Plan Administration Manual (PAM)

Emeriti Retirement Healthcare Savings Program

emeriti®
RETIREMENT HEALTH

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Section 1

OVERVIEW

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Partners of the Emeriti Program

TIAA is Emeriti's accumulation recordkeeper, trust services provider and investment manager.

CBIZ is the plan's disbursement recordkeeper for Emeriti Group Insurance administration and Emeriti Medical Expense Reimbursement processing. CBIZ, Inc. is a leading national provider of financial, insurance, and advisory services designed to help our clients and their businesses grow and succeed.

Aetna is the primary health insurer for the program, providing full insured medical insurance and health-related products. For over 150 years, Aetna has been an innovator in the delivery of insurance solutions and is a nationwide provider of Medicare-approved Part D prescription drug services.

For Minnesota institutions and their Minnesota-resident retirees, **HealthPartners** provides account holders with medical insurance and health-related products. HealthPartners is the largest consumer governed nonprofit healthcare organization in the nation.

Plan Administration Manual (PAM)

Emeriti Retirement Healthcare Savings Program. This is the name of the program and should be used consistently throughout the document.

The PAM is divided into five sections

1. Overview
2. Accounts Administration
3. Qualified Medical Expense Reimbursement Benefit Administration
4. Health Insurance Administration
5. Appendix A, B and C

Emeriti Program delivery

Emeriti

Emeriti manages and oversees the Emeriti Retirement Healthcare Savings Program (RHSP) and the roles of TIAA, CBIZ, Aetna and HealthPartners. Emeriti is responsible for the program design, legal framework and model plan documents, as well as filing of federal trust exemption 1024 application (and payment of all or most filing fees), and any required state exemption forms. Emeriti provides a plan audit referral, Summary Plan Descriptions (SPDs) and Summary Annual Reports (SARs). Emeriti utilizes the platforms of some of the most respected businesses in the financial services sector, healthcare administration and health insurance industry to deliver industry-leading products and services.

TIAA

TIAA provides plan- and account-holder-level recordkeeping services relating to Emeriti Retirement Healthcare Savings Programs. Account holders use their account to accumulate savings designed specifically for healthcare expenses in retirement. Account holders are automatically enrolled in an account when eligible for employer contributions or may elect to open an account for voluntary employee contributions where applicable. Employer (and employee) contributions are allocated to an age-appropriate TIAA-CREF Lifecycle Mutual Fund (retirement class). Nonproprietary mutual funds may also be available. Assets must remain in the VEBA—money cannot be rolled over into a retirement savings vehicle (e.g., 403(b), IRA, etc.). TIAA, FSB serves as directed trustee for the underlying investment trusts (VEBA, Grantor and Section 115 Trusts) that hold plan assets. Accounts may be accessed at **TIAA.org** and also appear on a consolidated quarterly statement. TIAA phone consultants are on hand at **1-866-EMERITI** (363-7484) weekdays, 9 a.m. to 5:30 p.m. (ET) to explain plan rules and help account holders with allocation changes and transfers from one mutual fund to another. TIAA fully integrates the account with CBIZ for a seamless account holder experience.

Emeriti Program delivery (cont'd)

CBIZ

CBIZ performs a variety of services for the Emeriti Program, including insurance plan enrollment and Qualified Medical Expense reimbursement processing. TIAA is the data manager of records for this program, and provides daily feeds to CBIZ with balance, census and enrollment data. All data updates must be made with TIAA, as the daily feeds will overwrite any manual updates to other partners' internal data systems. Account balances may be used to pay for health insurance or other eligible out-of-pocket medical expenses. CBIZ coordinates claim and insurance premium payment processing for all Emeriti Health plans by directing TIAA for the distribution of funds from the accounts. CBIZ duties also include enrolling account holders in the health insurance plans offered through Aetna or HealthPartners (retirees from a Minnesota domiciled institution), calculating monthly insurance premiums and, when needed, processing debits from account holder's personal checking/savings accounts to ensure monthly insurance plan premiums are paid without a lapse in coverage. CBIZ maintains a customized Emeriti dashboard for account holders to submit claims online, check outstanding claims, view program balances and, when eligible, enroll in/make changes to the health insurance.

Aetna and HealthPartners

When employees meet their employer's RHSP retirement eligibility, are separated from employment and qualify for Medicare, they can choose from among a range of medical, Medicare Part D prescription drug and dental plans, underwritten by Aetna nationally and HealthPartners in Minnesota.

Emeriti Program structure

ACCOUNTS

- Employer and Employee Trusts:
  - VEBA for private institutions; Section 115 for public institutions
- Grantor Trust

INVESTMENT OPTIONS

- Default series of TIAA-CREF Lifecycle and Money Market mutual funds
- Additional investment options may be added by each institution

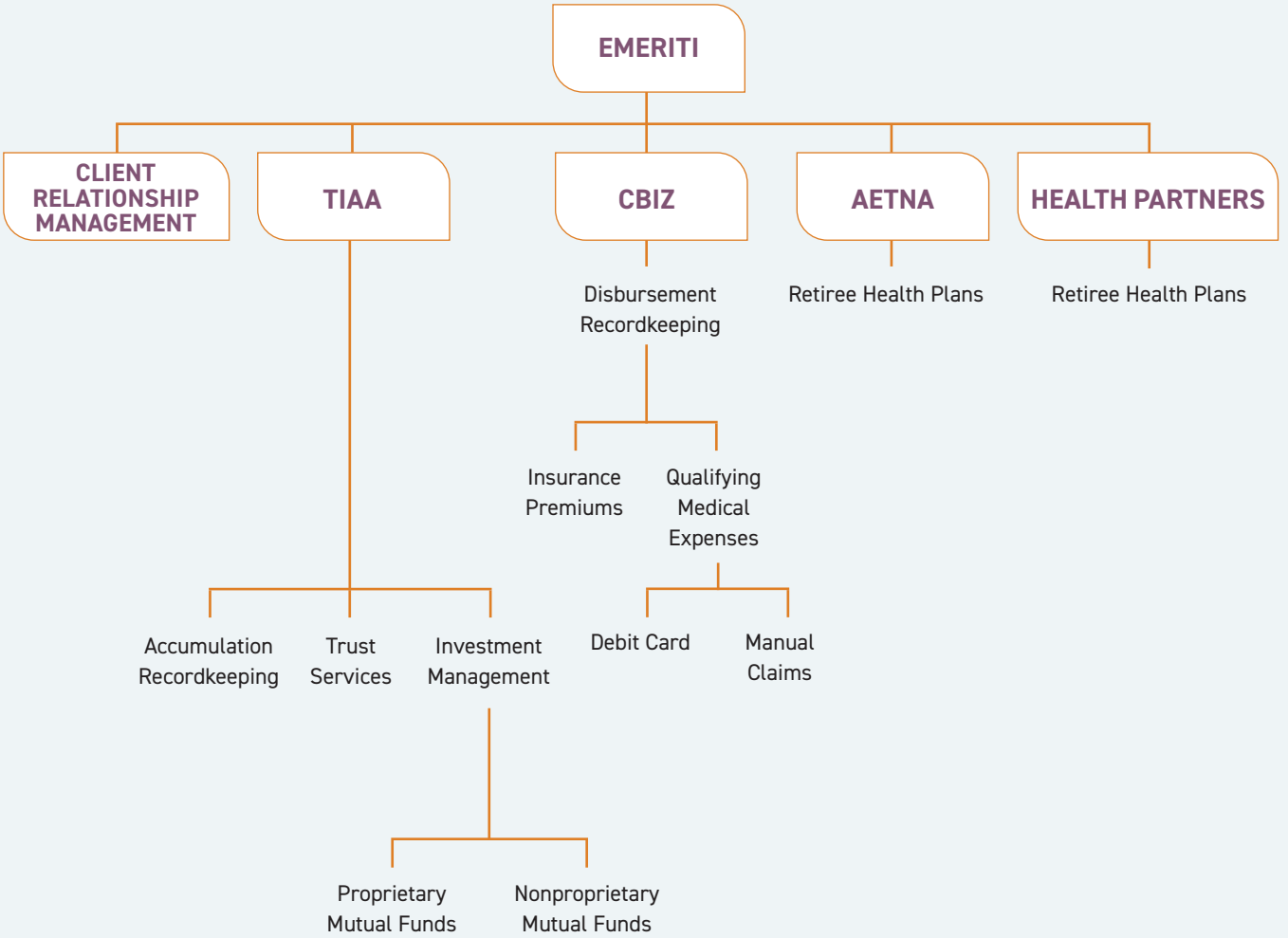
OPTIONAL HEALTH INSURANCE OPTIONS

- Group medical plans
- Medicare Part D prescription drug plans
- Dental plan

QUALIFIED MEDICAL EXPENSE REIMBURSEMENT

- Qualified Medical Expenses (QMEs) under IRC Section 213(d)

Integrated, end-to-end delivery of products and services



TIAA Client Services Manager

For assistance with any day-to-day administrative inquiries related to remittance files, forfeiture accounts, status and termination updates, please email the TIAA Client Services Manager: EmeritiAdministrator@TIAA.org

Online Access for Plan Sponsors

Emeriti's business partners provide online access for plan sponsors, making it easier to access employee account information.

TIAA online access

PlanFocus® is the TIAA plan sponsor website at **TIAA.org/public/plansponsors**. The site is available 24/7 for reporting, remittance file uploads and individual employee account maintenance and information.

Obtaining and managing secure access to PlanFocus®—the TIAA plan sponsor website

Protecting customer data is of the utmost importance to TIAA. For that reason, TIAA has put measures in place to ensure customer data is shared only with staff and auditors as authorized. The plan administrator/primary authorizer is responsible for granting access to PlanFocus® to the appropriate benefits staff.

PlanFocus® allows the primary authorizer to designate access to additional administrative staff or auditors, directly via the PlanFocus® site. Access can be granted for all of your institution's plans or can be limited to select plans, such as the retirement healthcare savings plan. Each individual granted access to PlanFocus® is assigned a unique customer number with which to create a user ID and login; these should not be shared with anyone else.

CBIZ plan sponsor access channels

For issues related to the Qualified Medical Expense Reimbursement Benefit, insurance premiums and processing, on behalf of your plan account holders and retirees, you can log in to **MyEmeritiBenefits.org**.

