available under the plan. In retirement, participants can use their accounts to pay for health insurance premiums and qualified out-of-pocket medical expenses on a tax-free basis (subject to eligibility) and may elect to participate in the retiree insurance coverage offered under the plan (subject to eligibility).

After an extensive review process, Emeriti selected TIAA-CREF to provide recordkeeping, trust and investment management services, Aetna to provide health insurance options, HealthPartners to provide health insurance options in Minnesota, and Savitz, a third-party administrator, to provide premium payment and claims administration services to the Emeriti Program.

If you ever have any questions about the Emeriti Program or your employer's Emeriti Retiree Health Plan, please call 1-866-EMERITI (1-866-363-7484). You will also find additional information on the Emeriti website: www.emeritihealth.org.

The terms of the Emeriti Health Insurance Plan Options (including covered services and other conditions of coverage) are described in the Coverage Documents for your state, which are separate documents incorporated by reference in this SPD. You may obtain a copy of the Coverage Documents by calling the number shown on your health insurance Identification Card. You can also find information about the Health Insurance Plan Options on the Emeriti website, www.emeritihealth.org.

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

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Most of the terms used in this SPD are self-explanatory or are explained when they first appear. For further explanation of most of these terms, you may also refer to the Plan document.

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

Who Qualifies As My Dependent Child?

A Dependent Child is any child of the Participant who is age 26 or younger. An individual satisfying this age requirement will be considered your child if he or she is your natural child, adopted child, stepchild, or a child placed for adoption by you, or if you are the individual's permanent legal guardian or permanent custodian.

Children of a Domestic Partner: An individual who satisfies the age requirement (age 26 or younger will be considered your Dependent Child under the Plan if he or she is the natural child, adopted child, stepchild, or a child placed for adoption by your Domestic Partner, provided that you may claim the child as a dependent for federal income tax purposes, or would have been able to do so, but for the childtsavxc (e) Tjdej0 Tcuc (l) Tjdc (o) Tj-0.036 Tc (m) Tj0 (h) Tjnt
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A Dependent Relative is any of the following individuals, *provided you may claim the person as a dependent for federal income tax purposes*. Specifically, such person must receive over 50% of his or her financial support from you and be one of the following:

- your child (other than a Dependent Child) or a descendent of your child;
- your sibling or stepsibling;
- your parent, or an ancestor of your parent;
- your stepparent;
- your aunt, uncle, niece, or nephew;
- your son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law; and
- any other individual to whom you are related who for the calendar year uses your home as his or her principal place of abode and is a member of your household.

The rules for Dependent Relatives differ from those for Spouses, Domestic Partners and Dependent Children:

- Dependent Relatives are eligible only for the Emeriti Reimbursement Benefit (i.e., the reimbursement of Qualified Medical Expenses from the Participant's Accounts). They are not eligible for Health Insurance Coverage.
- If an individual is your designated Dependent Relative on the date you die, he or she will remain a Dependent Relative so long as any amount remains in your Account(s).
- Dependent Relative status cannot be established after you die.

If you are an Eligible Employee (*defined in the previous section*), an Employer-Contribution Account will be established to record contributions made by your Employer on your behalf to the trust established for this purpose.

When Does My Employer Begin Making Employer Contributions?

Once you have attained age 40, your Employer will begin making Employer Contributions to your Account. 072 Tc (n) Tj0.p. Tj0.048 I436 Tc (A) Tj0 Tc (cc) 904 Tc (

e01744 0024 Tc 0.5084 0.24 Tc (f) Tj 94.048 Tc (i) Tj 37.080 0.24 Tc (F) 0.144 Tc (a) 0.864 Tc (s) 0.864 Tc 1.2504 0.24 Tc (i) Tj 0.0480 Tc T-0

How Long Will My Employer Make Employer Contributions?

Your Employer will cease making Employer Contributions to your Employer-Contribution Account on the earlier of:

- the date when the Employer has made Employer Contributions to your Employer-Contribution Account for 25 calendar years; or
- the date you cease to be employed by the Employer; or
- the date you die.

How Is the Amount of the Employer Contribution Determined?

Your Employer will determine the amount of its contributions for each payroll period using the formula described in Appendix C of this SPD. The Plan Sponsor can change this formula at any time.

What If I Am Already Over the Age that Employer Contributions Begin When the Plan Commences?

