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

Effective January 1, 2016


The Compensation Committee of the Board of Directors of State Farm Mutual Automobile Insurance Company, as the Plan Sponsor of the State Farm Insurance Companies Group Health and Welfare Plan for United States Employees, fully intends to continue the Group Health and Welfare Plan and this component benefit program. Nevertheless, the Compensation Committee of the Board of Directors reserves the right, in its sole and unfettered discretion, to amend, modify or terminate the Group Health and Welfare Plan or this component benefit program or its Policy 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.
State Farm Insurance Companies Health Care Flexible Spending Account Plan

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Name of Plan:

The name of the Plan is The State Farm Insurance Companies Health Care Flexible Spending Account Plan for U.S. Employees, referred to in this summary plan description as the “Plan.” The Plan is a component benefit Option (as that term is defined in the State Farm Insurance Companies Group Health and Welfare Plan for United States Employees) of the State Farm Insurance Companies Group Health and Welfare Plan for United States Employees.

Employer Name and Address:

This plan was established and is maintained by the State Farm Mutual Automobile Insurance Company, One State Farm Plaza, Bloomington, Illinois 61710.

In addition to State Farm Mutual Automobile Insurance Company, many of its subsidiaries and affiliates are also sponsors.

For purposes of identification, the number 524 has been assigned to the State Farm Insurance Companies Group Health and Welfare Plan for United States Employees. The Internal Revenue has assigned State Farm Mutual Automobile Insurance Company the employer identification number (EIN) 37-0533100. When writing about this component benefit Option, please identify the Group Health and Welfare Plan both by name and by the above two numbers.

Type of Plan:

Self-insured medical reimbursement plan.

Administration:

The State Farm Insurance Companies Health Care Flexible Spending Account Plan for U.S. Employees (HCFSA) is administered in accordance with the provisions of the Plan document. The Plan Administrator and Named Fiduciary is the Welfare Benefit Administrative Committee. The Plan Administrator has all records relating to the Plan, including admission thereto and eligibility for participation. All communication concerning the Plan should be directed to:

Welfare Benefit Administrative Committee
State Farm Mutual Automobile Insurance Company
One State Farm Plaza, C-1
Bloomington, IL 61710
1-309-766-2623
Questions regarding membership should be directed to the State Farm Benefits Center (SFBC) at 1-866-935-4015.

Claim administration will be performed by a third party administrator, Aon Hewitt. Questions regarding benefits or claims should be directed to:

Your Spending Account
P.O. Box 785040
Orlando, FL 32878-5040
1-866-935-4015

Service of Legal Process:

Annette R. Martinez, Vice President-Human Resources, One State Farm Plaza, Bloomington, Illinois 61710 is designated agent for service of legal process. In addition, service of legal process may be made upon the Plan Administrator.

Eligibility:

You are eligible to become a Participant in the Plan if, based on the Company's U.S. payroll records, you are a person in the employment of State Farm. The following persons are not Employees for purposes of this Plan and are excluded from participation:

1. Any director, unless he is otherwise regularly employed by the Company;
2. Any person whose terms and conditions of employment are determined by a collective bargaining agreement between the Company and a labor union which does not make the Plan applicable to them;
3. Any State Farm independent contractor agent or an employee of State Farm independent contract agent; and
4. Any individual performing services for the Companies who is classified as an external associate per the Companies’ records, including but not limited to any external claim resource, any external resource of any kind, any contingent worker, any leased employee or any person otherwise operating or performing under a service provider agreement. The term “leased employee” means an individual who is a “leased employee” within the meaning of Section 414(n)(2) of the Internal Revenue Code and any other person who provides services to the Companies pursuant to an agreement between the Companies and a leasing organization or similar organization.
5. Any employee operating under a Staff Assistance Agreement.

In each case with respect to those individuals described in clauses 1 - 4, regardless of whether a court or administrative agency determines at any time that any such individual is a common law employee.
Effective Date:

The Plan, as amended through March 13, 2016, is effective January 1, 2016.

Plan Year:

A calendar year beginning on January 1 and ending on December 31.

Participation:

Participation in the Plan is elected by allocating a portion of your salary to this Plan under the terms of the State Farm Insurance Companies Flexible Compensation Plan for U.S. Employees. The minimum amount that may be allocated to the Plan is $120; the maximum limit under the Plan for any Plan Year shall be determined by the Vice President-Operations of Human Resources, but in no event will exceed the applicable plan year limit established under Code Section 125(i).