You may also email CBIZ at **Emeritihealth@cbiz.com**

Emeriti Service Center and account holder online resources

Access channel	Method of access	Hours of operation	Transactions available
Emeriti Service Center Emeriti specialists from TIAA, CBIZ, Aetna and HealthPartners are available to assist account holders	**1-866-EMERITI** (1-866-363-7484) **OPTION #1** is for Health Insurance questions with suboptions for CBIZ, Aetna, HealthPartners	Weekdays, 9 a.m. to 5:30 p.m. (ET)	Enroll in insurance; obtain information about specific health plan options; ask about eligibility; inquire about specific medical claims; obtain member ID card information; request post-employment kit
	OPTION #2 is for Reimbursement Benefit questions and connects to CBIZ		Inquire about Qualified Medical Expense reimbursement and eligibility; request QME form and Rx debit card information
	OPTION #3 is for Health Account balance and investment questions, and connects to TIAA	8 a.m. to 10:00 p.m. weekdays, Saturday 9 a.m. to 6 p.m. (ET)	Change investment allocation; obtain balance inquiries; make contributions to Health Account
TIAA website	**TIAA.org**	24/7	Balance inquiries; investment allocations changes; and transfers among mutual funds
Emeriti Benefits website	**myemeritibenefits.org**	24/7	At-a-glance benefits website managed by CBIZ. Account holders can submit uploaded QME forms, and check their reimbursement transactions, health insurance choices and account balance
Emeriti Program website	**emeritihealth.org**	24/7	Emeriti Insurance Premium Rate Calculator. Information about all aspects of the program. Account holders can download forms and educational materials

Note: A detailed Emeriti Service Center call-routing diagram is included in Appendix C.

Section 2

ACCOUNT ADMINISTRATION

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Accounts—Overview

The Emeriti Plan enables employers and employees to make contributions via either Voluntary Employees' Beneficiary Association (VEBA) or Section 115 governmental trusts (Section 115), and allows account holders to direct the investment of those contributions from a range of TIAA-administered proprietary and nonproprietary mutual funds.

VEBA or Section 115 Trusts

As a plan sponsor, you join the consortium and adopt two VEBA Trusts or Section 115 Trusts: One for employer contributions and one for employee contributions.

The VEBA and Section 115 Trusts are the vehicles that provide the plan with a tax-advantaged way to help pay for Qualified Medical Expenses in retirement:

- **Employer contributions** are made tax free, and all contributions plus any earnings are disbursed tax free for Qualified Medical Expenses, as defined by IRC Section 213(d).
- **Employee contributions** (if elected by plan sponsor) are made after tax, and all contributions, plus any earnings, are disbursed tax free for Qualified Medical Expenses, as defined by IRC Section 213(d). There are no dollar- based limits on employee voluntary contributions and there is no dollar minimum distribution requirement.

Health Insurance Benefit Trust

You can also choose to establish a Health Insurance Benefit Trust (aka Grantor Trust), a retirement-focused solution for key employees. This supplemental benefit can be added to your overall benefit package to customize recruitment, retention, and retirement incentives, or, for transition funding when converting from a defined benefit to a defined contribution Retirement Healthcare Savings Program.

The Health Insurance Benefit Trust is not subject to nondiscrimination requirements, and, therefore, provides a great deal of flexibility for you to do differential funding for individuals or groups on a tax-free basis to achieve various objectives. You establish an employer trust and all funds must be used to pay for fully insured healthcare products by the retiree, spouse, dependent partner, or pre-majority child. Funding may be applied as a one-time lump-sum amount or as periodic contributions. There are no IRS limits on employer contributions, no integration requirements with the pension plan, and no minimal distribution requirements. This is an employer-only fully funded plan, and any unused assets are forfeited back to the employer.

Please contact Stephanie Servaites at **sservaites@emeritihealth.org** to learn more about establishing a Health Insurance Benefit Trust.

Accounts—Overview (cont'd)

Asset allocations in the VEBA, Section 115 and Grantor Trusts

Each account holder's contributions are allocated by default to a TIAA-CREF Lifecycle Mutual Fund that has a target date closest to the year the account holder will turn age 65. Some employers offer additional investment options, in which case, account holders are permitted to allocate future contributions to those funds. (**Note:** Account holders can make changes in their allocations by logging in to the secure TIAA website at **TIAA.org** or calling **866-EMERITI** and selecting option #3).

Employee voluntary contributions

Employees who wish to set up voluntary employee contributions, if your plan allows, will need to complete your institution's applicable salary deduction form. Employees may also make personal after-tax—one time or recurring—contributions automatically from their personal bank accounts via ACH by logging in to the TIAA secure account holder's website.

ACCUMULATED ASSETS IN THE VEBA OR SECTION 115 TRUSTS CAN BE USED FOR TWO PURPOSES

1. To pay for Emeriti or any other health insurance plan premiums in retirement
2. To pay for any other Qualified Medical Expenses, under IRC Section 213(d) for an account holder, spouse (or domestic partner, if plan allows) and eligible dependents

Accounts—VEBA, Section 115 and Health Insurance Benefit Trust

			Tax treatment		
Source	**Trust**	**Funding options**	**Contributions**	**Earnings**	**Payout**
Employer	Employer VEBA and Section 115 Trusts	Required	Pretax	Tax-free	Tax-free
Employee voluntary	Employee VEBA and Section 115 Trusts	Optional	After-tax	Tax-free	Tax-free
Employee mandatory*	Employer VEBA and Section 115 Trusts	Optional	Pretax	Tax-free	Tax-free
Employer	Health Insurance Benefit Trust	Optional	Pretax	Tax-free	Tax-free

* Employee mandatory contributions made in lieu of salary. Applicable FICA and Social Security tax reporting applies accordingly.

RHSP investment menu

Historically, the TIAA-CREF Lifecycle mutual funds—Retirement share class have been the standard investment options under the RHSP and the TIAA-CREF Money Market Mutual Fund—Retirement share class has been the fund from which QME reimbursements are paid. However, it is important to note the TIAA platform has the capability of supporting all the TIAA-CREF mutual funds—Retirement share class plus a wide array of nonproprietary mutual funds that a plan sponsor may consider for its RHSP menu.

As stated above, all the TIAA-CREF mutual funds-Retirement share class are available for the RHSP menu. The availability of the nonproprietary mutual funds will be subject to whether the respective money manager has chosen to make funds available on the TIAA platform and specifically for VEBA, Section 115, Grantor or similar trusts used to hold assets for retiree health plans. Therefore, if a plan sponsor selects nonproprietary mutual funds for its plan, TIAA must confirm its availability prior to committing to use a particular fund or money manager.

Adding funds to your investment menu

Neither TIAA nor Emeriti will assume a fiduciary role or liability associated with investment menu construction for your RHSP, and we will not select or advise in the selection of investment funds. Investment menu decisions are within the sole discretion of your institution as the plan sponsor. TIAA will reserve the right to limit the availability of a particular mutual fund company or specific fund(s) or the use of specific fund share classes to the extent necessary to maintain the economic stability of the RHSP. TIAA can supply fund prospectuses and investment performance on the funds available on its platform for you (or your investment committee/advisor) to evaluate the suitability of the fund(s) for your RHSP.

If you wish to make changes to the investment lineup, please contact Stephanie Servaites at **sservaites@emeritihealth.org**.

Enrollment and remittance process

Health Account enrollment

Enrollments are done based upon a contribution being received and reported by the plan sponsor on the remittance file submitted to TIAA. When all applicable employee data is provided, TIAA issues a new Health Account and the system automatically generates an enrollment confirmation letter that is mailed to the employee.

Remittance files

There are three remittance file options; the required data elements are the same for all three:

OPS (Open Plan Solution)

A proprietary TIAA file format.

- OPS is an ANSI-based system that automatically generates remittance files from the plan sponsor's payroll feed. The automation results in fewer errors, which in turn reduces the likelihood of file rejection and subsequent need for correction and resubmission.

SOPS (Simplified Open Plan Solution)

Layout is a manual, Excel-based system for delivering remittance data.

- Due to the manual file creation, there is a greater likelihood of errors in the account holder data and/or the formatting of the file versus a system-generated payroll file.
- This remittance format is best suited to programs with fewer than 100 account holders.
- Appropriate for retirees who receive subsidies and who would not be included on active payroll files.
- **Note:** Account holder data without a contribution amount will not be recognized or enrolled by the TIAA system. A contribution of $0.01 or more is required to create an enrollment for any employee.

OCL (Online Contribution List)

Online data entry via PlanFocus.®

- For use with no more than 100 account holders.
- Appropriate for retirees who receive subsidies and who would not be included on active payroll files.

For changes to your remittance file or layout specifications, please contact your Emeriti Client Service Manager at **EmeritiAdministrator@TIAA.org** for the most current TIAA file layout and information.

Enrollment and remittance process (cont'd)

Required indicative data elements

The plan sponsor must send to TIAA the following biographical data elements for each employee on every remittance file.

- Social Security Number
- Name
- Date of birth
- Date of hire
- Emeriti status code(s)—See Appendix A for a full list of status codes and definitions
- Physical street address
- Gender
- Termination date (when applicable)
- Date of death (when applicable)

Along with the indicative data, there are additional specifications to be included in your file layout. **Your Emeriti Client Services Manager will review the specifications with you**. Key fields that need to be completed include status, contribution source codes, date of hire and termination date (when applicable). See Appendix A and Appendix B, respectively, for details.

How can employees change their personal information?

If a change or correction needs to be made to an individual's name, address, date of birth or SSN, the employee should contact the Emeriti Service Center at **866-EMERITI** (option #3) to request changes. Account holders may also update their addresses by logging in to their account at **TIAA.org**. Alternatively, address updates may be submitted in writing via FAX at **800-842-5916** or via USPS mail at PO Box 1259, Charlotte, NC 28201.

Enrollment and remittance process (cont'd)

How can plan sponsors change personal information on behalf of the employee?

If you wish to make a change or correction to biographical data on behalf of the employee, you must submit the change directly to your Emeriti Client Services Manager at **EmeritiAdministrator@TIAA.org**. This is the only way to update biographical data in TIAA's recordkeeping system for an existing account holder. You should also update your remittance file on a go-forward basis.

Changes made on the remittance file for indicative data such as a hire date, termination date, date of death and status codes will be captured by TIAA upon receipt of the file. No further action is necessary. If a termination update needs to be made prior to the next scheduled remittance file submission, please log in to PlanFocus® to update the termination date. Please ensure that any changes entered through PlanFocus® are also included in the next remittance file.

Contributions—Funding your remittance file

You can choose to fund contributions by initiating a wire transfer request with the institution's bank or by using the Remit Funding feature on the TIAA plan sponsor website.

Good order processing (GOP)

Upon receipt of every remittance list, the file is reviewed by the TIAA operations team. Once the file is confirmed to be in good order, with no errors or issues, you will receive an email confirmation from the TIAA processing unit instructing you to proceed with funding.

