EMERITI FULLY-INSURED (GRANTOR TRUST) RETIREE HEALTH PLAN FOR SAINT MARY'S COLLEGE, CA

SUMMARY PLAN DESCRIPTION

EFFECTIVE DATE OF PLAN: JANUARY 1, 2017

INTRODUCTION

Saint Mary's College of California (the "Plan Sponsor") has adopted the Emeriti Fully-Insured Retiree Health Plan for **Saint Mary's College of California** (the "Plan") as of **January 1, 2017** (the "Effective Date"). This Plan is a separate plan from your Employer's VEBA-based Emeriti Retiree Health Plan. This Plan is solely intended to provide you and your eligible family members with insurance coverage during your retirement years. It does not provide reimbursement for qualified medical expenses. It is offered to select employees only.

If you meet the eligibility requirements, your Employer will credit amounts to your Insurance Premium Account, which are then deemed to be invested according to your directions in the Mutual Funds available under the Plan. Unlike your VEBA accounts under your Employer's Emeriti Retiree Health Plan, there are not actual dollars in your Insurance Premium Account, only credits, so your account is not actually invested in the Mutual Funds. Nevertheless, the balance of your Insurance Premium Account is adjusted for the performance of the Mutual Funds you select. By crediting amounts to your Insurance Premium Account, your Employer is agreeing to pay your premiums for the insurance plan you select when due, up to the total balance credited to your Insurance Premium Account (*after adjustment for deemed gains and losses, deemed changes in market valuation, expenses, premium payments, or forfeitures, if any*). You are not permitted to make contributions to your Insurance Premium Account.

If you are eligible for the insurance when you retire, your Employer will pay the premiums on your behalf based upon the balance credited to your Insurance Premium Account. You will not be taxed on any growth in your Insurance Premium Account or on premiums paid from your Insurance Premium Account. However, if the amounts credited to your Insurance Premium Account are exhausted and you are not eligible to enroll in the Emeriti Health Insurance Plan Options under another Emeriti plan offered by your Employer, you will be required to pay premiums out-of-pocket in order to remain enrolled in the insurance plan you selected under this Plan. Your Insurance Premium Account cannot be used for any purpose other than paying premiums for the insurance, so if you cease employment without being eligible for the insurance your Insurance Premium Account will be forfeited.

The Emeriti Health Insurance Plan Options generally become available when you retire after attaining Retirement Eligibility and enroll in Medicare Parts A and B (after attaining age 65). This coverage is generally available to retired Participants, Spouses (or Domestic Partners), and Dependent Children. The Emeriti Health Insurance Plan Options are underwritten by Aetna Life Insurance Company ("Aetna") or an alternate health insurer as elected by you. (Note that if you reside in, or your Employer is located in, Minnesota, New Mexico, Puerto Rico, or the U.S. Virgin Islands, your coverage may be underwritten by another insurer, in which case references in this SPD to Aetna may need to be read as references to that insurer – see Appendix C for more details.) The Emeriti Health

Insurance Plan Options will vary in certain states as a result of state insurance laws and Medicare requirements.

IMPORTANT: The rules described in the section entitled EMERITI HEALTH INSURANCE PLAN OPTIONS – ELIGIBILITY include 90-day enrollment windows, including in certain cases the requirement to enroll within 90 days of first becoming eligible. It is important that you review these provisions with your eligible dependents. If you and your eligible dependents do not enroll in one of the Emeriti Health Insurance Plan Options within the applicable enrollment window, eligibility to later enroll in the Emeriti Health Insurance Plan Options will be restricted. If you have any questions about enrollment, you should call 1-866-EMERITI (1-866-363-7484). In addition, in the event of the Participant's death, eligible dependents should call as soon as possible to discuss enrollment.

If you are eligible to enroll in the Emeriti Health Insurance Plan Options under this Plan and under your Employer's VEBA-based Emeriti Retiree Health Plan, you will first be enrolled in the Emeriti Health Insurance Plan Options under this Plan. While enrolled in the Emeriti Health Insurance Plan Options under this Plan, you will still be able to access your accounts under other Emeriti plans (assuming you have a balance) to reimburse qualified medical expenses (subject to eligibility). Once you have exhausted the amounts credited to your Insurance Premium Account under this Plan, if you have funds available under another Emeriti plan offered by your Employer to pay premiums for the Emeriti Health Insurance Plan Options, your coverage under this Plan will cease and you will be automatically enrolled in coverage in the Emeriti Health Insurance Plan Options under the other plan. These coordination issues are explained in more detail later in this summary plan description ("SPD").

Teachers Insurance and Annuity Association ("TIAA") provides record keeping and other services for the Insurance Premium Accounts, including offering a series of mutual funds that make up the "deemed" Mutual Funds for the Insurance Premium Accounts. Although not actually invested in these mutual funds, the balance of your Insurance Premium Account will increase or decrease based upon the deemed Mutual elections you make with respect to the amounts credited to your Insurance Premium Account.

Please note that the Plan is an unfunded, fully-insured single-employer welfare benefit plan governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), which means that under Federal law you, your Employer, and the Plan Sponsor (*either your Employer or an affiliate of your Employer*) each have certain obligations and rights with respect to the Plan. The principal applicable provisions of ERISA are the provisions on reporting and disclosure, fiduciary responsibility and administration and enforcement. The Plan is not qualified under Section 401(a) of the Internal Revenue Code, which deals with the tax treatment of qualified pension, profit-sharing and stock bonus plans. The Plan document, consisting of a core plan document and an adoption agreement, describes the terms of the Plan in detail. This SPD summarizes the terms of the Plan as of January 1, 2017. However, it is not meant to interpret, extend, or

change the terms of the Plan in any way, nor does it describe all of the detailed rules that may apply in special circumstances. By reading this SPD you should gain a working knowledge of how the Plan operates and your general rights and obligations under the Plan. ***However, this SPD is only a summary, and in the event of any conflict between this SPD and the Plan, the Plan's terms will control.***

You may request a copy of the Plan document or this SPD by contacting the Plan Sponsor. The terms of the Emeriti Health Insurance Plan Options (including covered services and other conditions of coverage) are described in the Coverage Documents for your state, which are separate documents incorporated by reference in this SPD. You may obtain a copy of the Coverage Documents by calling the number shown on your health insurance Identification Card. Nothing in the Plan or this SPD constitutes a contract of employment between you and your Employer or otherwise grants you any right to continued employment by the Employer.

Capitalized terms are generally defined in special definitions boxes throughout this Summary Plan Description ("SPD"). For a list of defined terms, refer to the section entitled DEFINED TERMS. Please refer to the section entitled IMPORTANT INFORMATION ABOUT THE PLAN for details regarding the sponsor and administrator of the Plan, and vital information about the Plan.

Emeriti Retirement Health Solutions* ("Emeriti") is a collaborative arrangement of, by, and for colleges, universities, and other higher education-related tax-exempt organizations. Emeriti creates innovative ways to save for retiree medical expenses, works with insurance companies to develop insurance products, leverages purchasing power, and achieves administrative efficiencies in the delivery of retiree medical benefits on behalf of its members and their participants. Emeriti's objectives are to provide high-quality retiree products and services in support of the health care needs of retirees and their families and to improve educational resources for making current and future retiree medical expenses an integral component of retirement planning. Emeriti is an Illinois not-for-profit corporation and 501(c)(3) organization made possible by the generous start-up support of the Andrew W. Mellon Foundation. If you ever have any questions about the Emeriti Program or this Plan, please call 1-866-EMERITI (1-866-363-7484).

* Emeriti's full legal name is The Emeriti Consortium for Retirement Health Solutions, An Illinois Not-For-Profit Corporation.

TABLE OF CONTENTS
(continued)

Page

TABLE OF CONTENTS
(continued)

Page

TABLE OF CONTENTS
(continued)

Page

TABLE OF CONTENTS
(continued)

Page

TABLE OF CONTENTS
(continued)

Page

DEFINED TERMS

Most of the terms used in this SPD are self-explanatory or are explained when they appear. However, a number of terms used throughout this SPD merit special attention:

ACH Transfer

The term "ACH Transfer" means an electronic transfer or debit of funds from your private checking account to the Plan for the purpose of paying premiums for the Emeriti Health Insurance Plan Options once the balance of your Insurance Premium Account has been depleted.

Authorized Leave of Absence

The term "Authorized Leave of Absence" means any period of absence authorized by your Employer under its applicable personnel practices (including any period covered by the Uniformed Services Employment and Reemployment Rights Act of 1994 or by the Family and Medical Leave Act of 1993). It does not include paid holidays, paid vacation, or regularly scheduled paid or unpaid summer absence. For example, if you go on an authorized sabbatical, you are considered to be on an Authorized Leave of Absence.

Break in Service

A "Break in Service" is any period of absence from service with the Employer other than an Authorized Leave of Absence, paid holiday, paid vacation, or regularly scheduled paid or unpaid summer absence.

Coverage Documents

The term "Coverage Documents" refers to the summary of coverage and certificate of coverage booklet governing the benefits and other terms of coverage provided by the Emeriti Health Insurance Plan Options. Refer to the section entitled EMERITI HEALTH INSURANCE PLAN OPTIONS – BENEFITS AND CLAIMS for more information.

Dependent Child

Refer to the section entitled PARTICIPANTS AND ELIGIBLE FAMILY MEMBERS (*Who Qualifies As My Dependent Child?*).

Domestic Partner

Refer to the section entitled PARTICIPANTS AND ELIGIBLE FAMILY MEMBERS (*Who Qualifies As My Domestic Partner?*).

Eligible Employee

Refer to the section entitled PARTICIPANTS AND ELIGIBLE FAMILY MEMBERS.

Employer

Refer to the section entitled PARTICIPANTS AND ELIGIBLE FAMILY MEMBERS.

Other Health Insurance

The term "Other Health Insurance" means health insurance obtained by a Participant, Spouse (or Domestic Partner), Dependent Child, and/or Dependent Relative outside of the Emeriti Program. The premiums for Other Health Insurance may be reimbursed from the Participant's Insurance Premium Account. The term "Other Health Insurance" includes insurance premiums offered by other carriers, COBRA continuation coverage, Long Term Care insurance premiums, Medicare Part B premiums, dental insurance premiums, but excludes coverage for any individual as an active employee (or as a spouse, domestic partner or dependent of an active employee) under an employer-sponsored group health plan.

Permanently Disabled

If you are a Participant, you will be considered Permanently Disabled if you have received a final determination from the Social Security Administration that you are permanently disabled and became permanently disabled no later than the date of cessation of employment with the Employer. It is your responsibility to notify the Plan Sponsor of the Social Security Administration's determination prior to the expiration of a three year Break in Service. Failure to do so will result in you not qualifying as Permanently Disabled under the Plan. The determination of the Social Security Administration that are permanently disabled is not subject to review and is final with respect to the Plan (other than to verify that such determination has occurred). For the definition of Permanently Disabled as it relates to family members, refer to the section entitled PARTICIPANTS AND ELIGIBLE FAMILY MEMBERS (*What Does It Mean For a Family Member To Be Permanently Disabled?*).

Plan

Refer to the section at the beginning of this SPD entitled INTRODUCTION TO YOUR EMERITI RETIREE HEALTH PLAN.

Plan Sponsor

Refer to the section at the beginning of this SPD entitled INTRODUCTION TO YOUR EMERITI RETIREE HEALTH PLAN.

Retirement Eligibility

The term “Retirement Eligibility” means that you have satisfied the Plan’s age and service requirements for retirement. Refer to the section entitled EMERITI HEALTH INSURANCE PLAN OPTIONS - ELIGIBILITY for more information.

Spouse

Refer to the section entitled PARTICIPANTS AND ELIGIBLE FAMILY MEMBERS (*Who Qualifies As My Spouse?*).

Year of Continuous Service

The term “Year of Continuous Service” means each 12-month period of employment with the Employer based upon the elapsed time between your date of hire and the date you cease employment with the Employer. The Plan Sponsor has the sole discretion to determine your Years of Continuous Service. For example, if you were hired on July 1, 1989, and worked continuously for your Employer until November 15, 2010, you would have 21 Years of Continuous Service. If you are absent from employment with the Employer during the calendar year for qualified military service, and you return to work within certain timeframes, you may be eligible to receive credit for service even though you were absent. If you will be absent from employment due to military service, you should contact the Plan Sponsor to discuss what you need to do to protect your rights under the Plan.