On the Plan's Effective Date if you are already over the age when Employer Contributions begin, then your Employer may make a special transition Employer Contribution on your behalf in addition to its contributions each payroll period. The terms of this transitional funding, including its effect on any future Employer Contributions, will be communicated to you separately by your Employer.

If you are an Eligible Employee, you may make voluntary contributions to the Plan on an after-tax basis. An Employee After-Tax Contribution Account will be established to record contributions you make to the trust established for this purpose.

What Should I Consider in Deciding Whether to Make Employee After-Tax Contributions and the Amount to Contribute?

You should consider a number of factors in deciding whether to make Employee After-Tax Contributions and the amount of any contributions. Some of the factors are particular to you and some relate to the Plan. You should consider your individual situation, including, for example, your health and the health of your eligible dependents who might be covered, your options for access to other health insurance and medical reimbursements in retirement, your alternatives for the payment of retiree medical expenses, your sources and the amount of your anticipated retirement income, your overall financial situation, and the amount of Employer Contributions that might be made on your behalf.

Finally, you should consider what an appropriate amount of contributions would be, given your anticipated cost of retiree health care and the range of investment gain or loss experienced on the contributions while they remain invested in the Plan. Although you do not want to save too little, you should be careful not to contribute too much taking into account your anticipated costs. For most people, the latter situation (accumulating too much in your Emeriti Health Accounts) is unlikely. However, if the amount in your Employee After-Tax Contribution Account is not fully expended for medical purposes (Qualified Medical Expenses and insurance premiums) during your lifetime and the lifetimes of your eligible dependents, the remaining amount will be forfeited back to the Plan, in which case the assets are redistributed among current Participan26c (P) Tj-0048 Tc (onp0.024 Tc ( ) Tj.0

section PLAN ADMINISTRATION (*Is The Plan Subject to Change?*) and the section AMENDMENT, TERMINATION, AND WITHDRAWAL.

When Can I Begin Making Employee After-Tax Contributions?

Your Employer will notify TIAA-CREF to establish an Employee After-Tax Contribution Account in your name when you become an Eligible Employee. You will then receive an enrollment "Welcome Letter" from TIAA-CREF and may

Is the Amount of My Employee After-Tax Contributions Limited?

There currently are no limits on the amount of Employee After-Tax Contributions that Participants may make, but limitations may be imposed at any time on the amount of Employee After-Tax Contributions that Participants may make if such limitations are necessary to comply with any Internal Revenue Code requirements.

Can I Get My Employee After-Tax Contributions Back?

Under Federal law, once you have made an Employee After-Tax Contribution, you can never receive that contribution or any earnings on it back in cash. The only distributions that you can receive are in the form of premium payments for the Emeriti Health Insurance Plan Options and reimbursements for Qualified Medical Ex048 Tc (o) Tj-00.024 Tc (l) Tj0.024 Tc () Tj-0.096 Tc (Q) Tj0.048 Tc (ua) Tj-0. Tj-0.Tc (M)

The amounts held in your Emeriti Health Accounts (your Employee After-Tax Contribution Account and Employer-Contribution Account) are invested in one or more Mutual Funds available through TIAA-CREF. These Mutual Funds are listed in Appendix D – Investm

Does Emeriti Provide Investment Advice or Assist Me In Making Investment Decisions?

Emeriti does not provide personalized investment advice to individual Participants regarding their particular investment choices. It is your responsibility to select and monitor your investments to make sure they continue to be appropriate taking into consideration your unique financial circumstances, risk tolerance, remaining years until retirement, and other factors you may consider relevant – and taking into consideration the investment performance of the investment options over time. Emeriti suggests that you reexamine your investment strategy at least annually or when your circumstances change. You should consult with your personal investment, tax or other financial adviser regarding your particular situation.

How Are Transactions in the Mutual Fund Priced?

Shares of the Mutual Funds are bought at the next Net Asset Value ("NAV") calculated for the Mutual Fund after the contribution is received by TIAA-CREF. Exchanges, transfers and sales will be executed at the next NAV calculated after the exchange, transfer or sale is received by TIAA-CREF. Transactions confirmed after the close of the market, normally 4 p.m. Eastern time, or on weekends or holidays, will receive the next available NAV. The NAV is usually calculated at the close of the market each business day. Please refer to Mutual Fund prospectuses for additional information.