<table>
<thead>
<tr>
<th>Year</th>
<th>Limit</th>
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<tbody>
<tr>
<td>2017</td>
<td>$2,550</td>
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</table>

If you are a new Employee or rehired Employee, the effective date of your elections is the first day of the following month unless you are hired on the first calendar day of the month. The effective date of coverage for employee hired on the first calendar day of the month is the date of hire. You must make your election to participate within 31 days from the date you became an employee.

Note: Elections may not be amended after the Plan Year begins unless the revocation of the current election and the making of a new election are consistent with the Qualifying Event rules. (See "Elections" and "Mid-Year Election Changes" in Flexible Compensation Summary Plan Description.). Mid-Year Election Changes are made prospectively (in the future) and when making a reallocation the amount reallocated may not be less than the amount that the Employee had already contributed. Only claims incurred on or after the date of the qualifying event will be considered for reimbursement.

Only claims incurred on or after your effective date of coverage (and within the Plan Year) will be considered for reimbursement.

If you cease to satisfy the definition of Employee, your participation in the Plan will end (see Termination of Employment and Continuation Coverage later).

Benefits:

Upon the submission of a proper reimbursement claim for eligible medical expenses (see below), including adequate documentation, a Participant, former Employee, or other
beneficiary, will be reimbursed in an amount that does not exceed the greater of the amount of the claim or the amount of annual coverage elected by such person for the Plan Year (reduced for prior reimbursements). However, no person shall be entitled to receive any amount credited to his or her account except as reimbursement for eligible medical expenses. Thus, if your annual allocation to your account under this Plan is $600 (with a contribution of $50 per month) and you incurred $700 in eligible medical expenses in January, $600 of the expenses would be reimbursed upon the submission of your claim (assuming no other expenses had already been claimed). Likewise, if your annual allocation is $300, and you receive only $200 in medical services during the reimbursement period, you will receive only $200 in reimbursement. Following the end of the Plan Year and the submission of all eligible expenses, unreimbursed amounts remaining in accounts will be forfeited and may be used by the Company to offset expenses of administering the Plan.

Medical Expenses:

The Company will reimburse out-of-pocket medical expenses which:

1. Are considered expenses for medical care under Internal Revenue Code section 213, but not including Group Plan contribution/premiums and other payments for other insurance, a non-insurance health coverage or long-term care insurance, and payments for over-the-counter drugs (prescribed over-the-counter drugs are still eligible with an actual prescription and/or physician’s statement);
2. Have not been reimbursed or are not reimbursable under any other health plan coverage;
3. Are incurred in the reimbursement period on behalf of a Participant or his or her dependents. Medical service is incurred on the date the medical care is provided or the date on which the prescribed medication is filled or device is received. The date on which the medical service is received is not based on the date the bill is received nor the date on which such bill is paid. The “reimbursement period” begins on the first day of the period for which the person is enrolled and ends with the earlier of the last day of the year or the last day of period for which the person is enrolled. For employees who sign up during annual enrollment, remain employed throughout the year, and do not make any changes during the year, the reimbursement period is the full calendar year. For a new employee, the reimbursement period may begin as early as his/her hire date; and
4. Are not more than the amount of annual coverage elected by such person for the Plan Year (reduced by prior reimbursements).

When medical necessity is not clear, a Physician's Statement is required to determine eligibility. The statement must list the disease or medical condition and the prescribed service, duration, treatment, or equipment necessary to alleviate the disease or medical condition.

Group health plans 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 caesarean
section, or require that a provider obtain authorization from the plan for prescribing a length of stay not in excess of the above periods.

**Dependent:**

A “dependent” includes:
- the participant's spouse,
- a child who, as of the end of the tax year, has not attained age 27; and
- in general, any person who is a dependent of the participant for tax purposes (more specifically, a dependent, as defined in Internal Revenue Code Section 152, but without regard to subsections (b)(1), (b)(2), and (d)(1)(B)). This typically picks up someone who is related to the participant if the participant provides over ½ of the individual’s support. Individuals who are related include: Sons, daughters, stepsons, stepdaughters, brothers, sisters, stepbrothers, stepsisters, fathers, mothers, stepfathers, stepmothers, grandfathers, grandmothers, grandchildren, aunts, uncles, nephews, nieces, sons-in-law, daughters-in-law, fathers-in-law, mothers-in-law, brothers-in-law, or sisters-in-law.

A child of divorced parents is treated as a dependent of both parents for purposes of this subsection.