PARTICIPANTS AND ELIGIBLE FAMILY MEMBERS

Who is Eligible to Participate?

You can participate in the Plan as an "Eligible Employee" if you are a common law employee of the Employer, you are at least age twenty one (21), and you are in a class of employees or are an individual employee listed on Schedule A of the Adoption Agreement for the Plan. Your Employer will notify you separately regarding the terms and conditions of qualifying as an Eligible Employee under the Plan.

DEFINITION OF EMPLOYER: The term "Employer" refers to the Plan Sponsor and any Participating Affiliate (i.e., an organization under common control with the Plan Sponsor that has elected to participate in the Plan). Your Employer may be the Plan Sponsor or a Participating Affiliate listed in Appendix A of this SPD.

You will become a "Participant" in the Plan on the date that your Employer first establishes an Insurance Premium Account in your name. If your Employer does not do so, you are not a Participant in this Plan. If you are a retired employee of the Employer when the Plan commences, you are only eligible to participate in the Plan if your Plan Sponsor has expressly provided for your participation under the design of its Plan. Your Employer will notify you separately regarding the terms and conditions of your participation in the Plan.

Which of My Family Members Can Benefit Under the Plan?

Although they may or may not qualify for benefits (as discussed later in this SPD), the following of your family members are eligible to benefit under the Plan:

- Your Spouse (or Domestic Partner)
- Any Dependent Child

Do I Need To Designate Each Family Member That I Want to Benefit Under the Plan?

Yes. As discussed below, you must call 1-866-EMERITI (1-866-363-7484) to designate each eligible family member who you want to cover under the Plan. You must do this when you first become a participant.. Subject to the rules related to enrollment for the Emeriti Health Insurance Plan Options, you can add additional eligible family members at a later date by calling 1-866-EMERITI (1-866-363-7484). Any time that you designate eligible family members, you may be required to provide verifying information.

Who Qualifies As My Spouse?

Your Spouse is the person to whom you are legally married (or were legally married upon your death). A common law spouse is not considered a Spouse under the Plan.

If you are divorced or legally separated, your former Spouse loses his or her rights to coverage under the Plan (*subject to continuation coverage rights for coverage in the Emeriti Health Insurance Plan Options under COBRA*). If you are divorced and later remarry, your new Spouse may be eligible for coverage under the Emeriti Health Insurance Plan Options.

If you die, your Spouse at the time of your death will be considered your Spouse under the Plan until he or she dies (regardless of subsequent marital status).

IMPORTANT: You must call 1-866-EMERITI (1-866-363-7484) to designate your Spouse (*you may be required to submit verification*).

Who Qualifies As My Domestic Partner?

In this SPD, if you see the term Domestic Partner, it refers to a person who is either your Dependent Domestic Partner or Non-Dependent Domestic Partner. If one or the other is meant, the SPD will specify which type of Domestic Partner is intended. In addition, any reference to a Domestic Partner in this SPD means an individual of either sex.

- *Dependent Domestic Partner:* Your Dependent Domestic Partner is any individual to whom you are not related and who for the calendar year: (1) receives over 50% of his or her financial support from you; (2) uses your home as his or her principal place of abode; and (3) is a member of your household; provided you have lived together for at least 6 months prior to enrollment and you have designated the individual as your Domestic Partner by calling 1-866-EMERITI (1-866-363-7484). An individual who meets these requirements is eligible to benefit under the Plan in the same manner as a Spouse in terms of access to the Emeriti Health Insurance Plan Options and payment of premiums from your Insurance Premium Account.

- *Non-Dependent Domestic Partner:* Your Non-Dependent Domestic Partner is any individual to whom you are not related and who for the calendar year: (1) uses your home as his or her principal place of abode; and (2) is a member of your household; provided you have lived together for at least 6 months prior to enrollment and you have designated the individual as your Domestic Partner by calling 1-866-EMERITI (1-866-363-7484). (Note that these are the same requirements as a Dependent Domestic Partner, except that there is no 50% support requirement.) The requirements of (1) and (2) above will continue to be satisfied if the

individual resides in an assisted living facility immediately following a period in which he or she satisfied the requirements of (1) and (2) above. A Non-Dependent Domestic Partner may be eligible for the Emeriti Health Insurance Plan Options, but Federal law requires that his or her premiums be paid out-of-pocket by electronic ACH Transfer, not from your Insurance Premium Account.

IMPORTANT: You must call an Emeriti specialist at 1-866-EMERITI (1-866-363-7484) to verify the status of your Domestic Partner over a recorded line (*and, if requested, submit an affidavit or other verification*). It is your responsibility to call this number to provide notice of any change in an individual's status as a Dependent Domestic Partner or Non-Dependent Domestic Partner.

If an individual is your Domestic Partner at the time you die, he or she will remain your Domestic Partner so long as he or she remains eligible for coverage under the Emeriti Health Insurance Plan Options (e.g., pays the required premiums and meets the other requirements for coverage). Domestic Partner status, whether Dependent or Non-Dependent, cannot be established after you die, so it is important that you promptly call 1-866-EMERITI (1-866-363-7484) and follow the required procedures.

You can only have one Domestic Partner, and you cannot have a Domestic Partner if you have a Spouse.

Who Qualifies As My Dependent Child?

A Dependent Child is any of the following who (i) is not currently married; (ii) has the same principal place of abode as you do for more than half the calendar year (not counting absences while away at school); and (iii) does not provide over half of his or her own support:

- Your child who has not attained age 26 (*higher ages may apply with respect to coverage under the Emeriti Health Insurance Plan Options in certain states, if required by law*).

- Your child, regardless of age, who is Permanently Disabled *(see definition).*

The following rules apply to the determination of whether an individual will be treated as your Dependent Child:

- *Child Status:* An individual will be considered your child if he or she is your natural child, adopted child, child placed for adoption, or stepchild, or if you are the individual's permanent legal guardian or permanent custodian. In addition, an individual will be considered your child if he or she is the natural child, adopted child, or child placed for adoption of your

Domestic Partner, provided that the child: (i) receives over half of his or her financial support from you; (ii) uses your home as his or her principal place of abode; and (iii) is a member of your household.

IMPORTANT: An individual will not be considered your Dependent Child under the Plan unless you designate him or her by calling 1-866-EMERITI (1-866-363-7484) and following the Plan's designation procedures (*you may be required to submit verification*).

- *Effect of Your Death:* If an individual is your Dependent Child when you die, he or she will remain a Dependent Child for purposes of the Plan so long as he or she remains eligible for coverage under the Emeriti Health Insurance Plan Options (e.g., pays the required premiums and meets the other requirements for coverage). However, an individual will cease to be a Dependent Child upon failing to meet the limiting age or Permanently Disabled requirements. Normally an individual has to be designated as your Dependent Child in order to be eligible to benefit under the Plan. However, the following exceptions apply:

    - If you die with a surviving designated Spouse (or Domestic Partner) or Dependent Child, then an individual who was not designated as your Dependent Child at the time of your death will be treated as your Dependent Child if such individual shows valid evidence that he or she would have qualified as your Dependent Child on the date of your death had you properly designated such individual as your Dependent Child, provided that on the date such evidence is submitted by such individual, the balance of your Insurance Premium Account has not been exhausted or forfeited in accordance with the terms of the Plan. Valid evidence can be submitted by calling 1-866-EMERITI (1-866-363-7484) and following the required procedures.

    - If you die with <u>no</u> surviving designated Spouse (or Domestic Partner) or Dependent Child, then an individual who was not designated as your Dependent Child at the time of your death will be treated as your Dependent Child if he or she shows valid evidence that he or she would have qualified as a Dependent Child on the date of your death had you properly designated such individual as your Dependent Child, provided that he or she does so within <u>30 days</u> following your death (by calling 1-866-EMERITI (1-866-363-7484) and following the required procedures).

  Except as described above, an individual cannot become your Dependent Child after you have died.

What Does It Mean For a Family Member To Be Permanently Disabled?

The term Permanently Disabled has different meanings depending upon the individual:

- *Spouse (or Domestic Partner):* If you are a Spouse (or Dependent Domestic Partner), you will be determined to be Permanently Disabled if you have received a final determination from the Social Security Administration that you are permanently disabled. Non-Dependent Domestic Partners are not eligible to be considered Permanently Disabled under the Plan.

- *Child:* If you are considered a child of the Participant under the definition of Dependent Child, you will be determined to be Permanently Disabled if you have received a final determination from the Social Security Administration that you are permanently disabled and became permanently disabled no later than the date that you attained age 26.

The determination of the Social Security Administration that an individual is permanently disabled is not subject to review and is final with respect to the Plan (other than to verify that such determination has occurred).

INSURANCE PREMIUM ACCOUNT

If you are an Eligible Employee, you will have an Insurance Premium Account established in your name with the Record Keeper. The Insurance Premium Account maintains a record of amounts that your Employer credits to the account. Your account does not contain actual dollars. Rather, upon your retirement, your Employer will pay premiums for the Emeriti Health Insurance Plan Options on your behalf up to the balance of your Insurance Premium Account (subject to eligibility for the Emeriti Health Insurance Plan Options and the other terms of the Plan).

How Does My Employer Credit My Account?

Your Employer may credit amounts to your Insurance Premium Account at any time and in any amount, subject to its sole discretion. The timing, number, and amount of these credited amounts may differ for different classes of employees or individual employees. The timing, number, and dollar value of your credited amounts may be subject to the terms of an agreement between you and your Employer outside of the Plan. Your Employer will notify you separately regarding the timing, number, and dollar value of amounts credited to your Insurance Premium Account.

How Can I Use My Insurance Premium Account?

If you cease employment and are eligible for insurance, your Employer will pay the premiums the insurance plan you select based upon the balance of your Insurance Premium Account during your life and the lives of your Spouse (or Dependent Domestic Partner) and Dependent Children (so long as they remain Dependent Children), subject to eligibility. However, if any residual amount remains credited to your account when you and your Spouse (or Dependent Domestic Partner) have died and your Dependent Children have died (or ceased to be Dependent Children), then the entire remaining balance credited to your Insurance Premium Account will be forfeited. In addition, if you cease employment and are not eligible for the insurance, the entire balance of your Insurance Premium Account will be forfeited.

DEEMED INVESTMENT OF ACCOUNT

One of the advantages of the Plan is that amounts credited to your Insurance Premium Account are deemed to be invested in one or more Mutual Funds available through TIAA. These Mutual Funds are listed in Appendix B of this SPD, which includes additional information about the Mutual Funds.

What Does It Mean That My Account is "Deemed" To Be Invested?

Your Insurance Premium Account is a notional account. This means that it contains credits, not actual dollars. Although these credits are not actually invested in mutual funds, they are "deemed" to be invested in the mutual funds you select, and the balance of your Insurance Premium Account over time is based upon their performance. As a result, your Insurance Premium Account is subject to investment risk and reward even though it is not actually invested.

Who Controls How My Account Is Deemed To Be Invested?

You control how your Insurance Premium Account is deemed to be invested, subject to TIAA's procedures and the terms of the Plan. Your Insurance Premium Account shows the aggregate of amounts credited by your Employer, after adjustment for deemed gains and losses, deemed changes in market valuation, forfeitures, expenses, and/or premium payments, if any. Since the balance credited to your Insurance Premium Account is subject to gains and losses as a result of deemed investment performance, it is very important that you carefully consider how you wish to direct the deemed investment of the balance in your Insurance Premium Account .

The deemed mutual fund options for the Insurance Premium Account primarily consist of TIAA-CREF Life Cycle Funds, each of which is a "fund of funds," meaning that each TIAA-CREF Lifecycle Fund invests in a combination of other TIAA-CREF mutual funds. The TIAA-CREF Life Cycle Funds are funds managed according to the fund's target retirement date, which begin with a more aggressive investment strategy (i.e., a higher percentage of equity funds) and become more conservative (i.e., a higher percentage of fixed income and money market funds) as the target retirement date approaches. The fund manager actively rebalances the fund to align it with its objective. TIAA-CREF Life Cycle Funds offered under the Plan are generally labeled with a date. This date reflects the anticipated retirement date.

Another investment option available before you retire is called the TIAA-CREF Money Market Mutual Fund, which is a money market fund.

Your Employer may have selected other investment options. If so, they are listed in Appendix B of this SPD.

