Guide to Your TIAA Health & Welfare Benefits Plan

Administrative Information Document
(Plan Document and Summary Plan Description)

Effective January 1, 2021

This Plan Document and Summary Plan Description (and accompanying Benefit Booklets) amended and restated effective January 1, 2021, except as otherwise noted, reflect benefit provisions applicable to the following individuals:

- Eligible employees (and their eligible dependents where applicable) of TIAA and its subsidiaries that are participating employers;
- Eligible retirees (and their eligible dependents where applicable) of TIAA and its subsidiaries that are participating employers and
- COBRA participants.

From time to time, TIAA modifies its benefits programs. When applicable, you will receive a Summary of Material Modification ("**SMM**") (or in some cases a notice) that explains material changes to the benefits programs.

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SECTION I. INTRODUCTION

This Plan Document and Summary Plan Description ("**Administrative Information Document**") summarizes the TIAA Health & Welfare Benefits Plan ("**Plan**") sponsored by Teachers Insurance Annuity Association of America ("**Company**" or "**Plan Sponsor**") for eligible employees, eligible retirees, and their eligible dependents, as well as those of related entities that have been selected by the Company to participate in the Plan as designated in Schedule A.

This document, together with Benefits Booklets (as defined below) constitute the written plan and, for those Component Programs designated in Schedule B, the summary plan descriptions ("**SPDs**") as required by Section 102 of the Employee Retirement Income Security Act of 1974, as amended ("**ERISA**") and U.S. Department of Labor Regulation Sections 2520.102-2 and 2520.102-3 for the Plan. Certain Component Programs as identified below have standalone SPDs.

This document also summarizes certain Component Programs (identified by an asterisk on the following pages), which are not employee benefit plans under ERISA and whose benefits are not covered by ERISA but are included here for your convenience.

This document is not intended to provide medical, legal, financial, or tax advice.

Component Programs

The Plan is composed of the following Component Programs (each a "**Component Program**") offered by the Company:

- Comprehensive Health Plan ("**Medical Program**"), including major medical, prescription drug, mental health and substance use disorder, and prescription drug benefits, composed of the following:
  - Aetna Choice Advantage POS ("**Standard Medical Option**");
  - Aetna Consumer Choice Point of Service (POS) with Health Savings Account (HSA) ("**HSA Medical Option**");
  - Kaiser-Colorado HMO – which is only available to employees in the HMO's service area ("**Kaiser Medical Option**") (Schedule B-1); and
  - Prescription Drug Program ("**Prescription Drug Program**")
- Dental Expense Plan ("**Dental Program**");
- Vision Service Plan ("**Vision Program**");
- Short-Term Disability Benefits ("**Short-Term Disability Program**" or "**STD Program**");
- Long-Term Disability Benefits ("**LTD Program**") (Schedule B-2);
- Grandfathered Long-Term Disability Benefits ("**Grandfathered LTD Program**") (Schedule B-3);
- Group Life Insurance for Active Employees ("**Life Insurance Program**") (Schedule B-4);
- Retiree Life Insurance ("**Retiree Life Insurance Program**") (Schedule B-5);

- Business Travel Accident Insurance ("**Business Travel Accident Program**") (Schedule B-6);
- Business Travel Medical Plan ("**Business Travel Medical Program**") (Schedule B-7);
- On-site Health Clinic ("**Health Clinic**");
- Employee Assistance Program ("**EAP**");
- Death Benefit for Active Employees ("**Death Benefit**") (Schedule B-8); and
- TIAA Cafeteria Plan*, including the **Health Care FSA Plan**, which includes the general purpose Health Care Flexible Spending Account ("**Health Care FSA**") feature and the Limited Purpose Flexible Spending Account ("**Limited Purpose FSA**"), Dependent Care Assistance Plan ("**Dependent Care FSA**"), and Health Savings Account Program ("**HSA Bank Account**") (collectively, "**Cafeteria Program**").

  *This Component Program (except for the Health Care FSA Plan) is not an employee benefit plan under ERISA and the benefits under this Component Program are not covered by ERISA.

The following Component Programs have separate standalone SPDs: the Standard Medical Option and the HSA Medical Option, the Prescription Drug Program, the Dental Program, the Vision Program, the STD Program, the Health Clinic, the Health Care FSA and Limited Purpose FSA, and the EAP. This document does not serve as the SPD for these programs.

Certain legal requirements specified below only apply to "group health plans" as defined under ERISA. For this purpose the following Programs qualify as "group health plans," and for purposes of simplicity will be referred to in the aggregate as the "**Group Health Plan**": Medical Program, Dental Program, Vision Program, EAP, and the Health Care FSA and Limited Purpose FSA components of the Cafeteria Program.

How to Use This Document

- This document describes general provisions that apply to the Component Programs. The accompanying policies, contracts, certificates of insurance, booklets or other governing documents (including any standalone SPDs) ("**Benefit Booklets**") for each underlying Component Program govern the benefits to be provided and include more details on how the Component Program features operate.
- Read this entire document and the associated Benefit Booklets. Share this information with your family and keep it in a safe place for future reference.
- Capitalized words in this document have special meanings, as defined in the document.
- This document supersedes any previous printed or electronic SPD for this Plan and Component Programs except those which have a separate plan document and/or summary plan description as indicated above.
- To review this document and any future amendments, active employees can go to the corporate intranet and, sign into HR Services. If you would like a printed copy of this document or any of the standalone SPDs and you are active employee, you can print one from the Corporate Intranet.

- If you are an active employee, eligible retiree or COBRA participant, you can call ***Your Benefits Center*** at **844-4-TIAAHR (844-484-2247)**, **option 4, then option 1**, and request that this Administrative Information Document be sent to you.
- If there is any conflict between this document and the Benefit Booklets (other than summaries of material modifications to this Administrative Information Document or the Benefit Booklets), then the Benefit Booklets will control unless otherwise required by law or specified herein.
- To the extent this document is inconsistent with the plan document for the TIAA Flexible Benefits Pan ("**Cafeteria Plan**"), to which the Health Care FSA Plan is a Component Program (as defined herein), the Cafeteria Plan controls.
- You and your dependents should not rely on any oral description of the Plan because the written terms of the Plan will always govern.
- Please contact Your Benefits Center at 844-4-TIAAHR (844-484-2247) if you have questions or need additional information about your benefits.

SECTION II. ELIGIBILITY

Employee Eligibility

In the Plan, the term "**Participating Employers**" refers to the Company and any other entity that has been selected by the Company to participate in the applicable Component Program as designated in Schedule A (as may be amended from time to time).

In general, subject to any special or different rule in the Benefit Booklets of the Component Programs, you are eligible to enroll in, and participate in, the Component Programs if you are an "**eligible employee**," which means:

- you are employed by a Participating Employer that participates in the applicable Component Program;
- you are an active full-time or part-time employee who, for all Component Programs other than the STD Program, Business Travel Program and Death Benefit for Active Employees, is regularly scheduled to work at least 21 hours per week for a Participating Employer or are no longer an active Employee but formerly met this hourly requirement during your employment;
- you are working in the United States or you are employed outside of the United States and you are classified by a Participating Employer as an expatriate or you are temporarily working abroad; and
- you are treated by your Participating Employer as an "**employee**" (that is, your Participating Employer withholds U.S. employment and other taxes from your wages and reports your wages on IRS Form W-2).

If you meet these eligibility requirements on the date you are first hired by a Participating Employer, you will be eligible as of your hire date, provided that if you are classified by a Participating Employer as an "**temporary employee**" (including the categories of short-term associates, on-call associates or interns) you are eligible to participate in the Component Programs after a 90-day waiting period (your "**eligibility effective date**"). If you do not meet these requirements when first hired by a Participating Employer, you will not be eligible until your employment status changes so that you meet the eligibility requirements outlined above.

Although many of the employees of a Participating Employer are eligible to participate in the Plan, some are not. Even if you otherwise meet the eligibility requirements of one of the Component Programs or the requirements listed above, you are not eligible to participate in the Plan if

- you are covered by a collective bargaining agreement or the continuing terms and conditions of a collective bargaining agreement unless the applicable collective bargaining agreement or its continuing terms and conditions specifically and explicitly provide for coverage by the particular Component Program;
- you are a nonresident alien who receives no earned income from a Participating Employer that constitutes income from sources within the United States (including, but not limited to, local national employees and international employees);

- you are classified by a Participating Employer as an "**independent contractor**" or "**consultant**" (which status may be evidenced by the payroll practices or records of the Participating Employer, or by a written or oral agreement or arrangement with you or with another organization that provides your services to the Participating Employer, under which you are treated as an independent contractor or are otherwise treated as an employee of an entity other than a Participating Employer (such as a leasing organization)), during the period so classified, irrespective of (i) whether you are treated as an employee of a Participating Employer under common law employment principles; (ii) whether such characterization is subsequently challenged, changed or upheld by a Participating Employer or any court or governmental authority, including, without limitation, if you are classified by a Participating Employer as a "**leased employee**" (as described in Section 414(n) of the Internal Revenue Code of 1986, as amended ("**Code**")); and (iii) how you may be treated by a Participating Employer for other purposes (such as employment tax purposes);
- you are classified by a Participating Employer as a "**temporary employee**," "**contract employee**," "**seasonal employee**," "**occasional employee,**" or similarly type of employee (which status may be evidenced by the payroll practices or records of a Participating Employer, or by a written or oral agreement or arrangement with you or with another organization that provides your services to a Participating Employer), during the period so classified, irrespective of (i) whether you are treated as an employee of a Participating Employer under common law employment principles; (ii) whether such characterization is subsequently challenged, changed or upheld by a Participating Employer or any court or governmental authority; and (iii) how you may be treated by a Participating Employer for other purposes (such as employment tax purposes;
- you perform services for a Participating Employer under an agreement or arrangement, or with another organization that provides your services to the Participating Employer, that states that you are not eligible for participation in the Component Program(s);
- you are a person acting only as a member of the Board of Trustees of a Participating Employer; or
- you are not employed by a Participating Employer.

Retiree Eligibility

Subject to the eligibility criteria of the specific Component Plans that are available to retirees, you are generally eligible to participate in specified Component Plans (including the Medical Program) as an "**eligible retiree**" if you were an eligible employee and have completed at least 30 years of continuous service (with a minimum of at least 10 years of continuous service just prior to retirement) prior to your retirement from a Participating Employer or meet one of the following requirements:

- If you were hired before January 1, 1989, you must meet the "rule of 70" requirement. This means you must be at least 50 years old and have a minimum of 10 years of continuous service with TIAA immediately preceding your retirement, with the sum of age and service (each rounded up to the next whole month) equaling 70. For example, if you were hired

before January 1, 1989 and are 55 years and 9 months old with 14 years and 6 months of service of service, you meet the “rule of 70” requirement.

- If you were hired on or after January 1, 1989, you must meet the “rule of 75” requirement. This means you must be at least 50 years old and have a minimum of 10 years of continuous service with TIAA immediately preceding your retirement, with the sum of age and service (each rounded up to the next whole month) equaling 75. For example, if you were hired on or after January 1, 1989, are 60 years and 1 month old with 14 years, 11 months of service, you meet the “rule of 75” requirement.

If you are a rehire and your period of original service is greater than your break in service, you are given credit for your prior service. In order to calculate your total service, you are assigned an adjusted hire date which is after your original date of hire and prior to your rehire date. Your rehire date will determine if you are to meet the “rule of 70” or the “rule of 75.” In addition to meeting the “rule of 70/75,” you must be at least 50 years old and have a minimum of 10 years of continuous service from your rehire date with TIAA immediately preceding your retirement.

Notwithstanding the language in a Benefits Booklet, to be eligible for the Medical Program as an eligible retiree, you must be under age 65.

Eligible Dependents

Your dependents may be eligible for certain (but not all) benefit options available under the Plan. Please see the applicable Benefit Booklets for the requirements for particular Component Program benefits and applicable conditions and limitations on eligibility.

Notwithstanding the language in a Benefits Booklet, under the Medical Program, if you enroll in one coverage option, you may also enroll the following eligible dependents in the same coverage option: one qualified adult dependent and your dependent children, as defined below.

Qualified adult dependents

You can elect to cover one “qualified adult” dependent under the medical, dental and vision plans and that qualified adult dependent must be the same for all eligible plans. An eligible qualified adult dependent for medical coverage can include:

- Your spouse. Your spouse is a same- or opposite-sex person whom you have legally married under the laws of any state or foreign jurisdiction. (Note that a spouse does not include an individual with whom you are only in a domestic partnership, civil union or other relationship not identified as a marriage under applicable state law.)
- Your domestic partner. Your domestic partner is a same- or opposite-sex person who:
    - Has lived with you for at least six continuous months and remains a member of your household for the period during which he or she is covered under the Component Program
    - Is in a serious and committed relationship with you
    - Is financially interdependent with you, and
    - Is not legally married to, or in a domestic partnership with, anyone else.

You may not cover a domestic partner while you are legally married to another individual.

- An extended family member. An extended family member is a person who:
    - Is between the ages of 18 and 65
    - Has lived with you for at least six continuous months and remains a member of your household for the period during which he or she is covered under the Component Program, and
    - Meets the definition of "qualifying relative" under the Internal Revenue Code and is listed as a dependent on your federal income tax return. Qualifying relatives could include:
        - Your mother, father, grandmother, grandfather, stepmother, stepfather, mother-in-law or father-in-law
        - Your brother, sister, stepbrother or stepsister
        - Your niece, nephew, aunt or uncle
        - Your son, daughter, stepson or stepdaughter (except that your son, daughter, stepson or stepdaughter who is under age 26 may be covered as a dependent child)
        - Your son-in-law, daughter-in-law, brother-in-law or sister-in-law, and
        - Another individual (other than a spouse) who lives in your home and is a member of your household.

