

EMERITI RETIREE HEALTH PLAN FOR REED COLLEGE

SUMMARY PLAN DESCRIPTION

PLAN EFFECTIVE DATE: JULY 1, 2006

PLAN RESTATED: JANUARY 1, 2026

ALL OF THE INVESTMENT OPTIONS IN THE PLAN ARE MUTUAL FUNDS REGISTERED UNDER THE SECURITIES ACT OF 1933, AS AMENDED AND THE INVESTMENT COMPANY ACT OF 1940, AS AMENDED, BUT THE RIGHT TO MAKE EMPLOYEE AFTER-TAX CONTRIBUTIONS HAS NOT BEEN REGISTERED UNDER THE SECURITIES ACT OF 1933, AS AMENDED AND THE EMPLOYEE AFTER-TAX CONTRIBUTION VEBA HAS NOT BEEN REGISTERED UNDER THE INVESTMENT COMPANY ACT OF 1940, AS AMENDED.

Overview of THE EMERITI PROGRAM

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

Emeriti has designed a retiree medical program, called the Emeriti Program, to help colleges, universities, and other higher education-related tax-exempt organizations and their employees cope with the rising costs of retiree healthcare. The Emeriti Program offers the following core features:

- **A tax-advantaged way to invest and accumulate assets** to pay for your insurance premiums and other health expenses in retirement—*the Emeriti Health Accounts*.
- A specially designed **group health insurance program building on the foundation of Medicare**—*the Emeriti Health Insurance Plan Options*—a range of plan options, including Medicare-approved Part D prescription drug coverage.
- **A tax-free way to pay for other qualified out-of-pocket medical expenses** – the *Emeriti Reimbursement Benefit*.

Here is how it works. Your employer adopts an Emeriti Retiree Health Plan and two related tax-exempt trusts—an employer-contribution trust and an optional employee-contribution trust. Contributions to these trusts, including employer contributions made on your behalf and your own contributions, are recorded in individual participant accounts. Participants direct the investment of their account balances among a range of federally registered investment options 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 OneBridge Benefits, Inc. to provide recordkeeping, premium payment and claims administrative services; Alta Trust Company to provide trust and investment management services; Charles Schwab & Company to provide sub-custodial and investment trading services; Aetna to provide health insurance options, and HealthPartners to provide health insurance options in Minnesota to the Emeriti Program.

[1] Emeriti's full legal name is The Emeriti Consortium for Retirement Health Solutions, an Illinois Not-For-Profit Corporation.

You will also find additional information and helpful resources on your Emeriti online participant portal account after logging in at www.MyEmeritiHealth.org and on the Emeriti website: www.emeritihealth.org.

If you ever have any questions about the Emeriti Program, your employer's Emeriti Retiree Health Plan, or how to login to or use your Emeriti online portal account, please call the Emeriti customer care center at 1-866-EMERITI (1-866-363-7484) between 8am ET and 8pm ET on normal business days.

INTRODUCTION TO YOUR EMERITI RETIREE HEALTH PLAN

Reed College (the "Plan Sponsor") adopted The Emeriti Retiree Health Plan for Reed College (the "Plan") as of January 1, 2006 (the "Effective Date"). The Plan was amended and restated effective as of January 1, 2026. The Plan is intended to assist you in dealing with your medical expenses, and those of your family, during your retirement years. You may be covered under the Plan as an employee of the Plan Sponsor or of a participating affiliate of the Plan Sponsor listed in Appendix A (referred to in this Summary Plan Description ("SPD") as your "Employer").

Funding for these benefits is through Emeriti Health Accounts established in your name during your working years. If you meet the eligibility requirements, your Employer will make contributions to your Employer-Contribution Account, and you will be permitted to make voluntary Employee After-Tax Contributions to your Employee After-Tax Contribution Account.

The employer contributions and your contributions are held in separate trusts where the earnings on contributions are not taxed.[2] Amounts in your Accounts grow tax-free. When you become eligible – primarily when you retire - the amounts paid out of your Accounts for reimbursement of Qualified Medical Expenses, including premiums for health insurance coverage, are also tax-free.

In addition, you may become eligible for retiree health insurance coverage when you retire after attaining Retirement Eligibility and enrolling in Medicare Parts A and B (on or after age 65). This coverage is generally available to eligible retired Participants, as well as their Spouses (or Domestic Partners), and Dependent Children. If you satisfy your plan's Retirement Eligibility criteria, you will be able to choose among several different Emeriti Health Insurance Plan Options. (Note the insurer writing your health insurance coverage may vary depending on where your Employer is located, and where you reside. For example, although Aetna provides most of the health insurance under the Emeriti Program in Minnesota coverage is provided by HealthPartners and in certain other places, including New Mexico, Puerto Rico, and the U.S. Virgin Islands, your coverage may be underwritten by another insurer. See Appendix E for more details.). Furthermore, the Emeriti Health Insurance Plan Options will vary in certain states because of state insurance laws and Medicare requirements.

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

[2] If your employer is a Section 501(c)(3) organization the trusts established for your plan will be "VEBAs." A VEBA is a "voluntary employees' beneficiary association" under Section 501(c)(9) of the Internal Revenue Code. If your employer is a governmental entity the trusts use may be VEBAs, or trusts formed under Section 115 of the Internal Revenue Code.

If you are not currently eligible to enroll in the Emeriti Health Insurance Plan Options or if you elect not to enroll in that coverage, you may still be eligible for the other benefit available under the Plan – the Emeriti Reimbursement Benefit: once you satisfy the age and service criteria establish by your Employer, you will be able to obtain the reimbursement of Qualified Medical Expenses up to the balance accumulated in your Accounts.

The Plan is a single-employer welfare benefit plan governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), which means that under Federal law you, your Employer, and the Plan Sponsor (*either your Employer or an affiliate of your Employer*) each have certain obligations and rights with respect to the Plan. The principal applicable provisions of ERISA are the provisions on reporting and disclosure, fiduciary responsibility and administration and enforcement. The Plan is not qualified under Section 401(a) of the Internal Revenue Code, which deals with the tax treatment of qualified pension, profit-sharing and stock bonus plans.

The Plan document, consisting of a core plan document and an adoption agreement, describes the terms of the Plan in detail. The terms of the trusts are described in separate trust agreements. This SPD summarizes the terms of the Plan as of January 1, 2026. However, it is not meant to interpret, extend, or change the terms of the Plan in any way, nor does it describe all of the detailed rules that may apply in special circumstances. By reading this SPD you should gain a working knowledge of how the Plan operates and your general rights and obligations under the Plan. ***This SPD is only a summary, and in the event of any conflict between this SPD and the Plan, the Plan's terms (as stated in the Plan document) will control.*** You will find a copy of the most current SPD on your Emeriti online participant portal account after logging in at www.MyEmeritiHealth.org. You may also request a copy of the Plan document or this SPD by contacting the Plan Sponsor or the Emeriti customer care center at 1-866-EMERITI (1-866-363-7484). Nothing in the Plan or this SPD constitutes a contract of employment between you and your Employer or otherwise grants you any right to continued employment by the Employer.

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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DEFINED TERMS

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.

PARTICIPANTS AND ELIGIBLE FAMILY MEMBERS

Who is Eligible to Participate?

You can participate in the Plan as an "Eligible Employee" if you are a common law employee of the Employer and you are at least age 21, unless any of the following statements describes you:

- If you are employed by the Employer on a seasonal basis or are regularly scheduled for less than 30 hours per week, you are excluded from participation.
- If you are in a class of employees listed on Appendix B of this SPD, you are excluded from participation.
- If you are an independent contractor, leased employee, temporary employee, or project contractor, you are excluded from participation.
- If you are a retired employee of the Employer when the Plan commences, you are only eligible to participate in the Plan if your Plan Sponsor has expressly provided for your participation under the design of its Plan (*you will be notified separately regarding the terms and conditions of your participation in the Plan*).

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

You become a "Participant" in the Plan once an Employee After-Tax Contribution Account or Employer Contribution Account is established for you. After you have left employment with a vested account balance and/or are enrolled in a Health Insurance Plan Option (if eligible), you will be considered a "Participant" even if your Accounts have been depleted. If you were retired at the date the Plan was established but are provided Health Insurance Coverage under the Plan (i.e., the option to enroll in a Health Insurance Plan Option), and you elect to do so, you also are considered to be a "Participant" in the Plan.

What if I Return to Work With My Employer?

If you are reemployed by your Employer, your right to receive benefits under the Plan is suspended until the first day of the month following your subsequent termination of employment. However, your accounts will participate in the investment earnings of the underlying mutual funds in which the accounts are invested.

Which of My Family Members Can Benefit Under the Plan?

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

- Your Spouse (or Domestic Partner)

- Any Dependent Child
- Any Dependent Relative (for reimbursement of Qualified Medical Expenses only)

Who Qualifies As My Spouse?

Under the terms of the Plan, your Spouse is the person to whom you are legally married. A common law spouse is not considered a Spouse under the Plan.

If you are divorced or legally separated, your former Spouse loses their rights to coverage under the Plan (*subject to continuation coverage rights under COBRA*). If you are divorced and later remarry, your new Spouse may qualify for benefits under the Plan (i.e., the Emeriti Health Insurance Coverage and/or the Emeriti Reimbursement Benefit) subject to limitations imposed by your Employer (in the adoption agreement for your Plan).

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

Who Qualifies As My Domestic Partner?