Even though these are deemed Mutual Funds, the Plan Administrator may impose restrictions upon any Mutual Fund, such as restrictions on frequency and amount of transfers to or from a Mutual Fund in accordance with the underlying prospectus. The Mutual Funds available for deemed investments under the Plan are subject to change at any time. You will be notified if any Mutual Funds are added or removed from the Plan and will be given the opportunity to make corresponding adjustments to the deemed investment of your Insurance Premium Account. If an existing Mutual Fund is removed and you do not make a new election regarding amounts in your Insurance Premium Account invested in that Mutual Fund, the Plan Administrator will transfer those amounts to one or more of the other Mutual Funds available under the Plan.

THE PREVIOUS DISCUSSION OF THE TIAA LIFECYCLE FUNDS AND THE ACCOMPANYING EXAMPLES ARE PROVIDED FOR ILLUSTRATION ONLY AND ARE NOT INTENDED TO PROVIDE YOU WITH MUTUAL ADVICE OR WITH A FULL DESCRIPTION OF EACH MUTUAL FUND. EACH MUTUAL FUND IS SUBJECT TO GAINS AND LOSSES DUE TO MUTUAL PERFORMANCE AS WELL AS FEES WHICH ARE DISCLOSED IN THE PROSPECTUS FOR EACH MUTUAL FUND. IN DECIDING HOW TO DIRECT THE DEEMED MUTUAL OF YOUR INSURANCE PREMIUM ACCOUNT, YOU SHOULD CAREFULLY REVIEW THE PROSPECTUS FOR EACH MUTUAL FUND, CONSULT YOUR FINANCIAL ADVISOR, AND CAREFULLY CONSIDER YOUR PARTICULAR CIRCUMSTANCES. THE MUTUAL FUNDS AVAILABLE UNDER THE PLAN ARE SUBJECT TO CHANGE FROM TIME TO TIME.

How Do I Make Elections Regarding How My Account Is Deemed To Be Invested?

When you first become a Participant, you must file an investment election with TIAA directing how your Insurance Premium Account is to be deemed invested. You will make a separate investment election for your Insurance Premium Account from any election you make for your accounts under another Emeriti plan. You must state, in whole percentage points from 1% to 100%, the percentage of amounts credited to your Insurance Premium Account that will be deemed to be invested in a particular Mutual Fund. If you fail to file an election, amounts credited to your Insurance Premium Account will be deemed to be invested in the TIAA-CREF Life Cycle Fund that corresponds to when you will reach age 65.

Can I Change How My Account Is Deemed To Be Invested?

You can change how future amounts credited to your Insurance Premium Account are deemed to be invested by filing a new election with TIAA. In addition, you may change how the current balance of your Insurance Premium Account is deemed to be invested by notifying TIAA. You can make an investment change through the internet or through a phone representative or the automated phone system of TIAA. You may make changes at any time and without any limits, except for restrictions imposed by the Mutual Fund on short-term and excessive trading. You will be notified in writing by TIAA if you become subject to these restrictions.

If you change the deemed investment of a current balance, your change must be stated in whole percentage points from 1% to 100% or in any dollar amount in excess of $250 or the current balance held in the Mutual Fund. You can have different investments for the existing credited balance in your Insurance Premium Account from new credited amounts. Your deemed investment elections remain in effect until you change them.

How Are Deemed Transactions in the Mutual Fund Priced?

Shares of the Mutual Funds are deemed to be bought at the next Net Asset Value ("NAV") calculated for the Mutual Fund after the crediting order is received by TIAA. Deemed exchanges, transfers and sales will be done at the next NAV calculated after the deemed exchange, transfer or sale is processed. Deemed transactions confirmed after the close of the market, normally 4 p.m. Eastern time, or on weekends or holidays, will receive the next available NAV. The NAV is usually calculated at the close of the market each business day.

Do I Receive Deemed Transaction Confirmations and Account Statements?

You will receive deemed transaction confirmations directly. If you transact through the internet, through a phone representative or the automated phone system of TIAA, you will have the choice of receiving a paper deemed transaction confirmation or an electronic version for each deemed transaction.

You will receive account statements once a year. You will also have access to a website where current account information is available, including updated performance statistics on the mutual funds. You can also obtain current account information by speaking to a phone operator or accessing an automated phone system at TIAA.

Do I Receive Prospectuses and Updates?

You will receive a prospectus as part of your initial enrollment information. When you first allocate a portion of your Insurance Premium Account to a particular mutual fund, you will receive the prospectus again. You can receive a prospectus before that time by calling TIAA or by accessing the TIAA web site. You will receive Supplements, Updates, Semi-Annual and Annual Reports, and Proxy Statements from TIAA for so long as you maintain an allocation in that fund. You can elect to receive electronic versions of some of these documents in place of paper by consenting to electronic delivery. You will also have access to a website where current versions of some of these documents are available at any time. You can also request current copies of these documents by calling TIAA.

How Is My Account Deemed To Be Invested If I Die?

If you die and your Insurance Premium Account remains available for your Spouse (or Dependent Domestic Partner), then your Spouse (or Dependent Domestic Partner) must direct the deemed investment of your Account(s).

Does the Deemed Mutual of My Account Change Once I Retire?

You may continue to direct that your Insurance Premium Account be deemed to be invested in the Mutual Funds listed in Appendix B of this SPD even after you retire. The balance credited to your Insurance Premium Account will remain subject to the performance of those Mutual Funds. No annuity investment option is available under this Plan.

Will My Account Pay For All of My Premiums?

There is no guarantee that the balance credited to your Insurance Premium Account will be sufficient to pay for all of your premiums for the insurance plan you select, either as a result of investment performance of your Insurance Premium Account or due to longevity. Your Employer will only pay your premiums up to the total balance credited to your Insurance Premium Account. When that credited balance is exhausted, your Employer will provide no further financial support for premiums for the insurance plan you select under this Plan. However, you may continue to have access to the insurance plan you select, provided you are either eligible for coverage under another Emeriti plan offered by your Employer (and have available funds in your accounts under that plan) or you designate a private account from which premium payments will continue via electronic ACH Transfer for coverage under this Plan. Your Insurance Premium Account is not subject to any liens against you. However, your Employer's ability to satisfy its obligations under the Plan is subject to the rights of your Employer's creditors.

Can I Transfer My Account to Someone Else?

No. Neither you nor your covered family members have any right to transfer, sell or otherwise dispose of your Insurance Premium Account. Your Insurance Premium Account is not subject to qualified domestic relations orders (QDROs) or any other order or agreement for the division of your Insurance Premium Account. The balance credited to your Insurance Premium Account represents an agreement on the part of your Employer to pay a specified amount of premiums for the insurance plan you select if you are eligible. It does not represent actual assets.

Will My Account Affect Medicaid Eligibility?

Medicaid (as opposed to Medicare) is a government program that pays for medical assistance for certain individuals and families with low incomes and resources. Medicaid has certain income and asset limitations for eligibility that

vary state by state. Please consult your local Medicaid office if you have questions about how your Insurance Premium Account may affect Medicaid eligibility for you, your spouse or domestic partner, or dependents.

FEES

Are Fees Charged to My Insurance Premium Account?

Yes. The Plan permits the reasonable costs of administering the Plan to be charged to the Insurance Premium Accounts of Participants. Your Employer actually pays this amount from its own assets, but the balance of your Insurance Premium Account is reduced accordingly. In the event that the balance of your Insurance Premium Account reach zero dollars ($0), you may be required to pay administrative fees by ACH Transfer in order to continue participation in the Plan (unless your fees can be paid from your account(s) under another Emeriti plan sponsored by your Employer).

What Fees Are Charged by Emeriti?

The fee charged by Emeriti for its services to the Plan is $4.67 per month for each Participant while in active service. The fee charged by Emeriti for its services to the Plan is $9.67 per month for each Participant following your employment with the institution.

Your portion of this fee is charged on a monthly basis first to your Insurance Premium Account. If you are not a participant in another Emeriti plan offered by your Employer and the balance credited to your Insurance Premium Account is exhausted, you must pay this fee by ACH Transfer in order to continue participation in the Plan. However, if you are a participant in another Emeriti plan offered by your Employer, this fee will not be charged twice. Rather, it is first charged against the balance credited to your Insurance Premium Account (and therefore actually paid by your Employer). When the amounts credited to your Insurance Premium Account are exhausted, it is then charged directly to your accounts under your Employer's VEBA-based Emeriti Retiree Health Plan (see the SPD for that plan). If those accounts are exhausted and you continue participation in your Employer's other Emeriti Plan, you must pay the fee directly by ACH Transfer.

What Fees Are Charged by TIAA?

As recordkeeper for the Plan, TIAA provides deemed investment services for Insurance Premium Accounts, handles Participant and dependent enrollment for the Emeriti Health Insurance Plan Options, processes premium payments for the Emeriti Health Insurance Plan Options, offers Participant education support, and carries out other ministerial functions essential to the operation of the Plan.

To cover its record-keeping and service costs, TIAA charges are included in the above Emeriti fee. However, if you are a participant in your Employer's VEBA-based Emeriti Retiree Health Plan, this fee will not be charged twice. In addition,

there are management fees and other fees and expenses for the TIAA Mutual Funds. These fees and expenses are reflected in the total return of the Mutual Funds that you select for deemed investments. These fees are detailed in the prospectus for each Mutual Fund.

What Fees Are Charged by Aetna?

The only payments to Aetna or an alternate non-sponsored health insurer are the monthly premiums paid from your Insurance Premium Account for initial and continuing enrollment in the Emeriti Health Insurance Plan Options.

What Fees Are Charged by My Employer?

You are not charged for any of the costs incurred by your Employer to participate in the Emeriti Program or associated with its ongoing operation of the Plan.

EMERITI HEALTH INSURANCE PLAN OPTIONS – ELIGIBILITY

This section describes eligibility for the Emeriti Health Insurance Plan Options underwritten by Aetna. (If you have any questions regarding eligibility for the Emeriti Health Insurance Plan Options, including questions regarding the timeframes for enrollment, you may call 1-866-EMERITI (1-866-363-7484).

IMPORTANT: The rules described in this Section include 90-day enrollment windows, including in certain cases the requirement to enroll within 90 days of first becoming eligible. It is important that you review these provisions with your eligible dependents. If you and your eligible dependents do not enroll in one of the Emeriti Health Insurance Plan Options within the applicable enrollment window, eligibility to later enroll in the Emeriti Health Insurance Plan Options will be restricted. If you have any questions about enrollment, you should call 1-866-EMERITI (1-866-363-7484). In addition, in the event of the Participant's death, eligible dependents should call as soon as possible to discuss enrollment.

You, your Spouse (or Domestic Partner) and your Dependent Children may be eligible to enroll in the Emeriti Health Insurance Plan Options. Eligibility for the Emeriti Health Insurance Plan Options and the terms of coverage are governed by the terms of the Plan and the Coverage Documents (defined in the Section entitled EMERITI HEALTH INSURANCE PLAN OPTIONS – BENEFITS).

The various optional levels of coverage under the Emeriti Health Insurance Plan Options generally consist of:

- One or more post-65 options integrating with Medicare Parts A and B, some of which may be offered under Medicare Part C (Medicare Advantage) or Medicare Part D (Prescription Drug) (referred to as "Post-65 Options"). The Post-65 Options are available to eligible: (1) Participants who have attained age 65 or are Permanently Disabled; (2) Spouses (or Domestic Partners) who have attained age 65 or are Permanently Disabled; and (3) Dependent Children who are Permanently Disabled — provided these individuals are enrolled in Medicare Parts A and B; and

- One pre-65 option (referred to as "Pre-65 Option"), which is available to eligible: (1) Spouses (or Domestic Partners) who have not attained age 65 (or who have attained age 65 but have not enrolled in Medicare Parts A and B); and (2) Dependent Children — provided these individuals are not Permanently Disabled.

Each of the Emeriti Health Insurance Plan Options has its own set of eligibility criteria, and the benefits provided will vary by state as necessary to comply with state insurance laws. A separate summary of benefits will be provided to you, or you may call 1-866-EMERITI (1-866-363-7484) to obtain information about the

specific benefits offered in your state. Coverage for Spouses (or Domestic Partners) and Dependent Children is contingent upon enrollment of the Participant, except as described below. Enrollment in and coverage under each Emeriti Health Insurance Plan Option is subject to the requirements of any applicable State or Federal laws, regulations, or regulatory guidance, including Medicare.