For information on qualified dependents under federal tax law, refer to IRS Publication 501, available at www.irs.gov/pub/irs-pdf/p501.pdf. Since you must certify an individual's eligibility as an extended family member, TIAA recommends that you consult a tax professional regarding an individual's status as a qualifying relative.

Dependent children

Your eligible dependent children for medical coverage (up to age 26) include:

- Children by birth
- Children by legal adoption (effective as of the date the child is placed for adoption)
- Stepchildren
- Children of a domestic partner as defined in the Qualified adult dependent section above
- Children of a qualified adult dependent whom you claim as dependents on your federal tax return
- Foster children who have been placed with you by an authorized placement agency or by judgment, decree or other order of a court, and whom you claim as dependents on your federal income tax return
- Children for whom you have legal guardianship or court-ordered custody, or have a pending application for legal custody or guardianship
- Children whom the Medical Program is required to cover under the terms of a Qualified Medical Child Support Order (QMCSO)

- Disabled dependent children age 26 or older, who are incapable of self-support as a result of a mental or physical condition that began before age 26 and who were covered under your benefits prior to age 26, and whom you claim as dependents on your federal income tax return. The child's physician must verify in writing that their disability occurred before age 26. Your Benefits Center will ask you each year to recertify that your dependent continues to be disabled.

If you are an eligible retiree that is under age 65, you may also enroll your eligible dependents in the same coverage, except that you may not cover (1) a spouse or domestic partner that is age 65 or over, or (2) a spouse or domestic partner who first becomes your spouse or domestic partner after your retirement date or December 31, 2015, whichever is later. Otherwise, eligible dependents for a retiree are considered the same as those for an active employee. If you meet the requirements for a pre-65 retiree noted above but are age 65 or over, your eligible dependents may be eligible to participate in the Medical Program option when you turn age 65, provided you certify that you have enrolled in retiree medical coverage through OneExchange.

Special Eligibility Rules for Certain Component Programs

In addition to or in lieu of the eligibility requirements set forth in the "**Employee Eligibility,**" "**Retiree Eligibility,**" and "**Eligible Dependents**" sections, a Component Program may have additional eligibility requirements as stated in the Benefits Booklets and which are incorporated into this Administrative Information Document. Please see the Benefit Booklets for more detail about the eligibility provisions that may apply to a particular Component Program.

Qualified Medical Child Support Orders

Each of the Group Health Plans will comply with all the terms of a Qualified Medical Child Support Order ("**QMCSO**"). A medical child support order is an order or judgment from a court or administrative body that directs the Plan to cover a child of a participant under the Group Health Plan. Federal law provides that a medical child support order must meet certain form and content requirements in order to be a QMCSO. When an order is received, each affected participant and each child (or the child's representative) covered by the order will be given notice of the receipt of the order and a copy of the plan's procedure for determining if the order is valid.

Coverage under the Group Health Plan pursuant to a medical child support order will not become effective until the Plan Administrator (or its delegee), determines that the order is a QMCSO. Children who may be covered under a QMCSO include children born out of wedlock, those not claimed as dependents on your federal income tax return, and children who do not reside with you. However, children who are not eligible for coverage under the Group Health Plan, due to their age for example, cannot be added under a QMCSO. If you have any questions or if you would like to receive a copy of the written procedure for determining whether a medical child support order is valid, free of charge, call ***Your Benefits Center*** at **844-4-TIAAHR (844-484-2247)**, option 4, then option 1.

Documenting your dependents

If you enroll your dependents in a Component Program, Your Benefits Center may request documentation to determine whether an enrolled dependent is eligible, based on the rules of the Component Program. This audit may occur either randomly or in response to uncertainty about a

dependent's eligibility. Note that it is your responsibility to understand if your dependents meet the definition of eligibility as described above. If you fail to provide any requested documentation to verify eligibility of any of your enrolled dependents on a timely basis – or the plan administrator is unable to verify the submitted documentation – your dependent will lose medical coverage whether the dependent is otherwise eligible for benefits under the Component Program. In addition, a dependent whose coverage is terminated due to lack of or insufficient documentation will not be eligible for COBRA coverage.

If you have questions after receiving a request to provide proof of dependent eligibility, please contact Your Benefits Center at 844-4-TIAAHR (844-484-2247), option 4, then option 1.

Your Benefits Center may ask you to certify that you are covering eligible dependents. Your Benefits Center may also periodically audit eligibility and you may be required to provide documentation that proves your relationship with the dependent, such as a marriage certificate, birth certificate, or even your federal tax return.

If you enroll a disabled dependent child over age 26 for coverage in a Group Health Plan, the child's physician must verify in writing that their disability occurred before age 26. Your Benefits Center may ask you each year to recertify that your dependent continues to be disabled.

Providing false or misrepresented eligibility information, and/or covering individuals who are not eligible is considered a violation of the TIAA Code of Conduct and subject to disciplinary action up to and including termination of employment. In addition, the Company reserves the right to terminate your and your dependent's coverage prospectively without notice for cause (as determined by the Plan Administrator), or if you and/or your dependent are otherwise determined to be ineligible for coverage under the particular benefit(s) at issue. Further, if you or your dependent commits fraud or intentional misrepresentation of a material fact in an application for health coverage under the Group Health Plan, in connection with a benefit claim or appeal, or in response to any request for information by the Company or his or her delegates (including the Plan Administrator or a claims administrator), the Plan Administrator may terminate your coverage retroactively upon 30 days' notice. Failure to inform any such persons that you are covered under another group health plan or knowingly providing false information in order to obtain coverage for an ineligible dependent are examples of actions that constitute fraud under the Plan. Coverage may also be terminated retroactively and without notice (unless required by law) if the Plan Administrator or his or her delegate determines that your dependent is ineligible for coverage under the particular benefit(s) at issue and such retroactive termination would not be considered a rescission under the Patient Protection and Affordable Care Act of 2010 ("PPACA"). The Plan Administrator shall decide such matters on a case-by-case basis. Of course, if the Group Health Plan pays benefits or expenses actually incurred or in excess of allowable amounts, due to error (including for example, a clerical error) or for any other reason (including, for example, your failure to notify the Plan Administrator or his or her delegates regarding a change in family status), the Plan Administrator reserves the right to recover such overpayment through whatever means are necessary, including, without limitation, deduction of the excess amounts from future claims and/or legal action.

For additional information about the Plans' ability to recover improperly paid benefits see the "**Reimbursement and Subrogation**" and "**Recovery Provisions**" sections in this Administrative Information Document along with the applicable Benefit Booklets.

Life, Spousal Life, Dependent Life, AD&D, and Business Travel Benefits Eligibility

The Company's life and accident insurance benefits are provided under insurance contracts that must be approved by and filed with state insurance commissions. The basic life insurance coverage provided under the Life Insurance Program covers only you. You may cover your eligible dependents under the other life and accident insurance plans to the extent permitted by those insurance contracts. For more information about the life and accident insurance benefits, please refer to the applicable Benefit Booklets.

Retiree Life Insurance Eligibility

The Company provides retiree life insurance under a separate contract for eligible retirees (as defined above) who retired from TIAA on or before December 31, 2009. Please consult the Benefits Booklet for retiree life insurance for more information.

No Duplicate Coverage

You may not be enrolled in any of the Programs as both an eligible employee or retiree and as a dependent of an eligible employee or retiree.

Your dependents also may not be enrolled by more than one eligible employee or retiree for a particular type of benefit. For example, if you and your spouse are both covered under the Medical Program as eligible employees, your eligible dependents may not be enrolled as eligible dependents of both you and your spouse. You will need to choose which parent will cover them.

SECTION III. ENROLLMENT PROCEDURES

This is only a summary of the enrollment procedures for the Component Programs. The enrollment procedures described in the Benefits Booklet for each underlying Component Program govern the applicable Program, and to the extent that there is a conflict between the procedures described in this summary and the applicable Benefits Booklet, the applicable Benefits Booklet controls. Please consult the Benefits Booklets and your open enrollment materials for more information. Enrollment in most Component Programs is not automatic. Subject to any special or different rule in the Benefit Booklets of the Component Programs, if you are eligible for coverage, you must enroll yourself and your eligible dependents in order to receive coverage.

Initial Enrollment

When you are first hired by a Participating Employer, you should receive an email from Your Benefits Center with benefits enrollment information. Employees who are eligible to participate in one or more of the Component Programs will receive instructions on how to enroll for benefits under such plans via **https://www.lifeatworkportal.com/TIAA-CREF.html**. Except as noted below or in the Benefits Booklets, if you are eligible to participate in one or more of the Component Programs and wish to participate in one or more of these plans, you must enroll through Your Benefits Center within 30 days of the date you meet the Component Program's eligibility requirements. If Your Benefits Center receives your completed election within this 30-day period in accordance with the procedures established by the Plan Administrator, the election will become effective as of the date you satisfy the Component Program's eligibility requirements.

If Your Benefits Center does not receive your completed election within 30 days of the date you meet the Component Program's eligibility requirements or your election is not made in accordance with the procedures established by the Plan Administrator, you will not be covered, and will not be able to enroll again until the next annual benefits open enrollment period, the date you experience a qualified life event or the date you are entitled to a special enrollment right. For information on qualified life events and enrollment rights, please refer to the "Qualified Life Status Change Events" section of this document.

There is more than one choice of Medical Program option available to most participants, but you will only be permitted to enroll in one option. The table below describes the timing for enrollment in each Component Program. The table also shows the third-party administrator administering or insurance carrier insuring the benefit.

Open Enrollment

You can enroll for or change coverage elections under each of the Component Programs during the annual benefits "open enrollment period," which is generally held in the fall of each year. The benefit choices you make during each year's open enrollment period take effect on January 1 of the following year and will remain in effect until December 31 of that year and will remain in effect until you revoke your election and make a new election to the extent permitted by such Program. You must drop coverage for any dependent who is no longer eligible. However, to the extent that you do not participate in an annual open enrollment period, except as set forth in any material provided to you in connection with that annual open enrollment period, your current benefit

elections for each Component Program will continue unchanged during the following year, unless otherwise specified in a Benefits Booklet.

If employee contributions are required for automatic coverage, they will be deducted from your pay on a pre-tax basis, as permitted under the Code, or on a post-tax basis. For more information about contributions, see the "**Paying for Coverage**" section.

In general, with respect to your Group Health Plan benefits, you may not make changes to your open enrollment elections until the following open enrollment period unless you experience a qualified life event as described in the section of this document entitled "Qualified Life Status Change Events" or are entitled to a special enrollment right.

When you enroll via **https://www.lifeatworkportal.com/TIAA-CREF.htm**, you have the option to print a confirmation statement. If you submit your elections via a paper form or do not make any changes, you will not receive a confirmation statement. If you are on an approved leave of absence other than long-term disability, you may enroll via the same website. If you are on long-term disability, you may only enroll by calling Your Benefits Center at 844-4-TIAAHR (844-484-2247).

Changing your coverage during the year

Your coverage election under the Group Health Plans is generally irrevocable during the plan year (January 1 to December 31).

Each year during Annual Benefits Enrollment, generally held in the fall, you can change your group health plan coverage elections – you can enroll in or drop medical coverage, change medical options and/or add or drop eligible dependents. You must drop coverage for any dependent who is no longer eligible. The election you make during Annual Benefits Enrollment will remain in effect for the following January 1 through December 31.

However, you may make changes to your medical coverage during a plan year if you experience a qualifying life event or if you experience another event that permits a mid-year election change. These special circumstances that permit you to make changes to your coverage during the year are described below.

HIPAA Special Enrollment Events

Under HIPAA, you and your eligible dependents (including your domestic partner) have special enrollment rights with respect to your Medical Program coverage that are described below.

Loss of Other Health Plan Coverage

If you declined medical coverage for yourself or your dependents (including your spouse/domestic partner) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your eligible dependents in a group health plan option, or switch options, if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other non-COBRA coverage). However, you must request enrollment within 30 days after the date your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). Loss of eligibility for coverage includes:

- Loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment or reduction in the number of hours of employment
- A situation in which a plan no longer offers any benefits to the class of similarly situated individuals of which the individual is a part, and
- In the case of an individual who has COBRA continuation coverage, at the time the COBRA continuation coverage is exhausted.

However, loss of eligibility for other coverage **does not** include a loss of coverage due to:

- The failure of the employee or dependent to pay premiums on a timely basis
- Voluntary disenrollment from a medical plan, 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).

Gaining a new dependent

If you have a new dependent as a result of marriage/domestic partnership, birth, adoption or placement for adoption, you may be able to enroll your newly-eligible dependent (if otherwise eligible for coverage) in the same coverage option you are enrolled in, or a new option if you decide to switch options. However, you must request enrollment within 30 days after the marriage/domestic partnership, birth, adoption or placement for adoption.

If you are not enrolled in the Medical Program option as an employee and want to enroll a newly-eligible dependent, you also must elect coverage for yourself when making that election. And, if your spouse is not enrolled, you may enroll him or her when you enroll a child due to birth, adoption or placement for adoption.

When you enroll your child, you may be required to provide proof of dependent status.

When coverage begins

For all election changes under the HIPAA special enrollment provisions, the change will be effective on the date of the event, provided you notify Your Benefits Center either online at www.lifeatworkportal.com/TIAA.html or by calling 844-4-TIAAHR (844-484-2247), option 4, then option 1 within 30 days after the event.

Loss or gain of eligibility for a state Children's Health Insurance Program (CHIP) or Medicaid

If you are eligible for, but not enrolled in the Medical Program (or your dependent is eligible for, but not enrolled in a medical option), you (and your dependent) may enroll in a medical option, or switch medical options, if either of the following conditions is met:

You or your dependent is covered under CHIP or Medicaid and such coverage is terminated as a result of loss of eligibility, and you request coverage under a medical option no later than 60 days after the date of termination of such CHIP or Medicaid coverage, or

You or your dependent becomes eligible for CHIP or a Medicaid premium assistance subsidy with respect to coverage under a medical option, if you request coverage under a medical option no later than 60 days after the date you or your dependent is determined to be eligible for such premium assistance subsidy.