**Qualified Medical Child Support Orders:**

If the Plan Administrator receives a judgment, decree, or order creating or recognizing the right of an Employee's child or children to enroll in the Plan, the Plan Administrator will notify the Employee and the child (or the child's designated representative) accordingly. The Plan Administrator will then determine whether the judgment, decree, or order is a qualified medical child support order. If the judgment, decree, or order is determined to be a qualified medical child support order, the Plan Administrator will comply with such order.

**Qualified Reservist Distribution (QRD):**

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

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

Any dollars remaining in an employee's HCFSA account upon employment termination (including retirement) can be used to reimburse only those medical expenses which were received before the end of the month in which the termination occurred unless the participant elects after-tax continuation coverage (see Continuation Coverage below).

Reimbursements up to the annual allocation, less amounts previously reimbursed, are allowed.

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

Continuation Coverage:

The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires employers to offer continuation of health coverage to individuals willing to pay the entire contribution payment.

The chart below lists the reasons (qualifying events) for loss of coverage.

<table>
<thead>
<tr>
<th>Individual Covered</th>
<th>Reasons for Loss of Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMPLOYEE (and covered dependents)</td>
<td>Termination for any reason</td>
</tr>
<tr>
<td>SPOUSE (and covered dependents)</td>
<td>Reduction of work hours, Death of employee, divorce or legal separation from employee, or employee's eligibility for Medicare</td>
</tr>
</tbody>
</table>

Election of continuation must be made within 60 days of loss of coverage as described above.

Since the Company has no way of knowing when a member divorces, legally separates, or a child becomes ineligible for coverage, it is your responsibility to notify the State Farm Benefits Center at 1-866-935-4015 and request continuation of coverage within 60 days of the event causing the loss of coverage and/or 60 days from the date coverage ceases. Once you have notified the State Farm Benefits Center of your request, the continuation election and contribution payment procedures will be provided.

If you choose to continue your coverage, it will continue until the earlier of any one of the following events:

1. The end of the Plan Year in which the qualifying event occurred.
2. The contribution for the continued coverage is not paid on or before the due date.
3. State Farm terminates all of its group health plans.
Changes by Plan Administrator:

If the Plan Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy any nondiscrimination requirement imposed by the Internal Revenue Code, the Plan Administrator will impose a pro rata reduction of the benefit elections of all highly compensated employees (as defined by the Code) who are participating in this Plan sufficient to assure compliance with the requirements.

Claims:

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

Rules and Regulations:

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 and the Employees and their beneficiaries, and all other interested parties.

HCFSA Claims Processing:

Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the person is entitled to them. The determination process usually takes about 5-7 business days and not longer than 60 days after receipt of the claim. This 60-day period may be extended one time for up to 15 days if the Plan Administrator determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant within the 60 days of the circumstances requiring the extension of time and the date by which the decision will be rendered. If the extension is needed due to failure of claimant to submit all necessary information, the notice will specifically describe the information, and the claimant shall have 45 days from receipt of notice to provide such information.

Denial of Claim:

If your claim is denied, you will receive written notice of the denial. The written notice shall provide the following:

- The specific reason or reasons for the denial,
- Specific reference to pertinent Plan provisions on which the denial is based,
- A description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary, and
- Appropriate information as to the steps to be taken to submit the claim for review.
Review Procedure:

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

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

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

Upon receipt of your claim for review, the Plan Administrator will make a decision not later than 60 days after the request for review is submitted.

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

Right to Amend or Terminate:

The Company reserves the right to amend or terminate this Plan, at any time, without consent of the Employees or any beneficiary, by action of the Compensation Committee of the Board of Directors for State Farm Mutual Automobile Insurance Company, with subsequent notice to the other participating Companies.

Scope of This Description:

This description summarizes only the principal provisions of the State Farm Insurance Companies Health Care Flexible Spending Account Plan for U.S. Employees (HCFSA). In the event this Summary Plan Description conflicts with the Plan, the Plan shall control. A complete copy of the Plan may be obtained from the Plan Administrator, One State Farm Plaza, Bloomington, Illinois 61710.
Provision of Protected Health Information to Plan Sponsor (Effective April 14, 2003)

Permitted and Required Uses and Disclosure of Protected Health Information.

Subject to obtaining written certification as required in the "Certification of Plan Sponsor" section below, the State Farm Insurance Companies Health Care Flexible Spending Account Plan for U.S. Employees (HCFSA) 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 HCFSA.
- Modifying, amending, or terminating the HCFSA.