SPECIAL NOTE REGARDING MEDICARE PART D

All of the Post-65 Emeriti Health Insurance Plan Options include prescription drug coverage. This means that you do not need to enroll in a separate Medicare Part D plan outside of this Plan. Just enroll in a Post-65 Option to obtain prescription drug coverage. Please note that if you enroll in a Post-65 Option under the Plan and then you enroll in a Medicare Part D plan elsewhere, you will automatically lose your prescription drug coverage under the previously selected Post-65 Option as a result of Medicare laws. There is no guarantee, if you make a second election of Part D insurance elsewhere, that a Post-65 Emeriti Health Insurance Plan Option without prescription drug coverage will be available to you. That means you may lose your coverage under the Emeriti Health Insurance Plan Options and may not be able to enroll in future years. As a result of Medicare laws, you should also be aware that late enrollment in the Emeriti Health Insurance Plan Options may result in premium penalties assessed by the Centers for Medicare and Medicaid Services on all future premiums.

What If I Cease to Be Employed Prior to Attaining Retirement Eligibility?

If you cease to be employed by the Employer *(for any reason including death)* prior to meeting the requirements for Retirement Eligibility established by the Plan Sponsor, then you, your Spouse (or Domestic Partner), and your Dependent Children will not be eligible to enroll in the Emeriti Health Insurance Plan Options. See below for a discussion of your rights if you cease employment with the Employer due to becoming Permanently Disabled.

DEFINITION OF RETIREMENT ELIGIBILITY: The term "Retirement Eligibility" is used to determine your eligibility for the Emeriti Health Insurance Plan Options.

You meet the criteria for Retirement Eligibility if you are employed by your Employer on the date you attain the first to occur of:

- **Age 55 with at least 15 Years of Continuous Service;**

If prior to meeting the criteria for Retirement Eligibility you incur a Break in Service and do not return to work with the Employer until after the expiration of three years, your Years of Continuous Service for purposes of determining whether you have satisfied the criteria for Retirement Eligibility will not include your service prior to commencement of the Break in Service.

What If I Cease to Be Employed On or After Attaining Retirement Eligibility (Except Due to Death)?

Enrollment of Participant:

If you cease to be employed by the Employer *(for any reason other than death)* on or after meeting the requirements for Retirement Eligibility, then once you have attained age 65 and enrolled in Medicare Parts A and B, you will be eligible to enroll in the Emeriti Health Insurance Plan Options under one of the Post-65 Options.

IMPORTANT: You must enroll within the 90-day period commencing on the later of the date you turn age 65 or enroll in Medicare Parts A and B. If you do not enroll in one of the Emeriti Health Insurance Plan Options within that enrollment window, your eligibility to later enroll in the Emeriti Health Insurance Plan Options will be restricted *(see the subsection below entitled What If I Fail to Enroll, or a Family Member Fails to Enroll, Within the Enrollment Window?)*. You may call 1-866-EMERITI (1-866-363-7484) prior to your enrollment eligibility date to obtain information about enrollment.

Enrollment of Spouse (or Domestic Partner):

At the time you enroll in a Post-65 Option, you may also be eligible to enroll your Spouse (or Domestic Partner) as follows:

- If your Spouse (or Domestic Partner) is at least age 65 and currently enrolled in Medicare Parts A and B, you may enroll your Spouse (or Domestic Partner) in the same Post-65 Option in which you are enrolled. You may not enroll in different Post-65 Options.

- If your Spouse (or Domestic Partner) has not attained age 65, you may enroll your Spouse (or Domestic Partner) in a Pre-65 Option. Similarly, if your Spouse (or Domestic Partner) has attained age 65 but has not enrolled in Medicare Parts A and B, you may enroll your Spouse (or Domestic Partner) in a Pre-65 Option. In either case, if your Spouse (or Domestic Partner) later enrolls in Medicare Parts A and B (after attaining age 65), then you may change your Spouse's (or Domestic Partner's) enrollment from a Pre-65 Option to the same Post-65 Option in which you are enrolled, provided you do so within the 90-day period commencing on the date your Spouse (or Domestic Partner) enrolls in Medicare Parts A and B or during any subsequent open enrollment period. You may not enroll in different Post-65 Options.

IMPORTANT: If your Spouse (or Domestic Partner) is eligible for the Pre-65 Option but chooses not to enroll in that option, you may later enroll your Spouse (or Domestic Partner) in the same Post-65 Option in which you are enrolled, provided you do so within the 90-day period commencing on the later of the date your Spouse or (Domestic Partner) attains age 65 or enrolls in Medicare Parts A

and B. Subsequent enrollment during an annual open enrollment period will not be permitted. You may call 1-866-EMERITI (1-866-363-7484) to obtain information about enrollment.

Please note that the Pre-65 Option is significantly more expensive because it typically will not coordinate with Medicare. Therefore it may be advantageous to enroll your Spouse (or Domestic Partner) in your Post-65 Option as soon as possible.

Enrollment of Dependent Child:

At the time you enroll in a Post-65 Option, you may also enroll your Dependent Children in the Pre-65 Option.

IMPORTANT: If you do not enroll your Dependent Child in one of the Emeriti Health Insurance Plan Options when you enroll, your eligibility to later enroll your Dependent Child in the Emeriti Health Insurance Plan Options will be restricted (*see the subsection below entitled What If I Fail to Enroll, or a Family Member Fails to Enroll, Within the Enrollment Window?*). You may call 1-866-EMERITI (1-866-363-7484) to obtain information about enrollment.

Exceptions for Permanently Disabled Dependents:

If your Spouse (or Dependent Domestic Partner) or Dependent Child is Permanently Disabled and enrolled in Medicare Parts A and B, then at the time you enroll in a Post-65 Option, you may elect to enroll the individual, but only in the same Post-65 Option in which you are enrolled.

IMPORTANT: You must enroll your Spouse (or Dependent Domestic Partner) or Dependent Child within the 90-day period commencing on the date he or she enrolls in Medicare Parts A and B. Otherwise, his or her eligibility to later enroll in the Emeriti Health Insurance Plan Options will be restricted (*see the subsection below entitled What If I Fail to Enroll, or a Family Member Fails to Enroll, Within the Enrollment Window?*). You may call 1-866-EMERITI (1-866-363-7484) to obtain information about enrollment.

If you have enrolled your Spouse (or Dependent Domestic Partner) or Dependent Child who is not Permanently Disabled and enrolled in Medicare Parts A and B according to the regular enrollment rules in a Pre-65 Option, then if that individual later becomes Permanently Disabled and enrolled in Medicare Parts A and B, you must call 1-866-EMERITI (1-866-363-7484) to change his or her enrollment from a Pre-65 Option to the same Post-65 Option in which you are enrolled.

What If I Become Permanently Disabled?

Enrollment of Participant:

If you cease employment after meeting the requirements for Retirement Eligibility, your disabled status will have no effect on your benefits. However, if

you cease employment prior to meeting the requirements for Retirement Eligibility as a result of becoming Permanently Disabled, then once you enroll in Medicare Parts A and B, you will be eligible to enroll in a Post-65 Option, provided that you enroll after receipt of the Social Security determination letter, but within the ninety (90)-day period commencing on the date that you enroll in Medicare Parts A and B.

IMPORTANT: You must enroll within the 90-day period commencing on the date you enroll in Medicare Parts A and B. If you do not enroll in one of the Emeriti Health Insurance Plan Options within that enrollment window, your eligibility to later enroll in the Emeriti Health Insurance Plan Options will be restricted (*see the subsection below entitled What If I Fail to Enroll, or a Family Member Fails to Enroll, Within the Enrollment Window?*). You may call 1-866-EMERITI (1-866-363-7484) to obtain information about enrollment.

Definition of Permanently Disabled: You will be considered Permanently Disabled if you have received a final determination from the Social Security Administration that you are permanently disabled and became permanently disabled no later than the date of cessation of employment with the Employer. It is your responsibility to notify the Plan Sponsor of the Social Security Administration's determination prior to the expiration of a three year Break in Service. Failure to do so will result in you not qualifying as Permanently Disabled under the Plan. The determination of the Social Security Administration is not subject to review and is final with respect to the Plan (other than to verify that such determination has occurred).

Enrollment of Spouse (or Domestic Partner) and Dependent Children:

At the time you enroll, you may enroll your Spouse (or Domestic Partner) and Dependent Children under the same rules described under the subsection above entitled, *What If I Cease to Be Employed On or After Attaining Retirement Eligibility (Except Due to Death)?* You should review that subsection carefully for important limitations on the right to enroll those individuals.

What If I Die After Attaining Retirement Eligibility?

If you have met the criteria for Retirement Eligibility and then die, your surviving dependents may be eligible to enroll or continue their coverage as described below.

IMPORTANT: The rules described below include 90-day enrollment windows, including in certain cases the requirement to enroll within 90 days of the Participant's death or the Spouse's (or Domestic Partner's) attainment of age 65 or enrollment in Medicare Parts A and B. It is important that you review these provisions with your eligible dependents. If they do not enroll in one of the Emeriti Health Insurance Plan Options within their enrollment window, their eligibility to later enroll in the Emeriti Health Insurance Plan Options will be restricted (*see the subsection below entitled What If I Fail to Enroll, or a Family Member Fails to Enroll, Within the Enrollment Window?*). In the event of the

Participant's death, eligible dependents should call 1-866-EMERITI (1-866-363-7484) as soon as possible to discuss enrollment.

Death While Employed / *Death Post-Employment But Pre-Enrollment:*

After attaining Retirement Eligibility, if you die: (1) while still employed by the Employer; or (2) after ceasing employment but prior to enrolling in one of the Emeriti Health Insurance Plan Options (*unless you were eligible to enroll and failed to do so within your enrollment window*), then within the 90-day period commencing on the date of your death, your Spouse (or Domestic Partner) and Dependent Children may enroll in one of the Emeriti Health Insurance Plan Options under the following conditions:

- If your Spouse (or Domestic Partner) is at least age 65 and currently enrolled in Medicare Parts A and B, he or she may enroll in a Post-65 Option provided he or she does so within the 90-day period commencing on the date of your death.

- If your Spouse (or Domestic Partner) has not attained age 65 or has attained age 65 but has not enrolled in Medicare Parts A and B, he or she may enroll in the Pre-65 Option. If he or she enrolls in a Pre-65 Option and later enrolls in Medicare Parts A and B (after attaining age 65), then he or she may change enrollment to a Post-65 Option, provided he or she does so within the 90-day period commencing on the later of the date he or she attains age 65 or enrolls in Medicare Parts A and B.

- Your Dependent Children may enroll in the Pre-65 Option.

- If your Spouse (or Domestic Partner) is eligible for the Pre-65 Option but chooses not to enroll in that option, he or she may later enroll in a Post-65 Option, provided he or she does so within the 90-day period commencing on the later of the date he or she attains age 65 or enrolls in Medicare Parts A and B. Subsequent enrollment during an annual open enrollment period will not be permitted.

- Note that if you cease employment after meeting the criteria for Retirement Eligibility, fail to enroll in an Emeriti Health Insurance Plan Option within your enrollment window, and then die, your Spouse (or Domestic Partner) and Dependent Children will be ineligible to ever enroll in the Emeriti Health Insurance Plan Options.

Death Post-Enrollment:

If you die after enrolling in an Emeriti Health Insurance Plan Option, the following rules apply:

- Your Spouse (or Domestic Partner) and Dependent Children who are currently enrolled in an Emeriti Health Insurance Plan Option may remain

enrolled in that same Emeriti Health Insurance Plan Option for so long as they continue to meet its qualifications (*subject to any rights to change Options at open enrollment—see below*).

- If your Spouse (or Domestic Partner) is enrolled on the date of your death in a Pre-65 Option and remains so enrolled, he or she may, upon attaining age 65 and enrolling in Medicare Parts A and B, elect to change enrollment to a Post-65 Option, but only if he or she does so within the 90-day period commencing on the later of the date he or she attains age 65 or enrolls in Medicare Parts A and B (or during any subsequent open enrollment period).

- If your Spouse (or Domestic Partner) is not enrolled on the date of your death in Health Insurance Coverage under a Pre-65 Option and is not eligible for Medicare Parts A and B, then if he or she later enrolls in Medicare Parts A and B (after attaining age sixty five (65)) he or she may elect to enroll in a Post-65 Option, but only if he or she does so within the 90-day period commencing on the later of the date he or she attains age 65 or enrolls in Medicare Parts A and B. Enrollment during a subsequent open enrollment period will not be permitted.