When coverage begins

If you enroll yourself, your spouse/domestic partner and/or your eligible dependent child(ren) in a medical option due to a loss or gain of eligibility for a coverage event described above, coverage under the medical option will begin as of the date the election is made in the enrollment system.

To request special enrollment or obtain more information, call Your Benefits Center at 844-4-TIAAHR (844-484-2247), option 4, then option 1.

If your enrollment election is not received by the Plan Administrator within the 30-day or 60-day (as applicable) period following the HIPAA special enrollment event or your election is not made in accordance with the procedures established by the Plan Administrator, the election will not become effective and you will have to wait until the next open enrollment period to make the change in enrollment in the applicable Component Program. In that case, your election will not be effective until January 1 of the following year.

Qualified Life Status Change Events

As noted in the previous section, you may be permitted to make a change (as long as you meet the consistency requirements, described below) to your Component Programs during the course of the year if you experience a “qualifying life event”. A qualifying life event means a change in your work or family status during the year that affects your, your spouse’s/domestic partner’s or your dependent’s coverage, as defined by the Internal Revenue Service (IRS). These provisions apply to active employees and COBRA participants, and generally apply to retirees.

You can change your benefit election only if the requested change is as a result of and consistent with the life event you experience. To satisfy the “consistency rule,” both the event and the corresponding change in coverage must meet the following requirements, as determined by the plan administrator:

- **Effect on eligibility**. The event must affect eligibility for coverage under the medical program or under a plan sponsored by your dependent’s employer. This includes any time you become eligible (or ineligible) for coverage or if the event results in an increase or decrease in the number of your dependents who may benefit from coverage under the medical program, and
- **Corresponding election change**. The election change must correspond with the event. For example, if your child loses eligibility for coverage under the terms of the Medical Program, you may cancel medical coverage only for that child. You may not cancel coverage for yourself, or other covered dependents.

You must request the status change within 30 days of the event.

Approved qualifying life events under the Component Program may include:

- Marriage, divorce, legal separation, annulment or change in domestic partnership status*

- Birth or adoption or placement for adoption of a child
- Death of a spouse, domestic partner, qualified adult or other qualifying dependent
- Change of employment status for you, your spouse/domestic partner/qualified adult or other qualifying dependent, including:
- Starting or ending a job, or
- Reduction in number of hours of employment
- Your dependent no longer meets the dependent eligibility requirements (e.g., your dependent child has reached age 26)
- Change in your residence or in the residence of your spouse or dependents that results in eligibility or ineligibility under your (or a dependent's) group health plan.

*Please note that as a retiree you cannot add a new spouse or domestic partner to your retiree medical coverage.

Certain life events will automatically change your enrollment elections:

- If you change to a non-benefits-eligible status, you will automatically lose coverage under your elections on the date of your status change. However, you may be eligible to elect to continue group health plan coverage under COBRA.
- If the cost of your Component Program participation increases or decreases, your pre-tax contributions for coverage will automatically be increased or decreased, as appropriate, to equal the entire new cost to you for this coverage, unless the change in the cost of coverage is significant, as determined by the Company. If the new cost is significant, you will be offered the opportunity to elect other similar coverage or to drop coverage.
- If you are required by a Qualified Medical Child Support Order (QMCSO) to provide medical coverage for a child, you will be enrolled in the appropriate Group Health Plan as specified in the QMCSO. You will pay the entire cost to you for this coverage with pre-tax money, but on a post-tax basis if it is a child of your domestic partner. In addition, you may make corresponding election changes as a result of such judgment, decree, or order. If the judgment, decree, or order requires another person (such as your spouse or former spouse) to provide coverage for the child, then you may cancel coverage for that child if you provide proof to the plan administrator that such other person actually provides the coverage for the child.
- If your dependent child turns 26 or your qualified adult dependent turns 65, coverage under each of the Medical Program, Dental Program and Vision Program will end as of the last day of the month of their birthday.
- If you are enrolled in pre-65 coverage under the Medical Program, Dental Program or Vision Program as a retiree, coverage will end as of the end of the month before the month in which you turn age 65. However, if your birthday falls on the first of the month coverage will end as of the end of the month two months before the month of your birthday.

- If your spouse/domestic partner is enrolled in pre-65 coverage under the Medical Program, Dental Program or Vision Program (where you are a retiree) and your spouse/domestic partner turns age 65, coverage will end as of the end of the month before the month in which your spouse/domestic partner turns age 65. However, if the birthday of your spouse/domestic partner falls on the first of the month coverage will end as of the end of the month two months before the month of his or her birthday.

Other events that allow you to change elections are:

- Entitlement to Governmental Benefits. If you, your spouse or dependent becomes entitled to, or loses entitlement to, Medicare, Medicaid or certain other governmental group medical programs, you may make a corresponding change for the Medical, Dental and/or Vision Programs.
- Approved Leave. If you go on an unpaid leave of absence, FMLA leave or military leave, you may choose to drop your coverage under the Group Health Plan. If you return to service and are otherwise eligible to participate in the Group Health Plan, your coverage under that Component Program will be reinstated to the then current terms that apply to the medical option provided that you re-enroll within 30 days of when you return from your leave. If you re-enroll in coverage, your coverage will be effective retroactive to the first day after you return to work.

When you have a qualifying life event, you must notify Your Benefits Center either online at www.lifeatworkportal.com/TIAA.html or by calling 844-4-TIAAHR (844-484-2247), option 4, then option 1, and provide information about your coverage changes within 30 days of your status change. Otherwise, you will have to wait until the next Annual Benefits Enrollment period to change your benefit elections. You should also contact Your Benefits Center to make sure appropriate changes are made to your personal records.

When coverage begins

Coverage will be effective as follows, provided you notify ***Your Benefits Center*** either online at www.lifeatworkportal.com/TIAA.html or by calling **844-4-TIAAHR (844-484-2247**) option 4, then option 1, within 30 days of the qualifying life event:

Event	Coverage Effective Date
• If you get married	On the date of the marriage, provided you make your election within 30 days of the marriage
• If you have a baby	On the date of birth (**Note:** coverage for a newborn child of an enrollee in the Medical Program is effective for the first 30 days of life whether or not the child becomes enrolled in a medical option)
• If you adopt a child	On the date of the child's adoption or placement for adoption
• If you are required to cover a spouse or child under a court order	On the date required by the court order

• If you or an eligible dependent loses coverage under COBRA continuation	On the date COBRA continuation ends
• In the case of loss of coverage for other reasons	Coverage is effective on the date of the loss provided you make your election within 30 days of the date of the loss

When coverage is dropped

Coverage will be dropped effective as of the last day of the month in which the qualifying life event occurs, provided you notify ***Your Benefits Center*** either online at www.lifeatworkportal.com/TIAA.html or by calling **844-4-TIAAHR (844-484-2247**) option 4, then option 1, within 30 days of the qualifying life event.

Coverage Events

In some instances, you can make changes to your Component Program coverage for other reasons, such as mid-year events affecting the coverage.

Coverage Changes

If there is one of the following coverage changes, as determined by the Plan Administrator, you may be permitted to make a corresponding coverage change mid-year:

- **Curtailment or loss of coverage**. If your benefits coverage under one or more Component Program(s) is significantly curtailed or ceases entirely, you may revoke your elections for that plan and elect coverage under another option providing similar coverage, if one is available. Coverage is significantly curtailed if there is an overall reduction in coverage generally. If the curtailment is equivalent to a complete loss of coverage, and no other similar coverage is available, you may revoke your existing election for coverage;
- **Addition to or improvement in coverage**. If the Company adds or significantly improves a Component Program option during the year, and you had elected an option providing similar coverage, you may revoke your existing election and instead elect the newly added or newly improved option. Similarly, if you previously decline coverage you may elect the significantly improved option; or
- **Changes in coverage under another employer plan**. If your spouse or dependent's health plan under another employer allows for a change in your family member's coverage (either during that employer's open enrollment period or due to a mid-year election change permitted under the Code), you may be able to make a corresponding election change. For example, if your spouse elects family medical coverage during his or her employer's open enrollment period, you may drop your Medical Program coverage.

When Coverage Begins

The effective date of coverage, which is the date coverage or participation begins in a Component Program, depends on the provisions of each such Program. For each of the Component Programs, the initial effective date of coverage is the date you meet the applicable Component Program's eligibility requirements.

SECTION IV. PAYING FOR COVERAGE

Employees

Please refer to the Benefits Booklets for a description of the premium cost share between you and the Company. Except as otherwise set forth therein, you will pay for coverage based on your elections as follows:

Component Program	Who Pays
Medical Program – Kaiser Medical Option	You and the Company share the cost.
Long Term Disability Program	You are automatically enrolled and the Company pays the full cost.
Grandfathered LTD Program	The Company pays the full cost
Life Insurance Program	
• Basic Life Insurance	You are automatically enrolled and the Company pays the full cost.
• Supplemental Life Insurance	You pay the full cost
• Dependent Life Insurance	You pay the full cost
• Accidental Death and Dismemberment Insurance	You are automatically enrolled and the Company pays the full cost
• Supplemental Accidental Death and Dismemberment Insurance	You pay the full cost
Retiree Life Insurance Program	The Company pays the full cost
Business Travel Accident Program	You are automatically enrolled and the Company pays the full cost.
Business Travel Medical Program	You are automatically enrolled and the Company pays the full cost.
Death Benefit for Active Employees	You are automatically enrolled and the Company pays the full cost

The Plan Administrator will notify you annually as to what your contribution rates will be for the upcoming year. The Company, in its sole and absolute discretion, shall determine the amount of any required contributions under the Component Programs and may increase or decrease the amount of the required contribution at any time. Any refund, rebate, dividend, experience adjustment, or other similar payment under a group insurance contract shall be applied first to reimburse the Company for its (or the Participating Employers') contributions, unless otherwise provided in that group insurance contract or required by applicable law.

Pre-Tax Contributions

As an eligible employee, when you enroll for coverage for which you pay a part or all of the cost under the Plan, you must authorize the Company to deduct from your paycheck any contributions needed to pay your portion of the cost for your benefit elections. Under federal law, some of your

contributions are taken from your earnings before taxes are deducted. As a result, you pay less in federal income and Social Security taxes. Depending on your state of residence, pre-tax contributions may also reduce your state and local income taxes. Except as noted in this section, premiums or contributions may be made on a pre-tax basis (pursuant to Section 125 of the Code) as described in the applicable Benefits Booklets (and for the Kaiser Medical Option). However, medical coverage for any of your enrolled eligible dependents who are not your spouse, federal tax dependents for health purposes, or children as defined in Code Section 152(f)(1) under age 26 as of the end of any month must be paid on an after-tax basis. You do not pay Social Security taxes on the pre-tax dollars you use to pay for coverage under the applicable Component Program. As a result, the earnings used to calculate your Social Security benefits at retirement will not include these contributions. This could result in a small reduction in the Social Security benefit you receive at retirement. However, your savings on current taxes under the applicable Component Program will normally be greater than any eventual reduction in Social Security benefits. Employees who are on an approved leave and not receiving regular paychecks may be required to pay on an after-tax basis in accordance with the policies of the Participating Employer.

Under the Long Term Disability Program, you will have imputed income on the amount of value of the LTD credit that TIAA pays on your behalf. Under the Life Insurance Program, you will have imputed income based on the cost of basic life insurance above $50,000 that is paid for by the Company (unless you choose to limit such coverage to $50,000) and you will pay for any supplemental life, dependent life or supplemental AD&D coverage on an after-tax basis. The level of contributions is determined by the Company. Contributions are deducted from your paychecks based on your elected level of coverage.

SECTION V. WHAT SERVICES ARE COVERED

Please refer to the Benefit Booklets for a specific listing of covered and non-covered services under your benefit plans.

SECTION VI. COORDINATION OF BENEFITS

The coordination of benefits feature applies when you or a covered dependent are covered under a Component Program that provides medical benefits and:

- Another plan that also provides medical benefits, such as Medicare;
- A plan provided by the employer of your spouse, or domestic partner; or
- A no-fault insurance plan.

This feature determines which plan or plans has primary responsibility for paying medical benefits and which plan has secondary responsibility.

For details about the coordination of benefit rules, please refer to the applicable Benefit Booklet for the medical benefit option in which you are enrolled.

SECTION VII. WHEN COVERAGE ENDS

Please see the applicable Benefit Booklets for the requirements for particular Component Program benefits and applicable conditions and limitations on eligibility. Coverage for the Death Benefit ends upon your termination of employment with a Participating Employer. Notwithstanding the language in a Benefits Booklet, under the Medical Program, coverage also ends on the following dates:

- For an eligible retiree, the last day of the month prior to the month in which you will turn age 65, unless your birthday is the first of the month, in which case the last day of the month two months before the month in which you will turn age 65 *
- For the dependent of an eligible employee or eligible retiree, the last day of the month in which your dependent no longer meets the definition of an eligible dependent because your child reaches age 26, your qualified adult dependent reaches age 65, or your spouse or domestic partner remarries
- For the dependent of an eligible retiree, the last day of the month prior to the month in which your covered spouse reaches age 65, unless their birthday is the first of the month, in which case the last day of the month two months before the month in which he or she will turn age 65.

*If you are a pre-65 retiree and lose your coverage when you reach age 65, you will have the option to enroll for post-65 medical coverage through OneExchange. Your eligible dependents will not lose coverage provided you certify that you have enrolled in medical coverage through OneExchange.

Depending on the reason for termination of coverage and the Component Program in which you had coverage, you and/or your covered dependents may have the right to continue health coverage temporarily under COBRA (see the "**COBRA – Continuing Coverage After Your Employment Ends or Certain Other Events**" section).

