State Street Health and Insurance Benefits Programs

Summary Plan Description

STATE STREET CORPORATION
January 1, 2014

This booklet is a Summary Plan Description (SPD) of the State Street Corporation Employee Benefit Plan (Plan), and replaces all prior descriptions of this Plan. The information contained in this booklet is intended as a summary of the Plan in effect as of January 1, 2014. This booklet is intended to be an easy-to-understand explanation of your benefits. It is not, however, a comprehensive explanation of all provisions of the Plan, which are described in detail in the official Plan documents (including contracts, plan documents and certificates), which legally govern the operation of the Plan. In the event of any conflict between the Plan provisions as stated in the Plan documents and this SPD, the provisions of the Plan documents will govern. State Street reserves the right to amend or terminate the Plan at any time, for current and/or future participants, retirees, beneficiaries and dependents, and no provision in this SPD shall grant a vested or guaranteed right in any future benefit.

You may refer to the applicable plan certificate of coverage or description of coverage for complete details on specific provisions, such as benefit coverage, definitions, coordination of benefits, waiting periods, exclusions, limitations and how to file claims. Such certificates of coverage and descriptions of coverage are incorporated into this SPD by reference.

The Plan is subject to approval by the Internal Revenue Service (IRS). Participation in the Plan is not an offer or guarantee of employment or an employment contract. State Street reserves the right to change, terminate or merge the Plan at any time.

This document and more information about your benefits plan are available on NetBenefits® at netbenefits.com/statestreet or by calling the GHR Service Center at +**1 855 447 7007, Option 1** (hours: 8:30 a.m. to 8:30 p.m. Eastern time). For International access, dial the toll-free AT&T Direct® access number, then enter 770 281 4858. For TDD communication services for the hearing impaired, call +1 888 343 0860.

What's Inside

Highlights

State Street offers a number of benefits to help you maintain your good health and protect your family income while you are employed at the Company. If you meet the eligibility requirements, certain plans (e.g., medical and life insurance) may be available to you when you retire from the Company. This document is a Summary Plan Description (SPD) for the following benefits that are part of the State Street Corporation Employee Benefits Plan, including the following:

- Medical (including pharmacy)
- Retiree Medical and Life Insurance
- Dental
- Vision
- Short-Term Disability
- Long-Term Disability
- Basic and Optional Life Insurance
- Basic and Optional Accidental Death & Dismemberment (AD&D)
- Business Travel Accident Insurance
- Employee Assistance Program
- Wellness
- MetLife Critical Illness Insurance*
- Hyatt Legal Plan*

*Note: These benefits are described in the SPD although they are not part of the Plan. Also note that although the Health Care Flexible Spending Account is part of the Plan, a description of that benefit can be found in the summary plan description for the State Street Health Care Flexible Spending Accounts and Dependent Care Flexible Spending Account by logging on to the NetBenefits website listed below.

You can access information about your benefits plan by logging on to **NetBenefits**® at netbenefits.com/statestreet or by calling GHR Service Center at **+1 855 447 7007, Option 1** (hours: 8:30 a.m. to 8:30 p.m. Eastern time). International callers, dial toll-free AT&T Direct® access number, then enter 770 281 4858. For TDD service for the hearing impaired, call +1 888 343 0860.

Eligibility, Enrollment and Participation

This section provides introductory information — such as eligibility, enrollment, when coverage for each benefit begins and ends, and how your coverage is affected by certain life or work events. For more details about each benefit, see that benefit's section of this SPD. Benefits are not available to interns, contractors or temporary employees. You must reside in the applicable program's service area to be eligible for coverage under that program.

Eligibility – Active Employees

Full-Time Employees

If you are regularly scheduled to work at least 29 hours per week, you are eligible to participate in the following benefits at State Street in accordance with the eligibility and enrollment requirements for each program:

- Medical (including pharmacy)
- Dental
- Vision
- Short-Term Disability (STD) Insurance
- Long-Term Disability (LTD) Insurance
- Life and Accident Insurance
- Business Travel Accident Insurance
- MetLife Critical Illness Insurance
- Employee Assistance Program (EAP)
- Hyatt Legal Plan
- Wellness

Part-Time Employees

If you are regularly scheduled to work at least 20 but less than 29 hours per week, you are eligible to participate in the following benefits in accordance with the eligibility and enrollment requirements for each program:

- Medical (including pharmacy)
- Dental
- Vision
- Short-Term Disability (STD) Insurance (with one-year service requirement)
- $10,000 Basic Life Insurance
- Business Travel Accident Insurance
- MetLife Critical Illness Insurance
- Employee Assistance Program (EAP)
- Hyatt Legal Plan
- Wellness (limited)

Eligibility – Retired Employees

See chart describing eligibility for Retiree benefits in the Retiree Medical and Retiree Life Insurance sections.

- Early Retiree Medical Coverage (under age 65)
- Retiree Health Expense Reimbursement Account (age 65 or older)
- Retiree Life Insurance

Eligible Dependents

At State Street, we recognize that with a diverse workforce comes a broad array of personal circumstances and individual needs.

Eligible Dependents for the medical, dental, vision and Employee Assistance Program include your:

- Spouse/Domestic Partner **or** an Other Adult Dependent
- Eligible Child up to age 26 regardless of marital status, student status or status as a tax dependent

To add a dependent, you are required to provide documentation to substantiate eligibility of each dependent. You will have 31 days from the date of the request for the required documentation for each dependent enrolled.

When a covered Spouse/Domestic Partner or dependent ceases to be an eligible dependent, he or she may continue coverage under COBRA, as explained in the Your Rights and Responsibilities section.

See the Life and Accident Insurance section to learn which dependents are eligible for Optional Term Life and Optional AD&D Insurance.

Dependent Definitions

- **Spouse—**Includes your legal spouse, either opposite or same sex if legally recognized under state law or other lawful jurisdiction as married.
- **Domestic Partner**—Includes anyone over age 18, either the opposite or same sex, with whom you share a committed, domestic relationship**.** To be covered under the Plan, a Domestic Partner must be a legally recognized partner of the employee under the laws of any state or lawful jurisdiction (i.e., registered partner or civil union) or meets all the following requirements:
    - Over age 18
    - Same or opposite sex
    - Shared a committed relationship with each other for at least six months and intend to remain in the relationship indefinitely
    - Shared a primary residence for at least six months
    - Are not blood relatives

- Share joint responsibility for each other's welfare
- Are each other's sole domestic partner
- Are not legally married
- Are legally able to enter into a contract

In addition, the employee and the domestic partner must have shared, for the previous six months, at least three of the six indicators of emotional and financial interdependence listed below:

- A joint lease, mortgage or deed
- Joint ownership of a vehicle
- A joint checking or credit account
- The designation of domestic partner as beneficiary of life insurance or retirement benefits
- The designation of domestic partner as a beneficiary in a will
- Shared household expenses

To be eligible for benefits, an employee and his or her domestic partner must either (i) submit legal documentation of domestic partnership from the applicable state or lawful jurisdiction or (ii) complete and submit an affidavit of domestic partnership attesting that their relationship meets the requirements described above. The relationship must be certified by submitting (i) or (ii) above within 31 days of enrollment or coverage will be terminated retroactive to the date of enrollment.

- **Eligible Children** — Include your and your spouse's or your Domestic Partner's natural children, step-children, foster children, legally adopted children, or children for whom either of you serves as legal guardian regardless of marital status, student status or status as a tax dependent up to age 26. You cannot elect coverage for the Eligible Child(ren) of your Domestic Partner without choosing coverage for your Domestic Partner as well. Child(ren) of an Other Adult Dependent are not eligible for State Street benefits. An unmarried disabled child may generally continue to be an eligible dependent for medical, dental, vision and life insurance as long as he or she remains incapable of self-sustaining employment due to a mental or physical handicap on the date he or she would normally lose eligibility under the applicable policy. Proof of disability must be submitted within 31 days after your dependent attains age 26. The coverage of a disabled child may vary by benefit program.

- **Other Adult Dependent** — Is a person (i) who is under age 65, (ii) who resides with you, (iii) whom you claimed as a dependent on your federal income tax return for the prior year, and (iv) who is not eligible for Medicare or any other employer medical plan. The following State Street plan options offer Other Adult Dependent coverage: PPO Plus — Cigna/Tufts HP Open Access with HSA, Blue Cross Blue Shield, Tufts HMO — Navigator by Tufts Health Plan, Delta PPO Plus Premier, DeltaCare USA, and EyeMed Vision Care. You may enroll an Other Adult Dependent in lieu of a Spouse or Domestic Partner. You cannot cover both. Currently, however, Aetna Global (International Plan), Kaiser HMO and MetLife Critical Illness do not offer Other Adult Dependent coverage.

Enrollment

Some benefits require that you enroll. For others, coverage is automatic.

Enrollment Is Required	Coverage Is Automatic
▪ Medical (including pharmacy) ▪ Dental ▪ Vision ▪ Optional Term Life ▪ Optional AD&D Insurance ▪ Long-Term Disability (70% of pay) ▪ MetLife Critical Illness Insurance	▪ $10,000 in AD&D Insurance ▪ Basic Term Life (2x pay) ▪ Business Travel Accident Insurance ▪ Short-Term Disability ▪ Long-Term Disability (50% of pay) ▪ Employee Assistance Program

How to Enroll

Annual enrollment elections can be made on the NetBenefits website or by calling the GHR Service Center (see contact information on the first page of this SPD). You have **31 days** from your date of hire to enroll in the Plan benefit options.

In some cases, if you do not enroll for coverage when you are first eligible and then later decide you wish to enroll for coverage, you will have to provide proof of good health before coverage can become effective.

Benefit Information

Be sure to read all the information provided on the NetBenefits website before completing your enrollment. Contact information is located on the front page of this SPD.

When Coverage Begins

If you elect to enroll in a specific benefit program, coverage for you and your dependents (if applicable) under that program will become effective in accordance with the following chart provided you are actively working on the effective date:

Benefit	Date of Eligibility
Medical (including pharmacy)	First of the month following your date of hire (Employees hired on the first day of the month are eligible immediately.)
Dental	First of the month following your date of hire (Employees hired on the first day of the month are eligible immediately.)
Vision	First of the month following your date of hire (Employees hired on the first day of the month are eligible immediately.)
Life and Accident Insurance	First of the month following your date of hire
Business Travel Accident Insurance	Date of hire
Employee Assistance Program	Date of hire
Short-Term Disability	Date of hire (full-time) After one year of employment (part-time)
Long-Term Disability	First of the month following your date of hire (Employees hired on the first day of the month are eligible immediately.)
Wellness	Date of hire
MetLife Critical Illness Insurance	First of the month following your date of hire (Employees hired on the first day of the month are eligible immediately.)
Hyatt Legal Plan	First of the month following your date of hire (Employees hired on the first day of the month are eligible immediately.)

For coverage that requires enrollment, coverage is effective based on the chart above provided you enroll within 31 days of your hire date.

If you are not actively working on the date coverage is scheduled to begin, coverage for you and your Eligible Dependents will not begin until the date you return to active work.

Coverage Levels

When you enroll in medical, dental, or vision coverage or critical illness insurance, you choose from the following coverage levels:

- Individual Only
- Individual + Child(ren)
- Individual + Spouse/Domestic Partner
- Individual + Family

If you and your Spouse/Domestic Partner both work for State Street, you cannot both enroll for "Individual + Child(ren)" or "Individual + Family" coverage in a State Street medical, dental or vision plan. However, both of you may enroll in "Individual Only" coverage. Or, one of you may elect "Individual + Children" or "Individual + Family" and cover your Spouse/Domestic Partner.

Your Right to Enroll for Medical Coverage after Waiving Coverage

If you are declining enrollment for yourself or your dependents (including your Spouse/Domestic Partner) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in the medical, dental and/or vision plan, provided that you request enrollment within 31 days of the date your other coverage ends.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in the medical, dental and/or vision plan, provided that you request enrollment within 31 days of the date of the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain information, log on to Fidelity NetBenefits®. (See front page of this SPD for contact information)

Pretax Benefits

Payroll contributions will be deducted evenly from each paycheck throughout the year. Your contributions for medical, dental, and vision coverage and your contributions to a Health Savings Account, if applicable, are typically deducted from your paycheck on a pretax basis. This means your contributions are deducted before federal, Social Security and (in most cases) state and local taxes are withheld. Pretax contributions help to lower your taxable income and offset the cost of your coverage.

Your pretax contributions for these benefits may have a slight effect on your Social Security benefits. You pay Social Security taxes (also known as FICA) based on your earnings after your pretax contributions are deducted. As a result, your future Social Security benefits could be slightly reduced. For most people, however, the current tax savings from making pretax contributions are generally greater than any slight reduction in Social Security benefits that might result.

Your pretax contributions will *not* reduce your eligible pay under any other State Street benefit, including life and accident insurance or disability coverage.

Important Note

Not all states' tax laws have been updated to conform to the federal changes that allow tax-free health plan coverage for your Eligible Child(ren) covered under a State Street medical plan until his or her 26th birthday. Therefore, state tax may apply to the related contributions if you reside in a non-conforming state.

Domestic Partner Tax Treatment

Under IRS regulations, there are different financial implications for covering Domestic Partner.

If you are considering providing benefit coverage for your Domestic Partner and his or her Eligible Child(ren), be aware that there are important tax implications for you to consider. In addition to the information below, you may want to consult a personal tax or legal professional for advice.

According to IRS regulations, if you cannot consider your Domestic Partner and his or her child(ren) as tax dependents for federal income tax purposes, you are not entitled to the tax advantages that apply to covering a Spouse or your own Eligible Child(ren). This means that the cost of coverage for your Domestic Partner and his or her Eligible Child(ren) is deducted from your pay on an *after-tax* basis. (The cost for covering yourself and your Eligible Child(ren) continues to be deducted on a pretax basis.) In addition, the Company-paid portion of any medical, dental and vision coverage for your Domestic Partner and his or her children must be considered additional income on which you are required to pay federal and state tax (except for states where Domestic Partners are legally recognized for tax purposes). This additional income will be reflected on your W-2 form and additional taxes will be withheld from your paycheck.

If your Domestic Partner (and his or her Eligible Child(ren)) is a tax-qualified dependent as defined by the Internal Revenue Code, your monthly contributions can be deducted from your pay on a pretax basis. There are no tax consequences for covering your tax-qualified Domestic Partner under a State Street benefit program.

In general, a person can be claimed as a tax-qualified dependent when you file your tax return, if they meet the criteria under Section 152 of the Internal Revenue Code for the calendar year, including that:

- The dependent is a citizen, legal resident or national of the United States;
- The dependent is considered a member of your household, lives with you for the entire year, and your household is considered his or her principal residence;
- The dependent receives over half of his or her support for the calendar year from you;
- Your relationship is not in violation of any local laws; and
- The dependent is not the qualifying child of any other taxpayer.

Other Adult Dependent Tax Treatment

If you are covering an Other Adult Dependent (or other tax-qualified dependent), the entire cost for this coverage is deducted from your pay on a pretax basis. This means that your payroll deductions for this coverage are not subject to federal income, Social Security and most states' income taxes.

How to Certify Tax-Qualified Dependents

If you believe your Domestic Partner or Other Adult Dependent is a tax-qualified dependent, please notify the GHR Service Center using the contact information located on the front page of this SPD.

In order to have pretax deductions apply to coverage for your Domestic Partner (and his or her Eligible Child(ren)), or your Other Adult Dependent, you must submit a copy of your most recent federal income tax form, in addition to other required documentation, to the GHR Service Center.

Since satisfying the definition of a tax-qualified dependent under the Internal Revenue Code can be complex, you should consult a tax professional for advice on your personal situation.

Changing Your Elections

This section primarily addresses changes to your pretax benefits, which include medical, dental and vision. Because you pay for these benefits on a pretax basis, certain IRS restrictions apply.

For information about changing Optional Term Life and Optional AD&D, LTD or MetLife Critical Illness Insurance elections, see those sections of this booklet. For Health Care Flexible Spending Accounts and Dependent Care Flexible Spending Account, see the specific summary plan description that describes those benefits by contacting the GHR Service Center using the information found on the front page of this SPD.

Annual Enrollment

The annual enrollment period is typically held each fall for benefits effective January 1 of the upcoming year. During annual enrollment, you may change your medical, dental and vision elections. If you do not change your medical, dental and vision plan elections during annual enrollment, your elections generally carry over into the following year.

IRS-Qualified Status Changes

Generally, according to IRS rules, you may change your medical, dental and vision elections only during annual enrollment. However, IRS rules allow you to change your elections during the year under certain circumstances, known as qualified status changes. Qualifying changes in status include:

- Marriage or addition of a newly eligible Domestic Partner or Other Adult Dependent;

- Divorce, legal separation or annulment, or dissolution of a Domestic Partnership or Other Adult Dependent relationship;
- Birth or adoption of a child (or placement of a child for adoption or legal guardianship);
- Death of a Spouse/Domestic Partner, dependent, or Other Adult Dependent;
- Ineligibility of a dependent (for example, with respect to medical and EAP benefits, your Eligible Child reaching age 26 and with respect to dental and vision benefits, your Eligible Child over age 26.
- A change in your or your Spouse's/Domestic Partner's employment (including a reduction in hours), if it results in a loss or gain in eligibility for coverage; or
- A move out of your HMO network service area.

The status change must cause a loss or gain of eligibility. In addition, your change in coverage must be consistent with and on account of your status change. For example, if you get married, you may add your spouse to your medical plan or cancel your coverage to join your spouse's medical plan.

Generally, any change you make is prospective (applies to the future) only. However, by law, if you add a newborn child, an adopted child or a child placed for adoption, the change will be effective as of the birth, adoption, or placement for adoption provided you make the change within 31 days of the date of birth, adoption or placement for adoption.

Other Events

IRS regulations allow participants to make a mid-year election change for certain other events such as:

- **Entitlement to Medicare or Medicaid.** If you, your spouse or dependent becomes entitled to Medicare or Medicaid, you may make a prospective election to cancel or reduce health coverage.
- **Judgment, Decree or Order.** If there is a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order) that requires a change in accident or health coverage for your dependent, you may make an election change to add or drop coverage as ordered.
- **Significant Curtailment of Coverage *that is not a Loss of Coverage***. If your coverage is significantly curtailed by a change in the plan without a loss of coverage, you may revoke your benefit election that is being curtailed, but must make a new election for similar coverage under a new benefit package option.
- **Significant Curtailment of Coverage *with a Loss of Coverage***. If your coverage is significantly curtailed by a change in the Plan with a loss of coverage, you may revoke coverage and make a new election for similar coverage under a new benefit package option.
- **Significant Change in Cost.** If there is a significant change in the cost of coverage, you may revoke coverage and make a new election for similar coverage under a new benefit package option.
- **Coverage Change of Another Employer.** You may change your election if the change is on account of and consistent with a change in another employer's plan and (i) the change is permitted under the cafeteria plan of the other employer or (ii) the periods of coverage under your plan are different from the periods of coverage under the plan of the other employer.
- **SCHIP Loss in Eligibility.** If you or your Eligible Child(ren) is otherwise eligible but not enrolled in a State Street health plan and your child experiences a termination of coverage under Medicaid or the State Children's Insurance Program (SCHIP), you may request enrollment for yourself, if you are not otherwise enrolled, and your child(ren). The election to participate must be requested within 60 days of the event.
- **SCHIP Gain in Eligibility**. If your Eligible Child(ren) is currently enrolled in a State Street health plan and gains eligibility for coverage under Medicaid or the State Children's Insurance Program Reauthorization Act (SCHIP), you may revoke your election to cover your child provided the revocation is requested within 60 days of the event.