In this SPD, if you see the term Domestic Partner, it refers to a person who is either your Dependent Domestic Partner or Non-Dependent Domestic Partner. Any reference to a Domestic Partner in this SPD means an individual of either sex. An individual who is a Dependent Domestic Partner is eligible to receive benefits under the Plan in the same manner as a Spouse. However, please note the following:

- There may be federal and state tax consequences when a Non-Dependent Domestic Partner receives benefits under the Plan. The distinction between a Dependent and Non-Dependent Domestic Partner is based on federal tax code regulations regarding persons whom you may claim as a dependent for federal income tax purposes.
- 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 they are 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 they are 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 child's age.

Handicapped Child: An unmarried dependent child who is mentally or physically handicapped may continue to be qualified beyond the maximum age provided the child is incapable of self-sustaining employment and is chiefly dependent upon the Participant for support and maintenance.

Effect of Your Death: If an individual is your Dependent Child when you die, they will remain a Dependent Child for purposes of the Plan until they fail to satisfy the definition of Dependent Child. This means that any balances in your Account(s) will be available to pay for their Qualified Medical Expenses, and they may be covered under the Emeriti Health Insurance Plan Options as long as they remain otherwise eligible for coverage and the required premiums are paid. However, these benefits cease once your child fails to satisfy the age requirement.

Normally an individual has to be designated as your Dependent Child in order to be eligible to benefit under the Plan. However, the following exception applies: an individual who was not designated as your Dependent Child at the time of your death will be treated as your Dependent Child if they show valid evidence that they would have qualified as a Dependent Child on the date of your death had you properly designated such individual as your Dependent Child, provided that they do so within the 180 days following your death (by calling 1-866-EMERITI (1-866-363-7484) and following the required procedures).

Who Qualifies As My Dependent Relative?

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 their 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 their principal place of abode and is a member of your household.

IMPORTANT: 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, they will remain a Dependent Relative so long as any amount remains in your Account(s).

- Dependent Relative status cannot be established after you die.

EMPLOYER CONTRIBUTIONS

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. Your Employer will make a contribution for each payroll period during which you are credited at least one Hour of Service, or as otherwise described in the adoption agreement for your Plan.

> **DEFINITION OF HOUR OF SERVICE:** The term "Hour of Service" means any hour for which you are directly or indirectly paid or entitled to payment by your Employer as an employee.

What Happens If I Am Not Credited With an Hour of Service In a Payroll Period?

If you are not credited with at least one Hour of Service during a payroll period, your Employer will not make a contribution to your Employer-Contribution Account except under the following circumstances:

- Your Employer will make an Employer Contribution for any payroll period during which you are on a paid Authorized Leave of Absence, paid holiday, paid vacation, or regularly scheduled paid or unpaid summer absence.
- Your Employer will not make an Employer Contribution for any payroll period during which you are on an unpaid Authorized Leave of Absence.
- Your Employer will make an Employer Contribution if required under the Uniformed Services Employment and Reemployment Rights Act of 1994 or the Family and Medical Leave Act of 1993.

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

How Long Will My Employer Make Employer Contributions?

Your Employer will make Employer Contributions to your Employer-Contribution Account for 25 years provided, however that Employer Contributions will cease immediately if you cease to be employed by the Employer.

If an Employee becomes Permanently Disabled, while still employed by the Employer, the Employer will continue to make an annual contribution up to the maximum of 25 years.

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.

EMPLOYEE AFTER-TAX CONTRIBUTIONS

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 Participants in the Plan. See the section USE OF EMERITI HEALTH ACCOUNTS.

When Can I Begin Making Employee After-Tax Contributions?

Your Employer will notify OneBridge 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 OneBridge and may begin making Employee After-Tax Contributions after you enroll.

How Do I Enroll For Employee After-Tax Contributions?

You must contact the Human Resources Office for your Employer or designated payroll services to begin voluntary contributions. You can enroll at any time after becoming eligible. If you have questions about your Health Account, please call 1-866-EMERITI (1-866-363-7484).

How Do I Make Employee After-Tax Contributions?

The primary way to make Employee After-Tax Contributions is by regular payroll deductions. If you elect to make contributions by payroll deduction, they will commence with the next payroll

period after your enrollment is processed by your Employer. Employee After-Tax Contributions can be made in any amount of whole dollars.

You also may have the option to make lump sum contributions to the Plan outside of the payroll process. The process for doing so will change from time to time, as administrative processes are updated.

If you are a retired employee, you will be eligible to make contributions via ACH Transfer – an electronic transfer from your private checking account - in order to pay insurance premiums (if you have elected an Emeriti Health Insurance Plan Option) and fees, if any are assessed against your Account(s) under your Employer's plan.

For more information about making contributions outside of the payroll process and to learn about ACH Transfers, please contact 1-866 Emeriti (1-866-363-7484).

Can I Change or Stop My Employee After-Tax Contributions?

You can change your payroll contributions or stop making contributions at any time by contacting your Human Resources office. The change will be made on the first payroll period after your new election is processed by OneBridge and your Employer.

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 Expenses incurred by you and your eligible dependents.

What if I'm Absent from Work for Military Service?

If you are absent from work for qualified military service covered by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), you may continue to make Employee After-Tax Contributions. You should contact your Employer prior to going on military leave so that the Plan Sponsor can inform you of the rules regarding military leave and Employee After-Tax Contributions, including how soon after military service you must return to employment with the Employer.

Can My Dependents or Anyone Else Make Contributions to My Account?

No. You are the only person permitted to make contributions to your Employee After-Tax Contribution Account.

INVESTMENT OF EMERITI HEALTH ACCOUNTS

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 under the Plan. The available Mutual Funds are designated by the investment fiduciary for your plan and can be found under the **Resources** and **Investments** tabs on your Emeriti online participant portal account after logging in at www.MyEmeritiHealth.org. All Investment Options are "mutual funds."

Who Controls How My Accounts Are Invested?

You control the investment of both your Employee After-Tax Contribution Account and your Employer-Contribution Account, subject to Plan procedures and the terms of the Plan.

It is very important that you carefully consider how you wish to invest the balance in your Accounts. Each Mutual Fund in which you may invest under the Plan is subject to gains and losses due to investment performance, as well as fees which are disclosed in the prospectus for each Mutual Fund. The Funds are subject to the volatility of the financial markets in the United States and abroad and, depending on the Mutual Fund, may be subject to the additional risks associated with investing in high-yield, small-cap, and foreign securities. Neither diversification nor asset allocation ensures a profit or guarantees against loss.

You can choose whether to invest the balance in your Accounts in one of the available Mutual Funds or in any combination of funds. Alternatively, if you do not make an active investment decision, the balance in your Accounts will be invested in a "default option." Your default option is the target date fund with the targeted retirement date that most closely approximates your own retirement date, assuming a retirement age of 65.

What Investment Options Are Available?

The Mutual Funds available under your Plan include a core portfolio of mutual funds, including "target date funds," and a money market fund (and additional funds selected by the Plan Sponsor). Additional information regarding investment options is available to you on your Emeriti online participant portal account after logging in at www.MyEmeritiHealth.org.

The Mutual Funds are selected by the Plan Sponsor (or another designated investment fiduciary) for use in your Plan from among a menu of investment options made available under the Emeriti Program. The Plan Sponsor or investment fiduciary may add or eliminate investment options from time to time. Similarly, Emeriti may alter the menu of mutual funds made available under the Emeriti Program from time to time. If a Mutual Fund is removed, you will be provided with notice of the change and time to adjust the investment of your Account balances. In rare circumstances that in the judgment of the Plan Sponsor or Emeriti require immediate action, you may be informed after a change is implemented.

THE INVESTMENT OPTIONS IN YOUR PLAN ARE MUTUAL FUNDS REGISTERED UNDER THE SECURITIES ACT OF 1933, AS AMENDED AND THE INVESTMENT COMPANY ACT OF 1940, AS AMENDED. MUTUAL FUND SHARES ARE HELD IN THE NAME OF THE PLAN'S TRUSTEE, ALTA TRUST COMPANY, ON BEHALF OF EACH OF THE TRUSTS. THE TRUSTS HAVE NOT BEEN REGISTERED UNDER THE INVESTMENT COMPANY ACT OF 1940. THE CORRESPONDING PARTICIPATION INTERESTS IN THE EMPLOYEE AFTER-TAX CONTRIBUTION TRUST HAVE NOT BEEN REGISTERED UNDER THE SECURITIES ACT OF 1933.

How Do I Make Elections Regarding How My Accounts Are Invested?

When you first become a Participant, you may file an investment election directing how your Accounts from the **Investments** tab of your Emeriti online participant portal account after logging in at www.MyEmeritiHealth.org (preferred) or by calling 1-866-EMERITI (1-866-363-7484).

If you fail to file an election, contributions to your Accounts will be invested in the default option that corresponds to the lifecycle fund associated with your retirement target date, which is the date on which you will attain age 65.

How Do I Reallocate Investments in My Account?

You can make allocation changes, re-balance your account, or change how future contributions to your Accounts from the **Investments** tab of your Emeriti online participant portal account after logging in at www.MyEmeritiHealth.org (preferred) or by calling 1-866-EMERITI (1-866-363-7484).

Are There Any Limitations or Restrictions Relating to The Reallocation of Investments?

Yes. You may make investment changes not more than once per 30 days.

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 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 OneBridge. Exchanges, transfers and sales will be executed at the next NAV calculated after the exchange, transfer or sale is received by OneBridge. 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.

Do I Receive Activity Notices, Account Statements and Prospectuses?

You will not receive *activity notices* when you reallocate assets between or among Mutual Funds or change the future allocation of new contributions. If you transact through a phone representative, your investment change directions will be made on a recorded line.