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before that time by calling 1-866-EMERITI (1-866-363-7484, select option #3) or by logging on to www.tiaa-cref.org. You will receive Supplements, Updates, Semi-Annual and Annual Reports, and Proxy Statements from TIAA-CREF for so long as you maintain an allocation in that fund. You can vote the proxies. You will also have access to a website where current versions of some of these documents are available at any time. You can also request current copies of these documents by calling 1-866-EMERITI (1-866-363-7484, select option #3) or by logging on to www.tiaa-cref.org.

How Are My Accounts Invested If I Die?

If you die and a balance remains in your Accounts (after application of the Plan's forfeiture rules), then your Spouse (or Domestic Partner) directs the investment of your Account(s). If you die with no surviving Spouse (or Domestic Partner), or if your Spouse (or Domestic Partner) later dies, and one or both otner) t tr) ear.144 Tc (w) Tj-0

Are Fees Charged to My Accounts?

Yes. The Plan permits the reasonable costs of administering the Plan to be charged against Plan assets, including your Accounts. If your Account balances reach zero dollars ($0) and you continue in Emeriti insurance coverage, you will be required to pay administrative fees (as well as your insurance premiums) by ACH Transfer in order to continue participation in the Plan.

What Fees Are Charged by Emeriti?

The fee charged by Emeriti for its services to the Plan is $5 per month for each Participant. Your Employer has agreed to pay the entire portion of this fee while you are employed and when you retire having satisfied the retirement criteria for SMU.

What Fees Are Charged by TIAA-CREF?

TIAA-CREF provides investment management, trust, administration and record-keeping services to the Plan, including the record-keeping of your Accounts, and it carries out other ministerial functions essential to the operation of the Plan.

TIAA-CREF charges a monthly fee of $0.67 (if you are an active employee or if you are a retiree) for its trust administration and record-keeping services. This fee is paid for by your employer while you are employed and when you retire having satisfied the retirement criteria for SMU. This fee ceases when you have no balance in your Accounts.

TIAA-CREF also earns investment management and related fees associated with the Investment Funds. These fees, which differ from fund to fund, are reflected in the total return of the Investment Funds that you select and are detailed in the prospectus for each Investment Fund.

What Fees are Charged by Savitz?

Savitz performs both insurance premium administration and processes claims for the reimbursement of Qualified Medical Expenses.. For these services, as well as Savitz's Call Center and website support, each retiree and terminated participant is charged $6.00 per month. Savitz charges $1 per month to each participant while he or she is employed to compensate it for its administrative services, including the maintenance of its Call Center and website. Your employer has agreed to pay this fee while you are employed and when you retire having satisfied the retirement criteria for SMU.

The only payments to Aetna are the monthly premiums paid from your Accounts for initial and continuing enrollment in the Emeriti Health Insurance Plan Options. If your Accounts are exhausted and you participate in the insurance, you must pay your portion of the premium by ACH Transfer.

What Fees Are Charged by My Employer?

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

Once you satisfy your Plan's eligibility criteria, you are eligible to use your Emeriti Health Account balances to be reimbursed for Qualified Medical Expenses. (You also may be eligible to enroll in Emeriti Health Insurance coverage once you satisfy the Plan's Retirement Eligibility rules. Please see the section "THE EMERITI INSURANCE BENEFIT: RETIREE HEALTH INSURANCE COVERAGE.") In many cases, Participants become eligible for the reimbursement of Qualified Medical Expenses prior to becoming eligible to enroll in the Emeriti insurance.

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Can I Access All My Accounts?

You cannot obtain reimbursement for QMEs prior to the eligibility date described above.

When Does the Right to Reimbursement of Qualified Medical Expenses Cease?

The reimbursements will cease when the balance of both your Accounts reaches $0.

Also, the reimbursements will cease, even if a balance remains, if there is no one to submit the claim and no remaining, eligible dependents. If you and your eligible dependents die, or if a child ceases to satisfy the Dependent Child definition, (-usually by becoming too old), the remaining Account balances are forfeited to the Plan.

What Happens if I Die?

If any balance remains in your Accounts when you die, your surviving Spouse, Dependent Children (until they cease to be Dependent Children), and Dependent Relatives may use the balance remaining in your Employee After-Tax Contribution Account for the reimbursement of Qualified Medical Expenses they incur and the payment of premiums for any Emeriti Health Insurance Plan Option under which they may be covered, subject to their eligibility for the health insurance.