SECTION VIII. CONTINUATION OF COVERAGE

Generally, the Plan provides continuation of coverage while on an approved leave of absence, including during a Family and Medical Leave Act ("FMLA") leave of absence and during a disability when you are approved for short-term or long-term disability, subject to the terms of the applicable Component Program and the Company's leave policies. Please refer to the Benefits Booklets or contact Your Benefits Center at 844-4-TIAAHR (844-484-2247) for additional information.

Continuing Medical Program Coverage During FMLA and Other Qualified Leaves

If you go on a qualifying leave under the Company's FMLA policy, then to the extent required by the FMLA, your coverage (and that of your eligible dependents) under the Medical Program will continue on the same general terms and conditions as if you were still active (that is, the Company will continue to pay its share of the contributions, if any, to the extent you opt to continue coverage). If you suspend your participation, benefit expenses incurred while you are on leave will not be covered under the applicable Component Program. You will have the right to be reinstated in that plan upon returning from FMLA or other qualified leave. Questions regarding your entitlement to this leave should be referred to the Company.

If you are on an approved unpaid leave of absence that does not qualify for FMLA or Military Leave (explained in the "Continuing Group Health Plan/FSA Coverage During Military Leave" section), coverage under the Medical Program for you and your dependents may continue for as long as you remain an employee of the Company. You are responsible for payment of elected benefits during the leave at the same rate as for active employees (but on an after-tax basis).

If you lose medical coverage during an FMLA leave because dropped or coverage or you did not make the required contributions and if you wish to have coverage, you must re-enroll within 30 days of when you return from your leave. If you re-enroll in coverage, your coverage will be effective retroactive to the first day after you return to work and make your required contributions. At the conclusion of your FMLA leave, you may be eligible for benefits for COBRA. Please see the "**COBRA – Continuing Coverage After Your Employment Ends or Certain Other Events**" section.

Continuing Group Health Plan and Health Care FSA Plan Coverage During Military Leave

If you take a Military Leave, whether for active duty or for training, you may be entitled to certain continuation coverage as provided in the applicable Benefits Booklets.

Under Component Programs, a "Military Leave" is an absence from employment with a Participating Employer due to the performance of duty, on a voluntary or involuntary basis, in a uniformed service of the United States, under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and a period for which you are absent from a position of employment for the purpose of an examination to determine your fitness to perform any such duty. Under the applicable Component Programs noted above, you will not be treated as absent due to Military Leave unless:

- you have given advance notice of your military service to Your Benefits Center;
- the cumulative length of your absence and absence for prior Military Leaves from the Participating Employer does not exceed five years or such other period of time permitted by the Uniformed Services Employment and Re-employment Rights Act of 1994, as amended ("USERRA"); and
- you report to, or submit an application for re-employment to the Participating Employer by the deadline imposed by the Company in accordance with USERRA.

For Military Leaves

If you go on military leave, whether for active duty or for training, while you are working at TIAA, you may continue your Group Health Plan coverage as provided in the applicable Benefits Booklets. Under the Medical Program, you may continue your coverage under the Medical Program for the first eight months by paying the same amount charged to active employees for the same coverage. Your Benefits Center will invoice you for your premiums. Unlike payroll deductions, any amounts paid will be paid on an after-tax basis. If your leave is for more than eight months, when your medical coverage ends, you can elect to continue coverage under the Medical Program for an additional period of 24 months (with the same cost and the same coverage offered under COBRA). This period runs concurrently with any COBRA continuation period for which you are eligible. If you choose not to continue your medical coverage while on military leave, you are entitled to be reinstated in coverage, provided that you re-enroll within 30 days of when you return from your leave.

Under the Life Insurance Program, your basic life insurance will continue during the first eight months and you may continue any supplemental coverage by continuing to pay your premiums. Your Benefits Center will invoice you for your premiums. At the end of the eight month period, your coverage under the Life Insurance Program will end.

Whether or not you continue coverage during Military Leave, you may reinstate coverage under the Component Programs effective as of the date you return to active employment under the provisions of USERRA. No waiting period or exclusion will be imposed in connection with such reinstatement (unless the waiting period or exclusion would have been imposed if you remained covered during your military service) except in the case of illness or injury connected with your military service. Separation for uniformed service that is dishonorable or based on bad conduct, on grounds less than honorable, absent without leave, or ending in a conviction under court martial would disqualify you from any rights under USERRA.

If you take a Military Leave, but your coverage under a Component Program is terminated, you will be treated as if you had not taken a Military Leave upon your re-employment.

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COBRA – Continuing Coverage After Your Employment Ends or Certain Other Events

This section contains important information about your right to a temporary extension of coverage under the Group Health Plans, except as otherwise provided in an applicable Benefits Booklet. The right to COBRA continuation coverage was created by a federal law, the Consolidated

Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA requires that the Company provide you and your covered dependents who are qualified beneficiaries under COBRA with the opportunity to continue coverage under these Component Programs for a temporary period in certain instances where your coverage under the Component Program would otherwise end.

This section explains COBRA continuation coverage, your right to obtain it, when it may become available to you and your family, and what you need to do to protect the right to receive it.

As a qualified beneficiary, you can elect to continue your coverage under the Component Programs as such coverage is in effect on the date your coverage would otherwise end. A "qualified beneficiary" is you (as employee or retiree), your spouse, (and, although not required under federal law, your domestic partner, or qualified adult dependent), and your dependent children who were covered under the Component Programs immediately before coverage ended due to a qualifying event. A qualified beneficiary also includes a child born or placed for adoption with you while you are enrolled in COBRA continuation coverage, provided you notify the COBRA Administrator within 30 days after the event.

The COBRA Administrator is:

Your Benefits Center
P.O. Box 5255
Cherry Hill, NJ 08034-5255
844-484-2247, option 4, then option 1

Who Is Covered

You should receive an initial COBRA notice entitled "Your Right to COBRA" from the Company shortly after you become eligible to participate in the Plan.

If you are an eligible employee who is covered by the Group Health Plan, you have a right to choose continuation coverage if you lose your coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse, or domestic partner of an eligible employee or retiree and are covered by the Group Health Plan on the day before the qualifying event, you are a qualified beneficiary and have the right to choose continuation coverage for yourself if you lose your coverage due to one of the following "qualifying events":

- termination of the employee's employment (for reasons other than the employee's gross misconduct) or a reduction in the employee's hours of employment;
- death of the employee;
- employee's entitlement to (that is, you enroll in) Medicare benefits under Part A, Part B or both, or
- divorce or legal separation from the employee.

If you are the dependent (other than a spouse, or domestic partner) of an eligible employee or retiree and are covered by the Group Health Plan on the day before the qualifying event, you are

a qualified beneficiary and have the right to choose continuation coverage if you lose your coverage due to:

- termination of the employee's employment (for reasons other than the employee's gross misconduct) or a reduction of the employee's hours of employment;
- death of the employee;
- employee's entitlement to (that is, you enroll in) Medicare benefits under Part A, Part B or both
- divorce or legal separation of the employee, or
- you were covered as a dependent child and you are no longer qualified as a covered dependent under the terms of the Group Health Plan.

A termination of the employee's employment will not be considered a qualifying event for which the employee or the employee's spouse/domestic partner or other dependents is entitled to continuation coverage where the employee transfers employment to another company within the TIAA Family of Companies (which generally includes corporations of which the Company owns at least 80%).

Sometimes an employer's filing of a bankruptcy proceeding under Title 11 of the United States Code is considered a qualifying event. If a bankruptcy proceeding is filed with respect to TIAA, and that bankruptcy results in the loss of coverage for any pre-65 retiree covered under the medical program, the retiree will become a qualified beneficiary with respect to the bankruptcy. The spouse, surviving spouse and dependent children of any pre-65 or post-65 retiree will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Component Program. For this purpose, "loss of coverage" also means any substantial elimination of retiree health coverage within one year before or after the date the bankruptcy proceeding commences, for a covered employee who had retired on or before the date of the substantial elimination of group health plan coverage.

For purposes of determining qualified beneficiaries other than the retiree, the term "employee" will include retirees who have covered dependents participating in the Component Program throughout this COBRA section unless otherwise noted.

Continuation Coverage for Domestic Partners and Qualified Adult Dependents

Although continuation coverage for domestic partners and qualified adult dependents is not required by federal COBRA, the Company currently provides continuation coverage equivalent to COBRA to domestic partners and qualified adult dependents who were covered under the Plan when group coverage otherwise would have been lost.

Only in this section of this document:

- The terms "spouse" and, when referring to a spouse, "qualified beneficiary" generally include domestic partners;
- The term "divorce" generally includes termination of a domestic partnership;

- The term “dependent” includes a qualified adult dependent, and “qualified beneficiary” generally includes qualified adult dependents, except that the qualified adult dependent will not be entitled to COBRA upon ceasing to qualify as an eligible qualified adult dependent under the terms of the medical program; and
- The term “COBRA continuation coverage” generally includes continuation coverage.

Your Duties

You or a family member has the responsibility to inform the Plan Administrator of a divorce, legal separation, or a dependent child losing dependent status under the Group Health Plan. (If you or your family member is already receiving COBRA continuation coverage and experience a second qualifying event, contact TIAA’s COBRA administrator, Your Benefits Center, by calling 844-484-2247, option 4, then option 1). This notice must be provided in writing and must include the name and address of the qualified beneficiary, the name of the covered employee, the relationship of the qualified beneficiary to the employee, the type of qualifying event, the date of the qualifying event, and supporting documentation within 60 days after the date of the divorce, legal separation or a child losing dependent status (or, if later, the date coverage would normally be lost because of the event). If the employee or a family member fails to provide this notice to the Plan Administrator during this notice period, any family member who loses coverage will not be offered the option to elect continuation coverage.

When the Plan Administrator is notified that one of these events has happened, the COBRA Administrator will notify you (or, if applicable, the qualified beneficiary) of the right to choose continuation coverage. If you or your family member fails to notify the Plan Administrator and any claims are mistakenly paid for expenses incurred after the date coverage would normally be lost because of the divorce, legal separation or a child losing dependent status, then the employee and family members will be required to reimburse the applicable Component Program for any claims mistakenly paid.

The Plan Administrator’s Duties

The Plan Administrator (or his or her delegate) will notify qualified beneficiaries of the right to elect continuation coverage automatically (without any action required by the employee or a family member) if any of the following events result in a loss of coverage:

- the employee’s death;
- the employee’s termination of employment (for reasons other than gross misconduct); a reduction in hours of the employee’s employment; or
- the employee's entitlement to Medicare benefits (under Part A, Part B or both), or
- commencement of a proceeding in bankruptcy under Chapter 11 of the United States Code with respect to TIAA.

Electing COBRA

To inquire about COBRA coverage, contact Your Benefits Center, by calling 844-484-2247, option 4, then option.

You must elect continuation coverage within 60 days after the date you would lose coverage because of one of the qualifying events described in the “COBRA - Continuing Coverage after Your Employment Ends or Certain other Events” section, or, if later, 60 days after the COBRA Administrator provides you notice of your right to elect continuation coverage. An employee or family member who does not choose continuation coverage within the time period described above will lose the right to elect continuation coverage.

You and your family may have other coverage options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse’s plan) if you request enrollment within 30 days, even if the plan generally does not accept late enrollees.

If you choose continuation coverage, your employer is required to give you coverage that, as of the time coverage is being provided, is identical to the coverage provided under your employer’s health plans to similarly situated employees or family members. This means that if the coverage for similarly situated employees or family members is modified, your coverage will be modified. “Similarly situated” refers to a current employee or dependent who has not had a qualifying event.

If you elect continuation coverage under the Component Program and then have a child (either by birth, adoption, or placement for adoption) during the period of continuation coverage, the new child is also eligible to become a qualified beneficiary. In accordance with the terms of the Component Program and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage upon proper written notification to the COBRA Administrator of the birth or adoption within 30 days after the birth or adoption. This notice should include the name of the employee, the name of the newly acquired dependent, the date of the birth, adoption, or placement for adoption, and supporting documentation.

If you fail to notify the COBRA Administrator in a timely fashion of the birth, adoption, or placement for adoption of your child, you will not be offered the option to elect COBRA coverage for the child. Newly acquired dependents (other than children born to, adopted by, or placed for adoption with you) will not be considered qualified beneficiaries but may be added to your continuation coverage during the open enrollment period.

Separate Elections

Each qualified beneficiary has an independent election right for COBRA coverage. For example, if there is a choice among types of coverage, each qualified beneficiary who is eligible for continuation of coverage is entitled to make a separate election among the types of coverage. This means, a spouse or dependent is entitled to elect continuation coverage even if you do not make that election. Similarly, a spouse or dependent child may elect different coverage than you elect.

Duration of COBRA

Except as otherwise provided in this section, the law requires that you be afforded the opportunity to maintain continuation coverage for 36 months under COBRA. If, however, you or your covered dependents who are qualified beneficiaries lose group health coverage because of a termination

of your employment or reduction in your hours of employment, the required continuation coverage period is 18 months. If your employment is terminated for gross misconduct, you and your covered dependents who are qualified beneficiaries will not be eligible for COBRA continuation coverage.

Additional qualifying events (such as a death, divorce, termination of domestic partnership, or Medicare entitlement) that occur while the continuation coverage is in effect may result in an extension of an 18month continuation period to 36 months. However, in no event will coverage last beyond 36 months from the date of the event that originally made a qualified beneficiary eligible to elect coverage. You should notify the COBRA Administrator in writing if a second qualifying event occurs during your continuation coverage period. This notice must be provided in writing and must include the name and address of the qualified beneficiary, your name, the type of the second qualifying event, the date of the second qualifying event, and supporting documentation. This notice must be provided within 60 days after the date of the second qualifying event (or, if later, the date coverage would normally be lost because of the second qualifying event). When the COBRA Administrator is notified that one of these events has happened, the covered dependent who is a qualified beneficiary will automatically be entitled to the extended period of continuation coverage. If an employee or covered dependent who is a qualified beneficiary fails to provide the appropriate notice and supporting documentation to the COBRA Administrator during this 60day notice period, the covered dependent who is a qualified beneficiary will not be entitled to extended continuation coverage.