You will receive quarterly and annual *account statements*, electronically through your Emeriti online participant portal account. When each account statement becomes available for viewing or downloading from your portal account, you will receive an email notification to the email address you have entered when registering for your portal account. You can also obtain current account information by calling 1-866-EMERITI (1-866-363-7484). Your Plan's investment fiduciary will provide a quarterly *Investment Fund Overview*, which will include short-term and longer-term performance information for each of the Mutual Funds. The most current Investment Fund Overview will be available on the **Investments** tab of your Emeriti online participant portal account after logging in at www.MyEmeritiHealth.org or upon request to the Emeriti customer care center by calling 1-866-EMERITI (1-866-363-7484).

Summary prospectuses and other important information for each of the Mutual Funds are available from the mutual fund company's website, which can be accessed from a link in the Investment Fund Overview described above. You may also request prospectuses by calling 1-866-EMERITI (1-866-363-7484). Your investment fiduciary will handle proxy voting for the mutual funds that are designated for your Plan's investment menu.

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 of your Accounts remain available for your Dependent Children or Dependent Relatives, then your estate controls the Accounts for your Dependent Children and Dependent Relatives.

In the event of your death, your eligible surviving dependents can continue to use your Emeriti Health Accounts to pay health insurance premiums and qualified, out-of-pocket medical expenses that they incur. (Amounts remaining in the Accounts after they die or cease being eligible are forfeited back to the Plan.) See the section entitled EMERITI REIMBURSEMENT BENEFIT: THE REIMBURSEMENT OF QUALIFIED MEDICAL EXPENSES.

Does the Investment of My Accounts Change Once I Retire?

You may continue to invest your Accounts in the available Investment Options for your Plan even after you retire. In that case, the balance in your Accounts will remain subject to the performance of those Mutual Funds.

FEES

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 to continue participation in the Plan.

What Fees Are Charged by OneBridge?

OneBridge provides record-keeping, insurance premium administration and claim processing services to the Plan.

OneBridge's monthly fees for these services are included in the Emeriti monthly fee.

What Fees Are Charges by Alta and Schwab?

Alta is Emeriti's trust services provider, and if selected by your Employer, is its investment manager and Schwab provides investment trading services.

Alta's and Schwab's fees for these services are included in the Emeriti monthly fee.

What Fees Are Charged by Aetna?

The only payments to Aetna and HealthPartners 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.

What Fees Are Charged by Emeriti?

The fees charged by Emeriti for its services to the Plan are:

- $5.00 per month for each retired or terminated participant and $2.50 per month for each participant while employed. If your Accounts are exhausted and you continue participation in the Plan by enrolling in the health insurance, you must pay your portion of the fee by ACH Transfer. Your employer pays these fees during your working years.

- an annual Platform Account fee of 50 basis points (.50%) is assessed on a daily basis against the assets in your Accounts.

THE EMERITI REIMBURSEMENT BENEFIT: THE REIMBURSEMENT OF QUALIFIED MEDICAL EXPENSES

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.")

What is a Qualified Medical Expense?

"Qualified Medical Expenses" or "QMEs" are those expenses incurred by you, your Spouse (or Domestic Partner), your Dependent Children, and your Dependent Relatives for "medical care" as defined in Internal Revenue Code Section 213(d). Most types of medical care are covered, and you may also receive reimbursement for health insurance premiums (but not coverage for any individual as an active employee or dependent of an active employee under an employer-sponsored group health plan), Medicare premiums, tax-qualified long term care premiums, over-the-counter pharmaceuticals with a physician's script, and medical goods, but only to the extent these expenses have not been covered by insurance or another benefit plan. If Aetna (or another insurer) pays only a portion of a medical expense, the unpaid portion may be submitted for reimbursement as a Qualified Medical Expense. More information about QMEs can be found under the **Resources** tab on your Emeriti online participant portal account after logging in at www.MyEmeritiHealth.org.

When Do I Become Eligible for the Reimbursement Benefit?

You become eligible for this benefit when the following occurs:

- You have met the Plan's definition of Retirement Eligibility and subsequently cease employment.

> For an explanation of the term "Retirement Eligibility," please refer to the section "What Does Retirement Eligibility Mean?"

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.

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.

What Happens to My Employee After-Tax Contribution Account If I Cease to Be Employed by the Employer (and What Happens If I Die)?

If you cease to be employed by the Employer, your Employee After-Tax Contribution Account will be available for the Emeriti Reimbursement Benefit (the reimbursement of Qualified Medical Expenses), subject to the eligibility provisions of your Plan. In addition to using the balance in your Employee After-Tax Contribution Account for the reimbursement of medical expenses, you also pay premiums for the Emeriti Health Insurance Plan Options from this Account after you retire, subject to your eligibility for Emeriti Health Insurance under the provisions of your Plan and your election to enroll in one of the Health Insurance Plan Options. Your Spouse (or Domestic Partner), Dependent Children, and Dependent Relatives, also may be eligible for certain benefits, subject to the eligibility provision of your Plan.

If 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 covered, subject to their eligibility for the health insurance.

If any balance remains 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 entire remaining balance of your Employee After-Tax Contribution Account will be forfeited to the Plan. Any amounts forfeited to the Plan will be reallocated to the Employee After-Tax Contribution Accounts of other Participants who have a positive Account balance in your Employer's Plan.

What Happens to My Employer-Contribution Account If I Cease to Be Employed by the Employer (and What Happens If I Die)?

The Plan requires you to satisfy specific age and service requirement in order to use the Employer-Contribution Account, specifically you are at least age 55 and have performed at least 20 years of Continuous Service when you cease employment. If you do not satisfy this requirement, the balance in your Employer-Contribution Account will be forfeited to the Plan after you cease employment with the Employer. If you have satisfied the age and service criteria, when you cease to be employed by the Employer, your Employer-Contribution Account will be available for the Emeriti Reimbursement Benefit (the reimbursement of Qualified Medical Expenses incurred after you terminate employment).

If any balance remains when you have died, when your Spouse (or Domestic Partner) has died, when your Dependent Children have ceased to be Dependent 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.

Are There Any 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 enrolled in an HSA-qualified high deductible health plan ("HDHP") and have elected to contribute to an HSA, the reimbursement account benefit is considered disqualifying coverage that prevents eligibility to contribute to the HSA. To become eligible to contribute to an HSA, you can limit all RHSP benefits accounts by submitting a **Limited HSA Election** form, which is available from the **Resources** tab on your Emeriti online participant portal account after logging in at www.MyEmeritiHealth.org.

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 – the Emeriti RHSP requires you to exhaust your entire FSA balance for the applicable plan year, before you submit claims under any of your Emeriti benefits accounts.

HOW TO SUBMIT QUALIFIED MEDICAL EXPENSE CLAIMS FOR REIMBURSEMENT

If you are eligible for the Emeriti Reimbursement Benefit, you will be able to submit claims for the reimbursement of Qualified Medical Expenses. We describe the process in this section. You also may have access to the Emeriti Benefit Card, which can be used at point of purchase at qualifying pharmacies, medical providers, and other qualifying merchants within the rules and limitations that are explained to you when you sign up for the card. See the section EMERITI BENEFIT CARD below.)

Who Can Submit a Claim?

Prior to the death of the Participant, only the Participant (or their representative in the event of incapacity) may submit claims for the reimbursement of a Qualified Medical Expense, regardless of whether the expense was incurred by the Participant, Spouse (or Domestic Partner), Dependent Child, or Dependent Relative. The only exception is that a Dependent Child (or another authorized individual on behalf of a Dependent Child) may submit claims pursuant to a qualified medical child support order (QMCSO)).

Who May Submit a Claim After I Die?

If a Participant dies and a balance remains available in their Account(s), the responsibility for submitting claims falls to the same person responsible for investing the Account balances. (See the section INVESTMENT OF EMERITI HEALTH ACCOUNTS.) Specifically, the surviving Spouse (or Domestic Partner) submits all claims (incurred by all eligible dependents). If there is no surviving Spouse (or Domestic Partner) or such person dies or opts out of this responsibility, the participant's estate manages the claims process on behalf all eligible dependents.

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

***What Do I Need to Do Before Submitting a Claim for Reimbursement*?**

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

You should check to be sure that OneBridge 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 OneBridge but may be subject to review by the Plan Sponsor.

There are multiple ways for you to request a reimbursement for a qualified medical care expense. These include:

1. Through your Emeriti online portal account - sign in to your portal account at MyEmeritiHealth.org, click **Claims**, then **Submit a Claim**.

2. Using the Emeriti Mobile app - sign in using your Emeriti portal login on the **HRAgo®** app, touch **Claims**, then **Submit a Claim** (you can download the app on the App and Play Stores)

3. By Mail - download the Claim Form from the **Resources** tab on your Emeriti online participant portal account after logging in at www.MyEmeritiHealth.org or call the customer care center at 1-866-EMERITI (1-866-363-7484) to request the form.

You can also use your Benefits Card to pay for qualified medical expenses directly from your Benefits Account without having to pay out-of-pocket and wait to get reimbursed. Refer to the **What Do I Need to Know About the Emeriti Benefits Visa® Card**? for more information.