If any balance remains in your Accounts when you and your Spouse (or Domestic Partner) have died, your Dependent Children have died (or ceased to be Dependent Children), and your Dependent Relatives have died, then the remaining balance will be forfeited to the Plan. Any amounts forfeited to the Plan and attributable to your Employee After-Tax Contribution Account will be reallocated to the Employee After-Tax Contribution Accounts of other Participants who have a positive Account balance in your Plan. If any balance remains in your Employer-Contribution Account, it will be forfeited to the Plan and will be kept in the Plan for Plan purposes defined by the Plan Sponsor, within the limitations imposed under ERISA.

Can I Transfer My Benefits to Someone Else?

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

Children (or have died), and when your designated Dependent Relatives have died, then the entire balance of your Employer-Contribution Account will be forfeited back to the Plan and will be kept in the Plan for Plan purposes defined by the Plan Sponsor.

There are two exceptions where this forfeiture provision will not apply: (1) terminal illness or injury situations; and (2) catastrophic expense situations. Each is described below. Each is also subject to limitations if you participate in a health savings account ("HSA") or health flexible spending account ("FSA"). See, "What if I Participate in an HSA or FSA?"

What is the Exception for Terminal Illness or Injury?

If you cease to be employed by your employer and you meet the criteria relating to terminal illness while employed or within twelve (12) months of termination of employment, your Employer Contribution Account will not be forfeited and you can be reimbursed from your Accounts for the Qualified Medical Expenses of a terminally ill or injured individual that incurred: (i) within one year prior to the date of the individual's death; or (ii) within one year prior to, or at any time following, the date of certification by the individual's physician that the individual has suffered an illness or injury expected to result in such individual's death within five (5) years of the date of certification.

In order to be eligible for reimbursements under this provision, the expenses must have been incurred on or after the date you became a Participant in the Plan. If the terminally ill or injured individual is your Spouse (or Domestic Partner), Dependent Child, or Dependent Relative, the expenses must have been incurred when the individual qualified for their status. For example, if your Spouse's expenses were incurred prior to the date of your marriage, they are not reimbursable. Similarly, if your child's expenses were incurred after he or she no longer qualified as a Dependent Child under the Plan (for example, when he or she was age 27), they are not reimbursable.

What is the Exception for Extraordinary Medical Expenses?

The Plan provides catastrophic protection. If you cease to be employed by your Employer and you meet the criteria relating to catastrophic medical expenses while employed or within twelve (12) months of termination of employment and you submit valid evidence (as a single claim) of Qualified Medical Expenses incurred by you, your Spouse (or Domestic Partner), Dependent Children, and/or Dependent Relatives during a single 12-month period, and those expenses exceed $15,000 in the aggregate, then your Employer Contribution Account will not be forfeited and the Plan will reimburse you for the portion of those Qualified Medical Expenses that exceed $15,000. QMEs do not include expenses incurred prior to the date you became a Participant. Similarly medical expenses incurred by a Spouse, (or Domestic Partner), Dependent Child, or Dependent Relative are not counted toward the $15,000 threshold (and, if above the

threshold, or, if they were incurred when the individual was not of qualifying status, are not reimbursable).

Are There Any Other Limitations That I Need to Know About:

Yes. There are limitations relating to the following:

The date on which the expense was incurred

The timeliness of claims submission

Your participation in an HSA or FSA

The balance in your Accounts and its investment in the Money Market Investment Option

What if I Participate in an HSA or FSA?

If you are still employed by the Employer and participate in a high deductible health plan ("HDHP") and are eligible to contribute to a health savings account ("HSA"), you are not eligible for the Emeriti Reimbursement Benefit until you have first satisfied the HDHP's minimum annual deductible for the year in which the Qualified Medical Expenses were incurred.

If you elect coverage under your Employer's health flexible spending account ("FSA") – or at a different employer after leaving your employment with the Employer -- you will not be eligible for the Emeriti Reimbursement Benefits until you have first exhausted the FSA for the year in which the Qualified Medical Expenses were incurred.

If a balance remains in your Accounts and there are no eligible dependents, then the balance is forfeited to the Plan

There are no limits on the amount of reimbursement for a Qualified Medical Expense, except the total amount in the Money Market of your Emeriti Health Account.

You should check the available balance in the Money Market Fund of your Emeriti Health Account(s). If there is an insufficient balance in the Money Market Fund, you may transfer funds from other investment positions to the Money Market Fund by calling 1-866-Emeriti (1-866-363-7484 and select option #3), or by going online at www.tiaa-cref.org. Claims that exceed the balance of your Money Market Fund will be denied until you replenish the Money Market Fund. You should also check to be sure that Savitz has current address and bank account information (if you request electronic funds transfer) for you, since incorrect information will delay receipt of payment.