Exceptions for Permanently Disabled Dependents:

If your Spouse (or Dependent Domestic Partner) or Dependent Child is Permanently Disabled and enrolled in Medicare Parts A and B, then he or she may enroll only in a Post-65 Option.

If your Spouse (or Dependent Domestic Partner) or Dependent Child is not Permanently Disabled and enrolled in Medicare Parts A and B and he or she is enrolled in a Pre-65 Option, then if he or she later becomes Permanently Disabled and enrolled in Medicare Parts A and B, he or she must call 1-866-EMERITI (1-866-363-7484) to change his or her enrollment from a Pre-65 Option to a Post-65 Option.

Continued Coverage:

If you die, your Dependent Child's coverage in a Pre-65 Option will cease on the date he or she fails to meet the requirements of a Dependent Child (for example, he or she turns 19 while not enrolled in school). Your Spouse's (or Domestic Partner's) Pre-65 or Post-65 Option coverage will not cease on account of your death (even if he or she remarries). However, the new spouse or domestic partner and any future dependents of your surviving Spouse (or Domestic Partner) are never eligible for coverage under the Emeriti Health Insurance Plan Options or any other benefits under the Plan.

IMPORTANT: If your Spouse (or Domestic Partner) or Dependent Child fails to enroll in an Emeriti Health Insurance Plan Option during the 90-day enrollment window for the date the individual is first eligible (*as described above*), then that

individual's eligibility to later enroll in that Emeriti Health Insurance Plan Option will be restricted *(see the subsection below entitled What If I Fail to Enroll, or a Family Member Fails to Enroll, Within the Enrollment Window?)*. In the event of the Participant's death, eligible dependents should call 1-866-EMERITI (1-866-363-7484) as soon as possible to discuss enrollment.

Is Medicare Enrollment Required?

An individual's coverage under any Post-65 Option is only effective if the individual is actually enrolled in Medicare Parts A and B.

What Is the Effective Date of Coverage Under the Emeriti Health Insurance Plan Options?

For any Post-65 Option once you retire, the effective date is the latest to occur of:

- The first month in which you attain age 65;
- The effective date of your Medicare Parts A and B entitlement; or
- The first of the month following the date you enroll in the Post-65 Option in accordance with Aetna's enrollment procedures and Aetna accepts your enrollment (and, if applicable, your enrollment is approved by the Centers for Medicare and Medicaid Services).

Thus, if you retire after age 65 and enroll in a Post-65 Option after your Medicare effective date, your Post-65 Option will be effective once Aetna accepts your enrollment. Note that the same rules apply to enrollment of your Spouse (or Domestic Partner).

For any Pre-65 Option, the effective date of coverage is the first of the month following the date the individual enrolls in the Pre-65 Option in accordance with Aetna's enrollment procedures and Aetna accepts the enrollment.

What If I Fail to Enroll, or a Family Member Fails to Enroll, Within the Enrollment Window?

If you or one of your eligible family members fails to enroll in an Emeriti Health Insurance Plan Option within their enrollment window (*see above*), then that individual will not be permitted to later enroll in that Emeriti Health Insurance Plan Option, except within 30 days of any of the events described below.

- The individual (i.e., you, your Spouse (or Domestic Partner), or Dependent Child) declined enrollment because he or she was enrolled in COBRA continuation coverage under another plan and the maximum period of continuation coverage has expired. If applicable to you, you may enroll in a Post-65 Option. If applicable to your Spouse (or Domestic Partner) and/or Dependent Child, they may each enroll in an appropriate Emeriti

Health Insurance Plan Option if you are already enrolled, or you enroll, in a Post-65 Option. Coverage will be effective the first of the month following the date of enrollment.

- The individual (i.e., you, your Spouse (or Domestic Partner), or Dependent Child) declined enrollment because he or she had coverage under another group health plan or had other health insurance coverage and that other coverage terminated as a result of loss of eligibility or employer contributions toward that coverage have been terminated. This includes loss of coverage due to legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of these events. This does not include loss of coverage due to failure to pay premiums on a timely basis or termination of coverage for cause, such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan. If applicable to you, you may enroll in a Post-65 Option. If applicable to your Spouse (or Domestic Partner) and/or Dependent Child, they may each enroll in an appropriate Emeriti Health Insurance Plan Option if you are already enrolled, or you enroll, in a Post-65 Option. Coverage will be effective the first of the month following the date of enrollment.

- You have a new Spouse (or Domestic Partner), in which case your new Spouse (or Domestic Partner) may be enrolled in an appropriate Emeriti Health Insurance Plan Option if you are already enrolled, or you enroll, in a Post-65 Option. Coverage will be effective the first of the month following the date of enrollment.

- You have a new Dependent Child by marriage, in which case the new Dependent Child may be enrolled in a Pre-65 Option if you are already enrolled, or you enroll, in a Post-65 Option. Coverage will be effective on the first of the month following the date of enrollment. The addition of a new Dependent Child will not result in a special enrollment right for existing Dependent Children who were not enrolled on a timely basis.

- You have a new Dependent Child by birth, adoption, or placement for adoption, in which case the new Dependent Child may be enrolled in a Pre-65 Option, provided that you are already enrolled, or simultaneously enroll, in a Post-65 Option. In addition, your Spouse (or Domestic Partner) may elect simultaneously to enroll in an appropriate Emeriti Health Insurance Plan Option (if not enrolled already). Your coverage will be effective on the date of your Dependent Child's birth, adoption, or placement for adoption; provided, however, that the effective date for you and your Spouse (or Domestic Partner) can be no earlier than the date permitted by Medicare. The addition of a new Dependent Child will not result in a special enrollment right for existing Dependent Children who were not enrolled on a timely basis.

An individual's eligibility for late enrollment is in all cases subject to the general eligibility requirements for each Emeriti Health Insurance Plan Option. Aetna may require proof that a special enrollment event has occurred as a condition of coverage.

In addition to the rules described above, if you are already enrolled in an Emeriti Health Insurance Plan Option and an individual becomes your Dependent Child due to an event other than one described above, then you may enroll that child in an Emeriti Health Insurance Plan Option, provided you do so within thirty (30) days of that individual becoming a Dependent Child. However, if you are not enrolled in an Emeriti Health Insurance Plan Option, you may not enroll in an Emeriti Health Insurance Plan Option by reason of an individual becoming your Dependent Child, except in the case of one of the events described above.

> In other words, you normally must be currently enrolled in order to enroll a child who begins to satisfy the conditions of a Dependent Child. However, if you acquire a new Dependent Child through marriage, birth, adoption, or placement for adoption, you do not have to be currently enrolled in order to enroll that child, provided you simultaneously enroll.

Are There Open Enrollment Periods?

Yes. The Plan will hold an annual open enrollment period. The timing and length will be announced each year. The purpose of the open enrollment period is solely to permit you and your Spouse (or Domestic Partner) who are currently enrolled in any of the Emeriti Health Insurance Plan Options to elect coverage under a different Emeriti Health Insurance Plan Option (subject to eligibility requirements). If an open enrollment period is ever held for any other reason, you will be notified about the terms and conditions of that special open enrollment period. If you are currently enrolled and do not wish to change to another Health Insurance Plan Option, you ordinarily will not have to reenroll at open enrollment unless required under Medicare rules.

What Are the Rules Regarding Payment of Premiums for the Emeriti Health Insurance Plan Options?

If you cease employment and are eligible for the Emeriti Health Insurance Plan Options, your Employer will pay the premiums the Emeriti Health Insurance Plan Options based upon the balance of your Insurance Premium Account during your life and the lives of your Spouse (or Dependent Domestic Partner) and Dependent Children (so long as they remain Dependent Children), subject to eligibility. However, if any residual amount remains credited to your account when you and your Spouse (or Dependent Domestic Partner) have died and your Dependent Children have died (or ceased to be Dependent Children), then the entire remaining balance credited to your Insurance Premium Account will be forfeited. If you cease employment and are not eligible for the Emeriti Health Insurance Plan Options, the entire balance of your Insurance Premium Account

will be forfeited. All premiums must be paid for initial and continuing enrollment in any Emeriti Health Insurance Plan Option. Failure to pay premiums will result in cancellation of coverage.

What If My Spouse (or Domestic Partner) and I Are Both Participants?

If you are a Participant and your Spouse (or Domestic Partner) is also a Participant, you must each enroll separately in the Emeriti Health Insurance Plan Options. Neither of you may be enrolled as a Spouse (or Domestic Partner) of the other for purposes of the Emeriti Health Insurance Plan Options. Either of you may enroll your Dependent Children in a Pre-65 Option, but both of you may not do so.

What If I Am Eligible For Coverage Under My Employer's Active Plan?

If you, your Spouse (or Domestic Partner), or your Permanently Disabled Dependent Child is enrolled in Medicare and eligible for coverage under your Employer's active employee health plan, then you and/or the other individual(s) are not eligible to enroll in a Post-65 Health Insurance Plan Option under this Plan. Once eligibility under the Employer's active employee health plan ceases, you and/or the other individual(s) may enroll in a Post-65 Health Insurance Plan Option (subject to the standard eligibility requirements).

What If I Am Already Retired When the Plan Commences?

If you are a retired employee when the Plan commences, you will be notified if you are eligible to participate in the Emeriti Health Insurance Plan Options. If you are eligible, an enrollment window will be made available for enrollment. This window is normally a period commencing no more than 90 days prior to the date that coverage is first available and ending at the end of the 90-day period commencing on the date that coverage is first available.

Can An Individual's Coverage Cease If His or Her Status Changes?

A Spouse's (or Domestic Partner's) or Dependent Child's coverage under the Emeriti Health Insurance Plan Options will not cease on account of the death of the Participant. However, except in the event of death, a Spouse's (or Domestic Partner's) or Dependent Child's coverage under the Emeriti Health Insurance Plan Options will cease on the last day of the month in which such individual fails to meet the requirements of a Spouse (or Domestic Partner) or Dependent Child, as applicable (whether prior to or following the death of the Participant). Further, a Spouse's coverage under the Emeriti Health Insurance Plan Options will cease on the last day of the month in which a court of competent jurisdiction enters an order that the Participant and Spouse are legally separated. You must call 1-866-EMERITI (1-866-363-7484) immediately to report the entry of such a court order. Coverage will not cease earlier than the date permitted by Medicare. See the Section below entitled "COBRA Continuation Coverage" for information

regarding continuation coverage rights in the event of a change in dependent status.

What If My Coverage is Cancelled Because of Something I Did?

Your coverage under the Emeriti Health Insurance Plan Options can be cancelled only due to: (1) non-payment of premiums; (2) failure to abide by the terms and conditions of the Plan and the coverage; or (3) voluntary cancellation on your part at any time (*subject to the Plan Sponsor's right to amend or terminate the Plan*). If your coverage is cancelled for any of these reasons, you will be ineligible to re-enroll, unless expressly permitted by Aetna. Coverage will not cease earlier than the date permitted by Medicare.

Is There Anything Else I Should Know About Eligibility for the Emeriti Health Insurance Plan Options?

Your and your family's enrollment in the Emeriti Health Insurance Plan Options is subject to the Plan's enrollment procedures. Health insurance benefits available under the Plan are limited to those provided under the available Emeriti Health Insurance Plan Options that you and/or your eligible family members select. If you elect to enroll in health insurance coverage outside of the Plan instead of enrolling in the Emeriti Health Insurance Plan Options, you will not be eligible to enroll in the Emeriti Health Insurance Plan Options at a later date unless you or your eligible family member has one of the life events described previously in this section.

Are the Emeriti Health Insurance Plan Options Subject to Change?

Emeriti and Aetna have a contract for Aetna's participation in the Program. Current terms of the Coverage Documents that may be significant include: (i) coverage is available and underwritten by Aetna; (ii) terms of the Coverage Documents will vary by state in accordance with state insurance laws; (iii) there is guaranteed issue for all participants; and (iv) you and your Spouse (Domestic Partner) have flexibility to change coverage choices at annual enrollment. You may call 1-866-EMERITI (1-866-363-7484) to determine any variation in the Emeriti Health Insurance Plan Options for your state or territory. The Emeriti Health Insurance Plan Options will be subject to change to address future changes in state and federal law, including changes to the Medicare program caused by the Medicare Modernization Act of 2003. There is no guarantee that the current terms of the Coverage Documents applicable to any state will continue as described, and there is no guarantee that coverage will be available in all states and territories.