Except in certain cases where a Benefits Card Transaction will be automatically substantiated per IRS rules, you will need to submit proper supporting documentation for reimbursement of an expense or to support a Benefits Card transaction. Proper supporting documentation contains the following five pieces of information:

1. Name of covered individual or policyholder (you, spouse, dependent)
2. Date item was purchased, service provided, or policy period for insurance premiums
3. Description of item purchased, service provided, or coverage for insurance premiums
4. Name of merchant or provider (pharmacy/store, doctor, hospital, insurance carrier, etc.)
5. Amount of expense

Insurance premium documentation must include the following information, which is usually contained in a premium billing statement or other similar documentation:

1. Name of policyholder
2. Date of Policy period (coverage months)
3. Description of coverage
4. Name of insurance carrier and address
5. Amount of premium

An explanation of benefits (EOB) from your insurance company usually works best to support a reimbursement request of Benefits Card transaction, as it has all five pieces of information required. If you don't have an EOB, try to get an itemized statement or detailed receipt from your provider or merchant.

For helpful information about filing claims and using your Benefits Card, refer to the following resources, which are available from the Resources tab on your Emeriti online participant portal account after logging in at www.MyEmeritiHealth.org:

What Do I Need to Know About Filing a Claim?
What is Proper Supporting Documentation?
What is a Qualified Medical Expense?

How Long Does It Take to Decide My Claim?

OneBridge will determine whether the claimed expense is a Qualified Medical Expense. If so, the claim will be paid. If OneBridge determines that the claim is not a Qualified Medical Expense, OneBridge generally will notify you of its decision within 15 days of its receipt of your claim. However, special circumstances may require a 15-day extension of time to review your claim. OneBridge will notify you of the need OneBridge for an extension, including the circumstances requiring the extension and the date a decision is expected.

What If I Don't Agree With the Claim Determination?

Except as described under "What If I Have a Claim Under Health Insurance Other Than the Emeriti Health Insurance Plan Options?", if your claim is denied in whole or in part, you may request review of your claim at any time within 180 days following the date you received written notice of the denial. If you fail to file a request for review within 180 days, you waive your right to request a review of the denial of the claim. Before you file a formal request for review, you should call the Emeriti customer care center at 1-866-EMERITI (1-866-363-7484). The customer care center will be able to quickly resolve most claims issues without the need for you to file a request for formal review.

Here is how to file a request for formal review:

- You may request review of your claim by contacting the Emeriti customer care center at 1-866-EMERITI (1-866-363-7484).

- You may submit a request for review to the Plan Sponsor at the address provided in the section IMPORTANT INFORMATION ABOUT THE PLAN.

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

What Happens If a Claim Is Overpaid?

With respect to overpayment of a claim for reimbursement of Qualified Medical Expenses or a Benefits Card transaction that is not substantiated as a Qualified Medical Expense, 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 Happens When I Pass Away or When other Covered Family Members who Survive Me Pass Away?

Upon OneBridge's receipt of notification of a participant's death, OneBridge will mail a bereavement packet to the deceased participant's spouse, next of kin, or other authorized estate representative, who will have an opportunity to file final claims incurred by the deceased

participant and any tax-qualified dependents prior to the date of death and to identify any survivors who may be eligible to continue filing claims against the remaining account balance. If there are no surviving tax dependents, the remaining balance will be forfeited. In all cases, survivors will have at least 180 days from the date of delivery of the bereavement paperwork to complete the bereavement process (and up to 12 months upon request for more time).

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.

Will My Accounts Pay For All of My Retirement Medical Expenses?

There is no guarantee that your Accounts will be sufficient to pay for all of your retirement medical expenses. The only benefit available is the total amount that you have accumulated in your Accounts. However, you may replenish your Employee After-Tax contribution Account by making after-tax contributions to the Account after you have ceased employment. The balance would be available for the reimbursement of Qualified Medical Expenses and the payment of premiums for the Emeriti Health Insurance Plan Options. Any investment gain on the balance would accumulate on a tax-free basis.

If you are eligible for and have enrolled in Emeriti Insurance Coverage, you may continue to have access to the Emeriti Health Insurance Plan Options even if you no longer have a balance in your Accounts. You will be required to designate a bank account from which premium payments will continue to be drawn via ACH Transfer.

THE EMERITI BENEFIT CARD

You have two options for accessing your account balance, once you become eligible to do so. You can file a claim as described in the preceding section, or you can use your Emeriti Benefit Card to purchase those Qualified Medical Expenses that can be processed on the Card.

How Do I Obtain an Emeriti Benefit Card?

The Plan makes the Emeriti Benefit Card available to Participants who are eligible for the Emeriti Reimbursement Benefit. Once you become eligible to file claims against any of your Accounts, you will automatically receive a Benefits Card by mail.

How Do I Use the Emeriti Benefit Card?

To pay for Qualified Medical Expenses directly from your Accounts, simply present your Card for payment. The amount of the qualified expense will be deducted from your Accounts, and the funds will automatically be transferred to the merchant for immediate payment. As we explain below, the Card cannot be used everywhere.

Where Can I use the Emeriti Benefit Card?

You may use the Card at qualifying providers or merchants where the Card is accepted.

What Do I Do if the Card is Not Accepted at Point of Purchase?

Your Card may not work for several reasons. For example, the merchant or provider may not recognize your purchase as a covered Qualified Medical Expense for which Emeriti permits the use of the Card.

In all cases, you can submit the claims for reimbursement of any Qualified Medical Expense you incur, rather than use the Card.

If you have a problem using the Card and cannot identify the reason, please contact 1-866 Emeriti (1-866-363-7484).

Do I Need to Save Documentation of Purchases With the Card?

The required documentation for Card transactions is the same documentation that is required for traditional claims submission, described in the preceding section. You must retain copies of all itemized receipts for each Card transaction. You will be notified if the plan needs you to submit your documentation to support your purchase. Keep all your documentation until you are notified that your transaction has been substantiated (or approved).

What Happens if the Card is Used to Purchase Something Other Than a Qualified Medical Expense?

If you use your Card to pay for ineligible purchases, you will be required to reimburse the Plan. If you do not reimburse the Plan, your Card may be deactivated, and steps may be taken to collect the amount on behalf of the Plan.

THE EMERITI INSURANCE BENEFIT: HEALTH INSURANCE COVERAGE

The basic rules relating to your eligibility for Health Insurance Coverage under your Plan are explained below. If you are eligible for this coverage, you will be able to enroll in one of the Health Insurance Plan Options available in the Emeriti Program after you reach age 65 and enroll in Medicare Parts A and B. However, it is important that you understand that even if you are eligible for coverage, you must enroll in a Health Insurance Plan Option within the prescribed enrollment period. If you do not enroll within the enrollment period, you will not be permitted to enroll at a later date, except in limited circumstances described below.

For more detail, please refer to your Plan document. You may also contact Emeriti at the following number: 1-866 Emeriti (1-866-363-7484).

Under What Conditions Do I Become Eligible for Health Insurance Coverage?

You become eligible for Health Insurance Coverage once you have satisfied the "Retirement Eligibility" criteria set forth in your Plan.

What Does "Retirement Eligibility" Mean?

The term "Retirement Eligibility" refers to the criteria the Plan Sponsor has established to determine whether you are eligible for Emeriti Retiree Health Insurance Coverage.

Under the terms of your Plan, you satisfy the criteria for Retirement Eligibility on the date you have ceased employment with your Employer, and have:

- 20 Years of Continuous Service and are age 55 or older OR
- 5 Years of Continuous Service and enrolling in Medicare Parts A and B

What If I Stop Working For My Employer Before I Satisfy the Retirement Eligibility Criteria?

If you stop working before you satisfy the Retirement Eligibility criteria, then you, your Spouse (or Domestic Partner) and Dependent Children will not be eligible for Health Insurance Coverage. Note, however, that your failure to satisfy the Retirement Eligibility criteria will not affect any rights you (or your family members) may have to the Emeriti Reimbursement Benefit (reimbursement of Qualified Medical Expenses).

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 ceased employment. ***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?

Your plan also makes available early coverage for those eligible Participants who retire prior to age 65.

IMPORTANT:

- 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.
- 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).
- 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.
- 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 1-866-EMERITI (1-866-363-7484)**.**
- If you have any questions about eligibility for coverage or enrollment, you should call 1-866-EMERITI (1-866-363-7484).

Will I Have a Choice of Health Insurance Plan Options When I Enroll?

Yes. A range of Health Insurance Plan Options are available. Your level of coverage will depend on which option you choose. The Health Insurance Plan Options generally consist of:

- Post-65 Options:

  One or more Health Insurance Plan Options for eligible individuals who are age 65 and older (referred to as "Post-65 Options"). Post-65 Options are either integrated with Medicare Parts A and B or offered under Medicare Part C (Medicare Advantage). The Post-65 Options are available to eligible: (1) Participants who have attained age 65 and enrolled in Medicare or who are Permanently Disabled; (2) Spouses (or Domestic Partners) who have attained age 65 or who are Permanently Disabled; and (3) Dependent Children who are Permanently Disabled. (In all cases, these individuals must be enrolled in Medicare Parts A and B.)

- One or more Medicare Part D prescription drug plans

- One or more dental insurance plans

- Pre-65 Options:

  At least one Health Insurance Plan Option for eligible individuals who have not yet attained age 65 (referred to as "Pre-65 Option"). The Pre-65 Option is available to eligible: (1) Spouses (or Domestic Partners) who have not attained age 65; (2) Dependent Children — provided these individuals are not Permanently Disabled.

Please note the following

- In certain circumstances the range of available Health Insurance Plan Options will be limited. For example, although Dependent Children are covered under most Health Insurance Plan Options, in some cases, this coverage will be unavailable.

- The exact benefits provided under each option may vary by state as necessary to comply with Federal and State laws and regulations and conform to changes in federal programs, such as Medicare.

- 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 at least 90 days 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) 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, except in limited circumstances described below.