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

Conditions of Disclosure. The HCFSA 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 HCFSA 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 HCFSA Plan any use or disclosure of the information that is inconsistent with the uses or disclosures permitted herein.
- Make available to a HCFSA Plan participant his or her protected health information in accordance with HIPAA (45 CFR §164.524).
- Make available to a HCFSA 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 HCFSA 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 HCFSA 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 HCFSA 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 HCFSA Plan and the Plan Sponsor exists.

Certification of Plan Sponsor. The HCFSA Plan shall disclose protected health information to the Plan Sponsor only upon the receipt of a Certification by the Plan Sponsor that the HCFSA 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 HCFSA 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:

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

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

Adequate Separation Between Plan and Plan Sponsor. The Plan Sponsor shall only allow members of the HCFSA Plan Appeals Committee and those members of the Corporate Law Department, the Accounting Department, the Human Resources Services Center, the State Farm Benefits Center, Total Rewards - Benefits and other supporting departments with responsibility for supporting and performing administrative functions for the HCFSA 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 HCFSA 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 HCFSA Plan:
"Protected Health Information" means information that is created or received by the HCFSA Plan and relates to the past, present, or future physical or mental health or condition of a member; the provision of health care to a member; or the past, present, or future payment for the provision of health care to a member, and that identifies the member or for which there is a reasonable basis to believe the information can be used to identify the member. Personal health information includes information of persons living or deceased. The following components of a member's information also are considered personal health information: 1) names; b) street address, city, county, precinct, zip code; c) dates directly related to a member, including birth date, health facility admission and discharge date, and date of death; d) telephone numbers, fax numbers, and electronic mail addresses; e) Social Security numbers; f) medical record numbers; g) health plan beneficiary numbers; h) account numbers; i) certificate/license numbers; j) vehicle identifiers and serial numbers, including license plate numbers; k) device identifiers and serial numbers; l) Web Universal Resource Locators (URLs) and Internet Protocol (IP) address numbers; m) biometric identifiers, including finger and voice prints; n) full face photographic images and any comparable images; and o) any other unique identifying number, characteristic, or code.

"Summary Health Information" means information that may be individually identifiable health information, and a) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and b) from which the information listed above as components of personal health information has been deleted, except that the geographic information need only be aggregated to the level of a five digit zip code.

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

Members Rights and Protections Under ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) guarantees certain rights and protections to participants of welfare plans. The Companies fully intend to support your rights. Nevertheless, federal law and regulations require that a Statement of ERISA Rights be included in this description.

As a Participant in the State Farm Insurance Companies Health Care Flex Spending Account Plan for U.S. Employees (HCFSA), you have the following rights:

- You may examine, without charge, all Plan documents -- including any annual reports and other documents filed with the Department of Labor. All documents are available for review by you or your dependents in the Human Resources Department – Total Rewards - Benefits, Corporate Headquarters, and Regional Human Resources Departments during normal business hours.
• If you want a personal copy of the Plan documents or related material, you should send a written request to the Plan Administrator. You'll be charged only the actual cost of reproduction of these copies.

Under ERISA, the people responsible for operating the Plan are called "fiduciaries." These individuals have an obligation to administer the Plan prudently and to act in the interest of Plan Participants and beneficiaries. No one may discriminate against you in any way to prevent you from receiving or exercising your rights under ERISA.

When you become eligible for payments from the Plan, you should follow the appropriate steps for filing a claim. In case of claim denial -- in whole or in part -- you will receive a written explanation of the reasons for the denial. Then, if you wish, you may request the Plan Administrator to review and reconsider your claim.

If you feel that your ERISA rights have been violated, you may file suit. Among the violations for which you may file suit, are:

• Improper denial of benefits.
• Misuse of Plan funds by a fiduciary or discrimination against you for asserting your rights. In either case, you may seek assistance from the Department of Labor or file suit in a federal court.
• Failure of the Plan Administrator to provide materials within 30 days after receiving your written request--unless due to reasons beyond the administrator's control. If violation exists, the court may require the Plan Administrator to provide the materials and to pay you up to $110 for each day's delay unless the material was not sent because of reasons beyond the control of the administrator. If coverage under this Plan is lost as a result of a qualifying event, you, your spouse or dependents may be able to continue this health coverage. Review this Summary Plan Description for more information.

The court will decide who should pay court costs and legal fees. For example, if you are successful, the court may order the person you sued to pay these costs and fees. If you lose -- or if the court finds your suit frivolous -- you may be ordered to pay these costs and fees.

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, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

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