Note that if the qualifying event is the bankruptcy of TIAA, and you are a covered pre-65 retiree, coverage under the medical program for you and your covered spouse and dependent children may be continued for the rest of your (the retiree's) life. In the event of your death (including if you were to die before any bankruptcy proceeding begins), your surviving spouse and children may continue retiree medical coverage you had as a pre-65 retiree for an additional 36 months after your death.

Special Rules for Disability

The 18 months may be extended to 29 months if the qualified beneficiary is determined by the Social Security Administration ("SSA") to be disabled (for Social Security disability purposes) at the time of the qualifying event or at any time during the first 60 days of continuation coverage. This 11-month extension is available to all family members who are qualified beneficiaries due to termination or reduction in hours of employment, even those who are not disabled. To benefit from the extension, the qualified beneficiary must provide notice of the SSA determination to the COBRA Administrator, Your Benefits Center at the address shown in the Benefits Booklet or in Schedule B. This notice must be in writing and must include the name and address of the qualified beneficiary, your name, information about the disability and supporting documentation and must be provided within 60 days after the Social Security Administration (or SSA) determination of disability and before the end of the original 18-month continuation coverage period. If, during continued coverage, the SSA determines that the qualified beneficiary is no longer disabled, the individual must inform Your Benefits Center at the address shown in the applicable Benefits Booklet or in Schedule B, of this re-determination within 30 days of the date it is made at which time the 11-month extension will end.

Medicare

If you experience a termination of employment or reduction in hours following Medicare enrollment, your covered dependents who are qualified beneficiaries may elect COBRA coverage for up to 36 months from the date you become covered by Medicare or 18 months from your termination or reduction in hours, whichever is longer.

Early Termination of COBRA

The law provides that your continuation coverage may be cut short prior to the expiration of the applicable 18-, 29-, or 36-month period for any of the following five reasons:

- the Company no longer provides health plan coverage to any of its employees;
- you (or someone on your behalf) does not pay the premium for continuation coverage on time (within the applicable grace period);
- the qualified beneficiary becomes covered—after the date COBRA is elected—under another health plan (whether or not as an employee);
- the qualified beneficiary becomes entitled to (that is, enrolled in) Medicare benefits (under Part A and/or Part B) after the date COBRA is elected; this does not apply to other qualified beneficiaries who are not entitled to Medicare and does not end retiree COBRA continuation coverage when bankruptcy is the qualifying event), or
- coverage has been extended for up to 29 months due to disability, and there has been a final determination made by the SSA that the individual is no longer disabled.

COBRA and FMLA

A leave that qualifies under the FMLA does not make you eligible for COBRA coverage. However, regardless of whether or not you lose coverage because of nonpayment of premiums during an FMLA leave, you will be eligible for COBRA if you decide not to return to active employment. Your continuation coverage will begin on the earliest of the following to occur:

- when you definitively inform the Company that you are not returning to work with a Participating Employer; or
- your FMLA leave ends and you terminate employment, assuming you do not return to work with a Participating Employer.

For purposes of an FMLA leave, you will be eligible for COBRA, as described in the “COBRA - Continuing Coverage after Your Employment Ends or Certain other Events” section, only if:

- you or your dependent is covered by the Group Health Plan on the day before the FMLA leave begins (or you or your dependent becomes covered during the FMLA leave); and
- you do not return to employment with a Participating Employer.

Cost of Coverage

You do not have to show that you are insurable to choose COBRA coverage. However, you will be required to pay the full Plan cost of covering an employee (employer and employee contributions), and any spouse or eligible dependents, if applicable, plus a 2% administrative fee,

making your payment a total of 102% of the cost of coverage. If your coverage is extended from 18 to 29 months for disability, you may be required to pay up to 150% of the cost of covering an employee, spouse, and any eligible dependents, if applicable. This cost increase begins with the 19th month of COBRA coverage, provided that the disabled individual is one of the individuals who elects the disability extension. The cost of group health coverage periodically changes. If you elect COBRA coverage, you will be notified of any cost changes.

COBRA coverage is not effective until you elect it and make the required payment. You have an initial grace period (45 days from the date of your initial election) to make your first premium payment.

Thereafter, payments are due by the first day of each month to which the payments apply (payments must be postmarked and or electronically received on or before the end of the 30-day grace period). If you pay part of, but not all, of the premiums, and the amount you paid is not significantly less than the full amount due, you will have 30 days from the end of the initial 30-day grace period to pay the outstanding amount due.

If you do not make timely payments, your COBRA coverage will be terminated as of the last day of the month for which you made timely payment.

Other State COBRA Rights

If you are enrolled in an insured medical coverage, you may have health care continuation coverage rights provided by state law. Any state health care continuation benefits are provided by insurance companies and are not the obligations of the Company or this Plan. Contact your insurance carrier if you have any questions.

Conversion of Coverage

After your coverage and the coverage of eligible dependents would otherwise end under a Component Program, you may have a right to purchase a conversion policy. For more information about whether a conversion right exists for a particular Component Program, see the applicable Benefit Booklets.

Keep your plan informed of address changes

In order to protect your rights as well as the rights of your spouse and dependents, you should keep the plan administrator informed of any address changes for your spouse and/or dependent s. You should also keep a copy of any notices you send to the plan administrator for your records.

SECTION IX. HIPAA

HIPAA Privacy Rights

HIPAA imposes rules on the Component Programs which are “group health plans” within the meaning of HIPAA with respect to the use and disclosure of each participant’s protected health information (PHI) in certain situations. In addition, HIPAA provides participants with certain rights with respect to their PHI, including the right to receive a privacy notice.

Please contact Your Benefits Center at 844-4-TIAAHR (844-484-2247) if you would like to receive a copy of the Group Health Plan’s Notice of Privacy Practices.

HIPAA Privacy and Security

The provisions in this section related to HIPAA Privacy and Security shall apply to the Group Health Plans. For purposes of this section, the following terms have the following meanings:

- “Business Associate” means a person or entity that performs a function or activity regulated by HIPAA on behalf of the component Programs provided under the Group Health Plan and involving individually identifiable health information. Examples of such functions or activities are claims processing, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation and financial services. A subcontractor of a Business Associate may be treated as a Business Associate. A Business Associate may be a Covered Entity (see below). However, Insurers and HMOs are not Business Associates of the plans they insure;
- “Covered Entity” means a group health plan (including an employer plan, insurer, HMO and government coverage such as Medicare);
- a health care provider (such as a doctor, hospital, or pharmacy) that electronically transmits any health information in connection with a transaction for which the U.S. Department of Health and Human Services has established an electronic data interchange standard; or
- a health care clearinghouse (an entity that translates electronic information between nonstandard and HIPAA standard transactions);
- “Protected Health Information” or “PHI” means individually identifiable health information created or received by a Covered Entity. Information is “individually identifiable” if it names the individual person or there is a reasonable basis to believe components of the information could be used to identify the individual. “Health information” means information, whether oral or recorded in any form or medium, that (i) is created by a health care provider, health care plan, employer, life insurer, public health authority, health care clearinghouse, or school or university; and (ii) relates to the past, present, or future physical or mental health or condition of a person, the provision of health care to a person, or the past, present, or future payment for health care. Protected Health Information excludes individually identifiable health information in: (i) education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g; (ii) records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and (iii) employment records held by a Covered Entity in its role as employer.

"Electronic Protected Health Information" or "e-PHI" is protected health information that is transmitted or maintained in electronic media including, but not limited to, hard drives, disks, on the internet, or on an intranet.

Uses and Disclosures of PHI

The Group Health Plan and Participating Employers may disclose a covered employee's PHI or e-PHI to the Company (or to the agent of the Company) for the plan administration functions, to the extent not inconsistent with the HIPAA regulations. The Group Health Plan will not disclose PHI or e-PHI to the Company except upon receipt of a certification by the Company that the Group Health Plan incorporates the agreements of the section of this document entitled "Privacy Agreements of the Company", except as otherwise permitted or required by law.

Privacy Agreements of the Company

As a condition for obtaining PHI from the Group Health Plan and its Business Associates, the Company agrees that it will:

- not use or further disclose such PHI other than as permitted by the Group Health Plan or as required by law;
- ensure that any of its agents, including a subcontractor, to whom it provides the PHI agree to substantially the same restrictions and conditions that apply to the Company with respect to such information;
- not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Company;
- report to the Group Health Plan's Privacy Officer any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for in the Group Health Plan of which the Company becomes aware;
- make the PHI of a particular participant available for purposes of the participant's requests for inspection, copying, and amendment, and carry out such requests in accordance with HIPAA;
- make records of certain types of disclosures that it may make of PHI of a particular participant so that the Company may make available to the Group Health Plan the information required for the Group Health Plan to provide an accounting of disclosures pursuant to the participant's request for such an accounting in accordance with HIPAA;
- make the Company's internal practices, books, and records relating to the use and disclosure of PHI received from the Group Health Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Group Health Plan with HIPAA;
- if feasible, return or destroy all PHI received from the Group Health Plan that the Company still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Company agrees to limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

- ensure there is adequate separation between the Group Health Plan and the Company.

Employees with Access to PHI

Only those employees designated in the Group Health Plan's HIPAA Policies and Procedures as "Authorized Employees" will be given access to the Protected Health Information. The Authorized Employees may only use the Protected Health Information for Group Health Plan administrative functions that the Plan Sponsor performs for the Group Health Plan.

Mechanism for Resolving Noncompliance

If the Company or the Authorized Employees determine that any Authorized Employee has violated any of the restrictions of the Group Health Plan, then such individual shall be disciplined in accordance with the policies of the Company up to and including dismissal from employment. The Company shall arrange to maintain records of such violations along with the persons involved, as well as disciplinary and corrective measures taken with respect to each incident.

Security Agreements of the Company

As a condition of obtaining or maintaining e-PHI from the Group Health Plan, its Business Associates, insurers, or HMOs, the Company agrees that it will:

- implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the e-PHI that it creates, receives, maintains, or transmits on behalf of the Group Health Plan;
- ensure that the adequate separation between the Group Health Plan and the Company is supported by reasonable and appropriate security measures;
- ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information;
- report to the Group Health Plan's Security Officer any security incident of which it becomes aware. For purposes of the Group Health Plan, security incident shall mean successful unauthorized access, use, disclosure, modification, or destruction of, or interference with, the e-PHI; and
- upon request from the Group Health Plan, provide information to the Group Health Plan on unsuccessful or attempted unauthorized access, use, disclosure, modification, or destruction of the e-PHI to the extent such information is available to the Company.

SECTION X. CLAIMS REVIEW AND APPEAL PROCESS

Your claims will be processed under the following procedures except to the extent inconsistent with the claims and appeals procedures set forth in the applicable Benefit Booklets in which case those claims and appeals procedures will apply as long as they comply with the Patient Protection and Affordable Care Act (PPACA) and guidance issued thereunder and U.S. Department of Labor (DOL) Regulation § 2560.503-1.

Filing a Claim

In general, any participant or beneficiary under the Component Programs (or his or her authorized representative such as a lawyer or power-of-attorney) may file a written claim for benefits using the proper form and procedure. A claimant can obtain the necessary claim forms from the applicable Claims Administrator to file a written claim (or oral claim, in the case of an "urgent" claim) or appoint his or her authorized representative by following the procedures set forth by the Claims Administrator. An "**authorized representative**" means a person you authorize, in writing pursuant to the procedures of the applicable Component Plan, to act on your behalf (such as a lawyer or power-of-attorney). The Plan will also authorize a court order giving a person authority to submit claims on your behalf, except that in the case of a claim under the Medical Program involving urgent care, a healthcare professional with knowledge of your condition may always act as your authorized representative. For a list of the persons or entities responsible for processing and reviewing claims for each Component Program, please refer to the applicable Benefits Booklet or Schedule B.

In general, when you need to file a claim use the addresses listed in the applicable Benefit Booklets, on the applicable claims form, or in Schedule B. When your claim is received by the Claims Administrator, it will be reviewed and the Claims Administrator will determine whether and how to pay your claim on behalf of the Component Program. Claims forms are available from the Claims Administrator.

To ensure proper filing of claims, please refer to the claims filing procedures that are set forth in the applicable Benefit Booklet. In general, any participant or beneficiary under the Component Program (or his or her authorized representative) may file a written claim for benefits using the proper form and procedure.

Claim-Related Definitions

This section provides general information about the claims and appeals procedures applicable to the Component Programs under ERISA. Note that state insurance laws may provide additional protection to claimants under the fully-insured arrangements and if so, those rules will apply. See the applicable Benefit Booklets for more information.

Claim

Under ERISA, a claim is a request for benefits under a plan made in accordance with the plan's claims- filing procedures, including any request for a service that must be pre-approved. Under the Component Programs, a casual inquiry (even if it is in writing) regarding eligibility requirements or a casual inquiry about benefits under such Component Program is not treated as

a claim and is not subject to these claim and appeal procedures, unless the Plan Administrator (or his or her delegate) decides to treat such inquiry as a claim.

The Component Programs of the Group Health Plan recognize four categories of health benefit claims:

- Urgent Care Claims – "Urgent care claims" are claims (other than post-service claims) for which the application of non-urgent care time frames could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function or, in the judgment of a physician, would subject the patient to severe pain that could not be adequately managed otherwise. An individual acting on behalf of the Plan, applying the judgment of a prudent layperson who has an average knowledge of health and medicine, can determine whether the urgent care definition has been satisfied. However, if a physician with knowledge of the patient's medical condition determines that the claim involves urgent care, it must be considered an urgent care claim.
- Pre-service Claims – "Pre-service claims" are claims for approval of a benefit if the approval is required to be obtained before a patient receives health care (for example, claims involving preauthorization or referral requirements).
- Post-Service Claims – "Post-service claims" are claims involving the payment or reimbursement of costs for health care that has already been provided.
- Concurrent Care Claims – "Concurrent care claims" are claims for which the Component Program previously has approved a course of treatment over a period of time or for a specific number of treatments, and the Component Program later reduces or terminates coverage for those treatments. A concurrent care claim may be treated as an "urgent care claim," "pre-service claim," or "post-service claim," depending on when during the course of your care you file the claim. However, the Component Program must give you sufficient advance notice of the initial claims determination so that you may appeal the claim before a concurrent care claims determination takes effect. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service time frames, whichever applies.