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 Spouse (or Domestic Partner) later enrolls in Medicare Parts A and B (after attaining age 65), then they will be requested to change from the Pre-65 Option to a Post-65 Option. They must do so within the 90-day period commencing on the date your Spouse (or Domestic Partner) enrolls in Medicare Parts A and B or during the next open enrollment period. **The Plan will notify you 90 days in advance of your 65th birthday to solicit what Post-65 plan you want to enroll in.**

- If your Spouse (or Domestic Partner) is not yet age 65 and does not enroll in a Pre-65 Option, they will have an additional opportunity to enroll in a Post-65 Option. Specifically, they will be provided with 90 days to enroll in a Post-65 Option once they reach age 65 and enroll in Medicare Parts A and B.

When May I Enroll My Dependent Children and What Health Insurance Plan Options Are Available?

You may enroll your Dependent Children in a Pre-65 Option when you enroll in a Health Insurance Plan Option. ***The same 90-day enrollment period that applies to you applies to your Dependent Children***. It is recommended that you do not defer their enrollment and enroll them at the same time that you enroll to reduce the risk that you fail to enroll them within the 90-day enrollment period.

IMPORTANT:

- Eligible Spouses (or Domestic Partners) and Dependent Children may enroll in Emeriti coverage *only if you (the Plan participant) are enrolled*. (Special exceptions may apply in the event of your death.)

- If your Spouse (or Domestic Partner) or your Dependent Children do not enroll in an Emeriti coverage within the applicable enrollment period, in most instances they will not be eligible to enroll at a later date.

- Although coverage for Dependent Children is available in most cases, Dependent Children are not covered under all Health Insurance Plan Options. This 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 to Participants residing in Minnesota who are participating in a Plan established by a Plan Sponsor located in Minnesota**.**

- If you have any questions about enrollment, you should call 1-866-EMERITI (1-866-363-7484).

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?

Generally, you will not have any additional opportunities to enroll: If you, your Spouse (or Domestic Partner) or Dependent Children do not enroll in a Health Insurance Plan Option during the applicable enrollment period, you or they will not be permitted to enroll in the Health

Insurance Coverage offered under your Plan. There are, however, exceptions to the following qualifying life events:

1. A Participant, Spouse (or Domestic Partner), or Dependent Child may enroll ***within 30 days*** *of the following events*:

   - if they were enrolled in COBRA continuation coverage in another plan and the maximum coverage period expired, or

   - if they had coverage under another group health plan and that coverage has been terminated (for reasons that are specified at Section 6.5 of your plan document),

2. If a Participant marries, the new Spouse may obtain coverage, if the Participant has already enrolled or has not been barred from enrolling as a result of failing to enroll during the applicable enrollment period.

3. If a Participant has a new Dependent Child by birth or adoption, the new Dependent Child may obtain coverage, if the Participant has already enrolled or has not been barred from enrolling as a result of failing to enroll during the applicable enrollment period.

In all these cases, the enrollment must occur within 30 days of the qualifying life event, and the Participant must already be enrolled or also enroll in Health Insurance Coverage.

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

"Permanent 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 they are 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 within the ninety (90)-day enrollment period commencing on the date that you enroll in Medicare Parts A and B.

A Permanently Disabled Participant may enroll their Spouse (or Domestic Partner) and Dependent Children in Health Insurance Coverage. Each must be enrolled within the same enrollment period applicable to the Permanently Disabled participant.

May a Permanently Disabled Spouse (or Domestic Partner) or Dependent Child Obtain Access to Health Insurance Coverage?

A Spouse (or Domestic Partner) or Dependent Child will be Permanently Disabled under the Plan, if they become permanently disabled when the Participant was enrolled in Health Insurance Coverage, in which case they will be able to enroll in Health Insurance Coverage after obtaining a final determination from the Social Security Administration that they are permanently disabled under SSA rules and enrolling in Medicare Parts A and B. In the case of a Dependent Child, they must have become permanently disabled while a "Dependent Child" under the Plan. They must enroll within the ninety (90)-day enrollment period commencing on the date that they enrolled in Medicare Parts A and B.

What if a Dependent Relative Becomes Disabled?

Dependent Relatives are not eligible for Health Insurance Coverage under the Plan irrespective of whether they are disabled.

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

If you die before you satisfy the Retirement Eligibility criteria, your Spouse (or Domestic Partner) and Dependent Children will not be eligible for Health Insurance Coverage. They may, however, be eligible for an Emeriti Reimbursement Benefit.

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

If you have satisfied your Plan's Retirement Eligibility criteria and die while still employed by the Employer, but before enrolling (or having the opportunity to enroll) in Health Insurance Coverage, then your surviving dependents may be eligible to enroll by electing one of the Health Insurance Plan Options. They must enroll within the ninety (90)-day enrollment period commencing on the date of the Participant's death. If they do not enroll within this enrollment period, they will not be able to enroll in Health Insurance Coverage in the future. There is one exception: A Spouse (or Domestic Partner) who is eligible for a Pre-65 Health Insurance Plan Option and chooses not to enroll in that option may enroll in a Post-65 Option at a later date, provided they does so within the 90-day period commencing on the later of the date they attain age 65 or enrolls in Medicare Parts A and B.

If you had the opportunity to enroll in Health Care Coverage prior to your death and failed to enroll within the applicable enrollment period, then after your death, your surviving dependents will not be eligible to enroll.

What if I Die After Having Enrolled in Health Care Coverage?

If you die after having enrolled in a Health Care Coverage, and your Spouse (or Domestic Partner) and/or Dependent Children *are enrolled in a Health Insurance Plan Option at the time of your death*, they may remain enrolled in the same option(s), subject to the following:

- A Spouse (or Domestic Partner) enrolled in a Pre-65 Option must elect a Post-65 Option upon their attainment of age 65 and enrolling in Medicare Parts A and B within 90 days.

- A Dependent Child who no longer satisfies the "Dependent Child" definition, for example, because they are too old, will lose coverage.

- The Spouse (or Domestic Partner) and/or Dependent Children will have the right to change to another Emeriti Health Insurance Plan Option during the open enrollment period.

- A Spouse (or Domestic Partner) or Dependent Child who is enrolled in a Pre-65 Option and becomes Permanently Disabled must enroll in a Post-65 Option within 90 days of becoming Permanently Disabled.

If your Spouse (or Domestic Partner) and/or Dependent Children *were not enrolled in a Health Insurance Plan Option at the time of your death*, they may enroll, subject to following:

- The Spouse (or Domestic Partner) and Dependent Children must enroll within the 180-day period after your death.

- If the Spouse (or Domestic Partner) is under age 65, they may choose not to enroll in a Pre-65 Option, and will have an additional opportunity to enroll in a Post-65 Option, within a 90-day enrollment period commencing on the later of the date they attain age 65 or enroll in Medicare Parts A and B.

- Dependent Children's status is determined at date of death for purpose of determining whether they have a right to enroll following the Participant's death.

- Dependent Children will lose coverage once they no longer satisfy the "Dependent Child" definition.

Are There Open Enrollment Periods?

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

What If I Am Eligible for Coverage Under An Employer's Plan for Active Employees?

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

Can an Individual's Coverage Cease If Their 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 they fail to meet the Plan's definition of "Spouse", Domestic Partner", or "Dependent Child", as applicable.

Please note, however, that Health Insurance Coverage of a Spouse (or Domestic Partner) or Dependent Child will not cease on account of the death of the Participant. Specifically, the Spouse (or Domestic Partner) retains their status (as of the date of death) after the death of the Participant. A Dependent Child will retain their status after the death of the Participant until they no longer satisfy the age requirements set forth in the definition of "Dependent Child".

Can My Health Insurance Coverage be Cancelled Because of Something I Did or Failed to Do?

Your Health Insurance Coverage can be cancelled due to your:

(1) non-payment of premiums;

(2) failure to abide by the terms and conditions of the Plan and the terms of the coverage; or

(3) voluntary cancellation of the coverage.

If your Health Insurance Coverage under a Health Insurance Plan Option is cancelled for any of these reasons, you will be ineligible to re-enroll in Health Insurance Coverage, unless expressly permitted by the insurer. The coverage, however, will not cease earlier than the date permitted by Medicare.

How Do I Pay Premiums For The Health Insurance Plan Option That I Have Selected?

If you have a sufficient balance, your premiums will be paid automatically from your Accounts on a monthly basis. Health Insurance premiums will be deducted first from the balance of your Employer-Contribution Account and, if an insufficient balance remains, then from your Employee After-Tax Contribution Account. If there is an insufficient balance in your Accounts, the premiums will be drawn from a personal bank account that you designate. You will be required to complete documentation so that the premium payment is drawn automatically from your designated bank account whenever the balance in your Accounts is insufficient.

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
- Program design decisions intended to reflect the overall needs of those participating in, or eligible to participate in, the Emeriti Program

- Insurer decisions relating to the range of insurance coverage they wish to provide.
- The contract between Emeriti and the insurer(s) providing coverage under the Emeriti Program may be terminated.

There is no guarantee that the current range of Health Insurance Plan Options, the details of each plan option, or the premium levels will continue as described in this SPD or in other information that may be provided to you by your Employer, Emeriti, or Emeriti's service providers, including the insurer(s).

There is no guarantee that the Emeriti Program will continue its relationship with the current insurers or that the insurers will continue to offer insured health plans to the Program in the future. In such circumstances, Emeriti would make its best efforts to find appropriate replacement(s), but there is no guarantee that a replacement insurance company (or companies) could be found in the future. If a replacement insurance company is not available to the Program, access to your Accounts would be only through the reimbursement of Qualified Medical Expenses (including the payment of premiums for individually procured insurance).