The contract between Emeriti and Aetna may be terminated by either party under certain circumstances, primarily at the end of the term of the contract. See the section below entitled AMENDMENT, TERMINATION, AND WITHDRAWAL. There is no guarantee that the Emeriti Program will renew Aetna's contract or

that Aetna will continue to offer insured health plans to the Program in the future. In such circumstances, Emeriti would make its best efforts to find appropriate replacement(s) for Aetna, but there is no guarantee that a replacement insurance company could be found in the future.

EMERITI HEALTH INSURANCE PLAN OPTIONS – BENEFITS AND CLAIMS

The Pre-65 and Post-65 Emeriti Health Insurance Plan Options described in the previous section, including premiums and benefits, are underwritten by Aetna and are described in the Coverage Documents. (Note that if you reside in, or your Employer is located in, Minnesota, New Mexico, Puerto Rico, or the U.S. Virgin Islands, your coverage may be underwritten by another insurer, in which case references in this SPD to Aetna may need to be read as references to that insurer – see Appendix C for more details.) Those documents are provided to you separately when you select an option at retirement but are considered part of this SPD. For information on how to obtain a copy of these documents call 1-866-EMERITI (1-866-363-7484).

DEFINITION OF COVERAGE DOCUMENTS: The term "Coverage Documents" refers to the summary of coverage and certificate of coverage booklet issued by Aetna governing the benefits and other terms of coverage provided by the Emeriti Health Insurance Plan Options underwritten by Aetna. If you reside in Minnesota, New Mexico, Puerto Rico, or the U.S. Virgin Islands and your coverage is underwritten by another insurer, the term "Coverage Documents" refers to the summary of coverage and certificate of coverage booklet (or corresponding documents) issued by that insurer governing the benefits and other terms of coverage provided by the Emeriti Health Insurance Plan Options underwritten by that insurer.

How Do I File a Claim for Benefits Under the Emeriti Health Insurance Plan Options?

Claims for benefits under the Emeriti Health Insurance Plan Options are processed solely by Aetna, as are reviews of denied claims. The procedures for filing claims (and appeals of denied claims) with the insurer are described in the Coverage Documents. The determination of your claim by Aetna (following any appeal to Aetna) is final, and no one else, including your Employer, TIAA, or Emeriti, has any authority to overrule that determination.

What Happens If a Claim Is Overpaid?

Overpayment of claims with respect to the Emeriti Health Insurance Plan Options is governed by the terms of the Coverage Documents (*see definitions section*).

Can Legal Action Be Brought Against the Plan For Benefit Claims?

Legal action may be brought against the Plan for benefits after the claimant exhausts the administrative procedures described above. Any action for benefits must be brought within one year from the expiration of the time within which a final appeal is denied.

Can I Transfer My Benefits to Someone Else?

No. Neither you nor your covered family members have any right to transfer, sell or otherwise dispose of any right to benefits payable to you under the Plan.

Do Women and Newborns Have Any Special Rights?

Newborns and Mothers Health Protection Act. Under the federal Newborns and Mothers Health Protection Act, group health plans and health insurance issuers generally may not 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 as applicable). 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. Group health plans and health insurance issuers that provide medical and surgical benefits with respect to a mastectomy must provide, in a case of a participant, spouse or dependent who is receiving benefits in connection with a mastectomy, coverage for:

- all stages of reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and physical complications of mastectomy, including lymphedemas;

in a manner determined in consultation with the attending physician and the patient. This coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage must be delivered to the participant upon enrollment and annually thereafter.

CLAIMS PROCEDURES – PREMIUMS FOR THE EMERITI HEALTH INSURANCE OPTIONS

Once you enroll in the Emeriti Health Insurance Options, premiums for that coverage will be paid by your Employer automatically based upon the balance credited to your Insurance Premium Account (in accordance with the terms of the Plan and procedures established by the Plan Administrator). If you have any questions about automatic payment of these premiums based upon the balance credited to your Insurance Premium Account, you should first contact TIAA. However, if necessary, you may file a claim for benefits.

How Do I Submit a Claim Involving Premiums for the Emeriti Health Insurance Options?

You must submit your claim involving premiums for the Emeriti Health Insurance Options to the Plan Sponsor within 60 days following the date you (or your dependent) receives notice that coverage has been cancelled as a result of non-payment of premiums. Claims submitted after that time will be denied, unless it was not reasonably possible to give proof of the claim within the 60-day period and you submitted the claim as soon as reasonably possible.

Who Can Submit a Claim Involving Premiums for the Emeriti Health Insurance Options?

Prior to the death of the Participant, only the Participant (or his or her representative in the event of incapacity) may submit claims. Upon the death of the Participant, only the Spouse (or Dependent Domestic Partner) may submit claims. Upon the death of the Spouse (or Dependent Domestic Partner), each Dependent Child may submit claims.

How Long Does It Take to Decide My Claim Involving Premiums for the Emeriti Health Insurance Options?

The Plan Sponsor generally will notify you of its decision within 30 days of its receipt of your claim. However, if special circumstances require a 15-day extension of time to review your claim, the Plan Sponsor will notify you of the need for an extension, including the circumstances requiring the extension and the date a decision is expected, prior to the end of the initial 30-day period. If the Plan Sponsor requires additional information from you to decide the claim, you will be given at least 45 days to provide the required information. The deadline for making a determination of your claim will then be extended for 45 days or, if shorter, for the length of time it takes you to provide the additional information.

What If I Don't Agree With the Determination?

If your claim involving premium payments is denied in whole or in part, you may request review of your claim at any time within 180 days following the date you received written notice of the denial. If you fail to file a request for review within 180 days, you waive your right to request a review of the denial of the claim.

If you believe the Plan Sponsor has made an error in processing your claim, you may request review of your claim by contacting the Plan Sponsor. Your request must be in writing and state your name and address, the fact that you are disputing the denial of a claim, the date of the initial notice of denial, and the reason(s) for disputing the denial (*you may be asked to submit additional information*). You may include written comments, documents, records and other information relating to your claim in your request for review. You also have the right to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim. You will be notified of the decision on review no later than 30 days after receipt of the written request for review.

Can Legal Action Be Brought Against the Plan For Benefit Claims?

Legal action may be brought against the Plan for benefits after the claimant exhausts the administrative procedures described above. Any action for benefits must be brought within one year from the expiration of the time within which a final appeal is denied.

ORDERING OF MULTIPLE PLANS UNDER THE EMERITI PROGRAM

If during your career you work for more than one employer who sponsors plans under the Emeriti Program (i.e., this Employer and one or more other employers), you will retain all of your accounts (*subject to eligibility*), but special rules apply to the order of payment from your accounts and your enrollment in the Emeriti Health Insurance Plan Options. The rules are a bit complicated, but the main thing to remember is that you may only enroll in the Emeriti Health Insurance Plan Options under one employer's Emeriti plan and you do not have to take any action to receive seamless payment of premiums from your various accounts. This is taken care of automatically by TIAA according to the following rules.

You may not rollover or otherwise combine your accounts in the Emeriti plans of your various employers. Instead, you must elect which one of those plans under which you will enroll in the Emeriti Health Insurance Plan Options (i.e., this Plan or one of the other plans under which you have satisfied the requirements for Retirement Eligibility as defined under each plan). Once you make that election, your right to enroll in the Emeriti Health Insurance Plan Options under the other plans (those not selected) is terminated. If your accounts in the selected plan are exhausted, you can use your accounts in other plans to continue your Emeriti Health Insurance Plan Options coverage in your selected Plan. However, if the employer sponsoring the Emeriti Program plan in which you initially elect to enroll in the Emeriti Health Insurance Plan Options ever withdraws from the Emeriti Program, you may elect to enroll in the Emeriti Health Insurance Plan Options under one of the other Emeriti Program plans in which you initially elected to decline coverage.

If you die prior to enrollment in the Emeriti Health Insurance Plan Options, this rule will apply to your surviving Spouse (or Domestic Partner) and Dependent Children with the additional condition that those individuals must all enroll under the same Emeriti Program plan (i.e., all under this Plan, or all under the other employer's Emeriti Program plan).

PLAN ADMINISTRATION

The administration of the Plan is under the supervision of the Plan Sponsor, who is the administrator of the Plan. Various service providers, such as TIAA, perform ministerial services for the Plan Sponsor to assist it in administering the Plan. However, the Plan Sponsor (or its delegate) has the sole discretion and authority to interpret and administer the Plan in all of its details. The determination of the Plan Sponsor (or its delegate) as to any question involving the administration and interpretation of the Plan shall be final, conclusive, and binding.

With respect to certain aspects of the Plan, the Plan Sponsor has expressly delegated its authority to Emeriti to act as administrator. To this extent the full discretion and authority to interpret and administer the Plan has been delegated to Emeriti, subject to oversight by the Plan Sponsor. In addition to any powers delegated to Emeriti as described in the other portions of this SPD, the Plan Sponsor has delegated the following powers to Emeriti:

- to make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan;
- to interpret the Plan, and to resolve any ambiguity or inconsistency in the terms of the Plan;
- to allocate and delegate responsibilities under the Plan and to designate other persons to carry out any responsibilities; and
- to carry out the powers and responsibilities of the administrator with respect to Mutual of Plan assets and administration of COBRA.

COBRA CONTINUATION COVERAGE

What is COBRA Continuation Coverage?

COBRA continuation coverage is a temporary extension of health care coverage for a "qualified beneficiary" who would otherwise lose coverage due to a "qualifying event." The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA").

Who Is Entitled to Elect COBRA Continuation Coverage?

If a Spouse loses coverage under the Emeriti Health Insurance Plan Options as a result of divorce or legal separation or a Dependent Child loses coverage under the Emeriti Health Insurance Plan Options as a result of ceasing to qualify as a Dependent Child, then he or she will be a qualified beneficiary who has incurred a qualifying event and is entitled to elect COBRA continuation coverage. No other individuals can become qualified beneficiaries, and there are no other qualifying events under the terms of the Plan (*but see the GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS provided below regarding a special qualifying event in the case of the Employer's bankruptcy*).

How Does COBRA Apply to This Plan?

COBRA provides *access* to continued coverage up to a maximum period, but it does not provide for *payment* of continued coverage. Qualified beneficiaries who elect to continue coverage under COBRA must pay for that continued coverage out of pocket. The Emeriti Health Insurance Plan Options are subject to COBRA. Thus, any individual covered under the Emeriti Health Insurance Plan Options who would lose coverage due to a "qualifying event" is considered a qualified beneficiary entitled to elect continued coverage in the Emeriti Health Insurance Plan Options under COBRA. COBRA continuation coverage for the Emeriti Health Insurance Plan Options is administered by the COBRA Administrator identified at the end of this SPD.

How Long Does Continuation Coverage Last?

The maximum period of continuation coverage is 36 months, beginning on the first day of the month following the qualifying event.

How Much is the Premium for Continued Coverage in the Emeriti Health Insurance Plan Options?

The premium for continued coverage in the Emeriti Health Insurance Plan Options under COBRA is 102% of the premium owed with respect to the qualified beneficiary immediately prior to the qualifying event. Qualified beneficiaries

share in any increases to premiums required for similarly situated spouses or Dependent Children. COBRA premium payments must be made on a monthly basis by the due date provided to the qualified beneficiary.

Can the Plan Terminate the Qualified Beneficiary's Continuation Coverage if He or She Fails to Pay the Required Premium?

Yes. If the qualified beneficiary fails to pay the required COBRA premium in a timely manner, his or her continued coverage under the Emeriti Health Insurance Plan Options will be terminated as of the end of the period for which the last payment was received. Payment is considered made on the date on which it is sent to the COBRA Administrator.

If the premium payment is the first payment and if the election of continuation coverage occurs after the qualifying event, the premium payment may be made within 45 days after the election. A payment of any premium, other than the first premium, is considered to be timely if the full amount of the premium is paid within 30 days after the premium due date.

Can the Plan Terminate the Qualified Beneficiary's Continuation Coverage for Other Reasons?

Yes. The following events occurring after the date of the COBRA election will trigger immediate termination of the spouse's or former Dependent Child's continued coverage under the Emeriti Health Insurance Plan Options:

- The individual becomes covered under any other group health plan (as an employee or otherwise), provided that such plan does not contain any exclusion or limitation with respect to any preexisting condition of such individual.