See How Your Benefits May Be Affected to learn about the types of changes you can make following certain qualifying status changes.

How to Make a Qualifying Status Change

Contact the GHR Service Center using the contact information found on the front page of this SPD within 31 days of your qualifying status change to make your corresponding enrollment changes.

Keep in mind that if you miss the 31-day window, you will have to wait until the next annual enrollment to make a change for coverage or changes effective the following January 1.

Dependent Eligibility

Dependents remain eligible for coverage up to age 26. Your dependent will not have coverage after his or her 26 birthday, unless he or she elects to continue coverage under COBRA. See the COBRA section for more information.

An unmarried disabled child may generally continue to be an eligible dependent for medical, dental, vision and life insurance as long as he or she remains incapable of self-sustaining employment due to a mental or physical handicap on the date he or she would normally lose eligibility under the applicable plan or policy. Proof of disability must be submitted within 31 days after your dependent attains age 26. The coverage of a disabled child may vary by benefit program. Refer to the applicable Certificate of Coverage or the applicable policy for more details.

Qualified Medical Child Support Orders

Your group health benefits may be subject to certain judgments by state courts extending medical coverage to child(ren) named in a Qualified Medical Child Support Order (QMCSO). A QMCSO is a court order, decree, judgment or administrative notice (including a settlement agreement) that requires the group health plan of a parent to provide health care benefits to one or more children. A QMCSO is generally issued by a domestic relations court or other court of competent jurisdiction or through an administrative process established under state law.

If State Street determines that the court order satisfies all legal requirements, you will be notified by the by the administrator that the Plan will cover the child(ren) named in the QMCSO. Any required contributions will be deducted from your pay.

The Plan Administrator has the complete authority, in its sole and absolute discretion, to construe the terms of the procedures for enforcing the court orders described above and to decide the eligibility for, and the extent of, benefits under the programs with respect to these orders. All such decisions shall be final and binding upon all parties affected. The Plan Administrator also reserves the right to amend any or all of the QMCSO procedures at its sole discretion, at any time.

You may request a copy of the procedures governing QMCSOs, free of charge, by contacting the GHR Service Center using the contact information found on the front page of this SPD.

When Your Employment Ends

The following table shows when your benefits end if your employment with State Street ends.

Benefit	When Coverage Ends
Medical Dental Vision Health Care Flexible Spending Account* Employee Assistance Program	Last day of the month in which date of termination occurs†
Business Travel Accident Insurance	Last day actively working
Basic and Optional Life and AD&D Insurance	Last day of the month in which date of termination occurs (See the 31-day conversion period described below.)

Dependent Care Flexible Spending Account* Short-Term and Long-Term Disability Coverage	Date of termination

*See the separate summary plan description that describes these benefits by contacting the GHR Service Center using the information found on the front page of this SPD.

†When your medical, dental, vision, Employee Assistance Program and Health Care Flexible Spending Account coverage ends, you may be eligible to continue coverage under COBRA. You may not be eligible to continue coverage during certain leaves of absence.

Note: Coverage may end sooner than shown above if you lose eligibility or fail to make required payments, or if a program is terminated.

Life Insurance and Accidental Death & Dismemberment (AD&D)

When your life insurance coverage ends, you may be able to convert your coverage to individual policies within 31 days of your last day of work. Coverage may continue during the 31-day conversion period. See the Life and Accident Insurance certificates for more information.

Your current Life Insurance and AD&D coverage (as applicable) continues until the last day of the month in which your date of termination occurs. After that, you may continue coverage by choosing either the "conversion" feature or the "portability" feature directly through MetLife. Both options allow you to continue coverage by paying premiums at group rates without having to show medical evidence of insurability. Keep in mind that, as a terminated employee, your premiums will be higher than they were when you were actively employed.

Both the conversion and portability features are available for Basic Life Insurance, Optional Life Insurance, Spouse/Domestic Partner Life Insurance and Child Life Insurance, as applicable. The portability feature is available for Basic AD&D and Optional AD&D. MetLife will send information about continuing your coverage directly to your home. If you have not heard from MetLife within 30 days from your termination date, you may call MetLife at +1 877 275 6387 for information about conversion coverage, and +1 866 492 6983 for information about portable coverage.

Certification of Health Care Coverage

When your, your Spouse's/Domestic Partner's or your dependent's medical coverage ends, you and/or your dependent(s) will be sent a coverage certification. In addition to receiving a coverage certification when your State Street coverage first ends, you will receive another one when COBRA coverage ends (if you elected COBRA), and then upon request (if you request it within 24 months after either coverage ends). This is a written record of the coverage you received under the State Street health care program and under COBRA, if applicable.

You should keep a copy of the coverage certification(s) you receive, since you may need to prove you had prior coverage when you join a new health plan. For example, if your new employer's plan has a preexisting condition limitation, the employer may be required to reduce the duration of the limit by one day for each day of your prior coverage (subject to certain requirements). You may also need to present the coverage certification to your insurer if you are buying individual coverage.

Family Status Changes

State Street benefits are designed to help and support you during the different stages and events in your life. This section provides an overview of how your medical, dental, vision, and life and accident insurance benefits are affected if you experience certain life events. Keep in mind that if you have a qualified status change during the year, you may make certain benefit changes within **31 days** of the event (such as marriage, birth of a child, etc.).

How Your Benefits May Be Affected		
	Medical, Dental and Vision	**Life and Accident Insurance**
You get married or enter into a domestic partnership.	Within 31 days of the event, you may enroll your spouse/domestic partner and other eligible dependents, or you may drop your coverage to join your spouse's plan. (You may be able to enroll in your domestic partner's plan if his or her employer offers domestic partner coverage.)	You may want to review and, if necessary, change your beneficiary designation. Within 31 days of the event, you may apply to enroll your spouse/domestic partner in Optional Term Life and/or Optional AD&D Insurance. You may also apply to enroll or increase spouse/domestic partner Optional Term Life and/or Optional AD&D Insurance.
You get divorced or legally separated, or end a domestic partnership.	Your Spouse's/Domestic Partner's coverage will end (except to the extent an applicable court order requires continued coverage). He or she may elect to continue coverage under COBRA for a period of time. If your coverage under your Spouse's/Domestic Partner's plan ends, you may enroll in the State Street plan within 31 days of the event.	You may want to review and, if necessary, change your beneficiary designations. Your spouse/domestic partner's Optional Term Life and/or Optional AD&D Insurance ends. He or she may convert to a non-group policy.
You have or adopt a child or a child is placed in your home for adoption.	Within 31 days of the event, you may enroll the child and other eligible dependents, or you may drop your coverage to join your spouse's/domestic partner's plan.	You may want to review and, if necessary, change your beneficiary designations. Within 31 days of the event, you may apply to enroll your child in Optional Term Life and/or Optional AD&D Insurance. You may also enroll in or increase your Optional Term Life and/or Optional AD&D insurance.
You have an Other Adult Dependent approaching age 65.	Your Other Adult Dependent coverage ends. He or she may elect to continue coverage under COBRA for a period of time.	Your Other Adult Dependent is not eligible for these benefits.
You take an unpaid leave of absence. (See Family and Medical Leave Act (FMLA) Leaves and Military Leave of Absence for special rules that apply to these leaves.)	You may continue coverage by paying your share of the cost of coverage, or you may suspend coverage.	Basic Life and AD&D coverage continues. You may continue coverage and Optional Term Life and/or Optional AD&D Insurance, provided you continue to pay your share of the cost.
You become unable to work due to disability and are receiving Short-Term Disability (STD) payments.	Coverage continues. Your share of the cost is deducted from your STD payments.	Coverage continues. Your share of the cost for Optional Term Life and/or Optional AD&D coverage is deducted from your STD payments.

How Your Benefits May Be Affected		
	Medical, Dental and Vision	**Life and Accident Insurance**
You are still unable to work due to disability and are receiving Long-Term Disability (LTD) payments (because you had elected LTD coverage).	You may continue coverage, provided you continue to pay your share of the cost of coverage. Any contributions you are making to your HSA end.	Your Basic Life and AD&D coverage continues. You may continue coverage under Optional Term Life and/or Optional AD&D Insurance, provided you continue to pay your share of the cost.
You are still unable to work due to disability but you had *not* elected LTD coverage.	Your coverage ends. You may elect to continue coverage under COBRA for a period of time.	Your coverage ends. You may be eligible to continue coverage through the insurance company.
Your employment ends.	Your coverage continues until the last day of the month in which your termination occurs. You may elect to continue coverage under COBRA for a period of time thereafter.	Your coverage continues until the last day of the month in which your termination occurs. You may be eligible to continue coverage through the insurance company through the conversion or portability options, where available.
You retire. (You leave the Company at age 55 or older with five or more years of eligible service.)	You may be eligible for Retiree Medical coverage and/or you may be eligible to continue coverage under COBRA.	You may be eligible for Retiree Life Insurance coverage.
You die while actively employed by or receiving disability benefits from State Street.	Coverage for your covered dependents continues for one year (at no cost). Thereafter, your covered dependents may be eligible to continue coverage under COBRA for up to 36 months.	Your life insurance (and, if applicable, AD&D) benefits are payable to your named beneficiary. Your covered spouse or dependent children may be eligible to continue their coverage under Optional Term Life and/or Optional AD&D Insurance (see below).
Your dependent dies.	You may change your coverage level within 31 days of your dependent's death.	If the dependent was covered under Optional Term Life and/or Optional AD&D Insurance, benefits are payable to you. You may want to review and update your beneficiary designation for your life insurance.
You lose your benefits eligibility due to a reduction in hours of employment.	Your coverage ends on the last day of the month in which you lose eligibility. Thereafter, you may be eligible to continue coverage under COBRA.	Your coverage continues until the last day of the month in which your reduction in hours occurs. You may be eligible to continue coverage through the insurance company through the conversion or portability options, where available.
Your child(ren) reaches age 26.	Your child(ren)'s coverage ends on his or her 26th birthday. Thereafter, your child(ren) may be eligible to continue medical coverage under COBRA.	Your child(ren) is not eligible for the Life and AD&D Insurance coverage through State Street.

Note: Short-Term Disability (STD), Long-Term Disability (LTD) and Business Travel Accident coverage generally cannot be changed due to any of the life events listed in the chart above.

Family and Medical Leave Act (FMLA) Leave

This leave may be paid, unpaid or a combination of both. If you take an approved leave under FMLA, you may be eligible to continue certain benefits, as described below.

Paid FMLA Leave

If your leave is paid because you are receiving sick leave, Short-Term Disability or vacation payments, your participation will continue under all benefits in which you participate. Your payroll contributions for the benefits will continue to be deducted from your pay.

Unpaid FMLA Leave

The following chart explains what happens to your benefits, as applicable, during an *unpaid* FMLA leave.

Benefit	What Happens during Unpaid FMLA Leave
Medical Dental Vision	You may: • Pay your share of the cost on an after-tax basis by direct bill; or • Suspend coverage.
Short-Term Disability	Coverage continues.
Employee Assistance Program	Coverage continues.
Long-Term Disability	If you elected this coverage, you may: • Continue coverage by continuing to pay the cost on an after-tax basis by direct bill; or • Suspend coverage until the next annual enrollment (pre-existing condition clause may apply).
Basic Life and Basic AD&D Insurance	Coverage continues – paid by Company.
Optional Life and Optional AD&D Insurance	You may: • Continue coverage by paying your share of the cost on an after-tax basis by direct bill; or • Suspend coverage.
Business Travel Accident Insurance	Coverage is suspended.

If you do not return to work, State Street has the right to recover any premiums you did not pay while you were on leave. You will receive more information about paying for coverage if you take an unpaid FMLA leave.

If you suspend your medical, dental, vision, Optional Life, and/or Optional AD&D coverage during your unpaid FMLA leave and your leave is 30 days or less, your benefit elections will be reinstated. Otherwise you will have to elect to have that coverage reinstated upon your return to work.

See the summary plan description for the Health Care Flexible Spending Account and Dependent Care Flexible Spending Account for leave information applicable to those benefits by contacting the GHR Service Center using the information found on the front page of this SPD.

Military Leave of Absence

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), employees who are called to active military duty are entitled to an unpaid leave of absence for military service, with reinstatement rights. State Street will comply with any benefit continuation or reinstatement requirements of USERRA. Because USERRA requirements are subject to change, please contact the GHR Service Center at +1 855 477 7007, Option 1for the most current information if you plan to take a military leave of absence. If you are not on a military leave when USERRA applies, the benefits for non-military approved leaves of absence apply.

Benefit	What Happens During Military Leave of Absence
Medical Dental Vision Employee Assistance Program	You and your covered dependents may continue your coverage for up to 24 months under COBRA while you are on a military leave. You must continue to pay your share of the cost of coverage, as follows: ▪ **If your leave is less than 31 days:** You pay the same cost that active employees pay. ▪ **If your leave is more than 30 days:** You can elect to continue coverage under COBRA for up to 24 months. If you elect to continue coverage under COBRA, for the first six months of your leave, you pay the same cost that active employees pay. After six months, you pay the COBRA rate equal to 102% of the full cost of coverage. If you do not continue coverage during your leave, you may re-enroll in coverage when you return to work at State Street, provided you return to work in an eligible position.
Basic and Optional Life Insurance and AD&D	Basic Life and AD&D coverage continues during your leave. You may continue coverage under Optional Term Life and/or Optional AD&D Insurance, provided you continue to pay your share of the cost. (Note: Certain line-of-duty coverage exclusions apply.)
Short-Term Disability Long-Term Disability Business Travel Accident Insurance	Coverage is suspended during your leave. Coverage will be reinstated (without requiring proof of good health) when you return to work at State Street, provided you return in an eligible position.

Medical Plan

State Street offers a choice of medical plan options, depending on the location in which you work:

- PPO Plus — Cigna/Tufts HP Open Access with HSA, a Cigna HealthCare High-Deductible Health Plan (HDHP) coupled with a health savings account (HSA), available to employees in all US locations
- PPO — BC/BS Blue Care Elect, a BlueCross BlueShield Preferred Provider Organization (PPO), available to employees in all US locations
- Health Maintenance Organizations (HMOs) in most locations, including BC/BS HMO — Network Blue New England Options, BC/BS HMO — Advantage Blue (available for employees located outside of New England), Tufts HMO — Navigator by Tufts Health Plan (Massachusetts, Rhode Island, and some areas of New Hampshire and Connecticut), Kaiser HMO (California)
- Expatriate employees have access to Aetna Global Benefits

You will find information about these options in several places throughout this SPD:

- Eligibility, Enrollment and Participation — Contains information about State Street's eligibility and enrollment provisions.
- Medical Plan Summary of Benefits Coverage/Certificates — Describes in detail how each option works and what is and is not covered. These materials are incorporated into this SPD by reference, and copies can be obtained by contacting the GHR Service Center using the information found on the front page of this SPD.
- Your Rights and Responsibilities — Contains information about your rights under the medical plan options, including your right to continue coverage under COBRA and other important information.

Waiver Option

If you, your spouse/domestic partner and/or your dependents are covered under another group health plan, you may elect to waive medical coverage through State Street. Be sure to review your options for medical coverage carefully to ensure that you are adequately covered before making any final decision.

If You and Your Spouse/Domestic Partner Both Work at State Street

If you and your Spouse/Domestic Partner both work for State Street, you cannot each enroll for "Individual + Spouse/Domestic Partner" or "Individual + Family" coverage in State Street's medical plans. Each of you may enroll in "Individual Only" coverage. Or, one Spouse/Domestic Partner may elect "Individual + Spouse/Domestic Partner" or "Individual + Family" coverage and include the other Spouse/Domestic Partner for coverage under a State Street medical plan.

Your Cost

You and State Street share the cost of medical coverage. Your medical coverage cost depends on the medical option you elect, the level of coverage (Individual Only, Individual + Child(ren), Individual + Spouse/Domestic Partner, or Individual + Family) and your individual compensation.

If you are enrolling in medical benefits as a new hire, your compensation for purposes of determining the cost of your medical coverage is based on your annual base pay. For subsequent years, compensation for this purpose will be based on a formula that includes your actual annual base pay as of a certain date in September of the prior year (the date to be determined annually), one full year of cash commissions paid in the second prior year (if applicable), the cash portion of your prior year Annual Incentive Plan award, and the cash portion of your prior year Sales Manager bonus (if applicable), and excludes any deferred cash or equity awards.

For example, for coverage effective as of January 1, 2015, your compensation for purposes of medical coverage cost will be based on the following:

- Your annual base pay as of a specified date in September 2014;
- Commissions (if applicable) paid from January 1, 2013–December 31, 2013;
- The cash portion of your 2012 Annual Incentive Plan award (paid during the annual bonus cycle in 2014); plus
- The cash portion of your 2012 Sales Manager bonus (if applicable) paid in February 2014.

For 2014, there are four levels of annual pay-based contributions for medical coverage as follows:

Level A — less than $70,000
Level B — $70,000 up to $129,999
Level C — $130,000 up to $189,999
Level D — $190,000 or higher

Generally, you pay your contributions on a pretax basis. See Eligibility, Enrollment and Participation for more information about pretax contributions. If you are on an unpaid leave, such as long-term disability, you will receive a monthly invoice for your health care premiums, which you will pay on a after-tax basis.

The current costs for medical coverage are listed on the Fidelity NetBenefits website. See front page of this SPD for contact information.

Tobacco Surcharge

You pay extra if you are a "Tobacco User." The tobacco surcharge for 2014 is $50 per month.

You can waive the tobacco surcharge by completing a tobacco cessation program. Contact the GHR Service Center at the number listed on the front page of this SPD. The tobacco surcharge will end after you submit the completed documentation. Please note that there will be no retroactive reimbursement. **Your tobacco surcharge designation will be changed back to Tobacco User for the next plan year.** If you have not used tobacco products in the 12 months preceding the next annual enrollment, you must log on to the Fidelity NetBenefits website during annual enrollment period and change your tobacco status to Non-Tobacco User.

Participating Providers

With the PPO, your out-of-pocket costs are lowest when you use network providers. With the HMOs, you must use network providers, except in the event of a life-threatening emergency.

Under the HMO, you must choose a primary care physician and obtain referrals to see specialists. (Tufts HMO — Navigator by Tufts Health Plan does not require that you choose a primary care physician or get referrals to see specialists. You must, however, receive services from a Tufts participating provider.)

The table below explains how to access the network provider directory for each plan. **Before scheduling any appointment, it is a good idea to call the telephone number on your medical identification card to be sure your provider is still in the network.**

Preventive Care

All State Street medical plans cover the full cost of routine in-network preventive care (according to federal guidelines) appropriate for your gender and age. For more information on the services covered as preventive care (according to federal guidelines), visit http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html

Newborns and Mothers Health Protection Act

Group health plans and health insurance companies 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 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 48 hours (or 96 hours). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

State Street's medical plan options cover expenses for reconstructive surgery following a mastectomy. If you or one of your covered dependents have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided for the following services in a manner determined in consultation with the attending physician and the patient:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of all stages of the mastectomy, including lymphedemas

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits available under your medical plan. For information on WHCRA benefits or details about any state laws that may apply to your medical plan, please refer to the benefit plan material for the medical plan in which you are enrolled.