Enrollment and remittance process (cont'd)

Remit funding

If you have selected the remit funding method via the TIAA PlanFocus® website, a funding amount equivalent to your remittance list total must be submitted after each and every remittance list. Please keep in mind that remittance funding must be separate for the VEBA and Grantor Trusts.

Please Note: Remit funding is a two-business-day transaction. If the request for funding is initiated prior to 4 p.m. (ET), weekdays (excluding holidays), funds will be removed from the plan sponsor's designated bank account and received by TIAA and posted as of close of business the next business day. If initiated after 4 p.m. (ET), weekdays (excluding holidays), funds will be received and posted as of close of business the second business day. For example, funding initiated on the website at 3:30 p.m. (ET) on a Monday will be received and applied to account holder accounts as of close of business on Tuesday. However, funding initiated on the website at 4:30 p.m. (ET) on a Monday will be received and applied to account holder accounts as of close of business on Wednesday. For instructions on using forfeiture accumulations to fund your remittance file, please see page 25.

Remitting retiree subsidy premiums

If you are making monthly subsidy contributions into retiree accounts to fund health insurance premiums, the following apply:

1. Subsidy funding must be applied by the 15th of the month. This ensures the money will be in the account holder's account when the insurance premium billing cycle begins each month. Please refer to page 52 of this document for more details on the monthly insurance premium billing process.
2. Ensuring funds are in the account and available for premium payments is solely the responsibility of the plan sponsor. Any plan that has indicated it will be providing a subsidy for the monthly insurance premium, will generally receive a courtesy email from CBIZ if the dollars have not been applied to the account holder accounts by the 15th of the month.
3. If funding is not received prior to the 15th of the month, the retiree could see 100% of their insurance premium payment deducted from their personal checking or savings account via ACH.

Enrollment and remittance process (cont'd)

WIRE INFORMATION

If you are funding contributions by wire, the wire information is as follows:

JPMorgan Chase Bank, N.A. New York, NY

ABA/Transit Routing Number 021-000-021

CR: TIAA

Account Number 304694517

Please include your institution's Emeriti retirement healthcare plan number in the detail, i.e., RVXXXX, RGXXXX.

These wire instructions are separate and distinct for the retirement healthcare program and should not be used for remittance to a retirement/pension plan [403(b), 401(a), 401(k)].

Updates to employment status

Please refer to the list of status codes and descriptions in Appendix A.

Making account holder status code changes

Receipt of retirement, termination, disability and rehire dates, along with an applicable Emeriti status code, is of the utmost importance for the following reasons:

- TIAA must be promptly notified of all termination dates and termination statuses in order to allow account holders access to the account. The same notification and data needs apply to retirees.
- Notification of a retired status code will trigger the mailing of the Emeriti Group Health Insurance kit 60 days before the retiree's 65th birthday. The account holder has only 90 days to enroll from the later of the two: date of retirement or reaching age 65.
- Where a delayed vesting schedule is applicable based on years of service, the hire date and termination date are necessary in order to calculate vested balances available for Qualified Medical Expense reimbursements. TIAA does not conduct an automatic calculation for every institution.
- Status Codes and Monthly Fees: Sponsors must submit proper status codes to TIAA each month to ensure that Emeriti fees are assessed according to the plan's Adoption Agreement. TIAA must receive the correct status codes on file at the end of each month to ensure that the proper charge is assessed for each individual who has an account balance greater than $0.

Refund request

Should you need to request a refund of a contribution amount made in error, please complete the retiree healthcare plan refund request. Use the online service request on PlanFocus.® Select the administration tab from the top menu, navigate to *service request* under the *Requests and Forms* section, and then select *RHSP Refund* from the drop-down menu. Complete the necessary fields and click on *submit*.

The request will need the following information:

- Plan number
- Account holder's name
- Social Security Number
- Amount requested
- Original contribution date
- Plan sponsor acknowledgment

Refund requests are processed within 10 business days

Note: Refunds will always credit to your forfeiture account as per the non-reversion clause in your Plan Document. Refund requests should not be submitted via your normal remittance file. TIAA will not accept a negative contribution adjustment on the remittance file.

Vesting—Access to account funds

Each plan defines its own vesting rules

Employee contributions are always accessible at termination. Please see the plan's adoption agreement for your plan's vesting provisions.

When an account holder meets the vesting schedule defined (where applicable) in the plan's adoption agreement, and the plan sponsor has provided the applicable hire and termination dates to TIAA, TIAA will update the account to reflect that the employer accumulation is vested. In most cases, the vesting update will occur automatically upon receipt of a termination date, where a simple age and/or years of service calculation is required, i.e., age 55 with ten years of service.

Upon permanent disability, the plan sponsor should update the disability status on the remittance file, and/or notify TIAA of the disability status. The plan sponsor will need to request that TIAA manually update the account holder's vested accumulation to allow access to the account balance in full.

Late hire provision (e.g., age 65 and five years of service)

If your Emeriti Plan maintains a standard vesting schedule, and if you have elected an exception to that schedule for those individuals who are considered "late hires," e.g., age 65 and five years of service, this exception is not automatically tracked by TIAA for those plan account holders.

TIAA must rely on notification from the plan sponsor when an account holder terminates and has met the "late hire provision." This notification should be made directly to your Emeriti Client Services Manager at TIAA (**emeritiadministrator@TIAA.org**). In the event that TIAA is not notified prior to receipt of a termination date, the standard vesting provision will be applied and a forfeiture of the non-vested balance will occur.

An inadvertent forfeiture can be avoided if TIAA is notified in advance of the termination date. Should an inadvertent forfeiture occur as a result of the "late hire provision," please request a reinstatement of the forfeited balance via the Online PlanFocus® Service Request. The reinstatement will be effective as of the date TIAA receives instructions from the plan sponsor to reinstate the forfeited funds.

Forfeiting account holder accumulations

There are very limited reasons why funds would be forfeited, including:

- Account holder terminates employment without meeting the plan's vesting requirements
- Death of the account holder without any qualified dependents

Should you need to request a manual forfeiture, please provide the following information:

- Account holder name
- Social Security Number
- Plan number
- Applicable source(s)—Employer, employee or both

Forfeitures will be invested in the TIAA-CREF Money Market Mutual Fund. The forfeiture account balance will be further dispersed in accordance with the Plan Document.

Forfeiture reinstatement

If a forfeitable amount is transferred to the forfeiture account upon an account holder's termination and subsequently that account holder is rehired, they may be entitled to reinstatement of the previously forfeited amount. You should log on to PlanFocus® and complete the online Service Request.

Reinstatement values for a rehired account holder are equal to the original forfeiture amount. You may also request a reinstatement of the lost earnings. Please note there are two underlying trusts that make up your forfeitures: an employee trust and an employer trust.

Use of forfeiture balances

Employee forfeiture accumulations

Forfeitures of after-tax employee contributions are reallocated to account holder accounts with positive balances in their employee after-tax source. To reallocate employee forfeitures to account holder accounts, you should send instructions via email to the **EmeritiAdministrator@TIAA.org** mailbox or to your Emeriti Client Services Manager. **Note:** There is a $10 reallocation credit minimum per account.

Employer forfeiture accumulations attributable to employer contributions

Your adoption agreement specifies how forfeited employer contributions will be used. Please reference the elections specified in your adoption agreement to see how forfeitures may be used in your plan. Based on your elections in the adoption agreement, forfeiture balances may be used to:

1. Offset/fund future employer contributions
2. Reallocate equally among plan account holders
3. Pay expenses related to plan administration, for example:
   - Auditors
   - Third-party administrators
   - Program fees

Should you wish to amend the forfeiture provisions in your adoption agreement, please contact your Emeriti client services representative.

PlanFocus® reports

Standard plan-level reporting and the ability to customize reports are available 24/7 through PlanFocus® at **TIAA.org/plansponsor**. Financial data is current within two business days. Reports available include the following:

Audit & transactions report	Provides audit and transaction reports for comprehensive plan financial reporting.
Balances report	Shows the plan balances for each employee including source balances.
Summary report	Shows the overall assets held at the plan level.
Contributions report	Provides plan contributions for each employee including contribution sources.
Distributions report	Shows claims/distribution and fee activity.
Employees report	Displays employee information, plan employee status and employee counts.
Enrollments report	Provides the number of enrollments and the corresponding account holder details in any given period.
Vesting report	Provides detail as to account holder vested percentage in the employer accumulation.
Custom reports	Options include investments, enrollment, contributions and distributions. Account status is a data field that can be included in the custom reports.

Tax reporting

Form 5500

CBIZ provides plan sponsors with a signature-ready Form 5500 and associated schedules with respect to the Emeriti Health Account VEBA Health Plan. Plan sponsors are responsible for electronic signature and filing of this form. CBIZ will also prepare the Summary Annual Report for the plan sponsor for their distribution to the plan account holders.

TIAA publishes the applicable reporting package used by CBIZ in order to prepare the Form 5500. Complete year-end reporting is made available to the plan sponsor and authorized third-party auditors within 120 days of the plan year-end close; reporting is located in the Compliance section of the TIAA plan sponsor website.

IRS Form-990 annual filing

TIAA is responsible for and will file the applicable Form 990 for the underlying VEBA Trust for your Emeriti Plan.

TIAA will ask that the plan sponsor review the Form 990 for accuracy prior to submission to the IRS.

Emeriti Program fees

All fees may be paid by one of the following methods:

- The employer directly
- Deducted from employee accounts
- A combination of both employer-paid and employee account-deducted fees

Emeriti is responsible for recording and acknowledging who is responsible for the fees

Emeriti instructs TIAA on how fee billing should be executed at each institution, and TIAA is required to follow those instructions according to plan rules. The plan sponsor should contact Roger Montgomery, Vice President for Finance, Emeriti Retirement Health Solutions by emailing **rmontgomery@emeritihealth.org** to make changes in how fees are billed or deducted.

Fee deductions from account holder accounts take place the third to last business day of each month. For those fees billed directly to the plan sponsor, invoices are delivered by Emeriti the first week of each month.

Fee deduction order

Unless account holder fees are billed directly to the plan sponsor via invoice, the consortium and administrative fees are deducted pro-rata across investments from account holders' accounts in the following sequence:

1. Grantor Trust, if established
2. Employer VEBA
3. Employee VEBA

Special note regarding fees for retirees enrolled in Health Insurance

Once a retiree's account balance has been depleted, CBIZ will calculate and include the amount required to cover the applicable fees (in cases where fees are deducted from the accounts as opposed to directly billed to the plan sponsor) along with the insurance premium amount, and the total amount will be debited from their bank account each month.