Is Health Insurance Coverage Under the Plan Available Nationwide?

The Emeriti Program is designed to provide coverage to residents across the United States. However, there is no guarantee that coverage will be available in all states and territories, or that the coverage will be uniform across all states and territories.

You may call 1-866-EMERITI (1-866-363-7484) to determine any variation in the Emeriti Health Insurance Plan Options for your state or territory.

For individuals residing in Minnesota: Insurance coverage in Minnesota is provided by HealthPartners, not Aetna. Coverage in Minnesota does not include coverage for Dependent Children. Please refer to Appendix E to this SPD.

How Does Medicare Part D Impact the Plan?

All of the Post-65 Health Insurance Plan Options include prescription drug coverage. By enrolling in a Post-65 Option, you will obtain prescription drug coverage. This means that you do not need to enroll in a separate Medicare Part D plan outside of this Plan.

Please note that if you enroll in a Post-65 Option under the Plan, and you also enroll in a Medicare Part D plan elsewhere, you will automatically lose your Emeriti prescription drug coverage under your Post-65 Option. There is no guarantee, if you make a second election of Part D insurance elsewhere, that a Post-65 Option without prescription drug coverage will be available to you. As a result you may lose your Health Insurance Coverage under this Plan and may not be able to enroll in future years.

EMERITI HEALTH INSURANCE PLAN OPTIONS – BENEFITS AND CLAIMS

The Pre-65 and Post-65 Emeriti Health Insurance Plan Options described in the previous section are underwritten by Aetna and are described in the Coverage Documents. These documents are provided to you separately when you select an option at retirement but are considered part of this SPD. For information on how to obtain a copy of these documents call 1-866-EMERITI (1-866-363-7484).

(Note that if your Employer is located in, and you reside in Minnesota, your coverage may be underwritten by another insurer, in which case references in this SPD to Aetna may need to be read as references to that insurer – see Appendix E for more details.)

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

How Do I File a Claim for Benefits Under the Emeriti Health Insurance Plan Option that I have selected?

Claims for benefits under the Emeriti Health Insurance Plan Options are processed by Aetna. Aetna is also responsible for reviewing denied claims, which are appealed. Aetna's procedures for filing claims (and appeals of denied claims) are described in the Coverage Documents. The determination of your claim by Aetna (following any appeal to Aetna) is final, and no one else, including your Employer, OneBridge, or Emeriti, has any authority to overrule that determination.

What If I Have a Claim Under Health Insurance Other Than the Emeriti Health Insurance Plan Options?

If you use your Emeriti Health Accounts to pay the premiums for health insurance other than the Emeriti Health Insurance Plan Options, then you must file any claims for benefits under that health insurance in accordance with its terms. (You may file for reimbursement of the premiums paid for this insurance. Please refer to the section titled "Reimbursement of Qualified Medical Expenses.")

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).

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 deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage.

ORDERING OF MULTIPLE PLANS UNDER THE EMERITI PROGRAM

What If I Have Been a Participant in More Than One Plan Established Under the Emeriti Program?

If you are a Participant in this Plan and a participant under plans of one or more other employers who are also members of the Emeriti Program, all of your accounts for each Emeriti plan sponsor will be visible and accessible from your portal account.

How Does My Participation in Multiple Plans Affect the Reimbursement of Qualified Medical Expenses?

Reimbursement Benefits are paid from the claims-eligible Emeriti Plan account from which you (or after your death, the person controlling your Accounts) elect to seek reimbursement of your Qualified Medical Expenses.

How Does My Participation in Multiple Plans Affect My Payment of Health Insurance Premiums?

The same rule that applies to Reimbursement Benefits also applies to your payment of premiums for Health Insurance Coverage. The premiums are paid first from the Emeriti Plan from which you (or after your death, the person controlling your Accounts) first elect to commence the payment of benefits. After the Accounts under the plan are exhausted, the premiums are paid from the next plan in which you had most recently established an Account.

How Does My Participation in Multiple Plans Affect My Health Insurance Coverage?

The rules relating to Health Insurance Coverage are those set forth in the Emeriti Plan from which you first elect to commence the payment of benefits. If your Accounts in that plan are depleted, you will retain the coverage elected under that particular Emeriti Plan. The rules of this plan will continue to apply. You will not be required or permitted to re-enroll in Health Insurance Coverage under another Emeriti Plan.

PLAN ADMINISTRATION

Who Administers the Plan?

The Plan Sponsor is the administrator of the Plan and responsible for the overseeing and monitoring its administration and operation. Various service providers perform ministerial services for the Plan Sponsor to assist it in administering the Plan. However, the Plan Sponsor (or its delegate) has the sole discretion and authority to interpret and administer the Plan in all of its details. The determination of the Plan Sponsor (or its delegate) as to any question involving the administration and interpretation of the Plan shall be final, conclusive, and binding, subject to any rights a participant may have under the Plan, for example, to appeal a benefits determination, or any legal action they may be entitled to commence under ERISA. (See the section titled "Legal Considerations Under ERISA and The Securities Laws" and the "Statement of ERISA Rights" in this SPD.)

The Plan Sponsor has expressly delegated its authority to Emeriti to act as administrator with respect to certain aspects of the Plan, subject to oversight by the Plan Sponsor. In addition to any powers delegated to Emeriti as described in the other portions of this SPD, the Plan Sponsor has delegated the following powers to Emeriti:

- to make and enforce such rules and regulations as Emeriti deems necessary or proper for the efficient administration of the Plan within the framework of the Emeriti Program;
- to interpret the Plan, and to resolve any ambiguity or inconsistency in the terms of the Plan where necessary for the efficient administration of the Plan within the framework of the Emeriti Program; and
- to allocate and delegate certain ministerial responsibilities under the Plan and to designate other persons to carry out any ministerial responsibilities, including those relating to the recordkeeping of Plan assets and participant-level accounts and the administration of COBRA.

Who Are the Plan's Service Providers and What Are Their Functions?

OneBridge Benefits Inc. provides record-keeping services relating to your participation in the plan, your and your Employer's contributions to the Plan, your investment options, and other administrative services. OneBridge also provides services that include insurance premium administration, qualified medical expense processing, and other administrative services.

Alta Trust Company provides directed trustee services for your Plan. In addition, if your employer has elected the Emeriti Standard Investment Menu and appointed Alta Trust to provide investment fiduciary services, Alta Trust will serve as the investment manager for your Plan. Alta Trust and OneBridge Benefits have entered into a contract with Charles Schwab Trust Bank to provide sub-custodial and investment trading services.

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, including Minnesota. In such states an insurer other than Aetna may provide the Health Insurance Plan Options available to you.)

Can the Service Providers Change?

Yes. While no changes are currently contemplated, the role of current service providers in support of the Emeriti Program and your Plan is not guaranteed. Contracts may be terminated, and service providers may change under certain circumstances.

Who Is the Trustee?

The Trustee for both VEBA Trusts established to hold your Plan's assets is Alta Trust Company. The principal duties of the Trustee are to hold, invest and reinvest the Trust Fund in accordance with the direction provided by the Plan Sponsor and you and to make payments from the Trusts as directed by the Plan Sponsor.

If your Employer elects, Alta may also serve as the Qualified Investment Manager for the selection of the Investment Menu.

What Protection Does the Use of a VEBA Trust Provide?

Because the balance in your Accounts reflects assets held by a VEBA trust, the assets can be used only to provide benefits under the terms of your Plan and cannot be reached by your Employer or any creditor of you or your Employer. If assets in a Participant's Account are forfeited, the assets remain in the Trust and may be used to pay certain plan expenses or future employer contributions. If the source of forfeited assets is a Participant's own contributions, the assets must be allocated among the Accounts of current Participants

What Government Reporting is Done For The Plan?

Each year, the Plan will file an annual report (DOL Form 5500) with the U.S. Department of Labor. In most cases, the Form 5500 filing must include an audited financial statement for the Plan that satisfies ERISA requirements.

Additionally, each of the VEBA trusts will file an IRS Form 990 (Exempt Organization Tax Return) with the Internal Revenue Service each year.

Do I Receive Any Information Connected to the Plan's Annual Report to the Government?

Within nine months after the end of each year, you will receive a Summary Annual Report that provides important information from the Form 5500. You also can obtain a copy of the Form 5500, including the audited financial statement, 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.

LEGAL CONSIDERATIONS UNDER ERISA AND THE SECURITIES LAWS

The Plan is an employee welfare benefit plan subject to the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides a comprehensive regulatory scheme for the regulation of employee welfare benefit plans and provides you with certain rights, protections and remedies. In addition, various remedies available under the federal securities laws may be applicable to your Plan.

ERISA Section 502(a)(2) allows a participant, fiduciary or beneficiary to bring suit against a fiduciary for breach of fiduciary duty under ERISA Section 409. ERISA Section 502(a)(3) allows a participant, fiduciary or beneficiary to bring suit to enjoin any act that violates ERISA or obtain equitable relief to redress a violation of ERISA. The fiduciaries of the Plan include the Plan Sponsor (your Employer) as the plan sponsor, named fiduciary and the plan administrator. (Each of these terms is defined in ERISA.) The fiduciary status of the trustee is limited by its status as a directed trustee. The fiduciary status of Emeriti is limited by the extent that the Plan Administrator has delegated to it certain fiduciary duties and discretionary authority with respect to the Plan. In most jurisdictions and most circumstances, remedies relating to the Mutual Funds may be pursued only by the Plan on behalf of all affected participants and any recovery would be retained in the Plan accounts of affected participants. Please also see the Statement of ERISA Rights set forth below.