Medical Plan	How to access network provider directory
PPO — BC/BS Blue Care Elect; BC/BS HMO — Network Blue New England Options; and BC/BS HMO — Advantage Blue	♦ Website: www.bcbsma.com/statestreet Click *Find a Doctor* ♦ Phone number: +1 800 352 6259
PPO Plus — Cigna/Tufts HP Open Access with HSA	♦ Website: Before enrollment: www.mycignaplans.com ID: statestreet2014 Password: cigna If already enrolled: www.mycigna.com ♦ Phone number: Before enrollment: +1 800 401 4041 If already enrolled: +1 800 244 6224
Tufts HMO — Navigator by Tufts Health Plan	♦ Website: www.tufts-health.com/statestreet Select *Doctor Search* in the *Quick Links* drop-down menu ♦ Phone number: +1 800 462 0224
Kaiser HMO	♦ Website: www.kaiserpermanente.org. Click the button for members, and select your region. On the *Members* page, select *Medical Staff Directory* under the *Locate Our Services* tab. ♦ Phone number: +1 800 464 4000
Aetna Global Benefits (expatriate employees only)	♦ Website: www.aetnaglobalbenefits.com. Click the *Members* link and select *Register*. ♦ Phone number: Inside the United States, call 813 775 0190. Outside the United States, call +1 800 231 7729. Refer to your AT&T Direct wallet card for the appropriate access code.

Medical Plan Summary of Benefits and Coverage

Detailed coverage information is available for each medical plan in the Summary of Benefits and Coverage documents located in the *Reference Materials* section on netbenefits.com/statestreet.

Health Savings Account (HSA)

Note: While the PPO component of the PPO Plus - Cigna/Tufts HP Open Access with HSA is subject to ERISA rights and responsibilities, the HSA itself is not. A brief description of this program and how it works is included here for your information only.

A health savings account (HSA), is a tax-free savings account you may use to pay out-of-pocket medical expenses. It is available only to individuals who enroll in a qualified high-deductible health plan (HDHP). Since deductibles are typically higher with these plans than with other plans, HSAs are offered to help cover your costs. In State Street's case, an HSA is offered to individuals who enroll in PPO Plus - Cigna/Tufts HP Open Access with HSA.

Note: The HSA is different than both the State Street Health Care Flexible Spending Account and the Limited Purpose Health Care Flexible Spending Account. For more information about the flexible spending accounts, see the State Street Health Care Flexible Spending Account summary plan description by contacting the GHR Service Center using the information found on the front page of this SPD.

HSA Eligibility

If you are enrolled in the PPO Plus — Cigna/Tufts HP Open Access with HSA and you have no other medical coverage, you may open an HSA, which is a savings account for health care expenses. You are not eligible to participate if:

- You can be claimed as a tax dependent of another individual;
- You are enrolled in Medicare; or
- You have medical plan coverage other than a State Street–sponsored HDHP, including secondary coverage under your spouse's/domestic partner's plan.

Important: It is up to you to make sure that you meet the tax requirements to establish and contribute to an HSA. Neither State Street nor Cigna has the information or the responsibility to monitor your status. You should consult a tax professional regarding your personal tax situation.

HSA Contributions

State Street will contribute to your HSA account each year that you are enrolled in the PPO Plus — Cigna/Tufts HP Open Access with HSA. You may also choose to contribute on a pretax basis each year that you are enrolled. For 2014, State Street will contribute $750 to your HSA if you elect Employee Only coverage, and $1,500 for other coverage levels. You may also contribute up to $2,550 for Employee Only coverage and $5,050 for any other coverage level. If you are age 55 or older in 2014, IRS rules allow a "catch-up" contribution of $1,000 per employee, in addition to the amounts shown above.

Setting Up Your HSA Account

When you select the PPO Plus — Cigna/Tufts HP Open Access with HSA, you must enroll in the HSA even if you do not want to contribute your own money. By enrolling in the HSA you must accept the terms and conditions of the HSA account with JP Morgan Chase as required by federal banking rules. **The application is located at** mycignaplans.com **(ID: statestreet2014; Password: cigna).**

Once your HSA account is opened, you:

- Will receive a debit card you can use at most doctor offices and pharmacies, or at an ATM to pay yourself back for qualified expenses (you may order a second debit card for your spouse), and
- Can order a checkbook . (A fee is charged for the checkbook.)

Note: Transaction fees may apply to transactions other than at a health care provider's facility. There also are fees for ATM transactions if you use a non-Chase ATM. For details, contact Cigna Customer Service at +1 800 244 6224.

Note: State Street cannot make its contribution to your account until your bank account with JP Morgan Chase is opened. You must open your account no later than the last day of February of the year following your enrollment in Cigna as the IRS only allows contributions for a previous year up until April 15th of the current year. If you do not open your account, you will forfeit any State Street contributions.

Using Your HSA Account

Both the Company's contributions and your optional contributions are placed in an individual, tax-deferred account. You can use your HSA to pay for expenses that count toward your deductible, for expenses not covered by your health plan (such as dental, vision and prescription drugs), or you can save the money to pay for future health care expenses, including retiree medical care.

The HSA is in your name, so you can take it with you if you leave State Street. In addition, HSAs offer tax advantages since you do not pay federal tax on your optional contributions. Different rules apply to state tax. In Alabama, California, and New Jersey, contributions are prior to federal tax but after state taxes. Please contact your tax advisor if you have questions.

Once contributions are made to your HSA account, provided you use it for qualified medical expenses, no further tax applies.

Expenses incurred before you open your HSA are not eligible for the tax savings, so it is important to open your account as soon as you enroll for PPO Plus — Cigna/Tufts HP Open Access with HSA.

If you contribute to an HSA and also choose to participate in the Limited Purpose Health Care Flexible Spending Account, federal rules restrict the way you can use your Limited Purpose Health Care Flexible Spending Account to pay for eligible medical expenses.

Eligible HSA Expenses

Eligible expenses include the following and the related deductibles and coinsurance, as well as other services that are on the IRS list of tax-deductible health care expenses (available at http://www.irs.gov/pub/irs-pdf/p502.pdf).

- Doctor office visits
- X-rays and laboratory services
- Surgery
- Inpatient and outpatient hospital services
- Emergency room
- Prescription drugs
- Dental and vision services

Keep in mind that in-network preventive care is covered at 100% and is not subject to the deductible. Also be aware that if you use all the money in your HSA before meeting the deductible, you must pay the full cost of additional health care services out-of-pocket until the deductible is met. You can minimize your out-of-pocket costs by taking advantage of the discounts offered by in-network providers.

If you use the money in your account for anything other than qualified health care expenses, the amount you use is considered taxable income and subject to a 20% IRS penalty if you use it before age 65.

Important consideration if you are covering an adult child

If you are covering an adult child who qualifies for medical coverage as an Eligible Child but does not qualify as a tax dependent under IRC Section 223, which governs HSAs, expenses for the adult child do not qualify for reimbursement under an HSA.

This means that even though you can cover your adult child up to age 26 under your State Street medical plan based on the recent health reform laws, you cannot use your HSA for expenses incurred for your adult child unless he or she is your dependent for tax purposes.

Investing Your HSA Account

Once your HSA balance has reached $1,000, you may invest your dollars in any or all of six JPMorgan Chase Mutual Funds. For details, contact Cigna Customer Service at +1 800 244 6224.

If You Have HSA Money Left Over

If you have money left in your HSA at the end of the plan year, it carries over to the following year generally tax-free, with any earnings. You may use it for future health care expenses, including medical expenses after retirement, long-term care or COBRA premiums. If you withdraw the money for anything other than eligible health care expenses, you must pay income tax and a 20% penalty. Your HSA is portable, which means you take it with you if you leave State Street.

If you cover a Domestic Partner

If you are considering providing benefit coverage for your Domestic Partner and/or his or her Eligible Child(ren), be aware that there are important tax implications for you to consider. For example, if you are covering a Domestic Partner, and he or she is not your qualified tax dependent, you cannot use your HSA funds to pay his or her medical expenses on a tax-free basis due to Internal Revenue Code provisions.

For more information about the tax treatment of benefits provided to Domestic Partners, see Domestic Partner Tax Treatment.

Where Can You Find Your HSA Balance?

You can keep track of the balance in your HSA, manage your transactions, and decide how and when you use your HSA with monthly statements, toll-free customer service, and online account access. Log on to mycigna.com or call +1 800 244 6224.

To avoid overdrawing from your HSA and facing a penalty, be sure to check your balance often, especially before writing a check from your HSA account.

TERMS YOU SHOULD KNOW

- **Copay —** A flat-dollar amount you pay for certain covered services, such as office visits, emergency room visits and prescription drugs. These services are not subject to the deductible or coinsurance.
- **Deductible —** The amount you are responsible to pay for certain covered services (for example, hospital care, X-rays and lab tests) each calendar year before the plan provides any benefits for these services. Copays do not count toward the annual deductible.
- **Coinsurance —** The percentage you pay for a covered service after you have satisfied your annual deductible. In most cases, this applies to services not subject to a copay.
- **Annual out-of-pocket maximum** — The maximum amount you have to pay in deductibles and coinsurance for certain covered services. Once you reach the out-of-pocket maximum, the plan pays 100% of these covered services for the rest of the calendar year. Copays do not count toward the annual out-of-pocket maximum.

Pharmacy Benefits (for Members of BlueCross BlueShield, PPO Plus — Cigna/Tufts HP Open Access with HSA and Tufts)

If you have medical coverage through one of the following medical plans, you will use a separate company called Express Scripts, instead of your medical plan, to obtain your pharmacy benefits:

- PPO Plus — Cigna/Tufts HP Open Access with HSA
- All BlueCross BlueShield Plans:
  - PPO — BC/BS Blue Care Elect
  - BC/BS HMO — Network Blue New England Options
  - BC/BS HMO — Advantage Blue
- Tufts HMO — Navigator by Tufts Health Plan

If you participate in one of these medical plans, you will not use your medical plan's Identification Card when you fill prescriptions at the pharmacy or order drugs by mail. **Instead, you will use a card issued to you by Express Scripts.**

Prescription Drug Copays — Express Scripts Plans

The following chart shows your copay for covered prescription drugs for all medical plans except Kaiser HMO:

	At the Pharmacy (up to a 30-day supply)	Mail Order (up to a 90-day supply)
Generic	$10 copay	$20 copay
Preferred Brand Name	$35 copay	$70 copay
Non-Preferred Brand Name	$70 copay	$140 copay

Important Note: If you are enrolled in the PPO Plus - Cigna/Tufts HP Open Access with HSA, you must fulfill your annual deductible before the copays apply.

Certain preventive, maintenance and contraceptive drugs are covered in full. More information about prescription drug coverage (other than coverage under the Kaiser HMO) is available at express-scripts.com.

The following chart shows your copay for covered prescription drugs if you are enrolled in the Kaiser HMO:

	At the Pharmacy (up to a 30-day supply)	Mail Order (up to a 100-day supply)
Generic	$10 copay	$20 copay
Brand Name	$35 copay	$70 copay

Certain preventive, maintenance and contraceptive drugs are covered in full. More information about prescription drug coverage under the Kaiser HMO is available at kp.org/formulary.

List of Formulary and Non-Covered Drugs

Express Scripts publishes a list, called a "formulary," that categorizes covered and non-covered drugs. This list is updated every year.

New and experimental prescription drugs will not be covered by Express Scripts unless they have been approved by the Food and Drug Administration (FDA) for a specific diagnosis.

To find the list of formulary drugs and drugs that are not covered:

- Log on to www.express-scripts.com, or
- Call Express Scripts at +1 866 344 2920 (TDD number: +1 800 899 2114).

Participating Pharmacies

You must use participating pharmacies and/or the Express Scripts mail-order program to receive benefits under the Pharmacy Plan. To find a list of participating pharmacies:

- Log on to www.express-scripts.com, or
- Call Express Scripts at +1 866 344 2920 (TDD number: +1 800 899 2114).

Specialty Drugs

Specialty drugs, such as growth hormone injectables and chemotherapy medications, will be provided exclusively by Accredo, Express Scripts' specialty pharmacy. Accredo representatives will work with you and your physician to deliver your specialty medications and supplies directly to you and to your physician.

For more information about specialty drugs, please visit www.accredo.com.

For More Information about Pharmacy Benefits

For more information about the Pharmacy Plan:

- Log on to www.express-scripts.com, or
- Call Express Scripts at +1 866 344 2920 (TDD number: +1 800 899 2114).

Kaiser HMO and Aetna Global Medical Plan Members

If you elect the Kaiser HMO or if you are an expatriate employee who participates in Aetna Global Benefits, you will continue to fill prescriptions via your medical plan. The Kaiser HMO uses only Kaiser pharmacies. Since Aetna Global Benefits is for use outside the United States, you may use any pharmacy.

For More Information

If you have any questions about your medical plan options call your plan directly at the number shown in the following table. **If you need emergency care, seek care at the nearest emergency room or call 911. If 911 services are not available in your area, call the local number for emergency medical services.**

Medical Plan	Member Services	Mental Health Services	Precertification*	For Hearing-Impaired People	Website
All BlueCross BlueShield Plans	+1 800 352 6259 or send an email to statestreet@bcbsma.com	+1 800 524 4010	+1 800 327 6716	+1 800 522 1254	www.bcbsma.com/statestreet
PPO Plus — Cigna/Tufts HP Open Access with HSA	Prior to enrollment: +1 800 401 4041 Once enrolled: +1 800 244 6224	+1 800 343 2183	+1 800 244 6224	+1 800 735 2929	*Prior to enrollment:* www.mycignaplans.com *ID: statestreet2014* *Password: cigna* *Once enrolled:* www.mycigna.com
Kaiser HMO	+1 800 464 4000	+1 800 464 4000	+1 800 464 4000	+1 800 777 1370	www.kaiserpermanente.org
Tufts HMO — Navigator by Tufts Health Plan	+1 800 423 8080	+1 800 208 9565	+1 800 423 8080	+1 800 868 5850 MassRelay +1 800 720 3480	www.tufts-health.com/statestreet
Aetna Global Benefits	In the United States: +1 813 775 0190 Outside the United States: +1 800 231 7729 Refer to your AT&T Direct wallet card for appropriate access code.			+1 800 325 6273	www.aetnaglobalbenefits.com

*Use this number to find out whether a particular medical issue or procedure is covered. You may also contact the GHR Service Center. See the front page of this SPD for the contact information.

Retiree Medical and Life Insurance

Eligibility

If you retire and you are currently participating in a company-sponsored medical plan, you may elect to continue your medical coverage until age 65 if you:

- Terminate employment at or after age 55 and before age 65;
- Have completed five or more years of Eligible Service; and
- Already participate in State Street's medical program at the time of retirement.

Eligible Service for this purpose means the service counted from your date of hire or adjusted service date (if applicable) through your termination date, as determined by State Street in its sole discretion. (Note: This definition generally includes all service with State Street and any service counted as a result of an acquisition that occurred before February 1, 2003, but does not include service as a result of an acquisition on or after February 1, 2003.)

You may also continue coverage for your eligible family members. Generally, eligible family members include your Spouse/Domestic Partner, your Eligible Child(ren) and Other Adult Dependents. Kaiser does not allow enrollment of Other Adult Dependents.

Note: If you are under age 65 and at least age 55, have completed five or more years of Eligible Service and are considering early retirement, please be aware that you must be a participant in a State Street-sponsored medical plan at the time of retirement in order to be eligible for State Street medical during early retirement.

If you are under age 65 and terminated under a State Street severance program, and you are retirement-eligible based on your age and years of Eligible Service when you terminate, you may also be eligible for retiree medical coverage once you reach the Benefits End Date for your severance period.

Changing Your Elections

You will have an opportunity to change your medical election at annual enrollment each year; however, you will not be able to increase your coverage level (for example, you could not increase from Individual Only to Individual + Spouse/Domestic Partner).

Coverage Ends at Age 65

Once you reach age 65, you will no longer have medical coverage through State Street. You may, however, be eligible to submit eligible expenses for reimbursement from the Retiree Health Expense Reimbursement Account funded by State Street. Also, you generally become eligible for Medicare at age 65. Please keep the following in mind:

- If the Tobacco User election should be updated once your coverage ends to reflect your spouse's or domestic partner's status, your spouse or domestic partner should call the GHR Service Center.
- If your spouse or domestic partner will remain enrolled in the PPO Plus — Cigna/Tufts HP Open Access with HSA, he or she will need an HSA with JPMorgan Chase in his or her own name in order to receive any State Street contribution. The opening of the HSA will be initiated on your spouse's/domestic partner's behalf by the GHR Service Center. However, if there is any delay in the opening of this account, your spouse/domestic partner will receive information from JPMorgan Chase.

Spouse/Domestic Partner/Dependent Coverage for Retirees under Age 65

Your Spouse's/Domestic Partner's and dependents' benefits depend on their age:

- **Spouse/Domestic Partner—Under Age 65—**If, upon your early retirement, your covered Spouse/Domestic Partner is under age 65, you may continue to cover him or her under your medical plan. If you reach age 65 before your Spouse/Domestic Partner does, he or she may continue to participate in the medical program at the individual coverage level, and you will have to pay 100% of the cost of this coverage. Once your Spouse/Domestic Partner reaches age 65, his or her State Street medical coverage will end. State Street will then credit $5,000 to your Retiree Health Expense Reimbursement Account, and you can apply for reimbursement for his or her eligible medical expenses that are not covered by Medicare or other insurance.

- **Spouse/Domestic Partner—Age 65 and Older—**If, upon your early retirement, your covered Spouse/Domestic Partner is age 65 or older, his or her medical coverage ends. State Street will credit $5,000 to your Retiree Health Expense Reimbursement Account, and you may apply for reimbursement for his or her eligible medical expenses that are not covered by Medicare or other insurance. As an early retiree, you will remain in your current plan but change to individual coverage, unless you have other eligible dependents.

- **Eligible Child(ren)—Under Age 26 and Other Adult Dependent—**Upon early retirement, you may continue medical coverage for your Eligible Child(ren) (Medical) who are under age 26 until you reach age 65. Once you reach age 65, medical coverage for dependents under age 26 will end.

COBRA

When coverage ends for you, your Spouse/Domestic Partner, and/or your eligible dependents, COBRA continuation coverage may be available. Any medical coverage elected through COBRA will be secondary to Medicare, if applicable. For more information about COBRA, see the Your Rights and Responsibilities section.

Cost Sharing for Retirees under Age 65

Hired on or after January 1, 2008

If you are at least age 55 but under age 65 with at least five years of Eligible Service on the date you retire, you pay the full cost of your retiree medical coverage at group rates. (You must be currently participating in a State Street–sponsored medical plan on the date you retire to be eligible for retiree medical coverage.)

Hired prior to January 1, 2008

The amount you pay toward your retiree medical coverage depends on your age and Eligible Service on December 31, 2007, as shown in the chart below. Please note that you can only qualify for the coverage described in one of the scenarios described below and you must meet all the eligibility criteria described in the applicable box.