Additionally, for those individuals who are terminated, retired, deceased or disabled, the fee-billing program will continue to run and debit fees as long as an account balance greater than $0.01 remains. For those plan sponsors that cover fees for any of these account holder statuses, you will be billed until the account hits a zero balance. In order to avoid unnecessary fees, please review the accounts of your terminated and deceased account holders to ensure that forfeitures have been processed and the account balances are zero. Once an account balance is zero, the fee-billing program will no longer bill or debit fees from that account.

Please refer to your plan's adoption agreement for information regarding fees covered by or billed to the plan sponsor. To amend your adoption agreement regarding fees for your Emeriti Plan, please contact Roger Montgomery, Vice President for Finance, Emeriti Retirement Health Solutions by emailing rmontgomery@emeritihealth.org.

Death of an account holder

Notification of death

TIAA will learn of an account holder's death in one of the following ways:

- Plan sponsor notifies TIAA
- Dependent, relative, next of kin or executor of the estate notifies TIAA

If you receive notice of the death of an account holder, please update the date of death and decedent status code via PlanFocus.®

Continuation of benefit to eligible dependents

Please note that when an account holder dies, the account remains in the name of the deceased. The original account holder's Social Security Number will remain on the account.

The account holder's spouse and other qualified dependents are entitled to receive reimbursement and insurance benefits under the plan.

CBIZ will also send a letter to the deceased member's estate outlining dependent benefits that may continue to be available through the Emeriti Plan, and how to file a claim.

Decedent forfeiture process

TIAA does not track dependents for the accounts. TIAA will take instruction from the plan sponsor when a forfeiture should occur if there is no known surviving spouse or dependent. In an effort to assist with account maintenance for deceased account holders, TIAA will distribute an annual report for your review. The report will include the name, date of death, total balance and date of last claim activity. If there are accounts without activity in a prior 12-month period, you may wish to request a forfeiture of the account.

Should TIAA be notified by the decedent's family that there are no surviving dependents, we will pass that information on to you promptly, to make a forfeiture decision prior to receipt of the annual report.

Note: There is never a lump-sum death benefit payout in retiree health accounts. If the funds are not used by the account holder and/or qualifying dependents, the accumulation will be forfeited back to the plan.

Domestic relations order (DRO)

If you receive a DRO that references this plan/individual account, please fax the documentation to TIAA at 800-842-5916 for review to ensure compliance with the plan.

Section 3

QUALIFIED MEDICAL EXPENSE REIMBURSEMENT BENEFIT ADMINISTRATION

emeriti®
RETIREMENT HEALTH

Reimbursement Benefit—Overview

The Reimbursement Benefit is a flexible, tax-favored tool for managing healthcare costs in retirement. Account holders can be reimbursed for a wide range of out-of-pocket health expenses under IRC Section 213(d) that are not paid by insurance. It also allows reimbursement of already-paid premiums for Medicare and other health insurance outside of the Emeriti Program, such as long-term care insurance.

Insurance premiums

- Medicare
- COBRA
- Medicare supplement plans
- Medicare Parts B and D premiums
- Prescription drug plans
- Dental and vision plans
- Long-term care plans
- Pre-65 retiree medical plans
- Other post-65 insurance premiums (if Emeriti coverage is not elected)

Non-insurance expenses

- Office visit copays
- Prescription drug copays
- Medical cost shares (deductibles, copays, coinsurance)
- Dental, vision and hearing care
- Medical equipment not covered by insurance

Please visit **www.irs.gov/publications/p502** to see a complete list of qualified medical expenses.

IMPORTANT

Qualified medical reimbursement claims are paid out of the TIAA-CREF Money Market Fund. Account holders will need to transfer sufficient amounts to that fund in order to receive reimbursement for qualified medical expenses.

Treatment of eligible expenses

Qualified Medical Expenses (QMEs) are defined as expenses incurred, on or after the date the account holder becomes eligible for Reimbursement Benefits, by an eligible individual, for "medical care" as defined in Section 213(d) of the Internal Revenue Code, but only to the extent such amounts are not compensated for by insurance or otherwise.

This includes premiums paid for "Other Health Insurance" and premiums paid for Medicare. "Other Health Insurance," as used above, pertains to fully insured health insurance outside the Emeriti Program but not including: (a) FSA or (b) coverage as an active employee under an employer-sponsored group health plan.

Examples:

- COBRA insurance
- Long-term care insurance
- Medicare supplement insurance

Reimbursement for insurance coverage

An insurance expense is considered incurred and will be processed when the following criteria is met:

- The coverage period begins on or after the account holder's reimbursement eligibility date.
- The claim is submitted on or after the bill's due date.

Reimbursement for all other eligible expenses

Other than for insurance premiums, an expense is incurred and will be processed when:

- The date of service is on or after the account holder's reimbursement eligibility date.
- The claim is submitted on or after the date of service.

Who is eligible for the Reimbursement Benefit

The following individuals are eligible to use the Reimbursement Benefit for Qualified Medical Expenses (QMEs). If the plan sponsor has not elected in the adoption agreement to cover domestic partners and/or dependent relatives, then no individual shall qualify as such a dependent under the plan.

1. **Account holder**
2. **Spouse**
   - Legally married
3. **Dependent domestic partner**
   - Same and/or opposite sex (as specified by the employer adoption agreement)
   - Not a relative of the account holder
   - Received over half of his or her support from the account holder
   - Principal place of abode is at account holder's home
   - Member of account holder's household
   - Designated by account holder as domestic partner in accordance with recordkeeper's administrative procedures
4. **Non-dependent domestic partner**
5. **Dependent children**
   - Child (natural, adopted, step) of account holder up until their 26th birthday, regardless of student status, marital status, dependency and residence
6. **Dependent relative**—any of the following individuals who receives over half of his or her support from the account holder:
   - Child of the account holder (other than dependent child as defined earlier) or a descendent of a child of the account holder
   - Sibling or stepsibling of the account holder
   - Parent of the account holder, or an ancestor of a parent
   - Stepparent of the account holder
   - Aunt, uncle, niece or nephew of the account holder
   - Son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law of the account holder
   - Any other individual to whom the account holder is related who for the calendar year has as his or her principal place of abode the home of the account holder and is a member of the account holder's household

When does eligibility begin

If the account holder separates from service with the employer and has fulfilled the vesting requirements at the institution, they are immediately eligible for reimbursements.

Only the vested account balance is eligible to be used for reimbursement.

CBIZ relies on the vested account balance provided by TIAA as an indication of current vested balance at any point in time after termination of employment.

Who can submit claims for the Reimbursement Benefit

Prior to the account holder's death, only the account holder may submit claims (even if incurred by a dependent).

After the account holder's death, if there is a living surviving spouse (or dependent domestic partner), then only he/she may submit claims (even if incurred by a different dependent).

After the account holder's death, if there is not a living surviving spouse (or dependent domestic partner), then each individual dependent must submit their own claims.

How to submit claims for the Reimbursement Benefit

Moving money to the TIAA-CREF Money Market Fund

To move money into the TIAA-CREF Money Market Fund, account holders can contact a TIAA representative at **1-866-EMERITI (1-866-363-7484)** and press "3" for assistance. Account holders may also log in to the TIAA secure website at **TIAA.org**, where they can review their account balances and transfer assets to the TIAA-CREF Money Market Fund.

Account holders may make fund transfers among investment options at any time in amounts of $1,000 or more or the full value of the account (if less than $1,000).

Choosing reimbursement method

In addition to having the QME reimbursement check delivered via mail, account holders may have their reimbursements deposited directly into their personal bank account. To activate this option, account holders may contact the Emeriti Service Center at **1-866-EMERITI** and press "2" to obtain a banking information form.

IMPORTANT

Claims are paid only from assets in the Emeriti Health Account that are invested in the **TIAA-CREF Money Market Fund.**

Obtaining QME claim forms

Account holders can obtain a claim form via the Participant Dashboard (**MyEmeritiBenefits.org**), the Emeriti website (**emeritihealth.org**) or by contacting the Emeriti Benefits Center. The claim form must be completed in its entirety and signed by the account holder (or power of attorney). Along with the supporting documentation, claims can be submitted via fax, mail or online.

How to submit QME claim forms

Fax to	Mail to	Submit online
215-563-9943 **Attention:** Emeriti Benefits Center	CBIZ **Attention:** Emeriti Benefits Center 3000 Chestnut Street, #8569 Philadelphia, PA 19104-9998	**MyEmeritiBenefits.org** At-a-glance benefits website to view insurance information, check status of QME reimbursements, and electronically submit uploaded QME claim forms

Emeriti Rx debit card

The Emeriti Rx debit card is an "Rx-only" card. Plan account holders who are eligible for the Emeriti Reimbursement Benefit may use the card for eligible prescription drug expenses at participating point-of-purchase locations, such as most local pharmacies and other stores where account holders may pick up prescriptions. The card may also be used to set up recurring mail-order Rx delivery, such as CVS Caremark® Mail Service Pharmacy, by establishing an online charge for routine scripts.

The Emeriti Rx debit card is an optional service. There is no fee for this service.

The Emeriti Rx debit card represents the available balance in the account holder's Emeriti Health Account Money Market Fund. Please note that an account holder needs to have a minimum total Emeriti Health Account balance of $250 to be eligible for the card.

Account holders will first receive the RX debit card election form to complete and return to CBIZ. Within two weeks, a package including two debit cards will arrive at the account holder's address of record.

IMPORTANT

Before using the card, account holders must transfer assets into the TIAA-CREF Money Market Fund.

Cards will only be issued after money has been transferred into the Money Market Mutual Fund.

Special notes for the Reimbursement Benefit

Reimbursement of Medicare Part B premium

CBIZ will accept the annual Centers for Medicare and Medicaid Services (CMS) letter as proof of Medicare premium for the year and establish a recurring monthly reimbursement for the calendar year (without the account holder's submission of monthly documentation).

Recurring claims process

Recurring monthly reimbursements for insurance premiums can be requested by completing a claim form and selecting the recurring claim indicator in the "List of Qualified Medical Expenses" section. This process will alleviate the need for an account holder to submit reimbursement each month for the same expense. Account holders must submit supporting documentation that clearly displays a start date and end date for the specific premium. Premiums will automatically be reimbursed at the beginning of each month for the prior month's coverage.

Examples of recurring claims supporting documentation include:

- Medicare award letters
- Carrier enrollment confirmation statements

Health insurance paid in advance

CBIZ will reimburse insurance premiums that are billed and due, without requiring proof of actual payment (the bill must show total amount due and the covered period).