All the Investment Options offered under your Plan are registered mutual funds, for which the prospectuses are available on the internet or can be requested by phone. The offerings of shares of the mutual funds are registered under the Securities Act of 1933 ("Securities Act"), and the mutual funds are registered under the Investment Company Act of 1940 ("Investment Company Act"). Potential remedies under the federal securities laws may include (1) Section 11 of the Securities Act, which provides a rescission remedy for securities sold under a registration statement where there is a material misstatement or omission; (2) Section 12(a)(2) the Securities Act, which provides a rescission-type remedy for securities sold under a prospectus which contains a material misstatement or as to which there is an omission of a material fact, and (3) Rule 10b-5 under the Securities Exchange Act that makes it unlawful to employ any device to defraud, to make any untrue statement of a material fact, or to engage in any transaction that operates as a fraud in the offer or sale of any security.

Participation interests in the Employee After-Tax Contribution VEBA under the Plan are securities that are not registered under the Securities Act and the Employee After-Tax Contribution VEBA is not registered under the Investment Company Act. The participation interests are subject to the anti-fraud provisions 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 not registered under the Investment Company Act, and the participation interests in the Employee After-Tax Contribution VEBA are not registered under the Securities Act.

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

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

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

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

Continue Group Health Plan Coverage:

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

Prudent Actions by Plan Fiduciaries:

In addition to creating rights for Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights:

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Sponsor

to provide the materials and pay you a penalty for each day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Sponsor. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds that your claim is frivolous.

Assistance with Your Questions:

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

COBRA CONTINUATION COVERAGE

What is COBRA Continuation Coverage?

COBRA continuation coverage is a temporary extension of health care coverage for a "qualified beneficiary" who would otherwise lose coverage due to a "qualifying event." The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA provides *access* to continued coverage up to a maximum period, but it does not provide for *payment* of continued coverage. Qualified beneficiaries who elect to continue coverage under COBRA must pay for the costs of that continued coverage out of pocket.

Who Is Entitled to Elect COBRA Continuation Coverage?

If a Spouse loses coverage under the Emeriti Insurance or Reimbursement Benefit (*i.e.,* loses the ability to file claims for reimbursement of Qualified Medical Expenses following the Participant becoming eligible to do so) as a result of divorce or legal separation or a Dependent Child loses coverage as a result of ceasing to qualify as a Dependent Child, then they will be a qualified beneficiary who has incurred a qualifying event and is entitled to elect COBRA continuation coverage. No other individuals can become qualified beneficiaries, and there are no other qualifying events under the terms of the Plan (*but see the GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS provided below regarding a special qualifying event in the case of the Employer's bankruptcy*). Note, however, that the Emeriti RHSP may be able to divide your claims-eligible Accounts according to a court approved divorce decree or other court order if your spouse elects this in lieu of COBRA. For more information about this, contact the Emeriti customer care center at 1-866-EMERITI (1-866-363-7484).

How Does COBRA Apply to This Plan?

The Emeriti Insurance and Reimbursement Benefit are subject to COBRA. Thus, any individual covered under the Emeriti Insurance and Reimbursement Benefits who loses coverage due to a "qualifying event" is considered a qualified beneficiary entitled to elect continued coverage in the Emeriti Insurance and Reimbursement Benefit under COBRA.

How Long Does Continuation Coverage Last?

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

How Much is the Premium for Continued Coverage?

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.

There is no premium cost for continued coverage in the Emeriti Reimbursement Benefit.

Can the Plan Terminate the Qualified Beneficiary's Continuation Coverage if They Fail to Pay the Required Premium?

Yes. If the qualified beneficiary fails to pay the required COBRA premium in a timely manner, their 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. Payment of any premium, other than the first premium, is considered to be timely if the full amount of the premium is paid within 30 days after the premium due date.

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

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

- The individual becomes covered under any other group health plan (as an employee or otherwise), provided that such plan does not contain any exclusion or limitation with respect to any preexisting condition of such individual.
- The Employer no longer sponsors or maintains any group health plan (including successor plans) for any of its retired employees.
- The former Spouse or Dependent Child becomes entitled to Medicare.

How Does a Qualified Beneficiary Elect Continuation Coverage?

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

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

A qualified beneficiary's election of continuation coverage is deemed to be made on the date the qualified beneficiary's election is sent to the COBRA Administrator. If a Spouse or Dependent Child waives continuation coverage during the election period, that waiver may be revoked at any time before the end of the election period. If any waiver is revoked before the end of the election

period, however, continued coverage under the Emeriti Health Insurance Plan Options is effective prospectively only from the date the waiver is revoked.

What if an Individual is a Qualified Beneficiary and an Alternate Account Holder Under the Next Section Entitled "Domestic Relations Orders"?

An individual who is a qualified beneficiary for the purposes of coverage under the Emeriti Health Insurance Plan Options must pay their COBRA premiums out of pocket. The COBRA premiums cannot be submitted for reimbursement as a Qualified Medical Expenses. However, if the individual is also an alternate account holder as described in the next section entitled "Domestic Relations Orders," they may submit claims for reimbursement of those premium payments from their account.

What if I Have Questions About COBRA Continuation Coverage?

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

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

This notice contains important information about your right to COBRA continuation coverage. It generally explains how COBRA continuation coverage works, when it may become available to you and your family, and what you and they need to do to protect the right to receive it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

Introduction

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

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

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

What is COBRA Continuation Coverage and Who is Eligible?

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

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

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

ability to file claims for reimbursement of Qualified Medical Expenses following the Participant becoming eligible to do so, the Emeriti RHSP may be able to divide your claims-eligible Accounts according to a court approved divorce decree or other court order, if you elect this in lieu of COBRA. For more information about this, contact the Emeriti customer care center at 1-866-EMERITI (1-866-363-7484).

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

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

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

Your Employer Must Give Notice of Certain Qualifying Events

The Plan will offer COBRA continuation coverage under the Emeriti Health Plan Options to qualified beneficiaries only after the COBRA Administrator has been notified that a qualifying event has occurred. If a filing in bankruptcy by the employer triggers a qualifying event, your employer must notify Emeriti. Emeriti will then inform the COBRA Administrator that a qualifying event has occurred.

The Qualified Beneficiary Must Give Notice of Certain Qualifying Events

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

How is COBRA Coverage Provided?

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

COBRA continuation coverage is a temporary continuation of coverage lasting for up to a total of 36 months (subject to proper election of COBRA continuation coverage). The coverage provided

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

There is no premium cost for COBRA continuation coverage for the Emeriti Reimbursement Benefit.

If You Have Questions

If you have questions regarding COBRA and the Plan, you should review the Plan's Summary Plan Description or call the number listed at the end of this notice. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at http://www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.

Keep Your Plan Informed of Address Changes

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

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

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

DOMESTIC RELATIONS ORDERS

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 Emeriti RHSP may be able to divide your claims-eligible Accounts according to a court approved divorce decree or other court order. For more information about this, contact the Emeriti customer care center at 1-866-EMERITI (1-866-363-7484).

The plan is not subject to Section 414(p) of the Internal Revenue Code.

You may call 1-866-EMERITI (1-866-363-7484) to request additional information.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

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

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

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

What If the Participant Is Not Eligible for Medical Benefits?

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

AMENDMENT, TERMINATION, AND WITHDRAWAL

Can the Plan Sponsor Amend or Terminate the Plan?

The Plan Sponsor intends to continue the Plan indefinitely. However, subject to the terms of its participation in the Emeriti Program, the Plan Sponsor reserves the right to modify, alter, 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 under the Plan, and its obligation to pay the Emeriti per-participant fee. The Plan Sponsor may change the Mutual Funds available for investment under the Plan.

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

Can Emeriti Amend or Terminate the Program?

Emeriti has the right to make certain changes to the Program that would affect the Plan. These changes could include, for example, the Investment Options the Health Insurance Plan Options, the Program's service providers, and the level and nature of the fees charged.

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

No. If you meet the criteria for Retirement Eligibility (and the eligibility requirements imposed by the relevant insurer), you have a right to enroll yourself and your eligible dependents in the Emeriti Health Insurance Plan Options, but only to the extent that they are offered under the Plan at the time of enrollment and only to the extent that you enroll within the required enrollment time frame. 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.

HEALTH PRIVACY

The Standards for Privacy of Individually Identifiable Health Information (codified at 45 CFR Parts 160 and 164), commonly called the HIPAA Privacy Rules, establish standards for the protection of individually identifiable health information. The HIPAA Privacy Rules apply to 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.

TAX EFFECTS OF PARTICIPATION IN THE PLAN

The following summary of Federal income tax consequences of participation in the Plan does not purport to be complete. In addition, in some cases it may be important to consider the effect, if any, of gift, estate and inheritance taxes. Finally, the following summary is based on Federal income tax law and regulations current as of January, 2024, and is subject to change at any time.

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

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

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

The contributions to the Plan by your Employer are not taxable to you when made to the Plan. All of your contributions to the Plan will be made on an after-tax basis and may not be deducted on your individual income tax return. Earnings on investments in your Accounts will not be taxable to you. You may not deduct any losses on investments in your Accounts.

Benefits distributed from the Plan for the "medical care" of participants and their eligible dependents will be exempt from Federal income tax. Medical care would include the payment of premiums for health insurance, including the Emeriti Health Insurance Plan Options, and the reimbursement of Qualified Medical Expenses. If a reimbursement of Qualified Medical Expenses is erroneously overpaid, the overpayment would be subject to tax and, if not reported on a timely basis, to penalties and interest.