Standard Early Retiree Medical Premium Schedule	
You Are an under Age 65 Retiree and …	**Cost to You**
You were hired prior to January 1, 2008, and meet all the following criteria on the date you terminate: • age 55 or older with ten or more years of Eligible Service as of December 31, 2007; and • you participate in a State Street sponsored medical plan.	You pay the rate an active employee pays in the lowest income band (subject to annual adjustments).
You were hired prior to January 1, 2008 and do not qualify for the option above, but you meet all the following criteria on the date you terminate: • on December 31, 2007, you were at least age 47 with at least seven years of eligible service; • are at least age 55 with at least ten years of Eligible Service when you terminate; and • you participate in a State Street–sponsored medical plan.	You pay the full cost of coverage at the Company's group rates, but you receive a monthly fixed dollar subsidy which is applied toward the monthly cost of coverage as follows: • $175 for Individual Only coverage • $345 for Individual + Spouse/DP coverage • $345 for Individual + Child(ren) coverage • $540 for Individual + Family coverage.
If you do not qualify for either option above but you have attained age 55 with five or more years of Eligible Service on the date you terminate and you participate in a State Street–sponsored medical plan.	You pay the full cost at group rates.

You pay your share of the cost in one of three ways:

- **Deducted from retirement plan annuity payments**—If you are receiving retirement plan annuity payments, you may elect to have your share of the cost of medical coverage deducted from your monthly annuity payments, provided they will cover the cost of medical coverage.
- **Monthly invoice**—You will receive a monthly invoice to use to pay your medical coverage each month.
- **Automatic Bank Withdrawal** — Allows you to pay for your health and insurance coverage via automatic deductions from your bank account each month, rather than receiving a monthly invoice.

If You Waive Medical Coverage

If you do not have medical coverage at the time of your retirement, or you elect not to continue it, you cannot enroll at a later date. You may, however, be eligible for the Retiree Health Expense Reimbursement Account when you reach age 65, as explained below.

Retiree Health Expense Reimbursement Account — Age 65 and Older

You are eligible for the Retiree Health Expense Reimbursement Account when you reach age 65 (or later, if you retire after age 65), whether or not you are enrolled in State Street medical coverage, if you:

- Terminate employment between age 55 and under age 65 and had completed five or more years of Eligible Service when you left State Street, or
- Terminate employment at or after age 65 and had completed five or more years of Eligible Service when you left State Street.

If you are eligible for the Retiree Health Expense Reimbursement Account when you reach age 65 (or on your retirement date, if you retire after age 65), State Street credits a Retiree Health Expense Reimbursement Account on your behalf that you can use to help pay for your eligible medical expenses (for example, medical plan premiums, Medicare premiums, deductibles or coinsurance). The credit depends on your coverage level when you reach age 65 (or your retirement date, if later). At the time of your retirement, you receive:

- **$5,000** if you have no medical coverage at State Street;
- **$10,000** if you cover just yourself through a State Street–sponsored US medical plan; or
- **$15,000** if you cover yourself and a Spouse/Domestic Partner through a State Street–sponsored US medical plan. (If your Spouse/Domestic Partner is under age 65, your account will be credited with $10,000 initially at the time of your retirement. The additional $5,000 will be credited when your Spouse/Domestic Partner reaches age 65.)

This is a one-time credit, *not* an annual credit.

In the event that you are married to another State Street employee, you may either keep separate accounts of $10,000 each (assuming that you were both covered by State Street's medical plan – either individually or on One + One coverage) or you may have a joint account of $20,000.

Note: If you are age 65 or older, terminated under a State Street severance program, and you are retirement-eligible based on your age and years of eligible service when you terminate, you may also be eligible for the Retiree Health Reimbursement Account once you reach the Benefits End Date for your severance period.

Reimbursement from Your Account

You may submit a reimbursement request for eligible medical expenses for yourself or for your eligible Spouse/Domestic Partner.

Note: Your Domestic Partner's expenses are generally not eligible for reimbursement unless he or she qualifies under the IRS rules as a tax dependent. You will have to certify that the expense is eligible for reimbursement each time you submit a claim.

You must apply for reimbursement of eligible expenses within 18 months of the date of service. Reimbursement Account forms are available on netbenefits.com/statestreet.

Medicare for Retirees

Medicare benefits will likely become available to you and your Spouse/Domestic Partner on the first day of the month after the date you each reach age 65. (If your 65th birthday falls on the first day of a month, your Medicare coverage will be effective the first day of the previous month. Information regarding Medicare eligibility and enrollment will be sent to you directly from the Social Security Administration. If you do not receive this information as you near your 65th birthday, you should contact the Social Security Administration at:

- +1 800 772 1213, or
- Online at http://www.ssa.gov.

Medicare enrollment may be automatic in certain circumstances (e.g., when you reach age 65 and you elect to receive your Social Security benefits). It is important that you review the rules for Medicare enrollment available on the website for the US Social Security Administration at http://www.ssa.gov and at the Medicare website http://www.medicare.gov.

Note: If you or your Spouse/Domestic Partner fail to enroll in Medicare when you each are first eligible to enroll the delay could increase the cost of monthly Medicare premiums and delay the effective date of

coverage. You should review the enrollment rules at the Medicare website http://www.medicare.gov for more information.

State Street assumes that you and/or your eligible Spouse/Domestic Partner are enrolled in Medicare upon reaching age 65. State Street recommends that you also consider purchasing a personal Medicare supplement plan (such as BlueCross BlueShield Medex or an HMO senior plan).

When you are eligible for Medicare and Medicare is allowed by federal law to be the primary payor, the coverage provided by your State Street–sponsored health plan will be reduced by the amount of benefits allowed under Medicare for the same covered services. This reduction will be made whether or not you actually receive the benefits from Medicare.

Spouse/Domestic Partner/Dependent Coverage for Retirees Age 65 or Older

Your Spouse's/Domestic Partner's and dependents' benefits depend on their age:

- **Spouse/Domestic Partner—Under Age 65—**If upon your retirement, your covered Spouse's/Domestic Partner's is under age 65, he or she may continue State Street medical coverage. You will pay 100% of the cost for this coverage. Once your Spouse/Domestic Partner reaches age 65, his or her coverage under the medical program will end. State Street will fund an additional $5,000 into your Retiree Health Expense Reimbursement Account over and above the $10,000 provided to you at age 65. You can then apply for reimbursement for your own and/or your Spouse's/Domestic Partner's eligible medical expenses that are not covered by Medicare or other insurance. Note: Your Domestic Partner's expenses are generally not eligible for reimbursement unless he or she qualifies under the IRS rules as a tax dependent. You will have to certify that the expense is eligible for reimbursement each time you submit a claim.
- **Spouse/Domestic Partner—Age 65 and Older—**If, upon your retirement, your covered Spouse/Domestic Partner is age 65 or older, his or her State Street medical coverage will cease. You will receive an additional $5,000 in your Retiree Health Expense Reimbursement Account for a total of $15,000. You can then apply for reimbursement for your own and/or your Spouse's/Domestic Partner's eligible medical expenses that are not covered by Medicare or other insurance. Note: Your Domestic Partner's expenses are generally not eligible for reimbursement unless he or she qualifies under the IRS rules as a tax dependent. You will have to certify that the expense is eligible for reimbursement each time you submit a claim.
- **Dependent Benefits: Eligible Child(ren)/Other Adult Dependent—**Upon your retirement at age 65 or later, medical coverage will end for your covered eligible child(ren)/Other Adult Dependent. They may be eligible to elect to continue coverage under COBRA.

COBRA

COBRA continuation coverage may be available when coverage ends for you, your spouse/domestic partner, and/or your eligible dependents. Any medical coverage elected through COBRA will be secondary to Medicare, if applicable. For more information about COBRA, see the Your Rights and Responsibilities section.

Other Events – Death or Divorce

See the applicable Summary Plan Description for the Plan for further information on what happens in the event of death or divorce, as well as for information on other benefits that may be impacted by your retirement.

If You Die

Spouse/Domestic Partner

If you had State Street–sponsored medical coverage at the time of your death, your covered Spouse's/Domestic Partner's benefits would be determined as follows:

Your Age at Death	Your under Age 65 Spouse/Domestic Partner	Your Age 65 or Older Spouse/Domestic Partner
Under 65	May continue State Street medical coverage until age 65, but must pay 100% of the cost of coverage Upon reaching age 65, would be eligible for up to $10,000 through the Retiree Health Expense Reimbursement Account	Would be eligible for up to $10,000 through the Retiree Health Expense Reimbursement Account
65 or Older	May continue State Street medical coverage until age 65, but must pay 100% of the cost of coverage Upon reaching age 65, would be eligible for your remaining Retiree Health Expense Reimbursement Account balance plus an additional $5,000	Would be eligible for the remaining Retiree Health Expense Reimbursement Account balance

If you did not have State Street–sponsored medical coverage at the time of your death, your Spouse/Domestic Partner would be eligible to submit eligible expenses to any remaining Retiree Health Expense Reimbursement Account balance. This account becomes available to your Spouse/Domestic Partner when he or she reaches age 65.

Other Covered Dependents

Any non-Spouse/non–Domestic Partner dependent's coverage would end upon your death. He or she may be eligible to continue coverage under COBRA. For more information about COBRA, see the Your Rights and Responsibilities section.

If You Divorce

If you divorce, your former spouse will no longer be eligible for State Street early retiree medical coverage (except to the extent an applicable court order requires continued coverage). He or she may be eligible to continue coverage under COBRA. For information about court orders and COBRA, see the Your Rights and Responsibilities section.

With regard to the Retiree Health Expense Reimbursement Account, your former spouse's expenses will not be eligible for reimbursement. Your account will be determined as follows

- **If your spouse is under age 65 at the time of your divorce,** your account will not be credited with the additional $5,000 that is normally provided to retirees with a Spouse/Domestic Partner.
- **If your spouse is age 65 or older at the time of your divorce,** your account will not be reduced. However, only your expenses can be reimbursed from the account after your divorce.

You cannot enroll a new spouse/domestic partner or other dependent in the future in a State Street–sponsored medical plan.

Eligibility Chart for Retiree Medical Benefits

Following is a summary of the retiree medical benefit eligibility rules for retirees, Spouse/Domestic Partners and other dependents.

HIRED ON OR AFTER JANUARY 1, 2008

The following chart describes the retiree medical coverage rules that apply to State Street retirees hired on or after January 1, 2008. *Please note that you can only qualify for the coverage described in one of the scenarios described below, and you must meet all the eligibility criteria described in the applicable box.*

Your Coverage		**Spouse/Domestic Partner Coverage**		**Other Dependents' Coverage**	
If you are a retiree who is…	**Benefits are…**	**If you have a Spouse/Domestic Partner who is…**	**Benefits are….**	**If you have Eligible Children who are…**	**Benefits are…**
Hired on or after January 1, 2008, and meet all the following criteria on the date you retire: • Age 55 or older with at least five years eligible service • Under age 65 • Participating in a State Street–sponsored medical plan	The active employee medical plan and you pay the full cost of coverage at the Company's group rates	Under age 65 and covered under your medical plan with State Street when you retire	Covered under the active employee medical plan as your dependent until he or she reaches age 65	Under age 26 or disabled as determined by your medical plan	Covered under the active employee medical plan until your dependents no longer meet the definition of an Eligible Child(ren) (Medical) or disabled, or you reach age 65, whichever happens first
		Age 65 or older and covered under your medical plan with State Street when you retire	State Street Retiree Health Expense Reimbursement Account funded at $5,000 lifetime applicable to Spouse/Domestic Partner eligibility		
Hired on or after January 1, 2008, and meet all the following criteria on the date you retire: • Age 65 or older • Five or more years of eligible service • Covered under State Street–sponsored medical plan	State Street Retiree Health Expense Reimbursement Account funded at the basic $5,000 level and by an additional $5,000 for $10,000 lifetime maximum	Under Age 65 and covered under your medical plan with State Street when you retire	Covered under the active employee medical plan as your dependent until he or she is age 65 at 100% of the premium	Under age 26 or disabled as determined by your medical plan	May be eligible for COBRA at 102% of the premium
		Age 65 or older and covered under your medical plan with State Street when you retire	Retiree Health Expense Reimbursement Account funded by an additional $5,000, bringing the account total for you and your Spouse/Domestic Partner combined to $15,000 lifetime		

Your Coverage		Spouse/Domestic Partner Coverage		Other Dependents' Coverage	
Hired on or after January 1, 2008, and meet all the following criteria on the date you retire: • Age 65 or older • Five or more years of eligible service • Not covered under a State Street–sponsored medical plan	State Street Retiree Health Expense Reimbursement Account funded at the basic $5,000 level	Any age	Eligible expenses may be reimbursed from your Retiree Health Expense Reimbursement Account	Under age 26 or disabled as determined by your medical plan	Not Applicable

Note: The 18-month COBRA period begins on the first of the month following your termination/retirement date and runs concurrent with any company-subsidized benefits.

If you are covering an Other Adult Dependent, coverage ends the earlier of the date they no longer meet the definition of Other Adult Dependent or the date you reach age 65.

HIRED PRIOR TO JANUARY 1, 2008

The following chart describes the retiree medical coverage rules that apply to State Street retirees hired prior to January 1, 2008. *Please note that you can only qualify for the coverage described in one of the scenarios described below and you must meet all the eligibility criteria described in the applicable box.*

Your Coverage		**Spouse/Domestic Partner Coverage**		**Other Dependents' Coverage**	
If you are a retiree who is…	**Benefits are…**	**If you have a Spouse/Domestic Partner who is…**	**Benefits are….**	**If you have other Eligible Children/Other Adult Dependent (Medical) who are…**	**Benefits are…**
Hired prior to January 1, 2008, and meet all the following criteria on the date you retire: • Under age 65 when you retire • Age 55 or older with ten or more years of eligible service on December 31, 2007 • Participate in a State Street–sponsored medical plan	The active employee medical plan and you pay the same medical plan costs for coverage as active employees	Under age 65 and covered under your medical plan with State Street when you retire	Covered under the active employee medical plan as your dependent until he or she reaches age 65	Under age 26 or disabled as determined by your medical plan	Covered under the active employee medical plan until your dependents no longer meet the definition of an Eligible Child(ren) /Other Adult Dependent (Medical), or you reach age 65, whichever happens first
		Age 65 or older and covered under the medical plan with State Street when you retire	State Street Retiree Health Expense Reimbursement Account funded at $5,000 lifetime		
Hired prior to January 1, 2008, and you do not qualify for the above option but meet all the following criteria on the date you retire: • Age 47 or older with 7 or more years of eligible service on December 31, 2007 • Retire when you are at least age 55 with at least ten years of eligible service • Under age 65 when you retire • Participate in a State Street–sponsored medical plan	The active employee medical plan and you pay the full cost of coverage at the Company's group rates, but you receive monthly fixed-dollar subsidy equal to 50% of the average cost of active employee coverage (set in 2007) applied toward the monthly cost of coverage	Under age 65 and covered under your medical plan with State Street when you retire	Covered under the active employee medical plan as your dependent until he or she reaches age 65	Under age 26 or disabled as determined by your medical plan	Covered under the active employee medical plan until your dependents no longer meet the definition of an Eligible Child(ren) or /Other Adult Dependent, or you reach age 65, whichever happens first
		Age 65 or older and covered under the medical plan with State Street when your retire	State Street Retiree Health Expense Reimbursement Account funded at $5,000 lifetime		

Your Coverage		Spouse/Domestic Partner Coverage		Other Dependents' Coverage	
If you are a retiree who is…	**Benefits are…**	**If you have a spouse/domestic partner who is…**	**Benefits are….**	**If you have other eligible children/Other Adult Dependent (Medical) who are…**	**Benefits are…**
Hired prior to January 1, 2008, and you do not qualify for either of the options above but you meet all the following criteria on the date you retire: • Age 55 or older with at least 5 years of eligible service • Under age 65 • Participate in a State Street–sponsored medical plan	The active employee medical plan and you pay the full cost of medical coverage at the Company's group rates	Under age 65 and covered under your medical plan with State Street when you retire	Covered under the active employee medical plan as your dependent until he or she reaches age 65	Under age 26 or disabled as determined by your medical plan	Covered under the active employee medical plan until your dependents no longer meet the definition of an eligible child(ren) or /Other Adult Dependent, or you reach age 65, whichever happens first
		Age 65 or older and covered under the medical plan with State Street when you retire	State Street Retiree Health Expense Reimbursement Account funded at $5,000 lifetime		
Hired prior to January 1, 2008, and meet all the following criteria on the date you retire: • Age 65 or older • Five or more years of eligible service • Participate in a State Street–sponsored medical plan	State Street Retiree Health Expense Reimbursement Account funded at the basic $5,000 level and by an additional $5,000 for $10,000 lifetime maximum	Under age 65 and covered under your medical plan with State Street when you retire	Covered under the active employee medical plan until age 65 at 100% of the premium	Under age 26 or disabled as determined by your medical plan	May be eligible for COBRA at 102% of the premium
		Age 65 or older and covered under the medical plan with State Street when your retire	Retiree Health Expense Reimbursement Account funded by an additional $5,000 bringing the account total for you and your spouse/domestic partner combined to $15,000 lifetime		

Your Coverage		Spouse/Domestic Partner Coverage		Other Dependents' Coverage	
Hired prior to January 1, 2008, and meet all the following criteria on the date you retire: • Age 65 or older • Five or more years of eligible service • Not covered under a State Street–sponsored medical plan	State Street Retiree Health Expense Reimbursement Account funded at the basic $5,000 level	Any age	Eligible expenses may be reimbursed from your Retiree Health Expense Reimbursement Account	Under age 26 or disabled as determined by your medical plan	Not Applicable

Note: The 18-month COBRA period begins on the first of the month following your termination/retirement date and runs concurrent with any company-subsidized benefits.

If you are covering an Other Adult Dependent, coverage ends the earlier of the date they no longer meet the definition of Other Adult Dependent or the date you reach age 65.

Retiree Life Insurance

Eligibility

If you meet the eligibility requirements for Retiree medical benefits described above, you are also eligible for Retiree Life Insurance. Your level of Retiree Life Insurance coverage depends on your full-time or part-time status as of your termination date:

Your Status at Retirement	Coverage at Retirement
Full-time (regularly work 29 or more hours per week)	$5,000
Part-time (regularly work at least 20 but less than 29 hours per week)	$2,500

If you are eligible for this benefit upon termination of employment, you will be provided with a statement called "Your Personal Fact Sheet" showing the amount of your Retiree Life Insurance coverage.

State Street pays the full cost of Retiree Life Insurance coverage.

You may also elect to convert your Basic and Optional Term Life Insurance coverage that was in effect as of your retirement date (less the applicable amount of Retiree Life Insurance). For more information, see the Conversion and Portability of Life Insurance Coverage section.

Note: If you are terminated under a State Street severance program, and you are retirement-eligible based on your age and years of eligible service when you terminate, you may also be eligible for Retiree Life Insurance once you reach the Benefits End Date for your severance period.

While State Street intends to continue Retiree Medical and Life Insurance coverage for the foreseeable future, the Company reserves the right to terminate, modify or amend retiree benefits, and change the cost charged for such coverage, if applicable, at any time and for any reason.

Dental Plan

Depending on your work location, you may have two options for dental coverage for yourself and your family, both administered by Delta Dental.

- Delta PPO Plus Premier
- DeltaCare USA (MA, CA, NY, NJ, PA and RI)

Since early and regular attention to dental health can help prevent the need for more costly procedures, no matter which option you choose, preventive services such as routine exams, X-rays and cleanings are generally covered at 100%. If needed, coverage is also available for minor and major restorative dental services at varying levels.

You will find information about these options in several places throughout this SPD:

- Eligibility, Enrollment and Participation—Contains information about State Street's eligibility and enrollment provisions.
- Dental Plan Comparison—Provides an at-a-glance comparison of your Dental Plan options.
- Dental Plan Subscriber's Certificate—Describes in detail how each plan works and what is and is not covered.
- Your Rights and Responsibilities—Contains information about your rights under the Dental Plan, including your right to continue coverage under COBRA, and other important information.