Death of an account holder

After the account holder's death, claims incurred by the account holder's spouse (or dependent domestic partner*), dependent children and dependent relatives are eligible for reimbursements from the balance in the account holder's account(s).

If a dependent child ceases to meet the definition of a dependent child (due to becoming over age), claims incurred by such former dependent child shall no longer be eligible for Reimbursement Benefits.

If, upon the last to die (or, in the case of dependent children, to become over age) of the account holder, spouse (or dependent domestic partner), dependent children and dependent relatives, there is a residual balance in the account holder's account(s), such residual balance shall be forfeited in accordance with the terms of the plan.

Special provisions for the Reimbursement Benefit

HSA/HDHP provision

If an account holder is eligible for a high deductible health plan ("HDHP") and is eligible to contribute to an HSA, the account holder is not eligible for reimbursements unless the account holder has first satisfied the HDHP minimum annual deductible for the year the expense was incurred.

FSA provision

If an account holder is participating in a Health FSA, the account holder is not eligible for reimbursements unless the account holder has first exhausted the FSA maximum coverage amount available to the account holder under the FSA for the year the expense was incurred.

* Dependent domestic partners are also eligible, if elected by your institution. Non-dependent domestic partners may also be eligible, if elected by your institution. Please note that there are tax implications for non-dependent domestic partners.

Claims incurred in non-U.S. currency

- Claims will be paid in U.S. dollars.
- CBIZ will use the exchange rate published on the Wall Street Journal (WSJ) website on the date the claim is processed.
- Payment will be either deposited into a U.S. bank account (if direct deposit is elected by the account holder) or mailed to the account holder's address on record (if direct deposit is not elected).

Claims submitted in language other than English

Claims forms and documentation are required to be submitted in English.

Form 1095 filing

Affordable Care Act (ACA) rules for reporting health benefits

Every employer is required to report to the Internal Revenue Service (IRS) about the health benefits they offer to employees and their dependents, whether or not the employee is a full-time employee for any month of the calendar year.

Reporting of Emeriti fully insured group account holders

For insured group health plans, the reporting obligation is on the insurer. Aetna will report the required information to the IRS about the type and period of coverage provided to each individual account holder enrolled in the insured plan, and will furnish the required statements to account holders. Aetna must report entire Social Security Numbers (SSN) to the IRS.

Aetna will need Social Security Numbers (SSN) for each account holder, including dependents, in order to complete the required reporting. If Aetna hasn't already received the SSN, the law requires Aetna to reach out to each subscriber up to three separate times to request the information.

TIMING

The employer must file the required returns with the IRS by no later than February 28 of the year following coverage (if filing on paper) or March 31 (if filing electronically), and furnish a statement to all full- time employees by January 31 of the year following the calendar year to which the return relates.

Reporting of Emeriti self-insured account holders

An employer that offers health coverage through an employer-sponsored, self-insured health plan (such as the Reimbursement Benefit) must complete Form 1095-C for any employee eligible for the coverage (that is terminated and vested individuals), whether or not the employee is a full-time employee for any month of the calendar year. **However, no reporting is required where the coverage is in addition to or supplements Medicare.**

As an example, for a retiree who was not a full-time employee for any month of the calendar year (meaning that for all 12 calendar months the employee was not a full-time employee), the employer may complete Form 1095-C and on Part II, enter code 1G on line 14 in the "All 12 Months" column (the employer need not complete Part II, lines 15 and 16 in this case).

As an alternative, the employer could file Form 1095-C to report the coverage for active employees and file Form 1095-B to report the coverage for retirees. You may submit a 1095-B if the person was not active at all in the reporting year but can submit a 1095-C in either case. Under either reporting option, a copy of the form should be sent to the employee.

Rehired retirees

Insurance and Reimbursement Benefit eligibility

In order for the Emeriti Program to comply with the Affordable Care Act (ACA), active employees and any eligible dependents cannot be enrolled in the Emeriti Insurance or use the Reimbursement Benefit while employed at your institution in any capacity; either full-time benefits eligible or part-time non-benefits eligible. **This includes retirees who are rehired on a part-time or by appointment basis.** Only when the retiree is not employed by the institution, can she/he and their eligible dependents be enrolled in the health insurance plans offered through the RHSP, and use the Reimbursement Benefit.

The ACA mandate only applies if the retiree is rehired by your institution. The account holder may work anywhere else and still maintain retiree status in the Emeriti Program and, therefore, still utilize all of the Emeriti benefits. Further, if the retiree is rehired by your institution, the account holder will not lose any of their Emeriti benefits; they will simply be suspended until the account holder moves back into "retired" status.

Section 4

HEALTH INSURANCE ADMINISTRATION

emeriti®
RETIREMENT HEALTH

Overview of health insurance coverage

A wide range of benefit coverage available only through the RHSP

Retirement Healthcare Savings Program (RHSP) retirees have access to group coverage.

There are a variety of Medicare Advantage plans with low out-of-pocket maximums, and very rich prescription drug plans, including some that cover all Medicare Part D prescription drugs through an open formulary. The Medicare Advantage and prescription drug plans can be packaged any way retirees and dependents wish, and they can easily change plans each year, knowing they won't be turned away.

Retiree health insurance provided through the RHSP is underwritten nationally by Aetna Life Insurance Company (HealthPartners in Minnesota).

National coverage

Retirees maintain consistent coverage wherever they live in the U.S., even if they live in a different part of the country for some of the year. For prescription drug needs, retirees can choose from 65,000+ pharmacies nationwide, including independent drugstores and large brand-name pharmacies.

No network restrictions

Healthcare providers do not have to be in the Aetna network. With this type of plan, retirees pay the same cost for any doctor or hospital, according to the costs listed on the plan benefits summary. Retirees can see any provider who is eligible to receive Medicare payment and accepts the Aetna Medicare Advantage plan.

Retiree eligibility for health insurance coverage

In order to enroll in the program's retiree health insurance, the retiree must meet all of the following criteria:

- Separate from service after retirement eligibility as specified in the employer adoption agreement (retirement eligibility confers eligibility for health insurance coverage)
- Achievement of this criteria is indicated via the employer's reporting of a "Retired" status to TIAA
- Be a resident of the United States, Puerto Rico or U.S. Virgin Islands
- Be enrolled in Medicare Parts A and B, unless the plan sponsor has elected to include pre-65 retirees in its adoption agreement. (Note: Medicare enrollment generally begins no earlier than the first of the month in which the individual attains age 65, except in the case of earlier disability. However, Medicare eligibility begins the first of the prior month if the individual's birthday is the first of the month)

The employer may elect (as specified in the Adoption Agreement) to move certain existing retirees into the insurance plans.

Pre-65 retiree coverage is an option of the plan as specified by the employer in the Adoption Agreement.

Dependent eligibility for health insurance coverage

Also eligible for Emeriti Insurance coverage are the following individuals:

- Retiree's spouse (or domestic partner*)
- Retiree's dependent children
- Retiree's permanently disabled children (Medicare designation must have been achieved by the age of 26)

The following definitions apply for purposes of retiree insurance enrollment

SPOUSE—must meet all of the following criteria:

- Opposite or same sex
- Legally married
- Not a common-law spouse

DOMESTIC PARTNER—must meet all of the following criteria:

- Opposite or same sex
- Principal place of abode is at retiree's home
- Member of retiree's household
- Designated by retiree as domestic partner

Please Note: Retiree must specify if the domestic partner is a dependent or nondependent domestic partner by answering all three of these questions. If the answer to any one of the three questions is "no," then the domestic partner is nondependent; otherwise he/she is dependent.

1. Throughout all of the plan year, did the individual have their principal place of residence at your home and is he/she a member of your household?
2. Throughout all of the plan year, did the individual receive over half of his/her support from you?
3. Does the individual qualify as a dependent of yours for federal tax purposes, according to IRS rules?

*A retiree may have a spouse or domestic partner, but not both.

Dependent child eligibility for health insurance coverage

Dependent child

Must meet all of the following criteria:

- Child (natural, adopted, step) of retiree or of domestic partner, or person for whom the retiree is legal guardian or permanent custodian
- If child of domestic partner but not retiree, the child must receive 50% of support from the retiree, live with the retiree and be a member of retiree's household
- The program allows for coverage of children until their 26th birthday, regardless of student status, marital status and residence

Enrollment for health insurance coverage

Retiree must enroll within the 90-day period beginning at the obtainment of coverage eligibility as outlined previously.

If the retiree does not enroll during the initial enrollment window, he/she may not ever enroll in the program's insurance (except in the event that the retiree loses coverage eligibility with respect to other group insurance that is in effect at the initial eligibility for program insurance).

Being enrolled in Medicare prior to age 65 as a result of disability is treated the same under the program as being enrolled in Medicare at age 65 or later.

West Coast institution retirees have a choice: They may enroll in Emeriti Insurance when first eligible or they may enroll in a Kaiser Permanente plan. **The Kaiser plan must be the Kaiser plan offered by the institution, not purchased directly through Kaiser.**

Retirees who were enrolled in Kaiser Permanente California, Oregon or Washington coverage are permitted to enroll in Emeriti coverage outside the normal terms of the Emeriti plan's enrollment window:

- If the retiree elects Kaiser coverage offered by the institution at retirement rather than Emeriti coverage, the following two exceptions apply:
  - The retiree may elect Aetna Dental as a stand-alone product.
  - If and when the retiree loses their Kaiser coverage, they have a one-time opportunity to elect Emeriti coverage at that time.

Verbal confirmation on a recorded phone line is evidence of Kaiser Permanente coverage. Coverage will not be retroactive.

ENROLLMENT VERIFICATION FOR ALL HEALTH INSURANCE COVERAGE

For new enrollments, CBIZ will provide an enrollment confirmation to the retiree.

Spouse (or domestic partner) enrollment in health insurance

If a spouse (or domestic partner) is enrolled in Medicare Parts A and B at the retiree's enrollment in health insurance, he or she may also enroll in the health insurance provided through the RHSP.

If a spouse (or domestic partner) is not enrolled in Medicare Parts A and B at the retiree's enrollment (e.g., because he or she is under age 65), he or she may also be enrolled in the Emeriti Insurance, as follows:

- Must enroll in one of the program's pre-65 health insurance options
- Upon later attainment of age 65 and enrollment in Medicare Parts A and B, he/she may enroll in the program's post-65 health insurance
- Must do so within 90 days of enrollment in Medicare Parts A and B
- Can enroll in different plans than the retiree
- The spouse (or domestic partner) may enroll in post-65 insurance coverage even if the spouse (or domestic partner) did not enroll in Emeriti's pre-65 insurance coverage

Spouse (or domestic partner) may enroll in different plan options than the retiree.