How Do I Submit a Claim?

You must file a claim in accordance with the procedures described below in order to receive reimbursement of Qualified Medical Expenses. Claims are processed by Savitz but may be subject to review by the Plan Sponsor.

Explanation of Benefits ("EOB"), receipt, or similar documentation from the provider of the service or goods showing the type of service or product, the date of service or sale, and the individual for whom the service or sale was provided.

You should submit your claim to Savitz at the following address:

Savitz
Attention: Emeriti Benefits Center
14th Floor
1845 Walnut Street
Philadelphia, PA 19103

by fax to: 215-563-9943, or

online at: www.myemeritibenefits.org

How Long Does It Take to Decide My Claim?

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right to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim. You will be notified of the decision on review no later than 30 days after receipt of the written request for review.

What Happens If a Claim Is Overpaid?

With respect to reimbursement of Qualified Medical Expenses, the Plan may seek return of the overpayment, deduct the overage from your personal bank account, or may reduce future benefits to offset the amount of any overpayment.

What Is the Time Limit For Submitting Claims After the Last To Die (or Reach Majority) of All the Covered Family Members?

Upon the last to die (or reach majority) of the Participant, Spouse (or Domestic Partner), Dependent Children, and Dependent Relatives, all claims must be submitted within 12 months following the date of death (or attainment of majority) or they will be denied.

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

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

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If I Am Eligible For Health Insurance Coverage, When May I Enroll, And Is There Any Time Frame Within Which I Must Enroll?

If you have satisfied your Plan's Retirement Eligibility criteria, you will be eligible to enroll in Retiree Health Insurance Coverage once you have

(1) reached age 65,

(2) ceased employment, and

(3) enrolled in Medicare Parts A and B.

You must enroll in one of the Health Insurance Plan Options within the 90-day period that starts when you have satisfied these three conditions. ***If you fail to enroll within the 90-day period, you will lose your right to enroll.*** There are limited exceptions. See "If I Fail to Enroll, or my Spouse (or Domestic Partner)or Dependent Child Fails to Enroll Within the Enrollment Period, Will There Be Additional Opportunities to Enroll", below.

What if I Retire Prior to Age 65?

If you retire prior to age 65, then you must wait until you reach age 65 to enroll, in which case you may enroll in a Post-65 Health Insurance Plan Option. At that time if your Spouse (or Domestic Partner) is under age 65, he or she may enroll in a Pre-65 Health Insurance Plan Option.

- **Ø** To take advantage of the opportunity to enroll in the Health Insurance Coverage provided under your Plan, you must enroll in a Health Insurance Plan Option within the applicable 90-day enrollment period.
- **Ø** Eligible Spouses (or Domestic Partners) and Dependent Children can enroll in Emeriti coverage only if you (the Plan participant) are enrolled (except, in some cases, they may enroll after your death).
- **Ø** If you, your eligible Spouse (or Domestic Partner) or your eligible Dependent Children do not enroll in one of the Health Insurance Plan Options within the applicable enrollment period, you (or they) will not be permitted to enroll at a later date, except in limited circumstances.
- **Ø** Although coverage for Dependent Children is available in most cases, Dependent Children are not covered under all Health Insurance Plan Options. This coverage will vary from state to state and insurer to insurer. For example, Dependent Children are not covered in Health Insurance Plan Options underwritten by HealthPartners (which are available for members of Plans established by Plan Sponsors located in Minnesota).

- In the event of the Participant's death, eligible dependents should call Emeriti as soon as possible to discuss enrollment

- If you have

- Premium rates for each option will vary depending on where you live.

- The details of each option and the premium charged may change annually, and the Emeriti Program may eliminate and add options from time to time.

When Will I Receive Specific Information About the Health Insurance Plan Options Available To Me?

A separate summary of benefits describing the Health Insurance Plan Options will be provided to you six months before you attain age 65, or if earlier, when you become eligible to enroll in insurance.

Can I Obtain Information About the Health Insurance Plan Options Now?

Yes. You may call 1-866-EMERITI (1-866-363-7484 and select option #2) at any time to obtain information about the current Health Insurance Plan Options. Remember, the information you receive will describe the options currently offered. The details may change by the time you become eligible to enroll.