Your Cost

You and State Street share the cost of dental coverage. Generally, you pay your contributions on a pretax basis. See Eligibility, Enrollment and Participation for more information about pretax contributions.

The current costs for dental coverage are listed on the Fidelity NetBenefits website listed on the front page of this SPD.

How the Plans Work

PPO Plus Premier

The Delta Dental PPO Plus Premier program combines two of Delta Dental's national dental networks – Delta Dental PPO and Delta Dental Premier.

You may see any dentist you choose, but typically your costs are lower when you see a dentist who participates in the Delta Dental network.

You will receive the greatest value when you visit a Delta Dental PPO dentist because they generally accept lower fees for their services. And if you choose to visit a dentist who participates in the Delta Dental Premier network, you will also enjoy savings.

Delta Dental's payment for services you receive from an out-of-network dentist is based on the lower of the dentist's fee or the maximum plan allowance for out-of-network dentists. You must pay the difference between Delta Dental's payment and the dentist's total charge.

For a listing of participating Delta Dental dentists, go to the Delta Dental website and click *Find a Dentist* in your state. Or, call the Delta Dental phone number to request that a list for your state be faxed or mailed to you at no cost. State-by-state websites and phone numbers are available in the For More Information section.

DeltaCare USA

DeltaCare works much like a dental HMO, where you and your family receive all your care from a network of participating dentists. You must choose a primary care dentist from the DeltaCare directory. Your benefits are determined based on a predetermined copayment schedule, which varies based on the type of service performed. The schedule lets you see what services are covered and what your out-of-pocket costs will be. For a copy of the schedule for your state, go to the DeltaCare USA website listed in the For More Information section below.

If you currently have a preferred dentist, be sure that he or she participates in DeltaCare USA before you enroll. Only certain dentists participate in the DeltaCare USA plan, so be sure to contact DeltaCare USA at the applicable telephone number listed in the chart below to be sure your dentist participates.

Dental Plan Comparisons

Here is a brief summary of the dental plan options. Full details appear in the applicable subscriber's certificate. If the information provided in the following chart differs in any way from the terms of the applicable subscriber's certificate, the applicable subscriber's certificate prevails.

This chart references different service "types"—Type I, Type II and Type III—as defined by Delta Dental. See Definitions of Service Types for more information.

Dental Plan Benefits	**Delta Dental Plus Premier** *All Locations* **Your Cost**	**DeltaCare USA** *MA, CA, NJ, NY, PA and RI only* **Your Cost**
Calendar-Year Deductible	Individual: $50 Family: $150 maximum	Participating providers: None Out-of-network providers: $100
Type I Services Preventive and Diagnostic	Covered in full; no deductible	Scheduled copay
Type II Services Minor Restorative	20% coinsurance; deductible applies	Scheduled copay
Type III Services Major Restorative	50% coinsurance; deductible applies	Scheduled copay
Orthodontics for Children and Adults	Lifetime maximum benefit of $1,500 per person	Scheduled copay
Annual Maximum Benefit	$1,500 per person	Unlimited
Rollover Max (ROM)	A portion of the $1,500 annual dental benefit maximum that you don't use during the year may be rolled over to next year. If you have at least one cleaning or oral exam and your covered claims don't exceed $700 for the calendar year, then an additional $500 will be added to the calendar year maximum in the following year. (For more details of ROM, please refer to the PPO Plus Summary of Coverage.)	N/A

Additional provisions and limitations apply to dental coverage under DeltaCare USA, depending on the state in which you live. For more information, see the applicable Delta Plan Summaries of Coverage located on netbenefits.com/statestreet.

Definitions of Service Types

Your dental benefits depend on the services you receive. Delta Dental classifies most services into three "types"—Type I, Type II and Type III. Here are some examples.

Type I—Preventive and Diagnostic Services

- Comprehensive evaluation
- Fluoride treatments
- Sealants
- Periodic oral exams
- Full mouth and bitewing X-rays
- Cleaning
- Space maintainers
- Chlorhexidine mouth rinse
- Fluoride toothpaste

Type II—Minor Restorative Services

- Amalgam (silver) fillings
- Composite (white) fillings–front teeth only
- Oral surgery
- Endodontics
- Periodontics
- Prosthetic maintenance
- Emergency dental care
- General anesthesia for covered surgical service

Type III—Major Restorative Services

- Prosthodontics
- Crowns and bridges
- Endosteal implants (in lieu of a three-unit bridge)

For More Information

If you have questions about the Dental Plan, contact Delta Dental directly at the applicable telephone number listed below.

Delta Dental PPO Plus Premier	+1 800 872 0500	www.deltadentalma.com
DeltaCare USA (MA)	+1 800 327 6277	www.deltadentalma.com
DeltaCare USA (CA)	+1 800 422 4234	www.deltadentalins.com
DeltaCare USA (NJ)	+1 800 422 4234	www.deltadentalins.com
DeltaCare USA (NY)	+1 800 422 4234	www.deltadentalins.com
DeltaCare USA (RI)	+1 800 422 4234	www.deltadentalins.com
DeltaCare USA (PA)	+1 800 422 4234	www.deltadentalins.com

Vision Plan

You may elect vision coverage for yourself and your eligible family members. The Vision Plan, offered nationwide through EyeMed, gives you access to a network of eye care providers and discounts on eyeglass lenses, frames, contact lenses and corrective laser eye surgery. Participating providers include Lens Crafters, Pearle Vision, Sears Optical and Target Optical, to name a few. Under the Vision Plan, you may enjoy significant savings on your vision care needs.

You will find information about these options in several places throughout this SPD:

- Eligibility, Enrollment and Participation—Contains information about State Street's eligibility and enrollment provisions.
- EyeMed Vision Summary—Describes in detail how the Vision Plan works and what is and is not covered.
- Your Rights and Responsibilities—Contains information about your rights under the Vision Plan, including your right to continue coverage under COBRA, and other important information.

Vision Plan Summary

The following chart summarizes the in-network and out-of-network benefits available through the Vision Plan. Because some of State Street's medical plans also cover certain eye care services, you might want to review the eye care coverage (if any) in your medical plan before selecting your vision coverage.

Vision Care Services	In-Network	Out-of-Network
Exam with dilation	You pay a $15 copay	The plan pays up to $50
Frames	The plan provides a $100 allowance and a 20% discount on any balance over $100	The plan pays up to $50
Standard plastic lenses		
Single	You pay a $15 copay	The plan pays up to $42
Bifocal		The plan pays up to $78
Trifocal		The plan pays up to $130
Basic Progressives		The plan pays up to $140
Lenticular	20% discount off retail price	
Lens options		
UV coating	You pay $15	No coverage
Tint (solid and gradient)	You pay $15	
Standard scratch-resistance	You pay $15	
Standard polycarbonate	You pay $40	
Standard antireflective coating	You pay $45	
Other add-ons and services	The plan provides a 20% discount off the retail price	
Contact lenses (materials only)		
Conventional	The plan provides a $115 allowance and a 15% discount off any balance over $115	The plan pays up to $92
Disposables	The plan provides a $115 allowance;	The plan pays up to $92

Vision Care Services	In-Network	Out-of-Network
	you pay any balance over $115	
Medically necessary	The plan pays the full cost	The plan pays up to $200
LASIK and PRK vision correction procedures	The plan provides a 15% discount off retail price OR 5% discount off promotional pricing at participating providers	No coverage
Frequency	Exams: Once per calendar year Frames: Once every two calendar years Standard plastic lenses: Once per calendar year Contact lenses: Once per calendar year (in lieu of eyeglass lenses)	

Note: If you do not use the full benefit allowance for a single visit or purchase, you cannot use the remaining amount for another visit or purchase in the future.

Your Cost

You pay the full cost of vision coverage. Generally, you pay your contributions on a pretax basis. See Eligibility, Enrollment and Participation for more information about pretax contributions.

The current costs for vision coverage are listed in the Reference Library on the Fidelity NetBenefits® website at netbenefits.com/statestreet.

For More Information

For more detailed information or to locate a provider near you, contact EyeMed:

- Call +1 866 723 0513
- Visit www.eyemedvisioncare.com.

Disability Benefits

Disability benefits provide income protection if you become disabled due to maternity or a non-work-related illness or injury. Short-Term Disability (STD) benefits are typically payable for up to 26 weeks per calendar year, including any incidental sick days taken in the calendar year. Long-Term Disability (LTD) benefits are payable after 26 weeks (six months) if you remain disabled and are eligible for and elect this coverage.

You will find information about these benefits in several places throughout this SPD:

- Eligibility, Enrollment and Participation—Contains information about State Street's eligibility and enrollment provisions.
- Long-Term Disability Plan Certificate of Coverage—Describes in detail how the LTD Plan works, including any exclusions and limitations. Available on the Fidelity NetBenefits website.
- Your Rights and Responsibilities—Contains information about your rights under the Long-Term Disability Plan and other important information.

Short-Term Disability

Short-Term Disability (STD) pays benefits if you become disabled due to maternity or a non-work-related illness or injury. Prudential administers this program.

Work-related illnesses and injuries are covered solely under the Workers' Compensation Program.

How STD Works

STD payments, if approved, replace all or part of your salary for up to 26 weeks per calendar year, starting with the eighth calendar day of your disability.

Full-time Employees (Employees scheduled to work 29 hours or more per week)

This chart shows the percentage of pay a full-time employee will receive based on the number of weeks you are absent if you qualify for benefits.

STD Payment Schedule for Full-Time Employees		
Years of Service When Disability Begins	**You Receive 100% of Base Pay for This Many Weeks …**	**Then 50% of Base Pay for This Many Weeks …**
0–3	8	18
4–6	14	12
7–9	20	6
10 or more	26	N/A

Part-Time Employees (Employees scheduled to work between 20 and 28 hours per week)

Part-time employees scheduled to work at least 20 hours per week are eligible for STD after one year of service. The benefit calculation is based on the normal work schedule in place before the disability began. This chart shows the percentage of pay a part-time employee will receive based on the number of weeks you are absent if you qualify for benefits.

STD Payment Schedule for Part-Time Employees	
Years of Service When Disability Begins	**You Receive 100% of Base Pay for This Many Weeks …**
1–3*	8
4–6	14
7–9	20
10 or more	26

Employees who are employed through an internship program ("Interns") or through a cooperative education program ("Co-op") are not eligible for STD benefits.

Reductions for Other Disability Income

Your STD benefits are reduced by any disability income you receive from other sources, such as Social Security or state disability plans.

Cost

State Street pays the full cost of STD coverage.

How STD Benefits Are Paid

Your STD benefits are paid in your regular State Street paycheck. Your regular benefit deductions (e.g., medical, dental and 401(k) plan contributions) will continue to be withheld from your STD benefits. See the Eligibility, Enrollment and Participation section for more information about how your benefits are affected while you are receiving STD benefits.

How to Apply for STD Benefits

Follow these steps to apply for STD benefits.

1. **Notify your manager.** If you are unable to work due to maternity or a non-work-related illness or injury, you should notify your manager at least two weeks in advance. If your absence is unanticipated, notify your manager as soon as possible. If you are unable to call, a family member or health care professional should call on your behalf. Failure to notify your manager could result in disciplinary action, up to and including termination. You do not have to disclose your condition or diagnosis to your manager.
2. **Report your claim.** If you are absent from work due to an injury, illness or pregnancy for five or more business days, call the GHR Service Center at +1 855 447 7007 and follow the prompts to report a disability claim. **You will then be connected to Prudential, our STD program administrator.**
3. **Submit a completed attending physician's statement and medical release.** You must submit an attending physician's statement (completed by your physician) and medical release (signed by you) and submit these forms to Prudential.

   On the attending physician's statement, your physician must indicate the nature of your illness or disability and the anticipated date that you can return to work. Failure to submit this documentation will result in STD benefits being delayed, rejected or discontinued.
4. **Keep your manager informed.** You should periodically contact your manager throughout your absence and before you return to work.

Prudential may, at its expense, require you to be examined by a physician other than your own before approving any STD payment. Prudential will periodically require additional evidence of your disability as a condition for continuing payment. If you fail to comply with such a request, the result may be an interruption in or suspension of benefits. Benefits may also be suspended if the results of the independent examination determine that you are not disabled under the definition of the STD Plan.

If your claim is denied, see the Short-Term and Long-Term Disability Claims and Appeals section for information about your right to appeal the denial.

When STD Payments Cease

STD payments stop on the earliest of:

- The date you are determined to no longer be disabled;
- The end of the STD Plan's maximum benefit period;
- The date you go to work for another employer and cease to be a State Street employee; or
- The date of your death.

If You Return to Work and Become Disabled Again

If you return to work for less than 30 days and then become disabled again due to the same or a related illness, your second disability (if approved) will be considered a continuation of the first. If the second disability is not related, or your disability recurs more than 30 days from when you returned to work, you will begin a new STD benefit payments period.

In any event, you must reapply for STD benefits if you return to work and then become disabled again.

Vacation Accruals During STD

You continue to earn vacation time while you are receiving STD benefits. If you are unable to use the accrued vacation time in the calendar year in which your STD leave begins, you will forfeit those unused days. You cannot carry over or accumulate vacation time from one calendar year to the next.

If a Third Party Is Liable

You must reimburse State Street for any STD payments that are paid to you if you receive compensation from a third party that is responsible for your illness or injury. This reimbursement will be required only if the amount you receive from the third party exceeds your expenses (including attorney's fees) for settlement and medical bills.

What Is Not Covered

STD benefits are not payable for disabilities caused by work-related injuries or illnesses (these may be covered by Workers' Compensation). The loss of a professional or occupational license or certification does not, in itself, constitute a disability.

For More Information

If you have questions about STD benefits or need to file a claim, please call +1 855 447 7007, Option 3 to be connected with a representative from Prudential.

Long-Term Disability

The Long-Term Disability (LTD) Plan is insured and administered by Prudential, and provides income protection for you and your family if you are totally disabled and unable to work. Following is a brief summary of the LTD Plan. See the Long-Term Disability Plan Certificate of Coverage for more information about how the LTD Plan works. This is available in the Reference Library on netbenefits.com/statestreet**.**

LTD Plan Options

You may elect LTD at a coverage level of either:

- 50% of your benefit salary up to a maximum benefit of $10,000 per month, or
- 70% of your benefit salary up to a maximum benefit of $15,000 per month.

Enrolling or Changing Coverage

You will be automatically enrolled in the 50% option. If you wish to opt out or change coverage to 70%, you must make the change within 31 days of your hire date. The coverage you elect will be in effect the entire plan year and cannot be changed until the next annual enrollment for a January 1 effective date.

TERMS YOU SHOULD KNOW

- **Benefit salary —** The salary used to calculate your benefit is your base pay plus shift differential, if applicable, not including overtime pay or other bonus compensation.
- **Disabled —** You are considered disabled if you cannot perform the material and substantial duties of *your* regular occupation for the first 24 months of your disability. After that period, you will continue to be considered disabled if you are unable to perform the duties of *any* gainful occupation for which you are reasonably qualified, taking into account your training, education and experience.

How the Plan Works

The LTD Plan begins to pay a benefit after you have been disabled and are unable to work for six continuous months, subject to approval by Prudential. LTD benefits are paid monthly.

Any benefits payable under State Street's LTD Plan will be reduced by primary and family Social Security benefits. In addition, the combination of the disability benefits under this plan and benefits you receive from all other sources — such as Social Security and Workers' Compensation — may never exceed 50% or 70% of your benefit salary, depending on the coverage level you elect.

For example, if you elect the 50% coverage level option and your monthly benefit salary is $1,500, you would be entitled to receive 50% of your benefit salary, or $750 a month, when LTD benefits are combined with income from other sources.

The minimum LTD benefit you will receive is $100 per month.

When Benefits End

LTD benefits typically continue until:

- You reach your normal Social Security retirement age or the maximum period for benefits specified in the LTD Plan Certificate;
- You retire (that is, you elect to begin receiving payments from the State Street Retirement Plan);
- You are no longer considered disabled by Prudential; or
- You die.

Your Cost

You pay the full cost of LTD coverage, if you elect this coverage. Your contributions for this benefit are paid with after-tax dollars. Because you pay for coverage with after-tax dollars, LTD benefit payments, should you ever qualify for this benefit, are not subject to federal income tax.

The current costs for LTD coverage are available on the Fidelity NetBenefits website at netbenefits.com/statestreet.

Policy Provisions

The LTD Certificate of Coverage is designed to encourage rehabilitation and return to work. You should be aware that there are certain limitations included in the Certificate of Coverage. The duration of benefits may be limited if your disability is caused by certain conditions. A new participant may be subject to pre-existing condition limitations. Please consult the LTD policy on NetBenefits for additional details.

How to Apply for LTD Benefits

Prudential will contact you prior to the end of your STD benefit period to begin the LTD application process.

If your claim is denied, see the Short-Term and Long-Term Disability Claims and Appeals section for information about your right to appeal the denial.

Other Benefits While on LTD

Employees who have elected LTD coverage continue participating in the following State Street benefit plans while receiving LTD payments from State Street:

- Medical (including pharmacy benefits)
- Dental
- Vision
- Employee and Spouse Life Insurance
- Employee AD&D Insurance
- State Street Retirement Plan (frozen)

Survivor Benefit

If you were disabled for at least 180 consecutive days or longer and you were entitled to LTD benefits under the plan when you die, your spouse, if living, otherwise your children under age 26, if any, will be paid a lump-sum benefit equal to six months of your gross disability payment, as of the date of your death.

Life and Accident Insurance

State Street–sponsored Life Insurance and Accident Insurance Plans are offered through MetLife. While determining how much coverage you may need is a personal decision, you may want to consider factors such as your age, whether you have dependents, your other financial resources and/or your financial obligations.

You will find information about the Life and Accident Insurance Plans in several places throughout this SPD:

- Eligibility, Enrollment and Participation—Contains information about State Street's eligibility and enrollment provisions.
- Life and Accident Insurance Summary of Benefits/Certificates—Describes in detail how the plans work, including any exclusions and limitations. Also available on the Fidelity NetBenefits website.
- Your Rights and Responsibilities—Contains information about your rights under the Life and Accident Insurance Plans and other important information.

Coverage Overview

The following comparison is a brief summary of the Life and Accident Insurance Plans for full-time employees who regularly work 29 or more hours per week. Part-time employees who regularly work at least 20 but less than 29 hours per week receive $10,000 in Company-paid life insurance coverage and may not elect dependent coverage.

Full details of the Life and Accident Insurance Plans appear in the Life and Accident Insurance certificates brochure located in the Summary Plan Descriptions section of the Fidelity NetBenefits website. If the information provided in the following chart differs in any way from the terms of the insurance policies, the insurance policies prevail.