Procedures for retiree enrollment in health insurance (Aetna)

Telephone insurance enrollment

To enroll retirees and dependents in insurance coverage, retirees can call **1-866-EMERITI (1-866-363-7484)** to speak to a CBIZ representative. The representative will verbally solicit and record the following elections from the retiree:

Enrollment of retired retiree

1. Expected date of coverage
2. Date of coverage under Medicare Part A and Part B
3. Medicare Beneficiary Indicator ("MBI")
4. Name on Medicare card
5. Plan options selected:
   - Medical plan
   - Rx plan
   - Dental plan (if any)

The representative will also confirm the following:

- Retiree's last four numbers of Social Security Number
- Retiree's date of birth
- Retiree's address
- CBIZ will also verbally accept a "mailing only" address from the retiree, and pass that address to Aetna (for mail-only, not coverage purposes) on the regular weekly data transmission

Note: If different from name in administration database, retiree is encouraged to contact TIAA to report their name change.

Online insurance enrollment

Insurance enrollment can also be made online via the Benefits Dashboard (**MyEmeritiBenefits.org**) by the retirees themselves.

To enroll online, retirees should follow these instructions:

- Go to **MyEmeritiBenefits.org**
- Either click on the "register now" link, or enter your user name and password then click "Login"
- For new users, registration will prompt you for your SSN, date of birth and zip code
- An email will be sent to you with your activation credentials

Once a retiree is logged on to the Dashboard, **he/she will see a banner titled, Insurance Enrollment, with a button which reads, "click to begin."** From here, the retiree will be able to review and select medical, prescription drug and dental plan options, as well as insurance plan options for their spouse/domestic partner.

Procedures for dependent enrollment in health insurance (Aetna)

Dependent(s) insurance enrollment

If a spouse (or domestic partner) and/or dependent children are being enrolled, the representative will verbally solicit and record the following elections from the account holder with respect to the dependent being enrolled:

1. Dependent's Social Security Number
2. Dependent's date of coverage under Medicare Part A and Part B, if applicable
3. Dependent's Medicare Beneficiary Indicator ("MBI"), if applicable
4. Dependent's name (on Medicare card, if applicable)
5. Plan options selected:
   - Medical plan
   - Rx plan
   - Dental plan (if any)
6. Dependent's date of birth

Note: Dependent's address (for insurance coverage purposes) is assumed to be the same as the retired account holder's address.

Enrollment procedures for health insurance coverage (HealthPartners)

HealthPartners enrollment process

- Retiree must complete a signed paper enrollment form for each enrolled person.
- Blank form(s) are provided by CBIZ to the enrolling retiree, who completes the form(s) and sends them back to CBIZ.
- CBIZ keeps the original(s) and sends copies to HealthPartners, which completes the enrollment process.

Health insurance coverage after a retiree's death

Upon the death of the retiree, eligibility for insurance coverage for surviving spouses (or domestic partners) and dependent children is as follows, depending on when the retiree's death occurs:

If the retiree's death occurs while employed (by the participating employer) but after retirement eligibility (i.e., age and service requirements under the program) has been attained:

- Surviving spouse (or domestic partner) has 90 days to enroll in program insurance—in either a pre-65 plan or post-65 plan, as applicable, depending on the surviving spouse's (or domestic partner's) age.
- If surviving spouse (or domestic partner) is pre-65 at retiree's death, he/she can later enroll in a post-65 plan when he/she attains age 65—even if pre-65 coverage was not elected. Surviving spouse (or domestic partner) has 90-day window to enroll upon attaining age 65.
- Surviving dependent children can also be enrolled (in accordance with regular plan rules).

If retiree's death occurs after termination of employment and after retirement eligibility (i.e., age and service requirements under the program) has been attained, but prior to enrollment:

- Same rules as above.
- Except that if the retiree was past his/her initial enrollment period under the program, surviving spouse (or domestic partner) cannot elect coverage.

If retiree's death occurs after termination of employment and after retirement eligibility (i.e., age and service requirements under the program) has been attained, and while enrolled in program insurance:

- Same rules as above.
- Surviving spouse and dependents gain coverage only when they themselves experience a qualified life event.

Insurance enrollment and premium change notifications

When is post-65 insurance enrollment information mailed?

- **Upon request:** To any eligible retiree, upon request (e.g., by contacting the Emeriti Service Center).
- **On a monthly basis:** To all retirees who are within 60 days of attaining age 65 (or who are over age 65 and were not previously sent a kit, due to their retirement after age 65).

Moving from the plan's pre-65 insurance to post-65 Insurance

- On a monthly basis, CBIZ will identify covered pre-65 individuals (i.e., retirees or dependents who have pre-65 insurance coverage) who are attaining age 65 within the next 60 days.
- CBIZ will call all individuals turning age 65 and collect their Medicare enrollment number (HICN) and enrollment elections.
- If such enrollment doesn't occur, the retiree's coverage will be canceled upon attainment of Medicare eligibility.

Open enrollment

On an annual basis—generally from October through a specified date in December—an open enrollment period occurs and currently enrolled retirees may change their plan options. Retirees will receive information in the mail before open enrollment begins.

If the retiree does not change his/her plan elections, coverage will default to his/her current plan for the following year (or under a different but "mapped" comparable plan, if the current plan is not continued for the following year).

If the retiree did not enroll in an insurance plan through the program during their initial enrollment period at retirement, he/she may not enroll during an annual open enrollment period in the future. However, he/she may enroll at any time (including during the open enrollment period) if he/she experiences certain qualifying life events.

Phone insurance enrollment

To change plan elections during an open enrollment period, the enrolled retiree can call **866-363-7484** to speak to an Emeriti service representative from CBIZ. The representative will solicit and record the retiree's revised elections, which will become effective beginning on the first day of the following calendar year.

If a spouse (or domestic partner) and/or child(ren) are currently enrolled, the retiree's desire for continued coverage for the next plan year will be confirmed.

If a spouse (or domestic partner) and/or child(ren) are being enrolled during the open enrollment period, the Emeriti service representative will solicit, record and confirm the dependent's information and coverage for the next plan year. **Note:** A spouse (or domestic partner) and/or child must have experienced a qualifying life event in order to be added to a retiree's existing enrollment, including (but not limited to) during the open enrollment period. Retiree and spouse/domestic partner may enroll in different insurance options.

Online insurance enrollment

Insurance enrollment changes can also be made online via the Benefits Dashboard (**MyEmeritiBenefits.org**) by the retirees themselves during the open enrollment period.

Qualifying life events

Enrollment must occur within 30 days following the applicable "event date," as shown below.

Event	Changes permitted	Changes permitted	Coverage begins
Retiree loss of coverage (The previous coverage must have been in effect at the account holder's initial eligibility for Emeriti Insurance enrollment)	Retiree may enroll in Emeriti coverage (if otherwise eligible)	Date of loss of insurance eligibility	First of month following enrollment in Emeriti Insurance coverage
Eligible dependent loss of coverage	The eligible dependent may enroll in Emeriti coverage	Date of loss of insurance eligibility	First of month following enrollment in Emeriti Insurance coverage
Gain spouse (or domestic partner)	New spouse (or domestic partner) may enroll in Emeriti coverage	Date of marriage (or gaining domestic partner)	First of month following enrollment in Emeriti Insurance coverage
Gain dependent child(ren) as a result of marriage	New child(ren) may enroll in Emeriti coverage	Date the individual becomes a dependent child	First of month following enrollment in Emeriti Insurance coverage
Gain dependent child(ren) as a result of birth or adoption	New child(ren) may enroll in Emeriti coverage	First of month following date of birth or date of adoption	First of month following enrollment in Emeriti Insurance Coverage

Monthly premium payment cycle

The following monthly billing cycle pertains to the premium for the following month's coverage in the case of Aetna and for the current month's coverage in the case of HealthPartners.

Step	Date (each month)	Premium payment step
Carrier sends bill to CBIZ	Bills are generally created on the sixth and passed to CBIZ the next business day	• CBIZ generates the bill for the "Aetna population" and receives a bill from the carrier for the "HealthPartner population." • Bill shows premium due per covered person. • Bill reflects data updates through the bill creation date. • Carrier will only accept full payment or $0 for each person. CBIZ overrides the bill to $0 for anyone whose coverage has ended prior to the coverage date pertaining to the bill. • Any overpayments in prior months are credited as a negative in the next month.
CBIZ sends premium billing report to plan sponsor	End of day on the business day following the sixth of the month, unless notified otherwise	CBIZ posts the premium billing report for plan sponsors on the plan sponsor dashboard.
Plan sponsor remits subsidy contribution	15th	• Subsidy paying plan sponsors remit their subsidy contributions to TIAA. • Such subsidy contributions are automatically invested in the money market fund of the Employer VEBA. *Subsidies remitted to "Source D" are directed to the money market fund and are restricted from being transferred elsewhere. They may only be used for insurance premiums. If you want to allow the subsidy to be used for QME reimbursements, it must be remitted to "Source F." We strongly caution you that remitting to other than Source D may result in a larger draw from the retiree's personal account to pay the insurance premium.*

Monthly premium payment cycle (cont'd)

Step	Date (each month)	Premium payment step
CBIZ draws retiree premium contributions from personal accounts	On or about the 23rd	**A retiree premium contribution (via ACH) is transacted if A > B, as follows:** A = Current billed premium, plus monthly fees expected to be drawn from the retiree's Health Account at end of the current month B = Source D balance + Source H balance + 95% of remaining balance • Account balances for this purpose are based on values as of the ACH assessment date. • If a retiree premium contribution is transacted, it is always for the full value of A. Retiree premium contributions are transacted via an ACH debit against the account holder's personal bank account. Such contributions are remitted to TIAA on the business day following the ACH draw date. These retiree premium contributions are invested in the money market fund of the Employee VEBA and are categorized as Source H.
Premium payments taken from VEBA/Grantor Trust accounts	Second to the last business day	CBIZ remits a monetary transaction fund (MTF) to TIAA, indicating the premium payments due per retiree. TIAA takes associated funds from VEBA/Grantor Trust.
Premium payment distributed to carriers	First business day of the next month	CBIZ sends an email to TIAA indicating the total amount due to each carrier. TIAA distributes the funds to the carriers.

Account usage hierarchy (insurance premiums)

To cover the retiree's portion of the monthly premium, funds are drawn from his/her plan accounts as outlined below:

1. **Allocation across "Accounts"**
   a. The following hierarchy is applied for insurance premium payments: Grantor Trust, then Employer VEBA, then Employee VEBA.
   b. CBIZ communicates to TIAA the specific amounts to pay from each account.