May I Change My Coverage From One to Another Health Insurance Plan Option After I Enroll?

Yes. There is an annual open enrollment period that will be announced in the fall of each year. You will be able to change your coverage from one Plan Option to another for the coming calendar year during the open enrollment period. (See "Are There Open Enrollment Periods", below.)

What If I Elect Not To Enroll in Health Insurance Coverage?

You do not have to enroll in the Health Insurance Coverage offered under your Plan. However, if you choose not to enroll within the established enrollment period – or if you simply fail to do so—you will not be permitted to enroll at a later date.

Remember, even if you do not enroll in Health Insurance Coverage, you may use your Emeriti Reimbursement Benefit for as long as you have balances in your Accounts.

Are My Spouse (or Domestic Partner) and Dependent Children Eligible for Health Insurance Coverage?

Yes, however, coverage for Spouses (or Domestic Partners) and Dependent Children is contingent upon your (the Participant's) enrollment and their enrolling within prescribed enrollment periods, except as otherwise described below.

Are My Dependent Relatives Eligible for Health Insurance Coverage?

No. Dependent Relatives are not eligible for Health Insurance Coverage.

When May I Enroll My Spouse (or Domestic Partner) and What Health Insurance Plan Options are Available?

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

- If your Spouse (or Domestic Partner) is at least age 65 and currently enrolled in Medicare Parts A and B, you may enroll your Spouse (or Domestic Partner) in a Post-65 Option.

- If your Spouse (or Domestic Partner) has not attained age 65, you may enroll your Spouse (or Domestic Partner) in a Pre-65 Option. When your Spouminr Domestnyy t

period, in most instances he or she will not be eligible to enroll at a later date.

- Although coverage for Dependent Children is available in most cases, Dependentt Child t (C) Tj0 Tc (h) Tj-0.0500 T :o( ) TTj0.8penden509.4 707.4 0.48 12.6 re

Will My Plan Provide Health Insurance Coverage if I Become Permanently Disabled?

"Permanently Disability" is a defined term in your Plan. Neither you, your Spouse (or Domestic Partner), or Dependent Children will be considered Permanently Disabled unless all criteria enumerated in your Plan are satisfied, and the individual seeking "Permanently Disabled" status has obtained a determination letter from the Social Security Administration ("SSA") stating that he or she is permanently disabled under SSA rules.

If you become permanently disabled either while working for your Employer (or, if you become permanently disabled after having ceased working for your Employer and have satisfied your Plan's Retirement Eligibility criteria) you will be considered Permanently Disabled and eligible to enroll in one of the Post-65 Health Insurance Plan Options after you obtain a Social Security Determination Letter stating that you are permanently disabled. You also must enroll in Medicare Parts A and B before enrolling in Emeriti coverage. It is your responsibility to notify the Plan Sponsor of the Social Security Administration's determination. Failure to do so will result in your not qualifying as Permanently Disabled under the Plan. You must enroll withi Tc (r) Tj0.048 Tc (o) Tjc (i) Tj0.0

What If I Die Before Satisfying My Plan's Retirement Eligibility Criteria?

If you die before you satisfy the Retirement Eligibility crite

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

Yes. A Spouse's (or Domestic Partner's) or Dependent Child's Health Insurance Coverage will cease on the last day of the month in which he or she fails to meet the Plan's definition of "Spouse", Domestic Partner", or "Dependent Child", as applicable.

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Are the Health Insurance Plan Options and the Insurers Who Underwrite Them Subject to Change?

Yes. The Health Insurance Plan Options are subject to change for a number of reasons, including, but not limited to the following:

- Changes in state and federal law, including changes to the Medicare program overseen by the Centers for Medicare and Medicaid Services

What If My Claim Relates to Payment of Premiums for the Emeriti Health Insurance Plan Options from My Accounts?

Once you enroll in an Emeriti Health Insurance Plan Option, premiums for that coverage will be paid automatically from your Emeriti Health Accounts in accordance with the terms of the Plan and procedures established by Emeriti. If you have any questions about automatic payment of these premiums from your Emeriti Health Accounts, you should first call 1-866-EMERITI (1-866-363-7484, select option #2).

What Happens If a Claim Is Overpaid?

Overpayments of claims are governed by the terms of the Coverage Documents.

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

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

Do Women with Cancer Have Any Special Rights?