Company-Paid Coverage	
Basic Life Insurance	Two times annual base salary, up to $2.5 Million
Basic AD&D Insurance	$10,000
Business Travel Accident Insurance	Five times annual base salary, up to $1 million*

Optional, Employee-Paid Coverage	
Optional Term Life Insurance Employee	From one to eight times annual base salary, up to $4 million
Spouse/Domestic Partner	$20,000, or 1 to 4 times your base salary, up to $250,000
Child(ren)	$5,000 or $10,000 per child You or your spouse/domestic partner must be enrolled to enroll your children.
Optional Accidental Death and Dismemberment (AD&D) Insurance† Employee	From one to eight times annual base salary, up to $2 million
If You Cover Spouse/Domestic Partner Only	60% of employee's coverage, up to $250,000
If You Cover Child(ren) Only	20% of employee's coverage, up to $50,000 per child
If You Cover Spouse/Domestic Partner and Child(ren)	Spouse: 50% of employee's coverage, up to $250,000 Child(ren): 15% of employee's coverage, up to $50,000 per child

**Commuting to and from work is excluded. The policy covers any loss caused by or resulting from declared or undeclared war, except within the United States and the District of Columbia. There is no double-indemnity provision.*

†Amounts shown are payable in the event of accidental death, as defined by MetLife. A percentage of the AD&D benefit may be payable in the event of certain severe injuries resulting from a covered accident.

TERMS YOU SHOULD KNOW

- **Base salary —** The salary used to calculate your benefit is your current base pay plus shift differential, if applicable, not including overtime pay or other extra compensation.

Eligible Dependents

Eligible dependents for Optional Term Life and Optional AD&D Insurance include:

- Your legal spouse either opposite or same sex if legally recognized under state law or other lawful jurisdiction or your Domestic Partner as defined in the Eligibility, Enrollment and Participation section, and
- Your children, beginning at age 15 days up to their 26th birthday, regardless of student or marital status. A unmarried disabled child may generally continue to be an eligible dependent as long as he or she remains incapable of self-sustaining employment due to a mental or physical handicap. Proof of disability must be submitted within 31 days after your dependent attains the maximum age limit. The coverage of a disabled child may vary by benefit program. Refer to the applicable Summary of Benefits/Certificate of Coverage or the applicable policy for more detail, log on to netbenefits.com/statestreet, and select the *Health & Insurance Reference Library*.

Designating Your Beneficiary

At the time of a Life and AD&D Insurance claim, benefits are paid to your beneficiary on file. It is a good idea to keep your beneficiary information current to avoid having benefits paid to someone you no longer wish to receive your life insurance proceeds.

In the absence of a beneficiary, your coverage will be paid in the following order:

1. Spouse/Domestic Partner
2. Child(ren)
3. Parents
4. Siblings
5. Estate

You are the automatic beneficiary for the coverage you have for your Spouse/Domestic Partner and/or dependent child(ren), unless another beneficiary is indicated.

How to Designate Your Beneficiary

To designate your beneficiary, log on to netbenefits.com/statestreet and go to the *Your Profile* tab at the top of the page.

Your Cost

State Street pays the full cost of Basic Life Insurance for full-time employees equal to two times your annual salary, up to $2.5 million. You pay imputed income tax on any portion of your basic life insurance coverage that exceeds $50,000. State Street also provides you with $10,000 in AD&D coverage and five times your base salary in Business Travel Accident Insurance, both at no cost to you.

The cost of your Optional Life and Optional Accident Insurance is determined by:

- The amount of insurance you elect

- Your and/or your spouse's age
- Whether you and/or your spouse are a tobacco user

Payroll deductions for Optional Term Life Insurance and Optional AD&D Insurance are made on an after-tax basis.

The current costs for Life and Accident Insurance coverage are listed on the Fidelity NetBenefits website.

Proof of Good Health

If You Enroll Within 31 Days of Your Date of Hire

Within the first 31 days of employment, you may elect the following coverage without having to provide a Statement of Health to MetLife (known as the guaranteed issue amount):

Person	If Requested Within 31 Days of Date of Hire (Plan Maximums Apply)
You	Up to two times annual salary to a maximum of $1 million
Spouse/Domestic Partner	$20,000
Eligible Child(ren)	Statement of Health not required

If you enroll for coverage greater than the amounts shown above, you and/or your Spouse/Domestic Partner must submit a Statement of Health for approval by MetLife. A Statement of Health is a medical questionnaire required by MetLife for approval of certain coverage amounts. Employees who are required to submit a Statement of Health will receive an email with a link to the MetLife website from "MetLife Statement of Health" within five to ten business days after you make your election. The subject heading will be: Statement of Health Required by MetLife. If your Spouse/Domestic Partner must submit a Statement of Health, MetLife will send you a letter along with a copy of the form via mail within this same time frame. If you do not receive this email and/or letter within ten business days, please contact the GHR Service Center immediately, as coverage cannot be considered in effect until approved by MetLife.

Until MetLife approves your coverage request (or if it denies your request), coverage will be limited to the amounts shown above. For status on your Statement of Health, call MetLife at +1 800 638 6420 and select Option 1.

Changes Due to Life Events

If you experience any of the following "Life Events" (IRS-qualified status changes) you and your Spouse/Domestic Partner may enroll for certain coverage amounts without providing a Statement of Health, provided you enroll within 31 days of the event:

- Marriage, divorce, legal separation or annulment, or dissolution of a Domestic Partnership
- Addition of a newly eligible Domestic Partner
- Birth or adoption of a child or placement of a child for adoption
- Death of a Spouse/Domestic Partner or Eligible Child(ren)
- A change in your Spouse's/Domestic Partner's employment, if the change results in a loss or gain in eligibility of life insurance coverage
- Purchase of a primary home

Within the first 31 days of the status change, you may elect the following coverage without having to provide a Statement of Health to MetLife:

Person	If Requested Within 31 Days of a Qualified Status Change (Plan maximums apply)
You	Enroll for up to one times base salary or increase your current coverage by one times base salary. A Statement of Health will be required the first time your coverage election exceeds the guaranteed issue amount.
Spouse/Domestic Partner	Enroll for $20,000 or increase current coverage by one times your base salary. A Statement of Health will be required the first time your coverage election exceeds the guaranteed issue amount.
Eligible Child(ren)	Statement of Health not required

If you enroll for coverage that is greater than the amounts shown above, you and/or your Spouse/Domestic Partner must submit a Statement of Health for approval by MetLife. Until MetLife approves your coverage request (or if it denies your request), coverage will be limited to the amounts shown above.

Changes During the Year

You may elect to change your Optional Term Life Insurance coverage for yourself or your Spouse/Domestic Partner at any time during the year. However, you or your Spouse/Domestic Partner must submit a Statement of Health for approval by MetLife to enroll for the first time or increase coverage. Until MetLife approves your coverage request (or if it denies your request), coverage will be limited to the current coverage amount, if any.

How to Elect Changes to Optional Term Life Insurance

You may make changes to your Optional Term Life coverage by calling the GHR Service Center at +1 855 447 7007, Option 1.

Continuation of Life Insurance Coverage

Your current Life Insurance and AD&D coverage (as applicable) continues until the last day of the month in which you terminate. After that, you may continue current coverage by choosing either the “conversion” feature or the “portability” feature directly through MetLife. Both options allow you to continue coverage by paying premiums at group rates without having to show medical evidence of insurability.

You may elect to convert or port your Basic Life, your Optional Employee Life, your Optional Spouse/Domestic Partner Life and your Dependent Child Life Insurance coverage after you leave State Street for any reason.

- MetLife will send information about continuing your coverage directly to your home. Please note that in order to continue coverage through either conversion or portability following the last day of the month in which your termination date occurs, you must elect such continuation within 30 days of such date. If you have not heard from MetLife within 30 days from the last day of the month in which your termination date occurs, you should call MetLife at either +1 877 275 6387 for information about conversion coverage or +1 866 492 6983 for information about portable coverage.

The portability feature, but not the conversion feature, is available for Basic AD&D Insurance and Optional AD&D Insurance. Business Travel Accident Insurance is not portable and cannot be converted to an individual policy when your State Street coverage ends.

Death in Service Benefit

If you are actively employed by State Street at the time of your death, State Street will provide assistance to your surviving family members to purchase tax and financial planning assistance. The value of the assistance will be equal to 2% of your base pay (as of the date of your death) with a minimum value of $1,000 and a maximum value of $4,000. Your family members should contact the GHR Service Center at +1 855 447 7007 for more details.

Corporate Credit Card Coverage

Eligible business travelers are covered by a $500,000 accidental death policy when they pay for their airline tickets with a corporate credit card. This is 24-hour coverage, and it is not limited to actual flight time. For more information, go to the Business Travel Talk community on the State Street Collaborative intranet site.

Workers' Compensation

State-mandated Workers' Compensation benefits provide income to workers or their beneficiaries for injury or death arising by accident out of and in the course of employment. Applicable state laws regulate the type and amount of death benefits and/or indemnity to which you are entitled. Effective on your date of hire, you are covered under State Street Corporation's Workers' Compensation/employers' liability policies. Because state law or country of hire governs these guidelines, they are subject to legislative revision.

International SOS

International SOS provides State Street Corporation travelers and expatriates with worldwide access to high-quality health care and emergency assistance services 24 hours a day. International SOS is the world's largest medical and security assistance company, with more than 3,500 professionals in 24-hour Alarm Centers, international clinics and remote-site medical facilities across five continents.

While not a replacement for your medical plan, International SOS is ready to help you with your medical and security needs when you are traveling on business.

For more information, visit the International SOS Portal, accessible from Corporate Security's intranet site or via the Internet at http://www.internationalsos.com. Click *Members Login*, and enter Membership Number: 11BCPS000162.

Employee Assistance Program

The Employee Assistance Program (EAP), administered by ValueOptions, is a free and confidential program for you and your family members. EAP counselors can help with a wide range of issues, such as:

- Anger, anxiety or grief
- Stress at work or home
- Domestic violence
- Eating disorders
- Emotional concerns
- Family, marital and relationship issues
- Substance abuse
- Child care and elder care consultation and referrals
- Work-related issues

Legal and Financial Consultation

You can also call the EAP for guidance on a number of legal and financial issues, including divorce, domestic violence, estate planning and family budgeting. If you need additional legal or financial assistance, your EAP counselor will refer you to a carefully screened attorney or financial counselor in your community at your expense.

Cost

State Street pays the full cost of the EAP. Fees charged by outside agencies or health care providers to whom you are referred are your responsibility but may be covered by your medical plan. If outside services are required, the EAP counselor will make every effort to help you secure services that you can afford. Be sure to seek authorization from your medical plan, if required.

Confidential and Voluntary

The EAP is confidential, and your conversations with EAP counselors are private. ValueOptions will not share any information about your involvement with or use of EAP services without your prior knowledge and written permission, except as required by law. In addition, your participation in the EAP is voluntary. It is up to you whether to use this benefit. The EAP is offered to support and help you and your family.

In the Event of Your Death

In the event of your death, your covered dependents may access the EAP for a one-year period after your death at no additional charge.

How to Access the EAP

Just call +1 800 249 2399 — 24 hours a day, seven days a week — to speak with a licensed counselor by phone or face-to-face. Telephone consultations and EAP sessions with a counselor for a limited period are provided at no cost to you. You may then be referred out for additional counseling, resources or specialized treatment, if necessary, at additional cost to you depending on your health plan benefits.

You can also access the EAP website at www.achievesolutions.net/statestreet.

Hyatt Legal Plans

You may elect legal plan coverage for yourself and your eligible family members through MetLaw. MetLaw is offered nationwide through Hyatt Legal Plans, a MetLife Company, and gives you access to a network of over 10,000 plan attorneys. With MetLaw, you can receive legal advice and fully covered legal services for a wide range of personal legal matters, including court appearances, document review and preparation, debt collection defense, wills, family matters and real estate matters.

Plan attorney assistance includes:

- Covered legal services
- Telephone and in-person consultations
- Document preparation
- Representation for many frequently needed personal legal matters

Once enrolled, you must remain in the plan for the calendar year.

For more information visit Hyatt Legal Plans online anytime at www.legalplans.com (password: MetLaw) or call +1 800 821 6400).

Continuation of Legal Plan Coverage

Hyatt Legal Plan coverage ends on the first of the month following your termination date. You may continue coverage by porting the plan. To do so, you must contact Hyatt Legal Plan's Client Service Center, at +1 800 821 6400, within 31 days of your termination date and indicate that you want to port coverage. You will be required to pay a fee upfront directly to Hyatt Legal Plans, equaling the monthly group legal plan rate multiplied by the number of months in the set portability period (currently 30 months). Coverage during the portability period is the same as group coverage; the plan design and dependent coverage remain the same.

Please note that portability is currently a set period of 30 calendar months, but that period is subject to change by Hyatt Legal Plans.

Claims and Appeal Process

Overview

For information on how to file an initial claim for benefits, see the relevant plan's section of this SPD below and the relevant Summary of Benefits/Certificates of coverage on NetBenefits.

If your initial claim for benefits is denied in whole or in part, you, your beneficiary or your authorized representative has the right to request reconsideration under the plan in accordance with the procedures outlined in this section or the relevant plan certificate. All requests for reconsideration must be submitted in writing to the applicable reviewing entity as outlined below.

The claims review and appeal procedures vary depending on the type of plan (health care, disability and all other types of plans). These procedures are described in the following pages. Failure to follow the appropriate claims and appeals procedures could prevent you from being allowed to contest a denial in court. All requests for reconsideration must be submitted in writing to the applicable reviewing entity outlined below.

Claims Administrators

The following is a list of the claims administrators and their respective contact information for each of the employee benefit programs that have the discretion and authority to interpret relevant plan provisions and to render benefit determinations for each of the respective benefit plans.

Benefit	Contact Information
Medical and Prescription Drugs	
PPO Plus - Cigna/Tufts HP Open Access with HSA	Cigna HealthCare National Appeals Unit P.O. Box 5225 Scranton, PA 18505-5225 Attn: Appeal Coordinator Tel: +1 800 558 7390
Blue Cross Blue Shield Plans: PPO — BC/BS Blue Care Elect BC/BS HMO — Network Blue New England Options BC/BS HMO — Advantage Blue BC/BS Blue Care Elect	Blue Cross Blue Shield of Massachusetts Member Grievance Program One Enterprise Drive Quincy, MA 02171-2126 Tel: +1 800 472 2689 Fax: 617 246 3616 email: grievances@bcbsma.com
Tufts HMO — Navigator by Tufts Health Plan	Tufts Health Plan Appeals and Grievances Department 705 Mount Auburn Street P.O. Box 9193 Watertown, MA 02471-9193 Tel: +1 800 462 0224
Kaiser HMO	Kaiser Foundation Health Plan, Inc. Expedited Review Unit P.O. Box 23170 Oakland, CA 94623-0170 Tel: +1 888 987 7247 Fax: +1 888 987 2252
Aetna Global Benefits (expatriate employees only)	Aetna Appeals Resolution Team

	P.O. Box 14463 Lexington, KY 40512 Tel: +1 800 231 7729 Fax: +1 800 475 8751 email: AGBService@aetna.com
Express Scripts (administrative appeal)	Express Scripts Attn: Administrative Appeals Department P.O. Box 66587 St. Louis, MO 63166-6587 Tel: +1 800 946 3979 Fax: +1 877 852 4070
Express Scripts (clinical appeal)	Express Scripts Attn: Clinical Appeals Department P.O. Box 66588 St. Louis, MO 63166-6588 Tel: +1 800 935 6103 Fax: +1 877 852 4070 Urgent Clinical Appeal: Tel: +1 800 753 2851
Dental	
Delta Dental PPO Plus Premier	Delta Dental of Massachusetts Attention: Grievances 465 Medford Street Boston, MA 02129 Tel: +1 800 872 0500 Fax: 617 886 1777 www.deltadentalma.com
DeltaCare (Massachusetts)	Delta Dental of Massachusetts Attention: Grievances P.O. Box 9595 Boston, MA 02114-9595 Tel: +1 800 872 0500 Fax: 617 886 1420 www.deltadentalma.com
DeltaCare (California)	Delta Dental Insurance Company Quality Management Department P.O. Box 6050 Artesia, CA 90702 Tel: +1 800 422 4234 www.deltadentalins.com
DeltaCare (Outside Massachusetts and California)	Delta Dental Insurance Company Quality Management Department P.O. Box 1860 Alpharetta, GA 30023 Tel: +1 800 422 4234 www.deltadentalins.com
Vision	
EyeMed Vision Care	FAA/EyeMed Vision Care, LLC Attn: Quality Assurance Dept. 4000 Luxottica Place Mason, OH 45040 Tel: +1 866 939 3633 Fax: 513 492 3259

Long-Term Disability

Prudential Insurance Company of America	Prudential Appeals Review Unit GLDI Main P.O. Box 13480 Philadelphia, PA 19176

Life and Accidental Death & Dismemberment Insurance
Business Travel Accident Insurance

MetLife	Metropolitan Life Insurance Company Group Life Claims P.O. Box 6100 Scranton, PA 18505-6100

When making your request, please be as specific as you can. Your request should:

- State exactly what you are requesting; and
- The reason(s) you believe your request should be approved (specify the plan terms upon which you are relying).

The claims administrator or reviewing person(s) or committees, whichever is applicable, have full discretion and authority to determine all claims under the plans. Any action or determination in the review procedure will be final, conclusive and binding on the claims administrator, Plan Administrator, State Street, you and your family members.

You Are Entitled to Receive …

If your claim for benefits is denied, in whole or in part, you, your beneficiary or your authorized representative will receive a written or electronic notice of your denial. The notice will include:

- The specific reason(s) for the adverse benefit determination;
- Reference to the specific plan provision(s) on which the determination is based;
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why it is needed;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all records, documents and other information relevant to your benefit claim;
- A statement that you have the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied on in making the determination, and, if the determination is based on medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances;
- A description of the plan's review procedures and time limits;
- For urgent care claims, a description of the plan's expedited review process; and
- A statement informing you about your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review.

If you appeal a claim, you, your beneficiary or your authorized representative will receive written or electronic notification of the determination of your appeal. If the claim on appeal is denied in whole or in part, the notice will include:

- The specific reason(s) for the adverse determination;
- Reference to the specific plan provision(s) on which the determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable

access to and copies of all records, documents and other information relevant to your benefit claim;

- A statement that you have the right to obtain, upon request and free of charge, a copy of internal rules or guidelines relied on in making the determination, and, if the determination is based on medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances;
- A statement informing you about the right to bring a civil action under section 502(a) of ERISA; and
- A statement describing any voluntary appeal procedures offered by the plan and your right, upon request, to obtain certain additional information concerning those procedures.

You, your beneficiary or your authorized representative must start any suit or legal action to receive benefits from these plans:

- Within three years after your claim is denied;
- Within three years after the employee dies, if the claim is for death benefits under any plan; or
- Within a shorter period of time, if required by state law.

The following describes the minimum claim review procedures for the various types of claims, as required by law. Each individual claims administrator may be different (e.g., more generous than required by law). You should contact the applicable claims administrator for the procedure that applies to your claim for benefits. (See chart above for contact information.)

Health Care Claims (Medical and Dental Plans and Employee Assistance Program)

Health Care Claim Review Procedures

First, you or your health care provider must file a claim with the appropriate plan. After receiving your claim, the plan's claims administrator will provide notice of its decision within the following time frames.

- *Pre-service claims.* A pre-service claim is a claim that requires notification or pre-approval before receiving care. For example, some plans require that you obtain pre-approval before receiving non-urgent behavioral health or hospital care.

  The claims administrator will provide written or electronic notice of a claim approval or denial within 15 days of receipt of your pre-service claim. This period may be extended up to an additional 15 days for matters beyond the control of the claims administrator. If an extension is necessary, you will be notified before the end of the initial 15-day period of the reasons for the delay and when the claims administrator expects to make a decision.

