD&D Option - State Farm Life Insurance Company is responsible for reviewing claims and the Group Medical Appeal Committee is responsible for deciding appeals of denied claims.

If your claim is denied, you will receive a written notification setting forth the reasons for the denial. You may then file an appeal with the Group Medical Appeal Committee. The Group Medical Appeal Committee will decide the appeal in accordance with its reasonable claims procedures, as required by ERISA. If you do not appeal in a timely fashion, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court).

For purposes of determining the amount of and entitlement to benefits under this Option, the Group Medical Appeal Committee is a fiduciary with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided under this Option.

More information regarding the claims procedures for this Option can be found in the applicable Attachment.

Group Voluntary AD&D Option - State Farm Mutual Automobile Insurance Company is responsible for reviewing claims and the Group Medical Appeal Committee is responsible for deciding appeals of denied claims.

If your claim is denied, you will receive a written notification setting forth the reasons for the denial. You may then file an appeal with the Group Medical Appeal Committee. The Group Medical Appeal Committee will decide the appeal in accordance with its reasonable claims procedures, as required by ERISA. If you do not appeal in a timely fashion, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court).

For purposes of determining the amount of and entitlement to benefits under this Option, the Group Medical Appeal Committee is a fiduciary with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided under this Option.

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More information regarding the claims procedures for this Option can be found in the applicable Attachment.

Claims for Benefits – Provided under Contracts

Dental Option - Connecticut General Life Insurance Company is responsible for reviewing claims and deciding appeals of denied claims.

If your claim is denied, you will receive a written notification setting forth the reasons for the denial. You may then file a level one appeal with Connecticut General Life Insurance Company followed by a level two appeal with the Connecticut General Life Insurance Company Committee. Connecticut General Life Insurance Company and the Committee will decide the appeal in accordance with their reasonable claims procedures, as required by ERISA. If you do not appeal in a timely fashion, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court).

For purposes of determining the amount of and entitlement to benefits under this Option, Connecticut General Life Insurance Company is a fiduciary with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided under this Option.

More information regarding the claims procedures for this Option can be found in the applicable Attachment.

Employee Assistance Option - Ceridian is responsible for reviewing claims for benefits and for deciding appeals of denied claims.

If your claim is denied, you will receive a written notification setting forth the reasons for the denial. You may then file an appeal with Ceridian for a review of the denied claim. Ceridian will decide the appeal in accordance with its reasonable claims procedures, as required by ERISA. If you do not appeal in a timely fashion, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court).

For purposes of determining the amount of and entitlement to benefits under this Option, Ceridian is a fiduciary with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided under this Option.

More information regarding the claims procedures for this Option can be found in the applicable Attachments.

11. NO CONTRACT OF EMPLOYMENT

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and the Company to the effect that you will be employed for any specific period of time.

12. COMPLIANCE WITH STATE AND FEDERAL MANDATES

With respect to the Options, the Plan will comply, to the extent applicable, with the requirements of all applicable laws, such as USERRA, COBRA, HIPAA, NMHPA (and the state version of NMHPA), WHCRA, MHPA, MHPAEA and FMLA.

13. PLAN DOCUMENTS

If the terms of this document conflict with the terms of the Plan, the terms of the Plan will control.

14. STATEMENT OF ERISA RIGHTS

Note that the Flexible Compensation Option and the DCFSA are not covered by ERISA and this Statement of ERISA Rights does not apply to these Options.

Your Rights: As a participant in the Plan, you are entitled, to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

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

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

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

Receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case the Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

**COBRA and HIPAA
Rights:**

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

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the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan 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 any denial, all within certain time schedules. Under ERISA, there are steps that you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500), if any, 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 per 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, and if you have exhausted the claims procedures available to you under the Plan (discussed in Section 10), 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 contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Attachments

Attachment #1: [Medical PPO Option](#)

Attachment #2: HMO Option* - See Endnote below

Attachment #3: Dental Option* - See Endnote below

Attachment #4: Vision Option* - See Endnote below

Attachment #5: Long-Term Care Option: [coverage provided under Group Policy 27281-LTC](#) (prior to 9/2006); [coverage provided under Group Policy 28862-LTC](#) (after 8/2006)

Attachment #6: Long Term Disability Option - retirees are not eligible to participate

Attachment #7: [Group Life and AD&D Option](#)

Attachment #8: Group Voluntary AD&D Option - retirees are not eligible to participate

Attachment #9: Employee Assistance Option (LifeWorks) - retirees are eligible to participate for 18 months after retirement date; phone 1-888-777-4774 for more information

Attachment #10: Flexible Compensation Option - retirees are not eligible to participate

Attachment #11: DCFSA Option - retirees are not eligible to participate

Attachment #12: HCFSA Option - retirees are not eligible to participate

Attachment #13: Involuntary Severance Option

Attachment #14: Voluntary Severance Option

Attachment #15: Florida Involuntary Severance Option

Attachment #16: Florida Voluntary Severance Option

Attachment #17: New Jersey Involuntary Severance Option

Attachment #18: [Retiree HRA Option](#)

* Retirees are not eligible to participate in these Options unless coverage is continued under COBRA.