Women's Health and Cancer Rights Act. Group health plans and health insurance issuers that provide medical and surgical benefits with respect to a mastectomy must provide, in a case of a participant, spouse or dependent who is receiving benefits in connection with a mastectomy, coverage for:

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

in a manner determined in consultation with the attending physician and the patient. This coverage may be subject to annual deductibthciiiit.048 Tc (pa) Tj0.024 Tc (t) Tj-0.024

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Aetna Life Insurance Company provides Health Insurance Plan Options under the Emeriti Program, which include fully-insured group plans for medical, prescription drug, and dental benefits. (Special rules may apply in certain states,

upon request to the Plan Sponsor. You may inspect a copy of the Form 990 filed for each VEBA trust associated with your Plan upon request to the Plan Sponsor.

of the federal securities laws. Emeriti has received several no-action letters from the SEC Staff stating that the staff will not recommend enforcement action to the SEC if the Employee After-Tax Contribution VEBA is n Tj-0.072 Tc (e) Tj0eTc (n) 0QAptededj0.0

Enforce Your Rights:

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Sponsor to provide the materials and pay you to up $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Sponsor. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition,

How Long Does Continuation Coverage Last?

Ordinarily, the period of continuation coverage is 18 months, beginning on the first day of the month following the qualifying event. There are two ways in which continuation coverage can be extended beyond 18 months. The first is in the event of disability, in which case coverage may be extended by another 11 months. This extension requires a ruling from the Social Security Administration that the covered person became disabled within the first 60 days of COBRA continuation coverage. A copy of that ruling must be submitted to the COBRA Administrator within 60 days after receipt. The disability must also last beyond the end of the original 18 month period of continuation coverage.

The period of continuation coverage may also be extended another 18 months (for a total of 36 months) if you, your spouse or a dependent child experiences another qualifying event which occurs during the initial 18 months of continuation coverage.

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

The premium for continued coverage in the Emeriti Health Insurance Plan Options under COBRA is 102% of the premium owed with respect to the qualified beneficiary immediately prior to the qualifying event. Qualified beneficiaries share in any increases to premiums required for similarly situated spouses or Dependent Children. COBRA premium payments must be made on a monthly basis by the due date provided to the qualified beneficiary.

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

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

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

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

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

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

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

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

How Does a Qualified Beneficiary Elect Continuation Coverage?

The affected qualified beneficiary must call 1-866-EMERITI (1-866-363-7484 and select option #2) to provide notice of the qualifying event within

In the event of any divorce, legal separation, or cessation of Dependent Child status, you and your former dependent cannot simply agree to divide your Accounts. However, the Plan recognizes domestic relations orders that meet certain requirements similar (but not identical) to the qualified domestic relations order ("QDRO") rules applicable to retirement plans. In the event of a divorce or other domestic relations situation, a court might order that your Accounts be divided between you and your Spouse or other dependent family member. If this happens, the Spouse or dependent family member may use his or her divided portion of the Accounts for Reimbursement Benefits in accordance with the court order.

In addition, if he or she has a right to continuation coverage in the Emeriti Health Insurance Plan Options under COBRA (described above), he or she may use his or her divided portion of the Accounts to pay the premiums tou dhet ieveraget

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

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

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

What If the Participant Is Not Eligible for Medical Benefits?

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

What Happens If the QMCSO Is Approved?

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

Does the Plan Honor National Medical Support Notices?

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

- § notify the State agency issuing the notice whether coverage of the child is available under the terms of the Plan and, if so, whether the child is covered under the Plan and either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent (or by the official

of a State or political subdivision thereof substituted for the name of such child) to effectuate the coverage; and

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

Can the Plan Sponsor Amend or Terminate the Plan?

The Plan Sponsor intends to continue the Plan indefinitely. However, subject to the terms of its participation in the Emeriti Program, the Plan Sponsor reserves the right to modify, alter, or amend the Plan, the Employer-Contribution VEBA Trust, and/or the Employee After-Tax Contribution VEBA Trust, in whole or in part, at any time. However, no modification, alteration, or amendment will have the effect of returning to the Employer any part of the principal or income of the trusts. In addition, subject to the terms of its participation in the Emeriti Program, the Plan Sponsor reserves the right to discontinue Employer Contributions, eliminate any form of benefit, or terminate this Plan at any time.