Adverse Benefit Determination

If the Component Program does not fully agree with your claim, you will receive an "adverse benefit determination" — a denial, reduction, or termination of a benefit, or failure to provide or pay for (in whole or in part) a benefit. An adverse benefit determination includes, for example, a decision to deny benefits based on:

- an individual being ineligible to participate in the Component Program;
- utilization review;
- a service being characterized as experimental or investigational or not medically necessary or appropriate;
- a concurrent care decision; and

- coverage determination, including Component Program limitations or exclusions.

Initial Claim Determination

Each Component Program has a specific amount of time, by law, to evaluate and respond to claims for benefits covered by ERISA. The period of time the Component Program has to evaluate and respond to a claim begins on the date the Component Program receives the claim. If you have any questions regarding how to file or appeal a claim, contact the Claims Administrator (listed in the applicable Benefits Booklet or Schedule B) for the benefit at issue.

The time frames on the following pages apply to the various types of claims that you may make under the Component Program, depending on the benefit at issue.

In the event of an adverse benefit determination, the claimant will receive notice of the determination. The notice will include:

- the specific reasons for the adverse benefit determination;
- the specific plan provisions on which the determination is based;
- a request for any additional information needed to reconsider the claim and the reason this information is needed;
- a description of the Component Program's review procedures and the time limits applicable to such procedures;
- a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review;
- if any internal rules, guidelines, protocols, or similar criteria was used as a basis for the adverse benefit determination, either the specific rule, guideline, protocols, or other similar criteria or a statement that a copy of such information will be made available free of charge upon request (for health and disability claims only);
- for adverse benefit determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request (for health and disability claims only); and
- for adverse benefit determinations for a Component Program of the Group Health Plan involving urgent care, a description of the expedited review process for such claims. This notice may be provided orally within the time frame for the expedited process, in which case, written notice will be provided no later than 3 days after the oral notice.

In addition to the notice standards described in this section, to the extent required by PPACA, any notice of denial to a claimant enrolled in Component Program of the Group Health Plan may include the following:

- information identifying the claim involved, including the date of service, the health care provider, the claim amount, and a statement describing the availability, upon request, of the diagnosis and treatment codes (and the corresponding meaning of those codes);

- the reason or reasons for the adverse benefit determination that includes the denial code and its corresponding meaning and a description of the Component Program's standard, if any, that was used to deny the claim;
- a description of available internal appeals and external review processes, including how to initiate an appeal; and
- contact information for any applicable office of health insurance consumer assistance or ombudsman established under PPACA to assist individuals with the internal claims and appeals and external review processes.

Time Frames for Initial Claims Decisions

Time frames generally start when the Component Program receives a claim. (See the special rule for "concurrent care" decisions to limit previously-approved treatments.) Notices of benefit determinations generally may be provided through in-hand delivery, mail, or electronic delivery before the period expires, though oral notices may be permitted in limited cases. A reference to "days" means calendar days.

	Group Health Plans			
	Urgent Care Claims	**Non-Urgent "Pre-Service' Claims**	**Non-Urgent "Post-Service" Claims**	**"Concurrent Care" Decision to Reduce Benefits**
Time frame for Component Program to Provide Notice of Determination	Notice of determination (whether adverse or not) must be provided by the Plan as soon as possible considering medical exigencies, but no later than 72 hours. Notice of determination may be oral with a written or electronic confirmation to follow within 3 days.	Notice of determination (whether adverse or not) must be provided by the Plan within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days.	Notice of adverse benefit determination must be provided by the Plan within a reasonable period of time, but no later than 30 days.	Notice of adverse benefit determination must be provided by the Plan enough in advance to give you an opportunity to appeal and obtain decision before the benefit at issue is reduced or terminated.
Extensions	If your claim is missing information, the Plan has up to 48 hours (subject to decision being made as soon as possible) from the earlier of (i) the Plan's receipt of the missing information, or (ii) the end of the period afforded to you to provide the missing information, to provide notice of determination.	The claims administrator has up to 15 days, if necessary due to matters beyond the claim administrator's control If such an extension is necessary, the claims administrator must notify you before the end of the first 15- or 30-day period of the reason(s) for the extension and the date it expects to provide a decision on your claim. If such an extension is necessary due to your failure to submit the information needed to decide the claim, the notice of extension must also specifically describe the required information.**		N/A
Period for Claimant to Complete Claim	You have a reasonable period of time to provide missing information (no less than 48 hours from when you are notified by the Plan that your claim is missing information).	You have at least 45 days to provide any missing information.		N/A
Other related notices	Notice that your claim is improperly filed or that information is missing must be provided by the claims administrator as soon as possible (no later than 24 hours after receipt of the claim by the claims administrator).* The notice must set forth the specific information needed to complete the claim.	Notice that your claim is improperly filed must be provided by the claims administrator as soon as possible (no later than 5 days after receipt of the claim by the claims administrator).* Notification may be oral, unless you request written notification.	N/A	N/A

	Long-Term Disability and Short-Term Disability Programs*	**Life Insurance, Business Travel Programs and Death Benefit**
Time frame for Component Program to Provide Notice of Determination	Notice of adverse benefit determination must be provided by the Plan within a reasonable period of time, but no later than 45 days.	Notice of adverse benefit determination must be provided by the Plan within a reasonable period of time, but no later than 90 days.
Extensions	The Plan has up to 30 days, if necessary due to matters beyond the Plan's control. A second 30-day extension may also be permitted. The Plan must provide the extension notice before the period(s) ends.**	The Plan has up to 90 days for special circumstances and must provide the extension notice before the period ends.
Period for Claimant to Complete Claim	You have at least 45 days to provide any missing information.	No rule.
Other Related Notices	N/A	N/A
* These rules also apply to another Component Program to the extent that a disability determination must be made by the claims adjudicator (and not a third party) in order to decide a claim. **15- or 30-day extension period (whichever is applicable) is measured from the time that the claimant responds to the notice from the Plan that the claim is missing information.		

Appealing a Claim

If you receive notice of an adverse benefit determination and disagree with the decision, you are entitled to apply for a full and fair review of the claim and the adverse benefit determination. You (or an appointed representative) can appeal and request a claim review in accordance with the time frames described in the chart below. The request must be made in writing, except for urgent care claims, which you may file orally or in writing, and should be filed with the appropriate Appeals Reviewer as listed in the applicable Benefits Booklet or Schedule B.

The review will be conducted by the Appeals Reviewer or other appropriate named fiduciary of the Component Program. In either case, for health and disability claims only, the reviewer will not be the same individual who made the initial adverse benefit determination that is the subject of the review, nor the subordinate of such individual (including any physicians involved in making the decision on appeal if medical judgment is involved). Where the adverse benefit determination (for health and disability claims only) is based in whole or in part on a medical judgment, the reviewer will consult with an appropriate health care professional. The person who conducts the appeal will not give any special weight or deference to the initial determination.

You will have the opportunity to submit written comments, documents, records, and other information relating to the claim; and you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits. Whether a document, record, or other information is relevant to the claim will be determined in accordance with the applicable DOL regulations. You also are entitled to the identification of medical or vocational experts whose advice was obtained on behalf of the Component Program in connection with your adverse benefit determination (for health and disability claims only). The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim without regard to whether such information was submitted or considered in the initial benefit determination.

The time periods for providing notice of the benefit determination on review depends on the type of claim, as provided in the following chart.

The Appeals Reviewer will provide you with written notification of the Component Program’s determination on review, within the time frames described below. For urgent care, all necessary information, including the benefit determination on review, will be transmitted between the Component Program and the claimant by telephone, fax, or other available similarly expeditious method. In the case of an adverse benefit determination, such notice will indicate:

- the specific reason for the adverse benefit determination on review;
- reference to the specific provisions of the Component Program on which the determination is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- a description of your right to bring a civil action under ERISA following an adverse benefit determination on review, except in the case of the STD Program, the HSA Bank Account, and the Dependent Care FSA, which are not ERISA plans;

- if any internal rules, guidelines, protocols, or similar criteria were used as a basis for the adverse benefit determination, either the specific rule, guideline, protocols, or other similar criteria or a statement that a copy of such information will be made available free of charge upon request (for health and disability claims only);
- for adverse benefit determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request (for health and disability claims only); and
- a description of the voluntary appeals procedure under the Component Program, if any, and your right to obtain additional information upon request about such procedures, as well as information as to how the claimant may obtain information about alternative dispute resolution options from the Department of Labor or state regulators.

In addition to the notice standards described above, to the extent required by PPACA, any notice of denial to a claimant enrolled in Component Program of the Group Health Plan will include the following:

- information identifying the claim involved, including the date of service, the health care provider, the claim amount, and a statement describing the availability, upon request, of the diagnosis and treatment codes (and the corresponding meaning of those codes);
- the reason or reasons for the adverse benefit determination that includes the denial code and its corresponding meaning and a description of the Component Program's standard, if any, that was used to deny the claim and a discussion of the decision;
- a description of available internal appeals and external review processes, including how to initiate an appeal; and
- contact information for any applicable office of health insurance consumer assistance or ombudsman established under PPACA to assist individuals with the internal claims and appeals and external review processes.

All decisions are final and binding.

Time Frames for Appeals Process

The claims appeals procedures for a specific benefit are set forth in the applicable Benefit Booklet for that benefit. Please consult the Benefit Booklet for the specific benefit involved. Where not otherwise covered by the Benefit Booklet, the following procedures will apply.

The time frame for filing an appeal starts when you receive written notice of adverse benefit determination. The time frame for providing a notice of the appeal decision (a "notice of benefit determination on review") starts when the appeal is filed in accordance with the Component Program's procedures. The notice of appeals decision may be provided through in-hand delivery, mail, or electronic delivery before the period expires. Urgent care decisions may have to be delivered by telephone, facsimile, or other available expeditious method. References to "days" mean calendar days.

The Component Program may require two levels of mandatory appeal review. For the fully-insured Component Programs, please refer to the applicable Benefit Booklet to determine if the claims and appeals procedures set forth there include a mandatory second level appeal.

The person(s) who conducts the second appeal will be different from the person(s) who made the first appeal decision and will not report directly to the person(s) who made the first appeal decision. The person who conducts the second appeal will not give any special weight or deference to the initial determination (or to the first appeal decision).

If you do not agree with the final determination on review, you have the right to bring a civil action under Section 502(a) of ERISA as described further in the “Judicial Review” section. You must exhaust your first appeal and second appeal rights before you commence any litigation, arbitration or administrative proceeding regarding an alleged failure by the Plan to pay benefits or any matter within the scope of the appeals process.

	Medical, Vision, Dental, Health Care FSA, and Limited Purpose FSA Programs			Long-Term Disability and Short-Term Disability Programs*	Life Insurance, Business Travel Programs and Dependent Care FSA
	Urgent Care Claims	**Non-Urgent "Pre- Service' Claims**	**Non-Urgent "Post-Service" Claims**		
Period for Filing Appeal	You must file within 180 days. If you wish to file a 2nd level appeal (where applicable), you must file it within 60 days from receipt of the first level appeal determination.	You must file within 180 days. If you wish to file a 2nd level appeal (where applicable), you must file it within 60 days from receipt of the first level appeal determination.	You must file within 180 days. If you wish to file a 2nd level appeal (where applicable), you must file it within 60 days from receipt of the first level appeal determination.	You must file within 180 days.	You must file within 60 days.
Time frame for Component Program to Provide Notice of Benefit Determination on Review	As soon as possible taking into account medical exigencies, but not later than 72 hours after receipt of request for review. If two levels of mandatory appeals review are required, notice must be provided within 36 hours of each appeal.	Within a reasonable period of time appropriate to medical circumstances, but not later than 30 days after receipt of request for review. If two levels of mandatory appeals review are required, notice must be provided within 15 days of each appeal.	Within a reasonable period of time appropriate to medical circumstances, but not later than 60 days after receipt of request for review. If two levels of mandatory appeals review are required, notice must be provided within 30 days of each appeal.	Within a reasonable period of time, but not later than 45 days after receipt of request for review.	Within a reasonable period of time, but not later than 60 days after receipt of request for review.
Extensions	None.	None.	None.	Additional 45 days if special circumstances require extension (with period (tolled" until you respond to any information request from the Plan).	Additional 60 days if special circumstances require extension.

* These rules also apply to another Component Program to the extent that a disability determination must be made by the claims adjudicator (and not a third party) in order to decide a claim.

An appeal of a concurrent care decision to reduce or terminate previously-approved benefits may be an urgent care, pre-service or post-service claim, depending on the facts.

Voluntary External Review

If you are enrolled in a Component Program of the Group Health Plan that is subject to PPACA and is not subject to a State external review process, and you exhaust the internal group health plan claim and appeal procedures, you will have the right to request an external (i.e., independent) review with respect to any claim that involves medical judgment or a rescission of coverage if you do so within four months after receiving notice of an adverse benefit determination or final internal adverse benefit determination. You do not have the right to an external review of an adverse benefit determination based on your ineligibility for coverage. If the Plan fails to strictly adhere to the applicable claims and appeals procedures, you will be deemed to have exhausted the internal claims and appeals procedures, and you may initiate any available external review process or remedies available under ERISA.

Within five business days after receiving your request, a preliminary review will be completed to determine whether:

- you are/were covered under the Component Program;
- the denial was based on an issue involving medical judgment (including, but not limited to, those based on a Component Program's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational, as determined by the external reviewer) or a rescission of coverage;
- you exhausted the Component Program's internal claims and appeals process, if required; and
- you provided all information necessary to process the external review.