- The Employer no longer sponsors or maintains any group health plan (including successor plans) for any of its retired employees.

- The former Spouse or Dependent Child becomes entitled to Medicare.

How Does a Qualified Beneficiary Elect Continuation Coverage?

The affected qualified beneficiary must call 1-866-EMERITI (1-866-363-7484) to provide notice of the qualifying event within 60 days after the later of the date of the qualifying event or the date coverage under the Emeriti Health Insurance Plan Options would be lost. The notice must include the qualified beneficiary's full name, address, and telephone number, the name of the participant, and a description of the Qualifying Event and the date on which it occurred. Within 14 days after TIAA receives notification of a Qualifying Event, the COBRA Administrator will notify each affected qualified beneficiary of his or her right to elect continuation coverage.

A qualified beneficiary who is entitled to elect continuation coverage must make that election within 60 days after the later of the date coverage under the Emeriti Health Insurance Plan Options ends or the date the qualified beneficiary is sent notice of his or her right to elect continuation coverage.

A qualified beneficiary's election of continuation coverage is deemed to be made on the date the qualified beneficiary's election is sent to the COBRA Administrator. If a Spouse or Dependent Child waives continuation coverage during the election period, that waiver may be revoked at any time before the end of the election period. If any waiver is revoked before the end of the election period, however, continued coverage under the Emeriti Health Insurance Plan Options is effective prospectively only from the date the waiver is revoked.

What if I Have Questions About COBRA Continuation Coverage?

If you have questions about COBRA continuation coverage, you should call 1-866-EMERITI (1-866-363-7484) or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

This notice contains important information about your right to COBRA continuation coverage. It generally explains how COBRA continuation coverage works, when it may become available to you and your family, and what you and they need to do to protect the right to receive it.

You are receiving this notice because you recently enrolled in, or may enroll in, one of the Emeriti Health Insurance Plan Options under the Plan described in this SPD. This Plan is considered group health coverage subject to COBRA, which requires a temporary extension of group health coverage in certain instances in which coverage would otherwise end.

The right to COBRA continuation coverage was created by a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). This is only a summary of your COBRA continuation coverage rights. For additional information about your rights and obligations under the Plan and under federal law, you should review the COBRA section of this SPD or call the number listed at the end of this notice.

What is COBRA Continuation Coverage and Who is Eligible?

COBRA continuation coverage is a continuation of group health plan coverage when that coverage would otherwise end because of a life event known as a "qualifying event." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is an individual who would otherwise lose coverage as a result of the qualifying event, as described below:

- If you are the participant (i.e., the employee/retiree), there are no circumstances under the terms of the Plan in which you can lose your coverage under the Emeriti Health Insurance Plan Options as the result of a qualifying event. Therefore, you will never be considered a qualified beneficiary eligible for COBRA continuation coverage under the Plan (*but see below regarding bankruptcy*).

- If you are the spouse of the participant (the employee/retiree), the only circumstances under the terms of the Plan in which you can lose your coverage under the Emeriti Health Insurance Plan Options as a result of a qualifying event is if you become divorced or legally separated from the participant. In these instances, you will become a qualified beneficiary.

- The only circumstances under the terms of the Plan in which your dependent child(ren) can lose coverage under the Emeriti Health Insurance Plan Options as a result of a qualifying event is if he or she ceases to qualify as a dependent child under the terms of the plan (e.g., reaches the limiting age for eligibility or otherwise ceases to qualify as a dependent child of the participant). In that case, he or she will become a qualified beneficiary.

- It is not anticipated that the employer's filing of a proceeding in bankruptcy under Title 11 of the United States Code would cause a loss of coverage in the Emeriti Health Insurance Plan Options for any participant, spouse, or dependent child under the terms of the Plan. However, if this occurred and it caused a loss of coverage or substantial elimination of coverage, the participant, spouse, and dependent children would each become a qualified beneficiary.

- There are no other circumstances under the terms of the Plan in which an individual could become a qualified beneficiary with respect to any benefits offered under the Plan.

Your Employer Must Give Notice of Certain Qualifying Events

The Plan will offer COBRA continuation coverage under the Emeriti Health Insurance Plan Options to qualified beneficiaries only after the COBRA Administrator has been notified that a qualifying event has

occurred. If a filing in bankruptcy by the employer triggers a qualifying event, your employer must notify TIAA. TIAA will then inform the COBRA Administrator that a qualifying event has occurred.

The Qualified Beneficiary Must Give Notice of Certain Qualifying Events

For all other qualifying events, the qualified beneficiary must call 1-866-EMERITI (1-866-363-7484) within 60 days after the later of the date that the qualifying event occurs or the date that coverage under the Emeriti Health Insurance Plan Options would be lost. The qualified beneficiary must provide his or her full name, address, and telephone number along with the name of the participant. TIAA will then inform the COBRA Administrator that a qualifying event has occurred.

How is COBRA Coverage Provided?

Once the COBRA Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each qualified beneficiary (i.e., the spouse or dependent child, as applicable). The election of one qualified beneficiary will not affect the right of any other qualified beneficiary to elect or decline COBRA continuation coverage. If the qualified beneficiary is a dependent child, the parent may elect COBRA continuation coverage on the child's behalf.

COBRA continuation coverage is a temporary continuation of coverage lasting for up to a total of 36 months (subject to proper election of COBRA continuation coverage). The coverage provided under COBRA continuation coverage is the same as the coverage that was provided to the qualified beneficiary prior to the qualifying event. Qualified beneficiaries who elect COBRA continuation coverage in the Emeriti Health Insurance Plan Options must pay for COBRA continuation coverage. As allowed by federal law, the Plan may charge up to 102% of the applicable premium to cover the administrative expense of administering COBRA continuation coverage. COBRA continuation coverage may end prior to the 36 month period due to non-payment of premiums, becoming covered under another group health plan, becoming entitled to Medicare after electing COBRA, or the employer ceasing to sponsor a group health plan.

If You Have Questions

If you have questions regarding COBRA and the Plan, you should review the Plan's Summary Plan Description or call the number listed at the end of this notice. 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.

Keep Your Plan Informed of Address Changes

In order to protect your family's COBRA rights, you should keep TIAA informed of any changes in the addresses of family members (once you are on COBRA continuation coverage you should keep the COBRA Administrator informed – contact information will be provided to you at the time you commence COBRA continuation coverage). If you correspond in writing regarding COBRA continuation coverage, you should keep a copy for your records.

Contact Information for Questions Regarding COBRA Continuation Coverage, Address Changes, and Providing Notice of a Qualifying Event:

1-866-EMERITI (1-866-363-7484)

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

The Plan is subject to the rules under Section 609 of ERISA governing "qualified medical child support orders" ("QMCSO"). A QMCSO is a court order providing for the enrollment of a Participant's child in the medical coverage provided under the Plan.

Where Should a Medical Child Support Order Be Sent for Processing?

Any QMCSO should be sent to the Plan Sponsor at the address listed in the section entitled IMPORTANT INFORMATION ABOUT THE PLAN. The Plan Sponsor has the sole discretion to determine whether a medical child support order is a QMCSO.

What If the Participant Is Not Eligible for Medical Benefits?

A medical child support order will not be considered a QMCSO under the Plan if it pertains to a Participant who is not currently eligible for coverage under the Emeriti Health Insurance Plan Options.

What Happens If the QMCSO Is Approved?

If the Plan Sponsor approves a QMCSO, the Participant's child identified under the QMCSO will be considered a Dependent Child for purposes of enrolling in the Emeriti Health Insurance Plan Options. The Participant's child identified under the QMCSO will be eligible to enroll in a Pre-65 Option only if the Participant is enrolled in a Post-65 Option or was eligible for the Emeriti Health Insurance Plan Options but waived coverage (in which case the Participant must enroll).

Does the Plan Honor National Medical Support Notices?

If Plan Sponsor receives a National Medical Support Notice (under Section 401(b) of the Child Support Performance and Incentive Act of 1998) issued in the case of a child of a Participant who is a non-custodial parent of the child, and the notice meets the requirements of a qualified medical child support order, the Plan Sponsor will:

- notify the State agency issuing the notice whether coverage of the child is available under the terms of the Plan and, if so, whether the child is covered under the Plan and either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent (or by the official of a State or political subdivision thereof substituted for the name of such child) to effectuate the coverage; and

- provide to the custodial parent (or such substituted official) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

OTHER INSURANCE OPTIONS

Are there insurance options besides the Emeriti Health Insurance Plan Options available under the plan?

Yes. Subject to the eligibility rules described on pages 17 to 21, you may elect to enroll for “Other Health Insurance”. Other Health Insurance means fully insured health insurance premiums offered outside of the Emeriti Program. The term “Other Health Insurance” includes insurance premiums offered by other carriers, COBRA continuation coverage, Long Term Care insurance premiums, Medicare Part B premiums, dental insurance premiums, but excludes coverage for any individual as an active employee (or as a spouse, domestic partner or dependent of an active employee) under an employer-sponsored group health plan.

The premiums for Other Health Insurance may be reimbursed from the Participant’s Account.

The benefits, processes, COBRA administration, claims procedures etc. will be those of the insurance carrier that controls the insurance plan you select.

AMENDMENT, TERMINATION, AND WITHDRAWAL

Can the Plan Sponsor Amend or Terminate the Plan?

The Plan Sponsor intends to continue the Plan indefinitely. However, subject to the terms of its participation in the Emeriti Program, the Plan Sponsor reserves the right to modify, alter, amend, or terminate the Plan, in whole or in part, at any time.

If the Plan Sponsor amends the Plan, all participants will be informed of the amendments by receiving a summary of material modifications annually. Participants will also receive a revised version of this SPD at least every five years if any material provision is revised, or every ten years if no material revisions are made.

Can Emeriti Amend or Terminate the Program?

Emeriti has the right to make certain changes to the Program that would affect the Plan. These changes could include the Mutual Funds offered and the service providers for the Program (including TIAA and Aetna).

Am I Guaranteed a Right to Coverage Under the Emeriti Health Insurance Plan Options?

No. If you meet the criteria for Retirement Eligibility (and the eligibility requirements imposed by Aetna), you have a right to enroll yourself and your eligible family members in the Emeriti Health Insurance Plan Options, but only to the extent that they are offered under the Plan at the time of enrollment. Any right of a Participant, Spouse (or Domestic Partner), or Dependent Child to coverage or benefits under the Emeriti Health Insurance Plan Options will at all times remain subject to the Plan Sponsor's right under the Plan and Emeriti's right under the Emeriti Program to amend, modify, or terminate the Emeriti Health Insurance Plan Options offered under the Plan or Emeriti Program, as applicable. In addition, the particular Emeriti Health Insurance Plan Options and particular coverage available in a particular state or territory may vary from that offered in other states or territories, or may become unavailable, as a result of state or federal law.

What if the Plan Sponsor Withdraws from the Emeriti Program?

The Plan Sponsor has established the Plan under the Emeriti Program. If the Plan Sponsor withdraws from the Emeriti Program, the Plan Sponsor may elect to continue the Plan. However, the Plan will no longer be maintained under the Emeriti Program, and this SPD shall cease to be effective on the date the Plan Sponsor withdraws from the Emeriti Program (unless you are notified to the contrary). In the event of withdrawal, the Plan Sponsor will notify you regarding

the status of the Plan, including whether the Plan Sponsor has any continued relationship with TIAA or Aetna.

What if TIAA, Aetna or Emeriti Cease to Provide Services?

Emeriti has a contract with TIAA in connection with the Program. If TIAA ceases to provide services under the Program, Emeriti would use its best efforts to locate and engage another company to provide administration, Mutual funds and trustee services. If another provider is not engaged by Emeriti, the Employer could make its own arrangement for administration of the Plan.

Emeriti has a contract with Aetna. If Aetna ceases to provide insurance under the Program, Emeriti would use its best efforts to locate and engage another insurance company to provide replacement insurance. If another insurance company is not engaged by Emeriti, the Employer could make its own arrangement for insurance coverage.

Emeriti is operated solely to provide services under the Program. If Emeriti ceased operations, the Employer could take over the Emeriti functions or obtain a replacement for Emeriti.

If neither Emeriti nor the Employer can make arrangements to replace TIAA or Aetna or if the Employer cannot make arrangements to replace Emeriti or assume its functions, the Plan could be terminated at the discretion of the Employer.