IMPORTANT: With respect to your family members who can have premiums or reimbursements paid from your Accounts, the Plan is intended to cover individuals who qualify as your spouse or dependent under Federal tax law. If you enroll an individual who does not qualify as your spouse or dependent under Federal tax law (such as a domestic partner), you may be required to report as taxable income the value of coverage and benefits received. Consult your tax advisor if you have any questions about an individual qualifying as your spouse or dependent under Federal tax law. There also may be different tax treatment under state and local income tax law.

Because your Employer is a tax-exempt organization, it does not receive a tax deduction for its contributions to the Plan. The earnings generated by contributions to the Plan will be exempt from Federal income tax, including the unrelated business income tax ("UBIT") provisions of Federal income tax law.

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

SECURITIES LAW STATUS

Emeriti's investment advisor status

No provision of investment advice. Emeriti Retirement Health Solutions is not a registered investment adviser. Emeriti does ***not*** provide personalized advice to participants about their individual investment selections. Impersonal educational materials that Emeriti may provide regarding investing and investments under your Plan are not intended to constitute and are not "investment advice."

No offer to sell, solicitation to buy, or recommendation of any securities or participation interests. This summary plan description, the plan document, and any materials or information provided by Emeriti are ***not***, and should ***not*** be construed as, an offer to sell, a solicitation of an offer to buy, or a recommendation of any security or participation interest.

No determination of suitability. Emeriti has ***not*** made any determination that any security, participation interest or investment strategy is suitable for any individual.

Regarding participation interests in the voluntary employee contribution VEBA Trust

Except to the extent federal law preempts state law: (i) the participation interests in the voluntary employee contribution VEBA trusts associated with the Emeriti plans may be treated as securities under various state securities laws; (ii) the offering of these participation interests is subject to compliance with any applicable state law; and (iii) for residents of Georgia, the participation interests are being offered in reliance on paragraph 13 of Code Section 10-5-9 of the Georgia Securities Act of 1973, as amended (the "Georgia Act"). The participation interests may not be sold or transferred.

IMPORTANT INFORMATION ABOUT THE PLAN

Name of Plan:	Emeriti Retiree Health Plan for Reed College
Plan Sponsor (and Plan Administrator):	Cypress Allard Human Resources Generalist allardc@reed.edu 503-777-7255
Employer Identification Number:	93-038-6908
Plan Number:	525
Type of Plan:	Health and welfare benefit plan.
Type of Administration:	Self-administered with certain elements of contract administration by third-party service providers.
Plan Effective Date:	July 1, 2006; restated January 1, 2026
Plan Year:	January 1 - December 31
Record Keeper:	OneBridge Benefits Inc. Emeriti RHSP PO Box 4391 Clinton, IA 52733-4391 1-866-EMERITI (1-866-363-7484)
Benefits Administrator:	OneBridge Benefits Inc. Emeriti RHSP PO Box 4391 Clinton, IA 52733-4391 1-866-EMERITI (1-866-363-7484)
Trustee:	Alta Trust Company c/o OneBridge Benefits Inc. Emeriti RHSP PO Box 4391 Clinton, IA 52733-4391

Insurers:	Aetna Life Insurance Company 151 Farmington Ave. Hartford, CT 06156 1-866-EMERITI (1-866-363-7484) for enrollment, and transfer to carrier for coverage ID or coverage claim questions.
COBRA Administrator:	Emeriti 828 E. Adams St. Muncie IN 47305 1-866-EMERITI (1-866-363-7484)
Agent for Service of Legal Process:	Service of legal process may be made on the Plan Sponsor at the above address. Service of Legal Process may also be made on the Plan's Trustee at the above address.

APPENDIX A – PARTICIPATING AFFILIATES

None.

APPENDIX B – OTHER CLASSES OF EMPLOYEES EXCLUDED FROM THE DEFINITION OF ELIGIBLE EMPLOYEE UNDER THE PLAN

Reed College further excludes temporary and on-call employees.

APPENDIX C – EMPLOYER CONTRIBUTIONS

Bronze Group: Employees hired on or after July 1, 2006 are eligible to fully participate in this Plan. Reed College will not subsidize any Emeriti, or OneBridge fees charged to Bronze Group Participant Accounts. Receives an annual flat dollar Employer Contribution of $2040.

Silver Group: Employees hired prior to July 1, 2006 who are ineligible for Reed College's pre-existing defined benefit retiree medical plan, which is frozen to new participants. Silver Group Participants are eligible for the Emeriti Retiree Health Insurance Plan Options and the Emeriti Reimbursement Benefit, if they satisfy the requirements. They are ineligible for standard Employer Contributions, but may make Employee After-Tax Contributions and will be eligible for "pay-as-you-go" premium payments made by Reed College to the Employer Contribution Account as described below. *All fees will be paid for this group.

Grandfathered Active Silver Group: Silver Group Participants who were hired on or before September 1, 2001 are eligible for the Emeriti Retiree Health Insurance Plan Options if they earned 10 years of continuous service and attained age 55 at the time of retirement. The amount contributed to such eligible Participant's Employer Contribution Account by Reed College shall be 100% for the Participant (and 50% for the Spouse) of the premium for Emeriti Health Option 1 made on a pay-as-you-go basis during retirement.

Current Active Silver Group: Silver Group Participants who were hired on or after September 2, 2001 but prior to July 1, 2006 (the start date of the plan) are eligible for the Emeriti Retiree Health Insurance Plan Options if they earned 10 years of continuous service and attained age 55 at the time of retirement. The amount contributed to such eligible Participant's Employer Contribution Account by Reed College shall be 100% for the Participant (and 50% for the Spouse) of the premium for Emeriti Health Option 1 made on a pay-as-you-go basis during retirement.

Current Retired Silver Group:

Retirees who retired prior to July 1, 2006 (the start date of the plan) and who are excluded from the Gold Group are eligible for the Emeriti Retiree Health Insurance Plan Options. The amount contributed to such eligible participant's employer contribution account by Reed College shall be 100% for the participant (and 50% for the spouse) of the premium for Emeriti Health Option 1 made on a pay-as-you-go basis during retirement.

All Silver Group participants who elect Kaiser Insurance are not eligible to receive a contribution to the Emeriti Health Insurance Plan. For purposes of clarity, Reed College will make a contribution on their behalf directly to the Kaiser Insurance Plan.

Gold Group: The Gold Group consists of all employees who retired under Reed College's pre-existing defined benefit retiree medical plan, which was frozen to new participants as of January 1, 2002. These retirees are completely ineligible to participate in this Plan.

APPENDIX D – INVESTMENT OPTIONS

FUND	TICKER
Vanguard Target Retirement 2020 Fund	VTWNX
Vanguard Target Retirement 2025 Fund	VTTVX
Vanguard Target Retirement 2030 Fund	VTHRX
Vanguard Target Retirement 2035 Fund	VTTHX
Vanguard Target Retirement 2040 Fund	VFORX
Vanguard Target Retirement 2045 Fund	VTIVX
Vanguard Target Retirement 2050 Fund	VFIFX
Vanguard Target Retirement 2055 Fund	VFFVX
Vanguard Target Retirement 2060 Fund	VTTSX
Vanguard Target Retirement 2065 Fund	VLXVX
Vanguard Target Retirement 2070 Fund	VSVNX
Vanguard Target Retirement Income Fund	VTINX
Vanguard Small Cap Index Adm	VSMAX
Vanguard Short Term Inflation Protected Sec Index Adm	VTAPX
BlackRock 20/80 Target Allocation K	BKCPX
BlackRock 40/60 Target Allocation K	BKMPX
BlackRock 60/40 Target Allocation K	BKGPX
BlackRock 80/20 Target Allocation K	BKAPX
Calvert US Large Cap Core Responsible Index I	CISIX
Fidelity U.S. Bond Index	FXNAX
Fidelity 500 Index	FXAIX
Fidelity Mid Cap Index	FSMDX
Fidelity International Index	FSPSX
Schwab® US Large-Cap Growth Idx	SWLGX
Schwab US Treasury Money Ultra	SUTXX

APPENDIX E – SPECIAL RULES APPLICABLE TO THE HEALTH INSURANCE PLAN OPTIONS

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

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

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

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

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

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

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

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

6. **Transfer Between Insurers:** If an enrolled Participant or other enrolled individual moves to a state or area where coverage in the Health Insurance Plan Options is underwritten by a different insurer, they may select from any of the Health Insurance Plan Options offered by that health insurer for which they are eligible without regard to the prior

Health Insurance Plan Option in which they were enrolled; provided they do so within 30 days of moving to the new state or coverage area.

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

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

   (a) If Participant 1 is eligible for the Post-65 Options and Participant 2 is not, then Participant 2 can be enrolled as the "Spouse (or Domestic Partner)" of Participant 1 in a Pre-65 Option. This is an exception to the normal rule that a Participant cannot enroll in a Pre-65 Option. If Participant 2 later becomes eligible for the Post-65 Options, Participant 2 may elect to remain enrolled as the "Spouse (or Domestic Partner)" and enroll in the same Post-65 Option as Participant 1, in which case all premiums will continue to be paid from Participant 1's Accounts. If Participant 1's Accounts are later exhausted, and Participant 2 has a positive balance in their Accounts, you may elect to reenroll with Participant 2 listed as the "Participant" and Participant 1 listed as the "Spouse (or Domestic Partner)," but you cannot use the event to change Post-65 Options. In that case, all premiums will be paid from Participant 2's Accounts.

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

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

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