The Plan Sponsor has the right to suspend or change the amount of Employer Contributions. The Plan Sponsor also has the right to change the Plan's design by amendment, including, for example, the age and service requirements its employees must satisfy in order to be eligible for Employer Contributions and/or to make Employee After-Tax Contributions to the Plan, the eligibility criteria that participants must satisfy to qualify for the Reimbursement Benefit, the Retirement Eligibility criteria that participants must satisfy to be eligible for Health Insurance Coverage, the extent to which Spouses, Domestic Partners, Dependent Children and Dependent Relatives are covered D c (r) Tj0.048 Tc (a) Tjc (r) Tj0.048 Tc (a) TjtfyD r a

Any right of a Participant, Spouse (or Domestic Partner), or Dependent Child to coverage or benefits under the Emeriti Health Insurance Plan Options will at all times remain subject to the Plan Sponsor's right under the Plan and Emeriti's right under the Emeriti Program to amend, modify, or terminate the Emeriti Health Insurance Plan Options offered under the Plan or Emeriti Program, as applicable. In addition, the particular Emeriti Health Insurance Plan Options and particular coverage available in a particular state or territory may vary from that offered in other states or territories, or may become unavailable, as a result of state or federal law.

What if the Plan Sponsor Withdraws from the Emeriti Program?

The Plan Sponsor has established the Plan under the Emeriti Program. If the Plan Sponsor withdraws from the Emeriti Program, the Plan Sponsor may elect to continue the Plan. However, the Plan will no longer be maintained under the Emeriti Program, and this SPD shall cease to be effective on the date the Plan Sponsor withdraws from the Emeriti Program. In the event of withdrawal, the Plan Sponsor will notify you regarding the status of the Plan, your Emeriti Health Accounts and the roles and duties of any new service providers.

The Standards for Privacy of Individually Identifiable Health Information (codified at 45 CFR Parts 160 and 164), commonly called the HIPAA Privacy Rules, establish standards for the protection of individually identifiable health information. The HIPAA Privacy Rules apply to both the Emeriti Health Insurance Plan Options and the reimbursement of Qualified Medical Expenses. Separate from this SPD, you will receive a Notice of Privacy Practices summarizing Aetna's protection of your health information with respect to the insured portion of the Plan and a Notice of Privacy Practices summarizing the Plan's protection of your health information with respect to the reimbursement of Qualified Medical Expenses portion of the Plan. You should read these documents carefully to understand how your health information, and the health information of your covered family members, may be used and disclosed in the process of administering the Plan.

The following summary of Federal income tax consequences of participation in the Plan does not purport to be com0 -13.8 TD 0.02(l) Tj0.048 Tc (e) Tj0.024 Tc (t) Tj-0.072 Tc (e

Name of Plan:	Emeriti Retiree Health Plan for Southern Methodist University
Plan Sponsor (and Plan Administrator):	Sheri Starkey Associate Director, Human Resources 214-768-2024 starkey@smu.edu
Employer Identification Number:	75-0800689
Plan Number:	507

COBRA Administrator:

Aetna
Individual Billing Unit
151 Farmington Ave MB52
Middletown, CT 06457
800-429-9526

Agent for Service Af

following address, including the address to which you would like the written disclosure statement to be sent:

Emeriti Retirement Health Solutions
103 Executive Dr., Suite 503
New Windsor, NY 12553

Alternately, Emeriti will accept requests for the written disclosure statement sesse ltattu Heri f (5) Tj-0.072 Tc (03) 024 Tc (t) Tj07gD 0 Tc (s) Tj0.048 Tc (ubTj-0.024

None.

Employees under age 40 excluded from employer contributions.

Employees not eligible for University benefits excluded from total plan participation (students, adjunct faculty, temporary faculty, temporary staff, contractors and outsourced associates of SMU business partners).

Benefit eligible employees not working 35 or more hours per week excluded from employer contributions.

Employer Annual Base Contribution: $624

Employee Mandatory Annual Base Contribution: $624

temporary lapse in coverage under the Health Insurance Plan Options if a Participant or other enrolled individual changes residence (e.g., from one state to another or between coverage areas).

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

7. If a Medicare-eligible individual is enrolled in a Post-65 Option that provides prescription drug coverage and his or her enrollment is cancelled due to subsequent enrollment in a Medicare Pa ieligel0.048 Tc (p)4.12 Tc (s) Tj0.024 Tc (t) Tj-0.036 dy0c ( ) T

2 will be paid from Participant 2's Accounts. If Participant 1's
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