  If your pre-service claim was filed improperly, you will be notified no later than five days after the pre-service claim is received. Notice of an improperly filed pre-service claim may be provided orally—or in writing, if you request. The notice will identify the proper procedures to be followed in filing the claim. In order to receive notice of an improperly filed pre-service claim, you, your beneficiary, or your authorized representative must have provided a communication regarding the claim to the claims administrator. This communication must include the patient's name, a specific medical condition or symptom and a request for approval for a specific treatment, service, or product.

  If more information is needed to process your pre-service claim, the notice will describe the information needed. Once you are notified of the need to provide additional information, you will have 45 days to supply this information. If you supply the requested information within 45 days, the claims administrator will notify you of its decision within 15 days after the requested information is received. If you do not supply the requested information within the 45-day period, your claim will be denied.

- *Post-service claims.* A post-service claim is a claim for payment of benefits after care has been received. For example, a claim that is submitted after you go to the doctor's office is a post-service claim. Health Care FSA claims are also considered post-service claims.

  The claims administrator will provide written or electronic notice of a claim denial within 30 days of receipt of your post-service claim. This period may be extended up to an additional 15 days for matters beyond the control of the claims administrator. If an extension is necessary, you will be notified before the end of the initial 30-day period of the reasons for the delay and when the claims administrator expects to make a decision.

  If you are notified of the need to provide additional information, you will have at least 45 days to supply this information. If you supply the requested information within 45 days, the claims administrator will notify you of its decision within 15 days after the requested information is received. If you do not supply the requested information within the 45-day period, your claim will be denied.

- *Urgent care claims.* An urgent care claim is a claim that requires notification or pre-approval before receiving care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or that, in the opinion of a physician with knowledge of your medical condition, could cause severe pain that cannot be managed without the requested treatment. (The determination of whether a claim involves urgent care will be made by an individual acting on behalf of the plan, applying the judgment of a "prudent layperson" who possesses an average knowledge of health and medicine. However, the claim will automatically be treated as urgent care if a physician who knows your medical condition determines that the claim involves urgent care.)

  For urgent care claims, the claims administrator will provide notice of claim approval or denial as soon as possible, taking into account the medical circumstances, but no later than 72 hours after receipt of your claim. To expedite the processing of an urgent care claim, the claims administrator's notice may be oral, but a written or electronic confirmation will follow within three days.

  If your urgent care claim was filed improperly, you may be notified no later than 24 hours after the urgent care claim is received. Notice of an improperly filed urgent care claim may be provided orally—or in writing, if you request. The notice will identify the proper procedures to be followed in filing the claim. In order to receive notice of an improperly filed urgent care claim, you, your beneficiary or your authorized representative must have provided a communication regarding the claim to the claims administrator. This communication must include the patient's name, a specific medical condition or symptom and a request for approval for a specific treatment, service or product.

If additional information is needed to process your urgent care claim, the claims administrator will notify you within 24 hours after receipt of your claim. You will have not less than 48 hours to provide that information. The claims administrator will then have 48 hours from the earlier of the plan's receipt of the requested information or the end of the additional 48-hour period. If you do not provide the additional information within 48 hours of when it is requested, the claim will be denied.

- *Concurrent care claims.* Concurrent care claims are claims to extend an ongoing course of treatment that was previously approved for a specific period of time or number of treatments. For example, if a hospital admission was initially approved for three days, and your doctor requests that it be extended to five days, that would be a concurrent care claim. Concurrent care claims also include claims where the plan reduces or terminates coverage for previously approved treatments.

  If you request an extension of ongoing treatment in an urgent care situation, the claims administrator will notify you as soon as possible given the medical circumstances, but no later than 24 hours of your request, provided your request is made at least 24 hours before the end of approved treatment. If your request for extended treatment is not made within 24 hours before the end of the previously approved treatment period, the request will follow the urgent care processes and time frames. If you request an extension of non-urgent care, your request will be considered a new claim and will be decided according to post-service or pre-service time frames, whichever applies. If an ongoing course of treatment will be reduced or terminated, the claims administrator will notify you sufficiently in advance to give you an opportunity to appeal before the decision takes effect.

Health Care Claim Appeal Procedures

If your claim for health care benefits is denied, in whole or in part, you, your beneficiary or your authorized representative may appeal the denial within 180 days of the receipt of the written or electronic notice of denial. You may, however, first want to contact the claims administrator to see if you can resolve the issue to your satisfaction.

If you choose to appeal your claim, your appeal should be submitted in writing and should explain why you believe the claim should be paid. Upon your request, you will have access to, and the right to obtain copies of, all documents, records and information relevant to your claim, free of charge.

You may submit with your appeal any written comments, documents, records and any other information relating to your claim, even if you did not include that information with your original claim. Reviewers must take all the information into account, even if it was not submitted or considered in the initial decision. The review will not afford any deference to the initial claim determination.

A qualified individual who was not involved in the previous claim determination (and is not that person's subordinate) will decide your appeal. If your appeal involves a medical judgment—including whether a treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate—the review will be done in consultation with a health care professional who has appropriate training and experience in the relevant field of medicine, who was not consulted in connection with the previous adverse claim determination and who is not that person's subordinate. As part of the appeal resolution process, you consent to this referral and the sharing of pertinent medical claim information.

If a medical or vocational expert is contacted in connection with an appeal, you will have the right to learn the identity of such individual.

After receiving your appeal, the claims administrator will provide notice of its decision within the following time frames. These are maximum time frames for all health plans. Some claims administrators have shorter response times for responding to appeals.

- *Pre-service appeals.* The claims administrator will provide notice of the appeal decision within 30 days following receipt of your appeal.
- *Post-service appeals.* The claims administrator will provide notice of the appeal decision within 60 days following receipt of your appeal.

- *Urgent care appeals.* You, your beneficiary, or your authorized representative should contact the claims administrator as soon as possible. You can request an expedited appeal process orally or in writing. In this case, all necessary information, including the plan's benefits determination on review, shall be relayed to you or your representative by telephone, fax or other similarly expeditious method. The claims administrator will provide notice of the appeal decision as soon as possible, taking into account the seriousness of your condition, but no later than 72 hours after receipt of your appeal.

Short-Term and Long-Term Disability Claims and Appeals

STD and LTD Claim Review Procedures

After you file a claim for STD or LTD benefits, the claims administrator will notify you of the claim determination within 45 days of the receipt of your claim. This period may be extended by 30 days if an extension is necessary to process your claim due to matters beyond the control of the claims administrator. A written notice of the extension, the reason for the extension and when the claims administrator expects to decide your claim will be furnished to you within the initial 45-day period. This period may be extended for an additional 30 days beyond the original extension (for a total of 105 days) if the claims administrator sends an additional written notice. If you are requested to provide additional information, you will have 45 days to provide the additional information. If you do not provide the information within the time frame, your claim will be denied.

STD and LTD Claim Appeal Procedures

You, your beneficiary or your authorized representative may appeal a denied claim in writing to the claims administrator within 180 days of the receipt of the written notice of denial. You may submit with your appeal any written comments, documents, records and any other information relating to your claim, even if they were not submitted with your original claim. Reviewers must take all the information into account, even if it was not submitted or considered in the initial decision. The review will not afford any deference to the initial claim determination.

The party reviewing your claim appeal will make a determination on your claim appeal within 45 days of the receipt of your appeal request. This period may be extended for an additional 45 days if special circumstances require an extension of time. A written notice of the extension, the reason for the extension and when the plan expects to decide your claim will be furnished to you within the initial 45-day period.

General Claims Review Procedures for Non-Health and Non-Disability Claims (such as Life Insurance, Vision and Wellness)

Claim Review Requests for Non-Health and Non-Disability Claims

After you file a claim for benefits, the claims administrator will notify you of the claim determination within 90 days of the receipt of your claim. This period may be extended by 90 days if an extension is necessary to process your claim due to matters beyond the control of the plan. A written notice of the extension, the reason for the extension and when the plan expects to decide your claim will be furnished to you within the initial 90-day period.

Appeal Procedures for Non-Health and Non-Disability Claims

If your claim for benefits is denied, in whole or in part, you, your beneficiary or your authorized representative may appeal a denied claim in writing to the claims administrator. Your claim appeal must be in writing and must be made within 60 days of the receipt of the written notice of denial. You may submit with your appeal any written comments, documents, records and any other information relating to your claim, even if they were not submitted with your original claim. Reviewers must take all the information into account, even if it was not submitted or considered in the initial decision. The review will not afford any deference to the initial claim determination.

In your appeal, state the reasons why you believe the claim was improperly denied and include all additional information that you consider relevant in support of the claim. You may also request reasonable access to and copies of all documents, records and other information relevant to your denied claim, free of charge.

For Wellness program–related claims, the US Appeals Committee serves as the final review committee. It will conduct a review at its next quarterly meeting following receipt of your written request for review, provided the written request is received at least 30 days before the meeting. If the written request is not received within 30 days of the next US Appeals Committee meeting, the Committee will conduct a review at the second meeting following receipt of your written request for review. The US Appeals Committee will typically notify you of its final decision within five business days after the date of the quarterly meeting at which your appeal is reviewed. If the US Appeals Committee needs additional time to make a decision, it will notify you in writing within five business days from the quarterly meeting and explain why more time is needed. The US Appeals Committee may then take until no later than the third quarterly meeting following receipt of your written request for review to decide and will notify you of its decision within five business days following that meeting. In addition, if additional time is needed because the Appeals Committee determines you did not provide sufficient information to make a determination on your claim, the period of time in which your claim is required to be considered will be tolled from the date on which notification of the extension is sent to you until the date on which you respond to the request for information.

Any interpretation or decision by the applicable appeals committee shall be binding and conclusive upon all interested persons. Any interpretation or decision of the applicable appeals committee will only be set aside if the committee is found to have acted arbitrarily and capriciously in interpreting or construing the terms of the plan.

Legal Action

You will not be able to bring a legal action for benefits under a plan unless and until you have:

- Submitted a claim for benefits in accordance with the applicable description of the claims process;
- You have been notified by the claims administrator that the claim has been denied; and
- You have filed a written request for a review of the claim in accordance with the applicable description of claims appeal procedures and the denial of the claim has been affirmed.

However, you are entitled to bring a legal action on any claim if the claims administrator fails to take any action on the claim within the applicable permitted time.

You, your beneficiary or your authorized representative must start any suit or legal action to receive benefits from a plan:

- Within three years after your claim is denied;
- Within three years after you die, if the claim is for death benefits under a plan; or
- Within a shorter period of time, if required by law.

Your Rights and Responsibilities

This section contains important information about your rights as a benefit plan participant—for example, your right to continue coverage under certain plans, your right to access information about your benefit plans, and your right to appeal denied claims.

This section also contains information about the steps you may take to exercise your rights under your State Street benefit plans. Take the time to read this section carefully and become familiar with your rights and responsibilities. Other details about your benefits are included in the section of this SPD for each plan.

Continuing Coverage under COBRA

Under a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you and/or your dependents may be eligible to continue medical, dental, vision, Health Care Flexible Spending Account (Health Care FSA) and Employee Assistance Program (EAP) coverage (called "COBRA coverage") at group rates. This COBRA coverage is available in certain instances, called "qualifying events," where coverage would otherwise end. You may elect to continue coverage at your own expense on an after-tax basis. The coverage described below may change as permitted or required by changes in any applicable law.

The following information is intended to inform you of your rights and obligations under the continuation coverage provisions of COBRA. In some states, state law provisions may also apply to the insurers offering benefits under the applicable programs. (For more information, contact the GHR Service Center at the address shown in If You Have Questions.)

COBRA coverage is provided subject to your eligibility for coverage as described below. State Street reserves the right to terminate your coverage retroactively if it is determined that you are ineligible under the terms of the applicable program.

You will have to pay the entire cost of COBRA coverage—your share and State Street's—plus a 2% administrative fee. There is a grace period of at least 30 days for the payment of the regularly scheduled premium. A 45-day grace period applies for your first premium payment.

Important: You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

COBRA at a Glance

The following table provides an overview of available COBRA coverage. See the sections following the table for more details.

Who Is Affected	Qualifying or Other Event	Who Is Eligible for COBRA Coverage	Duration of COBRA Coverage
You	Your employment ends for reasons other than gross misconduct	You, your Spouse/Domestic Partner and dependents (who lose coverage)	Up to 18 months
	You experience a reduction in hours below the level required for benefit eligibility	You, your Spouse/Domestic Partner and dependents (who lose coverage)	Up to 18 months

Who Is Affected	Qualifying or Other Event	Who Is Eligible for COBRA Coverage	Duration of COBRA Coverage
	You are Social Security disabled when you become eligible for COBRA (due to employment termination or reduction in hours) or within the first 60 days after an 18-month COBRA continuation coverage period begins	You, your Spouse/Domestic Partner and dependents (who lose coverage)	Up to 29 months*
Your Spouse/ Domestic Partner or Eligible Child(ren) / Other Adult Dependent	You die	Your Spouse/Domestic Partner and dependents (who lose coverage)	Up to 36 months
	You and your spouse become divorced or legally separated	Your Spouse	Up to 36 months
	You become eligible for Medicare while covered under COBRA (Part A, Part B, or both)	Your Spouse/Domestic Partner and dependents (who lose coverage)	Up to 36 months
	Your Spouse/Domestic Partner and/or your Eligible Child is disabled when he or she becomes eligible for COBRA (due to employment termination or reduction in hours) or within the first 60 days after an 18-month COBRA continuation coverage period begins	You, your Spouse/Domestic Partner and dependents (who lose coverage)	Up to 29 months*
Your Eligible Child(ren)/ Other Adult Dependent	Your Eligible Child(ren) is no longer eligible (for example, due to age limit)	Your Eligible Child(ren) (who loses coverage)	Up to 36 months

*You are required to provide proof of eligibility for Social Security disability benefits to be eligible for the additional 11 months of COBRA coverage.

Note: Continuation coverage for your Domestic Partner is not required by federal law. State Street has elected to provide this opportunity to allow your Domestic Partner to continue coverage in accordance with the eligibility rules established by State Street.

COBRA and FMLA

Taking an approved leave under the Family and Medical Leave Act (FMLA) is not considered a qualifying event that would make you eligible for COBRA coverage. However, a COBRA qualifying event occurs if:

- You or your dependent is covered by the plan on the day before the leave begins (or you or your dependent becomes covered during the FMLA leave), and
- You do not return to employment at the end of the FMLA leave or you terminate employment during your leave.

Your COBRA coverage may begin on the earlier of the following:

- When you definitively inform State Street that you are not returning to work, or
- The end of the leave, if you do not return to work.

COBRA Qualifying Events

If a qualifying event (as specified below) occurs, COBRA continuation coverage must be offered to each "qualified beneficiary." You, your spouse and your dependent child(ren), who are covered under the Plan on the day before the qualifying event, could become qualified beneficiaries if coverage under the Plan is lost due to the qualifying event. For purposes of COBRA eligibility under the Plan, the reference to "spouse" under this notice includes an eligible domestic partner.

Note: you may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace (**www.HealthCare.gov** or call 1-800-318-2596). By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

Employee

If you are an employee covered by the Plan, you will become a qualified beneficiary and have the right to elect COBRA continuation coverage if you lose your group health coverage due to any of the following qualifying events:

- Termination of your employment for any reason other than your gross misconduct
- A reduction in your hours of employment

Spouse/Domestic Partner

If you are the spouse of an employee and are covered by the Plan you will become a qualified beneficiary and have the right to elect COBRA continuation coverage for yourself if you lose your group health coverage due to any of the following qualifying events:

- The death of your spouse
- The termination of your spouse's employment for any reason other than gross misconduct
- A reduction in your spouse's hours of employment
- Divorce or legal separation from your spouse/termination of your domestic partnership
- Your spouse becomes entitled to Medicare (Part A, Part B or both)

Dependent

If a dependent child is covered by the Plan, he or she will become a qualified beneficiary and have the right to elect COBRA continuation coverage if group health coverage under the Plan is lost due to any of the following qualifying events:

- The death of the parent-employee
- The termination of the parent-employee's employment for any reason other than gross misconduct
- A reduction in the parent-employee's hours of employment
- Parent's divorce or legal separation
- The parent-employee becomes entitled to Medicare (Part A, Part B or both)
- The dependent child ceases to be a "dependent child" under the terms of the Plan

A child born to, adopted by or placed for adoption with the parent-employee during the period of COBRA continuation coverage would also be a qualified beneficiary and has the right to COBRA continuation coverage. Further, a child covered under the Plan pursuant to a qualified medical support order has the right to COBRA continuation coverage.

Retirees and spouses, surviving spouses and dependent children of retirees will become qualified beneficiaries and have the right to elect COBRA continuation coverage if their group health coverage is lost or substantially eliminated due to State Street filing a proceeding in bankruptcy under Title 11 of the United States Code.

Responsibilities Regarding COBRA Continuation Coverage

To be entitled to COBRA continuation coverage, you, your spouse or your dependents must notify the GHR Service Center within 60 days of the date on which any of the following qualifying events occur:

- Divorce
- Legal separation
- Child ceasing to be a dependent child under the terms of the Plan.

To notify the GHR Service Center, call **+1 855 447 7007, Option 1** (hours: 8:30 a.m. to 8:30 p.m. Eastern time).

State Street must notify the GHR Service Center of the following qualifying events:

- Reduction in hours of employment
- Termination of employment
- Death of the employee
- Medicare entitlement (Part A, Part B or both)
- Commencement of a proceeding in bankruptcy with respect to the employer.

Electing COBRA Continuation Coverage

Once the GHR Service Center is notified that a qualifying event has occurred, the GHR Service Center will notify you of your right to elect COBRA continuation coverage. You have 60 days from the later of the date your coverage ends or the date that you are notified of your right to COBRA continuation coverage, to notify the GHR Service Center that you want to elect COBRA continuation coverage.

You do not have to show that you are insurable to elect COBRA continuation coverage.

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

If you elect COBRA continuation coverage, State Street is required to allow you to purchase coverage that is identical to the coverage being provided under the Plan to similarly-situated active employees or family members. If coverage under the Plan is modified for such similarly-situated individuals, your coverage will also be modified.

If you do not elect COBRA continuation coverage within the time frame stated above, your State Street group health coverage will end.

Length of the COBRA Continuation Period

You, your covered spouse and any dependent child(ren) will be entitled to COBRA continuation coverage for up to a maximum of:

- 18 months when the qualifying event is termination of employment (other than for gross misconduct) or reduction in hours of employment; or
- 36 months when the qualifying event is the death of the employee, divorce or legal separation, the employee's entitlement to Medicare (Part A, Part B or both) or a dependent child ceasing to be a dependent under the Plan.

If the employee becomes entitled to Medicare before the date of his/her qualifying event, the employee's spouse and any dependent child(ren) are entitled to elect COBRA continuation coverage for up to the

greater of 36 months from the date of Medicare entitlement, or 18 months from the date of the employee's qualifying event.

Please note: Coverage under a health care flexible spending account may only be continued through the end of the plan year in which the qualifying event occurred.

Second Qualifying Event Extension

The 18-month COBRA continuation period may be extended to 36 months for your spouse and dependent children who are qualified beneficiaries if a second qualifying event (death, divorce, legal separation, Medicare entitlement (Part A, Part B or both) or a dependent child ceasing to be a dependent under the terms of the Plan) occurs during the 18-month COBRA continuation period. However, this extension will only be allowed if the second event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. To be granted an extension, the qualified beneficiary must notify the GHR Service Center within 60 days of the second qualifying event.