HEALTH PRIVACY

The Standards for Privacy of Individually Identifiable Health Information (codified at 45 CFR Parts 160 and 164), commonly called the HIPAA Privacy Rules, establish standards for the protection of individually identifiable health information. The HIPAA Privacy Rules apply to the Plan. Included in your enrollment package is a Notice of Privacy Practices from Aetna, summarizing Aetna's protection of your health information. You should read the Notice carefully to understand how your health information, and the health information of your covered family members, may be used and disclosed in the process of administering the Plan.

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Sponsor's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

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

- Receive a summary of the Plan's annual financial report. The Plan Sponsor is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage:

- Continue health care coverage for your Spouse or Dependent Children if there is a loss of coverage under the Emeriti Health Insurance Plan Options as a result of a qualifying event. Your Spouse or Dependent Children must pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Rights Under Newborns' and Mothers' Health Protection Act:

Group health plans and health insurance issuers offering group insurance coverage generally, under federal law, may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. Neither a group health plan nor a health insurance issuer may require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the above periods. However, the mother's or newborn's attending health care provider and the mother may agree to an earlier discharge.

Prudent Actions by Plan Fiduciaries:

In addition to creating rights for Participants, ERISA imposes duties upon the people who are responsible for the operation of the 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, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights:

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Sponsor to provide the materials and pay you to up $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Sponsor. 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 medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds that your claim is frivolous.

Assistance with Your Questions:

If you have any questions about your Plan, you should call 1-866-EMERITI (1-866-363-7484) or log on to TIAA. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Sponsor, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

TAX EFFECTS OF PARTICIPATION IN THE PLAN

The following summary of Federal income tax consequences of participation in the Plan does not purport to be complete. In addition, in some cases it may be important to consider the effect, if any, of gift, estate and inheritance taxes. Finally, the following summary is based on present Federal income tax law and existing and temporary regulations which may be subject to change at any time.

THE FOLLOWING STATEMENT IS PROVIDED PURSUANT TO U.S. TREASURY DEPARTMENT REGULATIONS:

THIS SUMMARY PLAN DESCRIPTION IS NOT INTENDED OR WRITTEN TO BE USED, AND CANNOT BE USED, BY A TAXPAYER FOR THE PURPOSE OF AVOIDING PENALTIES THAT THE INTERNAL REVENUE SERVICE MAY IMPOSE ON THE TAXPAYER.

NO REPRESENTATION RESPECTING TAX TREATMENT HAS BEEN MADE TO A PLAN PARTICIPANT. PLAN PARTICIPANTS ARE URGED TO CONSULT THEIR COUNSEL, ACCOUNTANTS, OR OTHER TAX ADVISORS REGARDING THE TAX CONSEQUENCES OF THEIR PARTICIPATION IN THE PLAN.

The amounts credited to your Insurance Premium Account by your Employer are not taxable to you when credited. Earnings on deemed investments in your Insurance Premium Account will not be taxable to you and you may not deduct any losses on deemed investments in your Insurance Premium Account. Premium payments made by your Employer based upon the balance credited to your Insurance Premium Account will be exempt from Federal income tax. Because your Employer is a tax-exempt organization, it does not receive a tax deduction for premiums it pays on your behalf. The state and local income tax treatment of participants and dependents should be the same as the federal income tax treatment. There may be differences for purposes of foreign income taxes.

IMPORTANT: With respect to your family members who can have premiums paid by the Employer based upon the balance of your Insurance Premium Account, the Plan is intended to cover individuals who qualify as your spouse or dependent under Federal tax law. If you enroll an individual who does not qualify as your spouse or dependent under Federal tax law, you may be required to report as taxable income the value of coverage and benefits received. Consult your tax advisor if you have any questions about an individual qualifying as your spouse or dependent under Federal tax law.

The state and local income tax treatment of participants and their beneficiaries should be the same as the federal income tax treatment. There may be differences for purposes of foreign income taxes.

IMPORTANT INFORMATION ABOUT THE PLAN

Name of Plan:	Emeriti Fully-Insured Retiree Health Plan for Saint Mary's College of California
Plan Sponsor (and Plan Administrator):	Ann Kelly Director of Human Resources akelly@stmarys-ca.edu
Employer Identification Number:	94-1156599
Plan Number:	626
Type of Plan:	Health and welfare benefit plan.
Type of Administration:	A combination of self-administration, contract administration, and insurer administration.
Plan Effective Date:	January 1, 2017
Plan Year:	January 1 - December 31
Record Keeper:	TIAA 1-866-EMERITI (1-866-363-7484)
The Emeriti Health Insurance Plan Options underwritten by Aetna are offered under one or more policies of insurance issued by Aetna Life Insurance Company, which processes and finances all claims for benefits offered under the Emeriti Health Insurance Plan Options.	Aetna Life Insurance Company 151 Farmington Ave. Hartford, CT 06156 1-866-EMERITI (1-866-363-7484)
COBRA Administrator:	Aetna Individual Billing Unit 151 Farmington Ave MB52 Middletown, CT 06457 800-429-9526
Agent for Service of Legal Process:	Service of legal process may be made on the Plan Sponsor at the above address.

APPENDIX A – PARTICIPATING AFFILIATES

Not Applicable

APPENDIX B – MUTUAL FUNDS FOR DEEMED MUTUALS

The Mutual Funds available under the Plan are:

TIAA-CREF Life Cycle Fund 2010, Retirement Class	Ticker: TCLEX
TIAA-CREF Life Cycle Fund 2015, Retirement Class	Ticker: TCLIX
TIAA-CREF Life Cycle Fund 2020, Retirement Class	Ticker: TCLTX
TIAA-CREF Life Cycle Fund 2025, Retirement Class	Ticker: TCLFX
TIAA-CREF Life Cycle Fund 2030, Retirement Class	Ticker: TCLNX
TIAA-CREF Life Cycle Fund 2035, Retirement Class	Ticker: TCLRX
TIAA-CREF Life Cycle Fund 2040, Retirement Class	Ticker: TCLOX
TIAA-CREF Life Cycle Fund 2045, Retirement Class	Ticker: TTFRX
TIAA-CREF Life Cycle Fund 2050, Retirement Class	Ticker: TLFRX
TIAA-CREF Life Cycle Fund 2055, Retirement Class	Ticker: TTRLX
TIAA-CREF Life Cycle Retirement Income Fund,	Ticker: TLIRX
TIAA-CREF Money Market Mutual Fund	Ticker: TIEXX

APPENDIX C – SPECIAL RULES APPLICABLE TO THE EMERITI HEALTH INSURANCE PLAN OPTIONS

This Appendix C, which is considered part of the Plan, describes certain specific terms and conditions related to the Emeriti Health Insurance Plan Options offered under the Plan.

1. **Minnesota Employers:** In the event that the Employer is located in Minnesota ("MN"):

   (a) Any Participant and any Spouse (or Domestic Partner) who permanently resides in MN and is eligible for coverage under the Emeriti Health Insurance Plan Options shall receive such coverage through Health Partners; provided, however, that an Aetna RX-only Plan Option may be made available to such individuals.

   (b) Any Participant and any Spouse (or Domestic Partner) who permanently resides outside of MN and is eligible for coverage under the Emeriti Health Insurance Plan Options shall receive such coverage through Aetna.

   (c) In the event that the Participant permanently resides in MN and the Participant's Spouse (or Domestic Partner) permanently resides elsewhere, the Spouse (or Domestic Partner) shall not be required to enroll in the same Emeriti Health Insurance Plan Option as the Participant. The same rule will apply if the Participant permenantly resides outside of MN and the Participant's Spouse (or Domestic Partner) permanently resides in MN.

   (d) If both the Participant and the Participant's Spouse (or Domestic Partner) or Permanently Disabled Dependent Child are eligible to enroll in a Post-65 Option offered by Health Partners, they do not have to enroll in the same Post-65 Option.

2. **Spouse (or Domestic Partner) Coverage Outside of Minnesota or New Mexico:** In the event that the Employer is located outside of MN, any Participant and any Spouse (or Domestic Partner) who is eligible for coverage under the Emeriti Health Insurance Plan Options shall receive such coverage through Aetna regardless of his or her state of residence.

3. **Dependents:** In the event that a Dependent Child is eligible for coverage under the Emeriti Health Insurance Plan Options, he or she will receive such coverage through the same Health Insurer as the Participant (except to the extent required in order to comply with a qualified medical child support order).

4. **Special Enrollment Rights in Minnesota:** With respect to any Participant who resides in MN, if such Participant is enrolled in an Emeriti Health Insurance Plan Option and is eligible to enroll a new Dependent Child as a result of birth, adoption, or placement for adoption, the requirement to enroll the Dependent Child within thirty (30) days of the special enrollment event does not apply.

5. **Transfer Between Options:** An enrolled Participant or other enrolled individual who moves to a State or coverage area may make a mid-year change to a different Health Insurance Plan Option if the Health Insurance Plan Options for that State or coverage area are different than those available in the State or coverage area from which he or she moved (subject to the other rules of the Plan regarding enrollment in the Health Insurance Plan Options). Application of Medicare rules may result in a temporary lapse in coverage under the Emeriti Health Insurance Plan Options if a Participant or other enrolled individual changes residence (e.g., from one State to another or between coverage areas).

6. **Transfer Between Insurers:** If an enrolled Participant or other enrolled individual moves to a State or area where coverage in the Emeriti Health Insurance Plan Options is underwritten by a different insurer, he or she may select from any of the Emeriti Health Insurance Plan Options offered by that health insurer for which he or she is eligible without regard to the prior Emeriti Health Insurance Plan Option in which he or she was enrolled; provided he or she does so within 30 days of moving to the new State or coverage area.

7. **Enrollment in Non-Emeriti Part D Plans:** If a Medicare-eligible individual is enrolled in a Post-65 Option that provides prescription drug coverage and his or her enrollment is cancelled due to subsequent enrollment in a Medicare Part D plan offered outside of the Plan, there is no guarantee that a Post-65 Option without prescription drug coverage will be available under the Plan or that reenrollment will be permitted at a later date.

8. **Participants Who Are Spouses (or Domestic Partners) of Each Other:** If you and another Participant are Spouses of each other (or are Domestic Partners of each other) (referred to below as "Participant 1" and "Participant 2"), the following rules will apply when you are each eligible to enroll in the Emeriti Health Insurance Plan Options:

   (a) If Participant 1 is eligible for the Post-65 Options and Participant 2 is not, then Participant 2 can be enrolled as the "Spouse (or Domestic Partner)" of Participant 1 in a Pre-65 Option. This is an exception to the normal rule that a Participant cannot enroll in a Pre-65 Option. If Participant 2 later becomes eligible for the Post-65 Options, Participant 2 may elect to remain enrolled as the "Spouse (or

Domestic Partner)" and enroll in the same Post-65 Option as Participant 1, in which case all premiums will continue to be paid from Participant 1's Accounts. If Participant 1's Accounts are later exhausted, and Participant 2 has a positive balance in his or her Accounts, you may elect to reenroll with Participant 2 listed as the "Participant" and Participant 1 listed as the "Spouse (or Domestic Partner)," but you cannot use the event to change Post-65 Options. In that case, all premiums will be paid from Participant 2's Accounts.

(b) If Participants 1 and 2 are both eligible for the Post-65 Options:

(i) You may elect to each enroll in separate Post-65 Options as "Participants." In that case, premiums for Participant 1 will be paid from Participant 1's Accounts, and premiums for Participant 2 will be paid from Participant 2's Accounts. If Participant 1's Accounts are later exhausted, and Participant 2 has a positive balance in his or her Accounts, you may elect to reenroll with Participant 2 listed as the "Participant" and Participant 1 listed as the "Spouse (or Domestic Partner)," in which case Participant 1 must enroll in the Post-65 Option in which Participant 2 is enrolled, and all premiums will be paid from Participant 2's Accounts; or

(ii) You may elect to enroll with Participant 1 listed as the "Participant" and Participant 2 listed as the "Spouse (or Domestic Partner)." In that case, you must enroll in the same Post-65 Option, but all premiums will be paid from Participant 1's Accounts. If Participant 1's Accounts are later exhausted, and Participant 2 has a positive balance in his or her Accounts, you may elect to reenroll with Participant 2 listed as the "Participant" and Participant 1 listed as the "Spouse (or Domestic Partner)," but you cannot use the event to change Post-65 Options. In that case, all premiums will be paid from Participant 2's Accounts.