Within one business day after completing the preliminary review, you will be notified in writing if your request is not eligible for an external review or if it is incomplete. If your request is complete but not eligible, the notice will include the reason(s) for ineligibility. If your request is not complete, the notice will describe any information needed to complete the request. You will have the remainder of the four- month filing period or 48 hours after receiving the notice, whichever is greater, to cure any defect. If eligible for an external review, your request will be assigned to an independent review organization (IRO). The IRO will provide written notice of its final external review decision within 45 days after the IRO receives the request for external review. If the IRO reverses the adverse benefit determination or final internal adverse benefit determination, then the Component Program will cover the claim.

In addition, you will have the right to an expedited external review in the following situations:

- following an adverse benefit determination involving a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; and
- following a final internal adverse benefit determination involving (i) a medical condition for which the time frame for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function or

(ii) an admission, availability of care, continued stay, or health care item or service for which you received emergency services but have not been discharged from a facility.

- The IRO will provide notice of its final external review decision as expeditiously as the claimant's medical condition or circumstances require, but not more than 72 hours after the IRO receives the request.

Judicial Review

You (or an appointed representative) must timely pursue all the claim and appeal rights described above before you may file a lawsuit under Section 502(a) of ERISA. This rule means that you may not bring any action to recover benefits under the terms of the Plan or Component Program, to enforce your rights under the terms of the Plan or Component Program, or to clarify your right to future benefits under the terms of the Plan or Component Program unless and until the applicable claim and appeal rights (including any mandatory second level appeal rights, to the extent applicable) described above have been exercised and the benefits (current or future) or rights requested in such appeal have been denied in whole or in part (or there is any other adverse benefit determination). If you wish to seek judicial review of the denial of any appeal under the Plan or Component Program, unless the documents governing a fully-insured plan provide for a different length of time, you must file a lawsuit under Section 502(a) of ERISA (to the extent applicable) within 24 months of the date on which all administrative remedies under the Plan or Component Program are fully exhausted – that is by the earlier of the date on which an adverse benefit determination on review is issued by the Appeals Reviewer (or, in the case of a Component Program subject to the voluntary external review process noted above, the IRO) or the last day on which a final decision should have been issued – or you will be forever prohibited from commencing such action. If any such judicial proceeding is undertaken, the evidence presented will be strictly limited to evidence timely presented to the Appeals Reviewer.

Under the non-ERISA plans, you are not entitled to file a lawsuit under Section 502(a) of ERISA since such plans are not employee benefit plans under ERISA. Under those plans, you are required to exhaust any administrative remedies before filing a lawsuit in connection with the denial of your appeal for benefits and any such lawsuits must be filed within the one-year period beginning on the earlier of: (i) the date the statute of limitations would commence under applicable law, or (ii) the date on which all administrative remedies under those plans are fully exhausted. If any such judicial proceeding is undertaken, the evidence presented will be strictly limited to the evidence timely presented to the Appeals Reviewer.

SECTION XI. PLAN ADMINISTRATION AND LEGAL INFORMATION

Plan Name

TIAA Health & Welfare Plan

Type of Plan

The TIAA Health & Welfare Benefits Plan is a welfare benefit plan under ERISA that provides various benefits, including group health, dental, vision, employee assistance, and health flexible spending account benefits, life insurance, long-term disability, and business travel accident and medical benefits.

Plan Number

The number assigned to the TIAA Health & Welfare Benefits Plan for governmental filing purposes is 501.

Plan Sponsor

The Plan sponsor and principal employer for the Plan is:

TIAA
730 Third Avenue
New York, New York 10017
(212) 916 4000

Employer Identification Number

The Internal Revenue Service has assigned the Employer Identification Number (EIN) 13-1624203 to the Company. If you need to correspond with a government agency about the Plan, use this number along with the applicable plan name and the Company's name.

Plan Year

The Plan year for each of the Plans is January 1 – December 31.

Plan Administrator

The Plan Administrator for the Plan is responsible for the general administration of the Plans, and will be the fiduciary to the extent not otherwise specified in this document or Benefit Booklet for a Component Program. The Plan Administrator has full discretionary authority to interpret provisions of the Plans, construe terms, determine the rights or eligibility of employees and any other others, and the amounts of their benefits under the Plan, and to remedy ambiguities, inconsistencies or omissions, and otherwise make all decisions and determinations regarding administration of the Plans. The Plan Administrator may make an adjustment on account of a mistake as it considers equitable and practicable, in light of applicable law. By participating in the Plans, you accept the Plan Administrator's authority.

The Plan Administrator for the Plan is:

Senior Vice President, Total Rewards
TIAA

730 Third Avenue
New York, NY 10017

Except as noted below, the Plan Administrator has responsibility for the interpretation and construction of the Plans and final authority with respect to operation and administration of the Plans, including the day-to-day responsibility for its operation and administration. The Plan Administrator has the power and the duty to take all actions and to make all decisions necessary or proper to carry out his or her responsibilities, powers, and duties under the Plan. All determinations of the Plan Administrator as to any question involving his or her responsibilities, powers, and duties under the Plans, including, without limitation, interpretation of the Plan, or as to any discretionary actions to be taken under the Plan, is solely at the discretion of the Plan Administrator and shall be final, conclusive and binding on all persons claiming to have any right or interest in or under the Plan.

In addition to any implied powers and duties, the specific powers and duties of the Plan Administrator include the power and duty to:

- make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan;
- construe and interpret the terms and provisions of the Plan and all documents, which relate to the Plans, and to decide any and all matters arising under the Plan, including the right to remedy possible ambiguities, inconsistencies, or omissions;
- determine the eligibility for benefits under the Plan, by investigation and review of the facts or otherwise; and
- investigate and make factual or other determinations with regard to any matter related to the Plan.

The Plan Administrator, unless otherwise provided, may delegate duties and responsibilities as it deems appropriate to facilitate the day-to-day administration of the Plan, as well as the right to interpret the terms and conditions of the Plans and to decide administrative and operational issues, including questions pertaining to eligibility for and the amount of benefits to be paid by the respective Plan, and, unless the Plan Administrator expressly provides to the contrary, any such delegation will carry with it the Plan Administrator’s full discretionary authority to accomplish the delegation.

Power and Authority of the Insurance Company

Certain Component Programs under the Plan are fully-insured. Benefits may be provided under a group insurance contract entered into between the Company and an insurance company. With respect to fully- insured benefits, claims for benefits are sent to the insurance company. The insurance company is the fiduciary with respect to these claims and has exclusive responsibility for paying claims, not the Company.

The insurance company is also responsible for:

- determining eligibility for and the amount of any benefits payable under the Plan;
- prescribing claims procedures to be followed and the claim forms to be used by employees and beneficiaries pursuant to the Plan; and

- acting as the Claims Administrator and Appeals Reviewer with respect to the Component Program it insures.

The insurance company also has the authority to require employees and beneficiaries to furnish it with such information as it determines is necessary for the proper administration of the applicable Component Program.

Agent for Service of Legal Process

The agent for service of legal process for the Plan:

TIAA
Office of the General Counsel
730 Third Avenue
New York, New York 10017

Legal process may also be served upon the Plan Administrator.

For information on funding, type of administration and source of contributions for the Component Programs, please see the applicable Benefits Booklet and/or Schedule B.

Claims Administrator and Appeals Reviewer

With respect to a claim for benefits under the Plan, each Claims Administrator, and with respect to an appeal of a denied claim for benefits under the Plan, each Appeals Reviewer (if different than the Claims Administrator), has responsibility for deciding claims and appeals, as the case may be. The Benefits Booklet and/or Schedule B identifies the Claims Administrator and Appeals Reviewer for each of the Component Programs. To carry out its responsibility, each Claims Administrator and Appeals Reviewer has the exclusive authority, in its sole and absolute discretion, to:

- construe and interpret the terms and provisions of the Component Program for which it has responsibility and all documents which relate to such plan and to decide any and all matters arising under the Component Program, including the right to remedy possible ambiguities, inconsistencies, or omissions;
- determine the eligibility for benefits under that Component Program, by investigation and review of the facts or otherwise; and
- investigate and make factual or other determinations with regard to any matter related to the Component Program.

All determinations of the Claims Administrator (if the Claimant does not appeal the decision of the Claims Administrator) and the Appeals Reviewer (if the Claimant does appeal) as to any question involving its responsibilities, powers and duties under the Plans, including, without limitation, interpretation of the Plans, or as to any discretionary actions to be taken under the Plan, are solely at the discretion of the Claims Administrator and Appeals Reviewer and are final, conclusive and binding on all persons claiming to have any right or interest in or under the Plan.

Unless otherwise specified in a Benefits Booklet or Schedule B, the Claims Administrator shall also act as the Appeals Reviewer.

SECTION XII. ERISA RIGHTS

Your Rights Under ERISA

As a participant in one or more Component Programs, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). The HSA Bank Account and Dependent Care FSA are not employee benefit plans under ERISA. Therefore, this section of the Plan does not apply to the HSA Bank Account and Dependent Care FSA.

ERISA provides that all participants under the ERISA Programs are entitled to the following:

- Review Information About Your Programs and Benefits;
- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Programs, 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 Employee Benefits Security Administration. These documents are available upon written request to the Plan Administrator;
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, copies of the latest annual report (Form 5500 Series) and an updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies; and
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual report.

Continue Group Health Plan Coverage

With respect to the Component Programs to which COBRA and HIPAA applies:

- Continue health care coverage for yourself, your spouse or dependents if there is a loss of coverage under the Plans as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the Continuation of Coverage section of this Administrative Information Document and the documents governing the plan for the rules governing your COBRA continuation coverage rights; and

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plans, called "fiduciaries" of the Plans, have a duty to do so prudently and in the interest of you and other participants and beneficiaries of the Plans. 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 benefit of the Plan or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit under a Component Program is denied in whole or in part, you must receive a written explanation of the reason for the denial and have a right to obtain without

charge copies of documents relating to the decision. You also have the right to have the applicable Component Program review and reconsider your claim, as described in the “Claims Review and Appeal Process” section.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plans and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. After exhausting your appeal rights, you may file suit in a state or federal court if you have a claim for benefits that is denied or ignored, in whole or in part, subject to the time limit described in the “Judicial Review” section. After exhausting your appeal rights, you may file suit in federal court if you disagree with the Plans’ decision or lack thereof concerning the qualified status of a medical child support order, subject to the time limit described in the “Judicial Review” section. If it should happen that Plan fiduciaries misuse the Plans’ money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about these Plans, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
US. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans by visiting U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) website at **www.dol.gov/ebsa** or call their toll-free number at [phone number]. For more information about the health insurance options available through a Health Insurance Marketplace, visit **www.health-care.gov**.

If you have any specific questions about any of the Programs discussed in this summary plan description, contact Your Benefits Center at 844-4-TIAAHR (844-484-2247).

Further assistance may be obtained by writing to the Plan Administrator.

SECTION XIII. MISCELLANEOUS

Limitations on Rights

Participation in the Plan does not give you the right to remain employed by the Company and its business units and subsidiaries. Also, you may not sell, transfer, or assign either voluntarily or involuntarily the value of your benefit under any Component Program, except as provided with respect to any life insurance benefits that may be assignable or as otherwise described below, and any attempt to cause such right to do so will not be recognized, except to such extent as may be required by law.

Benefits payable to you or a dependent (“covered person”) and any rights associated with those benefits or the covered person’s participation in the other Component Program cannot be assigned, sold, alienated or otherwise transferred to any other person or entity.

The plan administrator may, in its sole and exclusive discretion, pursuant to a written election or purported assignment by a covered person, remit payment directly to a provider who has rendered services to the covered person under the Component Program. Any such payment to a provider is provided solely as a convenience to the covered person and does not constitute an enforceable assignment of any benefit or rights associated with any benefit. Therefore, such a payment does not authorize the medical provider to exercise any rights that the covered person may have with respect to that benefit determination, including, but not limited to, the covered person’s rights to request documents, initiate an appeal or file suit.

Plan Amendment or Termination

While the Company intends to continue the Plan, the Company has the right, with or without advance notice (to the extent permitted by law), in an individual case or generally, to amend or terminate all or any part of the Plan at any time and for any reason, at its discretion. The Company has delegated the right to amend (but not terminate) the Plan to the TIAA Compensation & Benefits Committee. Any such action would be taken in writing and maintained with the records of the plan. Plan amendment, modification, suspension or termination may be made for any reason, and at any time, and may, in certain circumstances, result in the reduction of or elimination of benefits or other features of the plan to the extent permitted by law.

The Company’s rights include the right to obtain coverage and/or administrative services from additional or different insurance carriers, HMOs, third-party administrators, etc., at any time, and the right to revise the amount of employee contributions.

Subrogation and Reimbursement

When you or your covered dependents are injured or become ill because of the actions or inactions of a third party, a Component Program may cover your eligible Group Health Plan (medical, dental, and vision) expenses. However, to receive coverage, you must notify the Component Program that your illness or injury was caused by a third party, and you must follow special rules. This section describes the Group Health Plan’s procedures with respect to subrogation and right of recovery.

Subrogation means that if an injury or illness is someone else’s fault, the Component Program has the right to seek expenses it pays for that illness or injury directly from the at-fault party or

any of the sources of payment listed later in this section. A right of recovery means the Component Program has the right to recover such expenses indirectly out of any payment made to you by the at-fault party or any other party related to the illness or injury.

By accepting benefits from a Component Program to pay for treatments, devices, or other products or services related to such illness or injury, you agree that the Component Program:

- has an equitable lien on any and all monies paid (or payable to) you or for your benefit by any responsible party or other recovery to the extent the Component Program paid benefits for such sickness or injury;
- may appoint you as constructive trustee for any and all monies paid (or payable to) you or for your benefit by any responsible party or other recovery to the extent the Component Program paid benefits for such sickness or injury; and
- may bring an action on its own behalf or on the covered person's behalf against any responsible party or third party involved in the sickness or injury.