Disability Extension

The 18-month COBRA continuation period may be extended to 29 months if a qualified beneficiary incurs a disability at any time before the 60th day of the COBRA continuation period that qualifies as a disability as determined by Social Security, and the disability extends through the initial COBRA continuation period. This 11-month extension is available to all individuals who are qualified beneficiaries due to a termination or reduction in hours of employment. To be granted this extension, the qualified beneficiary must, within 60 days of the Social Security disability determination and before the end of the 18-month period: (1) notify the GHR Service Center of such disability determination; and (2) provide a copy of the determination of disability notification from the Social Security Administration.

The disabled individual must also notify the GHR Service Center within 30 days of any final determination that such individual is no longer disabled. To notify the GHR Service Center, call **+1 855 447 7007, Option 1** (hours: 8:30 a.m. to 8:30 p.m. Eastern time).

Terminating COBRA Continuation Coverage

The law provides that COBRA continuation coverage may be terminated for any of the following reasons:

1. State Street no longer provides group health coverage to any of its employees.
2. The premium for COBRA continuation coverage is not paid on a timely basis, as required by the Plan.
3. After the date of election, a qualified beneficiary becomes covered under another group health plan.
4. After the date of election, a qualified beneficiary becomes entitled to Medicare (Part A, Part B or both).
5. A qualified beneficiary extends coverage for up to 29 months due to disability and there has been a final determination that Social Security disability eligibility has ended.

If your COBRA continuation coverage terminates for any reason, it cannot be reinstated.

Cost of COBRA Continuation Coverage

As allowed by federal law, you have to pay 102% of the applicable premium for your COBRA continuation coverage. This includes the full cost of coverage plus a 2% administration fee.

However, the cost of the 11-month disability extension will be 150% of the applicable premium if the disabled qualified beneficiary is covered or 102% of the applicable premiums if only non-disabled qualified beneficiaries are covered.

At the end of the COBRA continuation period, you may be eligible to enroll in an individual conversion health plan subject to State Street health plan rules.

You may be eligible to get coverage through the Health Insurance Marketplace at a lower cost than through COBRA continuation coverage. You can learn more by contacting the Health Insurance Marketplace; go to **www.HealthCare.gov** or call +1 800 318 2596.

Address Changes

To protect your family's rights, you should keep the appropriate parties informed of any changes in address, as follows:

- Employee address: If your address changes, you should notify State Street.
- Dependent address: If your spouse or dependent(s) change address (to an address other than your address), contact the GHR Service Center as shown below.

You should also keep a copy for your records of any notices you send to the GHR Service Center or to the Plan Administrator.

Contact Information

If you have any questions about the Plan or your COBRA rights, please contact the GHR Service Center at **+1 855 447 7007, Option 1** (hours: 8:30 a.m. to 8:30 p.m.) Eastern time.

GHR Service Center
PO Box 770001
Cincinnati, OH 45277-0021

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at http://www.dol.gov/ebsa. Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website.

Your Right to Privacy under HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) protects the use and disclosure of individual health information. You may request a copy of the HIPAA Privacy Notice at any time by calling the GHR Service Center at +1 855 447 7007, Option 2. This notice is also available in the Forms section of the Fidelity NetBenefits website at netbenefits.com/statestreet.

Plan Amendment and Continuation

State Street expects to continue its benefit plans indefinitely for its employees, but State Street reserves the right to amend, modify, merge, suspend or terminate any benefit plan at any time and for any reason in its sole discretion. For example, State Street reserves the right to amend or terminate the entire plan, covered expenses, copays, lifetime maximums, and reserves the right to amend benefit plans to require or increase employee contributions. State Street also reserves the right to amend benefit plans to implement any cost control measures that it may deem advisable.

Any amendment, termination or other action by State Street with respect to its benefit plans described in this document shall be approved by the State Street North America Regional Benefit Committee, subject to applicable delegations of amendment powers. Amendments may be retroactive to the extent necessary to comply with applicable law. However, no amendment or termination shall reduce the amount of any benefit otherwise payable under a benefit plan for charges incurred prior to the effective date of such amendment or termination.

In the event of the dissolution, merger, consolidation or reorganization of State Street, the benefit plans shall terminate unless they are continued by a successor to State Street.

If a benefit is terminated and surplus assets remain after all liabilities have been paid, such surplus shall revert to State Street to the extent permitted under applicable law, unless otherwise stated in the insurance or administrative contract, or applicable plan document, or otherwise determined by the Board of Directors of State Street.

Right of Recovery

The plans are subrogated in accordance with the applicable certificates of coverage and insurance policies.

Plan Information

Plan Year

All plans operate and maintain records on a calendar-year basis (January 1 through December 31).

Employer Identification Numbers of Participating Employers

State Street Bank & Trust Co.	04-1867445
State Street Bank & Trust Co. N.A.	13-3191724
State Street Financial Services Inc.	04-2835718
State Street Bank & Trust Co. of CA	06-1143380
State Street California, Inc.	06-1588730
Princeton Financial Systems, Inc.	22-2874983
Elkins/McSherry LLC	04-3463496
Currenex, Inc.	94-3345255
Investment Management Services Inc.	13-3637605
International Fund Services (N.A.) LLC	11-3644300
State Street Mutual Fund Service Company LLC	27-0590034
State Street Fund Service, Inc.	22-3114019
State Street Fund Services (U.S.) LLC	20-2298863
State Street Investment Manager Solutions, LLC	04-3520677
State Street Public Lending Corporation (Effective September 1, 2014)	04-2981072

Plan Administrator

The Plan Administrator for the State Street Corporation Employee Benefit Plan is:

North America Regional Benefits Committee
State Street Corporation
c/o Vice President, Global Human Resources, Manager — US Benefits
One Lincoln Street, SCF/14
Boston, MA 02111
+1 617 664 3000

The Plan Administrator has the duty and the discretionary authority to interpret the terms of the Plan and to decide any dispute that may arise regarding the rights of any individual participant in the Plan. This includes the discretionary authority to make determination as to eligibility for participation and benefits under the Plan. Any interpretation or decision by the Plan Administrator will apply uniformly to all persons similarly situated and shall be binding and conclusive upon all interested persons. Any interpretation or decision of the Plan Administrator will only be set aside if the Plan Administrator is found to have acted arbitrarily and capriciously in interpreting or construing the terms of the Plan.

Plan Sponsor

State Street Corporation
One Lincoln Street
Boston, MA 02111
EIN: 04-2456637

Agent for Legal Process

If you believe that your rights under the Plan has been violated, you have the right to bring legal action against the Plan in a court of law. The Plan Administrator is the agent named to receive service of legal process.

You may contact the Committee's agent:

(a) For service of legal process, or

(b) Whenever any written material has to be submitted to the Committee.

Plan Fiduciary Responsibility

Plan fiduciaries are generally the Company and the North America Regional Benefits Committee. The Board of Directors, acting for the Company, has the authority to appoint and remove participants of the North America Regional Benefits Committee. In the case of insured plans, the insurer is the plan fiduciary.

Plan Funding

Certain benefits under the State Street Corporation Employee Benefit Plan are self-funded, which means that State Street funds the benefit payments through general assets and employee contributions, and it pays fees to a third party to administer the programs. Other benefits are funded through insurance policies. See the chart below for specific funding information.

Additional Employee Benefit Plan Information

Official Plan Name/Vendor	Plan Type	Funding Medium	How Plan Is Funded	Plan Number
State Street Corporation Employee Benefit Plan				501
PPO Plus — Cigna/Tufts HP Open Access with HSA (including Pharmacy)	Medical Welfare Plan	Self-funded	General assets of State Street and employee contributions	
PPO — BC/BS Blue Care Elect (including Pharmacy)	Medical Welfare Plan	Self-funded	General assets of State Street and employee contributions	
BC/BS HMO — Network Blue New England Options (including Pharmacy)	Medical Welfare Plan	Self-funded	General assets of State Street and employee contributions	
BC/BS HMO — Advantage Blue (including Pharmacy)	Medical Welfare Plan	Self-funded	General assets of State Street and employee contributions	
Tufts HMO — Navigator by Tufts Health Plan (including Pharmacy)	Medical Welfare Plan	Self-funded	General assets of State Street and employee contributions	
Kaiser HMO	Medical Welfare Plan	Insured	State Street pays insurance premiums from general assets and employee contributions	
Aetna Global (International Plan) (Expatriates)	Medical Welfare Plan	Insured	State Street pays insurance premiums from general assets and employee contributions	
Delta PPO Plus Premier	Dental Welfare Plan	Self-funded	General assets of State Street and employee contributions	
DeltaCare USA	Dental Welfare Plan	Insured	State Street pays insurance premiums from general assets and employee contributions	
EyeMed Vision Care	Vision Welfare Plan	Insured	State Street pays insurance premiums from employee contributions	501
Metropolitan Life Insurance Company	Life Insurance Welfare Plan	Insured	State Street pays insurance premiums from general assets and employee contributions	
Metropolitan Life Insurance Company	Accidental Death & Dismemberment	Insured	State Street pays insurance premiums from general assets	

Official Plan Name/Vendor	Plan Type	Funding Medium	How Plan Is Funded	Plan Number
	Welfare Plan		and employee contributions	
Metropolitan Life Insurance Company	Business Travel Accident Welfare Plan	Insured	State Street pays insurance premiums from general assets	
Prudential Insurance Company of America	Long-Term Disability Welfare Plan	Insured	State Street pays insurance premiums from employee contributions	
ValueOptions	Employee Assistance Program Welfare Plan	Insured	State Street pays insurance premiums from general assets	
Retiree Health Expense Reimbursement Account	Welfare Plan	Self-Funded	State Street credits the participant's accounts from general assets	
Health Care Flexible Spending Account	Welfare Plan	Unfunded	Employee Contributions	
State Street Flexible Benefit Plan	Flexible Benefit Plan	Unfunded	Employee contributions	n/a
State Street Dependent Care Assistance Plan	Flexible Spending Account Welfare Plan	Unfunded	Employee contributions	n/a
Pretax Transportation Accounts	Qualified Transportation Fringe Plan	Unfunded	Employee contributions	n/a

Your ERISA Rights

As a participant in certain benefit plans described in this booklet, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. The benefits covered by ERISA include:

- Medical
- Dental
- Vision
- Health Care Flexible Spending Account
- Retiree Health Expense Reimbursement Account
- Short-Term and Long-Term Disability
- Employee Assistance Program
- Life and Accident Insurance (including Business Travel Accident Insurance)
- Retiree Medical and Life Insurance
- Wellness

ERISA provides that participants in these benefits 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 work sites, all documents governing the State Street Corporation Employee Benefit Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the US 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 an updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

Continue Group Health Plan Coverage

- You have the right to 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 Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- You have the right to reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the 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 terminate you or otherwise discriminate against you in any way in order to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied, 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 you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a 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 US 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 questions about the Plan, you should contact the GHR Service Center. If you have 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, US Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, US Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the Employee Benefits Security Administration.

If You Have Questions

For specific questions, please contact the GHR Service Center directly at the website or telephone number listed below:

<table>
<tr><th>For Questions About...</th><th colspan="3">Contact ....</th></tr>
<tr><td>Enrollment, eligibility or when coverage ends

COBRA

Health Care Flexible Spending Account

Life and Accident Insurance</td><td colspan="3">○ Website: netbenefits.com/statestreet

○ Call the GHR Service Center +1 855 447 7007, Option 1. Participant services are available from 8:30 a.m. to 8:30 p.m. Eastern time, Monday through Friday (except holidays). Services for the hearing impaired, call +1 888 343 0860. International employees dial +1 770 281 485.

○ Write to

State Street Benefits Center

P.O. Box 770001

Cincinnati, OH 45277</td></tr>
<tr><td rowspan="6">Medical Plans</td><td>Plan</td><td>Telephone</td><td>Website</td></tr>
<tr><td>All BlueCross BlueShield Plans</td><td>+1 800 352 6259 or send an email to statestreet@bcbsma.com</td><td>www.bcbsma.com/statestreet</td></tr>
<tr><td>PPO Plus - Cigna/Tufts HP Open Access with HSA</td><td>Prior to enrollment:
+1 800 401 4041

Once enrolled:
+1 800 244 6224</td><td>Before enrollment:
www.mycignaplans.com
ID: statestreet2014
Password: cigna

If already enrolled:
www.mycigna.com/</td></tr>
<tr><td>Kaiser HMO</td><td>+1 800 464 4000</td><td>www.kaiserpermanente.org</td></tr>
<tr><td>Tufts HMO - Navigator by Tufts Health Plan</td><td>+1 800 462 0224</td><td>www.tufts-health.com/statestreet</td></tr>
<tr><td>Aetna Global Benefits</td><td>In the United States:
+1 813 775 0190
Outside the United States:
+1 800 231 7729
Refer to your AT&T Direct wallet card for appropriate access code.</td><td>http://www.aetnaglobalbenefits.com</td></tr>
</table>

For Questions About...	Contact ....
Dental Plans	Delta Dental +1 800 872 0500 www.deltadentalma.com www.deltadentalins.com
Vision	EyeMed ♦ www.eyemed.com (choose the Access network) ♦ 1-866-723-0596
Short-Term or Long-Term Disability	GHR Service Center at State Street +1 855 447 7007
Life Insurance	MetLife: ♦ For information about Basic Life conversion: +1 877 275 6387 ♦ For information about Optional Term Life portability: +1 866 492 6983 ♦ To request a Statement of Health: +1 800 638 6420, Option 1
Employee Assistance Program	ValueOptions at +1 800 249 2399 or www.achievesolutions.net/statestreet
Wellness	♦ GHR Service Center at State Street: +1 855 447 7007

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, you can contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1 877 KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer-sponsored plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have any questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free +1 866 444 EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2014. You should contact your state for further information on eligibility.

<table>
<tr><td>ALABAMA – Medicaid</td><td>COLORADO – Medicaid</td></tr>
<tr><td>Website: http://www.medicaid.alabama.gov

Phone: +1 855 692 5447</td><td rowspan="2">Medicaid Website: http://www.colorado.gov/

Medicaid Phone (In state): +1 800 866 3513
Medicaid Phone (Out of state): +1 800 221 3943</td></tr>
<tr><td>ALASKA – Medicaid</td></tr>
<tr><td>Website:
http://health.hss.state.ak.us/dpa/programs/medicaid/

Phone (Outside of Anchorage): +1 888 318 8890

Phone (Anchorage): 907 269 6529</td><td></td></tr>
<tr><td>ARIZONA – CHIP</td><td>FLORIDA – Medicaid</td></tr>
<tr><td rowspan="2">Website: http://www.azahcccs.gov/applicants
Phone (Outside of Maricopa County): +1 877 764 5437

Phone (Maricopa County): 602 417 5437</td><td>Website: https://www.flmedicaidtplrecovery.com/

Phone: +1 877 357 3268</td></tr>
<tr><td>GEORGIA – Medicaid

Website: http://dch.georgia.gov/
Click Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)
Phone: +1 800 869 1150</td></tr>
</table>

IDAHO – Medicaid and CHIP	**MONTANA** – Medicaid
Medicaid Website: www.medicaid.idaho.gov Medicaid Phone: +1 800 926 2588 CHIP Website: www.accesstohealthinsurance.idaho.gov CHIP Phone: +1 800 926 2588	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: +1 800 694 3084
INDIANA – Medicaid	**NEBRASKA** – Medicaid
Website: http://www.in.gov/fssa Phone: +1 800 889 9949	Website: www.ACCESSNebraska.ne.gov Phone: +1 800 383 4278
IOWA – Medicaid	**NEVADA** – Medicaid
Website: http://www.dhs.state.ia.us/hipp/ Phone: +1 888 346 9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: +1 800 992 0900
KANSAS – Medicaid	
Website: http://www.kdheks.gov/hcf/ Phone: +1 800 792 4884	
KENTUCKY – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: +1 800 635 2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603 271 5218
LOUISIANA – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: +1 888 695 2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: +1 800 356 1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: +1 800 701 0710
MAINE – Medicaid	
Website: http://www.maine.gov/dhhs/ofi/publicassistance/index.html Phone: +1 800 977 6740 TTY +1 800 977 6741	

MASSACHUSETTS – Medicaid and CHIP	**NEW YORK –** Medicaid
Website: http://www.mass.gov/ MassHealthPhone: +1 800 462 1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: +1 800 541 2831
MINNESOTA – Medicaid	**NORTH CAROLINA** – Medicaid
Website: http://www.dhs.state.mn.us/ Click on *Health Care*, then *Medical Assistance* Phone: +1 800 657 3629	Website: http://www.ncdhhs.gov/dma Phone: 919 855 4100
MISSOURI – Medicaid	**NORTH DAKOTA** – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573 751 2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: +1 800 755 2604
OKLAHOMA – Medicaid and CHIP	**UTAH** – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: +1 888 365 3742	Website: http://health.utah.gov/upp Phone: +1 866 435 7414
OREGON – Medicaid and CHIP	**VERMONT**– Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: +1 877 314 5678	Website: http://www.greenmountaincare.org/ Phone: +1 800 250 8427
PENNSYLVANIA – Medicaid	**VIRGINIA** – Medicaid and CHIP
Website: http://www.dpw.state.pa.us/hipp Phone: +1 800 692 7462	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: +1 800 432 5924 CHIP Website: http://www.famis.org/ CHIP Phone: +1 866 873 2647
RHODE ISLAND – Medicaid	**WASHINGTON** – Medicaid
Website: www.ohhs.ri.gov Phone: 401 462 5300	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: +1 800 562 3022 ext. 15473

SOUTH CAROLINA – Medicaid	**WEST VIRGINIA** – Medicaid
Website: http://www.scdhhs.gov Phone: +1 888 549 0820	Website: http://www.dhhr.wv.gov/bms/ Phone: +1 877 598 5820, HMS Third Party Liability
SOUTH DAKOTA - Medicaid	**WISCONSIN** – Medicaid
Website: http://dss.sd.gov Phone: +1 888 828 0059	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: +1 800 362 3002
TEXAS – Medicaid	**WYOMING** – Medicaid
Website: https://www.gethipptexas.com/ Phone: +1 800 440 0493	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307 777 7531

To see if any more States have added a premium assistance program since July 31, 2014, or for more information on special enrollment rights, you can contact either:

US Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
+1 866 444 EBSA (3272)

US Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
+1 877 267 2323, Ext. 61565

Appendix: Summary of Benefits/Plan Certificates

To access the Summary of Benefits/Plan Certificates for the benefit programs listed below, click the *Health & Insurance Reference Library* section located on netbenefits.com/statestreet.

Medical Plan Summary of Benefits/Certificates

PPO Plus — Cigna/Tufts HP Open Access with HSA

PPO — BC/BS Blue Care Elect

BC/BS HMO — Advantage Blue

BC/BS HMO — Network Blue New England Options

Tufts HMO — Navigator by Tufts Health Plan

Kaiser HMO — California

Aetna Global Benefits (International)

Employee Assistance Program (EAP)

Dental Plan Summary of Benefits/Certificates

Delta Dental PPO Plus Premier

DeltaCare USA (CA)

DeltaCare USA (MA)

DeltaCare USA (NJ)

DeltaCare USA (NY)

DeltaCare USA (RI)

DeltaCare USA (PA)

Vision Plan Summary of Benefits/Certificates

EyeMed

Life and Accident Insurance Program

MetLife Life and Accident Insurance Program

Long-Term Disability

Prudential Long-Term Disability Insurance Program