2. **Allocation within "Accounts" (by source)**
   a. Insurance premium payments are allocated by the trustee pro-rata across sources within each VEBA.
   b. Insurance premium payments are allocated by the trustee pro-rata across investment funds within each VEBA.

3. **Source H (Retiree contribution via ACH debits from personal account)**
   a. Upon deposit, Source H funds are invested in the TIAA-CREF Money Market Fund.
   b. Source H funds are restricted from ever being transferred to a different investment fund.
   c. Source H funds are restricted from QME disbursement.

4. **Source D (Employer contribution solely intended as retiree premium subsidy)**
   a. Upon deposit, Source D funds are invested in the TIAA-CREF Money Market Fund.
   b. Source D funds are restricted from ever being moved to a different investment fund.
   c. Source D funds are restricted from QME disbursement.

Unpaid premiums and coverage cancellation

For the Aetna-insured population

Upon receipt of a $0 payment, Aetna sends a late notice to the retiree. If there is a $0 payment for the subsequent month, Aetna cancels coverage and sends a cancellation notice to the retiree. The effective date of cancellation is the end of the month for which the retiree paid the last full premium.

Aetna may also cancel coverage in the event of a Centers for Medicare and Medicaid Services error notification to Aetna.

In the event Aetna terminates a retiree's coverage (regardless of whether due to a Centers for Medicare and Medicaid Services error notification or nonpayment), Aetna will communicate that change to CBIZ. Upon such notification, CBIZ will record the coverage termination in the CBIZ system.

For the HealthPartners population

As with the Aetna population, if a full premium cannot be paid, $0 is paid for that month. In that event, HealthPartners initiates a cancellation of insurance (a 30-day process). If the retiree is able to pay the next month, CBIZ notifies HealthPartners once that is known, so HealthPartners can reinstate coverage for the retiree.

Section 5

APPENDIX A: STATUS CODE DEFINITIONS

emeriti®
RETIREMENT HEALTH

Emeriti employee status codes and descriptions

0 Active status with account holder voluntary contributions (to Employee VEBA)

1 Active status with employer contribution (to Employer VEBA or to Grantor Trust)

V Terminated status—vested or non-vested:

- If vested, eligible for Reimbursement Benefit only (with employee assets, and employer contributions)
- If non-vested, eligible for Reimbursement Benefit only with employee assets only, employer contributions are forfeited

4 Retired status—met eligibility for Emeriti Health Insurance

6 Deceased status

5 Disabled status

L Leave of Absence status

3 Military Leave status

Important

- Each account holder will have only one Emeriti status code reported on the file.
- A new Emeriti status code will override any prior Emeriti status code that was submitted.
- New hires/new enrollees initially will be coded as a 0 or a 1.
- At a future date an account holder's Emeriti status code will change due to termination, retirement or leave.
- An Emeriti status code submitted on a remittance file will override any previously requested manual status code updates.

Where to Apply Emeriti Status Code Changes

- Via the TIAA PlanFocus® website
- Column AE on the SOPS remittance file
- Record Type 22, Field 9 on the OPS remittance file

Section 5

APPENDIX B: SOURCE CODE DEFINITIONS

emeriti®
RETIREMENT HEALTH

Contribution source code definitions

Emeriti Money Source Coding and Descriptions

VEBA TRUSTS

- Source F – Employer Contribution
- Source K – Employee Contribution
- Source D – Employer Insurance Premium Subsidy—exclusively for Aetna and HealthPartners' insurance subsidies
- Source G – Employee Mandatory Contribution
- Source H – Participant ACH Contribution (Debited by CBIZ)
- Source Q – Personal After-Tax Contributions made via the public website

GRANTOR TRUST

- Source F – Employer Contribution

Section 5

APPENDIX C: FORMS AND COMMUNICATIONS

emeriti®
RETIREMENT HEALTH

Emeriti call tree

1-866-EMERITI (363-7484)
Mon – Fri 9am – 5:30pm EST

NOTE: TIAA phone reps only
Mon – Fri 8am – 10pm EST
Sat 9am – 6pm EST

CALL
1-866-EMERITI

MAIN MENU STANDARD (1020)

"You will have 3 choices: For questions about Health Insurance, **PRESS 1**. Reimbursement Benefit, **PRESS 2**. Health Account Balances, Investments, or change of address, **PRESS 3**."

1 HEALTH INSURANCE MENU STANDARD (1025)

To enroll in Emeriti health insurance, or learn more about the Emeriti Program, **PRESS 1**. To speak with an Aetna representative, **PRESS 2**. To speak with a HealthPartners representative, **PRESS 3**."

1 ENROLL, LEARN
CBIZ REP (1049)
1-866-915-3852

2 AETNA MENU
(1050)

"If you are calling about Aetna's insurance plans for individuals under age 65, **PRESS 1**. For Medicare Advantage or prescription drug plans, **PRESS 2**. For other retiree medical plans, **PRESS 3**. For Dental plans, **PRESS 4**."

MEMBER ID CARD REMINDER
Having your member ID card ready will save you time.

1 AETNA - PRE-65
1-800-545-0247

2 AETNA - MEDICARE/ PRESCRIPTION
1-888-267-2637

3 AETNA - OTHER RETIREE
1-800-545-0247

4 AETNA - DENTAL
1-877-238-6200

3 HEALTHPARTNERS
HP REP (1052)
1-800-233-9645

2 REIMBURSEMENT
CBIZ REP (1049)
1-866-915-3852

3 BALANCES, INVESTMENTS, ADDRESS CHANGE
TIAA REP (1035)

MAIN MENU
ANNUAL ENROLLMENT (2000)

"For questions about Annual Enrollment Health Insurance, **PRESS 1**. Reimbursement Benefit, **PRESS 2**. Health Account Balances, Investments, or change of address, **PRESS 3**."

HEALTH INSURANCE MENU
ANNUAL ENROLLMENT (2025)

"For Annual Enrollment, or to learn more about the Emeriti Program, **PRESS 1**. To speak with an Aetna Representative, **PRESS 2**. To speak with a HealthPartners Representative, **PRESS 3**."

Aetna Medicare Advantage provider flyer

How to accept and bill claims for the Aetna Medicare℠ Plan (PPO) with Extended Service Area (ESA)

Your patient's plan is a customized group Aetna Medicare Advantage PPO plan with Extended Service Area (ESA). Under this plan, members pay the same amount whether they visit in-network or out-of-network providers.

Your patient's services will be covered as long as you are:

- Eligible to receive payment from Medicare, and
- Willing to accept the plan.

About the plan

The Aetna Medicare Advantage ESA PPO plan provides all the benefits of Original Medicare—and more. The plan includes coverage for unlimited hospitalization and certain preventive/wellness services beyond what Medicare covers. It also features:

- No contract
- Medicare rates for doctors who do not participate for good order claims (less member copayments, coinsurance or deductible, as required under Medicare Advantage regulations and the member's plan)
- One bill and one payment
- No referrals required
- Precertification recommended, but not required
- ID card indicating "Medicare ESA PPO" below Aetna logo

Claims instructions for your staff

For Aetna Medicare Advantage ESA PPO patients, your staff should:

- Collect the patient's copayment for covered expenses
- Submit all good order claims for covered services for payment
- Submit the patient-paid amount on claim

Aetna will process claims using:

- Original Medicare billing rules
- The Medicare fee schedule
- Prospective payment system requirements
- Local Coverage Determinations (LCDs)
- The patient's plan documents, including Evidence of Coverage

Medicare-limiting charges will apply. Aetna uses the Correct Coding Initiative (CCI) for bundling/unbundling logic. For more information, use the CCI link on the CMS website: **www.cms.gov/nationalcorrectcodinited/.**

More information about doing business with Aetna

Go to **www.aetnaeducation.com** for training and resources. Search for "Medicare Advantage."

We're here to help you and your Aetna Medicare Advantage plan patients.

Call us at **1-800-624-0756 (TTY: 711)**, weekdays, 8 a.m. to 5 p.m., local time.

Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. Our Special Needs plans also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal. See Evidence of Coverage for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, provider network, premium and/or copayments/co-insurance may change on January 1 of each year. Plans are offered by Aetna Life Insurance Company (Aetna).

You must continue to pay your Medicare Part B premium. Discount offers provide access to discounted services and are not part of an insured plan or policy. Discount offers are rate-access offers and may be in addition to any plan benefits. The member is responsible for the full cost of discounted services. Aetna may receive a percentage of the fee paid to a discount vendor.

Medicare evaluates plans based on a five-star rating system. Star ratings are calculated each year and may change from one year to the next. This material is for informational purposes only and is not medical advice. Health information programs provide general health information and are not a substitute for diagnosis or treatment by physician or other healthcare professional. Contact a healthcare professional with any questions or concerns about specific healthcare needs. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna is not a provider of healthcare services and, therefore, cannot guarantee any results or outcomes. The availability of any particular provider cannot be guaranteed and is subject to change. Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, refer to **www.aetnamedicare.com**.

Medicare Medical Claim Reimbursement Instructions

aetna®

How to complete this Medical Claim Reimbursement Form

When to use this form?

1. Fill out this form if you're asking for a medical, dental, vision, hearing, or vaccine reimbursement and you paid a doctor, healthcare professional, or service provider who did not bill us directly.
2. Don't use this form for prescription drug claim reimbursements. Visit **www.aetnamedicare.com** or call the member services number on your Aetna member ID card for a prescription drug claim form.

How to fill out this form?

1. Complete each section. Print clearly in black ink only, or type the information in the form online.
2. Sign and date the bottom of the completed form. Appointed representatives must have an Appointment of Representative form on file with the health plan, or you can submit one with this form. You can find an Appointment of Representative form on **www.aetnamedicare.com**.

Where to send the completed form?

1. Make copies of all of your receipts and itemized bills from your provider. Be sure to include your Aetna member ID number on each receipt and bill. All materials submitted will be retained by us and cannot be returned to you.
2. Mail this completed form and your original receipts and itemized bills to the medical claims address on your Aetna Medicare member ID card.
3. Or you can fax this completed form, your original receipts and itemized bills to **1-866-474-4040**.

Things to remember

1. Please submit this form within 365 days from the date you received the service or item.
2. If your request is incomplete, we'll return it to you and this will delay processing.
3. If the provider you paid is contracted with us, we will always pay the provider directly at the contracted rate. You should ask the provider to pay you back.
4. If we approve your request, it can take up to 45 days to send payment once we have all the required information.

Questions?

We're here to help. Just give us a call at the number on your Aetna Medicare member ID card.