If you (or your attorney or other representative) receive any payment from the sources listed later in this section – through a judgment, settlement, or otherwise – when an illness or injury is a result of a third party, you agree to place the funds in a separate, identifiable account and that the Component Program has an equitable lien on the funds, and/or you agree to serve as a constructive trustee over the funds to the extent that the Component Program has paid expenses related to that illness or injury. This means that you will be deemed to be in control of the funds.

You must pay the Component Program back first, in full, out of such funds for any health care expenses the Component Program has paid related to such illness or injury. You must pay the Component Program back up to the full amount of the compensation you receive from the responsible party, regardless of whether your settlement or judgment says that the money you receive (all or part of it) is for health care expenses.

Furthermore, you must pay the Component Program back regardless of whether the third party admits liability and regardless of whether you have been made whole or fully compensated for, or have received double recovery in connection with, your injury. If any money is left over, you may keep it.

Additionally, the Component Program is not required to participate in, contribute to, or reduce its recovery by, any expenses or fees (including attorneys' fees and costs) you incur in obtaining the funds.

The Component Program's sources of payment through subrogation or recovery include (but are not limited to) the following:

- money from a third party that you, your guardian, or other representatives receive or are entitled to receive;
- any constructive or other trust that is imposed on the proceeds of any settlement, verdict or other amount that you, your guardian, or other representatives receive;
- any equitable lien on the portion of the total recovery, which is due the Component Program for benefits it paid; and

- any liability or other insurance (for example, uninsured motorist, underinsured motorist, medical payments, workers' compensation, no-fault, school, homeowners, or excess or umbrella coverage) that is paid or payable to you, your guardian or other representatives.

As a Component Program participant, you are required to:

- cooperate with the Component Program's efforts to ensure a successful subrogation or recovery claim, including setting funds aside in a particular account. This also includes doing nothing to prejudice the Component Program's subrogation or recovery rights outlined in this Summary Plan Description;
- notify the Component Program within 30 days of the date any notice is given by any party, including an attorney, of your intent to pursue or investigate a claim to recover damages or obtain compensation due to sustained injuries or illness; and
- provide all information requested by the Component Program, the Claims Administrator or its representatives, or the Plan Administrator or his or her representatives.

The Component Program may require you to sign an agreement acknowledging and agreeing to the Component Program's subrogation rights prior to receiving additional Component Program benefits at any time. However, the rules of this section apply even if you do not sign such an agreement.

The Component Program may terminate your Component Program participation and/or offset your future benefits in the event that you fail to provide the information, authorizations, or to otherwise cooperate in a manner that the Component Program considers necessary to exercise its rights or privileges under the Component Program.

If the subrogation provisions in these "Subrogation and Reimbursement" provisions conflict with subrogation provisions in the Benefit Booklet for the applicable Component Program or an insurance contract governing these benefits, the subrogation provisions in that document will govern.

Recovery Provisions

Right of the Plans to Recover Improperly Paid Benefits

Each Component Program has the right to recover an amount paid by it in error. For example, if you receive benefits for a service under a Component Program in error, or you receive benefits from a Component Program and from another plan for the same service, the Component Program and the applicable Claims Administrator (identified in the applicable Benefits Booklet or Schedule B) have the right to recover the amount paid to you in error or paid to you by the other plan. You are not permitted to receive total benefits above the cost of the service provided.

The same is true if payment is made in excess of the amount that should have been paid under the Component Program.

If the right of recovery provisions in the "Subrogation and Reimbursement" provisions conflict with these "Recovery Provisions" in the Benefit Booklet for the applicable Component Program or an insurance contract governing benefits at issue, the recovery provisions in that document will govern.

Refund of Overpayments

If benefits are paid under a Component Program for expenses incurred, you or any other person or organization that received such payment must refund the overpayment to the applicable Component Program if:

- all or some of the expenses incurred were not paid by you or did not legally have to be paid by you, including for example, but not limited to, expenses incurred as a result of fraud; or
- all or some of the payment made under the applicable Component Program(s) exceeded the benefits available under the applicable Component Program(s).

The overpayment equals the amount of benefits paid in excess of the amount that should have been paid under the Component Program.

If the refund is due from another person or organization, then you agree to assist the Company in obtaining the refund when requested.

If you, or any other person or organization that was paid, do not promptly refund the full amount, the amount owed may be deducted from any future claim reimbursements. The reductions will equal the amount of the required refund. The Component Plan may also sue to recover such amounts or use any other lawful remedy to recoup any such amounts.

No Guarantee of Tax Consequences

The Company does not make any commitment or guarantee that any amounts paid to you or for the benefit of you will be excludable from your gross income for federal or state income employment tax purposes, or that any other federal or state tax treatment will apply to or be available to any participant. It is your obligation to determine whether each payment under one or more of the Component Programs is excludable from your gross income for federal and state income and employment tax purposes, and to notify the Company if you have reason to believe that any such payment is not so excludable.

Severability

If any provision of this Administrative Information Document is held invalid, unenforceable or inconsistent with any law, regulation or requirement, its invalidity, unenforceability, or inconsistency will not affect any other provision of this Administrative Information Document, and the Administrative Information Document shall be construed and enforced as if such provision were not a part of the Administrative Information Document.

Applicable Law

The Plans shall be construed, administered and enforced according to the laws of the state of New York to the extent not preempted by any federal law.

No Vested Interest

Except for the right to receive any benefit payable under the Plans in regard to a previously incurred claim, no person shall have any right, title, or interest in or to the assets of any Participating Employer.

Employer Records

The records of the Participating Employers with respect to any person's employment, employment history, absences, illnesses, and all other relevant matters are conclusive for plan administration purposes.

SCHEDULE A – LIST OF PARTICIPATING EMPLOYERS

As of January 1, 2021, unless otherwise noted, the following are Participating Employers:

- Nuveen Services, LLC
- TIAA, FSB and its subsidiaries

Notwithstanding anything in this document to the contrary, with the written consent of the Senior Vice President, Total Rewards of the Company, any other corporation or entity that is an affiliate or subsidiary may adopt this Plan and become a Participating Employer, by a properly executed document evidencing said intent and will of such Participating Employer.

SCHEDULE B – ADMINISTRATIVE INFORMATION SUMMARY FOR EACH COMPONENT PROGRAM THAT DOES NOT HAVE A STANDALONE SPD

SCHEDULE B-1 – Medical Program: Kaiser-Colorado HMO

Component Programs:	Kaiser-Colorado HMO
Type of Benefits:	Major medical and mental health and substance use disorder
Insured by:	Kaiser Foundation Health Plan of Colorado 2500 S. Havana Street Aurora, Co. 80014-1622
Medical Claims & Appeals Administered by:	The insurance company administers claims for medical benefits and is solely responsible for providing benefits.
COBRA Administered by:	Your Benefits Center P.O. Box 5255 Cherry Hill, NJ 08034-5255 844-484-2247, option 4, then option 1
Sources of Contributions:	The cost of benefits is shared by you and your Participating Employer.

Prescription drug benefits are administered by CVS Caremark and described in a separate standalone SPD.

CVS Caremark
1 CVS Drive
Woonsocket, RI 02895
866-251-9383

SCHEDULE B-2 – LTD Program

Component Programs:	Long-Term Disability Benefits
Type of Benefits:	Long-Term disability benefits
Insured by:	Metropolitan Life Insurance Company 200 Park Avenue, New York, New York 10166
Administered by:	The insurance company administers claims for benefits and is solely responsible for providing benefits.
Sources of Contributions:	The cost of benefits is paid entirely by you and your Participating Employer.

SCHEDULE B-3 –Grandfathered LTD Program

Component Programs:	Grandfathered LTD Program
Type of Benefits:	Long-term disability benefits
Insured by:	Metropolitan Life Insurance Company 200 Park Avenue New York, New York 10166
Administered by:	The insurance company administers claims for benefits and is solely responsible for providing benefits.
COBRA Administered by:	Not Applicable
Sources of Contributions:	Your Participating Employer pays the entire cost.

SCHEDULE B-4 –Life Insurance Program

Component Programs:	Life Insurance Program
Type of Benefits:	Basic and supplemental life insurance and accidental death and dismemberment benefits
Insured by:	Metropolitan Life Insurance Company 200 Park Avenue New York, New York 10166
Administered by:	The insurance company administers claims for benefits and is solely responsible for providing benefits.
Sources of Contributions:	Your Participating Employer pays the entire cost of basic life insurance benefits. The cost of the other benefits is paid by you.

SCHEDULE B-5 –Retiree Life Insurance Program

Component Programs:	Retiree Life Insurance Program
Type of Benefits:	Basic life insurance
Insured by:	Metropolitan Life Insurance Company 200 Park Avenue New York, New York 10166
Administered by:	The insurance company administers claims for benefits and is solely responsible for providing benefits.
Sources of Contributions:	Your Participating Employer pays the entire cost of the retiree life insurance benefits.

SCHEDULE B-6 – Business Travel Program

Component Programs:	Business Travel Program
Type of Benefits:	Business travel accident benefits
Insured by:	Cigna Life Insurance Company of New York 140 East 45th Street New York, NY 10017
Administered by:	The insurance company administers claims for benefits and is solely responsible for providing benefits.
Sources of Contributions:	The cost of benefits is paid entirely by your Participating Employer.

SCHEDULE B-7 –Business Travel Medical Program

Component Programs:	Business Travel Medical Program
Type of Benefits:	Business travel medical plan that provides medical coverage for urgent and emergency benefits for employees who are traveling outside of their home country for work on a short-term basis (less than 180 consecutive days, and 270 days in total per year).
Insured by:	Aetna
Administered by:	The insurance company administers claims for benefits and is solely responsible for providing benefits.
Sources of Contributions:	Your Participating Employer pays the entire cost of basic life insurance benefits.

SCHEDULE B-8 –Death Benefit for Active Employees

Component Programs:	Death Benefit for Active Employees
Type of Benefits:	Death Benefit: Beginning on April 1, 2020, the Company pays 1/4 of an employee's base salary to the estate of a deceased employee if the employee dies while an active employee.*
Insured by:	Self-funded benefit
Administered by:	TIAA
Sources of Contributions:	Your Participating Employer pays the entire cost of the death benefit.

*This benefit is not paid to employees receiving payments pursuant to the Company's long-term disability program.

LEGAL NOTICES

Women's Health and Cancer Rights Act (WHCRA)

The Women's Health and Cancer Rights Act of 1998 (WHCRA) provides protections for individuals who elect breast reconstruction after a mastectomy. For individuals receiving mastectomy-related benefits under the Medical Program, coverage will be provided in a manner determined in consultation with the individual's attending physician and the patient 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
- Prostheses, and
- Treatment of physical complications resulting from the mastectomy (including lymphedemas).

These mastectomy-related benefits are subject to deductibles and coinsurance limitations that are consistent with those applicable to other medical and surgical benefits under your medical option.

Newborns' and Mothers' Health Protection Act (NMHPA)

Under federal law, group health plans and health insurance issuers cannot restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to:

- Less than 48 hours following a normal vaginal delivery, or
- Less than 96 hours following a cesarean section.

However, the attending provider (who may be a physician or a nurse midwife) may decide, after consulting with the mother, to discharge the mother or newborn child earlier.

In addition, the plan or issuer may not require a provider to obtain authorization from your medical option for a length of stay that is within these time periods.

Uniformed Service Employment and Re-employment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) guarantees certain rights to eligible employees who enter military service. The terms "Uniformed Services" or "Military Service" mean the Armed Forces (that is, Army, Navy, Air Force, Marine Corps, Coast Guard), the reserve components of the Armed Services, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

Upon reinstatement, you are entitled to the seniority, rights and benefits associated with the position held at the time employment was interrupted, plus any additional seniority, rights and benefits that you would have attained if employment had not been interrupted.

If your military leave is for less than 31 days, you may continue your group health plan coverage by paying the same amount charged to active employees for the same coverage. If your leave is for a longer period of time, you may be charged up to the full cost of coverage plus a 2% administrative fee.

The maximum period of group health plan continuation coverage available to you and your eligible dependents is the lesser of (a) 24 months after the leave begins or (b) the period running from the day the leave begins through the day the leave ends.

When you go on military leave, your work hours are reduced. As a result, you and your covered dependents may become eligible for COBRA. Any COBRA continuation period for which you are eligible will run concurrently with any USERRA continuation period for which you are eligible.

If you choose not to continue your medical coverage while on military leave, under USERRA, you are entitled to reinstated medical coverage with no waiting periods or exclusions when you return from leave.

In general, to be eligible for the rights guaranteed by USERRA, you must:

- Return to work on the first full, regularly scheduled workday following your leave, safe transport home, and an eight-hour rest period, if you are on a military leave of less than 31 days
- Return to or reapply for employment within 14 days of completion of such period of duty, if your absence from employment is from 31 to 180 days
- Return to or reapply for employment within 90 days of completion of your period of duty, if your military service lasts more than 180 days.

Family and Medical Leave Act (FMLA)

Under the federal Family and Medical Leave Act (FMLA), if you meet eligibility and service requirements, you are entitled to take up to 12 weeks of unpaid leave for certain family and medical situations and continue your elected medical coverage benefits during this time.

For a copy of TIAA's FMLA policy, go to ***Your Benefits Center*** at www.lifeatworkportal.com/TIAA.html. Locate and click on the *Benefits Guide* and then the "Legal Notices" tab, and then "Family and Medical Leave Act (FMLA)." You can also call ***Your Benefits Center*** at **844-4-TIAAHR (844-484-2247)**, option 8, and request that a copy be sent to you.

HIPAA Privacy Rights

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the group health plans' privacy notice. You can obtain a copy of the HIPAA Privacy Notice by calling ***Your Benefits Center*** at **844-4-TIAAHR (844-484-2247)**.