Acknowledgement

You understand it is a crime to fill out this form with information you know is false. You understand that submission of a claim is not a guarantee of payment, or payment in the full amount. You understand if the services are deemed covered services then the health plan will reimburse you up to the benefit amount minus any applicable deductibles, coinsurance, or copayments. You understand we may need to disclose the information on the form to other persons and entities to process the claim.

Medicare Medical Claim Reimbursement Form

aetna®

Member information *(print clearly)*

Aetna member ID number:

Date of birth *(MM/DD/YYYY):* / /

Male ❑ **Female** ❑

Last name:

First name:

Middle initial:

Street address:

City:

State:

ZIP code:

Phone number *(with area code):* – –

Email address:

Doctor, healthcare professional or supplier information

Provider or supplier name:

Street address:

City:

State:

ZIP code:

Phone number *(with area code):* – –

Email address:

Claim request *(information must match your itemized bill)*

Date of service *(MM/DD/YYYY):* / /

Amount paid: $, .

Reimbursement type:

❑ Medical ❑ Dental ❑ Vision
❑ Hearing ❑ Vaccine ❑ Other

Description of procedure(s), service(s), or item(s) *(include procedure code if available)*:

Signature

By signing and submitting this form, you certify that the information is true and correct.

_____ _____

Member or authorized representative signature **Date**

Important disclaimers

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Alabama Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof. **Arkansas, District of Columbia, Rhode Island and West Virginia Residents**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **California Residents:** For your protection California law requires notice of the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. **Colorado Residents:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies. **Florida Residents:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. **Kansas Residents**: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law. **Kentucky Residents**: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. **Louisiana Residents**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application is guilty of a crime and may be subject to fines and confinement in prison. **Maine and Tennessee Residents**: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits. **Maryland Residents**: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Missouri Residents**: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, denial of insurance and civil damages, as determined by a court of law. Any person who knowingly and with intent to injure, defraud or deceive an insurance company may be guilty of fraud as determined by a court of law. **New Jersey Residents**: Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. **New York Residents**: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation. **North Carolina Residents**: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and subjects such person to criminal and civil penalties. **Ohio Residents**: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. **Oklahoma Residents**: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. **Oregon Residents:** Any person who with intent to injure, defraud, or deceive any insurance company or other person submits

an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law.
Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. **Puerto Rico Residents**: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years. **Texas Residents**: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any intentional misrepresentation of material fact or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. **Vermont Residents**: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. **Virginia Residents**: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties. **Washington Residents**: It is a crime to knowingly provide false incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. Our SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, and/or co-payments/co-insurance may change on January 1 of each year. See Evidence of Coverage for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

NR_0009_10581 09/2017

emeriti® RETIREMENT HEALTH

Reimbursement Claim Form

How to Submit a Reimbursement Claim

We offer three easy ways for you to access your healthcare account funds. **For the fastest results, we encourage you to use your Rx debit card for prescription drug reimbursements (if applicable) or to submit your claim online.**

Rx Debit Card

- Use your Rx debit card to directly pay for prescription drugs at your pharmacy.
- **Save your receipts!** When you swipe the card, a claim is created for you and eliminates the need for you to fill out a claim form. However, documentation may still be required. If a receipt is needed, you will be notified by letter within two weeks of your Rx debit card swipe.

Online Claim Submission

- Go to **MyEmeritiBenefits.org** and sign in with your user name and password. Click on the Reimbursement Benefit link and follow the instructions to upload your claim form and copies of your receipts.

Paper Claim Submission

- If you didn't use your Rx debit card and are unable to access the Internet, complete the manual claim form.
- Mail or fax it to **215-563-9943** with itemized receipts or other documentation, per the instructions below. When you fax the manual claim form and supporting documentation, there is no need to follow up with a hard copy in the mail. Remember to keep the original claim form and supporting documents for your records.
- If you choose to mail your claim form and documentation instead of faxing, the address is:

  CBIZ
  3000 Chestnut St. #8569
  Philadelphia, PA 19104-9998

If you have any questions, please call the Emeriti Service Center at 866-363-7484 and press option #2.

If this Claim Form is being completed by a legal representative of the participant (e.g., guardian, individual with power of attorney, executor), please submit appropriate proof for basis of authority with this claim.

07/22

emeriti® RETIREMENT HEALTH

Reimbursement Claim Form

Use this form to submit your claims for reimbursement of eligible medical expenses paid out of pocket that have not already been submitted.

- Do not use this form if expenses were already paid with your Rx debit card.
- Complete all entries on this submission form. Please print or type.
- Sign and date this form.
- Fax or mail it, along with the required documentation, to the Emeriti Service Center. (See instructions above.)

** IMPORTANT: Reimbursements are paid with money in the TIAA-CREF Money Market Mutual Fund **

Keep in mind that your employer contributions are defaulted into an age-appropriate TIAA-CREF Lifecycle Mutual Fund, so **you'll need to move money into the TIAA-CREF Money Market Mutual Fund in order to be reimbursed**. To transfer money into the TIAA-CREF Money Market Mutual Fund (or set up monthly transfers), **please call 866-363-7484 and press option #3**. You may also log in to your account at **TIAA.org** and follow the instructions.

Personal Information	
Name	Social Security Number
Street Address	Daytime Phone Number
City, State, Zip Code	Email Address
Institution	Date of Birth

Participant Eligibility

☐ I am eligible to receive reimbursement benefits because I no longer work for the employer sponsoring the plan.

emeriti® RETIREMENT HEALTH

Reimbursement Details

You must submit documentation with this form. Documentation must include the patient's name, description of service, date of service and amount charged. Cancelled checks, credit card receipts or balance forward statements are not acceptable. Examples of acceptable documentation include a copy of the Explanation of Benefits (EOB) from your insurance company, an itemized statement from a provider, or an itemized pharmacy receipt.

Date of Service	Patient Name	Date of Birth	Relationship to Retiree	Social Security Number	Name of Provider	Description of Service	Amount Requested	Set up as Recurring Claim? (Yes/No)

Total _____

Authorization and Certification

Read carefully. This claim will not be processed without your signature.

I certify that these expenses have been incurred by me or by my eligible spouse or dependent. The expenses have not been reimbursed and are not reimbursable under any other plan, such as a group medical plan, individual policy, or spouse's or dependent's plan. I understand that any amount reimbursed may not be used to claim any federal income tax deduction or credit on my or my spouse's or my dependent's income tax return. I understand that it is my responsibility to determine whether distributions are for qualified expenses and for any tax consequences that may occur.

I further certify that I understand that any person who, knowingly and with intent to defraud or deceive, files a claim containing any materially false, incomplete or misleading information may be prosecuted under state law and be subject to civil fines and criminal penalties. I hold CBIZ, its affiliated companies, officers, and employees, Emeriti Retirement Health Solutions, its officers and employees, TIAA Trust Company, its affiliated companies, officers and employees, and my Plan harmless for payment of any ineligible expenses presented in such a manner under the terms and conditions of the Emeriti Reimbursement Benefit.

Signature _____ **Date** _____

07/22

Emeriti Banking Information and Electronic Transfer Form

Participants in the Emeriti Program who have insurance coverage under the Program are required to complete this form in order to provide banking authorization to CBIZ, an Emeriti service provider, to facilitate timely payment of premiums from your personal bank account when insufficient funds remain in your Emeriti Health Account. By signing this Banking Information Form, CBIZ is able to perform two valuable benefit services on your and your eligible dependents' behalf:

1. Withdraw Insurance Premium Payments via electronic transfer (ACH) from your selected bank account, and

2. Deposit Qualified Medical Expense Reimbursements via electronic transfer (ACH) into your selected bank account.

Section A - Election of Benefit Payments and Benefit Deposits

Insurance Premium Payments via Electronic Transfer (ACH withdrawals)
(required when you elect Emeriti Health Insurance coverage)

☐ I (we) hereby authorize CBIZ to initiate debit electronic transfers (ACH) from my (our) selected bank account when there are not remaining sufficient funds in my Emeriti Health Account to pay for my (our) insurance premiums. I understand that these ACH funds will be deposited into my Emeriti Health Account and will be invested in the TIAA-CREF Money Market Fund to maintain a stable value until used to pay for my (our) health insurance premiums. I further understand that these ACH funds will be restricted from being transferred to any other investment option.

Qualified Medical Expense Reimbursements via Electronic Transfer (ACH deposits)
(optional if you use the Reimbursement Benefit)

☐ I (we) authorize CBIZ, to initiate credit electronic transfers (ACH) into my (our) selected banking account with the Financial Institution named below for reimbursement of Qualified Medical Expenses (QME) deducted from the available balance in my Emeriti Health Account.

By signing this Banking Information Form, I (we) also authorize CBIZ to initiate, if necessary, any adjustments or refunds of my Emeriti benefits electronically (ACH) to and from my (our) selected banking account.

NOTE: I (we) acknowledge that all electronic transfers (ACH) to and from my (our) selected banking account must comply with the provisions of applicable U. S. Laws.

Section B – Financial Institution

Bank Name _____

Branch Name _____

Routing Number _____ Account Number _____

Account Type: ☐ Checking ☐ Savings ☐ Other (Specify) _____

Bank Address

Street Address _____

City _____ State _____ Zip Code _____

Bank Representative _____ Telephone Number _____

Please verify all information with your financial institution or attach a voided check in this Section B
Please be sure to inform the Emeriti Retiree Benefits Center whenever any of the banking information listed above changes.

Emeriti Banking Information and Electronic Transfer Form

Section C - Plan Participant (and co-account holder) Authorization

This authorization is to remain in full force and effect until CBIZ has received written notification of termination from me (or either of us), and in such time and manner as to afford CBIZ and my (our) Financial Institution a reasonable opportunity to act on the change.

Plan Participant

Signature	Date
Name (please print)	Social Security Number (last 4 digits)
Telephone Number	Email (if available)

Co-Account Holder (if applicable)

Signature	Date
Name (please print)	Social Security Number (last 4 digits)

MAIL TO: (using enclosed envelope)

CBIZ
3000 Chestnut Street #8569
Philadelphia, PA 19104-9998

OR FAX TO:

CBIZ
215-563-9943

emeriti®
RETIREMENT HEALTH

Emeriti, TIAA, Aetna Life Insurance Company, and other service providers are independent corporations and are not legally affiliated. The full name of Emeriti Retirement Health Solutions is The Emeriti Consortium for Retirement Health Solutions, an Illinois Nonprofit Corporation. Emeriti Retirement Health Solutions is not an insurance company, insurance broker or insurance provider.

Interests in the retirement healthcare program are offered solely by the employer. Teachers Insurance and Annuity Association of America (TIAA) will provide services to the plan and may issue plan communications on behalf of the plan sponsor in its capacity as a plan recordkeeper.

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